Justice Health and
Forensic Mental Health Network

Justice Health and Forensic Mental Health Network
PO BOX 150 Matraville NSW 2036
Tel (02) 9700 3000
http://www.justicehealth.nsw.gov.au

Policy Rescinded

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Rescinded Policy

Date in Force: 22 March 2022 to 06 November 2025

Policy: 1.336 Referral (Adults and Adolescents) Forensic Hospital

Responsible Officer: Executive Director Clinical Operations

Replacement Document(s)

Date in Force: 06 November 2025

This policy has been replaced by Justice Health NSW Procedure: 6.203 Referral, Admission and Transfer of Care.

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Rescinded Policy

Date in Force: 16 June 2022 to 06 November 2025

Policy: 1.337 Admissions (Adults and Adolescents) Forensic Hospital

Responsible Officer: General Manager Forensic Mental Health

Replacement Document(s)

Date in Force: 06 November 2025

This policy has been replaced by Justice Health NSW Procedure: 6.203 Referral, Admission and Transfer of Care.

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Rescinded Policy

Date in Force: 22 March 2022 to 06 November 2025

Policy: 1.338 Transfer of Care (Adults and Adolescents) Forensic Hospital

Responsible Officer: General Manager Forensic Mental Health

Replacement Document(s)

Date in Force: 06 November 2025

This policy has been replaced by Justice Health NSW Procedure: 6.203 Referral, Admission and Transfer of Care.

Justice Health and
Forensic Mental Health Network

NSW GOVERNMENT

Justice Health NSW Procedure

Referral, Admission and Transfer of Care

Issue Date: 06 November 2025

Together for
Healthier Tomorrows

Referral, Admission and Transfer of Care

Procedure Number 6.203

Procedure Function Continuum of Care

Issue Date 06 November 2025

Next Review Date 06 November 2025

Risk Rating High

Summary The Forensic Hospital provides specialist therapeutic inpatient care for those patients who cannot be managed safely in conditions of lower security. This procedure covers patient referral, admission, and transfer of care to and from the Forensic Hospital.

Responsible Officer Service Director Forensic Hospital

Applies to
☐ Administration Centres
☐ Community Sites and programs
☐ Health Centres - Adult Correctional Centres or Police Cells
☐ Health Centres - Youth Justice Centres
☐ Long Bay Hospital
☒ Forensic Hospital

CM Reference PROJH/6203

Change summary New Procedure that combines 3 previous Policies:
Policy 1.336 Referral (Adults and Adolescents) Forensic Hospital.
Policy 1.337 Admission (Adults and Adolescents) Forensic Hospital.
Policy 1.338 Transfer of Care (Adults and Adolescents) Forensic Hospital.

Authorised by The Forensic Hospital Policies, Procedures and Guidelines Committee

Revision History

#	Issue Date	Number and Name	Change Summary
1	Nov 25	6.203 Referral, Admission and Transfer of Care	New Procedure that combines 3 previous Policies: Policy 1.336 Referral (Adults and Adolescents) Forensic Hospital. Policy 1.337 Admission (Adults and Adolescents) Forensic Hospital. Policy 1.338 Transfer of Care (Adults and Adolescents) Forensic Hospital

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1. Table of Contents

2. Preface

The Forensic Hospital (FH) provides specialist, therapeutic inpatient care for those patients who cannot be managed safely in conditions of lesser security. Nevertheless, those conditions impose significant restrictions on the liberty of patients. The restrictions on a patient's liberty whilst in the FH can only be justified when no lesser degree of security would provide a reasonable safeguard to the public. To maintain a person's rights, they should be detained in the least restrictive level of security required.

An appropriate hospital bed is one that can provide the necessary clinical treatment programs, is in the least restrictive environment consistent with the need to protect the patient and the public and is as close to the patient's home as possible. The security restrictions available within the FH are necessary to detain a person who, if in the community, would present a grave and/or immediate risk to the public and who could not be safely contained within a less secure unit.

This procedure provides directions on the lawful patient referral, admission, and transfer of care processes. Typically, patients are transferred to and from the FH are from; Correctional Centres (CC), Youth Justice Centres (YJC) or Local Health Districts (LHD).

This procedure presumes that the Clinical Director Forensic Hospital (CDFH) is the Medical Superintendent of the FH appointed under section 111 of the Mental Health Act 2007, hereafter the MHA. Any reference to the CDFH should be read, where applicable, as a reference to the Medical Superintendent. The powers of the Medical Superintendents under the MHA belong directly to that position and may be delegated.

This Secretary of NSW Health (the Secretary) has the power under the Mental Health and Cognitive Impairment Forensic Provisions Act 2020, hereafter the MHCIFPA, to grant orders for forensic and correctional patients. The Secretary's powers under the MHCIFPA have been delegated to certain position titles within Justice Health NSW and are set out in Chapter 10 of the Public Health Delegations Manual. The Forensic Mental Health Systems Manager (FMHSM) is responsible for noting the positions within Justice Health NSW who have the delegated powers under the MHCIFPA.

The FMHSM via [redacted] is the primary contact for all legal queries regarding referrals, admissions and transfers of care.

3. Procedure Content

3.1 Referral and Admission – Patient Types

1. The following types of patients may be referred and admitted to the FH. Section 4.1 defines each legal status as per the relevant legislation:
   a) Forensic Patients
   b) Correctional Patients
   c) Involuntary (Civil) Patients
2. In the FH, adolescent patients are generally aged 14 to 21 years (section 4.1). However, under special circumstances, referral and admissions for children under the age of 14 may be considered.

3.2 Referral and Admission – Gazettal Notice Exemptions

1. Under section 109(1) of the MHA the terms of the Gazettal Notice declaration as a mental health facility, the following section do not apply to the FH:
   a) Section 18 of the MHA when a person may be detained in mental health facility.
   b) section 19 of the MHA detention on certificate of medical practitioner or accredited person.
   c) section 20 of the MHA detention on information of ambulance officer.
   d) section 22 of the MHA detention after apprehension by police.
   e) section 24 of the MHA detention on order of Magistrate or bail officer.
   f) section 25 of the MHA detention after transfer from another health facility.
   g) section 26 of the MHA detention on request of designated carer, principal care provider, relative or friend.
2. In effect the exemptions above prevent scheduling a person directly from the community to the FH under the MHA (i.e. ambulance direct to FH).

3.3 Referral Process – Forensic Patients

1. Where a Court or Tribunal Order requires that a forensic patient be detained in a CC or YJC and transferred to the FH as soon as a bed becomes available, the patient will be placed on the Forensic Hospital Admissions Waitlist and Patient Flow Portal by the FMHSM.
2. The Forensic Hospital Admissions Waitlist is discussed by the NSW Forensic Patient Flow Committee who are responsible for determining waitlist order based on clinical need and legal requirements.
3. In the case of a correctional patient who is already an inpatient of the FH and who subsequently becomes a forensic patient, then the person's legal classification needs to be changed to that of a forensic patient. This process will be coordinated by the FMHSM.

3.4 Referral Process – Correctional and Civil Patients

1. Refer to Guideline 6.132 *Forensic Hospital Referrals (Correctional and Civil Patients)* and Procedure 6.212 *Transfer from correction/detention centres to mental health facilities under the MHCIFPA*.

3.5 Admission Process – Bed Availability and Notification of Admission

1. The FH Leave and Admissions Committee meets once a week and is responsible for the oversight of FH bed availability and transfers.
2. Once a bed becomes available at the FH the admitting NUM will begin the process of admission based on the Forensic Hospital Admissions Waitlist and Patient Flow Portal.
3. An admission date and time will be decided upon by the admitting NUM in consultation with the referring NUM.
   a) The admitting unit must contact the FMHSM [redacted] indicating the proposed date of admission.
   b) The FMSHM will send through a completed *Acceptance Form* to the admitting NUM.
   c) The admitting NUM must sign the *Acceptance Form* and return to the FMHSM via [redacted]
   a) The admitting NUM must complete an electronic Patient Admission, Discharge, Escort and Transfer Notification which will inform G4S of the planned admission.
4. All planned admissions to the FH should occur during business hours between 08:30 and 13:00 weekdays. Exceptional circumstances to this may include:
   a) **Patients in Correctional Centres**: In exceptional circumstances, admissions can be accepted outside of the stated times and must be directed and coordinated through the Nurse Unit Manager (NUM)/After Hours Nurse Manager (AHNM)/Deputy Director of Nursing (DDON) and FMHSM.
   b) **Civil**: In exceptional circumstances, when an urgent civil admission to the FH is required, the CDFH may use their discretion in consultation with the Service Director Forensic Hospital (SDFH) to admit the patient. Admission is based on imminent risk, whilst maintaining safety of patient and site. Collateral information and current risk assessment should be provided by the referring LHD as a minimum along with all legal documentation set out in Guideline 6.132 *Forensic Hospital Referrals (Correctional and Civil Patients)*.

3.6 Admission Process – Pre-Admission Legal Documents and Gathering Patient Information

1. As part of the ongoing referral and pre-admission process the FMHSM in collaboration with appropriate stakeholders will gather all relevant legal documentation and patient information.
2. The FMHSM will create a G:Drive folder where all appropriate information will be stored, these include:
   a) Legal Orders.
   b) MHRT Documents.
   c) Any Department of Communities and Justice (DCJ) documents and other relevant documents (i.e. OIMS, inmate profile reports, inmate classifications, etc.).

3. The below documents should be available in JHeHS for all Forensic and Correctional patients, for Civil patients the referring service must forward the below to the admitting NUM and FMHSM:
   a) A copy of any form SMR025.170 *Section 72 Nomination of Designated Carer* and/or SMR025.107 *Section 72A Identification of Principal Care Provider*.
   b) Pre-transfer documents (pre-transfer summary/discharge summary) completed by the referring service, which includes; demographic details, current mental state and presentation, disability information (including any adjustments required), behaviour, current medications and treatments, allergies, care needs and follow up, family support, date of last MHRT hearing, and any other relevant information.
   c) Other documentation in line with PD2019_045 *Discharge Planning and Transfer of Care for Consumers of NSW Health Mental Health Services*.
4. A verbal handover should occur including the person's current mental state, attitude towards transfer, requirement of an interpreter on admission for assessment and orientation and any other relevant information.
5. The admitting MDT must begin the Forensic Hospital Patient Admission Checklist *prior to admission* sections. This includes an initial TPRIM development from available pre-admission information (Procedure 6.100 *Clinical Risk Assessment and Management (CRAM) – Framework and Documentation*).

3.7 Admission Process – Prior to Transfer to FH

1. A nominated referring service clinician will actively support the transfer of care process with the admitting NUM.
2. The referring service will contact the patient's designated carer and/or principal care provider to advise them of the planned transfer to the FH and provide the relevant contact details.
   a) **Note**: For the purposes of security, the exact time and date of admission should not be disclosed to the patient or designated carer/principal care provider.
3. Transfer Orders (day before transfer):
   a) **Patients in Correctional Centres** (for more information refer to Procedure 6.212 *Transfer from correction/detention centres to mental health facilities under the MHCIFPA*)**:**
      i. If a Forensic Patient, the FMHSM will forward the MHRT order for transfer or *Section 115* and *Section 117 Order for Transfer* proforma signed by the Delegate to the admitting NUM.
      ii. If subject to a section 86 (MHCIFPA) nil further order is required.
      iii. If subject to a section 87(2) (MHCIFPA), the FMHSM will forward the MHRT order for transfer or *Section 115* and *Section 117 Order for Transfer* proforma signed by the Delegate to the admitting NUM (for this order to be considered and approved by the Delegate it must be supported by a JHeHS progress note by the referring services medical officer that the person is suitable for admission to the FH and a bed is available).
   b) **Civil Patients:**
      i. The referring services medical officer must complete a SMR025.215 *Section 78 and 80 Transfer of Involuntary Patient Between Mental Health Facilities* and forward

it to the FMHSM via [redacted] who will forward it to the admitting NUM.

4. Prior to Transfer:
   a) Patients should be assessed as medically fit for management in an isolated mental health setting that is not co-located within a general hospital immediately prior to transfer.
   b) Patients should not have any upcoming court dates (including planned diversions) within the immediate days post planned admission. If a court date is due, admission to the FH should be delayed until an outcome has been received. This will be assessed on a case-by-case basis dependant on the nature of the court date.
5. Transport:
   a) **Adult Patients in Correctional Centres:** once the FMHSM receives the signed *Acceptance Form* from the admitting NUM, this will be forwarded along with the appropriate order to the Metro Regional Manager and Forensic Liaison (MRMFL) via [redacted] who will organise transport. The FMHSM will inform the admitting and discharging NUM that the transport has been booked and the estimated arrival time.
   b) **Adolescent Patients in Youth Justice Centres:** once the FMHSM receives the signed *Acceptance Form* from the admitting NUM, transport will be arranged by the FH Adolescent NUM and FH Social Worker (SW) by liaising with the YJNSW Centre Manager and Court Logistics, Classifications and Placements Unit (CLCPU) via [redacted].
   c) **Civil Patients:** it is the responsibility of the referring service to organise transport to the FH. The referring service must ensure they liaise with the admitting NUM on the estimated arrival time.
6. The admitting NUM must communicate with G4S and all relevant stakeholders on the expected arrival of the patient.
7. The referring service will verbally handover to the FH team on the date of transfer.

3.8 Admission Process – Transfer to FH

1. [redacted]

[redacted]

3. Admitting staff must complete the Forensic Hospital Patient Admission Checklist *day of admission* sections and follow up any outstanding items from *prior to admission* sections. These include TPRIM review and update with admitting information, DASA commencement and safety plan development (Procedure 6.100 *Clinical Risk Assessment and Management (CRAM) – Framework and Documentation*).

3.9 Admission Process – Within 7 Days Post Admission to FH

1. Complete Forensic Hospital Patient Admission Checklist *week of admission* sections and any outstanding items. These include an MDT case review, comprehensive TPRIM and safety plan review and update and care plan development (Procedure 6.100 *Clinical Risk Assessment and Management (CRAM) – Framework and Documentation*).
2. **Correctional Patients admitted on a section 86 (MHCIFPA)** (for more information refer to Procedure 6.212 *Transfer from correction/detention centres to mental health facilities under the MHCIFPA*)**:**
   a) Correctional patients must have a JUS025.130 *Section 87(2) Notification* and a typed medical report completed within 7 days of admission (includes weekends and public holidays) outlining how the person satisfies criteria for continuing admission to the FH.
   b) This must be forwarded to the FMHSM via [redacted] for the Delegate to review and consider approval.
   c) If a section 87(2) (MHCIFPA) has been issued, the person may remain in the FH until such a time that they are no longer mentally ill or their condition is able to be managed in a CC/YJC.
   d) If the treating team consider a JUS025.130 *Section 87(2) Notification* will not be issued, the patient can no longer remain in the FH post 7 days of admission and must be returned to a CC/YJC. This must be organised in line with section 3.7 point 5.

3.10 Transfer of Care – Within the FH

1. Transfer of care between units of the FH is available for adult male patients as there are multiple male units but only one female and one adolescent unit. In rare circumstances this may occur for adolescent patients who age into adulthood.
2. At the appropriate stage during the patient's admission, the MDT will commence the referral process to a less acute unit within the FH.
3. The referring MDT must complete the relevant section of the JHeHS *Forensic Hospital Intra-Hospital Referral Form* (eForm).
4. The referring MDT must email and advise the referred MDT that there is a referral form awaiting assessment:
   a) The NUM of the referring team must add the patient's name to the Patient Flow Portal (under Waiting for What); and
   b) The NUM of the referred team should add the patient referral for discussion at the local MDT referral review meeting. Local referral review meetings should be inclusive of clinical staff.
5. After the referral has been reviewed, an MDT-to-MDT meeting must be scheduled. The purpose of this meeting is to confirm the patient's clinical presentation, treatment goals, risk factors, and risk management strategies, and to develop patient-specific support strategies such as transition planning if required. The meeting should also determine whether additional information or an in-person assessment of the patient is required.
6. The referred MDT must email the referring MDT with the outcome of the referral discussion and complete the relevant section of the JHeHS Forensic Hospital Intra-Hospital Referral form (eForm):
   a) If the patient is declined, the referred MDT must provide feedback to the referring MDT, including any treatment goals required for re-referral.
   b) If the patient is accepted, the referring NUM must add the patient to the Patient Flow Portal (under Inter Ward Transfer).
7. Transfer of care between units is discussed at the weekly FH Leave and Admissions Committee.
   a) Intra-ward transfer waitlists are generally prioritised based on wait time. However, environmental, interpersonal, or operational risk factors may require reprioritisation of the waitlist to mitigate these risks. If this occurs, the change must be escalated to the CDFH and the FH Leave and Admissions Committee for endorsement. The rationale for reprioritisation must be communicated to the referring teams along with a plan for when admission can occur.
   b) If there is a dispute regarding the referral or transfer decision, the matter must be referred to the CDFH for resolution.

3.11 Transfer of Care – Discharge Planning

1. In line with PD2019_045 *Discharge Planning and Transfer of Care for Consumers of NSW Health Mental Health Services*, "effective discharge planning and transfer of care relies upon active, collaborative planning involving consumers and their families/carers, the treating team and the receiving team". The principles set out in PD2019_045 should be followed when planning to discharge or transfer care of a patient.

