Latrobe Regional Hospital

Mental Health Services

Princes Highway
PO Box 424
Traralgon Victoria 3844
Telephone 03 5173 8000
Facsimile 03 5173 8417

Bairnsdale Community Mental Health Team
McKean Street
Bairnsdale Victoria 3875
Telephone 03 5150 3444
Facsimile 03 5150 3377

Community Aged Intensive Recovery (CAIR) Program
C/o Bass Coast Regional Health
Graham Street
PO Box 120
Wonthaggi Victoria 3995
Telephone 03 5672 3866
Facsimile 03 5173 8719

Community Residential Care Units
19 Garden Grove
PO Box 424
Traralgon Victoria 3844
Telephone 03 5128 0080
Facsimile 03 5128 0088

Korumburra Community Mental Health Team
4 Gordon Street
Korumburra Victoria 3950
Telephone 03 5658 1501
Facsimile 03 5658 1294

Latrobe Valley Community Mental Health Team

Aged Persons Mental Health Service

Child & Youth Health Service (CYMHS)

Primary Mental Health and Community Development
20 Washington Street
PO Box 424
Traralgon Victoria 3844
Telephone 03 5128 0100
Facsimile 03 5128 0099

Orbost Community Mental Health Team
Boundary Road
Orbost Victoria 3888
Telephone 03 5154 6721
Facsimile 03 5154 6729

Prevention and Recovery Care Service (PARCS)
54 Moroney Street
Bairnsdale Victoria 3875
Telephone 03 5152 1233
Facsimile 03 5152 4544

Sale Community Mental Health Team
Corner Palmerston and Cunninghame Streets
Sale Victoria 3850
Telephone 03 5143 1212
Facsimile 03 5143 0182

Warragul Community Mental Health Team
31 - 35 Gladstone Street
Warragul Victoria 3820
Telephone 03 5624 3600
Facsimile 03 5624 3666

Wonthaggi Community Mental Health Team
C/o Bass Coast Regional Health
Graham Street
PO Box 120
Wonthaggi Victoria 3995
Telephone 03 5672 3174
Facsimile 03 5672 5025

Yarram Community Mental Health Team
20 Nicol Street
PO Box 61
Yarram Victoria 3971
Telephone 03 5182 0245
Facsimile 03 5182 6578

ABN 18 128 843 652

11 July 2012

Coroner Jane Hendtlass
Coroner's Court
Level 11
222 Exhibition St
Melbourne 3000

Dear Madam

James Bloomfield: Coroner's Case No 4308/20

I am responding on behalf of the Latrobe Regional Hospital Mental Health Service (LRHMHS) in relation to the recommendations made by you in relation to the death of James Bloomfield.

> ***Recommendation 3: That the Latrobe Health Service ensure that Accident and Emergency staff report to police all patients who present in police custody and discharge themselves without assessment by a mental health practitioner***

The Coroner's recommendation set out above has been implemented as follows:

The LRHMHS Director of Mental Health and the Bairnsdale Regional Health Service (BRHS) Director of Nursing jointly collaborated and developed:

1. "Mental Health Patients in the Emergency Department: Management, Assessment and Treatment Policy"
2. 'Mental Health Patients in the Emergency Department: Management, Assessment and Treatment Protocol"

These documents outline the requirement for Emergency Department staff to report to police all patients who leave the department prior to a mental health assessment being undertaken. The policy and protocol were implemented at BRHS in March 2010. Copies of the Policy and Protocol are attached.

LRHMHS has also developed and implemented a MH Assessment and Treatment in ED protocol at the LRH Emergency Department in Traralgon. The LRHMHS collaborated with the Wonthaggi ED (Bass Coast Regional Health) and the Sale ED (Central Gippsland Health Service) to develop a protocol for their sites.

In relation to Mr Bloomfield's death, LRH undertook a range of other activities with BRHS, Ambulance Victoria and Victoria Police to improve communication and processes across the service sectors. This included the re-introduction of the Emergency Services Liaison Committee at Bairnsdale, the development of a Section 10 protocol for police and ambulance to use across the Gippsland Region, implementation of region wide training on the mental health triage system, the Ambulance Transport protocol, the Victoria Police and Mental Health protocol and other general mental health education.

The mental health triage team have had significant training in 2010 and 2011 in the mental health triage scale, clinical management of mental health telephone presentations including risk management and have been supported to undertake clinical supervision. A Consultant Psychiatrist now provides regular mentoring and governance.

The dual diagnosis team at LRHMHS has provided a range of training across the Gippsland Region, to ensure an integrated response to people with a dual diagnosis who present at emergency departments.

The relationships between LRHMHS, BRHS, Ambulance Victoria and Victoria Police have improved significantly since 2009.

Please contact me should you require further information.

Yours faithfully

Cayte Hoppner
Director Mental Health
Senior Psychiatric Nurse

MANAGEMENT, ASSESSMENT AND TREATMENT OF MENTAL HEALTH PATIENTS IN THE EMERGENCY DEPARTMENT

Scope (Area): Emergency Department
Scope (Staff): Emergency Department Staff

1 DESIRED OBJECTIVE/OUTCOME:

Bairnsdale Regional Health Service is committed to providing quality care to patients who present to the Emergency Department with mental health issues.

These patients require thorough and timely assessment of their medical and mental status, the latter in conjunction with AHMS mental health practitioners where appropriate, to facilitate accurate diagnosis and treatment.

