MENTAL HEALTH AND EMERGENCY SERVICES MEMORANDUM OF UNDERSTANDING

2010

SA HEALTH
SA AMBULANCE SERVICE
ROYAL FLYING DOCTOR SERVICE
SOUTH AUSTRALIA POLICE

Royal Flying Doctor Service
CENTRAL OPERATIONS

Government of South Australia
SA Health

SA
Ambulance
Service

FOREWORD

People who have a mental illness or mental disorder, or who exhibit behaviours of community concern may require a response by multiple agencies, including SA Health, South Australia Ambulance Service (SAAS), Royal Flying Doctor Service (RFDS) and South Australia Police (SAPOL), to ensure safe transport and timely access to assessment and treatment services.

The primary consideration is facilitating assessment and treatment for individuals in the least restrictive environment, through collaborative practices that ensure safety and management of identified risks.

The 2010 Mental Health and Emergency Services Memorandum of Understanding (MHMoU) is written in the context of the Mental Health Act, 2009 and has been developed to establish an agreed framework for agencies involved in the management of such situations. Consultation has occurred with local liaison groups, consumer and carer advisory groups convened via the Mental Health Unit, the signatory parties, GP SA and the Mental Health Coalition of South Australia.

The revised MHMoU acknowledges the service developments undertaken by a number of agencies since the implementation of the 2006 Memorandum. It also acknowledges the work of the Local Liaison Groups across the state in implementation and further development of collaborative practice.

The MHMoU commits the signatory parties to work in cooperation to promote a safe and coordinated system of care and transport, and defines the roles and accountabilities of the agencies throughout the process of ensuring access to assessment and treatment. Successful implementation and operation of this MHMoU and the *Mental Health Act 2009* requires a commitment from all participating and signatory parties to work cooperatively to develop protocols and procedures which address local needs. This includes the provision of ongoing education and the development and review of policies.

This MHMoU supersedes the 2006 MHMoU and all previous memoranda and will be effective from the date of the last signature. Whilst the MHMoU will be evaluated on a bi-yearly basis, it will remain in effect unless it is revoked, varied or modified in writing by signatory parties.

An Aboriginal Health Impact Statement has been developed by SA Health on behalf of the signatory agencies, following consultation.

We commit to and commend this MHMoU and endorse its implementation.

Dr Tony Sherbon
Chief Executive
SA Health

14 **July 2010**

Mal Hyde
Commissioner of Police
South Australia Police

12 **July 2010**

Ray Creen
Chief Executive Officer
SA Ambulance Service

8th **July 2010**

John Setchell
Acting Chief Executive Officer
Royal Flying Doctor Service

7th **July 2010**

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GLOSSARY OF TERMS

Please refer to the *Mental Health Act 2009* for definitions of categories of workers and an explanation of responsibilities.

Approved Treatment Centre—means a place determined by the Minister under Part 12 Division 5 of the *Mental Health Act, 2009* to be an Approved Treatment Centre;

Flinders Medical Centre.
Lyell McEwin Health Service.
Modbury Public Hospital.
Noarlunga Health Service.
Repatriation General Hospital.
Royal Adelaide Hospital.
Queen Elizabeth Hospital.
Women's & Children's Hospital.
Adelaide Clinic.
Glenside Campus.
James Nash House.
Oakden Services for Older People.

Limited Treatment Centre—means a place determined by the Minister under Part 12 Division 5 of the *Mental Health Act 2009* to be a Limited Treatment Centre;

Berri Hospital
Mt Gambier Hospital
Pt Lincoln Hospital
Whyalla Hospital

Commencement of these hospitals as Limited Treatment Centres is to be determined.

Mental Health Escort Officers—means a mental health escort officer employed by the SA Ambulance Service to transport mental health patients.

1. CONTEXT

The signatory parties to the Mental Health and Emergency Services Memorandum of Understanding (MHMoU) are SA Health, SA Ambulance Service (SAAS), Royal Flying Doctor Service (RFDS) and the South Australia Police (SAPOL). The significant contribution of general practitioners across South Australia in assessment, treatment and coordination of transport is acknowledged, although they are not signatories to this MHMoU. The primary responsibility for the safe assessment, transport and treatment of people with a mental illness lies with health professionals. The signatory parties acknowledge and accept their obligations pursuant to the *Mental Health Act 2009, Section 269 Criminal Law Consolidation Act (Amended), 1935* and *the Guardianship and Administration Act, 1993* and agree to work in cooperation to promote a safe and coordinated system of care and to ensure the efficient and effective use of signatory resources.

To ensure minimal interference with the rights, dignity and self respect of individuals and taking into account the proper protection and care of the individual and protection of the community, the use of SAPOL resources shall be considered an option of last resort, to ensure the safety of the individual and all others involved.

The MHMoU should be read in conjunction with:

- The *Mental Health Act 2009*, the Clinician's Guide and Code of Practice;
- *Transportation of Mental Health Patients from Country South Australia to Metropolitan Services—Guidelines and Protocols*. (Country Health SA);
- The *South Australian Carers Recognition Act 2005*;
- The Australasian Triage Scale (Australasian College of Emergency Medicine); and
- All relevant organisation specific policies and procedures.

2. MEMORANDUM DOES NOT HAVE LEGAL EFFECT

This Memorandum does not have legal effect, although Section 59(3) of the *Mental Health Act 2009* advises that Authorised Officers, Police and other persons engaged in the administration of this Act should endeavour to comply with the provisions of a Memorandum of Understanding approved by the Minister.

The relationship between the signatory parties is that of independent entities with the several rights, liabilities, duties and obligations described in this MHMoU and relevant legislation.

No party has the authority to act for or to incur any liability or obligation on behalf of another without first obtaining their express written consent.

3. OBJECTIVES

The objectives of this MHMoU are:

- To ensure individuals with a known or suspected mental illness or mental disorder, or who exhibit behaviours of community concern, are identified, assessed, treated and if appropriate, transported to a health facility in the least restrictive and timely manner, and consistent with the person's needs; and

- That signatory parties and service partners work in a collaborative manner which addresses the safety of the individual, the workers involved and the community.

4. OUTCOMES

This MHMoU will provide:

- Improved access to assessment and treatment for people with a mental illness or who exhibit behaviours of community concern.
- An agreed description of the processes to be undertaken by each agency to ensure safe transport, timely access to assessment and treatment:
  - A clear process to enable Police prisoners detained under the *Mental Health Act 2009* to access a secure Approved Treatment Centre.
  - A clear process to enable forensic mental health clients to be returned to MHS.
- Agreed operational protocols.
- The establishment of agreed data sharing processes to monitor the performance of the MHMoU.
- Agreed governance, via the Local Liaison Groups and the Mental Health and Emergency Services Memorandum of Understanding Steering Committee:
  - A commitment to agreed standards for the provision of services.
  - Interagency co-operation with respect to service delivery, joint problem solving and information sharing.
  - An agreed dispute resolution process.
  - Provide a structure for continuous improvement by reviewing protocols and processes, dispute resolution and performance monitoring.
  - A clear delineation of the accountabilities of signatory parties.
  - The establishment of a central coordination point within SA Health to monitor and resolve dispute resolution processes.

5. PRINCIPLES

The signatory parties commit to the following principles:

- The right of individuals to retain their freedom, rights, dignity and self respect as far as is consistent with their protection, the protection of the public and the proper delivery of the services.
- The rights, welfare and safety of carers, family members, children and other dependants of persons with a mental illness should always be considered and protected as far as possible.
- Individuals should receive timely access to specialist emergency mental health assessment and care (including safe transport to an appropriate health facility) based on the individual's needs and in the least restrictive manner. This should be provided on a voluntary basis as far as possible and should occur as near as practicable to where the person resides.

5.1 Service Principles

- The safety and welfare of the person with a mental illness, and others will be the primary decision making consideration;

- The rights, welfare and safety of the children and other dependants of patients should always be considered and protected as far as possible;
- Provision of assistance to any aged, infirm or child dependants or animals of a person with a mental illness who is assessed and requires treatment;
- The vision of the Premier of South Australia's vision of zero harm for the South Australian Public Sector (2007-1010) through :
  - A sustainable commitment, allowing every employee to feel safe at work; financial accountability, whereby safety performance promotes our competitive advantage;
  - Integrated risk management, which improves and embeds our safety culture; and
  - Rigorous evaluation, which assures our safety performance supports the objectives of South Australia's strategic Plan
- The need for efficient and effective use of signatory resources in assessment, detention, safety, transport and restraint;
- The requirement to work collaboratively with respect to the provision of mutual assistance, information sharing and the development of operational protocols to ensure best care is paramount and given priority;
- Current relationships that facilitate collaborative practice around individuals who have a known or suspected mental illness or who exhibit behaviours of community concern are to be supported and encouraged;
- The management of safety using appropriate assessment, planning and risk minimisation strategies including the provision of appropriate training and equipment;
- The involvement of Police is to apprehend individuals subject to legislation where no other option exists and / or assisting where there is a risk of serious harm to people or property which is current or imminent, or acting as a referral agency.

6. ROLES & RESPONSIBILITIES

6.1 Mental Health Services

- Please refer to the *Mental Health Act 2009* and any accompanying explanatory documents for an outline of roles and responsibilities.

6.1.1 Metropolitan Adult Mental Health Services

- Provide a 24 hour service within metropolitan Adelaide, to assist in ensuring that mental health consumers presenting in crisis situations are assessed and treated according to need. This includes Police custodial facilities and may include arranging transportation and sedation of an individual in preparation for transport.
- Provide systems to support requests for assistance from other signatories to this MHMoU as soon as possible.

- Arrange the attendance of a Medical Practitioner or an Authorised Health Professional to undertake an assessment and coordinate transport.
- Provide a metropolitan wide consultation and liaison service for mental health consumers and signatories to this MHMoU.
- Arrange access to available inpatient beds at an Approved Treatment Centre for metropolitan mental health consumers.
- Provide mental health assessment, clinical and safety risk assessments, care and behavioural management for people experiencing a mental illness or mental health disorder or who are at risk. This includes the facilitation of air transport from country or remote areas.
- Mental Health Services staff use their own organisational communication and documentation processes, and will provide all relevant information regarding an individual to the receiving service at the point of transfer.

6.1.2 Country Mental Health Services

- Provides mental health assessment and treatment services in inpatient and community based settings. This includes requesting the attendance of a Medical Practitioner or Authorised Health Professional to undertake an assessment, organise transport and coordinate or provide sedation of an individual prior to transport.
- Provides mental health assessment and intervention in crisis situations when requested by carers, family members, members of the public or MHMoU signatory agencies and service partners.
- Provides systems to support requests for assistance from other signatories to this MHMoU as soon as possible. This includes Police requests for assistance at custodial facilities when persons in Police custody whose behaviour may warrant a mental state examination.
- Provides continuation of involvement until a decision has been reached regarding future management and an appropriate transfer carried out. This may be continued via the Rural and Remote Emergency Triage and Liaison Service.
- Provides a consultation and liaison service.

