Foreword

The Accredited Person’s Program, introduced in New South Wales in 2003, has proven to be a significant step towards ensuring that people across New South Wales have access to prompt assessment and treatment for their mental illness.

The training for Accredited Persons is provided by the NSW Institute of Psychiatry and is funded by the Mental Health and Drug & Alcohol Office.

This updated Handbook provides a clear explanation of the legal and clinical framework within which accredited persons exercise their duties and responsibilities.

It is a valuable reference tool for all clinicians making decisions under the *Mental Health Act 2007*

---

Dr Ros Montague  
Director, NSW Institute of Psychiatry

David McGrath  
Director, Mental Health and Drug and Alcohol Office
Contents

1 Overview

2 Mental Health Act – General Principles
   Objects of the Mental Health Act
   Process of Involuntary Admission
   Key Definitions
      Who is a mentally ill person under the Act?
         Definition
      What is a mental illness for the purpose of the Act?
      What is serious harm?
      What is a continuing or deteriorating condition?
   Who is a mentally disordered person under the Act?
      Definition
      What is irrational behaviour and serious physical harm?
      Are there reasonable grounds for deciding?
   Exclusion Criteria
   Declared Mental Health facilities
   Cross Border Mental Health Agreements

3 The Role of Accredited Persons Under the Mental Health Act
   Detention on the certificate of an accredited person (s19)
      Element 1
      Element 2
      Element 3
      Element 4
      Element 5
      Element 6
      Time Limits
Detention following an order for medical examination (s23)  

4 Filling in Part 1 of a Schedule 1  
Obtaining Schedule 1 forms  

5 Administrative Decision-Making Principles  
The duty to act honestly  
Bad faith or improper purpose  
Irrelevant considerations  
Uncertainty (and lack of finality)  
Fettering discretion  
Acting on policy  
Acting under dictation  

Rules of Procedural Fairness  
The hearing rule  
The bias rule  
The ‘no evidence’ rule  

6 Clinical Considerations  
Assessment  
Establishing rapport  
Assessing the symptoms specified by the Act  
Assessing: risk of ‘serious harm’ to self  
Assessing: risk of ‘serious harm’ to others  
Assessing the person’s history  
Assessing the family’s views  
Assessing the social situation  
What are you trying to achieve?  
If the decision is made to schedule  
Elements of decision making in assessing for involuntary admission
7 Additional Considerations in Scheduling

Younger clients – under 16 years ......................................................... 37
Cultural issues ..................................................................................... 37
Aboriginal clients ................................................................................. 38
Clients from culturally and linguistically diverse backgrounds .......... 39
Booking an interpreter ....................................................................... 39
Cultural considerations ...................................................................... 39
Forensic clients in the community ....................................................... 40

8 Getting the Person to Hospital Safely .............................................. 41

Overview of transport options ........................................................... 41
Is police assistance required? .............................................................. 42
The general principles of the Memorandum of Understanding
  The role of the duty officer ................................................................. 43
  Determination of risk ....................................................................... 44
  Sharing information with the police .................................................. 44
  Practice issues .................................................................................. 44
  Flow charts ....................................................................................... 45

9 Reflecting on Your Practice ............................................................... 47

When the process goes well ............................................................... 47
The worst aspects of the process ......................................................... 48
Making improvements ......................................................................... 48

Appendices

List of Declared Mental Health Facilities ............................................ 51
Charts from the Memorandum of Understanding ................................ 55
Obtaining Schedule 1 Forms ................................................................. 62
Contacts – general .............................................................................. 62
Contacts – local .................................................................................. 63
Introduction

The primary role of an accredited person is to make an initial decision about a person’s need for involuntary admission under the NSW Mental Health Act 2007. As the circumstances surrounding these decisions are often complex and challenging, it is important that those responsible possess a high level of clinical experience and a thorough understanding of the legal requirements that regulate their role.

This Handbook has been revised, in line with changes to mental health legislation, to assist those who have been appointed as Accredited Persons.

It sets out the general principles that underpin the Mental Health Act 2007, and reviews the key sections that define the accredited person’s role. It summarises the clinical issues to be weighed during an assessment and highlights some of the additional considerations that are required when dealing with those whose needs are more complex because of their age or cultural background.

Finally the Handbook addresses the important issue of working effectively with the police when their assistance is required in transporting a person to hospital.

On behalf of the NSW Institute of Psychiatry, we would like to thank all those who assisted in the development of this Handbook, and those that have been involved in the development and the delivery of the training programme. In particular we would like to thank Pamela Verrall who prepared the original Accredited Person’s Handbook upon which this edition is based.

We would also like to thank those involved in the development and delivery of the training:

Dr Ian Ellis-Jones, Dr Fran Wilson, Dr Andy Campbell, Tony Ovadia, , Her Honour Judge Helen Syme, Superintendent Dave Donohue, Kevin McLaughlin, Elisabeth Barry, Simon Champ, John Fenely, Maria Bisgoni, and Marc Reynolds.

It is their contributions that form the basis of Handbook’s contents.

We hope that the material presented in the Handbook will assist those who have been accredited to perform their role in a way that enables the rights, dignity and self-respect of all those involved in the process to be maintained.

Peter Bazzana and Jenny Shaw
NSW Institute of Psychiatry
February 2012
Accredited persons are suitably qualified senior mental health practitioners, appointed by the Director-General of the Department of Health under s136 of the Mental Health Act 2007.

They are most commonly an allied health professional who is specifically empowered to write Schedule 1 certificates, usually in areas where there are insufficient medical practitioners.

These certificates, completed by either a medical practitioner or an accredited person, enable someone to be taken to a declared mental health facility against their will if necessary for the purpose of an assessment.

They provide the legal foundation for the majority of involuntary admissions in NSW. Accreditation attaches to an individual employed within an Area Health Service so each accredited person is subject to the relevant policies and procedures of that area.
Chapter 2
Mental Health Act – General Principles

The Mental Health Act 2007 is an Act to make provision with respect to the care, treatment and control of mentally ill and mentally disordered persons and other matters relating to mental health. While the Act contains certain provisions for the care of those who are admitted voluntarily to declared mental health facilities (voluntary patients), its primary concern is with the rights and procedures that pertain to those who are detained in a declared mental health facility or otherwise treated against their wishes.

Objects of the Mental Health Act
Section 3 of the Act specifies that the objects of this Act are:

a) to provide for the care, treatment and control of persons who are mentally ill or mentally disordered, and
b) to facilitate the care, treatment and control of those persons through community care facilities, and
c) to facilitate the provision of hospital care for those persons on a voluntary basis, and where appropriate and, in a limited number of situations, on an involuntary basis, and
d) while protecting the civil rights of those persons, and giving an opportunity for those persons to have access to appropriate care, and
e) to facilitate the involvement of those persons, and persons caring for them, in decisions involving appropriate care, treatment and control.

Process of involuntary admission
The Mental Health Act provides a number of ways in which the process of involuntary admission can be lawfully initiated:

- on a mental health certificate given by a medical practitioner or accredited person (see section 19),
after being brought to the facility by an ambulance officer (see section 20),
after being apprehended by a police officer (see section 22),
after an order for an examination and an examination or observation by a medical practitioner or accredited person (see section 23),
on the order of a Magistrate or authorised officer (see section 24),
after a transfer from another health facility (see section 25),
on a written request made to the authorised medical officer by a primary carer, relative or friend of the person (see section 26).

In 2007 for example there were 14861 involuntary admissions from the community under a combination of the 1990, and the 2007 Acts. Of these admissions the majority (67%) were initiated by a medical practitioner or an accredited person with a further 22% being initiated by police.

Regardless of the method by which a person is initially brought to declared mental health facility, their continued detention depends on a further 2 (and in some cases 3) examinations.

The first examination must be performed by an authorised medical officer, as soon as practicable, within a maximum 12-hour time limit (s27a).

If that doctor finds the person to be either ‘mentally ill’ or ‘mentally disordered’ then a second examination must occur ‘as soon as possible’ and be conducted by a psychiatrist (s27b).

Where the first doctor finds that the person is neither ‘mentally ill’ nor ‘mentally disordered’, then the person must be discharged. A third examination is required where the second doctor finds the person not ‘mentally ill’ or ‘mentally disordered’. (A more detailed explanation of the examination sequence can be found in the Mental Health Act Guide Book.) The results of these examinations are documented on Form 1s.

This procedure has been established to ensure that people are both thoroughly assessed and not detained unnecessarily. However, the complexity and inevitable delays involved at each stage can heighten the patient’s confusion and distress. Each accredited person therefore needs to be:

- conversant with the admission protocols of the declared mental health facilities in their area
- able to liaise with the unit to minimise admission difficulties
- able to explain the process simply to the person being scheduled and to relevant carers.

