

Department of Health

health

# Department of Health and Victoria Police

## Protocol for Mental Health





Department of Health  
and Victoria Police  
Protocol for Mental Health

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# Foreword

This protocol provides clear and practical guidance to police and clinicians on their respective roles and responsibilities when working together to respond to the needs of people with mental illness.

This document updates the 2004 protocol and reflects recent legislative amendments, innovations in mental health telephone triage and crisis assessment and treatment service delivery, and extensive consultation with frontline police and clinicians on the priority issues at the local level.

It also reflects the strengthening of cooperation between Victoria Police and the Department of Human Services (now Department of Health). In July 2008 our two organisations agreed a set of relationship principles in an overarching Memorandum of Understanding (MoU), and staff liaise regularly to develop strategic policy and practice initiatives. At the local level, police, ambulance services and mental health practitioners call on and support each other to respond to a wide range of circumstances involving mental health issues, and strive for better ways of collaborating through the Emergency Services Liaison Committees.

We encourage all staff to translate the guidance provided within this document into effective and appropriate working arrangements at the service delivery level – this protocol will not be useful if it sits on a shelf. Emergency Services Liaison Committees should drive the application of the protocol in their particular circumstances and use it as a basis for collaboration on local solutions, in the best interests of their shared patient group.



**Fran Thorn**  
**Secretary**  
**Department of Health**



**Simon Overland APM**  
**Chief Commissioner**  
**Victoria Police**

# Contents

## Foreword

<b>1. Introduction</b>	<b>1</b>
Legislation and policy framework	1
Rationale and objectives	2
Practice principles	3
<b>2. Requests by police for assistance from mental health clinicians</b>	<b>4</b>
Urgent referrals under the Mental Health Act	4
Criteria for apprehension - Section 10	4
Apprehending a person who is also drug or alcohol-affected	4
Apprehending a person who also has an intellectual disability	4
Apprehending a person after a siege or other high-risk situation	4
Arranging for an assessment	5
Arranging for an examination	6
When police custody ends	7
Non-urgent referrals – welfare concerns	7
Requesting and recommending involuntary treatment	7
Referral without consent	8
Referral with consent	8
Special warrants for persons incapable of caring for themselves	9
Requesting clinical advice	9
Supporting mental health needs of people in police custody or care	9
Detainees in police cells	9
Fitness for interview	10
Independent third persons	10
Support following interview	11
Forensic psychiatric reports for the court	11
<b>3. Requests by mental health clinicians for assistance from police</b>	<b>12</b>
Urgent requests – safety issues	12
Callout procedure	12
Carriage of police operational equipment	12
Critical incident in an AMHS facility	13
Use of mechanical restraints	13
Use of seclusion	14
Use of physical restraint	14
Non-urgent requests – welfare issues	14
Callout procedure	14
Apprehending and returning an involuntary patient	15
Locating a patient reported as missing	18
Conducting welfare checks	20

Reporting incidents to police	20
Principles for reporting an incident to police	20
Physical and sexual assault	21
Family violence	23
Victim support	24
Deaths involving a person with mental illness	25
<b>4. Transport</b>	<b>26</b>
Basis for transport	26
Transport without a recommendation	26
Use of restraint	27
Police involvement	27
Limits	27
Requesting ambulance/police assistance	27
Transport options	27
Arrival at the hospital or area mental health service	28
Review	28
<b>5. Disclosure of information</b>	<b>29</b>
Information that mental health clinicians can disclose	29
<i>Mental Health Act 1986</i>	29
Information that police can disclose	31
<i>Information Privacy Act 2000</i>	31
<i>Health Records Act 2001</i>	31
Factors to consider when deciding to disclose	32
<b>6. Liaison</b>	<b>33</b>
Local emergency services liaison committees	33
Description	33
Local protocols	34
Case planning	34
Local dispute resolution	34
Corporate – Inter-departmental Liaison Committee	34
<b>7. Execution of this schedule</b>	<b>36</b>
Review date	36
Document owners	36
Grievance procedures regarding the application of the protocol	37
Disclaimer	37
<b>8. Glossary</b>	<b>38</b>
<b>9. Contact details</b>	<b>45</b>
<b>10. Adult area mental health services</b>	<b>46</b>

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# 1. Introduction

This protocol sets out the agreed arrangements for interactions between Victoria Police and the Department of Health's health services staff when supporting people with mental illness, including:

- **requests by police for assistance from mental health clinicians:**
  - urgent referrals under the *Mental Health Act 1986*
  - non-urgent referrals of people who present welfare concerns
  - requests for clinical advice
- **requests by mental health clinicians for assistance from police:**
  - urgent requests for assistance with safety issues
  - non-urgent requests for assistance with welfare issues
  - reporting incidents to police
- **disclosure of information:**
  - information that police can disclose
  - information that mental health clinicians can disclose
- **inter-agency liaison:**
  - Emergency Services Liaison Committees
  - the Inter-departmental Liaison Committee.

## Legislation and policy framework

Collaboration between government services is critical to assist people with mental illness to receive treatment, support recovery, and participate fully in the community. Collaboration requires effective working arrangements between police and clinicians, within existing legislative and policy guidelines.

The key **legislation** underpinning this protocol is the *Mental Health Act 1986*, the *Health Records Act 2001*, the *Crimes Act 1958*, the *Crimes (Mental Impairment & Unfitness to Be Tried) Act 1997* and the *Sentencing Act (1991)*. The provisions of the Mental Health Act cover all age groups.