6.1.3 Rural and Remote Emergency Triage and Liaison Service (R&RETLS)

- Provides or coordinates a 24 hour crisis assessment and intervention service in country areas, to assist in ensuring that mental health consumers are assessed and treated according to need.
- Provides a country state-wide consultation and liaison service for mental health consumers and signatories to this MHMoU.

- Facilitates Police requests for assistance at custodial facilities when persons in Police custody display behaviour that may warrant mental state examination.
- Continues their involvement until a decision has been reached regarding future management and care and an appropriate transfer carried out.
- Coordinates access to inpatient beds at an Approved Treatment Centre or Limited Treatment Centre for mental health consumers.
- Consults with MedSTAR and the Royal Flying Doctor Service regarding any identified need for a retrieval service.

6.1.4 Forensic Mental Health Service

- Provides specialised forensic mental health assessment, risk assessment and treatment and management of consumers during usual working hours. This includes arranging the attendance of a Medical Practitioner or an Authorised Health Professional to undertake an assessment if required, and / or coordinating, and organising transportation.
- Provides a 24 hour consultation and liaison service to signatories to this MHMoU and other stakeholders.
- Provides 24 hour coordination of access to inpatient beds at James Nash House and other Approved Treatment Centres.

6.1.5 Child and Adolescent Mental Health Service

- Provides a statewide service during usual working hours through its northern and southern offices, via the Child Youth and Women's Health Service and regional locations.
- Provides a 24 hour service via the Pediatric Emergency Department, Women's and Children's Hospital.

6.1.6 The Mental Health Triage Service

- Provides a 24 hour emergency consultation service to MHMoU signatory parties and service partners.
- Maintains a single point of contact for any service requests to metropolitan mental health services.

6.1.7 Hospital Emergency Departments

- Provide safe and secure assessment and treatment facilities.
- Provide a secure environment for Police prisoners who have been detained under the *Mental Health Act 2009* within the facility or organise the transport of that person to a secure facility. This currently excludes the Modbury Hospital and non metropolitan hospitals due to resources.
- Have the capacity for a Medical Practitioner or an Authorised Health Professional to assess and treat a person presented by Authorised Officers (Section 56) or by Police (Section 57) where safety risks can be managed.

- Acknowledge receipt of information from another agency at the point of transfer of an individual's care by completion of the Mental Health Assistance form.
- Have established internal procedures and security systems (including provision of security staff) for handling emergencies involving violence or threats of violence.
- Coordinate any required transport for people who are transferred from their facility to another facility.

6.2 The SA Ambulance Service

Please refer to the *Mental Health Act 2009* and any accompanying explanatory documents for an outline of roles and responsibilities

- Provide a 24 hour emergency consultation service to signatory agencies.
- Provide clinical assessment, management and transport of a person pending a mental health assessment.
- Provide assessment and management of a person including any need for apprehension and transport pending a mental health assessment by a Medical Practitioner or Authorised Health Professional**.** (Section 56 *Mental Health Act, 2009*).
- Provide and/or coordinate transport as requested by:
  - A Medical Practitioner or Authorised Health Professional (using a detention and / or transport request); or
  - Director of an Approved Treatment Centre or Limited Treatment Centre; or
  - Authorised Officers; or
  - Police.
- Provide an effective handover to an Approved Treatment Centre or Limited Treatment Centre or other hospital.
- Provide other assistance as requested by an Authorised Health Professional, Medical Practitioner, Authorised Officer and a Director of a Treatment Centre or Police.
- Provide clinical direction in the safe restraint and sedation of disturbed patients.
- Ensure safe and appropriate clinical care and supervision during transport of mental health patients including collaboration with other health professionals (including Mental Health Escort Officers and retrieval services) as required.

6.3 Royal Flying Doctor Service

Please refer to the *Mental Health Act 2009* and any accompanying explanatory documents for an outline of roles and responsibilities.

- Provide ongoing assessment, treatment, chemical or mechanical restraint during transport.
- Provide clinical assessment, management and transport of a person pending a mental health assessment.
- Provide transport as requested by a Medical Practitioner or Authorised Health Professional.

- Provide information about their assessment and treatment of a person who requires further treatment at the point of handover of care.

6.4 South Australia Police

Please refer to the *Mental Health Act 2009* and any accompanying explanatory documents for an outline of roles and responsibilities.

- Police involvement is restricted to compliance with legislative obligations and intervention where there is a risk of serious harm to people or property which is current or imminent or acting as a referral service.
- Ensure public safety at the request of signatory agencies when there is a serious risk to an individual or others which is assessed as current or imminent. On attendance Police will determine the need for its continuing involvement based on the safety risk assessment and risk minimisation strategies used.
- If Police accept a transfer of risk based on a safety risk assessment, then Police will determine their involvement and how the risk is managed until the risk is minimised to a safe and acceptable level and will then have the capacity to depart. This process will be undertaken in consultation with other agencies.
- Provide an effective handover of information and the outcome of any assessment at the point of transfer of care by using the Mental Health Assistance Form.

7. STANDARDS

Signatory parties commit to and agree to the requirements for and delivery of agreed and measurable standards by ensuring that:

- Health professionals including Authorised Officers and Mental Health Clinicians (*Mental Health Act 2009*) provide the primary response for safe assessment, apprehension, detention (under the *Mental Health Act 2009*), transport and treatment of individuals suffering a mental illness.
- Each party initiates a single point of contact for the coordination of service requests;
- Each agency is accountable for the application of their specific policies in the implementation of the MHMoU. No policies will be implemented that may impact on another party without consultation.
- Each agency provides information to assist assessment and treatment at the point of transfer of the individual. Staff use their own organisational communication and documentation processes, and will provide all relevant information regarding an individual to the receiving service at the point of transfer.
- Local and organisational processes are implemented to facilitate, monitor and evaluate the implementation of the MHMoU.
- Agreed standard inter agency documentation is developed, promoted and utilised.
- Accountabilities as outlined within Section 6—Roles and Responsibilities of this MHMoU are actioned.

7.1 Assessment Standards

- The definition of mental illness within the *Mental Health Act 2009* is recognised as the basis for a clinical assessment.
- All signatory parties and service partners will use their agency mandated methodology for risk assessments.
- Priority will be given for mental health assessments and treatment to be undertaken by a Medical Practitioner or Authorised Health Professional wherever practicable within a person's home, medical clinic or community mental health service, or any other place in the community. If the person is a Police prisoner being held in a custodial facility, priority is given for assessment within that facility.
- Aboriginal and Torres Strait Islander People who are in Police custody will have access to an Aboriginal Liaison Officer / Community Constable wherever practicable.
- A Medical Practitioner or Authorised Health Professional will be available to participate in an assessment whether in person by use of an audio visual device where there is a clinical requirement.

7.2 Benchmarks

- In Emergency Departments, the benchmarks for assessment as outlined in the Australasian Triage Scale in Emergency Departments for Category 1, 2 and 3 apply .i.e., the assessment must commence within 30 minutes of the person's arrival.
- For Police, the benchmark to complete a mental health assessment is 30 minutes from time of arrival.
- Police and Authorised Officers (RFDS/SAAS) may hand over the care of a person to a mental health clinician in an Emergency Department when no safety issue exists.
  - This does not apply to prisoners presented by Police.
  - Please refer to section 18.4 with respect to support for children and young people.
- A benchmark response time of sixty minutes applies to requests for assessment, transport or service assistance in the community.

7.3 Transport Standards

- Transport should be by the least restrictive means possible and in a way that provides for the care of the person with a mental illness and the protection of the public and minimises interference with the person's privacy, dignity and self-respect.
- Use of Police vehicles should be as an option of last resort.
- For health workers, a clinical risk assessment (including safety) determines the most appropriate form of transport.
- If an individual is assessed as likely to become violent, appropriate sedation, restraint or other risk minimisation strategies i.e. chemical and/or mechanical restraint, delay of transport etc should be considered to ensure the safety of the person, family members and staff.

- Health workers will consider the following alternatives in determining transport methods:
  - Private vehicle driven by family, friend, carer (If the individual is cooperative, voluntary status, and prefers to have a family member accompany them).
  - Taxi with family member (If the individual is voluntary, and oral sedation is sufficient to address distress and disturbance, and they prefer a family member to accompany them).
  - Agency vehicle, driven by mental health worker, with family and / or mental health worker (If the individual is detained, if oral sedation is sufficient to address any immediate distress or disturbance a family member could also accompany the person if this is their preference).
  - Transport via road or air (If there a clinical decision that the individual should be treated in an inpatient facility, and clinical assessment and intervention may be required during transport) or the person is subject to chemical/mechanical restraint for the purpose of the transport or a person has a co-occurring serious physical health need.
  - A medical retrieval team in conjunction with an aviation provider, if there is a concern about the medical welfare of the individual or the safety of staff has been assessed as being at risk and there are no further options for safely administering more sedation, without the use of a retrieval team.
  - Any other reasonable option that meets current clinical and safety needs.
- Requests for transport between an Approved Treatment Centre, Limited Treatment Centre and other hospitals will be undertaken between health agencies.

7.4 Assessment and Treatment of Police Prisoners

- The application of the *Mental Health Act 2009* does not limit any other custody powers, obligations or legislative requirements that Police may have in relation to an apprehended person;
- If Police have arrested a person for an offence or apprehended a person under some other law, the person may, despite any other law, be released from Police custody for the purpose of medical examination or treatment under the *Mental Health Act, 2009.*
- Assessment of the person in the location that they are being held by Police (e.g. Police custodial complex) is preferable, wherever practicable.
- If a person has been arrested by Police for an offence and is released from Police custody for the purpose of medical examination or treatment under this Act:
  - the Commissioner of Police must be notified in accordance with the regulations of the action taken under this Act in relation to the person; and

- the person must, at the request of the Commissioner of Police, be held and returned to Police custody in the event that a detention and treatment order is not made in respect of the person or ceases to apply to the person.
- Section 57(9)(10) of the *Mental Health Act 2009* provides for the placement of a Police prisoner also detained under the Act to be held within a treatment centre until all obligations or legislative requirements that Police may have in relation to that person are completed or the requirements of the Act in respect of detention are fulfilled. In the event a detention order is revoked Police shall be contacted.
- A SAPOL—Mental Heath Custodial form (PD 146) shall be provided by Police when Section 57(9)(10) is required to be actioned.

7.5 Missing Persons and Patients at Large

This relates to:

- Individuals treated under Section 32 of the *Guardianship and Administration Act 1993,* or
- Individuals treated via an order under the *Mental Health Act 2009,* or
- A voluntary patient who is missing from a health care facility for whom there are current and / or serious safety concerns to the individual or the community (Draft National Missing Persons Policy).

Mental health workers are required to notify Police of missing consumers of mental health services and any need to apprehend and return the person where a current safety risk assessment and knowledge of the patient indicates.

In all cases where a Detention and Treatment Order or Community Treatment Order exists, Police shall be advised as soon as possible.