Once a person has gone through the examination procedure and been found to be a ‘mentally ill person’ they must be brought before the Tribunal for a mental health inquiry as soon as practicable (s27d). Part of the magistrate’s role is to examine the Schedule 1 and the Form 1s to ensure that the correct procedures have been followed.
and that the person’s detention is valid. Particular care must therefore be taken in completing the Schedule 1, as a defective document can invalidate a person’s involuntary admission.

Key definitions

The Mental Health Act contains 2 key definitions that underpin the decisions of an accredited person. These are the definitions of:

- a mentally ill person
- a mentally disordered person.

Who is a mentally ill person under the Act?

Definition (s14)

A mentally ill person is someone who is suffering from a mental illness and owing to that illness there are reasonable grounds for believing that care, treatment or control of the person is necessary:

- for the person’s own protection from serious harm, or
- for the protection of others from serious harm.

In considering whether someone is a mentally ill person, their continuing condition, including any likely deterioration in their condition, is to be taken into account.

What is a mental illness for the purpose of the Act? (s4)

Mental illness for the purposes of the Act means a condition that seriously impairs, either temporarily or permanently the mental functioning of a person, and is characterised by the presence of any one or more of the following symptoms:

- delusions
- hallucinations
- serious disorder of thought form
- severe disturbance of mood
- sustained or repeated irrational behaviour indicating the symptoms mentioned above.

When completing a Schedule 1 your observations should be expressed in these terms rather than the diagnostic and clinical terminology with which you may be more familiar. It is important to remember that not every condition characterised as a mental illness in the DSM or the ICD will be a mental illness for the purposes of the Mental Health Act.
A person experiencing a mild depressive episode in the absence of a risk to self and others may have a recognised mental condition but not a mental illness for the purposes of the Act.

The symptoms included in the definition should be given their ordinary accepted meanings in the psychological sciences, without reference to overly clinical complexities or distinctions. For example a ‘delusion’ may be simply considered to be a belief held in the face of evidence normally sufficient to destroy the belief, and a ‘hallucination’ to be a subjective sense experience for which there is no appropriate external source.

What is serious harm?

Serious harm is a broad term that is to be understood in terms of its everyday usage. It can include any of the following:

- harm to reputation or relationships
- financial harm
- self-neglect
- neglect of others, e.g. the person’s children
- physical harm.

Serious harm under the definition of a ‘mentally ill’ person is not restricted to serious physical harm.

What is a continuing or deteriorating condition?

This is a broad and open concept that requires an accredited person to consider:

- a person’s clinical history including their understanding of their illness
- a person’s capacity or willingness to follow a voluntary treatment plan
- the likely impact on the person’s condition if they fail to follow a treatment plan.

This provision allows an intervention to occur before a person deteriorates to the most acute phase of their illness.

Who is a mentally disordered person under the Act?

Definition(s)

A mentally disordered person is someone whose behaviour for the time being is so irrational that there are reasonable grounds to justify a conclusion that temporary care, treatment or control of the person is necessary to protect them or others from serious physical harm.
What is irrational behaviour and serious physical harm?

These terms have no particular legal definition and are to be understood in terms of their everyday usage. Under the ‘mentally disordered’ definition the concept of harm is restricted to considerations of serious physical harm.

The mentally disordered provision is most commonly used when a person presents as suicidal following a personal crisis e.g. a relationship breakup. Intoxication (drugs and alcohol) and impulsivity often feature in these situations.

Are there reasonable grounds for deciding?

Your conclusion that a person is ‘mentally disordered’ needs to be based on relevant facts and observations simply and legibly summarised on the Schedule 1. It is not sufficient to believe that there are reasonable grounds. Some evidence supporting your decision must be documented.

Exclusion Criteria (s16)

These criteria are included in the Act to prevent the broad scope of s9 & 10 being used to sanction or control behaviour that is not related to mental illness. Therefore a person is not to be defined as ‘mentally ill’ or ‘mentally disordered’ MERELY because of the presence or lack of any one or more of the following:

- religious, political beliefs or philosophy
- sexual preferences/orientation
- sexual promiscuity
- immoral or illegal conduct
- developmental disability
- drug or alcohol abuse
- antisocial behaviour
- economic or social status
- member of a particular cultural or racial group

Declared Mental Health Facilities

Declared mental health facilities are premises subject to an order in force under section 109, that is, premises declared by order of The Director General (and published in the Gazette) to fulfil certain functions under the Act.
Under section 109 of the Act, the Director-General may specify classes of declared mental health facilities and limit the sections of the Act that apply to each class.

The full list of facilities which will play a role in the assessment and management of persons detained under the Act has yet to be finalised.

The three initial classes are:

- a mental health emergency assessment class (to deal with short term detention for initial assessment);
- a mental health assessment and inpatient treatment class (which would enable the full range of inpatient functions under the Act, in a similar manner to “gazetted hospitals” under the previous Act, even if not in all cases providing all of those functions); and
- a community or “health care agency” class (to administer community treatment orders).

These arrangements are relevant to Accredited Persons because of the fact that on the basis of a mental health certificate issued by a medical practitioner or accredited person (s19), a person may only be detained in a declared mental health facility of class a) or b) above.

Accredited Persons may be directly involved in the transport of a person from the community to a declared mental health facility or they may be advising staff of NSW Health, NSW Police Force or the Ambulance Service of NSW regarding the transport and they need to be aware of the appropriate facilities in their local area.

**Cross border mental health agreements**

The Act makes provision with respect to the following matters:

- the interstate transfer of patients under mental health legislation,
- the interstate recognition of documents enabling detention of persons under mental health legislation,
- the treatment of interstate persons and persons in this State subject to community treatment orders or similar orders made in other States,
- the apprehension of persons subject to certain interstate warrants or orders, or otherwise liable to apprehension, under mental health legislation.

With the development of local protocols between services along the border a more flexible approach to the delivery of mental health services for these communities is anticipated.

Accredited persons who are exercising their powers along this border should familiarise themselves with the local protocols between services as they develop. They should be aware that a mental health certificate issued by them (s19) ceases to have any effect under this Act if the person concerned is taken to and detained in a mental
health facility in another State.

NSW has the following Ministerial Agreements with bordering jurisdictions:

- agreements for the return of absconding forensic mental health patients with Victoria and Queensland;
- agreements for the treatment, care and transfer of civil mental health patients with Victoria, Queensland, SA and the ACT

Guidelines providing operational guidance for the implementation of the Agreements are being developed. The Guidelines establish the agreed principles for when and how mental health services are provided to residents of the other States. They are being written in the expectation that local protocols between services along the Victorian-NSW border will be developed to adopt a more flexible approach to improve mental health service delivery for local communities.

The Agreements and Guidelines will be available via the NSW Health website.
Chapter 3

The role of Accredited Persons under the Mental Health Act

The accredited person’s role is set out in sections 19 and 23 of the Mental Health Act.

Detention on the certificate of a medical practitioner or an accredited person (s19)

This section of the Act specifies six elements that must be satisfied before a person is detained on a Schedule 1.

Element 1

- You must personally examine or personally observe the patient.
  
  *This may include examining a person by video-conference or from behind a closed door. A phone call however, is insufficient. The contact needs to be direct and involve intentional awareness or scrutiny of the person and their behaviour.*

- You must complete the certificate shortly after the examination.

Element 2

- You must be of the opinion that the person is either ‘mentally ill’ (s14) or ‘mentally disordered’ (s15).
  
  *In some situations others may try to exert undue influence on your decision e.g. relatives, colleagues, superiors, police etc. The Act requires that you be satisfied that the person meets the criteria set out in ss 14 or 15.*
Element 3
You must be satisfied that no other appropriate means for dealing with the person are reasonably available and that involuntary admission and detention are necessary.

*Even if your examination leads to the view that the person is ‘mentally ill’ or ‘mentally disordered’, involuntary admission may not be necessary or appropriate. You need to assess the person’s social resources and consider any realistic options e.g. what can be expected of friends and family; what can the community mental health team provide; is a voluntary admission possible?*

Element 4
You must not be a near relative or the primary carer of the person.

*A near relative is a parent, brother, sister, child, spouse.*

Element 5
You must use the prescribed form (Schedule 1).

*Information on where to obtain forms can be found in Contacts.*

Element 6
You must declare any pecuniary interest either direct or indirect held by yourself, near relative, partner or assistant in any private mental health facility.