2. The MDT is responsible for assessing a patient as ready for discharge/transfer of care in collaboration with the patient and their families/carers.
3. Where the patient can be discharged/transferred to is largely based on legal status, responsiveness to treatment, and risk.
4. When planning discharge/transfer of care, staff should contact the appropriate victims register indicating the proposed discharge plan, reinforcing that it is in the planning stage, requesting any guidance around if registered victims may be impacted by the proposed discharge plan.
   a) **Forensic:** Special Victims Support Service via svss@dcj.nsw.gov.au.
   b) **Correctional (Adult):** CSNSW Victims Register via victims.register@dcj.nsw.gov.au.
   c) **Correctional (Adolescent):** YJNSW Victims Register JJVictimsRegister@justice.nsw.gov.au.
5. At a minimum the MDT must provide the following for any referral from the FH:
   a) Referral Form and Recent MHRT Report.
   b) Key risk assessments and management plans as outlined in Procedure 6.100 *Clinical Risk Assessment and Management (CRAM) – Framework and Documentation*.
   c) External services documentation (i.e. Police documentation, criminal history, etc.).
   d) Court documentation (i.e. court reports, judgements, psychiatrists' reports, etc).
   e) Information regarding the person's psychosocial and any other disabilities, disability support needs and adjustments required, NDIS status and the engagement of any disability service providers.
   f) Any other relevant information.

3.12 Transfer of Care – Medium Secure Unit (MSU) and Low Secure Unit (LSU)

1. The MSU/LSU pathway is applicable for forensic patients and is the typically pathway for most forensic patients.
2. The MDT must send all referral documents outlined in section 3.11 point 5 to the FMHSM via [redacted] stipulating which MSU or LSU the patient is being referred to.
3. The FMHSM will forward all documents to the relevant MSU or LSU and add the patients to the MSU and LSU Referral Waitlist and Patient Flow Portal (under Waiting for What).
   a) The FMHSM will arrange an assessment date at the time of referral and notify the relevant MDT members via calendar invite.
   b) It is an expectation that the relevant MDT members be available and participate in the assessment.
   c) The MSU and LSU Referral Waitlist will be discussed at the NSW Forensic Patient Flow Committee and FH Leave and Admissions Committee.
4. Assessments can be done in person or via AVL.
   a) If in person ensure access as per Policy 5.002 *Access to the Forensic Hospital*.
5. Post assessment date the MSU or LSU must forward their assessment report outlining the outcome of the assessment to the FMHSM via [redacted] who will forward the assessment report to the relevant members of the MDT, MHRT and Mental Health Advocacy Service (MHAS).

6. Where the patient is found to be suitable for admission, the FMHSM will add the patient to the MSU and LSU Admission Waitlist and Patient Flow Portal (under Inter Hospital Transfer).
    a) Where the patient has been found to be suitable for admission for a number of MSUs/LSUs, the patient will await transfer to each unit, with transfer being to the unit with the first available bed.
7. A Notice of Intent (NOI) must be made requesting transfer to another facility.

3.13 Transfer of Care – Conditional Release

1. The conditional release pathway is available to forensic patients whose risks have been assessed as safe to be managed in the community, this is typically into the care of a LHD community team, NDIS provider or SIL accommodation.
    a) Procedure 6.119 *National Disability Insurance Scheme (NDIS)* may assist in this process for NDIS participants.
2. The MDT must send all referral documents outlined in section 3.11 point 5 to the receiving service supporting the patient's placement in the proposed setting and add the referral into the Patient Flow Portal (under Waiting for What).
3. Once the receiving service has accepted the referral the MDT must send all referral documents outlined in section 3.11 point 5 to the Community Forensic Mental Health Service (CFMHS) via [redacted] seeking an independent assessment.
    a) This is required under section 84 (MHCIFPA) prior to the MHRT granting conditional release.
4. Post assessment by the CFMHS they must forward their assessment report outlining their decisions and recommendations to the MDT.
5. If accepted by the referred service and supported by the CFMHS a Notice of Intent (NOI) must be made requesting conditional release.
    a) The FMHSM will add the patient to the MSU and LSU Admission Waitlist.
    b) A Ministerial brief for the NSW Minister for Mental Health must be completed by the Consultant and forwarded to the Delegate (via the FMHSM) at least three weeks prior to the proposed MHRT hearing date.

3.14 Transfer of Care – Local Health District (LHD) Inpatient Unit or Community

1. Transfer of care pathway available for civil patients.
2. As per Guideline 6.132 *Forensic Hospital Referrals (Correctional and Civil Patients)* the LHD which referred the patient to the FH will have already agreed to receive the patient back upon completion of treatment and a discharge pathway should already be established prior to admission.
3. The MDT must send all referral documents outlined in section 3.11 point 5 to the LHD/community team supporting the patient's placement in the proposed setting and add the referral into the Patient Flow Portal (under Waiting for What).
    a) The FMHSM via [redacted] must be notified of the referral.

4. If pursuing a Community Treatment Order (CTO) the following must also be completed:
   a) In the referral to the community team outline the request to pursue a CTO.
   b) The community team must accept the patient's continued care in the community and provide a community treatment plan to the referring MDT.
   c) The referring MDT must complete a Community Treatment Order Hearing Application Form and send along with the community treatment plan to the FH MHRT Administrator via [redacted] who will forward to the MHRT via [redacted]
5. The decision to transfer a Civil patient back to a LHD or community placement will be made by the MDT/CDFH in consultation with the Clinical Director of that service or via MHRT Order.
8. Where the patient is accepted, the FMHSM will add the patient to the MSU and LSU Admission Waitlist.
   a) If accepted to an inpatient unit the referring MDT must add the referral into the Patient Flow Portal (under Inter Hospital Transfer).

3.15 Transfer of Care – Correctional/Youth Justice Centre

1. Transfer of care pathway available for correctional patients when the treating team have formulated the opinion that the patient has ceased to be mentally ill, impaired or other, or care of an appropriate kind would be reasonably available in a CC/YJC.
2. Discharge/Transfer Order Documents. (for more information refer to Procedure 6.212 *Transfer from correction/detention centres to mental health facilities under the MHCIFPA*):
   a) **Section 86 (MHCIFPA)**: before expiry of the section 86 the patent must be sent back to a CC/YJC. No other order is required.
   b) **Section 87(2) (MHCIFPA)**: if the patient is being sent back to another Gazetted facility (only LBH available). A MHRT order for transfer or *Section 115* and *Section 117 Order for Transfer* proforma signed by the Delegate (supported by a JHeHS progress note supporting transfer).
   c) **Section 87(3) (MHCIFPA)**: The medical officer must complete a JUS025.130 *Section 87(3) Notification* with a typed medical report and send to the FMHSM via [redacted] for the delegate to review and consider approval.
3. The FMHSM via [redacted] will inform key stakeholders of the outcome of the Delegate review, including relevant members of the MDT, MHRT, MHAS and CSNSW/YJNSW.
4. If pursuing a Forensic Community Treatment Order (FCTO) see Procedure 6.013 *Forensic Community Treatment Order*.

3.16 Transfer of Care – Ceasing to be a Correctional Patient

1. As per section 104 (MHCIFPA) a correctional patient ceases to be a correctional patient if one of the following circumstances occurs:
   a) The person is transferred to a CC, YJC or other place (other than another mental health facility) from the mental health facility.
   b) The person's sentence of imprisonment expires.
   c) The person is ordered to be released on parole.

d) The person is otherwise released on the order of a court.

e) The relevant charges against the person are dismissed.

f) The Director of Public Prosecutions notifies the court or the Tribunal that the person will not be further proceeded against in respect of the relevant charges.

2. Transfer in the case of (a), (b) or (c) above will usually be able to be planned in advance, however where release occurs as a result of (d), (e) and (f) and is earlier than anticipated, then every effort must be made to accelerate the processes for transfer while maintaining consistent standards of communication, consultation and documentation in relation to management, follow-up plans and risk assessments.
3. Typically, the FMHSM will inform the patients MDT and CDFH of the immediate release of the patient.
4. Prior to the expiry of a patient's sentence or the date of parole, the MDT must consider whether, following the expiry of the sentence, the patient is likely to continue to require treatment as an inpatient involuntarily.

   a) The authorised medical officer should communicate with the patient's legal representative regarding issues which may arise with expedient release and recommendations to avoid these difficulties.

5. If the patient is likely to require treatment as an inpatient:

   a) The authorised MO must inform the CDFH.

   b) The authorised MO must identify and contact the appropriate mental health facility of the LHD for the patient's expected place of residence and advise the appropriate officer of the facility of the expected date of transfer of the patient.

   c) The authorised MO for the patient must complete a SMR020.100 *Section 19 Schedule 1 – Medical Certificate as to Examination or Observation of Person* prior to the patient's transfer.

6. **Note**: If it is known that the patient has a court appearance and there is a possibility they may be discharged by the court, and the patient requires continued admission then consideration should be given to completing a SMR020.100 *Section 19 Schedule 1 – Medical Certificate as to Examination or Observation of Person* so that if the court releases the patient they can be transported by police to a declared mental health facility.
7. **Note**: If the patient is not being considered for scheduling under section 19 of the MHA the MDT must determine if the patient was homeless prior to their incarceration, or the patient would otherwise be homeless on discharge from the FH. A patient who has been detained involuntarily in the FH must have, wherever possible, appropriate, and stable accommodation arranged prior to discharge to the community.

   a) If they do not, consideration for SMR020.100 *Section 19 Schedule 1 – Medical Certificate as to Examination or Observation of Person* should be made.

3.17 Transfer of Care – Unexpected Discharge to the Community

1. The nature of the population in a secure hospital is such that transfers will be carefully planned and coordinated. However, within forensic mental health services, unusual situations can arise. Occasionally, patients may be transferred unexpectedly from the FH directly to the community. This may occur as a result of:

   a) The release of a person on bail, or

   b) An appeal to the MHRT or Court resulting in an Order for discharge.

2. If this were to occur, then the MDT must make every reasonable effort to expediate the gathering of required patient discharge information and collaboration with external services which may include:
   a) The FMHSM.
   b) Local LHD mental health service in the area where the patient previously, or is expected to reside, including where possible:
      i An MDT-to-MDT meeting.
      ii A Consultant-to-Consultant handover.
      iii Out-patient appointment with the LHD.
   c) Department of Communities and Justice (DCJ).
   d) CFMHS for forensic patients.
   e) CSNSW/YJNSW for correctional patients.
   f) Other available community services.
3. Unplanned/unexpected patient transfers/discharges from the FH are, by their very nature, unusual. Consideration should be giving to holding a critical incident review of the process.

3.18 Transfer of Care – Pre-Discharge Legal Documents and Gathering Patient Information

1. Once a discharge pathway has been set and agreed upon by all parties and all legal orders have been gained the process of gathering transfer of care documentation should begin.
2. The discharging MDT must begin the Forensic Hospital Patient Discharge Checklist *prior to discharge* sections.
3. As part of the discharge process the discharging NUM in collaboration with the FMHSM and appropriate stakeholders will gather all relevant legal documentation and patient information.
4. Transfer of care documentation will be specific to the patients' needs, but at a minimum the following should exist:
   a) Written confirmation from the receiving service that the patient has been accepted and that a transfer of care date has been set.
   b) Updated documentation outlined in section 3.6 point 3 and section 3.11 point 5.
   c) Legal orders such as Forensic Community Treatment Order (FCTO), Community Treatment Order (CTO), Financial Management Order, Guardianship Order, etc.
5. Discharge/Transfer Order Documents:
   a) **Forensic**: order by the MHRT or *Section 115 and Section 117 Order for Transfer* proforma signed by the Delegate.
   b) **Correctional**: as per section 3.15.
   c) **Civil**: SMR025.215 *Section 78 and 80 – Transfer of Involuntary Patient Between Mental Health Facilities* or CTO order.
6. The treating team is responsible for ensuring that the designated carer/principal care provider has been informed of the decision to discharge from to the FH.
   a) **Note**: For the purposes of security, the exact time and date of admission should not be disclosed to the patient and designated carer/principal care provider unless it is into the care of the designated carer/principal care provider.

3.19 Transfer of Care – Prior to Discharge from the FH

1. Forensic and civil patients will be transferred in accordance with section 81 (MHA) by FH staff. The discharging FH NUM is responsible for organising this transport in collaboration with the admitting service. This is typically either a G4S vehicle or Pool Vehicle.
2. Correctional patients will be transferred in accordance with security conditions outlined in Section 117 (MHCIFPA) by CSNSW/YJNSW.
   a) Acceptance:
      i. An admission date and time will be decided upon by the admitting NUM in consultation with the discharging NUM.
      ii. The discharging NUM must contact the FMHSM [redacted] indicating the proposed date of discharge.
      iii. The FMSHM will send through a completed *Acceptance Form* to the admitting NUM.
      iv. The admitting NUM must sign the *Acceptance Form* and return to the FMHSM via [redacted]
   a) Transport:
      i. **Adult Correctional Patients:** once the FMHSM received the signed *Acceptance Form* from the admitting NUM, this will be forwarded along with the appropriate order to the Metro Regional Manager and Forensic Liaison (MRMFL) via [redacted] who will organise transport. The FMHSM will inform the admitting and discharging NUM that the transport has been booked and the estimated arrival time.
      ii. **Adolescent Correctional Patients:** once the FMHSM receives the signed *Acceptance Form* from the admitting NUM, transport will be arranged by the FH Adolescent NUM and FH Social Worker (SW) by liaising with the YJNSW Centre Manager and Court Logistics, Classifications and Placements Unit (CLCPU) via [redacted]
3. The discharging NUM must complete an electronic Patient Admission, Discharge, Escort and Transfer Notification which will inform G4S of the planned discharge.
   a) The discharging NUM must communicate with G4S and all relevant stakeholders on the expected arrival of the patient.
4. All planned discharges from the FH should occur during [redacted].
   a) However exceptional circumstances may arise, i.e. court proceedings ordering release, all reasonable efforts must be made to facilitate the required transfer/release.

3.20 Transfer of Care – Discharge from the FH

1. Discharging MDT must complete the Forensic Hospital Patient Discharge Checklist *day of discharge* sections and follow up any outstanding items from *prior to discharge* sections.
2. Staff must ensure that all patient property and all discharge documentation is placed in the transport vehicle for forensic and civil patients or made available to CSNSW/YJNSW for correctional patients.
3. A member of the MDT must provide a verbal handover to the receiving service.

4. **Forensic and Civil**: in normal circumstances the G4S or Pool Vehicle will be driven up to the unit on the day of discharge.
5. **Correctional**: in normal circumstances CSNSW/YJNSW transport vehicle will wait in the Sally Port to collect patient for transfer.
    a) On exceptional circumstances if the patient is extremely agitated and combative on discharge and if in agreement with CSNW/YJNSW, they may drive directly to the discharging unit where the patient is being housed.
    b) FH staff will likely have the patient in physical and/or mechanical restraints. FH staff and CSNSW/YJNSW will work together in transferring the patient from FH MR to CSNSW/YJNSW MR and placing them in the vehicle.
6. The decision to transfer may be deferred if the patient presents with active risks at the time and the transfer cannot be safely facilitated, except in the circumstance of mandatory transfers, i.e. the person's sentence has expired.
7. Once the patient reaches the discharging destination and/or is handed over to transporting staff the patient is then considered to be discharged from the care of the FH.

4. Definitions

Must

Indicates a mandatory action to be complied with.

Should

Indicates a recommended action to be complied with unless there are sound reasons for taking a different course of action.

4.1 Patient Legal Status Definitions

"Involuntary Patient" (Civil patient) as defined by section 4 of the MHA:

a) A person who is ordered to be detained as an involuntary patient after a mental health inquiry or otherwise by the Tribunal and is not a correctional or forensic patient.

"Forensic patient" as defined by section 72 of the MHCIFPA:

a) A person who is found unfit to be tried for an offence and who is detained in a mental health facility, correctional centre, detention centre or other place,

b) A person for whom a limiting term has been nominated after a special hearing (including a person who is subsequently subject to an extension order or an interim extension order) and who is detained in a mental health facility, correctional centre, detention centre or other place or who is released from custody subject to conditions under an order made by the Tribunal,

c) A person who is the subject of a special verdict of act proven but not criminally responsible and who is detained in a mental health facility, correctional centre, detention centre or other place or who is released from custody subject to conditions under an order made by a court or the Tribunal,

d) A person who is a member of a class of persons prescribed by the regulations for the purposes of this section.

For the avoidance of doubt, a person is NOT a forensic patient if the person has been found unfit to be tried for an offence and has been released on bail.

"Correctional patient" as defined by section 73 of the MHCIFPA:

a) The person has been transferred from a correctional centre or detention centre to a mental health facility while:

   i serving a sentence of imprisonment, or

   ii on remand, or

   iii subject to a high-risk offender detention order, and

The person is not a forensic patient and has not ceased to be a correctional patient under section 104 of the MHCIFPA or been classified as an involuntary patient under this Part.

"Adolescent Patient"

An adolescent patient is defined by two legislative Acts.

a) The Children and Young Persons (Care and Protection) Act 1998 defines a 'child' as a person under 16 years, and a 'young person' as aged 16 years or above but under 18 years of age.

b) The Children (Detention Centres) Act 1987 defines a 'juvenile inmate' as an inmate under the age of 21.