Police and mental health workers undertake all necessary activities to locate and return them safely.

Children and young people who are missing will be reported to Police using established procedures and communication processes.

Upon a request to Police to attend a specific location where a missing person is located, mental health workers will also attend to provide clinical support to Police and assessment of the individual, wherever practicable.

Upon Police apprehending a patient at large, Police will advise the treating Approved Treatment Centre, Limited Treatment Centre or other hospital that the person has been located and an anticipated time of return.

Where the person is located a considerable distance from the treating Approved Treatment Centre, Limited Treatment Centre or other hospital the person may be transported to the nearest Approved Treatment Centre, Limited Treatment Centre or other hospital. Ongoing transport to the treating facility will be by other transport options as outlined in this MHMoU.

MHS will contact Police if a patient at large has been located by an Authorised Officer or others. This will allow Police to update their missing person's records and end any active investigation.

See Appendix 'L'—Mental Health Missing Persons Flow Chart

7.6 Missing Person Media Releases

Responsibility for media releases rests with the mental health facility and health region from which a patient is at large.

A consultative approach with appropriate signatory agencies will be undertaken prior to any media release.

Any media communication regarding a consumer of a mental health service or a person who is detained under the *Mental Health Act 2009* will be coordinated through the Media Unit, SA Health.

Where the mental health facility declines to issue a media release, Police may issue subject to any legislative provisions and the Department for Premier and Cabinet Circular 12, The Information Privacy Principles.

7.7 Part 8a Section 269 *Criminal Law Consolidation Act 1935* (CLCA)

If a person has been released on licence and has contravened or is likely to contravene a condition of their licence the court by which a supervision order was made may on application of the Crown, review the supervision order. When an application for review of a supervision order is made the court may issue a warrant to have the person subject to the order arrested and brought before the court, and may if appropriate make orders for the detention of that person until the application is determined (section 269U CLCA).

Consumers of the Forensic Mental Health Service who are on licence are to be returned to James Nash House or another mental health facility and will be managed through the provisions of the MHMoU, and legislative authorities.

A person who is an escapee or is absent without proper authority from a place of detention (section 269 ZB(1)(a)(b) CLCA) is also deemed to be a missing person.

Either the Forensic Mental Health Service or the Department for Correctional Services may request Police to apprehend a person who escapes from a place of detention or is absent without proper authority from a place of detention. This apprehension may take place without a warrant being issued. The requirement is that the person is brought before a court.

A court may issue a warrant to have a person who has been released on licence to be brought before a court if they have contravened or failed to comply with a condition of a licence (section 269ZB (2) (CLCA).

See Appendix 'K'—Return of Forensic Mental Health Patients Flow Chart.

8. DOCUMENTATION

8.1 Standard Documentation

Signatory parties agree to use agreed standard MHMoU documentation for the exchange of information and service requests.

Signatory parties may agree to revoke, vary or add any standard document without also requiring resigning of the MHMoU. This requires agreement across all signatory parties.

8.1.1 The Mental Health Assistance Form

All parties agree to use and promote the use of a Mental Health Assistance Form when transferring the care of a person between a health agency and Police, to ensure the effective communication regarding the individual's circumstances.

See Appendix 'C'—Mental Health Assistance Form.

8.1.2 SAPOL—Mental Health Custodial Holding Form

SA Health and SAPOL agree to utilise and promote the use of a SAPOL—Mental Health Custodial Holding Form for Police prisoners who are detained pursuant to the *Mental Health Act 2009*.

See Appendix 'D'—SAPOL Mental Health Custodial Holding Form

8.1.3 Missing Persons (Patients at Large)

SAPOL's form for missing persons will be used to report missing persons or patients at large**.**

See Appendix 'L'—Mental Health Missing Persons Flow Chart

8.2 Legislative Documentation

In accordance with the terms and conditions of this MHMoU all parties acknowledge the requirement to provide any documentation required by the *Mental Health Act 2009*, the Guardianship and Administration Act *1993*, the *Criminal Law Consolidation Act (Amended) 1935* or any other relevant legislation upon the attendance of an assisting party.

9 PROTOCOLS

All parties agree to use any operating procedures and protocols that are developed across agencies to facilitate the implementation of the MHMoU.

These protocols and procedures will be endorsed by the Mental Health and Emergency Services Steering Committee and will be distributed via members of that group.

Signatory parties may agree to revoke, vary or add any operating procedures and protocols without also requiring resigning of the MHMoU. This requires agreement across all signatory parties.

The procedures will be reviewed three months after the implementation of this MHMoU to ensure operational effectiveness.

10 OCCUPATIONAL HEALTH, SAFETY AND WELFARE

Signatory parties are committed to ensure that their staff, including those employed under contract, understand their responsibilities with regard to their occupational health and safety by ensuring appropriate training is provided in relation to:

- Safety risk assessment and management.
- Risk minimisation strategies.
- Working alone.
- Management of aggression and violence.
- Restraint and / or seclusion.
- Policies and procedures developed by other signatory parties that impact upon the workplace.

11 RISK

- In assessing whether a person requires a mental health assessment, transportation or any other intervention, the attending parties will undertake a safety risk assessment to ensure appropriate treatment. All signatory parties will manage clinical and / or safety risk through their own risk management processes, following consultation.
- Where risk is transferred following a risk assessment, the party accepting the risk will determine how it is managed.
- Interagency crisis response plans may be developed for individuals who exhibit behaviour of community concern or pose significant risk issues. These individual plans will be reviewed at Local Liaison Group meetings to determine the ongoing risk. Initial plans will be for a maximum of 3 months.
- At the point of interface between services, risk will be managed using:
  - An agreed process for consultation and handover,
  - Transfer of information regarding any safety risk, including risk minimisation strategies utilised.

11.1 Health Risk

Any clinical assessment or treatment plan undertaken by health workers (SAAS, RFDS, and SA Health) will include a risk assessment and management plan, and will identify the relevant health agency as the lead agency.

11.2 Safety Risk

Response to safety risks may escalate based on the assessed level of threat to safety.

Police may be requested to attend where a safety risk assessment has determined there is a current or imminent serious threat to the safety of an individual, carer, health practitioner or any other person or property and risk mitigation strategies utilised are unable to reduce the risk to a safe and acceptable level.

Upon attendance, if Police accept a transfer of risk (based on a safety risk assessment), then Police will determine their involvement and how the risk is managed until the risk is minimised to a safe and acceptable level. Police will then have the capacity to depart.

11.3 Responsibility to Warn

If a person authorised under the *Mental Health Act 2009* believes that an individual presents a safety risk to another person or property, they will inform Police and any person to whom a threat has been specifically made.

11.4 SAPOL Security Assistance

- When Police attend an Approved Treatment Centre, Limited Treatment Centre or other hospital in relation to a person where a risk assessment has determined an imminent or current serious safety risk, Police may assist until the risk is reduced to a safe and acceptable level.

- Police will liaise with the Approved Treatment Centre, Limited Treatment Centre or other hospital staff regarding risk minimisation strategies which have or are to be employed in preference to only using Police resources. These may include chemical/mechanical restraint, or use of security personnel.

11.5 Searching Patients and Patient Belongings

- Sections 56 (Authorised Officers) and 57(Police) of the *Mental Health Act 2009* provide authorities to search persons subject to the Act:
  - in respect of whom a transport request has been made; or
  - who are apprehended as a person at large from a treatment centre; or
  - who are apprehended as they are suspected of having a mental illness and require assessment; or
  - as reasonably required for the purpose of enabling or facilitating their medical examination or treatment.

  Any search of a person must be carried out expeditiously and in a manner that avoids causing the person any humiliation or offence as far as reasonably practicable.

  Anything taken into the possession of an Authorised Officer or Police under these provisions may be held for as long as is necessary for reasons of safety, but must otherwise be returned to the person from whom it was taken or dealt with according to law.
- Searching persons and their belongings must comply with the policies and procedures applicable to the searching agency.
- Where a person's care is transferred to another agency the information from the results of the search is communicated and any property removed from the person transferred to the receiving agency. A further search may be undertaken by the agency providing ongoing care.

12 REFERRALS AND REQUESTS FOR ASSISTANCE

- In determining requests for assistance, liaison should commence at the earliest opportunity to ensure a timely and efficient response.
- An agency making a request shall be informed;
  - What action was taken in response to their request for assistance; or
  - If a request is deemed inappropriate; or
  - Why the assistance requested was not provided; and
  - Any delay in meeting the benchmarks within this MHMoU.

13 INFORMATION EXCHANGE

Section 106 of the *Mental Health Act 2009* states:

(1) Subject to subsection (2), a person engaged or formerly engaged in the administration of this Act must not disclose personal information relating to a person obtained in the course of administration of this Act except to the extent that he or she may be authorised or required to disclose that information by the Chief Executive.

(2) Subsection (1) does not prevent a person from—

(a) disclosing information as required by law, or as required for the administration of this Act or a law of another State or a Territory of the Commonwealth; or

(b) disclosing information at the request, or with the consent, of the person to whom the information relates or a guardian or medical agent of the person; or

(c) disclosing information to a relative, carer or friend of the person to whom the information relates if—

(i) the disclosure is reasonably required for the treatment, care or rehabilitation of the person; and

(ii) there is no reason to believe that the disclosure would be contrary to the person's best interests; or

(d) subject to the regulations (if any)—

(i) disclosing information to a health or other service provider if the disclosure is reasonably required for the treatment, care or rehabilitation of the person to whom the information relates; or

(ii) disclosing information by entering the information into an electronic records system established for the purpose of enabling the recording or sharing of information in or between persons or bodies involved in the provision of health services; or

(iii) disclosing information to such extent as is reasonably required in connection with the management or administration of a hospital or SA Ambulance Service Inc (including for the purposes of charging for a service); or

(e) disclosing information if the disclosure is reasonably required to lessen or prevent a serious threat to the life, health or safety of a person, or a serious threat to public health or safety; or

(f) disclosing information for medical or social research purposes if the research methodology has been approved by an ethics committee and there is no reason to believe that the disclosure would be contrary to the person's best interests; or

(g) disclosing information in accordance with the regulations.

(3) Subsection (2)(c) does not authorise the disclosure of personal information in contravention of a direction given by the person to whom the information relates.

(4) Subsection (3) does not apply to a person to whom a community treatment order or detention and treatment order applies.

(5) In this section—

personal information means information or an opinion, whether true or not, relating to a natural person or the affairs of a natural person whose identity is apparent, or can reasonably be ascertained, from the information or opinion.

The interest of personal and community safety should outweigh considerations of confidentiality and therefore the release of relevant information is appropriate as part of a collaborative practice and the principle of duty to warn of imminent or foreseeable danger.

The process of information sharing must comply with the requirements of each agency.

All information relating to a person's treatment, care, safety, property and the outcome of any search will be provided at the point of transfer of care.

All information relating to assessment of safety and interventions to manage risk will also be provided.