*A ‘private mental health facility’ is usually a privately owned hospital that has been granted a licence to admit, treat and care for patients. A pecuniary interest in such a hospital does not preclude an accredited person from completing a Schedule 1.*

Time limits
A Schedule 1 remains valid for:

- 5 days after it is written for a mentally ill person and
- 1 day after it is written for a mentally disordered person.

*Undated Schedule 1s are not to be left with family members to fill in if and when the person’s mental state deteriorates.*
Detention following an order for medical examination or observation (s23)

Although not a commonly used part of the Mental Health Act (112 occasions in 2007), the section becomes important if you are asked to assess a person who is believed to be mentally unwell, but is inaccessible. This section enables a magistrate, or an authorised officer, to authorise forceful entry to a person’s premises for the purpose of examination under section 19 of the Act.

An application can be made (by any interested party) to a magistrate. If the magistrate is satisfied that:

- the person is a ‘mentally ill’ or ‘mentally disordered’ person and
- because of physical inaccessibility that person cannot be examined

then the magistrate can make an order authorising an accredited person (accompanied by the police if required) to visit and examine the person.

Such an order:

- authorises the use of force to enter premises (if necessary)
- enables the person to be scheduled (if necessary) and
- requires the accredited person to notify the magistrate in writing of the outcome of the order.
Chapter 4

Filling in Part 1 of a Schedule 1

The Schedule 1 is an important legal document that:

■ deprives a person of their liberty for the purpose of ensuring their further assessment
■ authorises their transport to hospital against their will.

It also:

■ communicates pertinent information to other professionals involved in the person’s admission
■ becomes part of the person’s medical record
■ will be scrutinised by a magistrate should the person be admitted as a mentally ill person.

The following information should be clearly stated on the form:

■ who has been scheduled
■ when this occurred
■ who made the decision
■ whether the person is regarded as ‘mentally ill’ or ‘mentally disordered’
■ a brief summary of the reasons for that decision
■ any physical factors that may have an impact on the person’s mental state.

While the information provided on the Schedule 1 is legally sufficient to commence the process of involuntary admission, where possible it should be accompanied by additional material such as a referral letter or mental state examination. This will provide a more detailed picture of the person’s circumstances for the subsequent decision-makers.

*Notes accompanying Schedule 1 can be found on pages 60–61*
MENTAL HEALTH ACT 2007

(Section 19)

Schedule 1 - medical certificate as to examination or observation of person

PART 1

1. ............................................................................................................ (Medical Practitioner/Accredited person)
   Name ............................................................................................................
   (full name—use block letters)

   Immediately before or shortly before completing
   on ............................................................................................................ 20 ..... immediately before or shortly before completing
   this certificate, at ............................................................................................................
   (State place where examination/observation took place)

   I personally examined/observed ............................................................................
   (name of person in full)

   for a period of ............................................................................................................
   (state length of examination/observation)

   I certify the following matters.

   1. I am of the opinion that the person examined/observed by me is a mentally ill person suffering
      from mental illness or a mentally disordered person and that there are reasonable grounds for
      believing the person's behaviour for the time being is so irrational as to justify a conclusion on
      reasonable grounds that temporary care, treatment or control of the person is necessary:
      (a) in the case of a mentally ill person:
          (i) for the person's own protection from serious harm, or
          (ii) for the protection of others from serious harm, or
      (b) in the case of a mentally disordered person:
          (i) for the person's own protection from serious physical harm, or
          (ii) for the protection of others from serious physical harm.

   2. I have satisfied myself, by such inquiry as is reasonable having regard to the circumstances of
      the case, that the person's involuntary admission to and detention in a mental health facility are
      necessary and that no other care of a less restrictive kind is appropriate and reasonably available
      to the person.

   3. Incidents and/or abnormalities of behaviour and conduct (a) observed by myself and (b)
      communicated to me by others (state name, relationship and address of each informant) are:
      (a) ............................................................................................................
      ............................................................................................................
      ............................................................................................................
      ............................................................................................................

      (b) ............................................................................................................
      ............................................................................................................
      ............................................................................................................
      ............................................................................................................

Provide brief summary of
behaviours/symptoms
supporting conclusion that
person either mentally ill or
mentally disordered

Clearly delete
either (a) or (b)

Provide brief summary of
behaviour/symptoms
reported by 3rd parties
including their names etc.
Obtaining Schedule 1 Forms

- Schedule 1 at back of Mental Health Act
Chapter 5

Administrative Decision-making Principles

The decisions you make as an accredited person are not only framed by the legal definitions and requirements of the Mental Health Act, but are more broadly underpinned by the principles of administrative law. These principles are there to guide you in making fair and proper decisions.

The duty to act honestly

The duty to act honestly means to refrain from exercising the powers vested in you as an accredited person in order to:

- obtain some private advantage, or
- achieve some object other than that for which the power was conferred.

A breach of the obligation to act honestly involves:

- a consciousness that what is being done is not in the interests of your client, employer or the community, and
- deliberate conduct in disregard of that knowledge.

On Friday afternoon you receive a call from one of your colleagues asking you to complete a Schedule 1 in relation to a client who is well known to the service. Your colleague describes the client’s condition and it seems to fit the definition of ‘a mentally ill person’. It will take you an hour and a half to get to the client’s house. You know something of the client and trust the judgement of your colleague so you agree to complete the Schedule 1 and drop it off at the Emergency Department in town. This seems like the quickest and safest way of ensuring that the person gets to hospital for further assessment.

In failing to personally examine or observe the person you have acted dishonestly, however good your intentions may have been.
Bad faith or improper purpose

An accredited person must not exercise their powers in bad faith or for an improper purpose i.e. a purpose other than that for which the power was conferred.

As a newly accredited person you have not had the opportunity to schedule anyone for the first 9 months. Fearing that your authorisation may be removed, you decide to schedule a dozen people to get in some practice and show that you’ve got what it takes.

This would clearly be an improper use of the power.

Irrelevant considerations

Every decision maker must take into account and give proper attention to all the relevant considerations, and likewise disregard extraneous or irrelevant matters. As an accredited person this means weighing all of the elements specified in the Schedule 1 before coming to a decision. While irrelevant considerations will often form part of the context in which a decision is made, they must not provide the basis for your decision.

During an assessment you recall that this person used to bully your sister on the school bus 15 years ago. You observe some indications of mental illness and risk of harm, but you are not sure that a Schedule 1 is warranted in these circumstances. However, you decide that scheduling this person can be justified and taking them to hospital against their wishes will provide some kind of ‘justice’ for your sister.

The person’s past behaviour in relation to your sister is an irrelevant consideration.

Uncertainty (and lack of finality)

A decision may be declared invalid if:

- it is so uncertain that no reasonable person could comply with it, or
- it cannot be given any sensible meaning.

A Schedule 1 may be so poorly completed that it is declared invalid at the magistrate’s inquiry. If this occurs then all the subsequent decisions relating to the person’s involuntary status are also invalid. If the person is unwilling to remain in hospital as a voluntary patient they must be discharged immediately.
Fettering discretion

An accredited person must be capable of giving genuine consideration to the matter in hand and not approach the situation with a closed mind.

This may present difficulties where a client is well known, even if not to you personally. Commonly held views about particular individuals may be held within mental health teams e.g. opinions about who is ’non-compliant’ or who has ’no insight’. Additional effort will be needed to approach these clients with an open (unfettered) mind rather than a pre-formed view.

Acting on policy

As an accredited person it is important to adhere to the policies and guidelines developed by your local Area Health Service concerning the use of accredited persons in your area. These policies and guidelines provide additional guidance in relation to your obligations and accountabilities under the Mental Health Act.

Acting under dictation

In making your decisions under ss 19, 20 and 23 of the Mental Health Act you need to act in an independent manner, not dictated to by a third party e.g. relative, colleague or superior. If a decision–maker feels obliged to decide a matter in a particular way because of another’s views on the matter, this can be construed as ’dictation’ even though no specific direction has been given. This does not of course preclude listening to, or having regard for sources of relevant opinion.

Rules of procedural fairness

These rules relate not so much to which matters are to be considered in making a decision, but how a fair decision is reached.

The hearing rule

The general law requires that a person be informed of the case against them and be given the opportunity to reply before a decision is made that deprives them of some right, interest or benefit.

In the context of scheduling this means that you should make every effort to:

- explain as clearly as possible your view of the situation and the options
- listen to the person’s point of view
answer questions from the person or their friends and family about the options before arriving at your decision.

**The bias rule**

The bias rule states that if a decision-maker has an interest (pecuniary or otherwise) in the outcome of a particular decision that person is barred from dealing with the matter.