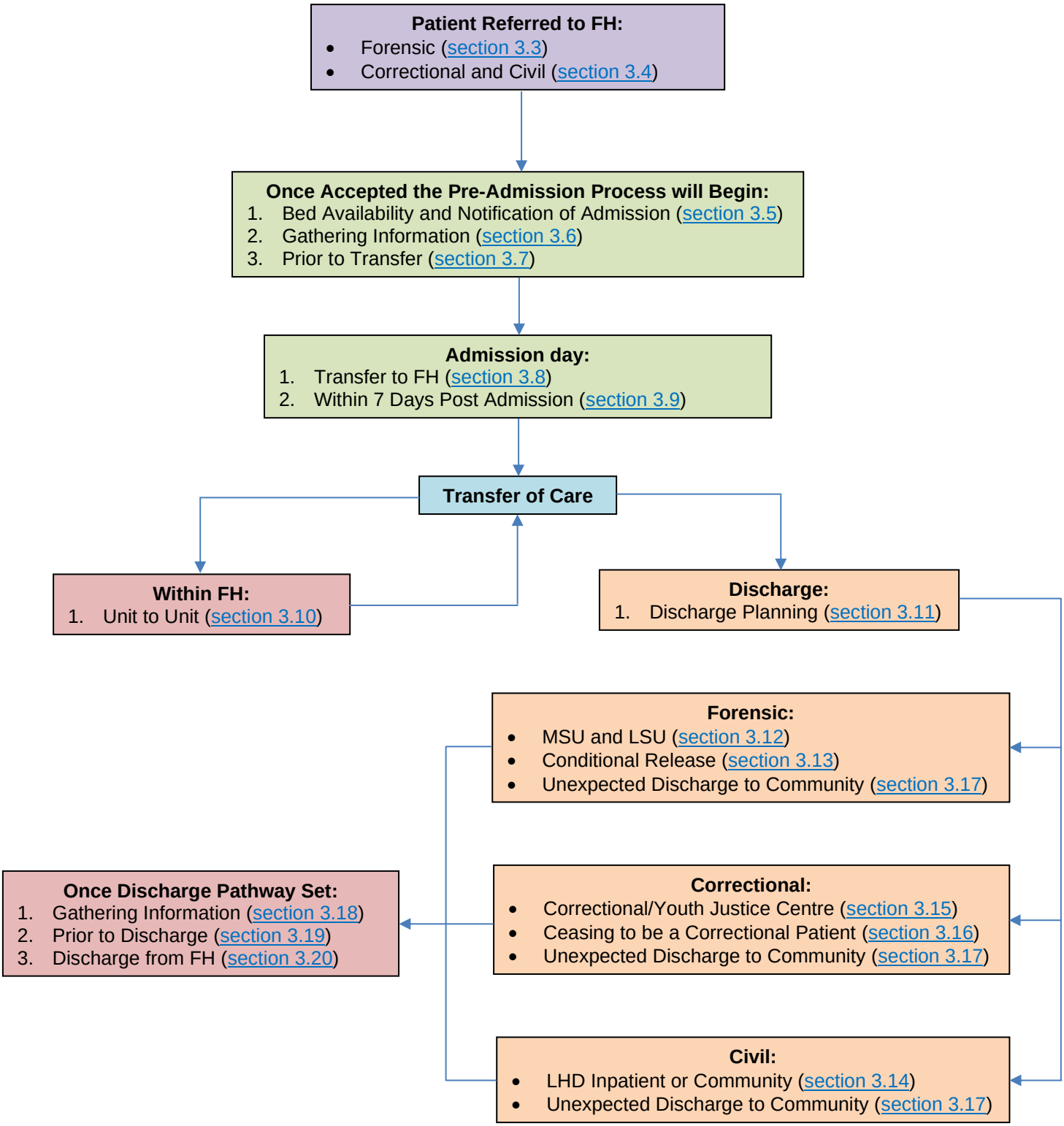
5. Related documents

Legislations	Children (Detention Centres) Regulation 2015 Children and young Persons (Care and Protection) Act 1998 Crimes (Administration of Sentences) Act 1999 Crimes (High Risk Offenders) Act 2006 Crimes (Administration of Sentences) Regulation 2014 Criminal Appeal Act 1912 Health Administration Act 1982 Mental Health Act 2007 Mental Health Regulation 2019 Mental Health and Cognitive Impairment Forensic Provisions Act 2020 Mental Health and Cognitive Impairment Forensic Provisions Regulation 2021 Terrorism (High Risk Offenders) Act 2017 Work Health and Safety Act 2011 Work Health and Safety Regulation 2011
Justice Health NSW Policies, Guidelines and Procedures	Policy 1.078 *Care Coordination, Risk Assessment, Management, Planning and Review* Policy 5.002 *Access to the Forensic Hospital* Procedure 6.084 *Urine Drug Screening* Procedure 6.086 *Clinical Handover and Registrar Contact* Procedure 6.093 *Physical Health Assessment and Care* Procedure 6.100 *Clinical Risk Assessment and Management (CRAM) – Framework and Documentation* Procedure 6.119 *National Disability Insurance Scheme (NDIS)* Procedure 6.139 *Custodial Mental Health Patient Flow* Procedure 6.156 *SCALE, Internal Ground Access and Outside Leave* Procedure 6.212 *Transfer from correction/detention centres to mental health facilities under the MHCIFPA* Procedure 7.005 *Photography, Videography and Camera Use* Procedure 9.014 *Prohibited and Controlled Items* Procedure 9.015 *Searches* Procedure 9.032 *Patient Property and Valuables* Guideline 6.132 *Forensic Hospital Referrals (Correctional and Civil Patients)*
Justice Health NSW Forms	JUS025.130 *Section 87 Notification* JUS025.135 *Section 86 – Schedule 1 – Medical Certificate as to Examination of Inmate*

	JUS025.136 *Section 86 Profile Form* Section 115 and Section 117 Pro Forma (MHCIFP Act) Patient Admission, Discharge, Escort and Transfer Notification Forensic Hospital Civil Patient Referral Form Forensic Hospital Patient Admission Checklist Forensic Hospital Patient Discharge Checklist Referral Form
NSW Health Policy Directives and Guidelines	PD2012_050 *Forensic Mental Health Services* PD2019_020 *Clinical Handover* PD2019_024 *Adult Mental Health Intensive Care Networks* PD2019_045 *Discharge Planning and Transfer of Care for Consumers of NSW Health Mental Health Services* PD2021_039 *Mental Health Clinical Documentation* PD2022_012 *Admission to Discharge Care Coordination* PD2024_030 *Responding to the Health Care Needs of People with Disability* PD2025_013 *Patient Admission and Discharge to NSW Health Facilities* GL2014_002 *Mental Health Clinical Documentation Guidelines*
Other documents and resources	Notice of Intent SMR020.100 *Section 19 Schedule 1 – Medical Certificate as to Examination or Observation of Person* SMR025.108 *Application for Discharge from Mental Health Facility* SMR025.107 *Section 72A Identification of Principal Care Provider* SMR025.110 *Section 27 or 27A Form 1 – Clinical Report as to Mental State of a Detained Person* SMR025.170 *Section 72 Nomination of Designated Carer* SMR025.215 *Section 78 and 80 – Transfer of Involuntary Patient Between Mental Health Facilities* Security Conditions Protocol – CSNSW and JHFMHN Information Sharing Protocol – CSNSW and JHFMHN

6. Appendix

6.1 Forensic Hospital Patient Pathway



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Referral (Adults and Adolescents) Forensic Hospital

Policy Number 1.336

Policy Function Continuum of Care

Issue Date 22 March 2022

Summary The Forensic Hospital provides specialist therapeutic inpatient care for those patients who cannot be managed safely in conditions of lower security. This policy covers the referral of forensic, correctional and civil adult patients admitted to the Forensic Hospital

Responsible Officer Executive Director Clinical Operations

Applicable Sites

- ☐ Administration Centres
- ☐ Community Sites (e.g. Court Liaison Service, Community Integration Team, etc.)
- ☐ Health Centres (Adult Correctional Centres or Police Cells)
- ☐ Health Centres (Youth Justice NSW)
- ☐ Long Bay Hospital
- ☒ Forensic Hospital

Previous Issue(s) Policy 1.336 (Nov 2018); Policy 1.325 (May 2015); Policy 1.327 (Dec 2015)

Manual 1.325M (Sep 2017); Manual 1.327M (Sep (2017)

Change Summary

- Updating of position titles
- Update Juvenile Justice to Youth Justice
- Updating of references and related documents
- Updating MHFP Act to MHCIFP Act

HPRM Reference POLJH/1336

Authorised by Chief Executive, Justice Health and Forensic Mental Health Network

1. Preface

The Forensic Hospital (FH) provides specialist, therapeutic inpatient care for those patients who cannot be managed safely in conditions of lesser security. Nevertheless, those conditions impose significant restrictions on the liberty of patients. This policy provides directions to Justice Health and Forensic Mental Health Network (The Network) staff, on adult and adolescent patients who are referred to the FH from correctional centres, including the Long Bay Hospital 1 (LBH), Youth Justice NSW (YJNSW) centres, and adult and adolescent civil patients from Local Health Districts (LHDs).

2. Policy Content

2.1. Mandatory Requirements

2.1.1. Referral – Patient Types

The following types of patient may be referred to the FH:

- correctional patients (includes adolescent correctional patients),
- forensic patients,
- involuntary (civil) patients from other mental health facilities who satisfy the criteria set out in this policy,
- involuntary (civil) patients who were forensic patients on a limiting term order or an interim extension order and whose limiting term has expired and have been detained in another mental health facility and satisfy criteria set out in this policy,
- involuntary (civil) patients who are classified as an 'offender' under the *Crimes (High Risk Offenders) Act 2006* or classified as an 'eligible offender' under the *Terrorism (High Risk Offenders) Act 2017* and satisfy criteria set out in this policy.

Under the terms of its declaration as a mental health facility, a person cannot be:

- referred directly from the community, on the certificate of a medical practitioner or accredited person, in accord with the *Mental Health Act 2007*, hereafter the *MH Act*;
- brought by an ambulance officer or a police officer under sections 20 or 22 of the *MH Act*;
- sent by a medical officer from another health facility under section 25 of the *MH Act*;
- detained on the written request of principal care providers/designated carers, relative or friend of a person under section 26 of the *MH Act*; or
- detained on the order of a Magistrate or bail officer in accordance with section 24 of the *MH Act*.

An adolescent patient is defined by two legislative Acts. The *Children and Young Persons (Care and Protection) Act 1998* defines a 'child' as a person under 16 years, and a 'young person' as aged 16 years or above but under 18 years of age. The *Children (Detention Centres) Act 1987* defines a 'juvenile inmate' as an inmate under the age of 21. In the FH, adolescent patients are generally aged 14 to 21 years. However, under special circumstances, admissions for children under the age of 14 may be considered.

2.2. Implementation - Roles & Responsibilities

Co-Directors Forensic Mental Health has overarching responsibility for the development, review and implementation of this policy and performance management of the referral process.

Director of Nursing and Services Forensic Hospital (DNS) is responsible for coordinating the development, review and implementation of all policies in the FH.

Deputy Director of Nursing (DDoN) and Nursing Unit Managers (NUM) are responsible for ensuring that this policy is implemented in all units in the FH and all patients are allocated a Care Coordinator(CC) within the specified time.

Clinical Director Forensic Hospital CDFH (CDFH) is currently the 'Medical Superintendent' of the hospital for the purposes of the *MH Act* and the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020*, hereafter the *MHCIFP Act* and is responsible for ensuring that all medical staff comply with this policy.

The Forensic Hospital Admissions Committee (FHAC) functions to oversee all referrals of patients into, within and out of the FH.

NSW Forensic Patient Flow Committee functions are to**:**

- have oversight of the admission, transfer and discharge of all adult and adolescent forensic patients across correctional centres, the FH, Bunya Unit, Cumberland Hospital; Kestrel Unit, M Psatorisset Hospital and Macquarie Unit, Bloomfield Hospital;
- review the case of each forensic patient, potential correctional patient and civil patient referred for admission to the FH;
- determine a clinical priority for admission for each patient reviewed;
- review the priority for admission of all patients on the inpatient waiting lists;
- manage the FH inpatient waiting lists;
- review the case of each forensic patient deemed suitable by the FH for lower secure care;
- determine the most appropriate unit to which each patient reviewed should be transferred; and notify the treating team of the patients reviewed of the Committees determination.

The Forensic Mental Health Liaison Officer (FMHLO) functions are to**:**

- Manage the MSU, LSU and FH waitlists
- Manage mental health orders
- Liaise with referring agencies and the FH

3. Procedure Content

Referrals for admission

These procedures facilitate the appropriate referral of adult and adolescent patients to the FH by ensuring decisions are:

- lawful, based on clear criteria, documented in the person's health record and

communicated promptly to referrers; and

- based on least restrictive care principles and take fully into consideration the safety of the person, staff of the NSW public health system and the public.

3.1. Referral of Forensic Patients

1. Persons who have received a special verdict of act proven but not criminally responsible (APNCR), unfit to plead or subject to a limiting term and detained are forensic patients and either:
   a) already under the care of the Network in :
      i) correctional centre, or
      ii) youth justice centre
      iii) the FH, or
      iv) LBH.
   b) not currently under the care of the Network and in:
      i) correctional centre, or
      ii) youth justice centre
      iii) the community
      iv) LHD mental health unit (including medium secure unit)

   In the case of a correctional patient who is already an inpatient of the FH and who subsequently becomes a forensic patient (for example after an APNCR finding), then the person's legal classification needs to be changed to that of a forensic patient. Where a Court or Tribunal Order requires that a forensic patient be detained in a correctional centre, youth justice centre, or the LBH and transferred to the FH as soon as a bed becomes available, the patient will be placed on the *Forensic Patients Awaiting Admission to the Forensic Hospital* waitlist by the Forensic Mental Health Liaison Officer (FMHLO).
2. In the case of a person who is being transferred to the FH who self identifies or is identified through health records as being an Aboriginal or Torres Strait Islander person, the clinician referring the person should ensure that the FH Aboriginal Mental Health Worker or equivalent is advised before the transfer.

3.2 Referral of Correctional Patients

- An authorised medical officer (psychiatrist, psychiatry registrar, career medical officer) working in custodial settings may determine that a person requires involuntary mental health care in a mental health facility. A mental health clinician who is not an authorised medical officer may not directly refer a person from a correctional or YJNSW centre to a mental health facility for admission. The clinician must refer the person to the mental health service for that correctional or YJNSW centre for a specialist mental health assessment before involuntary admission can be considered.
- For adults, where there is no clinical necessity for immediate transfer, it is recommended that the person be transferred to the Mental Health Screening Unit (MHSU).

- A psychiatrist who wishes to transfer a person in a correctional centre to the FH must:
  a) ensure that two JUS025.135 *Schedule 1 - Medical Certificate as to Examination of Inmate* forms are completed (at least one of the two Schedule 1s must be completed by a psychiatrist);
  b) complete the JUS025.137 *Consent to Mental Health Treatment* form (if the person consents to the transfer to a mental health facility for care and treatment pursuant to section 86(45) of the MHCIFP Act)
  c) complete the JUS025.136 *Profile Form*
  d) complete a typed report indicating why the person requires admission to a mental health facility, including the following information where available:
     i) person's name, DOB, legal status, offence/current charges, earliest date of release and current location
     ii) psychiatric history
     iii) drug and alcohol history
     iv) medical history
     v) personal history
     vi) social history
     vii) treatment history
     viii) forensic history
     ix) current mental state
     x) statement regarding how the person meets the criteria for admission including assessment of risk to self and others in the current environment and why care in conditions of lesser security or in a YJNSW facility is not appropriate
     xi) statement regarding goals of admission to the FH
     xii) acknowledgement that the person and the person's designated carer/principal care provider have been informed of the referral (unless valid reasons are outlined as to why this information has not been shared)
     xiii) evidence that the Department of Communities and Justice (DCJ) has been informed of the referral where a young person is in the care of the Minister
  e) ensure that the above documents are sent to the FMHLO at [redacted] for approval by the Delegate of the Secretary of the Ministry of Health and issue an Order for Transfer pursuant to section 86 of the *MHCIFP Act*.
- The person may then be placed on the waitlist for admission to the FH.
- Where an adolescent referral has been accepted as appropriate for assessment, an assessment team from Austinmer Adolescents Unit should undertake a further assessment of the young person within two weeks. It is preferable that the MDT will endorse the referral, but not necessary if the FH has already been decided as the most appropriate place of treatment by two medical professionals. The NUM must then update the PAS record and inform the referring psychiatrist, YJNSW clinic and centre of the decision.
- The referrer is responsible for ensuring a *Nomination of designated carer/principal care*

provider is completed in accord with section 72 and section 72A of the *MH Act*, or if not completed, that a note is made of the name of the person who is the applicable designated carer/principal care provider from the list of automatic appointees contained in section 71 of the *MH Act*.