The **policies and procedures** that guide operational policing are in the Victoria Police Manual. As part of public sector health services, Area Mental Health Services (AMHS) have their own policies and procedures, often informed and guided by the Victorian *Chief Psychiatrist's Guidelines*, *Program Management Circulars* and the *National Mental Health Standards*.

However, this protocol applies only to situations where either agency has requested assistance from the other; it does not alter existing internal agency legislative and policy guidelines. More detailed operational arrangements can be decided, monitored and reviewed through the local Emergency Services Liaison Committees (see Section 6 'Liaison').

## Rationale and objectives

The **rationale** for this protocol is to outline the processes and approaches required to ensure that people with mental illness receive the highest standard of response, care and support from police and mental health clinicians.

The *Mental Health Act 1986* provides that people with mental illness should receive the best possible care in the least restrictive and least intrusive manner consistent with the effective giving of that care and treatment (MHA 4(2)(a)). In providing for this care and the protection of members of the public, any restriction on the liberty of the person with a mental illness and any interference with their rights, privacy, dignity and self-respect should be kept to the minimum necessary in the circumstances.

In practice, this means that:

- mental health clinicians are responsible for the assessment, treatment and care of people with mental illness and for providing advice about matters relating to mental illness, and
- police are responsible for preserving the peace, protecting life and property, preventing offences, detecting and apprehending offenders, and helping those in need of assistance.

However, there are situations that require collaboration, referral or assistance, such as:

- when police encounter a person they believe has a mental illness and is at imminent risk of harming themselves or others,
- when mental health clinicians seek to provide treatment and care in a situation where there is a recognised risk of harm or threat to staff, or
- when mental health clinicians report a patient missing or requiring return for involuntary treatment.

The **objectives** of the protocol are:

- to clarify the respective roles, responsibilities and procedures agreed to by the Department of Health on behalf of AMHS and Victoria Police for interactions involving staff from both agencies,
- to provide the framework for local inter-agency agreements, and
- to give people with mental illness, their families and carers certainty and confidence in the joint responses to their needs by police and mental health clinicians.

## Practice principles

The following principles underpin this protocol and should inform day-to-day decision-making:

**Collaboration:** Staff from Victoria Police and public sector health services will work together in the best interests of the person with a mental illness. This means communicating all relevant information at the earliest opportunity, respecting professional judgment and independence (for example: operational decisions rest with police and clinical decisions rest with clinicians) and applying a problem solving approach to requests for assistance.

**Duty of care:** The safety and welfare of the person with a mental illness, and of any other persons present, will be the primary consideration in decision-making. This means using the necessary professional judgment, skills and resources for as long as such persons are in the care or custody of staff from either service, and in a manner that upholds their human rights. It also means transferring the responsibility to staff from the other service only when it is appropriate.

**Timely response:** Staff will respond to requests for assistance from the other service promptly. Regarding urgent requests, police or AMHS staff will attend situations as soon as practicable and without undue delay, giving top priority to such referrals. It also means recognising the importance of releasing staff from the other service as soon as they have performed their function and are no longer required.

**Confidentiality and exchange of information:** Staff will share personal information only with the consent of the patient, or where authorised under legislation, to prevent a serious threat to the health, safety or welfare of the person with a mental illness or others at risk of harm. This means respecting patient confidentiality and professional codes of conduct, as well as recognising the need for informed decision-making. (See Section 5 'Disclosure of information')

**Least restrictive service option:** Staff from Victoria Police and health services will respond to the needs of a person with mental illness in the least restrictive and least intrusive manner possible.

## 2. Requests by police for assistance from mental health clinicians

### Urgent referrals under the Mental Health Act

#### Criteria for apprehension - Section 10

Police may apprehend a person who appears to be mentally ill, if police have reasonable grounds for believing that the person:

- has recently attempted suicide or attempted to cause serious bodily harm to themselves or another, or
- is likely by neglect or act to attempt suicide or serious bodily harm to themselves or another.

'Reasonable grounds' are based on the person's behaviour and appearance, and any other relevant information available. Police are not required to exercise any clinical judgment as to whether the person has a mental illness.

In apprehending a person, a registered medical practitioner or mental health practitioner may accompany police and police may, with such assistance as required:

- enter the premises, and
- use such force as is reasonably necessary.

While the mental health clinician should contribute to the risk assessment, the decision as to whether reasonable grounds exist to force entry is ultimately a police decision. Police procedures for the reporting of any property damage and the reimbursement of costs also apply.

#### Apprehending a person who is also drug or alcohol-affected

Police can apprehend a person under section 10, who along with appearing to be mentally ill is also drug or alcohol-affected, as intoxication is not a barrier to commencing an assessment. Police therefore do not need to detain the person in a police cell until the person is no longer under the influence of either substance for assessment or examination. However, police must still fulfil their mental health custody obligations. This means the person remains in police custody until an assessment is completed or until a formal handover to a registered medical practitioner has occurred.

#### Apprehending a person who also has an intellectual disability

A mental health practitioner or a registered medical practitioner may diagnose that a person who police apprehend under section 10 also has an intellectual disability. The clinician will address the needs that appear the most pressing: namely involuntary psychiatric treatment if the person meets the criteria under section 8 of the *Mental Health Act 1986*, or referral to an appropriate service, including Disability Intake and Response Service.