14 INTER AGENCY LIAISON

All signatory parties agree that liaison / communication / coordination will occur through the following single point service request / dispute resolution telephone contact numbers:

- **SAPOL** **131444 (Emergency 000)**
- **SAAS** **08 8274 0597**
- **RFDS** **08 8648 9555**
- **Mental Health Triage** **131 465 (24 hours, state wide)**
- **Forensic Mental Health Service** **08 8266 9600 (24 hours, state wide)**

15. GOVERNANCE

Each party will nominate a central contact officer to monitor the application of the MHMoU.

15.1 Requirements of Contact Officers

Contact Officers shall:

- Maintain ongoing liaison between contact officers of other signatory parties
- Provide a response to requests within 3 working days. Provide annual reports to their respective Chief Executives or Commissioner for Police on unresolved issues emanating from the Mental Health and Emergency Services Memorandum of Understanding

15.2 Mental Health & Emergency Services Steering Committee

The state wide governance of this MHMoU will be managed by the Mental Health and Emergency Services Steering Committee. *See Appendix 'A'— Mental Health and Emergency Services Steering Committee Terms of Reference.*

All signatory parties shall ensure representation and participation by nominated representatives or delegates.

The Chair of the Mental Health and Emergency Services Steering Committee may co opt others as required.

15.3 Local Liaison Groups

Mental Health Services will develop and establish one or more Local Liaison Groups (LLGs) in each SAPOL Local Service Area. *See Appendix 'B'—Local Liaison Groups Terms of Reference.*

All signatory parties shall ensure representation and participation by nominated representatives or delegates.

The Chair of the LLG may co opt others as required.

16 DISPUTE RESOLUTION

The signatory parties recognise that the primary resolution of disputes resulting from the MHMoU may not require to be pursued to the extreme at operational incidents. It is preferable to complete the task and ensure the safety of all involved, and resolve the issue through the LLG process.

A dispute constitutes a situation where the processes agreed in the MHMoU are not undertaken. This includes:

- MHMoU standards and benchmarks,
- Communication,
- Assessment and management of risk,
- Provision of documentation,
- Non compliance with the MHMoU in respect of Police prisoners, patients at large or consumers of Forensic Mental Health Services

Disputes will be recorded on signatory party systems and on the Mental Health Assistance Form (PD145) where the dispute involves SAPOL. A copy will be forwarded to the relevant signatory party LLG representative.

16.1 LLG Dispute Resolution

All discussions and endeavours made in good faith shall be made by LLGs to resolve disputes prior to any consideration of forwarding the dispute to the Mental Health and Emergency Services Steering Committee.

16.2 Mental Health & Emergency Services Steering Committee—Dispute Resolution

The primary intent of the Mental Health and Emergency Services Steering Committee is strategic, aimed at policy and standards.

In the event that the Mental Health and Emergency Services Steering Committee is unable to resolve any dispute the matter shall be forwarded to the Chief Executives of the signatory parties and the Commissioner for Police for determination.

16.3 Chief Executive Dispute Resolution

Signatory Chief Executives and the Commissioner for Police will determine approaches to be utilised in resolving the dispute.

17 TRAINING

All signatory parties will collaborate to ensure that their professional development and mandatory training programs are provided and reviewed regularly to ensure the content is relevant and reflects the content of this MHMoU, and legislative requirements and changes.

All parties will use the LLGs to provide feedback on any changes in interagency operating procedures and communication as the MHMoU is implemented.

Each agency is committed to ensuring that this MHMoU is promulgated to its staff and other services which impact on the delivery of services to people with a known or suspected mental illness, or who exhibit behaviours of community concern.

18 SPECIFIC ISSUES

18.1 Firearm Safety SAPOL Operational Safety Equipment

It is recognised that at times the carriage of firearms and other Police operational safety equipment is not appropriate. If risk is transferred to Police, the decision to use, remove and store operational equipment rests with Police and shall be based on its operational safety philosophy and any legislative requirements (Civil Aviation Safety Authority Regulations). This will be decided in collaboration with the appropriate partner agencies.

18.2 Dealing with Weapons and Illicit Substances

It is acknowledged that each party to this MHMoU has its own policies and guidelines based on legislative requirements in dealing with illegal weapons and illicit substances.

18.3 Children, Aged and/or Infirm Dependants, and Animals of People with a Mental Illness

When signatory party workers identify a child or an aged or infirm dependant or animals of a person requiring assessment and care, enquiries and arrangements shall be made to ensure the child, aged and/or infirm dependent or animal (s) is adequately cared for.

18.4 Children and Young People—Support

Where Police or Authorised Officers present a child to a Medical Practitioner or Authorised Health Professional for examination, a guardian will be requested to attend and be present during the examination.

When a guardian is not present, they shall be notified as soon as possible. When a guardian is not available or declines to attend, Police or Authorised Officers shall notify an adult (nominated by the child) being a relative, care giver, medical agent or other suitable person and invite them to be present during any examination.

In the event a child is also under the care of the Minister for Families and Communities, Police or Authorised Officers will advise Families SA.

18.5 Forced Entry

When a request is made for Police to conduct a forced entry to premises, the decision to conduct that forced entry rests with Police. This decision will be reached in consultation with the party making the request.

When Police utilise forced entry authorities on behalf of another signatory party, that party is responsible for the security and cost of repair of any damage undertaken.

18.6 Use of Physical Restraint

The use of physical restraint should generally be used as an option of last resort to contain a situation and to ensure the safety of a person concerned and/or other persons present.

19 INTERSTATE CIVIL ORDERS

Part 10 provisions of the *Mental Health Act 2009* allow for the interstate transfer of persons requiring assessment and treatment when a Memorandum of Agreement between health services exists.

Authorised Officers and Police may transport any person apprehended pursuant to a Civil Interstate Civil Apprehension Order (CIAO) to the Approved Treatment Centre, Limited Treatment Centre or other hospital nearest the apprehension. Ongoing transport is the responsibility of health providers.

A Civil Interstate Transfer Request Notice (CITRN) is used for the planned transfer of inpatients (after admission) between treatment centres in SA and other jurisdictions. Transfers require the approval of the Chief Psychiatrist.

Any costs incurred by signatory parties involved in the interstate transfer of patients between South Australia and other jurisdictions will be met by SA Health.

Forensic patients and Police prisoners are excluded from these arrangements.

20 IMPLEMENTATION

An implementation strategy with time frames will be developed and coordinated by the Mental Health and Emergency Services Steering Committee.

21 COMMUNICATION

The signatory parties will develop a communication strategy which shall be coordinated by the Mental Health and Emergency Services Steering Committee that ensures the information contained within this MHMoU and operating protocols is disseminated to their members.

At minimum signatory parties will:

- Distribute the MHMoU to staff and ensure easy electronic / hardcopy access to the document.
- Produce and distribute practice guidelines.
- Conduct information and orientation sessions for current staff.
- Ensure the MHMoU is included in any induction packages relating to their staff.
- Distribute to the MHMoU to other government and non government agencies.

22 PERFORMANCE MONITORING AND REVIEW OF THE MEMORANDUM

The monitoring and evaluation of this MHMoU is essential for the ongoing improvement of service partnerships and service delivery.

Key performance indicators developed by the Mental Health and Emergency Services Steering committee will be reported upon by each LLG. Mental Health Services will undertake an annual audit of LLGs operating within their health service and forward results to the Mental Health and Emergency Services Steering Committee who will provide a report to the Chief Executives of SA Health, SAAS, RFDS and the Commissioner for Police.

See Appendix 'M'—MHMoU Key Performance Indicators

22.1 Review Date

This MHMoU will be formally evaluated by the Mental Health and Emergency Services Steering Committee on a bi annual basis and a report provided to the Chief Executives of SA Health, SAAS, RFDS and the Commissioner for Police. The report will be provided in relation to consumer outcomes, key performance indicators & operational disputes.

No changes to the MHMoU will occur without prior agreement of the Chief Executives and the Commissioner for Police. This includes any changes that are made to relevant legislation, which may result in the revision of operating policies and protocols. Requests for amendment will be coordinated by the signatory party representatives to the Mental Health and Emergency Services Steering Committee.

APPENDIX A

MENTAL HEALTH AND EMERGENCY SERVICES STEERING COMMITTEE TERMS OF REFERENCE

Signatory parties will provide a senior representative to the Mental Health and Emergency Services Steering Committee which will be convened by the Director, Mental Health Operations.

The primary intent of the Mental Health and Emergency Services Steering Committee is strategic.

The Steering Committee will:

- Meet on a quarterly basis as a minimum.
- Establish agendas which include:
  - MHMoU implementation and documentation;
  - Compliance;
  - Dispute resolution processes;
  - Identified best practice which may have a state wide impact;
  - Reporting initiatives, strategies and legislative proposals from each signatory party;
  - Fostering cross portfolio training and education initiatives;
  - Disseminating exemplary local practice and agreed cross portfolio service response to frontline personnel via the Local Liaison Groups (LLGs) ;
  - Monitoring the implementation of the MHMoU and provide ongoing evaluation;
  - A feedback mechanism for LLGs.
- Provide advice and feedback to LLGs via the minutes of the meetings and also via direct communication from the relevant committee member.
- Provide advice to respective Chief Executives and Commissioner for Police as outlined in the dispute resolution process within this MHMoU.
- Form working groups as required to develop further agreements and ensure interagency collaboration.
- Provide an annual report to the Chief Executives of the signatory agencies, the Commissioner for Police, and the Chief Executive of GPSA.
- Conduct a review of the Mental Health and Emergency Services Memorandum of Understanding on a bi-annual basis.

APPENDIX B

LOCAL LIAISON GROUPS (LLGs) TERMS OF REFERENCE

Local Liaison Groups:

- Comprise local senior representatives from
  - Mental Health Services, Forensic Mental Health Services, Child and Adolescent Mental Health Services, Mental health Services for Older People
  - SAPOL;
  - SAAS;
  - Hospital emergency departments;
  - Medical practitioners;
  - Representatives from Divisions of General Practice;
  - Non government services, where a crisis response plan is being discussed and developed for a person of mutual concern;
  - Other health providers;
  - Consumer / carer / community representatives as appropriate;
  - RFDS representatives will participate in LLG meetings wherever possible, and particularly when they are involved with a person for whom an interagency crisis response plan is being developed or reviewed.