The Mental Health Act 1986 requires that people who have a mental illness are to receive the best possible care and treatment in the least possible restrictive environment and least possible intrusive manner.

2 DEFINITIONS:

AHMS	The approved and gazetted area mental health service for the region, Latrobe Regional Hospital Mental Heath Service
ED	The Emergency Department at Bairnsdale Regional Health Service

3 POLICY:

The ED is a common site for presentation of patients experiencing acute behavioural change or situational crisis. Many patients with physical illness have co-morbid psychological problems complicating their condition. The ED is an important entry point for people with mental illness to access care.

3.1 ED Triage and AHMS Triage

People who present to the ED with a mental illness or suspected mental illness problem are triaged in the ED in a timely and appropriate way and managed according to the principles set out in the ED Mental Health Triage tool. Nurses shall not be responsible for triage unless they have undergone the appropriate training (see Triage Policy). Where a mental health assessment by an AHMS mental health practitioner is deemed appropriate, a referral shall be made to the centralised AHMS triage. Even where it is likely that a patient has been referred to AHMS Triage by another service, their GP or the police, ED staff must still contact AHMS Triage and confirm that the patient has been referred and will be seen in the ED by AHMS mental health practitioners.

3.2 Informed Consent

People with a mental illness shall be informed of their rights and shall be involved in decisions about their own individual treatment.

3.3 Clinical Care

All senior clinicians working in the ED shall be proficient in conducting a basic mental health assessment, including risk assessment, of all presenting conditions.

A specialised assessment can be arranged with an AHMS mental health practitioner through a referral to AHMS Triage. Advice from the on-duty AHMS psychiatrist can be obtained through AHMS Triage.

People who present with a mental illness or suspected mental illness shall have an appropriate physical assessment to exclude organic issues and assess and monitor other co-morbidities. Appropriate diagnostic tests should be initiated where appropriate.

3.4 Collaborative Approach

A collaborative approach shall be followed by ED staff with AHMS mental health practitioners, GPs in the community and other services where appropriate. This includes timely referral to AHMS Triage where it is decided that an assessment by a mental health practitioner is appropriate.

4 ASSOCIATED DOCUMENTATION:

Management, Assessment and Treatment of Mental Health Patients in the Emergency Department Procedure
Triage Policy
Triage Procedure

5 REVIEW CIRCULATION:

Director of Nursing, ED Nurse Unit Manager, Senior Medical Officer ED, Director Mental Health Latrobe Regional Hospital

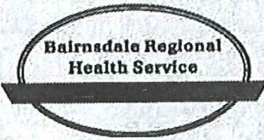
6 REFERENCES:

National Mental Health Policy 2008. Commonwealth of Australia 2009
Mental Health Care. Framework for Emergency Departments. 2007. Victorian Department of Human Services
Mental Health Act 1986
Victorian Emergency Department Mental Health Triage Project 2005-06. Victorian Department of Human Services

7 KEY WORDS:

Mental, health psychiatric

Endorsed by: Clinical Standards Emergency Department	Date Effective: May 2009
Review Responsibility: NUM Emergency Department	Date Revised: May 2009
Signed (Chair of Committee):	Date for Review: May 2012



MENTAL HEALTH PATIENTS IN THE EMERGENCY DEPARTMENT - MANAGEMENT, ASSESSMENT AND TREATMENT

Scope (Area): Emergency Department
Scope (Staff): Emergency Department staff

1. DESIRED OBJECTIVE/OUTCOME:

Bairnsdale Regional Health Service is committed to providing quality care to patients who present to the Emergency Department with mental health issues.

These patients require thorough and timely assessment of their medical and mental status, the latter in conjunction with AHMS mental health practitioners where appropriate, to facilitate accurate diagnosis and treatment.

The Mental Health Act 1986 requires that people who have a mental illness are to receive the best possible care and treatment in the least possible restrictive environment and least possible intrusive manner.

2. DEFINITIONS:

AHMS — The approved and gazetted area mental health service for the region, Latrobe Regional Hospital Mental Heath Service

ED — The Emergency Department at Bairnsdale Regional Health Service

ANUM — Associate Nurse Unit Manager

3. PROCEDURE:

3.1 On Presentation

By Police
Where a person is brought to the ED by a member of Victoria Police, the officer shall be asked whether they have exercised their power under section 10 of the Mental Health Act. Irrespective of the reason for bringing the patient to the ED, the officer shall fill out the Mental Disorder Transfer form. See Appendix 1.

Where the police have exercised their power under section 10 of the Mental Health Act, they are required to remain with the patient until such time as the patient is assessed as not having a mental illness by the AHMS mental health practitioner or until a senior Medical Officer has accepted the transfer of responsibility of the person into their care. The nurse conducting ED triage shall inform the ANUM that a patient has presented under Section 10 apprehension and make a note in the triage record accordingly.

By Self or Others
Proceed to ED triage.

3.2 ED Triage
The triage nurse shall assess the patient using the ED Mental Health Triage tool. See Appendix 2.

If the patient has been brought to the ED by police exercising their powers under section 10 of the Mental Health Act, the triage nurse shall make a referral to AHMS triage and state that the patient has been apprehended under section 10. This referral is to be made even if the police state that they have made a referral.

In all other cases, the triage nurse may make a referral to AHMS triage where warranted by the urgency of the matter.

Where AHMS triage is contacted with a referral, the time should be noted as well as the name of the person taking the referral. Where possible, the time of expected arrival of the AHMS practitioner and their name should be obtained and noted.