#### Apprehending a person after a siege or other high-risk situation

Police will respond to incidents where a person poses an imminent risk of harm to themselves and/or to others, such as a siege, hostage situation or an attempted or threatened suicide. In addition to requesting the appropriate policing expertise (such as trained police negotiators in the Critical Incident Response Teams and the Special Operations Group), police should contact their local Mental Health Triage as soon as it becomes apparent that mental health issues may be involved in order to:

- notify the mental health services of a serious incident and the impending request for an assessment or examination,

- request any relevant patient information that would assist in safely resolving the situation, and
- seek clinical advice on communication and response strategies.

Police remain responsible for incident control and the safety of all persons present at the scene. Mental health service personnel cannot act as negotiators.

Police should keep the Mental Health Triage informed of the situation to enable the Mental Health Triage to monitor the need for onsite attendance, plan for the deployment of the Crisis Assessment and Treatment (CAT) service or provide advice in response to any changes in the person's behaviour or demeanour.

Police will not request mental health clinician attendance unless it is safe to do so. Upon attending, police, ambulance and mental health services should treat the situation as they would any other section 10 apprehension.

Having apprehended a person under section 10, police **must** arrange for an **assessment** by a mental health practitioner or an examination by a registered medical practitioner as soon as practicable.

### Arranging for an assessment

The purpose of an assessment is to determine if the person meets the criteria for involuntary treatment under section 8 of the *Mental Health Act 1986*.

An assessment:

- **is conducted by a mental health practitioner** (see Glossary)
- **must be conducted in person.** A mental health practitioner cannot assess a person via telephone, fax or email information. Police will arrange for an assessment by notifying the Mental Health Triage of the nearest approved mental health service of the apprehension whenever possible; the current location of the presenting person; their behaviours and any other persons present. This applies regardless of whether the person is an existing client or whether they reside in another catchment area. Triage will advise police of the next steps and any other information that would assist police in safeguarding the person until the assessment. Police will document sufficient information on the circumstances of the person's apprehension in the Mental Disorder Transfer form (VP L42) to assist the mental health practitioner in conducting an assessment
- **can be conducted in a person's home; at a medical clinic or community mental health service; at a hospital; or elsewhere in the community.** Section 10 does not mandate the transport of a person to a specific location for assessment. Good practice is to assess the person onsite in the community and to avoid unnecessary transport. Police are responsible for the safety of all persons present. However police will not transport a person to a police station and lodge them in a cell or interview room to await assessment where there is no operational need to do so
- **requires police to remain until the mental health practitioner completes the assessment.** The mental health practitioner will either advise police:
  - to release the person from apprehension
  - that the mental health practitioner will complete an Authority to *Transport without Recommendation*; or
  - to arrange for an examination by a registered medical practitioner. If the mental health practitioner advises police to arrange for a psychiatric examination, police must do so as soon as practicable

- in the community, via the Mental Health Triage and with the assistance of the mental health practitioner
- in an emergency department (ED), via ED mental health staff in line with current mental health service delivery and clinical care framework.

*If the person does not meet the criteria for involuntary treatment*

If the mental health practitioner advises police to release a person from apprehension and police have concerns about the risk that the person poses to themselves or to others, the Act authorises police to maintain custody of the person in order to arrange for a psychiatric examination by a registered medical practitioner. Police must document the seeking of an examination on the *Mental Disorder Transfer form*.

A person who does not meet the criteria for involuntary treatment or does not have a mental illness (for example they have an intellectual disability, personality disorder or substance abuse problem) may nonetheless require some assistance. The mental health practitioner is responsible for providing information on the appropriate treatment, care or support service (for example: a drug and alcohol service) and, where possible, making a referral if the person consents. The mental health practitioner will also consider whether the person needs counselling and additional support in relation to their apprehension and the events leading up to it. Police are responsible for making any other mandatory police referrals.

### Arranging for an examination

The purpose of a psychiatric examination is to determine if the person meets the criteria for involuntary treatment under section 8 of the *Mental Health Act 1986*. If the person does, the registered medical practitioner will complete a Recommendation for involuntary treatment.

An examination:

- **is conducted by a registered medical practitioner** (see Glossary)
- **must be conducted in person.** A registered medical practitioner cannot examine a person via telephone, fax or email. Police will document sufficient information on the circumstances of the person's apprehension in the Mental Disorder Transfer form to assist the registered medical practitioner in conducting an examination;
- **can be conducted in a person's home, at a medical clinic or community mental health service, at a hospital, or elsewhere in the community.** Section 10 does not require the transport of a person to a specific location for examination. Good practice is to examine the person onsite in the community and to avoid unnecessary transport. Police are responsible for the safety of all persons present. However police should not transport a person to a police station and lodge them in a cell to await examination where there is no operational need to do so;
- **requires police to remain until they formally hand over responsibility to the registered medical practitioner.** Police will note the name of the registered medical practitioner on the Mental Disorder Transfer form.

## When police custody ends

The person remains in police custody until:

- a mental health practitioner completes the psychiatric assessment and advises police to release the person, or completes an *Authority to Transport without Recommendation* for ambulance transport, or
- a registered medical practitioner formally accepts responsibility for the person in order to conduct a psychiatric examination, or
- any law enforcement matters are resolved.

Police cannot delegate custody to a security guard, receptionist or nurse in a hospital ED.

Nor can police leave a person who is still in police custody in a secured room within a hospital.