  Other agencies will be included or co opted for specific discussions as required. This will be agreed by the LLG members.
- Meet on a bimonthly basis as a minimum to deal with local service issues.
- Establish agendas which include:
  - Information sharing (subject to information privacy principles instruction);
  - Partnership development;
  - Dispute resolution;
  - Identified best practice;
  - Key performance Indicators and benchmarks;
  - Interagency Training;
  - Developed local operational protocols;
  - Critical incidents;
  - Development and monitoring of inter agency crisis response plans for people whose behaviour is of mutual concern.
- Review and develop local operational protocols to improve collaboration processes and resolve local issues. These are to be forwarded to the Mental Health and Emergency Services Steering committee for ratification and registration.
- Share information regarding local practice to improve relationships and facilitate effective interagency service provision to improve consumer outcomes
- Use their best endeavours to resolve local operational disputes prior to any consideration of forwarding the dispute to the Mental Health and Emergency Services Steering Committee.
- As required develop agreed inter service crisis response plans for intervention with persons having challenging behaviours. Interagency Crisis Response Plans will be reviewed at each meeting to determine their ongoing relevance and need. An initial plan shall be for a maximum of a 3 month period.
- Identify all other local agencies involved and ensure their participation where required, and dissemination of any decisions.
- Minutes of all LLGs shall be forwarded to each signatory party contact officer.
- Provide quarterly reports through their representative on the Mental Health and Emergency Services Steering Committee on the agenda items.

APPENDIX C

MENTAL HEALTH ASSISTANCE FORM

REPORT DATE D D M M Y Y REPORT TIME

MEMBER NAME MEMBER ID NO.

MEMBER STATION CODE MEMBER STATION NAME / MHS LOCATION NAME

PERSON DETAILS

CAD NO. / CASE FILE NO. 1st NAME

FAMILY NAME 2nd NAME

DOB D D M M Y Y AGE SEX ☐ MALE ☐ FEMALE ETHNIC APPEARANCE

ARE YOU OF ABORIGINAL AND/OR TORRES STRAIT ISLANDER ORIGIN? ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither ☐ Not Stated/Unknown

FLAT NO. STREET NO. STREET NAME

TOWN/SUBURB STATE POSTCODE

PHONE NO'S (Home) (Work) (Mobile)

CONTACT DETAILS OF NEXT OF KIN / PERSON TO ASSIST *(i.e. name and phone number of family member / carer / guardian / power of attorney / other)*

NAME PHONE NO. (mobile preferred)

RISK FACTORS

☐ Self Harm ☐ Threat to others/property ☐ Weapons ☐ Drugs ☐ Medical condition ☐ Recommend medical examination

☐ Suicidal ☐ Assault police/staff ☐ Alcohol ☐ Spitting ☐ Uses bodily fluids ☐ Recommend restraint

Circumstances of Incident/Details of Current Detention or Treatment Orders, Safety Risk assessment.

SERVICE(S) REQUESTED (tick as many as apply)	RESPONSE TIME(S)
☐ Ambulance	30 mins ☐ 1 hr ☐ 1.5 hrs ☐ 2 hrs ☐ 2+ hrs ☐ Not available ☐
☐ ACIS/MHS	30 mins ☐ 1 hr ☐ 1.5 hrs ☐ 2 hrs ☐ 2+ hrs ☐ Not available ☐
☐ AHP	30 mins ☐ 1 hr ☐ 1.5 hrs ☐ 2 hrs ☐ 2+ hrs ☐ Not available ☐
☐ Local GP	30 mins ☐ 1 hr ☐ 1.5 hrs ☐ 2 hrs ☐ 2+ hrs ☐ Not available ☐
☐ RFDS	30 mins ☐ 1 hr ☐ 1.5 hrs ☐ 2 hrs ☐ 2+ hrs ☐ Not available ☐
☐ SAPOL	30 mins ☐ 1 hr ☐ 1.5 hrs ☐ 2 hrs ☐ 2+ hrs ☐ Not available ☐
☐ Other	30 mins ☐ 1 hr ☐ 1.5 hrs ☐ 2 hrs ☐ 2+ hrs ☐ Not available ☐

TYPE OF REQUEST
☐ Attendance
☐ Assessment
☐ Transport
☐ Info Sharing/Advice
☐ Safety Escort
☐ Referral
☐ Dispute Resolution

☐ Welfare concerns *Referrals, non-urgent assessment*	☐ ACIS Mental Health Triage ☐ Other e.g. GP, community service	Form faxed to:

TRANSPORTED BY	TRANSPORTED TO	RESPONSIBILITY OF CARE TRANSFERRED TO
☐ Family/friend/carer ☐ Area MH Service ☐ Ambulance ☐ Other ☐ Police ☐ Not necessary ☐ Police escort provided	☐ Hospital ED ☐ Approved Treatment Centre ☐ Limited Treatment Centre ☐ Medical Practitioner ☐ Authorised Health Professional	Name: ..... Service: ..... Contact no.: ..... Date: ..... Time: .....

ESTIMATED TOTAL POLICE TIME ON TASK	30 mins ☐ 1 hr ☐ 1.5 hrs ☐ 2 hrs ☐ 2.5 hrs ☐ 3 hrs ☐ 3.5 hrs ☐ 4+ hrs ☐

MENTAL HEALTH ASSISTANCE FORM

OUTCOME ACKNOWLEDGEMENT (Authorised Health Professional or Medical Practitioner to complete)

Pursuant to the provisions of the *Mental Health Act 2009*, the respondent was:

EXAMINED / NOT EXAMINED at (Location) _____

at (Time) _____ hours on (Date) _____ And **DETAINED / NOT DETAINED**

Assessment decision details.

_____

_____

_____

Signature & Qualifications **Name (Print)**

Comments:

PERSON OBSERVATIONS

(Circle / comment appropriately to best describe the person – Leave blank if heading not applicable)

AFFECTED BY:	COMMENTS	Mild	Moderate	Gross
Alcohol				
Drugs				
Injuries				
Communicable Disease(s)				
Current Medication(s)				

(Circle appropriately to best describe the person – Leave blank if heading not applicable)

LANGUAGE

Mute Uncommunicative
Mild Peculiar use, rambling
Moderate Difficult to Understand
Severe Incomprehensible

ODD, ECCENTRIC OR BIZARRE BEHAVIOUR

Mild Noticeable peculiar behaviour (inappropriate loud talking or eye contact, unusual person rituals)
Moderate Clear bizarre behaviour (fixed staring for minutes, loud talking to self, inappropriate laughter)
Severe Behaviour attracting attention of others and intervention of authorities (directing traffic, public nudity, conversing loudly to self, unresponsiveness)

SELF NEGLECT

Mild Hygiene / personal appearance low (dishevelled appearance, stained clothing, unkempt hair)
Moderate Aromatic / dirty clothing / skin
Severe Dishevelled, torn or ragged clothing and / or stained urine / faeces, skin excoriated, long dirty nails

DISORIENTATION

Mild Seems muddled, minor inaccuracies in person, time / place
Moderate Frequently confused, cannot remember personal material
Severe Disoriented in person and / or time, cannot give name or age

UNCO-OPERATIVE

Mild
Moderate Verbally resists but eventually complies after repeated requests
Severe Refuses to cooperate, active efforts to escape

SUSPICIOUS

Mild Seems on guard, reluctant to respond to personal questions
Moderate Says other persons are talking about them maliciously, have negative intentions or may harm self, incident of suspected persecutions
Severe Delusional – speaks of plots (government, poisoning water / food, persecution by supernatural forces)

SUICIDALITY

Mild Occasional thoughts without intent or plan
Moderate Frequent thoughts (many fantasies of suicide by various methods)
Severe Preoccupied with suicidal ideas, has intent, plans and means or attempt to do so

HOMICIDAL TENDANCIES

Mild Occasional thoughts without intent or plan
Moderate Frequent thoughts (many fantasies of committing homicide by various methods)
Severe Preoccupied with homicidal ideas, has intent, plans and means or attempt to do so

HOSTILITY

Mild Irritable, argumentative, sarcastic
Moderate Overtly angry, yelling, abusive
Severe Assaults others by slapping or pushing, destroys property
Extreme Attacks others with intent to harm, use of weapons, siege

APPENDIX D

SAPOL MENTAL HEALTH CUSTODIAL HOLDING FORM

PD146

(Section 57(10)(a)(b) *Mental Health Act 2009*)
(General Order – **Mental incapacity** & General Order – **Arrest and custody management**)

SAPOL members to complete form when delivering a prisoner to an Approved Treatment Centre pursuant to the *Mental Health Act 2009*. Note: If a Level 1 Detention and Treatment Order (DTO) is confirmed, arrange a bedside Magistrates' Court hearing. If a DTO is not confirmed, the person is being treated as a voluntary patient or a Community Treatment Order has been issued return to a SAPOL custodial care facility responsible for the prisoner. Secure this form in the prisoner's Charge and Custody Management Record (PD464).

SAPOL MEMBER COMPLETION

Prisoner Name: _____ **D.O.B:** ___/___/___ **M / F**

Has prisoner been charged? YES / NO **Service Area/Branch/Group responsible for Prisoner:** _____

Service Area/Branch/Group Contact Telephone: _____ **PD145 – Mental Health Assistance Form provided? YES / NO**

Charge and Custody Management Record Number (if applicable): _____

Comments e.g. Communicable Diseases / Medication Taken / Injuries / Safety risks etc.: **High Need? YES / NO**

Safety Search? YES / NO	**Property transferred? YES / NO**	**Property Receipt obtained? YES / NO**

Pursuant to s 57(10)(a)(b) of the *Mental Health Act 2009* I request that this person be held and returned to police custody.

Name, ID and Rank Conveying Member (Print): _____

Service Area/Branch/Group: _____

Signature: _____ **Date:** ___/___/___

SECURE APPROVED TREATMENT CENTRE (ATC) COMPLETION

Treatment Centre Name: _____

Receiving Person: _____ **Title:** _____

Comments:

PRISONER RECEIVED: **Date:** ___/___/___ **Time:** ___:___ **am / pm**

SAPOL NOTIFIED TO COLLECT: **Date:** ___/___/___ **Time:** ___:___ **am / pm**

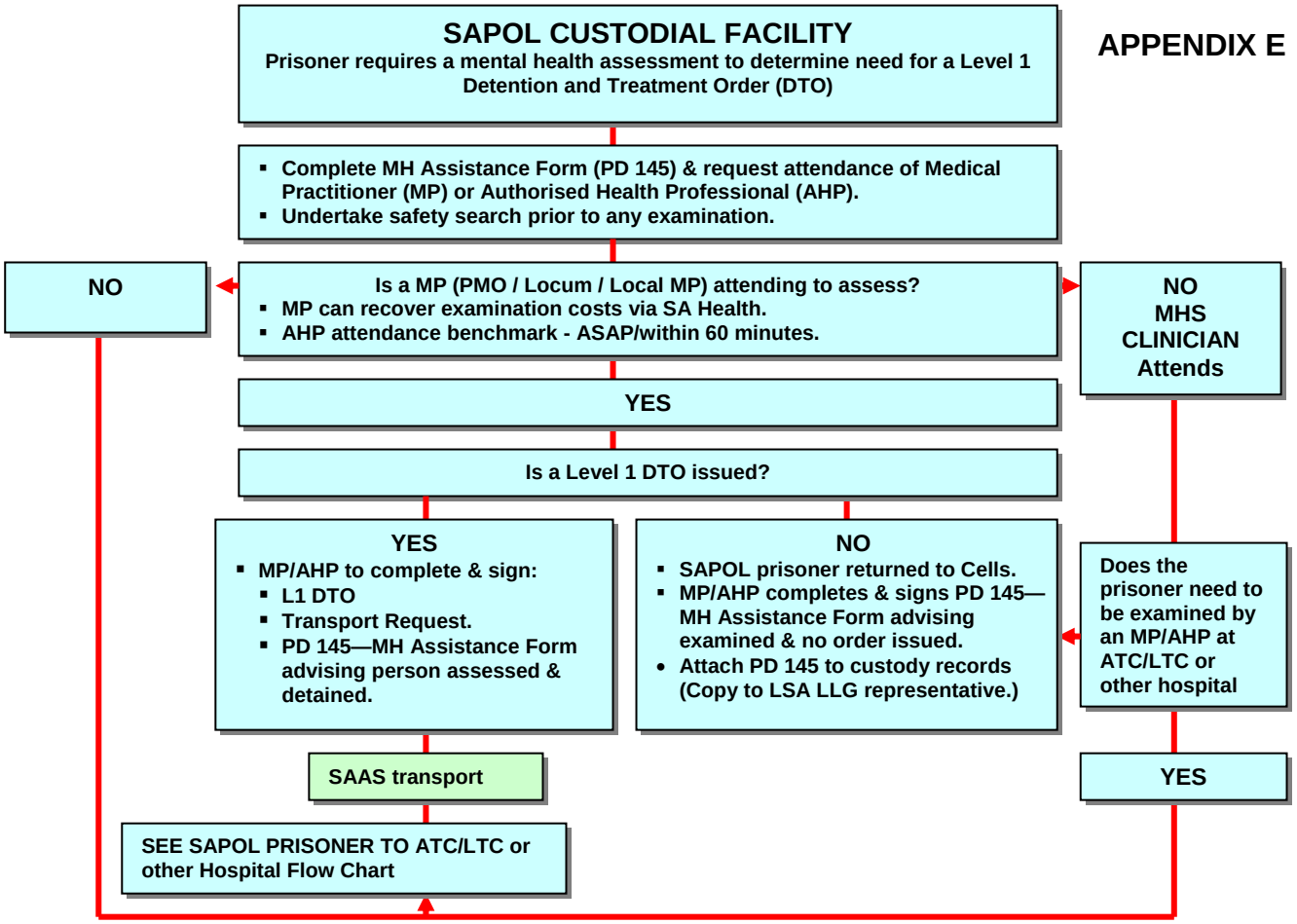
Name & ID SAPOL member receiving notification: _____

RETURNED TO SAPOL: **Date:** ___/___/___ **Time:** ___:___ **am / pm**

Name & ID SAPOL member receiving prisoner: _____

DISTRIBUTION:
Service Area/Branch/Group Local Liaison Group member
Prisoner Charge and Custody Management Record (PD464)

APPENDIX E



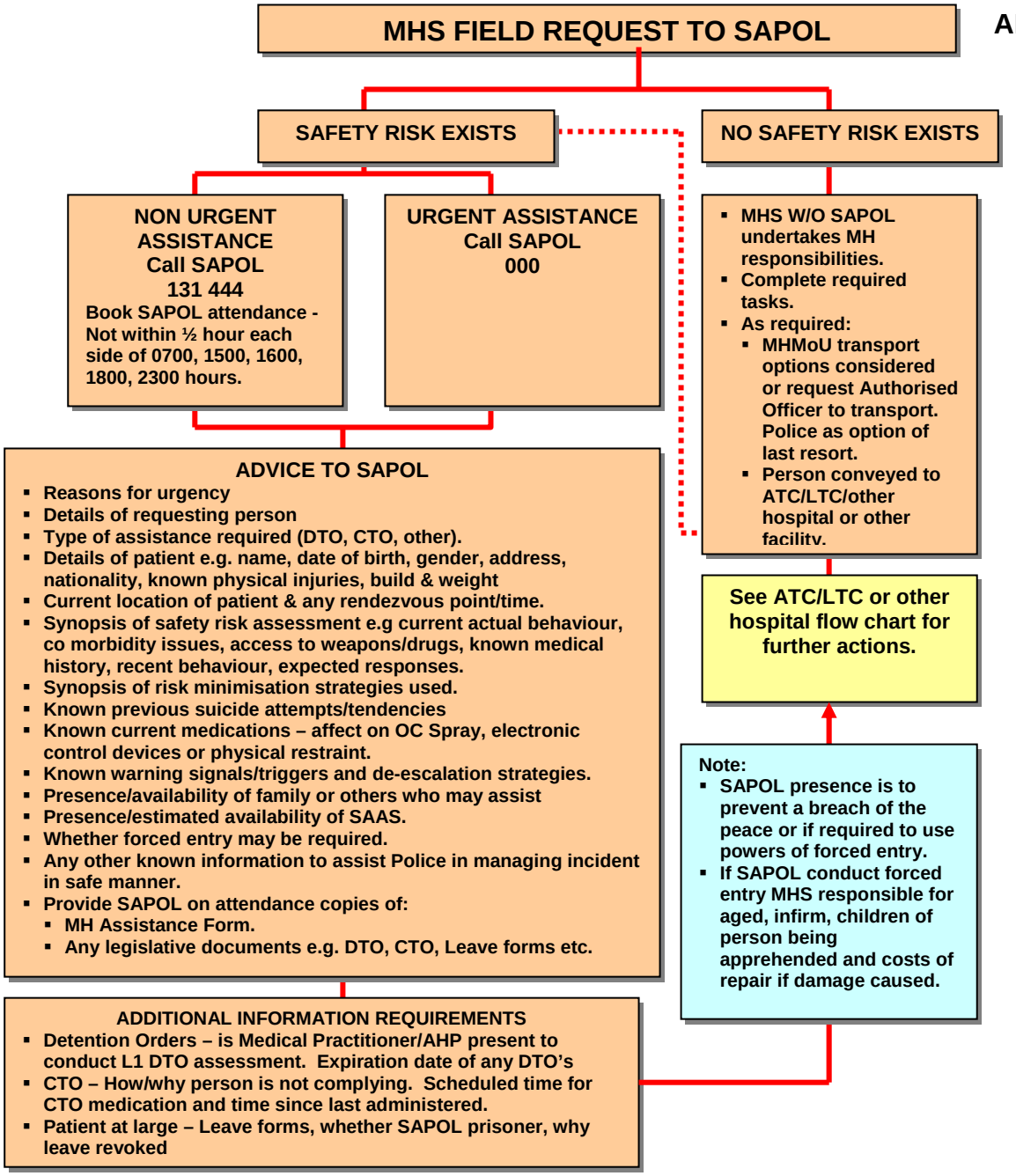
CELL SUPERVISORS TO CONSIDER

- Releasing person under the provisions of Section 785) SOA 1953 (dependent on severity of offence) with view to instituting criminal proceedings at a later stage)
- Commencing and completing charging procedures to ensure court appearance.
- Police Bail (notwithstanding legislative requirements pursuant to Bail Act, 1985, police bail may not be appropriate when it is apparent that the person is not capable of understanding the bail conditions.
- GO—Arrest Custody Management
- Notify Criminal Justice Section that person has been detained pursuant to the Mental Health Act. Submit CJS file (Attach PD 108 Charge Discontinuance Notice for advice if it is considered that unlikely successful prosecution will result from any mental health detention).
- If safe to do so prisoner to be assessed in medical room
- Provide assistance to MP/AHP conducting MH assessment if requested
- Explain any safety risks if MP/AHP requests private examination. Provide guard outside assessment room if MP/AHP requires private examination and does not accept advice concerning safety risks.

GENERAL REQUIREMENTS

- A safety search is conducted prior to each handover between agencies.
- If MOU benchmarks/standards not met, safety risk assessment not accepted, or any other MOU issues contact signatory party manager and provide details. All attempts to be made to resolve the dispute before referring. Disputes and resolution decisions to be noted on PD 145 and provided to signatory party LLG representative and SAPOL LLG representative.
- Transport options within the MOU are considered.
- If SAPOL accept a transfer of risk (based on a safety risk assessment), then SAPOL will determine their involvement and how the risk is managed until the risk is minimised to a safe and acceptable level.
- LSA from which prisoner is transferred responsible for all actions required for any return, preparation/transfer of court files/notification to Adelaide CJS (if transferred from country) etc