AHMS triage is the sole point of referral, do not refer directly to the local AHMS mental health staff.

AHMS Triage (24 hour service)
1300 363 322

3.3 ANUM Response

After triage, the ANUM shall allocate nursing responsibility for the patient who shall

- alert ED medical staff
- ensure continuous visual surveillance of the patient unless accompanied by police
- provide a safe environment for the patient and others (including staff)
- consider use of the ED assessment room (always to remain unlocked)
- complete the appropriate observations, e.g. vital signs
- consider use of Code Black and call Police if there is a safety concern
- where a referral has been made to AHMS Triage, monitor progress.

3.4 Progress Notes and Handover

The nurse responsible for the patient shall record in the notes where the patient has been apprehended under section 10 including the following information:

- whether the police have been relieved of their responsibility to stay, by the direction of a senior Medical Officer (e.g. patient recommended and awaiting transport)
- whether assessed by AHMS mental health staff and if not, when that is expected
- whether recommended and awaiting transfer by ambulance and when it is expected
- clinical observations

This information shall be summarized at the end of a shift and communicated to the relieving nurse on handover.

The ANUM shall also communicate this information to the relieving ANUM on handover.

3.5 Medical Assessment

Physical Examination and Diagnostic Tests

The patient shall have an appropriate physical assessment to exclude organic issues and assess and monitor other co-morbidities. Appropriate diagnostic tests should be initiated where appropriate.

Intoxicated Patients

Where a patient presents intoxicated at time of assessment, and issues cannot be clearly identified, further assessment needs to be completed and AHMS triage contacted for advice.

Patients Apprehended under Section 10

Patients apprehended under section 10 require an assessment by an AHMS mental health practitioner and a BRHS senior Medical Officer.

Conditions Warranting a Referral to AHMS Triage

Generally, patients with

- Suicide attempt/ideation
- Self-harm
- Agitation
- Severe distress
- Severe depression
- Psychosis
- Confusion with behavioural disturbance

should be referred to AHMS Triage for assessment.

Recommendation of a Patient

The Medical Officer may make a recommendation under section 9 if the patient meets the following criteria under the Mental Health Act:

- The person appears to be mentally ill; and
- The person's mental illness requires immediate treatment and that treatment can be obtained by the person being subject to an involuntary treatment order; and
- Because of the person's mental illness, involuntary treatment of the person is necessary for his or her safety (whether to prevent a deterioration in the person's physical or mental condition or otherwise) or for the protection of members of the public; and
- The person has refused or is unable to consent to the necessary treatment for the mental illness; and
- The person cannot receive adequate treatment for the mental illness in a manner less restrictive of his or her freedom of decision and action.

The Medical Officer will complete the appropriate paperwork for recommendation and transfer. See Appendix 3.

Consultation with Senior Medical Officer or VMO or Duty Psychiatrist
A junior Medical Officer shall consult with a senior Medical Officer or the VMO of the day. The LRH AHMS duty Psychiatrist can be contacted by ringing AHMS triage.

3.6 Accepting Responsibility for a Patient Apprehended under Section 10
No member of the nursing staff has the authority to accept a transfer of responsibility from the police where they have apprehended a person under section 10. The police may only leave if a senior Medical Officer has agreed to accept the transfer of such a patient and has signed the Police Referral to ED form or the medical officer has recommended the patient.

3.7 Where a Patient Absconds after Transfer of Care or after Recommendation
If a Medical Officer has accepted the transfer of care of a person apprehended by the police under section 10 and that person leaves prior to discharge, the police must be contacted to retrieve the person. If a patient has been recommended but absconds while awaiting transport, the police shall be contacted to retrieve the person.

4. ASSOCIATED DOCUMENTATION:
Management, Assessment and Treatment of Mental Health Patients in the Emergency Department Policy
Triage Policy
Triage Procedure
Aggression & Violence Prevention Policy/Procedure (C/5.1/09[05])
Code Black Personal Threat Policy/Procedure (C/5.1/04/[01])

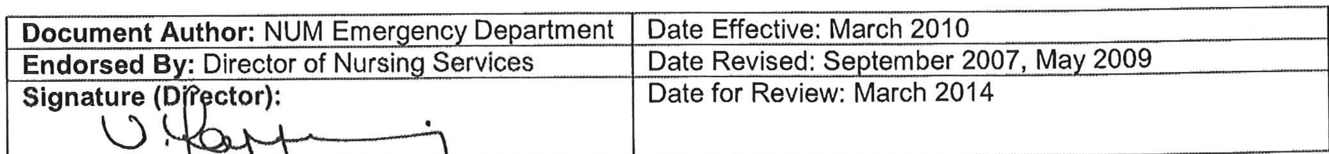
5. APPENDICES:
Appendix 1 – Mental Disorder Transfer Form
Appendix 2 – ED Mental Health Triage Tool
Appendix 3 – Procedure for making a request and recommendation for involuntary treatment flow chart
Appendix 4 – Request and recommendation form for involuntary treatment

6. REFERENCES:
National Mental Health Policy 2008. Commonwealth of Australia 2009
Mental Health Care. Framework for Emergency Departments. 2007. Victorian Department of Human Services
Mental Health Act 1986
Victorian Emergency Department Mental Health Triage Project 2005-06. Victorian Department of Human Services