A mental health practitioner can conduct an assessment or a registered medical practitioner can conduct an examination even if the person is also subject to other law enforcement action (for example: to be interviewed or charged over an offence).

The application of Section 10 does not limit any other custody powers, obligations or legislative requirements that the police may have in relation to an apprehended person.

## References

Section 3(1), *Mental Health Act 1986*

Section 10, *Mental Health Act 1986*

*Clinical practice guideline: Assessment of intoxicated persons*, Policy Issue No.2, December 1999

*An introduction to Victoria's public clinical mental health services* 2006

*Mental health care framework for emergency department services* 2007

*Program management circular: Mental health responses in emergency departments* 2008

*Taking persons into police care or custody guidelines, Victoria Police Manual*

*Preventative action guidelines, Victoria Police Manual*

## Non-urgent referrals – welfare concerns

### Requesting and recommending involuntary treatment

Section 8(1) of the *Mental Health Act 1986* authorises involuntary treatment for a person who:

- appears to be mentally ill, and
- has a mental illness that requires immediate treatment; and that treatment can only be obtained by the person being subject to an involuntary treatment order, and
- should be admitted for his/her own health or safety (prevent physical and/or mental deterioration) or to protect the public, and
- has refused or is unable to consent to voluntary treatment, and
- cannot receive adequate treatment in a manner less restrictive of freedom of decision and action.

The person must meet all five criteria at the time of their assessment or examination. An involuntary patient receives treatment via an AMHS (such as an inpatient psychiatric unit or secure extended care unit), a forensic mental health service (Thomas Embling Hospital), or while living in the community (for example, on a Community treatment order). Involuntary treatment does not always involve admission.

Initiating involuntary treatment involves completing:

- a *Request* form, by any person over the age of 18, including police a *Recommendation* form, by a registered medical practitioner, based on whether the person meets the criteria for involuntary treatment

- an *Authority to transport without recommendation* form, by a mental health practitioner if a registered medical practitioner is not available within a reasonable time to complete the Recommendation form .

Police may consider completing a *Request* form for a person they believe has urgent mental health needs but who does not present the imminent threat of harm to themselves or to others required for a section 10 apprehension and who therefore does not require referral (including transport) to a mental health service in police custody.

Once completed, these forms authorise police, ambulance and other specified personnel to take the person to an approved mental health service. Police should only be involved in such transport or making arrangements as a last resort and where there are safety risks. Police are responsible for assessing the safety risks and should draw on the clinical advice provided by the clinicians and/or ambulance. Where police involvement is appropriate police may, with such assistance as is required and such force as may be reasonably necessary:

- enter any premises in which police have reasonable grounds for believing that the person may be found
- if necessary to enable the person to be taken safely, use such restraint as may be reasonably necessary.

The decision as to whether reasonable grounds exist to force entry is ultimately a police decision. Police procedures for the reporting of any property damage and the reimbursement of costs also apply.

## References

Sections 8 and 9, *Mental Health Act 1986*  
Schedules 1-3, *Mental Health Regulations 2008*  
Preventative action guidelines, *Victoria Police Manual*

## Referral without consent

A person with mental illness may seek and consent to treatment on a voluntary basis from a variety of services, including general practitioners, community health centres, private psychiatrists and AMHS. They may receive this treatment in the community or as an admitted patient.

Police have no power to intervene if a person chooses to cease voluntary treatment. Police can only refer a person to a mental health service with their consent.

## Referral with consent

If police encounter a person who appears to have a mental illness but does not require crisis intervention, police can arrange for follow-up or support by faxing a *Mental Disorder Transfer* form to their local treating practitioner (eg. a GP) or Mental Health Triage. Police must obtain the verbal consent of the person, or their parent if the person is a minor or their legal guardian if the person is unable to give informed consent, to ring the proposed referral service to discuss the person's presentation and needs. If the service determines that a welfare referral is appropriate, the service will provide police with the fax number for sending the *Mental Disorder Transfer* form. The service is responsible for contacting the person and giving appropriate advice and contacts.

## Reference

Taking persons into police care or custody guidelines, *Victoria Police Manual*

## Special warrants for persons incapable of caring for themselves

Police or any other person may give information upon oath to a magistrate about a person they have reasonable grounds for believing appears to be mentally ill and is, because of mental illness, incapable of caring for themselves. Police may seek information or clinical advice from their local Mental Health Triage, to support the application for a warrant.

The magistrates may issue a special warrant authorising and directing police, accompanied by a registered medical practitioner, to visit and examine the person.

In doing so police may, with such assistance as is required, enter any premises and use such force as may be reasonably necessary to enable the registered medical practitioner to examine that person.

While the clinician should contribute to the risk assessment, the decision as to whether reasonable grounds exist to force entry is ultimately a police decision. Police procedures for the reporting of any property damage and the reimbursement of costs also apply.

### References

Section 11, *Mental Health Act 1986*  
Schedule 5, *Mental Health Regulations 2008*  
Preventative Action guidelines, *Victoria Police Manual*

## Requesting clinical advice

This should be read in conjunction with Section 8 of this protocol 'Disclosure of information'. Clinicians operate the Mental Health Triage of each AMHS. Police may contact their nearest Mental Health Triage to request advice on:

- whether the person they are concerned about is a patient of a mental health service and if so, the name of an appropriate contact person in the service
- communication and response strategies to assist with managing the person's presenting behaviours
- referral options.