APPENDIX F



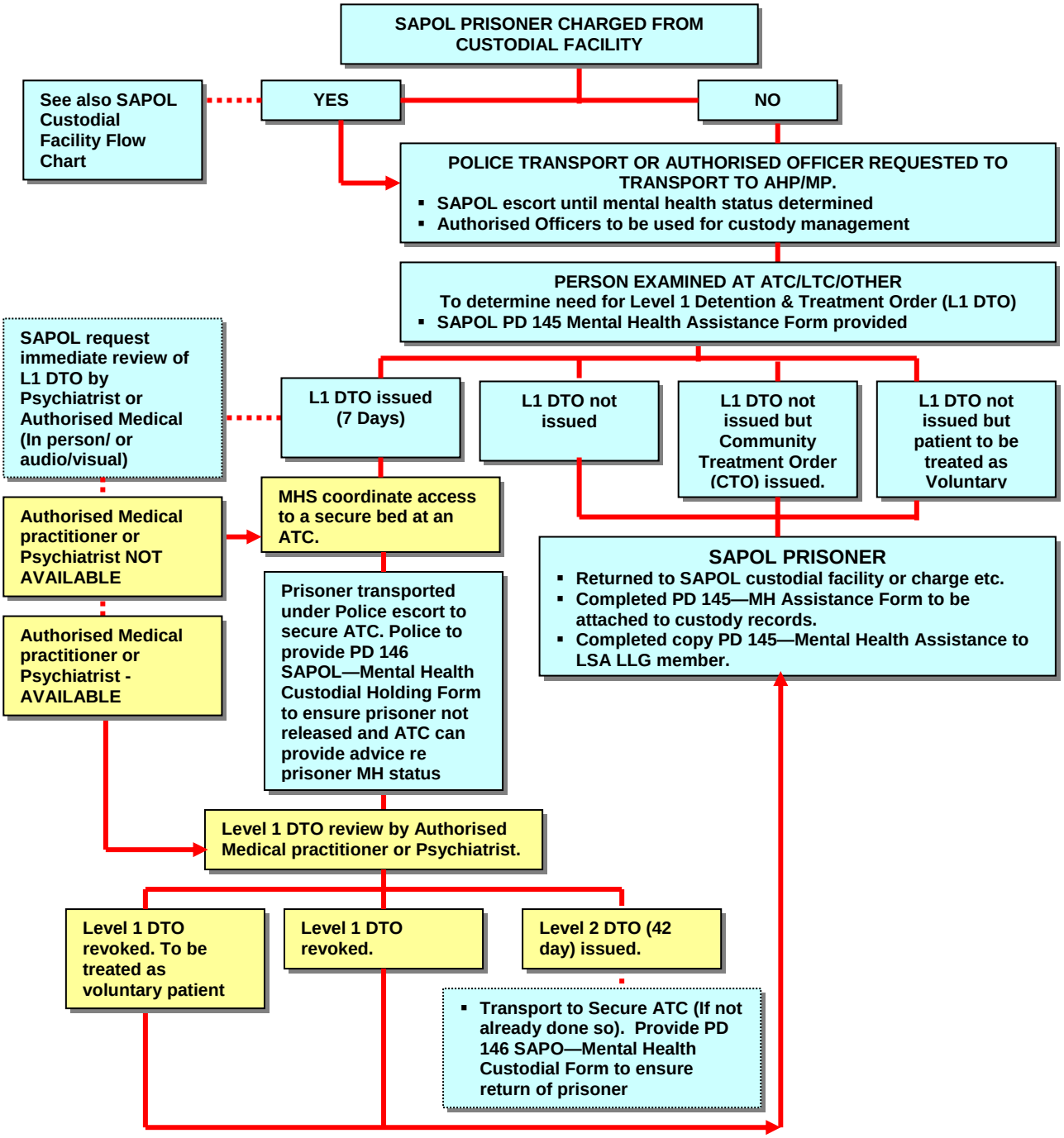
GENERAL REQUIREMENTS

- A safety search is conducted prior to each handover between services.
- If MHMoU standard/benchmarks not met or other MHMoU issues occur contact signatory party manager and provide details. All attempts to be made to resolve the dispute before referring. Disputes and resolution decisions to be noted on MH Assistance Form and provided to signatory party LLG representative.
- Transport options within the MHMoU are considered.
- A plan is developed to address a current situation considering all risks.
- An agreed crisis response plan is implemented for those mental health consumers who pose an ongoing safety risk.
- On arrival SAPOL reviews safety risk assessment. If SAPOL accept a transfer of risk (based on a safety risk assessment), then SAPOL will determine their involvement and how the risk is managed until the risk is minimised to a safe and acceptable level. In consultation SAPOL will then have the capacity to depart or provide ongoing security to ATC/LTC or other hospital.
- SAPOL ongoing security provision is to an ATC or LTC. SAPOL then will have the capacity to depart (Dependent on safety risk present) The ATC/LTC to initiate risk minimisation strategies allowing SAPOL to leave.

NOTE: Pursuant to 55(1) MHA 2009 Police or Authorised Officers (includes Mental Health Clinicians) may only apprehend persons not complying with a CTO if a transport request has been issued by Medical Practitioner or Mental Health Clinician. SAPOL/Authorised Officers have no authority to restrain persons whilst CTO medication is administered.

SAPOL PRISONER PRESENTED TO ATC/LTC OR OTHER HOSPITAL

APPENDIX G



POLICE CONSIDERATIONS

- At point of handover provide advice re safety searches
- Coordinate bed side charging (if not already done so)
- Coordinate magistrate's bed side sitting (If not already done so).
- If magistrate provides court bail – Police custody ceases
- If magistrate issues remand warrant – Notify DCS of location of Prisoner and Warrant – SAPOL custody ceases.
- Monitor progression of prisoner within health system during period as above.
- If MH status changes before charging or magistrates hearing coordinate return of prisoner to Police custody
- If any benchmarks or standards within the MHMoU are not met or prisoner cannot be placed in a secure ATC initiate MHMOU Dispute process and notify an Officer of Police. Remain with the prisoner until they are lodged in a secure ATC.

NOTE: Service/Branch/Group responsible for the prisoner is responsible for coordinating the above and any required return to custody (This includes coordination of escorts)

APPENDIX H

APPROVED TREATMENT CENTRE, LIMITED TREATMENT CENTRE OR OTHER HOSPITAL
Presentation by Authorised Officers or Police (Non Prisoner)

HOSPITAL CONSIDERATIONS

NOTE:

- **Benchmark for assessment is the Australasian Triage Scale in Emergency Departments**
- **Police and Authorised Officers may handover the care of a person to a mental health clinician (if available) in an Emergency Department if there are no safety risks**
- **For Police the benchmark to complete a mental health assessment is 30 minutes from time of arrival**
- **Emergency departments to provide safe/secure facilities for management of presentations (away from public).**
- **Hospital EDs are responsible for safety and security within their facilities. Other risk minimisation strategies to be used in preference to using SAPOL.**

CONDUCT MENTAL HEALTH ASSESSMENT
Medical Practitioner or Authorised Health Professional

Level 1 DTO issued.

- **Bed access facilitated.**
- **Pending establishment of LTCs, all L1 DTO country patients transferred to an ATC.**

NOTE: All SAPOL prisoners will require transport to a secure ATC

- **Transport Request Form completed for SAAS transport (As required).**
- **To consider other transport options as per the MHMoU**

Level 1 Detention & Treatment Order (DTO) not issued.
Options:

- **Release**
- **Treat as voluntary patient**
- **Issue Community Treatment Order (CTO)**

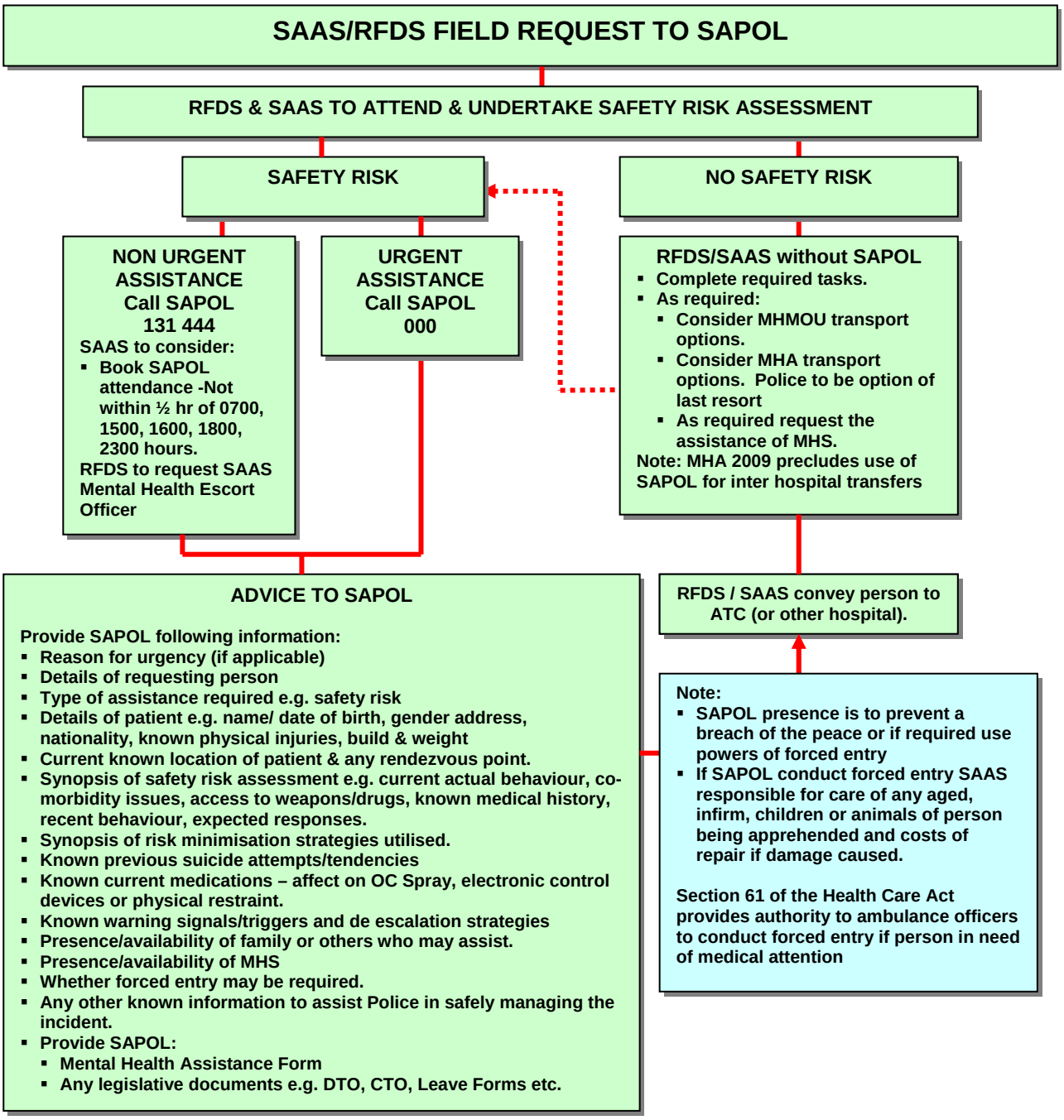
NOTE: SAPOL prisoners shall not be released but returned to SAPOL custody. (MHA 2009 & Regulations)

SAAS / RFDS transport person to ATC (as required). SAAS Mental Health Escort Officers to be utilised.

GENERAL REQUIREMENTS

- **Although a safety search may be done by Authorised Officers or Police this should be verified. Regardless of whether a safety search has been conducted hospitals have responsibilities for the safety of there staff and any patient. Accordingly hospitals have a responsibility to determine whether a further safety search and removal of property is required.**
- **If SAPOL accept a risk based on a safety risk assessment, then SAPOL will determine their involvement and how the risk is managed until the risk is minimised to a safe and acceptable level. All risk minimisation strategies should be considered in preference to using SAPOL resources.**

APPENDIX I



GENERAL REQUIREMENTS

- A safety search is conducted prior to each handover between services.
- If MHMoU standard/benchmarks not met or other MHMoU issues occur contact signatory party manager and provide details. All attempts to be made to resolve the dispute before referring. Disputes and resolution decisions to be noted on MH Assistance Form and provided to signatory party LLG representative.
- Transport options within the MHMoU are considered.
- A plan is developed to address a current situation considering all risks.
- An agreed crisis response plan is implemented for those mental health consumers who pose an ongoing safety risk.
- On arrival SAPOL reviews safety risk assessment. If SAPOL accept a transfer of risk (based on a safety risk assessment), then SAPOL will determine their involvement and how the risk is managed until the risk is minimised to a safe and acceptable level. In consultation SAPOL will then have the capacity to depart or provide ongoing security to ATC/LTC or other hospital.
- SAPOL ongoing security provision is to an ATC or LTC. SAPOL then will have the capacity to depart (Dependent on safety risk present) The ATC/LTC to initiate risk minimisation strategies allowing SAPOL to leave
- SAAS Mental Health Escort Officers should be utilised for any inter-hospital transfers

NOTE: Pursuant to 55(1) MHA 2009 Police or Authorised Officers (includes Mental Health Clinicians) may only apprehend persons not complying with a CTO if a transport request has been issued by Medical Practitioner or Mental Health Clinician. SAPOL/Authorised Officers have no authority to restrain persons whilst CTO medication is administered.

APPENDIX J

SAPOL FIELD REQUEST TO MHS

SAPOL complete PD 145 MH Assistance Form.
ENSURE Safety search conducted on the person.