- In the case where the delegate decides not to make a section 86 order, the FMHLO must refer the matter back to the referrer for additional information which must be provided as soon as possible.
- Where the delegate makes a section 86 order, the FMHLO must ensure that the following are informed of the order:
  a) The referrer, usually the relevant NUM of the centre where the person is detained or if an adolescent, the relevant referrer of the YJNSW centre
  b) CSNSW, Senior Project Officer Forensic Liaison (SPOFL)
  c) NUM/Nurse in Charge (NiC) of the proposed unit to which the person will be transferred
  d) Mental Health Advocacy Service
  e) Mental Health Review Tribunal (MHRT)
  f) Forensic Legal Advisor (FLA)
- If it is intended to admit a person to the FH under section 86, then the referral must have been reviewed by the CDFH and the Bed Demand Committee (BDC), and an admission priority assigned before the person can be transferred. In an emergency or other special circumstance, the CDFH as Medical Superintendent of the FH may authorise an admission without first consulting the BDC. Any such decisions will be noted at the following BDC Meeting.
- The CDFH or delegate must:
  a) Review all PAS referrals weekly at the admission meeting and
  b) If a section 86 order has been made in respect of the patient, and it is intended that the patient be transferred to the FH, the referral is reviewed at subsequent meetings of the FHAC until the patient is admitted or is deemed to no longer require admission and a revocation order is obtained.
  c) Ensure that the NSW Forensic Patient Flow Committee is advised.

3.2.1 Transfer of Correctional Patient Health Information

Following the decision to admit the person under s86 of the MHCIFP Act, the nursing or clerical staff of the referring correctional/YJNSW centre must arrange for all the documentation listed in the JHFMHN Nursing Checklist – Transfer out of Centre form (JUS010.000) to be given to the FH in accordance with JHFMHN policy 1.395 Transfer and Transport of Patients.

3.2.2 Waitlist and Bed Management

1. When there is no bed immediately available for the person, an interim management plan must be developed by the referring team in conjunction with the CD Custodial Mental Health (CDCMH) or CD Adolescent Mental Health. The person will continue to be managed by CMH or YJNSW until they can be admitted to the FH, or until an order is made under s86(6) of the MHCIFP Act revoking the order for transfer. The designated carer/principal care provider must be updated, wherever possible, in line with section 78(1)(b) of the MH Act and Ministry PD2019_045 Transfer of Care from Mental Health Inpatient Services.

2. All persons continuing to wait for admission, with an active section 86 order, will be discussed at a minimum once each week at the BDC and Forensic Hospital Admissions Committee, and the person's order of priority for admission will be recorded.

   Where there is a significant deterioration in the mental state of the person being referred and/or level of risk and a bed is available or can be made available, and provided there is an active section 86 order or court/MHRT order for transfer to the FH, the Medical Superintendent of the FH (designated as the CDFH or delegate) in conjunction with the NUM LBH MHU, DDoN FH and if after hours, the AHNM, may approve the urgent transfer of the person to the FH without consulting the BDC or the FHAC.

3.2.3 Urgent Referrals Without a Section 86 Order

In the case of an identified person who is in urgent need of admission to LBH MHU but for whom a section 86 order has not yet been made, CSNSW may transfer the person to LBH without a s86 MHCIFP Act order under the classification of 'inmate'. The effect of this for the Network staff is that the person cannot be treated involuntarily and cannot be admitted to the FH until the s86 order is made. The referrer may contact the CDCMH or the CDFH for further advice.

3.3 Referral of High Risk Civil Patients

3.3.1 Referral Criteria for Civil Patients

1. The restrictions on liberty in the FH can only be justified when the highest level of security is required and no lesser degree of security would provide a reasonable safeguard to the public. It is an unacceptable infringement of a person's rights to detain them in a higher level of security than is required. An appropriate hospital bed is one that can provide the necessary clinical treatment programs, is in the least restrictive environment consistent with the need to protect the person and the public and is as close to the person's home as possible. The high security available within the FH is necessary to detain persons who, if in the community, would present a grave and/or immediate risk to the public and who could not be safely contained within a less secure unit.
2. To be considered for admission to the FH, a civil patient must:
   - manifest a significant risk of serious harm to others, either through violence or other endangering behaviour, who cannot be appropriately managed in a setting of lesser security;
   - have a clearly documented history of a mental illness. Comorbid diagnoses such as substance abuse and personality disorder may be present, but are not essential in order to be considered a 'high risk civil patient'. Intellectual disability and other cognitive impairments may be present, but cannot be the only clinical problem.
   - In the case of an adolescent patient there may not be a clearly documented history of mental illness, but a high risk civil patient may be admitted for diagnostic clarification; and
   - have demonstrated, in the past, significant risk of serious harm to others.
   - If an adolescent referral is over 18 years of age, details must be included as to why it is considered more appropriate to manage the patient within the Adolescent Unit, rather than a FH adult unit.
3. Admission to conditions of high security is not generally suitable for civil patients who:
   - have a diagnosis of personality disorder, substance use disorder and/or severe

developmental disorder not accompanied by a psychotic or severe mood disorder, even where those disorders have resulted in criminal behaviour;

- require close observation to prevent self-injury or suicide, unless this is associated with a significant risk to others;
- require long-term care, but for whom lesser conditions of security would be adequate;
- would benefit from the stability and support of the conditions in high security but are not a significant risk to self or others.

4. There would need to be evidence of a failure of management in a less secure hospital, including assertive interventions over an extended period, in patients fulfilling the above criteria before referral for admission to the FH could be considered.

3.3.2 Referrals from LHDs

1. The Network will provide support and advice on the safe care and management of high risk civil patients by LHD request.
2. The Community Forensic Mental Health Service (CFMHS) and the Forensic Risk Assessment and Management Adolescent Service (FRAMAS) provide a consultation and liaison service for adult and adolescent patients respectively and will collaborate with the LHD regarding recommendations on the safe care and management of high risk civil patients.
3. A recommendation for admission from the CFMHS and FRAMAS for a high risk civil patient must be made to the NSW Forensic Patient Flow Committee. This Committee places the person on a waiting list for a forensic unit if they agree. Priority for admission of civil, forensic and correctional patients to forensic units is reviewed regularly by the NSW Forensic Patient Flow Committee, chaired by the Co-Director Forensic Mental Health (Clinical) Co-DFMH (Clinical). The CFMHS should liaise with the LHD regarding outcomes of the NSW Forensic Patient Flow Committee. The LHD should liaise with the designated carer/principal care provider.
4. Prior to a high risk civil patient's admission to a forensic unit, the Network and the LHD will collaborate regarding discharge planning and transfer back to the LHD for continued care and management, taking into consideration LHD resources. In addition, a statement from the LHD must be provided giving assurance that if the person is admitted, they will remain involved in the person's ongoing care through.
5. In exceptional circumstances when an urgent admission to the FH is required, the medical superintendent (CDFH) may use their discretion to admit a civil patient in consultation with the DNS. Admission is based on imminent risk, whilst maintaining safety of patient and site. Collateral information and current risk assessment should be provided by referring hospital/centre as a minimum

3.3.3 Referrals from Custodial Mental Health and Adolescent mental Health

1. The referral of a person approaching the end of their sentence, or a person detained in custody approaching the end of their Continuing Detention Order under the *Crimes (High Risk Offenders) Act 2006* must have the endorsement of:
   - the CDCMH (for adults) or the CDAMH (for young persons) and

- at the discretion of the Medical Superintendent, the Clinical Director Mental Health of the LHD where the person most recently resided or received mental health care.

In the case of high risk offenders their case must have been reviewed by the Supreme Court.

2. The referral requires the support of the relevant LHD Clinical Director at the point of referral because the person's care is being retained within the Network following release from custody. This will facilitate transfer of care back to the LHD at the end of the admission to the FH.

Referrals from CMH of 'potential' civil patients are forwarded to the NSW Forensic Patient Flow Committee. The committee will review the referral and if considered appropriate for the FH, will forward the referral to the FHAC [redacted].

3. In accord with section 78(b) of the *MH Act*, the designated carer/principal care provider must be advised of the referral.

3.4 Emergency Transfer to the Forensic Hospital – Civil Patients

1. The transfer from the LHD mental health facility to the FH is by an arrangement, made under section 80 of the *MH Act* between the CDFH and the referring mental health facility.
2. The referring LHD is responsible for transporting the person to the FH, unless the CDFH approves otherwise. The transport of the person must be in accordance with section 81 of the *MH Act*.

3.5 Forensic Patients in the Community or LHD Mental Health Unit

1. When a forensic patient on conditional release in the community has breached a condition of their order or the person's mental condition has deteriorated and there is a risk of serious harm to self or others, an apprehension order issued by the President of the MHRT pursuant to section 109 of the *MHCIFP Act* authorises the detention of the person at a mental health facility, correctional centre, youth justice centre or other place specified in the order.
2. The MHRT must review the case of a person apprehended under section 109(4) of the *MHCIFP Act*. The consultant psychiatrist responsible for the forensic patient in the community must seek the agreement of the FHAC. The person's forensic patient status does not automatically indicate a need for care in a high secure facility.
3. The referral of a person in this scenario is made to the NSW Forensic Patient Flow Committee as this committee has representatives from the FH, CFMHS and the MHRT. The FHAC assesses the person and determines whether or not the person is to be admitted. The FHAC's decision is reported back to the referring psychiatrist and the NSW Forensic Patient Flow Committee.
4. When a forensic patient located in a LHD mental health unit (including medium secure unit) presents a risk of serious harm to self or others or there has been a significant deterioration in mental state necessitating admission to a higher level of security, an order by the MHRT pursuant to sections 81 and 82 of the MHCIFP Act designating the FH as the hospital where the person is to be detained, will be required before the person can be admitted to the FH.
5. The referral of a person in this scenario requires the support of the CDFH for admission to

the FH. Pre-admission assessment of the patient and discussion with the referring psychiatrist.

4. Definitions

In this policy the term Clinical Director means the Clinical Director, Forensic Hospital. This policy presumes that the Clinical Director is also the Medical Superintendent of the FH. Any reference to the Clinical Director should be read, where applicable, as a reference to the Medical Superintendent. The terms 'forensic patient' and 'correctional patient' have the meanings given in the *MHCIFP Act*.

Must

Indicates a mandatory action or requirement.

Should

Indicates a recommended action that needs to be followed unless there are sound reasons for taking a different course of action.

Civil Patient

An involuntary detained patient of a declared mental health facility who is not also a forensic patient and is detained in accordance with the *MH Act*.

Correctional Patient

A person, other than a forensic patient, who has been transferred from a correctional centre or youth justice centre to a mental health facility while serving a sentence of imprisonment, on remand or subject to a high risk offender detention order and who has not been classified by the MHRT as an involuntary patient.

Forensic Patient

A person who:

1. Has been found unfit to be tried for an offence and ordered to be detained in a mental health facility, correctional centre, youth justice centre or other place. .
2. Is subject to a limiting term (including a person who is subsequently subject to an extension order or an interim extension order) and who is detained in a mental health facility, correctional centre, youth justice centre or other place.
3. Is subject to a special verdict of act proven but not criminally responsible and ordered to be detained in a mental health facility, correctional centre, youth justice centre or other place.
4. Is a person who is a member of a class of persons prescribed by the regulations (currently includes a person found not guilty of an offence by reason of mental illness or mental impairment under the law of Norfolk Island, and who is transferred to a held in the custody of NSW) Clause 30 of the Mental Health and Cognitive Impairment Forensic Provisions Regulation 2021.

Designated Carers

(1)The designated carer of a person (the patient) for the purposes of the *MH Act* s71 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, a person nominated by the patient as a designated 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 individual 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.

relative of a patient who is an Aboriginal person or a Torres Strait Islander includes a person who is part of the extended family or kin of the patient according to the indigenous kinship system of the patient's culture.

1.1.1 Principal Care Providers

(1) The ***principle care provider*** of a person for the purposes of the *MH Act* s72A is the individual who is primarily responsible for providing support or care to the person (other than wholly or substantially on a commercial basis).

(2) An authorised medical officer at a mental health facility or a director of community treatment may, for the purposes of complying with a provision of this Act or the regulations, determine who is the principal care provider, of a person.

(3) The authorised medical officer or the director of community treatment must not determine that a person is the principal care provider of another person if the person is excluded from being given notice or information about the other person under this Act.

(4) An authorised medical officer or a director of community treatment is not required to give effect to a requirement relating to a principal care provider of a person under this Act or the regulations if the officer or director reasonably believes that to do so may put the person or the principal care provider at risk of serious harm.

(5) A principal care provider of a person may also be a designated carer of the person.

1.1.2 Serious harm

Is not defined in the *MH Act*. However it is intended to be a broad concept that may include:

- physical harm
- emotional/psychological harm
- financial harm
- self-harm and suicide
- violence and aggression including sexual assault or abuse
- stalking or predatory intent

- harm to reputation or relationships
- neglect of self
- neglect of others (including children)

5. Legislation and Related Documents

Legislations	Mental Health Act 2007 Mental Health Regulation 2019 Mental Health and Cognitive Impairment Forensic Provisions Act 2020 Criminal Appeal Act 1912 Health Administration Act 1982 Crimes (High Risk Offenders) Act 2006 Terrorism (High Risk Offenders) Act 2017
The Network Policies and Procedures	1.037 Long Bay Hospital Admission Policy (Referral, Admissions and Assessment 1.230 Health Care Interpreter Services – Culturally and Linguistically Diverse and d/Deaf Patients 1.395 Transfer and Transport of Patients 1.407 Transport of Forensic Patients from the Metropolitan Remand and Reception Centre and the Silverwater Women's Correctional Centre
The Network Forms	FH2 Forensic Hospital Patient Discharge Checklist FMR025.010 The Mental Health Assessment Form JUS005.001 Health Problem Notification Form JUS010.000 Nursing Checklist – Transfer out of Centre JUS025.136 Profile Form – Mental Health Act
NSW Health Policy Directives, and Guidelines	PD2010_018 Mental Health Clinical Documentation PD2012_050 Forensic Mental Health Services PD2013_007 Child Wellbeing and Child Protection Policies and Procedures for NSW Health PD2012_042 Aboriginal and Torres Strait Islander Origin – Recording of Information of Patients and Clients PD2016_007 Clinical Care of People Who May Be Suicidal PD2019_045 Discharge Planning and Transfer of Care for Consumers of NSW Health Mental Health Services GL2014_002 Mental Health Clinical Documentation Guidelines

Other	Mortality and Hospitalisation Due to Injury in the Aboriginal Population of New South Wales

Health
Justice Health and
Forensic Mental Health Network

policy

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Admission (Adults and Adolescents) Forensic Hospital

Policy Number 1.337

Policy Function Continuum of Care

Issue Date 16 June 2022

Summary The Forensic Hospital provides specialist therapeutic inpatient care for patients who cannot be managed safely in conditions of lower security.

This policy covers the admission of forensic, correctional and civil adult patients to the Forensic Hospital.

Responsible Officer Executive Director Clinical Operations

Applicable Sites

- ☐ Administration Centres
- ☐ Community Sites (e.g. Court Liaison Service, Community Integration Team, etc.)
- ☐ Health Centres (Adult Correctional Centres or Police Cells)
- ☐ Health Centres (Youth Justice NSW)
- ☐ Long Bay Hospital
- ☒ Forensic Hospital

Previous Issue(s) Policy 1.325 (May 2015); Policy 1.327 (Dec 2015) Manual 1.325M (Sep 2017); Manual 1.327M (Sept 17); Policy 1.337 (Nov 2018)

Change Summary

- Updating of position titles
- Update Juvenile Justice to Youth Justice
- Updating of references and related documents
- Update MHFP Act to MHCIFP Act
- Addition FMHLO to roles and responsibilities

HPRM Reference POLJH/1337

Authorised by Chief Executive, Justice Health and Forensic Mental Health Network

1. Preface

Inpatient care is one element of the continuum of health and social care for a person. An admission to a mental health facility can be a distressing experience for the individual and their family. Their experiences during the admission process can define their views, expectations and confidence in the services they subsequently receive in the short to longer term. It is important, therefore, that the experience of the person and family is helpful, beneficial and therapeutic. Moreover, an admission can be the start of the engagement and assessment process and the commencement of the therapeutic alliance with each person and their family or designated carer/principal care provider.

The Forensic Hospital (FH) provides specialist, therapeutic inpatient care for those patients who cannot be managed safely in conditions of lower security. The restrictions on a patient's liberty whilst in the FH can only be justified when no lesser degree of security would provide a reasonable safeguard to the public. To maintain a person's rights they should be detained in the least restrictive level of security required. An appropriate hospital bed is one that can provide the necessary clinical treatment programs, is in the least restrictive environment consistent with the need to protect the patient and the public and is as close to the patient's home as possible. The security restrictions available within the FH are necessary to detain a person who, if in the community, would present a grave and/or immediate risk to the public and who could not be safely contained within a less secure unit.

This policy provides directions to Justice Health and Forensic Mental Health Network (The Network) staff on the admission of adults and adolescents who are admitted from correctional centres, including Long Bay Hospital (LBH), Youth Justice Centres (YJC) and from Local Health Districts (LHDs).