The Mental Health Triage will provide the information that is appropriate for communication by telephone and determine the need for a mental health service response. Based on the information that police provide, the Mental Health Triage **may be able** to determine whether a mental health service response is appropriate and inform police on the most advisable course of action or link the person directly with a more appropriate service. **Police should not determine whether to apprehend a person under section 10 of the *Mental Health Act 1986* based on telephone advice alone.**

## Supporting mental health needs of people in police custody or care

### Detainees in police cells

The Victoria Police Custodial Risk Management Unit is responsible for assessing the physical and mental health of people detained in police cells (for example: on remand or due to go to court). The unit comprises custodial medical officers and custodial nurses who provide a statewide service. These clinicians will either manage the person's health needs (for example: by instructing police in the required care) or advise police to transfer the person to hospital or an AMHS. Police can contact the local Mental Health Triage for further advice if they need to engage the AMHS after the completion of the police process or to arrange a transfer.

## **Fitness for interview**

Police may need to interview a person who is receiving inpatient treatment or treatment while living in the community if police have a reasonable belief that they may have committed, witnessed or been the victim of a criminal act. Police may identify that a person has mental health issues by their words or actions, by asking the person directly, by checking police records of any previous interactions, or by contacting their nearest Mental Health Triage to check whether the person is, or has been, a patient of a mental health service.

If police require clinical advice on whether a person is fit for interview, fit for charging or fit to plead in court, police will arrange for an assessment by a Forensic Medical Officer. These clinicians are available statewide and may be required to give evidence on the outcome of their assessment in court.

Police will seek a forensic assessment from the Forensic Medical Officer regarding a person's fitness for interview. Police may on occasion request that an AMHS clinician assess a person's fitness for interview if awaiting the availability of a clinician from the forensic medical service would cause unreasonable delay.

While there is no statutory definition of 'fitness for interview', a Forensic Medical Officer will consider the person's:

- ability to understand the nature of the questioning,
- ability to follow questioning,
- ability to give instruction to legal representatives,
- ability to understand when they are cautioned, and
- awareness of their surroundings and not being in an excessively suggestible state.

A Forensic Medical Officer may assess a person as unfit for interview on one occasion, but may deem the person fit for interview on another occasion if their condition changes over time.

If the person is a client of an AMHS, the Forensic Medical Officer may consult with the treating clinician to form a view regarding fitness for interview.

The AMHS will facilitate access by police and the Forensic Medical Officer to an inpatient service for assessment of a patient's fitness for interview if requested. Police will advise of any subsequent arrangements required and may request documentation to support a person's non-attendance.

## **Independent third persons**

This should be read in conjunction with Section 8 of this protocol 'Disclosure of information'. A person with a mental illness assessed as fit for interview may nonetheless have a cognitive impairment. If police believe the person has a cognitive impairment, they must arrange for an independent third person to be present during the interview. Police may identify that a person has a cognitive impairment by their words or actions, by asking the person directly, by checking police records of any previous interactions, or by contacting their nearest Mental Health Triage to check whether the person is, or has been, a patient of a mental health service.

This policy applies regardless of whether the person police wish to interview is a victim, witness or suspect.

The role of the independent third person is to:

- facilitate communication between police and the person being interviewed
- provide emotional support to the person being interviewed, and
- ensure that the person understands their rights and the caution. However, they are not the person's legal counsel or advocate and should not make decisions on behalf of the person.

Police may invite the independent third person to read and sign any statement made by the person to indicate that it is a true and correct account of the interview. The independent third person cannot vouch for the content of the statement. The independent third person may be required to appear at court in relation to the interview.

The independent third person may be a close relative or friend who is not associated with the police inquiry or a volunteer trained by the Office of the Public Advocate. Police should not request that clinical staff or the person's treating practitioner perform this role.

### **Support following interview**

The AMHS can arrange debriefing or a supportive interview for patients who have undergone a police interview. During the debrief, a person's mental state can be assessed with particular attention to issues of safety, and to determine if the experience of the interview has had any clinical impacts.

### **Forensic psychiatric reports for the court**

The Victorian Institute of Forensic Mental Health (Forensicare) is responsible for the provision of adult forensic mental health services in Victoria. Forensic mental health is a specialised area within mental health, providing services to meet the needs of mentally disordered offenders, the mental health and justice sectors and the community. Forensic mental health clinicians can conduct forensic mental health assessments at the specialised unit at Melbourne Assessment Prison in relation to cases heard before the Magistrates' Court.

### **References**

Interviewing specific categories of person guidelines, *Victoria Police Manual*  
Taking persons into police care or custody guidelines, *Victoria Police Manual*  
Victoria Police Ready Reckoner: *Responding to a person who may have a cognitive impairment*  
*Chief Psychiatrist's Guideline: Managing persons required to attend police interview or court*, January 2005

## 3. Requests by mental health clinicians for assistance from police

### Urgent requests – safety issues

#### Callout procedure

In most circumstances, clinicians will manage a person requiring assessment, examination or treatment through internal clinical guidelines and procedures.

However, clinicians may request urgent police assistance where:

- there is a genuine and immediate risk of self-harm and injury to any person,
- a person is violent towards the clinician or any other person,
- a person is causing significant damage to property and if not contained may cause further damage,
- a person is believed to have committed a criminal offence,
- a person present is armed with any weapon,
- there are other parties present who pose a threat, or are abusive or violent towards the clinician or any other person,
- the clinician has knowledge or experience of a person's recent prior history of violence and a police presence is reasonably necessary for the clinician's safety, or
- the clinician believes that due to the geographical location, isolated location, time of day or nature of the situation, a police presence is reasonably necessary for safety.

