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Transfer of Care (Adults and Adolescents) Forensic Hospital

Policy Number 1.338

Policy Function Continuum of Care

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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 JHFMHN-MHOrders@health.nsw.gov.au 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 JHFMHN-MHOrders@health.nsw.gov.au 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 JHFMHN-MRRCMHSU@health.nsw.gov.au 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 MH.Orders@justicehealth.nsw.gov.au 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*