7. REVIEW CIRCULATION:
Director of Nursing Services, ED Nurse Unit Manager, ED Senior Medical Officer, ED Clinical Standards Committee, Director Mental Health Latrobe Regional Hospital

8. KEY WORDS:

Mental health psychiatric



Document Author: NUM Emergency Department	Date Effective: March 2010
Endorsed By: Director of Nursing Services	Date Revised: September 2007, May 2009
Signature (Director):	Date for Review: March 2014

Appendix 1

MENTAL DISORDER TRANSFER (POLICE COPY) | INCIDENT FAX SEQUENCING Page No / Total No. of Pages | VP Form L42

REPORT BY MEMBER NAME ☐ | MEMBER Reg. No. ☐ | MEMBER STATION ☐

REPORT DATE ☐ | REPORT TIME ☐ | STATION NAME ☐

Cross box if supplementing an existing incident ☐ | AND provide the INCIDENT No. ☐

COMMENCED AT ☐ hrs on ☐

Sub-Inc Location ☐

Flat No. ☐ | Street No. ☐ | Street Name & Type ☐

TOWN / SUBURB ☐ | Committed AT RZ ☐

PERSON DETAILS MNI No ☐ | 1st Name ☐

FAMILY NAME ☐ | 2nd Name ☐

DOB ☐ | Age ☐ | Sex ☐ Male ☐ Female

Flat No. ☐ | Street No. ☐ | Street Name ☐

TOWN / SUBURB ☐ | State ☐ | Postcode ☐

Phone No's: (Home) | (Work) | (Mobile)

REASON FOR POLICE INVOLVEMENT

- ☐ Psychiatric crisis *(s. 10, Mental Health Act 1986)*
- ☐ Return involuntary or security psychiatric patient *(s 43, Mental Health Act 1986)*
- ☐ Return involuntary or security disability resident *(s 160, s.174 or s.201, Disability Act 2006)*
- ☐ Return person on a supervision order *(s.30, Crimes (Mental Impairment & Unfitness to be Tried) Act 1997)*

RESPONSE TIMES OF SERVICES REQUESTED (HOURS) *Cross only 1 box per line where applicable*

Service											
Ambulance	☐ 0.5	☐ 1	☐ 1.5	☐ 2	☐ 2.5	☐ 3	☐ 3.5	☐ 4	☐ 4.5	☐ 5+	☐ Not avail
Mobile CAT	☐ 0.5	☐ 1	☐ 1.5	☐ 2	☐ 2.5	☐ 3	☐ 3.5	☐ 4	☐ 4.5	☐ 5+	☐ Not avail
Hospital ECAT	☐ 0.5	☐ 1	☐ 1.5	☐ 2	☐ 2.5	☐ 3	☐ 3.5	☐ 4	☐ 4.5	☐ 5+	☐ Not avail
Hospital doctor	☐ 0.5	☐ 1	☐ 1.5	☐ 2	☐ 2.5	☐ 3	☐ 3.5	☐ 4	☐ 4.5	☐ 5+	☐ Not avail
Local GP	☐ 0.5	☐ 1	☐ 1.5	☐ 2	☐ 2.5	☐ 3	☐ 3.5	☐ 4	☐ 4.5	☐ 5+	☐ Not avail.

☐ Welfare concerns *(Police want to arrange non-urgent follow-up support, with the consent of the person, their parent or their legal guardian)*

TRANSPORTED BY

- ☐ Family/friend/carer
- ☐ CAT/Area Mental Health Service
- ☐ Ambulance
- ☐ Police
- ☐ Not Transported
- ☐ Police escort provided
- ☐ Other

TRANSPORTED TO

- ☐ Hospital ED
- ☐ Psychiatric facility
- ☐ Disability Services facility
- ☐ Residential address
- ☐ Police station
- ☐ Other

OUTCOME OF POLICE INVOLVEMENT *(cross one box only)*

- ☐ CAT assessed the person under s.10 and advised police to release them
- ☐ Doctor to examine the person under s.10 *(doctor's name)* ☐
- ☐ Person admitted to a psychiatric facility
- ☐ Person returned to a Disability Services facility
- ☐ Person referred by (Agency copy) fax to Mental Health Triage
- ☐ Person referred by (Agency copy) fax to Disability Services Intake

ESTIMATED TOTAL POLICE INVOLVEMENT TIME (HOURS)

☐ 0.5 ☐ 1 ☐ 1.5 ☐ 2 ☐ 2.5 ☐ 3 ☐ 3.5

☐ 4 ☐ 4.5 ☐ 5 ☐ 5.5 ☐ 6 ☐ 6.5 ☐ 6.5+

CIRCUMSTANCES *(details of incident, typical behaviours/triggers, effective communication strategies, contact persons, known risks, other mental disorder-related information (eg. subject to a treatment order), source of information, and location details if returning a missing person* ***Indicate if you have conducted a pat-down search as per VPM.)***

PERSON WARNING FLAGS *(must comply with VPM criteria)*

- ☐ Self injury
- ☐ Suicidal
- ☐ Violent
- ☐ Drug Association
- ☐ Carries weapon
- ☐ Carries firearm
- ☐ Medical condition
- ☐ Mental disorder

USE OF FORCE FORM (VP FORM 237) SUBMITTED ☐ Yes ☐ No

SUB-OFFICER'S APPROVAL

Signature

Rank/No

THE INFORMATION CONTAINED HEREIN IS CONFIDENTIAL AND MAY ATTRACT LEGAL PROFESSIONAL PRIVILEGE AND/OR PUBLIC INTEREST IMMUNITY. IF YOU HAVE RECEIVED THIS DOCUMENT IN ERROR TELEPHONE VICTORIA POLICE ON 03 9247 6471