Police will prioritise attendance at these calls as they do any other emergency call.

In these circumstances, clinicians should:

- **call Police Communications directly on '000' (not the local police station)**
- tell the operator their name, telephone number and identify the mental health service
- explain the situation, including:
  - their immediate safety threat level
  - what the person is saying and doing
  - whether the person is affected by alcohol or drugs
  - whether weapons are present
  - who else is present
  - the location of the incident (for example: at the person's home, in an inpatient facility)
- provide details to assist police in identifying the person (name, date of birth, address) and provide any other information that would assist police in determining the appropriate response (for example: typical behaviours, triggers, effective communication strategies, known risks, contact person).

Police Communications will allocate the request to the relevant police unit or supervisor, who will provide an estimated response time and advice on risk management strategies, where necessary.

#### Carriage of police operational equipment

The Department of Health prefers that police, where possible, avoid carrying firearms when attending inpatient services and community mental health services. Nevertheless, the carriage of police operational equipment (firearm, capsicum spray or foam) within a hospital or health facility is a police decision. Police will base their decision on an operational risk assessment, mindful of the consequences of the deployment of capsicum spray or foam in particular, in these environments.

Where police judge that there is no operational necessity to carry their operational equipment, they should store these appropriately in the police equipment safe available in most hospitals and inpatient facilities. The senior registered nurse will have access to the key for the safe and must hand the key to police until they collect their equipment.

### **Critical incident in an AMHS facility**

The senior registered nurse on duty (or their equivalent) is responsible for making any request for urgent police assistance with a critical incident in an AMHS facility.

The senior registered nurse on duty will also brief police on arrival on the specific nature of the situation and assist with the development of a clear plan of action. Police are responsible for decisions about the management of the critical incident according to operational procedures. Clinicians are responsible for decisions about health and treatment matters according to clinical guidelines.

Police must confirm with the senior registered nurse on duty the status of the person concerned:

- If the person is a visitor to the facility, standard police operating procedures apply.
- If the person is a patient of the facility, police must verify:
  - the identity of the patient,
  - the legal status of the patient under the *Mental Health Act 1986*, and
  - the authority of the relevant clinical staff.

The senior registered nurse on duty is responsible for:

- ensuring compliance with the requirements of the *Mental Health Act 1986*,
- arranging for support and debriefing patients and staff of the inpatient service affected by the incident, and
- notifying the family or carers of the patient involved, with the patient's consent, of the incident and keeping them informed of the patient's current health status.

Once the incident is resolved, good practice is for:

- senior police and clinicians to ensure all staff directly involved participate in formal operational incident debriefing, preferably a joint debriefing, and
- the local Emergency Services Liaison Committee to review any issues arising from the incident and document and implement any improvements required.

### **Use of mechanical restraints**

Both police and clinicians have mechanical restraints for use in certain circumstances and subject to reporting and review. Good practice is to use the full range of situational problem-solving approaches before resorting to the use of mechanical restraint, while safeguarding all persons present and property.

The *Mental Health Act 1986* allows the mechanical restraint of a person receiving treatment for a mental illness in an approved mental health service if that restraint is necessary:

- for the purpose of the medical treatment of the person, or
- to prevent the person from causing injury to himself or herself or to any other person, or
- to prevent the person from persistently destroying property.

An authorised psychiatrist or, in the case of an emergency the senior registered nurse on duty, must authorise the use of mechanical restraint. The person must be subject to clinical observation and review at specified intervals.

The use of handcuffs is a police decision and must only be for operational purposes. Police must submit a *Use of Force* form for any such use of handcuffs.

### **Use of seclusion**

An authorised psychiatrist or in the case of an emergency, the senior registered nurse on duty, may authorise the use of seclusion to protect the person or any other person from imminent risk to their health and safety.

Seclusion is not an alternative to police custody for a person apprehended under section 10 of the *Mental Health Act 1986*. Police may be advised by triage in ED to lodge a person in a secure room in the hospital because they are acting aggressively while awaiting assessment or examination. If so, police are responsible for monitoring their safety and for seeking medical attention if required.

### **Use of physical restraint**

The use of physical restraint should be as a last resort to contain the situation and to ensure the safety of the person concerned and the other people present, in accordance with the duty of care held by clinical staff. It is not appropriate except in circumstances of extreme risk for clinical staff to request police attendance solely to apply physical restraint to assist with the administration of treatment to an involuntary patient (for example: for police to hold the person down).

If police are already at a critical incident at a health facility, they may make an operational decision to assist with the physical restraint of a person in order to manage the incident.

Local Emergency Services Liaison Committees should review any police involvement in physical restraint and document and implement any improvements required.

### **References**

Preventative action guidelines, *Victoria Police Manual*  
Operational safety and equipment guidelines, *Victoria Police Manual*  
*Chief Psychiatrist's Guideline: Mechanical Restraint* October 2006  
*Chief Psychiatrist's Guideline: Seclusion* October 2006

## **Non-urgent requests – welfare issues**

### **Callout procedure**

A clinician may request police back-up when responding to the welfare issues of a person with mental illness, including:

- apprehending and returning an involuntary patient
- locating a patient reported as missing
- conducting a welfare check on a patient with current known risks.