Note: an adolescent patient is defined by two legislative Acts. The *Children and Young Persons (Care and Protection) Act 1998* defines a 'child' as a person under 16 years, and a 'young person' as aged 16 years or above but under 18 years of age. The *Children (Detention Centres) Act 1987* defines a 'Youth inmate' as an inmate under the age of 21. In the FH, adolescent patients are generally aged 14 to 21 years. However, under special circumstances, admissions for people under the age of 14 may be considered.

2. Policy Content

2.1. Mandatory Requirements

2.1.1 Admission - Patient Types

a) The following types of patient may be admitted to the FH:

- correctional patients (includes YJNSW patients),
- forensic patients,
- involuntary (civil) patients from other mental health facilities who satisfy the criteria set out in this policy,
- involuntary (civil) patients who were forensic patients on a limiting term or an interim extension order and whose limiting term has expired and have been detained in another mental health facility and who satisfy the criteria set out in this policy,

- involuntary (civil) patients who are classified as an 'offender' under the *Crimes (High risk Offenders) Act 2006* or classified as an 'eligible offender' under the *Terrorism (High risk Offenders) Act 2017* who satisfy the criteria set out in this policy,

b) Under the terms of its declaration as a mental health facility, a person cannot be:

- admitted directly from the community, on the certificate of a medical practitioner or accredited person, in accord with the *Mental Health Act 2007* hereafter, the *MH Act*;
- brought by an ambulance officer or a police officer under sections 20 or 22 of the *MH Act*;
- sent by a medical officer from another health facility under section 25 of the *MH Act*;
- detained on the written request of a designated carer/principle care provider, relative or friend of a person under section 26 of the *MH Act*; or
- detained on the order of a Magistrate or bail officer in accordance with section 24 of the *MH Act*.

However, a person listed under point b) may be admitted to the FH if they are an involuntary patient in an LHD mental health facility and satisfy criteria set out in this policy.

In exceptional circumstances when an urgent admission to the FH is required, the medical superintendent (CDFH) may use their discretion to admit a civil patient in consultation with the DNS. Admission is based on imminent risk, whilst maintaining safety of patient and site. Collateral information and current risk assessment should be provided by referring hospital/centre as a minimum.

2.1.2 Assessment

Assessment is in three stages leading to the formulation of treatment and management plans that include a provisional transfer of care (discharge) plan for return to the community or custody. Those stages are:

- pre-admission assessment,
- initial assessment on admission to the FH, and
- ongoing comprehensive multidisciplinary team (MDT) assessment and review as per the Clinical Risk Assessment and Management (CRAM) framework.

Clinical staff must:

- make every effort to ensure that the patient, their family, and/or designated carer/principal care provider are given the opportunity to actively participate in the care and treatment planning process. To achieve this outcome, clinical staff must ensure that patients are provided with information about the assessment, treatment and management planning process in a form they can understand.
- use the appropriate clinical modules and outcome measures (formerly known as MH-OAT *Mental Health Outcomes and Assessment Tools)* or the Network-approved forms to record all assessments, treatment and management plans. Refer also to PD2021_039 *Mental Health Clinical Documentation.*
- adhere to the CRAM framework in accord with the Network policy 1.078 *Care Coordination, Risk Assessment, Management, Planning and Review – Forensic Hospital.*

- ensure that a *Nomination of designated carer/principal care provider* under section 72 and section 72A of the *MH Act* is completed or if not completed, that a note is made in the health record of the name of the person who is the applicable designated carer/principal care provider under section 71 of the *MH Act.*
- ensure that all legal requirements are met including the obtaining of an order under Section 87(2) of the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020,* hereafter the MHCIFP Act within seven days of a correctional patient's admission to the FH where continued detention in the FH is required beyond that seven day period.
- ensure all assessments, treatment and management plans are filed in each patient's health record.

2.2. Implementation - Roles & Responsibilities

Executive Director Clinical Operations (EDCO) – has overarching responsibility for the development, review and implementation of this policy and performance management of the admission process.

Director of Nursing and Services (DNS) – is responsible for the development, review and implementation of all policies in the FH.

Clinical Director Forensic Hospital (CDFH) – is currently the 'medical superintendent' of the hospital for the purposes of the *MH Act* and the *MHCIFP Act* and is responsible for ensuring that all medical staff comply with this policy.

Deputy Director of Nursing (DDoN) and Nursing Unit Managers (NUM) – are responsible for ensuring that this policy is implemented in all units in the FH and all patients are allocated a Care Coordinator (CC) within the specified time.

Forensic Mental Health Liaison Officer (FMHLO) – is responsible for the management of MSU, LSU and FH waitlists, managing mental health orders and liaison with referring agencies and the FH.

Manager Allied Health (MAH) – is responsible for ensuring that all allied health staff comply with this policy.

Care Coordinator (CC) – is responsible for initiating and coordinating the admission process, and implementing, coordinating and monitoring the patient's transfer of care plan.

The Forensic Hospital Admissions Committee (FHAC) functions to:

- oversee all patient flow into, within and out of the FH;
- assess and approve all admissions to the FH; and
- participate in the Bed Demand Committee (BDC) for correctional and forensic patients.

The role of the BDC is to prioritise correctional and forensic patients who are on the *Patient Administration System* (PAS) waiting list. The CDFH, on advice from the FHAC, may admit correctional and civil patients from the inpatient waiting list to the FH.

3. Procedure Content

3.1 Admission to the Forensic Hospital

These procedures facilitate the assessment of all patients admitted to the FH by ensuring:

- patients are assessed within an appropriate time following admission,
- assessments include all appropriate mental and physical health, drug and alcohol and risk assessments,
- assessments take into consideration the cultural, gender and age related needs of patients,
- patients and their family or designated carer/principal care provider are informed of the assessment process,
- Treatment, Placement, Restrictions, Implementation and Monitoring (TPRIM) Management Plan is developed for all patients admitted to the Forensic Hospital and documented in their health record.
- All patients are admitted to the FH on default SCALE A2.

All planned admissions to the FH should occur during business work hours between 08:30 and 17:00 weekdays. In exceptional circumstances, admissions can be accepted outside of the stated times and must be directed through the Nurse Unit Manager (NUM)/After Hours Nurse Manager (AHNM)/Deputy Director of Nursing (DDON).

3.2 Admission Criteria for Civil Patients

To be admitted to the FH, a civil patient must:

- manifest a significant risk of serious harm to others, either through violence or other endangering behaviour, who cannot be appropriately managed in a setting of lesser security;
- have a clearly documented history of a mental illness. Comorbid diagnoses such as substance abuse and personality disorder may be present, but are not essential in order to be considered a 'high risk civil patient'. Intellectual disability and other cognitive impairments may be present, but cannot be the primary clinical problem;
- have demonstrated, in the past, significant risk of serious harm to others.

Note: Refer to section 4 *Definitions* for guidance on the meaning of 'serious harm'. Documented evidence must be provided that assertive intervention has been unable to safely manage the patient. Each case is considered on its own merits, taking full account of the circumstances and patterns of behaviour of the patient.

- If an adolescent civil referral is over 18 years of age, details must be included as to why it is considered more appropriate to manage the patient within the Adolescent Unit, rather than a FH adult unit.

Admission to conditions of high security is not generally suitable for civil patients who:

- have a diagnosis of primary personality, substance use and/or severe developmental disorder not accompanied by a psychotic or severe mood disorder, even where those disorders have resulted in criminal behaviour;
- require close observation to prevent self-injury or suicide, unless this is associated with a significant risk to others;
- require long-term care, but for whom lesser conditions of security would be adequate;

- would benefit from the stability and support of the conditions in high security but are not a significant risk to others, or
- are over the age of 65.

There would need to be evidence of a failure of management in a less secure hospital (including assertive interventions over an extended period) in patients fulfilling the above criteria before admission to the FH could be considered.

3.3 Multidisciplinary Team Pre-admission Assessment

1. Once a referral has been accepted as appropriate for admission by the FHAC or the medical superintendent, an assessment team will be allocated to undertake a further assessment within a reasonable time period.
2. The assessment team should include representatives from the MDT, and will comprise at least one representative from each of the medical, nursing and allied health disciplines from the potential admitting unit treating team. Ideally one of the nursing representatives should be the identified CC. It may also be useful to have a peer worker attend if available.
3. If the patient being referred identifies as Aboriginal or Torres Strait Islander, the Aboriginal Mental Health Professional or delegate must be informed and where possible, be a part of the Pre-admission Assessment Team.
4. Prior to assessment the assessment team should be provided with the following information, whenever available:
   a) A letter of referral outlining mental health needs and risks that are unable to be contained in the environment.
   b) Progress notes and medication charts for the previous 6 months. This information should be provided from the referring unit NUM, or appropriate representative, to the admitting unit NUM.
   c) Most recent Mental Health Review Tribunal (MHRT) reports and other documentation from the Forensic Mental Health Liaison Officer (FMHLO) to the admitting unit NUM.
   d) Corrective Services NSW (CSNSW) *Offender Information Management System* (OIMS), inmate profile document and case notes (only relevant for forensic or correctional patients referred by CSNSW) from the Forensic Mental Health Liaison Officer (FMHLO) to the admitting unit NUM. These are saved in the units G:Drive under Future Admissions folder.
   e) Youth Justice NSW (YJNSW) *Client Information Management System for Adolescent Health Staff (CIMS)* inmate profile document and case notes (only relevant for forensic or correctional patients referred by YJNSW) from the Social Worker to the admitting unit NUM. These are saved in the units G:Drive under the Future Admissions folder.
   f) NSW police Criminal Record Check and national police certificates from the Forensic Mental Health Liaison Officer (FMHLO) to the admitting unit NUM.
5. Pre-admission assessment should occur in person or by audio visual link (AVL) and should be inclusive of the following:
   - mental state examination

- preliminary risk assessment
- clarification of family and carer input
- drug and alcohol history
- cultural considerations
- dietary requirements
- explanation of the FH environment including the admission process
- the person's opinion of their admission to the FH

If assessment occurs in person a Forensic Hospital Patient Information Booklet should be provided to the patient following assessment.

6. Once assessed and all the relevant information has been considered, the case should be presented at the weekly MDT clinical review meeting, unless urgency requires a review of the case sooner than this, in which case it can be discussed with the treating consultant and the NUM outside of that process.
7. Once reviewed and assessed as appropriate for admission, a summary of the patient must be provided by the assessment team to the Forensic Hospital Admissions Committee (FHAC) outlining the case, recommendations and any special circumstances or requirements in regard to the admission. Any discussion in relation to admission to the FH should be recorded in the minutes of the FLBH Admissions and Leave Committee meeting. The committee must endorse the decision to admit on the basis of the team assessment.
8. Following endorsement of the decision to admit by the FHAC the NUM must update the PAS record and inform the referring psychiatrist, LHD, correctional centre or YJC and the FMHLO of the decision.
9. The NSW Forensic Patient Flow Committee must be informed via the FMHLO who will include the person on the agenda. The outcome of the assessment is provided by the CDFH.

3.4 Notification of Admission

1. The NUM of the admitting unit contacts the referring LHD/correctional centre/YJC and the FMHLO by email to commence the transfer process. The FMHLO can be contacted at [redacted] If the person is being admitted from an adult correctional centre [redacted] must also be e-mailed.
2. On notification of admission, the referring LHD/correctional centre/YJC must provide the following documentation to the admitting unit NUM:
   - Pre-transfer documents (pre-transfer summary/discharge summary) completed by the transferring nursing staff, which includes: demographic details, current mental state and presentation, behaviour, current medications, allergies, care needs, family support, date of last MHRT hearing,
   - a copy of the order for transfer,
   - a copy of any form SMR025.170 *Nomination of Designated Carer* and the name and contact details of the designated carer/principal care provider,

- a verbal handover including the person's current mental state, attitude towards transfer, requirement of an interpreter on admission for assessment and orientation, etc., and
- Any Department of Communities and Justice (DCJ) documents

3. The referrer is responsible for ensuring that the designated carer/principle care provider has been informed of the decision to admit to the Forensic Hospital (Note: For the purposes of security, the exact time and date of admission should not be disclosed).

3.5 Transfer of a Person to the Forensic Hospital

An admission date will be decided upon by the NUM of the admitting unit in consultation with the admitting Consultant, the FHAC and the referring team.

3.5.1 Transfer of Civil Patients:

1. The transfer from the LHD mental health facility to the FH is by arrangement between the CDFH and the authorised medical officer of the referring mental health facility. The authorised medical officer of the referring mental health facility must complete a *Transfer of Involuntary Patient Between Declared Mental Health Facilities* form (SMR025.215) under section 80 of the *MH Act*, the original of which must be sent to the FH with the patient. The patient must not be admitted to the FH without the original copy of this form.
2. The referring LHD is responsible for transporting the patient to the FH, unless the CDFH approves otherwise. The transport of the patient shall be in accordance with section 81 of the *MH Act*.
3. The referring LHD will have agreed in the referral letter to remain involved in the patient's ongoing care through attendance at clinical review meetings and/or in-depth case reviews (case conferences) which may be via teleconference if unable to attend in person. The LHD must agree to resume responsibility at discharge and provide, or arrange, appropriate aftercare upon transfer of care from the FH.

3.5.2 Transfers from Correctional Centres/Youth Justice Centres to the Forensic Hospital:

Forensic Patients

The MHRT may order a Forensic Patient to be transferred to the FH from a correctional centre (including LBH) or YJC.

1. An admission date will be decided upon by the NUM of the admitting unit in consultation with the admitting Consultant and the FH Admissions Committee.
2. The NUM of the admitting unit must notify the FMHLO when a bed becomes available by emailing [redacted] advising the details, including date and time of admission.
3. The FMHLO must prepare a *Notice of Transfer of Forensic Patient* to be signed and approved by the NUM of the admitting unit. Once this has been approved, the form must be sent back to the FMHLO.
4. The FMLHO must send the approved *Notice of Transfer of Forensic Patient* form and the order for transfer issued by the MHRT to the Senior Project Officer (Forensic Liaison)

(SPOFL), CSNSW.

5. The FMHLO must circulate the *Notice of Transfer of Forensic Patient*, order for transfer issued by the MHRT to notify the following of the new admission:
   a) NUM of the admitting unit
   b) Clinical Director Custodial Mental Health (CDCMH)
   c) Service Director Custodial Mental Health (SDCMH)
   d) CDFH
   e) Co-Director Forensic Mental Health (Clinical) (Co-DFMH(Clinical))
   f) MSFS
6. CSNSW/YJNSW is responsible for transporting the Forensic Patient to the FH.

Correctional/Youth Justice NSW Patients

1. Before an admission date can be decided upon, the referring psychiatrist and admitting psychiatrist must ensure that the following are completed under section 86 of the *MHCIFP Act*:
   a) Two JUS025.135 *Schedule 2 - Medical Certificate as to Examination of Inmate* forms, at least one being completed by a psychiatrist
   b) A *Consent to Treatment – MHCIFP Act* form (JUS025.137) if the person consents to the transfer to a mental health facility for care and treatment pursuant to section 86(5) of the *MHCIFP Act*.
   c) *Profile Form Mental Health and Cognitive Impairment Act* (JUS025.136)
   d) A typed report from a medical practitioner outlining how the patient meets the criteria for admission to a mental health facility.

   The above documents must be emailed to the FMHLO at [redacted] to arrange an order for transfer under section 86 of the *MHCIFP Act.*
2. The referring correctional centre/YJC is responsible for transporting the person to the FH in line with CSNSW and YJNSW transporting policies.
3. Once the person has been admitted to the FH, the patient's mental health status will be assessed. Section 86 (2) of the *MHCIFP Act* states that "the person must be transferred back to the correctional/detention centre within 7 days of admission unless the Secretary of NSW Health (or Delegate) is of the opinion that:
   a) the person is a mentally ill person or has a mental health impairment or other condition for which treatment is available in a mental health facility, and
   b) other care of an appropriate kind would not be reasonably available to the person in a correctional or detention centre."
4. This requires the examining authorised medical officer to complete a *Section 87(2) Notification* form (JUS025.130) and a typed medical report outlining how the person satisfies criteria for admission to a mental health facility (including the FH).
5. The completed *Section 86 (2) Notification* form and the typed medical report must be

emailed to the FMHLO at [redacted] immediately to arrange for the Delegate of the Secretary of NSW Health to authorise approval.

6. In effect, once a *Section 87(2) Notification* has been issued, the person remains in the mental health facility (including the FH) until such a time that they are no longer mentally ill or their condition is able to be managed in a correctional or detention centre.

Note: failure to comply with this procedure will result in illegal detention and treatment of the patient.

3.6 Communication of Confirmed Admission

1. The NUM of the admitting unit must advise admission details including the patient's name, legal status, date of birth, date and time of expected admission and transport arrangements in an email to [redacted] This has the following recipients:
   - FH After Hours Nurse Manager (AHNM)
   - FH Manager Security and Fire Safety (MSFS)
   - G4S Security Services Operations Manager (SSOM)
   - Clinical Director Forensic Hospital (CDFH)
   - FH Director of Nursing and Services (DNS)
   - FH Deputy Director of Nursing (DDoN)
   - Manager of Allied Health (MAH)
   - Forensic Hospital Patient Information Reporting Centre (FHPIRC)
   - FH PAS Inpatient Clerk: creates MRN, appointments are transferred over
   - FH Patient accounts
   - FH MHRT Coordinator
   - FMHLO at JHFMHN-MHOrders
   - FH Aboriginal Clinical Lead or equivalent if the patient identifies as Aboriginal or Torres Strait Islander

2. The NUM of the admitting unit must e-mail the full MDT to provide an overview of the assessment and notify the team of the admission.