PRINTED 10/09 NEW 10/09

Appendix 2

Victorian Emergency Department
Mental Health Triage Tool – Department of Human Services

<table>
<tr><th>Triage Code</th><th>Description</th><th>Treatment acuity</th><th>Typical Presentation</th><th>General Management principles*</th></tr>
<tr><td>1</td><td>Definite danger to life (self or others)

Australasian Triage Scale[1] states:
– Severe behavioural disorder with immediate threat of dangerous violence</td><td>Immediate</td><td>Observed
– Violent behaviour
– Possession of weapon
– Self-destruction in ED
– Displays extreme agitation or restlessness
– Bizarre / disoriented behaviour
Reported
– Verbal commands to do harm to self or others, that the person is unable to resist (command hallucinations)
– Recent violent behaviour</td><td>Supervision
Continuous visual surveillance 1:1 ratio (see definition below)
Action
– Alert ED medical staff immediately
– Alert mental health triage or equivalent
– Provide safe environment for patient and others
– Ensure adequate personnel to provide restraint / detention based on industry standards
Consider
– Calling security +/- police if staff or patient safety compromised. May require several staff to contain patient
– 1:1 observation
– Intoxication by drugs and alcohol may cause an escalation in behaviour that requires management</td></tr>
<tr><td>2</td><td>Probable risk of danger to self or others
AND / OR
Client is physically restrained in emergency department
AND / OR
Severe behavioural disturbance

Australasian Triage Scale[1] states:
Violent or aggressive (if):
– Immediate threat to self or others
– Requires or has required restraint
– Severe agitation or aggression</td><td>Emergency
Within 10 minutes</td><td>Observed
– Extreme agitation / restlessness
– Physically / verbally aggressive
– Confused / unable to co-operate
– Hallucinations / delusions / paranoia
– Requires restraint / containment
– High risk of absconding and not waiting for treatment
Reported
– Attempt at self-harm / threat of self-harm
– Threat of harm to others
– Unable to wait safely</td><td>Supervision
Continuous visual supervision (see definition below)
– Alert ED medical staff immediately
– Alert mental health triage
– Provide safe environment for patient and others
– Use defusing techniques (oral medication, time in quieter area)
– Ensure adequate personnel to provide restraint / detention
– Prompt assessment for patient recommended under Section 9 or apprehended under Section 10 of Mental Health Act.
Consider
– If defusing techniques ineffective, re-triage to category 1 (see above)
– Security in attendance until patient sedated if necessary
– Intoxication by drugs and alcohol may cause escalation in behaviour that requires management</td></tr>
</table>

[1] **Australasian College of Emergency Medicine (2000). Guidelines for the implementation of the Australasian Triage Scale (ATS) in Emergency Departments**

3	**Possible danger to self or others** – Moderate behaviour disturbance – Severe distress **Australasian Triage Scale[1] states:** – Very distressed, risk of self-harm – Acutely psychotic or thought-disordered – Situational crisis, deliberate self-harm – Agitated / withdrawn	**Urgent** Within 30 minutes	**Observed** – Agitated / restless – Intrusive behaviour – Confused – Ambivalence about treatment – Not likely to wait for treatment **Reported** – Suicidal ideation – Situational crisis **Presence of psychotic symptoms** – Hallucinations – Delusions – Paranoid ideas – Thought disordered – Bizarre / agitated behaviour **Presence of mood disturbance** – Severe symptoms of depression – Withdrawn / uncommunicative – And / or anxiety – Elevated or irritable mood	**Supervision** Close observation (see definition below) – Do not leave patient in waiting room without support person **Action** – Alert mental health triage – Ensure safe environment for patient and others **Consider** – Re-triage if evidence of increasing behavioural disturbance o Restlessness o Intrusiveness o Agitation o Aggressiveness o Increasing distress – Inform security that patient is in department – Intoxication by drugs and alcohol may cause an escalation in behaviour that requires management
4	**Moderate distress** **Australasian Triage Scale[1] states:** – Semi-urgent mental health problem – Under observation and / or no immediate risk to self or others	**Semi-urgent** Within 60 minutes	**Observed** – No agitation / restlessness – Irritable without aggression – Co-operative – Gives coherent history **Reported** – Pre-existing mental health disorder – Symptoms of anxiety or depression without suicidal ideation – Willing to wait	**Supervision** Intermittent observation (see definition below) **Action** Discuss with mental health triage **Consider** – Re-triage if evidence of increasing behaviour disturbance o Restlessness o Intrusiveness o Agitation o Aggressiveness o Increasing distress o Intoxication by drugs and alcohol may cause an escalation in behaviour that requires management
5	**No danger to self or others** – No acute distress – No behavioural disturbance **Australasian Triage Scale[1] states:** – Known patient with chronic symptoms – Social crisis, clinically well patient	**Non-urgent** Within 120 minutes	**Observed** – Co-operative – Communicative and able to engage in developing management plan – Able to discuss concerns – Compliant with instructions **Reported** – Known patient with chronic psychotic symptoms – Pre-existing non-acute mental health disorder – Known patient with chronic unexplained somatic symptoms – Request for medication – Financial, social, accommodation or relationship problems	**Supervision** General observation (see definition below) **Action** – Discuss with mental health triage – Refer to treating team if case managed