A clinician may request this assistance by:

- **calling the police station nearest to where police attendance is sought and requesting to speak to the duty sergeant or senior member in charge at the time**
- providing their name, telephone number and the address of their mental health service
- explaining the situation, including the type and urgency of assistance requested (for example: to apprehend an involuntary patient, locate a missing patient or to accompany clinicians on a welfare check)
- giving identifying information about the person (name, physical description, dress, date of birth, address)
- detailing steps already taken to contact or locate the person
- advising of the legal status of the person (ie. whether they are an involuntary patient)
- providing any other information to assist police in determining the appropriate response (such as known risks, typical behaviours, triggers, effective communication strategies).

The clinician may follow-up this conversation by faxing relevant documentation to the station. It is not appropriate for a clinician to fax a request directly to a police station without any preliminary discussion of the need for police involvement; doing so risks the transmission of insufficient information and delays in police response.

### **Apprehending and returning an involuntary patient**

The *Mental Health Act 1986* provides that in certain circumstances people may be compelled to receive treatment for their mental illness. This may be as an inpatient of an AMHS or while living in the community. An involuntary patient is a person who is:

- on an involuntary treatment order (an inpatient Involuntary Treatment Order or a Community Treatment Order)
- on a restricted involuntary treatment order (a Restricted Community Treatment Order made under section 93 of the *Sentencing Act 1991*)
- on an Assessment Order or a Diagnosis, Assessment and Treatment Order
- a security patient on a Hospital Transfer Order from prison
- an interstate involuntary patient.

An authorised psychiatrist or delegate, the Chief Psychiatrist or a prescribed person within the meaning of section 7 of the *Mental Health Act 1986* may authorise the apprehension and return of an involuntary patient to an approved mental health service if the patient:

- is absent without leave from an inpatient facility
- fails to comply with their community treatment order. When a Community Treatment Order is revoked, the person is deemed to be an involuntary patient absent without leave from an AMHS and **must** return to the approved mental health service. The *Mental Health Act 1986* requires the authorised psychiatrist or delegate (or Chief Psychiatrist if applicable) to make reasonable efforts to contact the person and inform them of the revocation and that they must return to the designated approved mental health service, or
- requires treatment that can only be provided by admission to an approved mental health service.

### **Procedure for seeking the return of an involuntary patient**

In the first instance, clinicians will attempt to contact the person, request that they return to the inpatient unit and offer to assist them in doing so. If appropriate, family members may assist with the return of the person. The person may choose to return of their own accord, or may accept assistance from family, carers or mental health service staff.

If these measures are unsuccessful and there is no significant risk, staff of the inpatient unit and the community mental health service will liaise with each other and attempt to locate and return the person.

The Act authorises the following categories of person to apprehend the involuntary patient absent without leave for the purpose of being returned to an approved mental health service:

- a prescribed person within the meaning of section 7 of the Act
- the authorised psychiatrist or delegate, or
- an officer of the Department of Health authorised by the Chief Psychiatrist.

Prescribed persons (such as ambulance/paramedic MICA officers) may enter premises and apprehend a person in order to return them to the inpatient service. This includes the use of reasonable restraint if necessary to enable the safe apprehension and transport of the person.

The decision about the most appropriate form of transport should reflect the least restrictive option suitable for the current risk assessment (for example: transport by family or friends, or for CAT staff to use an agency vehicle wherever possible).

### **Police involvement**

Where police involvement is required, section 43 of the Act authorises police to apprehend an involuntary patient who is absent without leave or who has had their treatment order revoked, in order to return them to an approved mental health service. The approved mental health service will only request police assistance in apprehending and returning the involuntary patient where a current risk assessment and knowledge of the patient indicate probable safety issues.

Clinicians in the inpatient unit will provide a documented request, such as the *Authority to Apprehend* form, to instigate the return of the patient to the unit. The document or form can be faxed to the police and will include a description of the patient, the status of the patient and the time when the order expires. For persons who have had their Community Treatment Order or Restricted Community Treatment Order revoked, police can sight a copy of the relevant form to proceed.

When requesting police assistance with apprehending and returning an involuntary patient, the AMHS will advise police of:

- the involuntary order to which the person is subject
- whether police assistance is required to locate the person (they are missing) or to apprehend and return the person (their order has been revoked but their whereabouts are known)
- the safety issues involved: the level of concern held by staff for the safety of the person and/or the community and the urgency of the situation
- the name and address of the AMHS providing treatment to the person.

Wherever possible and appropriate, a mental health clinician should accompany the police. Any decision about whether reasonable grounds exist to enter a premise is ultimately a police decision. Police procedures for the reporting of any property damage and the reimbursement of costs also apply.

Police will complete a *Mental Disorder Transfer* form and notify the Mental Health Triage that they have apprehended the person and the likely time of their return. Where possible, police will return the person to their treating AMHS, provided it does not prolong the time that the person is in police custody (for example if the police locate the person a considerable distance from their home). Otherwise, police should take the person to the nearest approved mental health service.

Mental health staff will arrange for the transfer of care upon police arrival at the Health Service (the person does not need to remain in police custody pending assessment) and, if applicable, the subsequent return to the appropriate AMHS. It is the responsibility of the service making the request to locate an available inpatient bed.