3. The NUM (or delegate) must:
   - inform G4S security regarding the pending admission by completing the *Forensic Hospital Patient Admission, Discharge, Escort and Transfer Notification eForm*.
   - An updated meal request will be sent to Medirest to advise the admission date and time.
   - Review if increased resources are required and if they are, escalate this to the DDoN.

3.7 Prior to day of admission

1. A time of arrival must be agreed in advance, written in the unit diary and conveyed to G4S via telephone.

2. The NUM of the admitting unit must:
   - ensure that a CC is allocated to each patient prior to admission; this should ideally be the nurse who assessed the patient. In exceptional circumstances, for example, where the needs of the patient are complex, the NUM may choose to delay the allocation of the CC until the first clinical review meeting of the patient;
   - delegate a nurse who will be on duty on the day of admission to receive the new patient and make all practical arrangements for the patient's admission. The delegated nurse will preferably be the patient's CC or allocated nurse;
   - ensure is appropriate that a peer worker is available to provide additional support to the new patient;
   - ensure that supplied information from the referring team such as the *Historical, Clinical and Risk Management - 20* (HCR-20) is added to the patient's health record; and
   - allocate a bedroom to the patient.
3. Using information supplied by the referring team, the MDT must develop a pre-admission provisional TPRIM in accord with the CRAM framework, which includes as a minimum the following information:
   - potential risks including type of aggression, diversion, any known associations
   - SCALE
   - placement in unit (room number)
   - any specific risk management needs
   - level of observation
4. The identified CC (or delegate) must commence an anamnestic assessment in accord with the CRAM framework, with the most recent episode of aggression identified, in order to inform the interim risk management plan.
5. The ward clerk must commence a health record for the patient, ensuring all information provided by the referring team is placed within the record.
6. Where possible a psychology handover should take place between the referring team psychologist and admitting team psychologist with relevant documentation provided to the admitting team psychologist.
7. The need for an interpreter will be identified through the referral process and, where required, an interpreter must be arranged to interpret for the assessment and orientation to the unit. If an interpreter is required, the assessment and orientation process cannot commence without an interpreter being present. A phone interpreter can also be provided. Staff must follow policy 1.230 *Health Care Interpreter Services – Culturally and Linguistically Diverse Patients.*
8. Where a patient is admitted from a correctional centre/YJC, a Urine Drug Screen (UDS) and patient search should be completed by the Network staff, with the results being available on JHeHS prior to transfer. Other screening may be requested by the FH as required (e.g. Covid screening), prior to transfer.

3.8 The Day of Admission

The NiC of the admitting unit is responsible for:

- informing the NUM and/or AHNM of expected time of admission prior to the patient arriving at the FH;
- coordinating the admission escort team which includes a minimum of 3 staff trained in Violence Prevention and Management (VPM) Team Restraint Techniques. If the patient identifies as Aboriginal or Torres Strait Islander the Aboriginal Mental Health Professional and or equivalent should form part of the Admission Escort team;
- confirming with the NUM that a CC and ACC have been identified and where possible are part of the admission escort team;
- informing Medirest of the pending admissions arrival via Helpdesk;
- ensuring that the seclusion area, assessment room and identified interview room are available, searched in line with FH Procedure Searches and prepared with all required equipment; and
- if required, ensuring that the arranged interpreter is present for the assessment and orientation process; and
- ensuring all known prescribed medications are available.

3.9 Arrival at the Forensic Hospital

[redacted]

[redacted]

3.10 Escorting the Patient to the Unit of Admission

1. The admission escort team must consider the planned path, route and destination prior to escorting the patient. A staff member must be available to open doors to ensure a clear pathway.

2. The admission escort team must escort the patient from the Sally Port to the admission unit's identified seclusion room in VPM holds, to facilitate the initial personal search/assessment.

3. If there is an increased escort risk, level 4 containment may be necessary for the duration of the escort to the unit.

4. In some circumstances it may be necessary for the patient to be driven to the admission unit, if arriving in an ambulance, a police escort or a CSNSW/YJNSW transport. The Security Control Room must be notified in advance. [redacted]

5. If YJNSW is providing the transport, then they may escort the patient to the seclusion room with the handcuffs remaining in situ. Upon arriving at the seclusion room, the handcuffs should be removed with the allocated FH staff taking over care and management of the

patient.

3.11 Patient Admission to the Unit – Initial Assessment

1. The Forensic Hospital works to embed trauma informed care in all aspects of care. The Admission process is no different. Staff must be cognisant of the possibility that the admission processes may be re-traumatising, and therefore all interactions must be done with the dignity of the patient in mind.
2. On arrival at the unit a personal search of the patient must be conducted in an identified seclusion room with the door open in accord with FH Procedure *Searches*. Personal searches of Adolescents must be approved as per FH Procedure Searches and in the presence of a medical officer. Following the search, the patient must provide a UDS sample; female patients should have a pregnancy test. Refer to the Network policy 1.430 *Management of Pregnant Women in Custody*. The patient is to remain in the seclusion area until the UDS/pregnancy test has been attended to.
3. If the patient displays imminent risk of harm to others during admission and requires seclusion, staff must refer to PD2020_004 *Seclusion and Restraint in Mental Health Facilities in NSW*.
4. Following search and UDS procedures, patients will be taken from the seclusion area to the unit assessment room (or other appropriate area) if it is safe to do so, to be assessed by medical and nursing staff prior to entering the communal areas.
5. Nursing staff should obtain baseline physical observations, ECG and metabolic monitoring from the patient prior to the psychiatry registrar conducting a full physical examination and interview.
6. The initial assessment of a patient must include assessments of:
   a) mental state, including suicidality and history of suicide attempts,
   b) risks to self or others,
   c) substance use, and
   d) physical health.
7. The assessment and care planning process should address a person's aspirations and strengths, as well as the persons mental health issues and identified risks.
8. Patients must be told that they may practice their religion and have access to representatives of their religion during their stay in the FH.
9. Clinical staff must assist patients to understand information relevant to them by providing both written documentation and verbal explanations.
10. Once assessed, the patient should have a full orientation to the unit as soon as possible.

3.12 Patient Admission to the Unit – Following Initial Assessment

1. Clinical staff must ensure all tasks are completed on Form FH001 Forensic Hospital Patient Admission Checklist.
2. The patient's designated carer/principal care provider must be notified of the admission, wherever possible, by the unit SW/CC or delegate.

3. The psychiatry registrar must complete initial medication charts and initiate a Medication Management Plan (MMP).
4. The treating consultant (or delegate) must be informed of the details of the initial registrar assessment and should interview the patient on the day of admission.
5. Following consultant interview, the pre-admission provisional TPRIM must be updated post-admission assessment. The TPRIM must identify the risk factors for self or others including sexual safety and risk of exploitation, and specify:
   a) the initial observation level of the patient,
   b) the group or individual activities on the unit and within the FH in which the patient is permitted to participate,
   c) the personal belongings to which the patient may have access, and
   d) the areas of the unit which the patient may access.

3.13 Comprehensive Multidisciplinary Assessment

1. The patient must have a MDT Clinical Review within one week of admission. The MDT must develop a comprehensive and individualised program of care for the patient, which will be represented in the TPRIM. The TPRIM should include recommendations for assessments by other disciplines which should be arranged by the CC or psychiatry registrar.
2. A patient care plan should be commenced by the MDT following admission. This should identify the targets and choice of interventions in collaboration with the patient.
3. The treating consultant is responsible for convening the clinical review meeting, and ensuring that each discipline contributes to the TPRIM. The treating consultant must also give consideration to inviting outside agencies to attend clinical review meetings, including the patient's family or designated carer/principal care provider. The patient will be encouraged, if appropriate, to actively participate in this process and contribute to the development of the TPRIM.
4. Once the patient is admitted to the hospital the Manager of Security and Fire Safety (MSFS) can request the NSWPF Full Profile Report and Criminal History / Bail Report from NSWPF. This may take up to a month. Once received the MSFS will provide these to the unit NUM.
5. A family welcome meeting should be organised by the social worker, ideally within four weeks of admission. The family welcome meeting allows for the patient's family or designated carer/principal care provider(s) to meet the entire MDT, learn about each role, explain their expectations for the admission and outline any concerns that they may have. This may be a face-to-face meeting or via AVL or phone.
6. The family and designated carer/principal care provider must be informed of any risks to them if visiting, wherever possible.

   The TPRIM forms the basis of care in the FH. It must be reviewed regularly at the clinical review meetings and in-depth case reviews in accord with policy 1.078. *Care Coordination, Risk Assessment, Management, Planning and Review - Forensic Hospital*. The TPRIM will be updated whenever there is a significant change in the patient's presentation, risk status or proposed management.

4. Definitions

In this policy the term Clinical Director means the Clinical Director, Forensic and Long Bay Hospitals. This policy presumes that the Clinical Director is also the Medical Superintendent of the FH. Any reference to the Clinical Director should be read, where applicable, as a reference to the Medical Superintendent. The terms 'forensic patient' and 'correctional patient' have the meanings given in the *MHCIFP Act.*

Must

Indicates a mandatory action or requirement.

Should

Indicates a recommended action that needs to be followed unless there are sound reasons for taking a different course of action.

Civil Patient

An involuntary detained patient of a declared mental health facility who is not also a forensic patient and is detained in accordance with the *MH Act*.

Correctional Patient

A person, other than a forensic patient, who has been transferred from a correctional centre to a mental health facility while serving a sentence of imprisonment, or while on remand, and who has not been classified by the Tribunal as an involuntary patient.

Forensic Patient

A person who:

1. has been found unfit to be tried for an offence and ordered to be detained in a mental health facility, correctional centre, detention centre or other place. A person is not a forensic patient if the person has been found unfit to be tried and has been released on bail.
2. is subject to a limiting term and ordered to be detained in a mental health facility, correctional centre, detention centre or other place.
3. Is subject to a special verdict of act proven but not criminally responsible and ordered to be detained in a mental health facility, correctional centre, detention centre or other place.
4. Is subject to an extension order or an interim extension order and is detained in a mental health facility, correctional centre, detention centre or other place. .
5. is a person who is a member of a class of persons prescribed by the regulations (currently includes a person found not guilty of an offence by reason of mental illness or mental impairment under the law of Norfolk Island, and who is transferred to and held in the custody of in NSW).

Designated Carers

(1) The designated carer of a person (the patient) for the purposes of the *MH Act* s71 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, a person nominated by the patient as a designated 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 individual 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.

relative of a patient who identifies as Aboriginal person or a Torres Strait Islander includes a person who is part of the extended family or kin of the patient according to the kinship system of the patient's culture.

Youth Justice Centre

is the widely accepted descriptor for facilities housing Youth inmates, and is interchangeable with 'Youth Detention Centre'.

Principal Care Providers

(1) The ***principle care provider*** of a person for the purposes of this Act is the individual who is primarily responsible for providing support or care to the person (other than wholly or substantially on a commercial basis).

(2) An authorised medical officer at a mental health facility or a director of community treatment may, for the purposes of complying with a provision of this Act or the regulations, determine who is the principal care provider of a person.

(3) The authorised medical officer or the director of community treatment must not determine that a person is the principal care provider of another person if the person is excluded from being given notice or information about the other person under this Act.

(4) An authorised medical officer or a director of community treatment is not required to give effect to a requirement relating to a principal care provider of a person under this Act or the regulations if the officer or director reasonably believes that to do so may put the person or the principal care provider at risk of serious harm.

(5) A principal care provider of a person may also be a designated carer of the person.

Serious harm

is not defined in the *MH Act*. However, it is intended to be a broad concept that may include:

- physical harm
- emotional/psychological harm
- financial harm
- self-harm and suicide
- violence and aggression including sexual assault or abuse
- stalking and predatory intent
- harm to reputation or relationships
- neglect of self
- neglect of others (including children)

5. Legislation and Related Documents

Legislations	*Children and Young Persons (Care and Protection) Act 1998* *Children (Detention Centres) Act 1987* *Crimes (Administration of Sentences) Act 1999* *Criminal Appeal Act 1912* *Crimes (High Risk Offenders) Act 2006* *Health Administration Act 1982* *Mental Health Act 2007* *Mental Health Regulation 2013* *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* *Terrorism (High risk Offenders) Act 2017*
The Network Policies and Procedures	1.078 *Care Coordination, Risk Assessment, Management, Planning and Review – Forensic Hospital* 1.230 *Health Care Interpreter Services – Culturally and Linguistically Diverse Patients* 1.395 *Transfer and Transport of Patients* 1.407 *Transport of Forensic Patients from the Metropolitan Remand and Reception Centre and the Silverwater Women's Correctional Centre* 1.434 *Working With Families and Carers – Forensic Hospital* 1.336 *Referral (Adults and Adolescents) Forensic Hospital* 1.338 *Transfer of Care (Adults and Adolescents) Forensic Hospital* *JHFMHN Medication Guidelines 2021* *The Forensic Hospital Patient Information Booklet*

	FH Procedure Clinical Risk Assessment and Management (CRAM) *FH Procedure Property and Valuables* *FH Procedure Photography, Videography and Camera Use* *FH Procedure Searches*
The Network Forms	FMR025.010 *The Mental Health Assessment Form* FH9R *Patient Movement Register* *Patient Admission, Discharge, Escort and Transfer Notification* JUS020.105 *Application for Ground Access* JUS020.110 *Application for Outside Leave* JUS005.001 *Health Problem Notification Form* JUS010.000 *Nursing Checklist – Transfer out of Centre* JUS020.100 *Consent for Photography* JUS025.136 *Profile Form – Mental Health Act* JUS025.137 *Consent to Treatment – Mental Health Act* JUS200.035 *Medical Certificate Consideration for Special Transport* JUS200.110 *Schedule 2 - Medical Certificate as to Examination of Inmate* SMR025.170 *Nomination of Designated Carer* SMR025.215 *Transfer of Involuntary Patient Between Declared Mental Health Facilities*
NSW Health Policy Directives, and Guidelines	PD2021_039 *Mental Health Clinical Documentation* PD2022_012 *Admission to Discharge Care Coordination* *PD2012_050 Forensic Mental Health Services* *PD2016_007 Clinical Care of People Who May Be Suicidal* *PD2019_045 Discharge Planning and Transfer of Care for Consumers of NSW Health Mental Health Services*
Other	*State Records Authority of New South Wales, (2004) General Retention and Disposal Authority Public Health Services: Patient/Client Records (GDA 17)* *Rampton Hospital Admissions Guidelines, East of England Specialised* *Commissioning Group, NHS, UK*

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Transfer of Care (Adults and Adolescents) Forensic Hospital

Policy Number 1.338

Policy Function Continuum of Care

Issue Date 22 March 2022

Summary Transfer of care is a structured, standardised process for ensuring the safe, efficient, and effective transition of patients with a mental illness between inpatient, community or custodial settings. This policy sets out the principles and requirements for the safe transfer of care of forensic, correctional, and civil patients across a number of treatment settings.

Responsible Officer Executive Director Clinical Operations

Applicable Sites

- ☐ Administration Centres
- ☐ Community Sites (e.g. Court Liaison Service, Community Integration Team, etc.)
- ☐ Health Centres (Adult Correctional Centres or Police Cells)
- ☐ Health Centres (Youth Justice NSW)
- ☐ Long Bay Hospital
- ☒ Forensic Hospital

Previous Issue(s) Policy 1.338 (Nov 2018); Policy 1.325 (May 2015); Policy 1.327 (Dec 2015)

Manual 1.325M (Sep 2017); Manual 1.327M (Sep 2017)

Change Summary

- Updating of position titles
- Update Juvenile Justice to Youth Justice
- Updating of references and related documents
- Updating MHFP Act to MHCIFP Act

HPRM Reference POLJH/1338

Authorised by Chief Executive, Justice Health and Forensic Mental Health Network

1. Preface

Transfer of care is a structured, standardised process for ensuring the safe, efficient and effective transition of patients with a mental illness between inpatient, community or custodial settings. Transfer of care is part of the continuum of care that starts with the patient's admission to hospital. Effective transfer of care planning is delivered by mental health services that are responsive to patient needs and inter-linked with other agencies, service providers, carers and the patient, using a collaborative approach.

Patients admitted to the Forensic Hospital (FH) have a wide range of complex health issues; the aim of this policy is to ensure a coordinated approach to transfer of care for FH patients. It also provides directions to FH staff on the processes required when transferring patients' care to:

- a Local Health District (LHD) inpatient mental health facility, or
- a LHD Community Mental Health Service, or
- a correctional or youth justice centre.

2. Policy Content

2.1. Mandatory Requirements

2.1.1 Transfer of Care

The FH secure physical environment and clinical context must be taken into consideration when planning, assessing and reviewing care provision. The Justice Health and Forensic Mental Health Network (the Network) has a duty to ensure the safety of the patients, FH staff, visitors and the community of which the FH is part. When considering transfer of care for a FH patient, clinical review processes outlined in the Network policy 1.078 *Care Coordination, Risk Assessment, Planning and Review – Forensic Hospital* must be followed.