Management Definitions *

Continuous visual surveillance – *person is under direct visual observation at all times*
Close observation – *regular observation at a maximum of 10 minute intervals*
Intermittent observation – *regular observation at a maximum of 30 minute intervals*
General observation - *routine waiting room check at a maximum of 1 hour intervals*

Appendix 3

Procedure for making a request and recommendation for involuntary treatment as an inpatient or in the community under the *Mental Health Act 1986*

PROCEDURE FOR MAKING A REQUEST AND RECOMMENDATION FOR INVOLUNTARY TREATMENT AS AN INPATIENT OR IN THE COMMUNITY UNDER THE MENTAL HEALTH ACT 1986

CRITERIA FOR INVOLUNTARY TREATMENT

Section 8(1) Mental Health Act 1986:

(a) the person appears to be mentally ill *(a person is mentally ill if he or she has a mental illness, being a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory)*; and

(b) the person's mental illness requires immediate treatment and that treatment can be obtained by the person being subject to an involuntary treatment order; and

(c) because of the person s mental illness, involuntary treatment of the person is necessary for his or her health or safety (whether to prevent a deterioration in the person s physical or mental condition or otherwise) or for the protection of members of the public; and

(d) the person has refused or is unable to consent to the necessary treatment for the mental illness; and

(e) the person cannot receive adequate treatment for the mental illness in a manner less restrictive of his or her freedom of decision and action.

PRESCRIBED PERSON

A prescribed person is a member of the police force, an ambulance officer or a:
- Registered medical practitioner
- Registered nurse
- Registered psychologist
- Social worker
- Occupational therapist

employed to provide care and treatment to persons with a mental disorder in an approved mental health service, a child and adolescent psychiatry service, a premises licensed under section 75 of the Act, a hospital admitting or caring for persons with a mental disorder, a mental health service of a community health centre, a psychiatric outpatient clinic or a community mental health service.

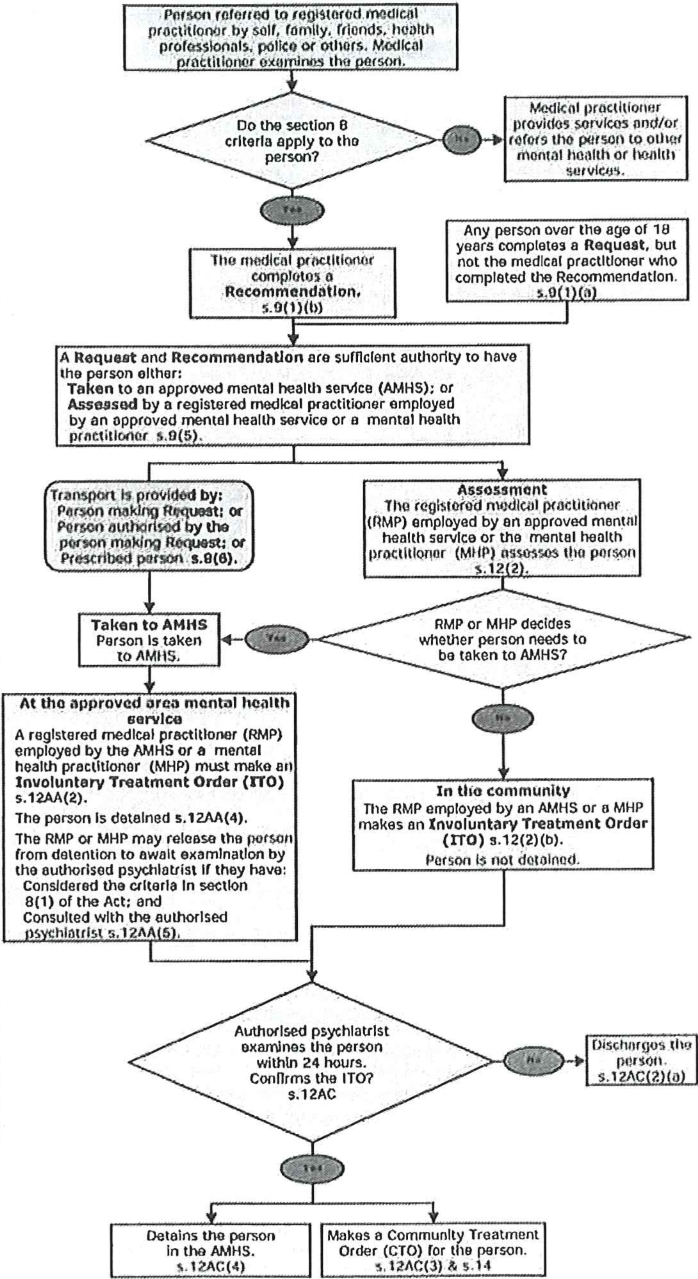
APPROVED MENTAL HEALTH SERVICE

An approved mental health service (AMHS) is any service or premises that has been proclaimed by the Governor in Council under section 94 of the **Mental Health Act 1986** as a place at which treatment can be provided to patients under the Act. Typically, public hospitals that have an acute psychiatric in-patient unit are proclaimed as approved mental health services.