This issue is dealt with specifically in Question 7 of the Schedule 1 where you are asked to disclose any pecuniary interest that you, or your partner or near relative might have in a declared mental health facility. In this case your declaration does not exclude you from making the decision. However, an active and particular dislike for the person to be assessed would exclude you on the grounds of bias.

**The ‘no evidence’ rule**

This rule states that an administrative decision must be based on logically probative material and not mere speculation, suspicion or hearsay.

As an accredited person this means that you need to directly examine or observe the person being assessed. Your decision must be based on your own contemporaneous observations and not rely on the opinions of others. This means that you can’t complete a Schedule 1 after merely talking to the person’s relatives and friends.

If the person to be assessed leaves before you arrive you can certainly speak to others to gain relevant information, but you cannot fill out the Schedule 1, sign it and leave it with the relatives for them to bring the person in when they return.
Chapter 6

Clinical Issues

At different times you may be called in early on during an assessment, or after an assessment has been conducted by someone else from the mental health team. Whatever the circumstances you need to make your own observations upon which to base your decision.

Assessment

The following factors should be considered during your assessment.

Establishing rapport:
- greet the person and their family and friends
- if possible speak to the person first
- be open to the person’s experience and views
- find some common ground
- reassure the person that their view is important.

Assessing the symptoms specified by the Act.

Hallucinations:
- perceptions occurring in the absence of the corresponding sensory stimulus
- experienced as immediate, vivid, independent of will and often, even if only momentarily, felt to be real.
- may be experienced by well people under unusual circumstances e.g. in acute bereavement, sensory deprivation.
**Delusions:**
- unshakeable and false beliefs inconsistent with person’s cultural, religious or social background.

It is preferable to make gentle enquiries rather than challenging the person’s delusions directly.

**Thought disorder:**
This is often evidenced by the following:
- circumstantial or tangential speech
- blocking or derailment
- loosening of associations
- non-sequiturs and verbal perseveration
- flight of ideas

**Severe disturbance of mood:**
This is often evidenced through a sustained subjective feeling state that is:
- depressed, anhedonic
- elated, euphoric
- irritable, angry
- fearful or guarded
- detached, indifferent, apathetic.

This may be elicited by asking about personal losses, disappointments and joys; hobbies and interests; relationships and work (successes and failures).

**Sustained or repeated irrational behaviour:**
This is often evidenced by:
- self harm or harming others
- agitation (increased purposeless behaviours)
- neglecting self care
- acting on delusions or command hallucinations
- disinhibition – sexual, physical or financial
- catatonia.
Assessing risk: ‘serious harm’ to self

► **Physical harm**

In assessing suicidality it is important to take note of:

- threats or attempts current and past
- degree of intent or planning
- hope for the future
- lethality of means
- attitude after resuscitation
- contributing factors e.g. grief, mental illness, substance abuse, physical illness.

► **Non-physical ‘serious harm’**

- social harm – e.g. damage to reputation by anti-social or disinhibited behaviour/capacity to care for self
- financial harm – e.g. squandering resources or delusions of poverty
- psychological harm – e.g. developmental arrest in young person with schizophrenia who is refusing treatment.

Assessing risk: ‘serious harm’ to others

► **Physical harm**

The risk of serious physical harm to others may be increased by:

- paranoia
- incorporation of others into delusions
- danger to children of untreated mental illness in a parent.

► **Non-physical ‘serious harm’**

- social harm – e.g. social isolation of family, withdrawal of children from education or peers because of a parent’s untreated illness
- financial harm – e.g. effects on family of loss of job, squandering of financial resources
- psychological harm – e.g. PTSD in children or spouses.
Assessing the person’s history
- psychiatric – first episode or part of a continuing condition (consider the likelihood and consequences of deterioration)
- medical
- family

Assessing the family’s views
- pre-morbid personality and functioning
- family history
- recent changes in person being assessed: degree, duration, persistence
- behavioural manifestations of psychosis
- what’s the family’s explanatory model and what do they want?

Assessing the social situation
What resources are available to family and friends?
- time
- personal support network
- level of care that can be provided by the community team.

What are the attitudes of family and friends to the person’s illness?
- knowledge and understanding
- willingness and ability to care for the person
- ability to assist with management of medication
- ability to contain the person.

What are you trying to achieve?
While each situation requires a specific and individual response the following general principles apply:
- minimise the trauma
- reduce the delay
- organise treatment at home where possible
- provide information and support to the family
- involve family and friends where appropriate
provide a clear explanation of processes
minimise police involvement.

If the decision is made to Schedule
facilitate the admission and transport
provide a clear explanation of the process to the person and/or family
if you are not accompanying the person to hospital ensure that family and friends are clear about the process and their options (e.g. accompanying the person).

Elements of decision-making in assessing for involuntary admission
establish rapport with the person that encourages communication, care planning and the achievement of common goals
make decisions in collaboration with team members where possible
what is the least restrictive environment in which the person can be safely treated at this time?
is the person likely to cause ‘serious harm’ to themselves or others (‘serious physical harm’ in the case of mental disorder)?
is the person a ‘mentally ill’ or ‘mentally disordered’ person as defined by the Act?
base your assessment on reports from relevant others and your own observations of the person.
Chapter 7
Additional Considerations in Scheduling

While the provisions of the Mental Health Act apply generally, the appropriateness of scheduling particular individuals may require the consideration of additional issues such as age and cultural background.

Younger clients – under 16 years

Young people who come within the definitions of ‘mentally ill’ or ‘mentally disordered’ persons can be scheduled in the same way as adults. It is particularly important in this situation, however, to explore the option of an informal (voluntary) admission with the consent and cooperation of the parent(s) or guardian if treatment at home is not an option.

The Mental Health Act also contains the following specific provisions in relation to the voluntary admission of children:

- a child may request voluntary admission (s5)
- if the child is under 16, the hospital must notify the parent or guardian as soon as practicable of a voluntary admission (s6(1))
- if the child is 14 or 15 they may choose to continue as a voluntary patient even where a parent or guardian objects (s6(2))
- if the child is under 14 parental consent is essential for the admission to proceed (s6(3))
- if the child is under 14, where a parent or guardian objects to the care or treatment, the medical superintendent must discharge them (s6(4)).

Cultural issues

The Mental Health Act specifies that the ‘religious, cultural and language needs’ of clients be taken into account throughout the different stages of their care, control and treatment, and that they be informed of their legal rights and entitlements in ‘the language or terms that they are most likely to understand’. These provisions are
particularly important in relation to those from an Aboriginal or culturally and linguistically diverse background (CALD).

**Aboriginal clients**

In dealing with Aboriginal clients reference should be made to the NSW Aboriginal Mental Health Policy. It outlines a number of major issues in relation to improving services for Aboriginal people including the following:

- the need for mainstream services to work in partnership with Aboriginal community controlled health organisations i.e. Aboriginal Medical Services
- the need for mainstream mental health workers to acknowledge the historical factors influencing Aboriginal Australians (including the enforced separation of Aboriginal children from their families)
- the need for mainstream services to address the close association between an Aboriginal person’s health, both physical and mental, and their social, spiritual, cultural, historical, and economic context.

The policy also details a number of specific outcomes including:

- assessment, admission and case management for all Aboriginal clients to incorporate consultation with an Aboriginal health worker
- Aboriginal clients to receive services from either a mainstream service provider accompanied by an Aboriginal person or an Aboriginal service provider
- Aboriginal clients to be provided with the option to receive services that involve their families/extended families and/or significant others.

In assessing an Aboriginal client it is important to:

- consider the person within their family and cultural environment
- include an Aboriginal health worker in the assessment
- consult with the person’s family to find out what the family needs and hopes for in the situation
- explore the family’s capacity and desire to manage the person at home
- pay particular attention to the assessment of risk factors within the person’s environment including the impact of grief and trauma
- consider the impact of the person’s physical health
- be prepared to consider alternative treatment strategies
- consult with the Aboriginal Medical Service (or other agencies) who may have knowledge of the person and skills in managing them
- try to arrange an admission close to the person’s family to facilitate their involvement in the person’s inpatient care (if appropriate).
Clients from Culturally and Linguistically Diverse Backgrounds (CALD)

Clients from CALD backgrounds experience a relatively higher level of involuntary treatment under the Mental Health Act than those from English-speaking backgrounds. The adoption of practical measures to address language and cultural barriers throughout the assessment and admission process is therefore essential.