Due to the complexity of the patients within the FH, it is essential that there is a Multidisciplinary Team (MDT) approach to transfer of care processes. This document sets out the responsibilities in relation to referral, internal and external collaboration, information sharing, planning, legislative requirements and documentation to ensure continuity of care and safety throughout the transfer of care process.

Transfer of care from the FH occurs in conjunction with, and, in most cases, is dependent on, the process of review conducted by the Mental Health Review Tribunal (MHRT).

Mental health legislation requires that a patient be treated in the least restrictive environment possible. Once the MDT determines that a patient no longer requires care in a secure setting, the team must take the steps detailed in this policy to arrange for the transfer of the patient to a care setting that is appropriate and reasonably available.

NSW Ministry of Health (the Ministry) PD2019_045 *Discharge Planning and Transfer of Care for Consumers of NSW Health Mental Health Services* and PD2012_50 *Forensic Mental Health Services* requires that each patient has a Transfer of Care Plan. The Transfer of Care Plan is a package of documents that together provide comprehensive information for the patient, designated carer/principal care provider, receiving service, MHRT and relevant health care professionals.

The Ministry PD2019_045 *Discharge Planning and Transfer of Care for Consumers of NSW Health Mental Health Services* requires a care coordinator (CC) to be nominated for each patient. For the

purposes of this policy, a patient's CC as defined in the Network policy 1.078 *Care Coordination, Risk Assessment, Planning and Review – Forensic Hospital* is deemed to be the patient's Transfer of Care Planning Coordinator.

The legal framework for this policy is determined by the *Mental Health Act 2007* (hereafter, the *MH Act*), the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* (hereafter, the *MHCIFP Act*), the *Health Administration Act 1982* and the *Health Records and Information Privacy Act, 2002*. The transfer of a forensic patient from the FH to an LHD mental health facility or community service requires an order permitting the transfer by the MHRT.

The decision to apply to the MHRT for the transfer of a forensic patient will be made at a Clinical Review Meeting when the MDT is present. In the alternative the Secretary of the Ministry of Health (or Delegate) can issue an order for transfer pursuant to section 115 of the *MHCIFP Act* The CC (or delegated representative), must ensure that the designated carer/principal care provider is aware of the meeting and if possible arrange their attendance. Assistance with travelling must be offered, if required. The MDT must consider the type of facility to which the patient could be transferred and the level of security that would be appropriate to manage the patient's level of risk. Where the patient identifies as Aboriginal or Torres Strait Islander the Aboriginal Mental Health Professional or equivalent must attend these meetings.

Civil patients may be transferred from the FH to another declared mental health facility under the provisions of sections 80 and 81 of the *MH Act* by arrangement with the authorised medical officer of the receiving unit. A *Transfer of Involuntary Patient Between Declared Mental Health Facilities* form (SMR025.215) must be completed by an authorised medical officer of the FH with a copy sent to the receiving unit with the person. The person must not be transferred from the FH without this form.

Correctional patients in the FH under section 86 of the *MHCIFP Act,* may at any time be transferred back to a correctional centre or youth justice centre pursuant to section 87(3) by the Secretary of the Ministry of Health (or Delegate) if they are of the opinion that:

- the person has ceased to be a mentally ill person or to have a mental health impairment or other condition for which treatment is available in a mental health facility, or
- other care of an appropriate kind would be reasonably available to the person in a correctional/youth justice centre

2.2. Implementation - Roles & Responsibilities

Executive Director Clinical Operations (EDCO) has overarching responsibility for the development, review and implementation of this policy and performance management of the transfer of care process.

Clinical Director Forensic Hospital (CDFH) is currently the 'medical superintendent' of the hospital for the purposes of the *MH Act* and the *MHCIFP Act* and is responsible for ensuring that all medical staff comply with this policy.

Director of Nursing and Services FH (DNS) is responsible for coordinating the development, review and implementation of all policies in the FH.

Deputy Director of Nursing FH (DDoN) and Nursing Unit Managers (NUM) are responsible for ensuring that this policy is implemented in all units in the FH and all patients are allocated a CC within the specified time.

Care Coordinator (CC) is responsible for initiating and coordinating the transfer of care planning process, and implementing, coordinating and monitoring the patient's transfer of care plan.

Authorised Medical Officer (MO) is the medical superintendent of the FH or MO nominated by the medical superintendent and is responsible for ensuring that:

- the patient and the patient's designated carer/principal care provider are consulted in relation to planning the transfer and follow-up care;
- consultation occurs with relevant agencies, the patient's designated carer/principal care provider and any dependents; and
- the patient and designated carer/principal care provider are provided with follow-up care information.

The Forensic Hospital Admissions Committee (FHAC) functions to:

- oversee all patient flow into, within and out of the FH; and
- assess and approve all admissions to the FH.

NSW Forensic Patient Flow Committee functions are to:

- have oversight of the admission, transfer and discharge of all adult and adolescent forensic patients across correctional centres, the FH, Bunya Unit, Cumberland Hospital; Kestrel Unit, Morisset Hospital and Macquarie Unit, Bloomfield Hospital;
- review the case of each forensic patient, potential correctional patient and civil patient referred for admission to the FH;
- determine a clinical priority for admission for each patient reviewed;
- review the priority for admission of all patients on the inpatient waiting lists;
- manage the FH inpatient waiting lists;
- review the case of each forensic patient deemed suitable by the FH for lower secure care;

determine the most appropriate unit to which each patient so reviewed should be transferred; and notify the treating team of patients reviewed of the Committee determination.

The Forensic Mental Health Liaison Officer (FMHLO) functions are to**:**

- Manage the MSU, LSU and FH waitlists
- Manage mental health orders
- Liaise with referring agencies and the FH

3. Procedure Content

3.1. Transfer of Care – Referral

3.1.1 Requirements for all patients

The processes outlined in this section must be followed for all patients. For specific patients there may be additional requirements to be completed, these requirements are outlined in section 3.1.2 to 3.1.4.

1. A MDT Meeting and In-Depth Case Review as outlined in the Network policy 1.078 *Care Coordination, Risk Assessment, Planning and Review – Forensic Hospital* must occur on a regular basis to review and plan a patient's care and treatment, which includes transfer of care planning.
2. At the appropriate stage during the patient's admission the MDT will identify and commence

referral processes to LHD Inpatient Mental Health Facilities, the Community Mental Health Services or Correctional/Youth Justice Centres.

3. The patient should be actively engaged in all aspects of their care and empowered to make their own decisions where possible.
4. The peer worker should engage the patient in recovery planning and goal setting and provide support and assistance where required.
5. Where the patient identifies as Aboriginal or Torres Strait Islander, the Aboriginal Mental Health Professional or equivalent should attend MDT meetings to assist staff in ensuring a safe, culturally appropriate transfer of care plan, e.g. engage with designated carer/principal care provider and or nominated Aboriginal Medical Service.
6. The Victims Services, Department of Justice must be contacted concerning registered victims and consideration given to any ongoing risks to the registered victims if the patient is transferred to a less secure environment.
7. Prior to a referral being made the consultant psychiatrist must ensure that a structured risk assessment is completed in accordance with policy 1.078 *Care Coordination, Risk Assessment, Planning and Review – Forensic Hospital* and FH Procedure *Clinical Risk Assessment & Management (CRAM).* Risk of harm to self must be assessed in accordance with PD2016_007 *Clinical Care of People Who May Be Suicidal*.
8. The MDT must contact the relevant LHD, correctional/youth justice centre or community support providers, who may be a consultant psychiatrist, community care coordinator or case manager, psychologist, private psychiatrist, and/or HASI provider to discuss the referral.
9. The MDT aims to provide the receiving service with comprehensive clinical documentation. The following information, at a minimum must be provided on referral:
    - Referral letter
    - Recent MHRT report
    - Current Clinical Risk Assessment & Management (CRAM) Report
    - Current Treatment & Management Plan (TPRIM)
    - Current Historical Clinical Risk Management-20 Version 3 (HCR-20) or Structured Assessment of Violence Risk in Youth (SAVRY) risk assessment
    - Current Dangerousness, Understanding, Recovery and Urgency Manual (DUNDRUM) Quartet
    - Psychopathy Checklist List (if available)
    - Other structured risk assessments (if clinically warranted)
    - Anamnestic assessment
    - OAT program considerations as per the Network Drug & Alcohol procedures (if clinically warranted)
    - Neuropsychological assessment (if clinically warranted)
    - Occupational Therapy Functional Assessment (if clinically warranted)
    - Social Work report (if clinically warranted)
    - Aboriginal Mental Health Professional or equivalent report (if clinically warranted)
    - Police documentation (if available: record of interview at time of arrest, police fact sheets, criminal record history (adult and youth)

- Court documentation (if available: court reports, crown case summary, judgements, psychiatrist reports, pre-sentence reports, judges' comments, victims' statements)

3.1.2 Additional Requirements for Referral to Medium Secure Units (MSU) and Low Secure Units (LSU)

1. When a MDT decides to refer a patient to a MSU or LSU the Transfer of Care Plan documents outlined in section 3.1.1.7 must be forwarded to the Forensic Mental Health Liaison Officer (FMHLO) via email [redacted]. This email should stipulate which MSU(s) or LSU(s) the patient is being referred to.
2. The FMHLO must forward the Transfer of Care Plan documents to the relevant MSU(s) or LSU(s) and activate the referral by adding the patient to the *MSU & LSU Referral Waitlist*.
3. The *MSU & LSU Referral Waitlist* must be tabled and discussed monthly at the NSW Forensic Patient Flow Committee meeting and weekly at the Forensic Hospital Admissions Committee (FHAC).
4. The relevant MSU(s) or LSU(s) should contact the MDT to inform them of a planned patient assessment date, the NUM must ensure access for the MSU or LSU team is organised in accord with policy 5.002 *Access to the Forensic Hospital*.
5. Post assessment, the MSU or LSU should forward their assessment report outlining the outcome of the assessment to the FMHLO.
6. The FMHLO must forward the assessment report to the relevant members of the MDT, MHRT and Mental Health Advocacy Service (MHAS).
7. Where the patient is found to be suitable for admission to a MSU or LSU, the FMHLO will add the patient to the *MSU & LSU Admission Waitlist*(s).
8. If a patient has been assessed and found to be suitable for admission to a number or all MSU(s) and LSU(s), the patient will await transfer to each unit, with transfer being to the unit with the first available bed.

3.1.3 Additional Requirements for Referral to Community Mental Health Services – Forensic Patients

1. Where the MDT considers that it would be appropriate for a forensic patient to be conditionally released, a referral to the LHD must be made with documentation supporting the patient's placement in the proposed setting.
2. Once the patient's referral has been accepted by the LHD, the MDT must then complete a referral to the Network's Community Forensic Mental Health Service (CFMHS) seeking an independent assessment. This is a requirement under section 84 of the MHCIFP Act prior to the MHRT granting conditional release. This referral to the CFMHS should be made in line with policy 1.439 *Community Forensic Mental Health Service Remit of Services*, and allow for a minimum of ten weeks prior to the proposed MHRT hearing date. The referral should be accompanied by the transfer of care documentation, including the plan to discharge the patient to an inpatient or community mental health service.
3. Following the assessment, the CFMHS must consult the treating team regarding the assessment findings and proposed recommendations. The report is to then be finalised and forwarded to the MDT.
4. A Ministerial Brief for the NSW Minister for Mental Health must be completed by the CDFH and forwarded to the Co-Director Forensic Mental Health (Clinical) at least three weeks prior to the

proposed MHRT hearing date.

3.1.4 Additional Requirements for Referral to Mental Health Inpatient Facility or Community – Civil Patients

1. In the case of a civil patient, the LHD which referred the patient to the FH will have already agreed to receive the patient back upon completion of treatment. The decision to transfer a civil patient back to a LHD mental health facility or community placement will be made by the MDT in consultation with the Clinical Director for that service.
2. Post assessment, the LHD should forward their assessment report outlining the outcome of the assessment to the MDT.

3.2. Transfer from the Forensic Hospital Back to a Correctional or Youth Justice Centre

Transfer to a Correctional/Youth Justice Centre

1. Where a treating team have formed the opinion that a person transferred from a correctional centre or youth detention centre into the FH under section 86 of the *MHCIFP Act* has ceased to be a mentally ill person or to have a mental health impairment other condition and care of an appropriate kind would be reasonably available in a correctional or youth justice centre, the team must seek the approval of the Delegate of the Secretary of the Ministry of Health to discharge the person.
2. An order pursuant to section 87(3) of the *MHCIFP Act* using the *Section 87 Notification* form (JUS025.130) must be completed by an authorised medical officer.
3. The authorised medical officer must complete a typed medical report outlining that care of an appropriate kind would be reasonably available to the person in a correctional centre or youth justice centre.
4. The authorised medical officer must ensure that the *Section 87 Notification* form (JUS025.130) together with the typed medical report is sent to the FMHLO via email [redacted] to arrange for approval.
5. For cases where the Delegate is of the opinion that the *Section 87 Notification* does not adequately satisfy criteria and declines to approve the order, the FMHLO must ensure that the appropriate authorised medical officer is informed.
6. For cases where the Delegate approves the *Section 87 Notification*, the FMHLO must ensure the following are informed:
   a) the authorised medical officer, NUM, and NiC of the unit where the person is detained
   b) the Clinical Director Custodial Mental Health
   c) the Nurse Manager Custodial Mental Health (with a copy sent to the [redacted] address)
   d) the relevant NUM and NiC of the correctional/youth justice centre to where the person is returning
   e) Senior Project Officer (Forensic Liaison), CSNSW (SPOFL)
   f) Mental Health Review Tribunal
   g) Mental Health Advocacy Service

Note: once the Section 87 (3) Notification has been approved and circulated, the person must be discharged from the hospital

7. The person's case should be tabled and discussed monthly at the monthly NSW Forensic Patient Flow Committee meeting and weekly at the FHAC meeting.

3.3. Transfer of Care – Planning

3.3.1 Requirements for all Patients

The processes outlined in this section must be followed for all patients. For specific patient types there may be additional requirements to be completed, these requirements are outlined in section 3.3.2 to 3.3.5.

1. A Transfer of Care Plan (a package of documents that together provide comprehensive information) must be commenced on acceptance of the receiving service approving the transfer.
2. The Transfer of Care Plan provides comprehensive information for the patient, designated carer/principal care provider, receiving service, MHRT and relevant health care professionals. It is important to note, that the components of the Transfer of Care Plan must be tailored to the recipient's needs. The MDT must ensure clinical and security information shared with the recipients does not breach the patient's confidentiality or the FH security procedures.
3. The Network Transfer of Care Plan, at a minimum, must comprise:
    - Written confirmation from the receiving service that the patient has been accepted and that they agree to provide them with the level of care outlined by the Network.
    - Transfer Summary clinical module prepared in accordance with the Service Level Agreement regarding the provision of mental health services to forensic patients under the care of general mental health services and high risk civil patients.
    - Recent MHRT report
    - Legal orders, such as a Forensic Community Treatment Order (FCTO), Community Treatment Order (CTO), Financial Management Order or Guardianship order (including length and expiry dates).
    - If a view is formed that a patient with a Protected Estate order no longer requires management of their affairs, then the consultant psychiatrist must advise the Office of the Protective Commission.
    - Current Clinical Risk Assessment & Management (CRAM) Report
    - Current Treatment & Management Plan (TPRIM) (including protective factors),
    - Current Patient Care Plan
    - Patient Safety Plan
    - Current Historical Clinical Risk Management-20 Version 3 (HCR-20) or Structured Assessment of Violence Risk in Youth (SAVRY) risk assessment
    - Current Dangerousness, Understanding, Recovery and Urgency Manual (DUNDRUM) Quartet
    - Psychopathy Checklist List (if clinically warranted)
    - Other structured risk assessments (if clinically warranted)Anamnestic Assessment
    - OST program considerations as per the Network Drug & Alcohol procedures (if clinically

warranted)

- Medical and community support follow-up arrangements
- Neuropsychological assessment (if clinically warranted)
- Occupational Therapy Functional Assessment (if clinically warranted)
- Social Work report (if clinically warranted)
- Aboriginal Mental Health Professional or equivalent report (if clinically warranted)
- Police documentation (if available: record of interview at time of arrest, police fact sheets, criminal record history (adult and youth)
- Court documentation (if available: court reports, crown case summary, judgements, psychiatrist reports, pre-sentence reports, judge's comments, victims' statements)

4. The MDT must ensure that the patient and the patient's designated carer/principal care provider are involved in transfer planning and are kept informed of the patient's expected transfer of care dates and times, if appropriate and subject to security considerations.
5. At an appropriate stage during the planning of the patient's transfer of care, the MDT should invite representatives from the receiving LHD and other anticipated care providers including the patient's designated carer/principal care provider to attend a MDT Meeting or In-depth Case Review.
6. The consultant psychiatrist or delegate must ensure that a 'Notice of Intent' is submitted to the MHRT at least four weeks in advance of a required hearing date indicating the patient's readiness for transfer and that arrangements for follow-up have been established and agreed.
7. The relevant members of the MDT must prepare reports for the MHRT.
8. On confirmation from the receiving service of the patient's transfer date, a member of the MDT must contact the FMHLO at [redacted] to ensure that transfer documents meet the requirements in accord with the *MH Act* or *MHCIFP Act.*
9. The FMHLO must then forward the appropriate paperwork to the relevant members of the MDT upon completion.
10. On confirmation from the receiving service of the patient's transfer date, the MDT must ensure the processes outlined in form FH002 *Forensic Hospital Patient Transfer of Care Checklist* are completed.