MENTAL HEALTH PRACTITIONER (MHP)

A mental health practitioner is a member of the following categories of health professionals employed by a public sector mental health service (within the meaning of section 120A of the Mental Health Act) that is an approved mental health service or a community mental health service and engaged in the provision of acute psychiatric assessment and treatment functions in the community:
- (a) Registered nurses
- (b) Registered psychologists
- (c) Social workers
- (d) Occupational therapists.

Typically mental health practitioners are members of community based mental health teams, such as Crisis Assessment & Treatment Services (CATS) or integrated teams with a crisis, assessment and treatment function.



Appendix 4

Mental Health Act 1986

Section 9
Mental Health Regulations 1998
Regulation 5(1)

Mental Health Statewide Patient Number: ______

Local Hospital Patient Number: ______

Family Name: ______

Given Names: ______

Date of Birth: ______ Sex: ______

Alias: ______

REQUEST

FOR PERSON TO RECEIVE INVOLUNTARY TREATMENT FROM AN APPROVED MENTAL HEALTH SERVICE

TO THE *REGISTERED MEDICAL PRACTITIONER EMPLOYED BY AN APPROVED MENTAL HEALTH SERVICE / MENTAL HEALTH PRACTITIONER

Notes to completing this form

This Request may be completed by any person over the age of 18 years.

The person must not also complete the:
- Recommendation (Schedule 2); or
- Authority to Transport (Schedule 4)

Please make an Involuntary Treatment Order for:

______ GIVEN NAME/S ______ FAMILY NAME (BLOCK LETTERS) of person who should be made subject to an Involuntary Treatment Order

of: ______ address of person who should be made subject to an Involuntary Treatment Order

______ GIVEN NAME/S ______ FAMILY NAME (BLOCK LETTERS) of person making the request

of: ______ address of person making the request

Signed: ______ Date: ______

AUTHORISATION (Optional)

I authorise: ______ GIVEN NAME/S ______ FAMILY NAME (BLOCK LETTERS) of other person authorised by the person making the request

of: ______ address of other person authorised by the person making the request

☐ To take the abovenamed person to an appropriate approved mental health service

OR

☐ To arrange for a registered medical practitioner employed by an approved mental health service or a mental health practitioner to assess the person

(please cross X one option only)

Signed: ______ signature of person making the request Date: ______

Definitions
See the Mental Health Regulations 1998 or the back of this Request (Schedule 1) for definitions of:
- prescribed person
- mental health practitioner
- prescribed registered medical practitioner
- authorised person

NEXT STEPS

1. Once you have completed this **Request** further documents must be completed. This **Request** only becomes effective if it is accompanied by either:
   - a **Recommendation (Schedule 2)** signed by a registered medical practitioner; or
   - an **Authority to Transport (Schedule 4)** signed by a mental health practitioner.
2. If a **Request** and a **Recommendation** are completed, together they give sufficient authority to a 'prescribed person' or the person making the Request to:
   - take the person to an appropriate approved mental health service for an Involuntary Treatment Order to be made; or
   - arrange for a registered medical practitioner employed by an approved mental health service or a 'mental health practitioner' to assess the person.

   OR

   If a **Request** and an **Authority to Transport** are completed, together they give sufficient authority to a 'prescribed person' to take the person to an approved mental health service for examination by a registered medical practitioner for the purpose of making a **Recommendation**.

Transport

3. For the purpose of taking the person to an approved mental health service, a 'prescribed person' may with such assistance as is required and such force as may be reasonably necessary, enter any premises in which the 'prescribed person' has reasonable grounds for believing that the person may be found and if necessary to enable the person to be taken safely, use such restraint as may be reasonably necessary.
4. A 'prescribed person' who uses restraint must complete the form **Restraint** attached to the **Recommendation** or the **Authority to Transport**.

The person may, in the future, have access to this Request under the **Freedom of Information Act 1982** or through Mental Health Review Board proceedings.

* Delete as necessary

DEC 2005

White - ADMIN Green - PATIENT FILE Make copy for own file if required

SCHEDULE 1 - REQUEST

Mental Health Act 1986

Section 9
Mental Health Regulations 1998
Regulation 5(2)

Mental Health Statewide Patient Number

Local Hospital Patient Number:

Family Name:

Given Names:

Date of Birth: **Sex:**

Alias:

RECOMMENDATION
FOR PERSON TO RECEIVE INVOLUNTARY TREATMENT FROM AN APPROVED MENTAL HEALTH SERVICE

PART A
TO THE *REGISTERED MEDICAL PRACTITIONER EMPLOYED BY AN APPROVED MENTAL HEALTH SERVICE / MENTAL HEALTH PRACTITIONER

Notes to completing this form

This Recommendation must be completed by a registered medical practitioner.

It is valid for 72 hours following the examination of the person by the recommending registered medical practitioner.

In considering whether a person has refused or is unable to consent to the necessary treatment, only the person's personal refusal or consent is relevant and not the refusal or consent of a guardian, a medical treatment agent or a person responsible (if there are any) or the Victorian Civil and Administrative Tribunal.

You must personally observe some facts at the examination that indicate the application of all the criteria in section 8(1) of the **Mental Health Act 1986** to the person.

You may rely on facts communicated by other people, for example family members, in addition to the facts personally observed, so long as you have reasonable grounds for relying on those facts.

If you are unable to observe any facts to support the Recommendation, you may rely solely upon facts communicated directly to you by another registered medical practitioner who has personally examined the person within the previous 28 days. Please complete Part B.