Second language competency may decrease dramatically in times of crisis. The difficulties and trauma associated with an episode of mental illness can often exacerbate language difficulties, even when a person is normally quite confident and fluent in English. If an interpreter is not used during an initial assessment important cultural and religious issues that affect the mental health care of a person may be overlooked or misconstrued.

Accredited interpreters must be involved with:

- the examination process prior to the decision being made about whether an involuntary admission is warranted
- gathering information about the person’s condition from relatives and others involved in the person’s care
- explaining the process to the person and their family.

Where a bilingual mental health worker is available they can assist with care planning and the clarification of cultural issues.

Booking an interpreter

Each Area Health Service has a Health Care Interpreter Service. When making a booking the following information should be provided:

- country of birth
- language required (and dialect where appropriate)
- person’s name
- name and contact of mental health worker/accredited person
- location and anticipated duration of assessment
- preferred gender of interpreter.

If the Health Care Interpreter Service is unable to provide a service at the time required the Telephone Interpreter Service is available 24 hours a day, 7 days a week on 131 450.

Cultural considerations

Even where language is not an obstacle, linguistic and religious differences may have a profound impact on decisions about assessment and treatment.

There are transcultural mental health services that can provide:
information about the cultural, political or religious aspects of an assessment
referral to community support services or bilingual mental health professionals
consultation and assessment regarding diagnosis and care planning
(see Contacts on page 62).

Forensic clients in the community

A forensic patient is a person who has been found by a court to be unfit to be tried for a criminal offence, and is detained in a hospital, prison or other place, or is detained in a hospital after being transferred there from a prison, or who has been found not guilty by a court because of mental illness.

Many of these people will continue to be forensic patients when conditionally released in the community under a plan of management.

These patients generally receive long-term treatment in a specialist forensic unit before their return to the community is considered. The Mental Health Review Tribunal plays an important role in monitoring these patients and must review the case of a forensic patient at least once every six months and make a recommendation to the Minister for Health concerning the person’s continued detention, care and treatment, or the appropriateness of their release.

That recommendation may stipulate where the patient is to be detained, under what kind of security, the range and kinds of leave (if any) which can be enjoyed, and, if the patient is on conditional release, the range and kinds of conditions which apply in order to allow the patient’s continuing presence in the community.

As at 30 June 2008 there were 315 forensic patients in NSW.

Once in the community, these patients are closely monitored by their case manager, psychiatrist and their Area Mental Health Service.

As an accredited person, you may from time to time be asked to examine a person on bail or conditional release.

While there is nothing in the Mental Health Act to preclude your involvement, it is useful to know that the terms of the conditional release provide the case manager with a broad discretionary power to direct the person to go to hospital should their condition begin to deteriorate.

Scheduling a forensic patient, however, is a valid means of taking the person to hospital for assessment and possible admission where the elements of s19 are satisfied. Further information about a person’s circumstances can also be obtained from the Mental Health Review Tribunal and the Justice Health.
Once the decision has made to schedule a person it is then necessary to arrange appropriate transport and negotiate the admission with the declared Mental Health Facility. Every effort should be made to minimise the delays and complications that add to the distress and confusion of an already difficult situation. The admission officer should be advised of:

- person’s name
- date of birth
- address
- estimated time of arrival
- risk factors (if any)
- need for any particular security arrangements.

As an accredited person you may not be directly involved in this stage of the process. You should however, ensure that these matters are addressed by another member of the mental health team.

**Overview of transport options**

In deciding how best to get the person to hospital the following factors should be considered.

What kind of transport:

- reflects the person’s rights and dignity
- is the least restrictive option in the circumstances
- is not dependent upon expediency
- is appropriate for the risk factors as currently assessed
- and can be provided as promptly as practicable (see MOU Transport Options – Appendix C).

Accredited persons should be aware that under s81 they are also authorised to take or
transfer a person (who has been detained under the Act) to a mental health facility (Option 2, Appendix C, MOU) if the person is co-operative and there is low risk to safety.

Accredited persons are also authorised to use reasonable force in restraining the person if necessary and may sedate the person if they are legally authorised to do so.

They may also carry out a frisk or ordinary search if they believe that the person is carrying anything which might pose a risk to that person or any other person or could be used to escape from their custody.

Is police assistance required?

“I didn’t like the scene of the police coming here. I thought it was a bit weird to have the whole street see that my mum was taken in the paddy wagon. It was just weird! And we were following behind! It made me feel a bit like: ‘Why can’t the [mental health staff] handle it on their own? Why do they have to drag the police into it?’ That made me feel like my mother was treated like she was a criminal or something when she was taken in the paddy wagon. Her little hands sticking out [of the paddy wagon’s air flaps at the back]! I just laughed because she’s so innocent and she was in the back of a paddy wagon.” (Elena)

For the person being scheduled and their family the involvement of police is often the most bewildering and painful aspect of the whole process. For the clinician balancing the risk of violence with the person’s rights to privacy, dignity and respect is likely to be one of the most difficult parts of the accredited person’s role.

The importance given to this area of practice is apparent in the principles of the Memorandum of Understanding between NSW Police and NSW Health 2007. All accredited persons should be familiar with the Memorandum as it determines how the power under s21 of the Mental Health Act is to be utilised.

Section 21 provides that an accredited person may request the assistance of police in transporting a person to hospital where:

- there are serious concerns for the safety of the person or other persons if the person is taken to a declared mental health facility (DMHF) without the assistance of a police officer

Such assistance is formally requested by completing Part 2 of the Schedule 1.

Part 2 of the Schedule 1 authorises the police to if practicable:

- apprehend the person or assist in taking them to a declared mental health facility
- enter premises by force to apprehend the person.
The General Principles of the Memorandum of Understanding

In addition to the state-wide Memorandum of Understanding, each Area Health Service has developed local protocols with both the Police and Ambulance Services to facilitate the transport of mentally ill persons to a DMHF.

The role of the duty officer

As well as being familiar with your local protocols, it is equally important to introduce yourself to the duty officers in your area and explain your role. As the officers who assign operational duties during a shift, they play a vital role in determining who will attend and when. It is the duty officer who will:

- determine the level of police escort
- be responsible for resolving disputes relating to risk assessments
- resolve disputes concerning the ongoing supervision of persons and waiting times at hospitals in consultation with the on-call medical officer.
**Determination of risk**

Any involvement of police under s22 of the Mental Health Act should be underpinned by a risk assessment. All accredited persons should:

- use the Multi-Agency Brief Risk Assessment Guidelines from the Memorandum of Understanding (see Appendices)
- provide a full picture of the situation to the police.

The risk of absconding in and of itself is not sufficient to warrant the involvement of police. Safety concerns must be present.

**Sharing information with the police**

Apart from completing Part 2 of Schedule 1 in appropriate circumstances it is important to provide the following information:

- name, gender, d.o.b. of client
- indigenous/cultural background
- usual address and where they are now
- details of current situation and concerns regarding actual/potential violence to self and others
- medication taken
- influence of illicit drugs or alcohol
- involvement of accredited person/case manager
- others involved e.g. family and friends
- mandatory notification of any children at risk.

**Practice issues**

It is not acceptable to give police a schedule and ask them to enforce it without assisting in the identification of the person concerned and negotiating transport arrangements.

- Police vehicles should only be used in extreme cases.
- Transports should where possible be undertaken during business hours when police resources are more available.
- Where an ambulance is also involved police prefer that one officer travel inside the ambulance and one officer follow in a police vehicle.
- A person brought to hospital in a police truck is to be promptly transferred from the vehicle to preserve the person’s safety and dignity.
Flow Charts

The following flowcharts from the Memorandum of Understanding are included in the Appendices of the Handbook.

- Multi-agency brief risk assessment guidelines
- Transport options – community setting
- High risk situations
- Scheduling under s19.
Chapter 9
Reflecting on Your Practice

“The scheduling event is a complex experience. Clinicians practice in an ad hoc fashion, not based on any evidence other than how it is always done, how they are taught on the job, and what they believe needs doing. The relatives of people who are scheduled see the event as both distressing and relieving; a way to bring an end to pain and distress, and a way of achieving either treatment or respite for their loved one. Those who are scheduled [commonly] see the benefit of this ‘final action’ and accept its results, albeit not its means.” (Fiorillo, 2001).

While some aspects of involuntary treatment have been studied, to date little attention has been paid to the scheduling event itself. A recent NSW study (Fiorillo, 2001) however, explored the subjective experiences of those most involved: the clinicians, the person scheduled and their relatives. The following provides a brief summary of some of the best and worst aspects of the procedure as reported by the participants in this study and their views on how the process could be improved.

When the process goes well?

