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

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 JHFMHN-MHOrders@health.nsw.gov.au. If the person is being admitted from an adult correctional centre JHFMHN-MHOrders@dcs.nsw.gov.au 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 JHFMHN-MHOrders@health.nsw.gov.au and/or MHOrders@dcs.nsw.gov.au 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 JHFMHN-MHOrders@health.nsw.gov.au 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 JHFMHN-MHOrders@health.nsw.gov.au 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 JHFMHN-FHAdmissons@health.nsw.gov.au. 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

1. New admissions to the FH take priority over all other activity, except where hospital security or staff safety could be compromised due to an incident in progress.
2. G4S Security Services staff must notify the NUM/NiC of the admitting unit of the person's arrival. The NUM/NiC then communicates the arrival and expectations to the admission escort team, DDoN/AHNM and admitting medical staff, and ensures the timely arrival of the admission escort team to the Sally Port.
3. On arrival to the Sally Port, the patient and transferring team will be met initially by G4S Security Services staff then by the admission escort team. The patient must remain in the vehicle until the external roller door of the Sally Port is closed.
4. On arrival at the Sally Port, the NUM/AHNM or delegate must check that transfer paperwork is provided; all required paperwork must be present and correct before officially taking over the care of the person. If the person is transferred from a correctional centre or YJC, the person may be in handcuffs in line with CSNSW and YJNSW transporting policies. Once CSNSW/YJNSW staff remove the handcuffs, the patient is then in the care of the Network.
5. A member of the admission escort team must provide the patient with support and reassurance and explain the admission process in terms that they can understand.
6. The G4S Security Services officer will conduct the security screening, including ordinary search.
7. For identification purposes, all patients who are admitted to the FH should have their biometric data recorded on the Biometric Recognition System (BRS) at the time of admission. If the person's clinical presentation is such that biometric data cannot be obtained at the time of admission due to current mental state or risk, the patient should be

admitted directly to the unit. When the patient has been risk assessed as able to attend the Sally Port to complete recording of biometric data the NUM/NiC must contact the Security Control Room via telephone to organise an appropriate time for this to occur.

8. All patients admitted or re-admitted to the FH must be photographed for identification purposes. Patients should be photographed by G4S Security in the Sally Port on arrival. All patients within the FH should have their images taken using the medium of digital photography and stored in the FHPIRC database. The consent of the person to be photographed must be verbally obtained by G4S Security Services prior to the photograph being taken. The photograph is then sent to the JHFMHN-FHPIRC. MSFS or delegate will electronically transfer the photograph onto the Network *Consent for Photography form* (JUS020.100) and take it to the unit of admission for the nursing staff to arrange completion of this form. If the person's clinical presentation indicates the risk is too high to obtain a photograph, nursing staff can obtain a photograph on the unit when it is safe to do so. Refer to FH Procedure *Photography, Videography and Camera Use*.
9. If the person becomes agitated or aggressive at any time on arrival, the admission escort team must remain in the Sally Port until the Emergency Response Team (ERT) can attend.
10. In exceptional circumstances, medication may need to be administered in the Sally Port prior to escorting the patient to the admitting unit. In such cases the ERT must be called to attend.
11. Patient property is to remain in the Sally Port until the patient has been safely escorted to the unit as per agreed risk assessment. At the earliest opportunity, two staff members must return to the Sally Port to search/x-ray items with a G4S Security Services officer. All forms of identification within the patient's property such as Medicare cards, bank cards etc. must be given to the NUM/AHNM immediately to be placed in a security bag and kept in the secure safe in accord with FH procedure *Patient Property and Valuables.*

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. The vehicle must be screened by G4S security prior to entry into the hospital grounds (FH Procedure Prohibited and Controlled items/ FH Procedure Searches).
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*