SAPOL request MHS attendance via SAPOL communications centre.
NOTE: Benchmark of attendance of MHS is ASAP or at least within 60 minutes.

MHS ATTENDS FOR ON SCENE ASSESSMENT.
SAPOL provide MH Assistance Form to attending Medical Practitioner (MP), Authorised Health Professional (AHP) or MHS worker.

MHS MP/AHP PRESENT

DETAINED
MP/AHP to provide:
- Level 1 Detention * Treatment Order (L1 DTO) Detention Order Form 1.
- Completed & signed PD 145 MH Assistance Form advising person assessed and detained.
- Transport Request

NOTE: Transport Request should be to an Authorised Officer in preference to SAPOL (Dependent on safety risk assessment SAPOL escort may be provided to ATC/LTC or other hospital

- MHS to facilitate entry to an ATC/LTC or other hospital.
- Until an appropriate transfer has been carried out MHS provide assistance until a clinical decision has been reached regarding future management

NOT DETAINED
MP/AHP to provide:
- Completed & signed PD 145 MH Assistance Form advising person assessed & not detained.
  - SAPOL to release / arrest / report person (As applicable).
  - SAPOL refer to other service as required.

MHS MP or AHP NOT PRESENT

Based on available evidence SAPOL will determine whether they utilise their authority to apprehend (S57).

NOTE:
SAPOL members may determine that for expediency the person is apprehended & conveyed to an ATC/LTC, other hospital or other location for a mental health assessment.

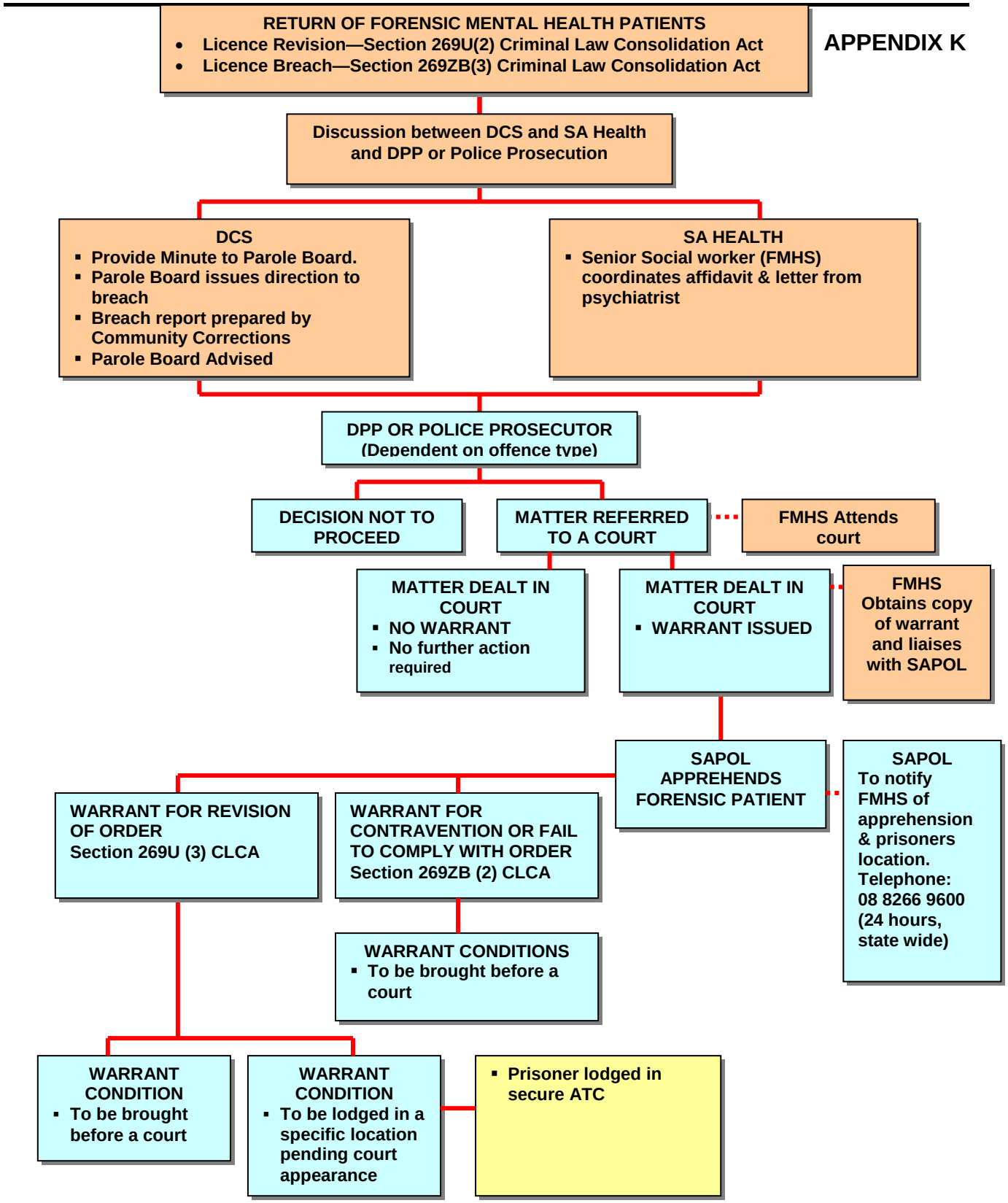
RFDS / SAAS convey to a ATC/LTC.

- Police escort based on safety risk assessment.
- Police escort provided for all SAPOL prisoners until they are lodged in a secure ATC.
- NOTE: SAPOL members also see following Flow Charts
  - SAPOL Custodial Facility
  - SAPOL Prisoner presented to ATC'LTC or other hospital.
  - Authorised Treatment Centre/Limited Treatment Centre or other Hospital – Presentation by Authorised Officer or Police

GENERAL REQUIREMENTS

- A safety search is conducted prior to each handover between services.
- If benchmarks or other standards within the MHMOU are not met, safety risk assessment not accepted or there are any other MHMoU issues contact signatory party manager and provide details. All attempts to be made to resolve the dispute before referring. Disputes and resolution decisions to be noted on MH Assistance Form and provided to signatory party LLG representative.
- Transport options within the MHMoU are considered.
- A plan is developed to address a current situation considering all risks.
- An agreed joint agency management plan is implemented for those mental health patients who pose an ongoing safety risk.
- If SAPOL accept a transfer of risk (based on a safety risk assessment), then SAPOL will determine their involvement and how the risk is managed until the risk is minimised to a safe and acceptable level.

APPENDIX K



GENERAL REQUIREMENTS

- Compliance with the wording of the warrant is required.
- Custody management during any transport is not to be transferred to Authorised Officers.
- If Warrant specifies prisoner to be lodged at James Nash House, FMHS is responsible to coordinate placement of the Forensic Patient.

NOTE: If Forensic Patient is required to be lodged in specific location pending court appearance any required medical clearances is the FMHS. SAPOL willl depart upon warrant conditions being met.

APPENDIX L

MENTAL HEALTH MISSING PERSONS

Persons suffering from a mental illness and who are either a voluntary consumer, subject to orders pursuant to Section 32 of the Guardianship and Administration Act, 1993, Mental Health Act,2009, or 269 Criminal Law Consolidation Act,1935, may at times abscond from or fail to return to a treatment centre or a place of detention.

Some mental health consumers may be considered a risk to themselves or the community. Based on identified risk, all attempts shall be made to safely return the person is to be conducted as below:

SA HEALTH

Determine if the person is:

- ☐ A voluntary status consumer.
- ☐ Subject to either a Level 1 or 2 Community Treatment Order.
- ☐ Subject to either a Level 1,2,3 Detention and Treatment Order
- ☐ Guardianship and Administration Act.
- ☐ A person subject to S269 Criminal Law Consolidation Act (Warrant issued or not).

SA HEALTH STAFF

- ☐ Complete appropriate incident reports.
- ☐ Determine a Grade of Risk :
  - **Grade of Risk 1—Serious.**
  - **Grade of Risk 2—Moderate.**
  - **Grade of Risk 3— Low.**

SA HEALTH STAFF

- ☐ Search grounds, contact security, next of kin, conduct reasonable enquiries at places where the person frequents or with persons they associate with.
- ☐ Contact appropriate manager to discuss actions undertaken or proposed to be undertaken.
- ☐ Provide SAPOL missing person report to the nearest SAPOL Local Service Area. Provide copy of any CTOs or DTOs and the date of expiry which is existence for the person. Also provide details of the facility from which the person is missing and contact details of the treating medical practitioner/authorised medical practitioner, psychiatrist or mental health clinician etc
- ☐ Provide SAPOL any risk grading, reasons for concern, all available details to assist in locating the missing person.
- ☐ Provide SAPOL with sufficient information so that SAPOL may locate and return the person in a safe manner (See MHS Field Request to SAPOL Flow Chart with types of information required).
- ☐ Notify SAPOL immediately upon locating the missing person (Note: - In consultation with SAPOL, a person may be considered located if sighted).

SOUTH AUSTRALIA POLICE

- ☐ Submit a SAPOL Missing Person Report—including risk grading.
- ☐ Notify SAPOL Communications (All patrols message). Patrol to be tasked.
- ☐ Patrol supervisor to coordinate response.
- ☐ Liaise with relevant SA Health staff.
- ☐ SAPOL will return person to facility from where they have absconded or in the case of a person located and an order has expired consider the provisions of Section 57 Mental Health Act, 2009 and present the person for a medical examination to determine their mental health status.

MEDIA RELEASES

- ☐ Responsibility for media releases rests with SA Health.
- ☐ Consultation between SA Health and SAPOL is to be undertaken prior to any media release.
  - ☐ Contact SA Health Media Section—**8226 6488**.
  - ☐ Contact SAPOL - LSA Operations Manager.
- ☐ Where there is a public safety concern in relation to the missing person, SAPOL may release information subject to legislative restrictions and the Information Privacy Principles.

APPENDIX M

MHMoU KEY PERFORMANCE INDICATORS

Key Performance Indicator	Benchmark	Source	Responsible Group
Number of MHMoU disputes	Nil	Minutes from LLG meetings and information from contact officers	Mental Health and Emergency Services Steering Committee
Number of assessment benchmarks met	• 66% improvement in meeting benchmark	SAPOL/SAAS/MHS	SAPOL/SAAS/MHS
Number of response benchmarks met	• 66% improvement in meeting benchmark	SAPOL/SAAS	SAPOL/SAAS
Number of inter hospital transfers	• 100 % reduction in use of Police, except via the requirements of the MHA 2009. • 50% reduction in SAAS transfers between 2200 - 0800	SAPOL SAAS	SAPOL SAAS
Number of patients at large from an ATC/LTC	• 66% improvement	SAPOL missing persons records	SAPOL.
Operation of LLGs	• No of meetings • Full agency attendance • No of LLG protocols implemented • No of education activities undertaken • No of incidents requiring dispute resolution • No of interagency crisis response plans initiated.	LLG Annual audit	Mental Health and Emergency Services Steering Committee