▶ Clinicians valued:
  ■ the time to provide support
  ■ gentleness shown by those involved in containing the person
  ■ the provision of thorough information
  ■ good communication between the parties
  ■ the prompt marshalling of necessary resources.

▶ The person scheduled valued:
  ■ hearing words that expressed care and concern
  ■ experiencing a personalised interaction with clinician
  ■ support after discharge.
Relatives valued:
- the clinician’s genuine interest and respectful approach
- a prompt response to the crisis
- reassurance from the clinician about the decision
- clear explanations about what was happening and why.

The worst aspects of the process

Clinicians disliked:
- use of deception and feelings of betrayal
- distress experienced by those being scheduled
- lack of resources preventing the provision of less restrictive care
- family distress
- where decision overturned by the hospital and person not admitted.

Person scheduled disliked:
- use of coercion e.g. involvement of police
- their own passivity and resignation
- being left out of the discussion about admission and treatment planning
- lack of support through the process.

Relatives disliked:
- breakdown of relationships after family member scheduled
- use of deception and lying to their relative
- police involvement
- sense of helplessness
- lack of support from the clinicians.

Making improvements
The following general themes emerged:
- improving family involvement where possible during and after the scheduling event
“Families don’t know what is going on because of the stigma of mental illness. They don’t say anything, don’t talk to anybody, and it may be too late when somebody is scheduled. Certainly I would think that if anyone was working with someone on an ongoing basis then part of their role would be to educate both the family and the client about the Mental Health Act.” (Louise)

- discussing the options with the person to be scheduled at the time
- providing information to relatives throughout the process
- ensuring that the person has the opportunity to talk about their experience of being scheduled

“ It was very helpful just to review the whole scheduling procedure. It was, I think, just a week after she was admitted to hospital. I went and sat and talked to her about the whole process. She found it helpful just to talk about it. We talked about how the experience was, what it was like with the police officers coming and getting her. I think we neglect [this] and we shouldn’t. Because afterwards, months later, it’s just so far away and [we] have to go back over it when we could have just talked about it [there and then].” (Angela)

- follow-up and early intervention after discharge.
### Declared Mental Health facilities

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Telephone Number</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albury (Nolan House)</td>
<td>(02) 6058 4450</td>
<td>Albury Base Hospital, Eorella Road, Albury 2640</td>
</tr>
<tr>
<td>Bankstown (Banks House)</td>
<td>(02) 9722 8974</td>
<td>Clarabel St, Bankstown, 2200</td>
</tr>
<tr>
<td>Blacktown (Bungarribee House)</td>
<td>(02) 9881 8820</td>
<td>Marcel Crescent, Blacktown 2148</td>
</tr>
<tr>
<td>Bloomfield</td>
<td>(02) 6360 7700</td>
<td>Forest Rd, Orange 2800</td>
</tr>
<tr>
<td>Broken Hill (Special Care Suite)</td>
<td>(08) 80801547</td>
<td>Thomas Street, Broken Hill 2880</td>
</tr>
<tr>
<td>Campbelltown (Waratah House)</td>
<td>(02) 4634 3000</td>
<td>Therry Road, Campbelltown 2560</td>
</tr>
<tr>
<td>Coffs Harbour (Psychiatric Unit)</td>
<td>(02) 6556 7969</td>
<td>345 Pacific Highway, Coffs Harbour 2450</td>
</tr>
<tr>
<td>Concord Centre for Mental Health</td>
<td>(02) 9767 8900</td>
<td>Concord Hospital, Hospital Road, Concord 2137</td>
</tr>
<tr>
<td>Cumberland</td>
<td>(02) 9840 3000</td>
<td>1/11 Hainsworth Street, Westmead 2145</td>
</tr>
<tr>
<td>Dubbo Base (Special Care Suite)</td>
<td>(02) 68858707</td>
<td>Myall Street, Dubbo 2830</td>
</tr>
<tr>
<td>Gladesville Macquarie</td>
<td>(02) 9888 1222</td>
<td>Wicks Road, North Ryde 2113</td>
</tr>
<tr>
<td>Gosford (Mandala Clinic)</td>
<td>(02) 4320 3170</td>
<td>Holden St, Gosford 2250</td>
</tr>
<tr>
<td>Location</td>
<td>Phone Number</td>
<td>Address</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-----------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>Goulburn Base (Chisholm Ross Centre)</td>
<td>(02) 48273003</td>
<td>155A Clifford St, Goulburn 2580</td>
</tr>
<tr>
<td>Greenwich (Riverglen Unit)</td>
<td>(02) 9903 8311</td>
<td>97-115 River Rd, Greenwich</td>
</tr>
<tr>
<td>Hornsby (Lindsay Madew Ward)</td>
<td>(02) 9477 9476</td>
<td>Gate 6A, Darby Rd, Hornsby 2077</td>
</tr>
<tr>
<td>James Fletcher</td>
<td>(02) 4924 6500</td>
<td>72 Watt Street, Newcastle 2300</td>
</tr>
<tr>
<td>Kenmore</td>
<td>(02) 4827 3111</td>
<td>Taralga Road, Goulburn 2580</td>
</tr>
<tr>
<td>Lismore (Richmond Clinic)</td>
<td>(02) 6620 2240</td>
<td>72 Hunter St, Lismore 3480</td>
</tr>
<tr>
<td>Liverpool (Macquarie Clinic)</td>
<td>(02) 9828 6175</td>
<td>L1, Don Averett Bldg, Liverpool Hosp, Elizabeth St, Liverpool 2170</td>
</tr>
<tr>
<td>Long Bay Prison Hospital (Ward A; Ward C)</td>
<td>A – 9289 2975</td>
<td>Anzac Parade, Matraville 2036</td>
</tr>
<tr>
<td>Maitland (Mental Health Unit)</td>
<td>02 4939 2444</td>
<td>Melby House, High St Maitland</td>
</tr>
<tr>
<td>Manly (East Wing)</td>
<td>(02) 9976 4222</td>
<td>Darley Rd, Manly 2095</td>
</tr>
<tr>
<td>Manning Base Hospital (Mental Health Unit)</td>
<td>(02) 6592 9525</td>
<td>York Street, Taree 2430</td>
</tr>
<tr>
<td>Morisset</td>
<td>(02) 4973 0222</td>
<td>Dora Street, Morisset 2264</td>
</tr>
<tr>
<td>Nepean (Pialla Unit)</td>
<td>(02) 4734 2544</td>
<td>Barbara Ave, Kingswood 2747</td>
</tr>
<tr>
<td>Nexus Unit</td>
<td>(02) 4985 5830</td>
<td>John Hunter Hospital, Lookout Road, New Lambton 2305</td>
</tr>
<tr>
<td>Port Kembla District</td>
<td>02 4223 8000</td>
<td>Cowper Street, Warrawong 2502</td>
</tr>
<tr>
<td>Prince Henry (Psychiatric Unit)</td>
<td>02 9382 4352</td>
<td>Prince of Wales Hospital, Kiloh Centre, Easy St, Randwick 2031</td>
</tr>
<tr>
<td>Prince of Wales (Psychiatric Unit)</td>
<td>(02) 93824352</td>
<td>Prince of Wales Hospital, Kiloh Centre, Easy St, Randwick 2031</td>
</tr>
<tr>
<td>Location</td>
<td>Contact Details</td>
<td>Address</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-------------------------------</td>
<td>----------------------------------------------</td>
</tr>
<tr>
<td>Queanbeyan (Special Care Suite)</td>
<td>(02) 6298 9264</td>
<td>Cnr Erin &amp; Collett Streets, Queanbeyan 2620</td>
</tr>
<tr>
<td>Royal North Shore (Cummins Unit)</td>
<td>(02) 9926 7450</td>
<td>Pacific Highway, St Leonards 2065</td>
</tr>
<tr>
<td>Royal Prince Alfred (Missenden Unit)</td>
<td>(02) 9515 9870</td>
<td>Missenden Road, Camperdown 2050</td>
</tr>
<tr>
<td>Shellharbour (Psychiatric Unit)</td>
<td>(02) 4295 2548</td>
<td>Madigan Boulevard, Mount Warrigal 2529</td>
</tr>
<tr>
<td>Shellharbour (Mirrabook Unit)</td>
<td>(02) 42966633</td>
<td>Madigan Boulevard, Mount Warrigal 2529</td>
</tr>
<tr>
<td>St. George (Pacific House)</td>
<td>(02) 9350 2433 or 9350 2559</td>
<td>11 South Street, Kogarah 2217</td>
</tr>
<tr>
<td>St. Joseph’s (Psychogeriatric Unit)</td>
<td>(02) 9749 0308</td>
<td>Normanby Road, Auburn 2144</td>
</tr>
<tr>
<td>St. Vincent’s (Caritas Centre)</td>
<td>(02) 8382 1800</td>
<td>299 Forbes St, Darlinghurst 2010</td>
</tr>
<tr>
<td>Sutherland (Psychiatric Unit)</td>
<td>(02) 9545 3744</td>
<td>2a/16 Boyle St, Sutherland 2232</td>
</tr>
<tr>
<td>Tamworth Base (Banksia Unit)</td>
<td>(02) 6766 1722</td>
<td>Dean Street, Tamworth 2340</td>
</tr>
<tr>
<td>The Tweed Valley Clinic (Tweed Heads Hospital)</td>
<td>(02) 5506 7310</td>
<td>Powell St, Tweed Heads, 2485 PO Box 904, Tweed Heads 2485</td>
</tr>
<tr>
<td>Wagga Wagga (Gissing House)</td>
<td>(02) 6938 6235</td>
<td>Edward St, Wagga Wagga 2650 PO Box 159, Wagga Wagga 2650</td>
</tr>
<tr>
<td>Westmead (Acute Adolescent Unit)</td>
<td>(02) 9845 7950</td>
<td>Redbank House, Institute Rd, Westmead 2145</td>
</tr>
<tr>
<td>Westmead (Adult Psychiatric Unit)</td>
<td>(02) 9845 6688</td>
<td>Hawkesbury Road, Westmead 2145</td>
</tr>
<tr>
<td>Westmead (Psychogeriatric Unit)</td>
<td>(02) 9845 6688</td>
<td>Hawkesbury Road &amp; Darcy Road, Westmead 2145</td>
</tr>
</tbody>
</table>
Wollongong Mental Health Unit | (02) 4253 4300 | Block C, Level 3, Wollongong Hospital, Loftus St, Wollongong 2500
APPENDIX A
Multi-Agency Risk Information and Assistance (MARIA) Guideline