3.3.2 Additional Requirements for Transfers to the Community – Forensic Patients

1. The MDT must ensure prior to transfer that the patient has an appointment with a named LHD clinician and that the first follow-up appointment has been set for within 1 week of the transfer. The MDT must also confirm and document the steps that the LHD community mental health service, GP or other health provider must take if the patient misses the appointment, which must include informing the CDFH or Co-Director Forensic Mental Health (Clinical). A member of the LHD community mental health service should also be invited to meet the patient prior to discharge either in person or virtually.
2. In addition to the Transfer of Care Plan documents outlined in section 3.3.1.7 the following information/documents must also be included:
   - Independent assessment by CFMH
   - Emergency contact numbers
   - Contingency and relapse response plans – this information should be incorporated into the

Patient Care Plan

3. The patient will only be transferred into the care of family and/or designated carer/principal care provider at a time when support services have been confirmed or the FH has arranged the necessary travel.

3.3.3 Additional Requirements for Transfers to a Mental Health Inpatient Facility or Community – Civil Patients

1. For civil patients, the LHD which referred the patient to the FH will have already agreed to receive the patient back upon completion of treatment. The decision to transfer a civil patient back to an LHD mental health facility will be made by the MDT in consultation with the Clinical Director for that mental health facility.
2. The MDT must ensure prior to transfer that the patient has an appointment with a named LHD clinician and that the first follow-up appointment has been set for within 1 week of the transfer. The MDT must also confirm and document the steps that the LHD community mental health service, GP or other health provider must take if the patient misses the appointment, which must include informing the CDFH or Co-Director Forensic Mental Health (Clinical).
3. In addition to the Transfer of Care Plan documents outlined in section 3.3.1.7 the following information/documents must also be included:
    - Emergency contact numbers
    - Relapse response plans – this information should be incorporated into the Patient Care Plan
4. When a civil patient is to be transferred to another inpatient mental health facility, the NUM will arrange a date for transfer with the appropriate officer of the LHD, for example the Bed Manager of the receiving facility.
5. The patient will only be transferred into the care of family and/or designated carer/principal care provider at a time when support services have been confirmed or the FH has arranged the necessary travel arrangements.

3.3.4 Additional Requirements for Transfer Back to a Correctional Centre / Youth Justice Centre

1. When an adult correctional patient is to be discharged from the FH, the NUM/NiC must contact the FMHLO. The FMHLO must consult with the Corrective Service NSW (CSNSW) Senior Project Officer (Forensic Liaison) (SPOFL) to determine placement and transport arrangements and finalise any paperwork required by CSNSW.
2. When a youth correctional patient is to be discharged, the NUM/NiC should consult with the Youth Justice NSW (YJNSW) Transport and Logistic Officer (TLO) to determine placement and transport arrangements and finalise any paperwork required by YJNSW.
3. For all correctional patients, transport arrangements must be made in accordance with the procedures associated with the administration of security conditions and information sharing protocols between CSNSW/YJNSW and the Network in relation to correctional patients.
4. The NUM/NiC and SPOFL or TLO will negotiate the transfer of care date and time, in order to ensure the completion of paperwork and compliance with Mental Health legislation.
5. Where the patient identifies as Aboriginal or Torres Strait Islander, the Aboriginal Mental Health Professional or equivalent will contact the Aboriginal Health Worker or equivalent at the receiving location to discuss the cultural needs of patient.

6. In addition to the Transfer of Care Plan documents outlined in section 3.3.1.7 the following information/documents must be included:
   - PAS Waitlist entries and medical alerts from PAS
   - JUS005.001 *Health Problem Notification Form* (HPNF).
   - If the patient requires special transport considerations, a JUS200.035 *Medical Certificate Consideration for Special Transport* form must be completed and sent to the EDCO for authorisation in accordance with the Network policy 1.395 *Transfer and Transport of Patients*. The CC must ensure that copies of these forms are given to CSNSW and the originals kept in the patient's health record.

Expiry of a Correctional Patient's Sentence or Release during an Admission

7. A correctional patient detained in the FH under section 86 and section87(2) of the *MHCIFP Act* may be released because:
   a) the person is transferred to a correctional centre, youth justice centre or other place (other than another mental health facility) from the mental health facility;
   b) the person's sentence of imprisonment expires;
   c) the person is ordered to be released on parole;
   d) the person is otherwise released on the order of a court;
   e) the relevant charges against the person are dismissed;
   f) the Director of Public Prosecutions notifies the court or the Tribunal that the person will not be further proceeded against in respect of the relevant charges.

   Transfer in the case of (a), (b) or (c) above will usually be able to be planned in accordance with FH procedures. Where release occurs as a result of (d), (e) and (f) and is earlier than anticipated, then every effort must be made to accelerate the processes for transfer while maintaining consistent standards of communication, consultation and documentation in relation to management, follow-up plans and risk assessments.
8. The consultant psychiatrist must inform the CDFH of the immediate release of the patient.
9. Prior to the expiry of a patient's sentence or the date of parole, the MDT must consider whether, following the expiry of the sentence, the patient is likely to continue to require treatment as an inpatient either voluntarily or involuntarily. The authorised medical officer should communicate with the patient's legal representative regarding issues which may arise with expedient release and recommendations to avoid these difficulties.
10. If the patient is likely to require treatment as an inpatient:
    a) the authorised medical officer must inform the CDFH;
    b) the authorised medical officer must identify and contact the appropriate mental health facility of the LHD for the patient's expected place of residence and advise the appropriate officer of the facility of the expected date of transfer of the patient;
    c) the authorised medical officer for the patient must complete a Schedule 1 under the *MH Act* prior to the patient's transfer.
11. If it is known that the patient has a court appearance and:
    a) there is a possibility they may be discharged by the court, and
    b) the patient requires continued admission,

    then consideration should be given to completing a Schedule 1 under Section 19 of the *MH Act*

so that if the court releases the patient they can be transported by police to a declared mental health facility.

12. If the patient was homeless prior to their incarceration or the patient would otherwise be homeless on discharge from the FH, then the CC must consult with the MDT social worker. A patient who has been detained involuntarily in the FH must have, wherever possible, appropriate and stable accommodation arranged prior to discharge to the community.

3.3.5 'Unexpected' Transfer of Care Directly to the Community from the Forensic Hospital

1. The nature of the population in a secure hospital is such that transfers will be carefully planned and in accordance with the guidelines already set out in these procedures. However, within forensic mental health services, unusual situations can arise. Occasionally, patients may be transferred unexpectedly from the FH directly to the community. This may occur as a result of:
    - the release of a person on bail, or
    - an appeal to the MHRT or Court and the order being discharged.
2. Contingency plans must be made to cover such 'unexpected' events. For example, prior to a MHRT hearing, the Clinical Review Meeting must have in place contingency plans in response to a MHRT or court decision not to continue detention.
3. When any of these events occur it is essential that the receiving LHD mental health service, relevant carers and the Department of Communities and Justice (DCJ) are fully aware and able to offer appropriate and intensive support within the community.
4. Where possible, a MDT Meeting (pre-transfer meeting) must occur, involving as many of the MDT as practicable. Whenever possible, a representative from the receiving LHD mental health service should also be present. When this is not possible, a telephone clinical review between the patient's consultant psychiatrist at the FH and the consultant psychiatrist from the LHD must occur.
5. The MDT must ensure that the designated carer/principal care provider is invited to the meeting and where appropriate, family and/or other carers.
6. The Transfer of Care Plan must identify services that are available in the community.
7. If the patient's transfer of care occurs without the benefit of a MDT Meeting, the MDT should ensure that an early date for review is set with the community mental health service. This will be included in the Transfer of Care Plan.
8. If possible, an out-patient appointment with the appropriate LHD consultant psychiatrist should be made for immediately following release.
9. The MDT must collaborate and negotiate with the receiving service to alert and activate all required community services.
10. A Clinical Review Meeting determining the resources and expertise required to successfully support the patient in their own LHD/community will be held between the FH and the LHD mental health service in the area where the patient previously resided, or is expected to reside, as soon as practicable.
11. The relevant Transfer of Care Plan documents must be provided as soon as possible to the local LHD mental health service.
12. In the case of a forensic patient being transferred unexpectedly, CFMH must be informed as soon as practical.
13. The patient's transfer, wherever possible, should be on a normal working day and within normal

working hours.

14. 'Unplanned' patient transfers/discharge from the FH are, by their very nature, unusual. Consideration should be given to holding a critical incident review of the process.
15. In the case of transferred civil patients who return to the FH within 12 months, an intensive review will be undertaken with the LHD and if possible the Ministry, with an emphasis on determining the resources and expertise required to successfully support the patient in their own LHD/community at the next attempt.

3.4 Transfer of Care – Day of the Transfer

3.4.1 Requirements for all patients

1. The allocated nurse and available members of the MDT must complete an assessment of the patient's mental state immediately prior to transfer, including risk of harm to self and others. This assessment must be documented in the patient's health record.
2. The decision to transfer may be deferred if the patient presents with active risks at that time (except in the case of mandatory transfer i.e. where the person's sentence has expired).
3. The patient must be provided with the relevant components of the Transfer of Care Plan.
4. The allocated nurse or authorised medical officer must provide a verbal hand-over to the receiving service in accord with FH Procedure *Clinical Handover*.
5. The final Transfer of Care Plan must be scanned and sent by email to the receiving service. Where FH staff are escorting the patient to an inpatient facility, the escorting team must provide the receiving clinician with a hard copy of the Transfer of Care Plan.
6. If the patient identifies as Aboriginal or Torres Strait Islander the Aboriginal Mental Health Professional or equivalent wherever possible should be a part of escort team.
7. The MDT must ensure the processes outlined in form FH002 *Forensic Hospital Patient Discharge Checklist* are completed on the day of transfer.

3.5 Transfer of Care – Internal to the Forensic Hospital

1. A MDT Meeting and In-Depth Case Review as outlined in the Network policy 1.078 *Care Coordination, Risk Assessment, Planning and Review – Forensic Hospital* must occur on a regular basis to review and plan a patient's care and treatment, which includes transfer of care planning.
2. At the appropriate stage during a male patient's admission, the MDT will identify and commence referral processes to a less acute unit within the FH.
3. The members of the MDT must complete the relevant sections of the *Forensic Hospital Intra-Hospital Referral* Form located on JHeHS.
4. Once all sections of the *Forensic Hospital Intra-Hospital Referral* Form have been completed, the current NUM must email and advise the Referred NUM that there is a Referral form awaiting assessment.
5. The Current NUM must add the patient name to the *Intra-hospital Referral Waitlist.*
6. The Referred NUM should add the patient referral for discussion at the unit Business Meeting.
7. The Current NUM should email the Referred NUM with the outcome of the referral discussion; the admitting unit MDT may request to complete an assessment of the patient or request additional information.

8. Where the patient is accepted to the admitting unit, the referring unit NUM must add the patient to the
Intra-hospital Transfer Waitlist.
9. The *Intra-hospital Referral Waitlist* and *Intra-hospital Transfer Waitlist* should be tabled and discussed weekly at the FHAC meeting.

4. Definitions

In this policy the term Clinical Director means the Clinical Director, Forensic Hospital. This policy presumes that the Clinical Director is also the Medical Superintendent of the FH. Any reference to the Clinical Director should be read, where applicable, as a reference to the Medical Superintendent. The terms 'forensic patient' and 'correctional patient' have the meanings given in the MHCIFP Act.

1. Must

Indicates a mandatory action or requirement.

2. Should

Indicates a recommended action that needs to be followed unless there are sound reasons for taking a different course of action.

3. Civil Patient

An involuntary detained patient of a declared mental health facility who is not also a forensic patient and is detained in accordance with the *MH Act*.

4. Correctional Patient

A person, other than a forensic patient, who has been transferred from a correctional centre or youth justice centre to a mental health facility while serving a sentence of imprisonment, on remand or subject to a high risk offender detention order and who has not been classified by the MHRT as an involuntary patient.

5. Forensic Patient

A person who:

A. Has been found unfit to be tried for an offence and ordered to be detained in a mental health facility, correctional centre, youth justice centre or other place. A person is not a forensic patient if the person has been found unfit to be tried and has been released on bail.
B. Is subject to a limiting term and ordered to be detained in a mental health facility, correctional centre, youth justice centre or other place.
C. Is subject to a special verdict of act proven but not criminally responsible and ordered to be detained in a mental health facility, correctional centre, youth justice centre or other place.
D. Is a person who is a member of a class of persons prescribed by the regulations (currently includes a person found not guilty of an offence by reason of mental illness or mental impairment under the law of Norfolk Island, and who is transferred to and held in the custody of NSW) Clause 30 of the *Mental Health and Cognitive Impairment Forensic Provisions Regulation 2021*.

6. Designated Carers

1. The designated carer of a person (the patient) for the purposes of the *MH Act* s71 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, a person nominated by the patient as a designated 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 individual 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:

(a) ***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.

(b) ***relative*** of a patient who is an Aboriginal person or a Torres Strait Islander includes a person who is part of the extended family or kin of the patient according to the indigenous kinship system of the patient's culture.

Principal Care Providers

1. The ***principle care provider*** of a person for the purposes of the *MH Act* is the individual who is primarily responsible for providing support or care to the person (other than wholly or substantially on a commercial basis).
2. An authorised medical officer at a mental health facility or a director of community treatment may, for the purposes of complying with a provision of this Act or the regulations, determine who is the principal care provider of a person.
3. The authorised medical officer or the director of community treatment must not determine that a person is the principal care provider of another person if the person is excluded from being given notice or information about the other person under this Act.
4. An authorised medical officer or a director of community treatment is not required to give effect to a requirement relating to a principal care provider of a person under this Act or the regulations if the officer or director reasonably believes that to do so may put the person or the principal care provider at risk of serious harm.
5. A principal care provider of a person may also be a designated carer of the person.

5. Legislation and Related Documents

Legislations	*Crimes (High Risk Offenders) Act 2006* *Health Administration Act 1982* *Mental Health Act 2007* *Mental Health and Cognitive Impairment Forensic Provision Act 2020* *Mental Health Regulation 2019* *Mental Health and Cognitive Impairment Forensic Provisions Regulation 2021* *Terrorism (High Risk Offenders) Act 2017* *Crimes (Administration of Sentences) Act 1999*
The Network Policies and Procedures	1.037 *Long Bay Hospital Admission Policy (Referral, Admission and Assessment)* 1.075 *Clinical Handover* 1.078 *Care Coordination, Risk Assessment, Planning and Review Forensic Hospital* 1.230 *Health Care Interpreter Services – Culturally and Linguistically Diverse Patients and d/Deaf Patients* 1.395 *Transfer and Transport of Patients* 1.407 *Transport of Forensic Patients from the Metropolitan Remand and Reception Centre and the Silverwater Women's Correctional* 1.434 *Working With Families and Carers* 1.439 *Community Forensic Mental Health Service Remit of Services* 4.030 *Requesting and Disclosing Health Information* *JH&FMHN Medication Guidelines 2021* FH Procedure *Clinical Handover* FH Procedure *Clinical Risk Assessment & Management (CRAM).* FH Procedure *Searches* *Guidelines on the use and disclosure of inmate/patient medical records and other health information* January 2018 Forensic Mental Health Network Protocol 2013 -01 *Standard Information to be sent on Referral, Assessment and Transfer of Patients*
The Network Forms	FH002 *Forensic Hospital Patient Transfer of Care Checklist* JUS005.001 *Health Problem Notification Form* JUS025.130 *Section 56 Notification* form

	JUS200.035 *Medical Certificate - Consideration for Special Transport* JUS200.110 *Schedule 2 - Medical Certificate as to Examination of Inmate* SMR025.215 *Transfer Between Declared Mental Health Facilities of Involuntary Patient or Other Person Detained*
NSW Health Policy Directives, and Guidelines	PD2019_020 *Clinical Handover* PD2010_018 *Mental Health Clinical Documentation* PD2011_015 *Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals* PD2012_050 *Forensic Mental Health Services* PD2016_007 *Clinical Care of People Who May Be Suicidal* PD2019_045 *Discharge Planning and Transfer of Care for Consumers of NSW Health Mental Health Services* PD2012_50 *Forensic Mental Health Services* GL2014_002 *Mental Health Clinical Documentation Guidelines* *PD2012_042 Aboriginal and Torres Strait Islander Origin – Recording of Information of Patients and Clients*
Others	*State Records Authority of New South Wales, (2004) General Retention and Disposal Authority Public Health Services: Patient/Client Records (GDA 17)* *Rampton Hospital Admissions Guidelines, East of England Specialised Commissioning Group, NHS, UK* *Mental Health Review Tribunal Forensic Guidelines Version August 2018* *Mortality and Hospitalisation Due to Injury in the Aboriginal Population of New South Wales*