Please make an Involuntary Treatment Order for

GIVEN NAME/S FAMILY NAME (BLOCK LETTERS) of person who should be made subject to an Involuntary Treatment Order

of: ....
address of person who should be made subject to an Involuntary Treatment Order

(1) I am a registered medical practitioner

(2) I **personally examined** the abovenamed person:

on the .... day of .... 20 .... at .... (24 hour)

(3) It is my opinion that **all** the following criteria in section 8(1) of the **Mental Health Act 1986** apply to the person

(a) the person appears to be mentally ill *(a person is mentally ill if he or she has a mental illness, being a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory)*; and

(b) the person's mental illness requires immediate treatment and that treatment can be obtained by the person being subject to an involuntary treatment order; and

(c) because of the person's mental illness, involuntary treatment of the person is necessary for his or her health or safety (whether to prevent a deterioration in the person's physical or mental condition or otherwise) or for the protection of members of the public; and

(d) the person has refused or is unable to consent to the necessary treatment for the mental illness; and

(e) the person cannot receive adequate treatment for the mental illness in a manner less restrictive of his or her freedom of decision and action.

(4) I do not consider the person to be mentally ill by reason only of any one or more of the exclusion criteria listed in section 8(2) of the **Mental Health Act 1986**.

(5) I base my opinion on the following facts.
Facts personally observed by me on examination to support this Recommendation

Facts communicated to me by another person to support this Recommendation:

* delete as necessary

DEC 2005

Mental Health Act 1986 Section 9 Mental Health Regulations 1998 Regulation 5(2) **Mental Health Statewide Patient Number**	**Local Hospital Patient Number:** **Family Name:** **Given Names:** **Date of Birth:** **Sex:** **Alias:**

PART B
TO BE COMPLETED WHERE NO FACTS ARE PERSONALLY OBSERVED

If you are unable to observe any facts to support the Recommendation, you may rely solely upon facts communicated directly to you by another registered medical practitioner who has personally examined the person within the previous 28 days.

The other registered medical practitioner must have personally observed some fact/s that indicate the application of all the criteria in section 8(1) of the Mental Health Act 1986 to the person.

The other registered medical practitioner must not be a relative or guardian of the person.

(6) As no facts were personally observed by me to support this Recommendation, the following facts were communicated directly to me *in person/in writing/by telephone/by electronic communication by:

Dr ______________________ ______________________
GIVEN NAME/S FAMILY NAME (BLOCK LETTERS) of other registered medical practitioner

of: ______________________
address of other registered medical practitioner

doctor's telephone number ______________________

who examined the person on the ______ day of ______________ 20____
(being a period not more than 28 days prior to today's date)

Facts communicated to me by other examining registered medical practitioner:

PART C
SIGNATURE

... must not:
- ... complete the Request (Schedule 1);
- ... a relative or guardian of the person being recommended.

(7) I consider that an involuntary treatment order should be made for the abovenamed person.

______________________ ______________________
GIVEN NAME/S FAMILY NAME (BLOCK LETTERS) of recommending registered medical practitioner

Signed: ______________________ Date: ☐☐☐☐☐☐
signature of recommending registered medical practitioner

Qualifications: ______________________

Address: ______________________

Telephone no: ______________________

Definitions
... the Mental Health Regulations 1998 or ... of the Request (Schedule 1) for ... of:
- prescribed person
- prescribed registered medical practitioner
- authorised person
- mental health practitioner

NEXT STEPS
1. This **Recommendation** only becomes effective if it is accompanied by a **Request (Schedule 1)**.
2. If a **Request** and a **Recommendation** are completed, together they give sufficient authority to a 'prescribed person', the person making the Request or a person authorised by the person making the Request to:
   - take the person to an appropriate approved mental health service, or
   - arrange for a registered medical practitioner employed by an approved mental health service or a 'mental health practitioner' to assess the person.

Transport

3. For the purpose of taking the person to an approved mental health service, a 'prescribed person' may with such assistance as is required and such force as may be reasonably necessary, enter any premises in which the 'prescribed person' has reasonable grounds for believing that the person may be found and if necessary to enable the person to be taken safely, use such restraint as may be reasonably necessary. A 'prescribed person' who uses restraint must complete the form **Restraint** attached.
4. If a 'prescribed registered medical practitioner' considers that it is necessary to sedate the person so that the person can be taken safely to the approved mental health service, the 'prescribed registered medical practitioner' may administer or direct an 'authorised person' to administer sedation to the person. A person who prescribes or administers sedation must complete the form **Sedation** attached.

Making an Involuntary Treatment Order (Schedule 6)

5. If a **Request** and a **Recommendation** are completed and the person has been taken to, or is in, an approved mental health service (including gazetted Emergency Departments), a registered medical practitioner employed by the approved mental health service or a 'mental health practitioner' must make an **Involuntary Treatment Order** for the person
   OR
   If a **Request** and a **Recommendation** are completed and a registered medical practitioner employed by an approved mental health service or a 'mental health practitioner' has been requested to assess the person, the practitioner must either:
   - **Take, or arrange for the person to be taken, to an appropriate approved mental health service. (An Involuntary Treatment Order will be made at the approved mental health service); OR**
   - **Make an Involuntary Treatment Order** if the person is not to be taken to the approved mental health service, for example, if a community treatment order is to be made in the community.

... person may, in the ... have access to ... Recommendation ... the Freedom of Information Act 1982 ... through Mental Health Review Board ... proceedings

* delete as necessary

SCHEDULE 2 RECOMMENDATION