This guideline is to be used by Health Services, Ambulance Service of NSW, and NSW Police Force in the community setting, to provide:

- Information that might be sought in assessing the situation and communicated between agencies either pre site visit or at site (Box A)
- A common way to identify risk and the need for agency assistance in the community setting during events where a person is thought to be suffering from a mental illness or mental disorder (Box B)

THIS GUIDELINE 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 effective and appropriate services. Collection and disclosure should be limited to personal information that is necessary for and relevant to these purposes and occur in accordance with the Health Records and Information Privacy Act 2002 (NSW).

Box A
Information for Assessing the situation. This table provides a guide to key questions and sources of information about the person suspected of having a mental illness or mental disorder and the current event that may be helpful to all agencies for assessing the situation and communicating between them.

Key questions

- What is the level of risk in the current situation (see Risk situation list overleaf)?
- What is the history of risk for this person?
- Is the person known to Police / Ambulance / Mental Health Service?
- Is the Person under a Mental Health Order (breach orders, CTO orders, forensic breach, interstate apprehension orders) or Warrant?
- Is the situation escalating, and if so how rapidly?
- Is the person an absconder?
- Does the person have children / dependents (at site or elsewhere) and what are their needs?
- Is mandatory reporting or Department of Community Services involvement required?
- Is a trusted friend or carer present or able to be contacted?
Key sources of information:

- **Mental Health Telephone Triage service is available 24/7** (see Appendix J ‘Agency Contacts’) to the community, Police, Ambulance, and Hospitals, and provides assistance to assess the urgency or the persons need for care. This service can provide advice to Police and Ambulance where local mental health services are not readily available on site or by telephone.

- **Interagency Management Plans** may be available for individuals who are frequent users of emergency mental health services.

- **COPS** is a Police data base that may provide details of a person’s risk history. COPS is available 24/7 to all registered Police officers. Police utilise this intelligence as appropriate.

### Box B

**Risk and Assistance Guidelines:** This table provides a guide to assessing risk and the need for the attendance of agencies in the community. The guideline suggests the minimum agency presence. Some instances may require additional assistance.

The decision regarding the appropriate transport to hospital is to be guided by Appendix C ‘Transport Options – Community Setting’ of the MOU.

<table>
<thead>
<tr>
<th>RISK SITUATION</th>
<th>ASSISTANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Siege situation or presence of firearm / lethal weapon (or history of use of)</td>
<td>Police presence indicated</td>
</tr>
<tr>
<td>- Dangerous environment (eg dangerous dog; isolated site; late night)</td>
<td>Police presence indicated</td>
</tr>
<tr>
<td>- Actual or threatening violence (self or others)</td>
<td>Police presence indicated</td>
</tr>
<tr>
<td>- Presence of ideas or hallucinations of suicide / homicide, with impulsive or aggressive behaviour (or history of)</td>
<td>Police and Ambulance presence indicated; Mental Health desirable</td>
</tr>
<tr>
<td>- Ideas / hallucinations of suicide / homicide with no behavioural disturbance (or history of)</td>
<td>Mental Health (MH) presence or involvement indicated</td>
</tr>
<tr>
<td>- Physical illness or injury (actual or suspected)</td>
<td>Ambulance presence indicated</td>
</tr>
<tr>
<td>- Overdose (drug / alcohol / medication)</td>
<td>Ambulance presence indicated</td>
</tr>
<tr>
<td>- Under the influence of alcohol or drugs</td>
<td>Ambulance presence indicated</td>
</tr>
<tr>
<td>- Highly distressed or acute mental health problems but no dangerous behaviour</td>
<td>MH presence or involvement indicated</td>
</tr>
<tr>
<td>- Unco-operative or unwilling to accept help / care</td>
<td>MH presence or involvement indicated</td>
</tr>
<tr>
<td>- Shows little interest in, or comprehension of efforts made on their behalf</td>
<td></td>
</tr>
</tbody>
</table>

Dispute resolution: If agencies differ in opinion as to the level of risk or requirement for attendance, the request for the highest level of agency attendance as indicated above is to apply in the immediate. Where a specific dispute is not able to be resolved in the immediate, it is to be escalated for resolution to the Police Duty Officer / Ambulance Operations Centre Supervisor / MHS or ED Manager, or delegate.
APPENDIX B - HIGH RISK SITUATIONS

High Risk Situations are incidents where police judge that there is a real or impending violence or threat to an individual or the public. Examples relevant to this MOU include: sieges, any situation where a person is threatening to, or it is suspected they may, attempt to take their own life. Threatening violence with possession of a weapon or any situation where it is believed that a trained negotiator would be of assistance to police. **

Police attend scene, gather, analyse and disseminate relevant intelligence and assess support needed from other agencies/units. Respond by containment and negotiation (Guideline for High Risk Incidents). If any doubt exists as to whether the situation is high risk, the TOU (Tactical Operations Unit) should be contacted via the Duty Operations Inspector (DOI), at any hour, to provide advice. Where Police suspect the individual to be mentally ill or mentally disordered, Police are to contact MHS — see circle below.

If Forensic patent, Police to notify FESU on 0418 427 862.

Contact MHS to attend in an advisory capacity. Where person is known to MHS, MHS provides: background information relevant to the situation and may include psychiatric history, history of violence, level of contact and cooperation with services, weapons, treating doctors, medication, drug and alcohol background, involvement of family, current contact with service. Where person is not known to MHS, MHS attends to observe, provide advice and assistance as appropriate and as requested.

Contact Ambulance Operations Centre on 131233 for dispatch of ambulance to site on standby for transport & medical assistance. If necessary, consult with Ambulance Duty Supervisor re use of SCAT officers.

Activate high risk response with TOU through DOI. VKG will contact the Police Negotiation Unit who will liaise directly with the Duty Officer and either:
- attend the scene to negotiate — advise the Duty Officer of other courses of action eg use of TOU where weapons are involved or use of Police Rescue Unit etc.

* Health PD 06_121  
** Police MCPES MO18

MOU for Mental Health Emergency Response – July 2007

23
APPENDIX C - TRANSPORT OPTIONS - COMMUNITY SETTING

Option 1 - Family/Friends
- person is co-operative and no risk
- person conducting transport is suitable and reliable

Option 2 - MHS Vehicle
- person is co-operative
- low risk to safety

Option 3 - by Ambulance
- where person's clinical needs require ongoing care and monitoring (Health Circular 98/119)

Option 4 - by Ambulance with appropriate Health escort where clinically indicated
- patient needs ongoing mental health care
- medium risk to self / others
- where sedation has been administered

Option 5 - Ambulance with Police escort
- serious risk to self/others and need for physical restraint
- patient requires ongoing mental health care
- Police to determine firearm security (Section 39 (1) Firearms Act 1996 (NSW))

Option 6 - Police Caged Truck
- serious concerns relating to the safety of the person or the public

Transport must:
(a) reflect person's rights and dignity
(b) be the least restrictive under the circumstances
(c) not be dependent upon expediency
(d) be appropriate for risk factors
(e) be provided as promptly as practicable.

ALL AGENCIES REFER TO MARIA GUIDELINE TO DETERMINE AGENCY PRESENCE

MHS contacts the Police LAC (Duty Officer or Team Leader) and provides information on name, DOB, physical characteristics, behaviour, risk factors & destination.

Police to contact Ambulance Operations Centre Supervisor and arrange mutually convenient time. Police to advise MHS accordingly.
Scheduling Process for an Accredited Person Under S19

Assessment by Accredited Person

Mentally ill or Mentally disordered and requires further assessment in a DMHIF – Complete s 15

INITIAL ASSESSMENT

Does not meet the criteria of the Act – offer community alternative s

MARIA Guidelines

RISK ASSESSMENT

RISK – Yes

S22 – Police assistance required

RISK – No

S81 – other transport arrangements, as per MOU

MOU Transport Options – Community Settings
1. Family/friends
2. Minibus Vehicle
3. By Ambulance
4. By Ambulance with appropriate Health Escort where clinically indicated.
5. Ambulance with Police escort and appropriate Health escort
6. Police caged Truck

TRANSPORT OPTIONS

Declared Mental Health Facility - detained for assessment under s27

S27 ASSESSMENT
Schedule 1 - Medical certificate as to examination or observation of person - continued

Notes
1 Sections 13–16 of the Mental Health Act 2007 state:

13 Criteria for involuntary admission etc as mentally ill person or mentally disordered person
A person is a mentally ill person or a mentally disordered person for the purpose of:
(a) the involuntary admission of the person to a mental health facility or the detention of the person in a facility under this Act, or
(b) determining whether the person should be subject to a community treatment order or be detained or continue to be detained involuntarily in a mental health facility,
if, and only if, the person satisfies the relevant criteria set out in this Part.

14 Mentally ill persons
(1) A person is a mentally ill person if the person is suffering from mental illness and, owing to that illness, there are reasonable grounds for believing that care, treatment or control of the person is necessary:
(a) for the person’s own protection from serious harm, or
(b) for the protection of others from serious harm.
(2) In considering whether a person is a mentally ill person, the continuing condition of the person, including any likely deterioration in the person’s condition and the likely effects of any such deterioration, are to be taken into account.

15 Mentally disordered persons
A person (whether or not the person is suffering from mental illness) is a mentally disordered person if the person’s behaviour for the time being is so irrational as to justify a conclusion on reasonable grounds that temporary care, treatment or control of the person is necessary:
(a) for the person’s own protection from serious physical harm, or
(b) for the protection of others from serious physical harm.

16 Certain words or conduct may not indicate mental illness or disorder
(1) A person is not a mentally ill person or a mentally disordered person merely because of any one or more of the following:
(a) the person expresses or refuses or fails to express or has expressed or refused or failed to express a particular political opinion or belief,
(b) the person expresses or refuses or fails to express or has expressed or refused or failed to express a particular religious opinion or belief,
(c) the person expresses or refuses or fails to express or has expressed or refused or failed to express a particular philosophy,
(d) the person expresses or refuses or fails to express or has expressed or refused or failed to express a particular sexual preference or sexual orientation,
(e) the person engages in or refuses or fails to engage in, or has engaged in or refused or failed to engage in, a particular political activity,
(f) the person engages in or refuses or fails to engage in, or has engaged in or refused or failed to engage in, a particular religious activity,
(g) the person engages in or has engaged in a particular sexual activity or sexual promiscuity,
(h) the person engages in or has engaged in immoral conduct,
(i) the person engages in or has engaged in illegal conduct,
(j) the person has developmental disability of mind,
(k) the person takes or has taken alcohol or any other drug,
Schedule 1 - Medical certificate as to examination or observation of person - continued

   (i) the person engages in or has engaged in anti-social behaviour;
   (m) the person has a particular economic or social status or is a member of a
      particular cultural or racial group.

(2) Nothing in this Part prevents, in relation to a person who takes or has taken
alcohol or any other drug, the serious or permanent physiological, biochemical or
psychological effects of drug taking from being regarded as an indication that a person is
suffering from mental illness or other condition of disability of mind.

2 In addition to matters ascertained as a consequence of personally examining or observing
the person, account may be taken of other matters not so ascertained where those matters:
   (a) arise from a previous personal examination of the person, or
   (b) are communicated by a reasonably credible informant.

3 In the Mental Health Act 2007, mental illness is defined as follows:
   mental illness means a condition that seriously impairs, either temporarily or
   permanently, the mental functioning of a person and is characterised by the
   presence in the person of any one or more of the following symptoms:
   (a) delusions,
   (b) hallucinations,
   (c) serious disorder of thought form,
   (d) a severe disturbance of mood,
   (e) sustained or repeated irrational behaviour indicating the presence of any one or
      more of the symptoms referred to in paragraphs (a)–(d).

4 In the Mental Health Act 2007, primary carer is defined as follows:

   71 Primary carer
   (1) The primary carer of a person (the patient) for the purposes of this Act is:
       (a) the guardian of the patient, or
       (b) the parent of a patient who is a child (subject to any nomination by a
           patient referred to in paragraph (c)), or
       (c) if the patient is over the age of 14 years and is not a person under
           guardianship, the person nominated by the patient as the primary carer
           under this Part under a nomination that is in force, or
       (d) if the patient is not a patient referred to in paragraph (a) or (b) or there is
           no nomination in force as referred to in paragraph (c):
           (i) the spouse of the patient, if any, if the relationship between the
               patient and the spouse is close and continuing, or
           (ii) any person who is primarily responsible for providing support or
               care to the patient (other than wholly or substantially on a commercial
               basis), or
           (iii) a close friend or relative of the patient.

   (2) In this section:
      close friend or relative of a patient means a friend or relative of the patient
      who maintains both a close personal relationship with the patient through
      frequent personal contact and a personal interest in the patient’s welfare and
      who does not provide support to the patient wholly or substantially on a
      commercial basis.

5 For admission purposes, this certificate is valid only for a period of 5 days, in the case of a person
who is a mentally ill person, or 1 day, in the case of a person who is a mentally disordered person,
after the date on which the certificate is given.
Obtaining Schedule 1 forms

- Schedule 1 at back of Mental Health Act
- Download from the Department of Health website

Contacts

- Mental Health and Drug & Alcohol Office
  (02) 9391 9464
- Mental Health Advocacy Service
  (02) 9745 4277
- NSW Institute of Psychiatry
  (02) 9840 3833
- Telephone Interpreter Service
  131 450
- Transcultural Mental Health Centre
  (02) 9840 3766
  Toll free: 1800 648 911
- STARTTS
  (Service for the Treatment and Rehabilitation of Torture and Trauma Survivors)
  (02) 9794 1900
- NSW Refugee Health Service
  (02) 8778 0770
- Bilingual Counsellors are attached to Area Health Services.
## Contacts – Notes

### Gazetted Unit

<table>
<thead>
<tr>
<th>Unit/Hospital:</th>
<th>Phone no:</th>
<th>Contact:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Emergency Department

<table>
<thead>
<tr>
<th>Name:</th>
<th>Phone no:</th>
<th>Contact:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Police

<table>
<thead>
<tr>
<th>Local Area Command:</th>
<th>Phone no:</th>
<th>Mental Health Contact Officer/Duty Officer:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Local Area Command:</th>
<th>Phone no:</th>
<th>Mental Health Contact Officer/Duty Officer:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name:</td>
<td>Phone no:</td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>-----------</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Accredited Persons – Other Areas

Name: __________________________________________________________
Phone no: __________________________________________________________

Name: __________________________________________________________
Phone no: __________________________________________________________

Name: __________________________________________________________
Phone no: __________________________________________________________

Name: __________________________________________________________
Phone no: __________________________________________________________

Ambulance

Area: __________________________________________________________
Phone no: __________________________________________________________
Contact: __________________________________________________________

Aboriginal Health Worker/ Aboriginal Medical Service

Name: __________________________________________________________
Phone: __________________________________________________________
Contact: __________________________________________________________

Name: __________________________________________________________
Phone: __________________________________________________________
Contact: __________________________________________________________

Health Care Interpreter Service

Phone no: __________________________________________________________