#### **Interstate apprehension orders**

Section 93K of the *Mental Health Act 1986* authorises the apprehension and return of a patient who has absconded from either a NSW or South Australian interstate health service to Victoria. The interstate service will issue an Interstate Apprehension Order (IAO) that authorises the apprehension and return of the patient. Pending their return to a facility in the patient's home state, the Act allows the patient to be taken to the nearest Victorian approved mental health service.

The interstate service will determine the most appropriate authorised persons to apprehend the patient and will fax the IAO to the persons nominated. The list of authorised persons includes police, ambulance officers and clinicians. In most cases the interstate mental health service will negotiate directly with the Victorian mental health service regarding the return of an interstate involuntary patient, without police involvement.

Where the interstate service's risk assessment indicates a need for police involvement, the interstate service will fax the IAO to Records Services Division, Victoria Police. Records Services Division will create and record a *Person Whereabouts Desired* (VP Form L12) and *Person Physical Description* (VP Form L10) report on LEAP for each IAO. The interstate service will provide a copy of the IAO to the Office of the Chief Psychiatrist for security and forensic patients. There is no requirement for police to lodge the executed IAO at court.

The person executing an IAO must:

- confirm the person's identity,
- confirm with the interstate service or their own Records Services that the IAO remains outstanding,
- notify the Triage of the nearest AMHS of the patient's apprehension and estimated time of arrival,
- arrange for a copy of the IAO to be faxed to the receiving AMHS if it is not practicable to have a copy of the IAO in their possession,
- formally transfer responsibility for the patient to a clinician as soon as practicable upon arrival at the AMHS ( there is no requirement for police to retain custody of the patient pending an assessment or examination), and

- complete the IAO Execution Details form and forward it to the interstate Facility that issued the Civil IAO. The interstate Facility that issued the order will notify any other nominated authorised persons of the apprehension. The AMHS will fax a copy of the execution details to the Victorian Chief Psychiatrist, where the IAO concerns a security or forensic patient. Police must also fax a copy of the form to Records Services Division, in order to update LEAP.

Transport will be to the AMHS that is the nearest geographically to where the patient is apprehended.

The Victorian mental health service is responsible for arranging for the timely return of the patient to their home state.

If an interstate involuntary patient is not subject to an IAO, only the powers in the *Mental Health Act 1986* apply.

### Forensic patients

Police can also apprehend a forensic patient on a custodial or non-custodial supervision order who needs to attend an appropriate mental health facility (Thomas Embling Hospital). The same procedures apply as for apprehending other categories of involuntary patient.

### References

*Sections 3, 9B, 42, 43 and 93K, Mental Health Act 1986*  
*Section 30, Crimes (Mental Impairment and Unfitness to the Tried) Act 1997*  
*Escapees and absconders guidelines, Victoria Police Manual*  
*Chief Psychiatrist's Guideline: Community treatment orders November 2005*

### Locating a patient reported as missing

If a patient leaves without notice and clinicians hold fears for the welfare of the patient and of others, they can report the disappearance to police. Police can take a missing person report for any patient who meets the following criteria:

- their whereabouts are unknown, and
- there are genuine fears for the safety or concern for the welfare of that person.

To assist with the investigation, clinicians should provide the following information to police, as appropriate:

- the person's full name, date of birth, address and a recent photograph, if available
- a description of the person's physical appearance and the clothes they were wearing
- any medical considerations (for example: taking medication) or vulnerability (for example: infirmity)
- details about the circumstance surrounding the person going missing such as the activity and location
- the precise location where the person was last seen
- features of the person's presentation, such as mood, that may influence how police approach the person
- any significant events leading up to the incident that may have contributed to the person leaving
- confirmation that the facility and immediate surrounds have been thoroughly searched
- the person's legal status: voluntary or involuntary (including Community Treatment Orders and Restricted Community Treatment Orders)

- details about the person's networks and family to assist with where the person might be found
- details of what enquires have been made with family and friends
- any likely destinations or places of interest that the person frequents
- whether the person poses a risk to themselves or others
- the name and contact details of the clinician and the AMHS.

AMHS **must** notify police if they locate the patient or if the patient returns to the service without police involvement. This will allow police to update their missing person records and to end the active investigation.

### **Voluntary patients**

At times, voluntary patients may choose to discharge themselves or leave hospital against medical advice. When this occurs, the inpatient unit staff will make a judgement based on the person's current mental state as to whether to change their status to an involuntary patient, in order to ensure the patient remains safe and has access to the most appropriate form of treatment.

Police have no apprehension power for a voluntary patient reported as missing and will treat the patient as a general missing person. This means that if police find the patient and have no concerns about their current welfare and the patient does not wish to return to an AMHS, police can only notify the service that the patient has been located but cannot divulge their whereabouts without the patient's consent.

### **Involuntary patients**

It is important to note that involuntary treatment in a mental health facility usually does not involve detention. Nonetheless, it is good practice for mental health services to have in place processes and infrastructure that minimise the opportunity for patients to leave without notice, particularly for patients with a pattern of such departures.

Police do have an apprehension power for an involuntary patient reported as absent without leave and missing. This means that when police locate the patient, they will confirm with the AMHS that the person is an involuntary patient. Once confirmed, police will follow the procedures for apprehending and returning an involuntary patient.

The AMHS must update police on any change to the legal status of the patient and police must confirm this status when they locate the patient. For example, an involuntary patient who has been absent for a continuous period of 12 months is automatically discharged, unless the Chief Psychiatrist or authorised psychiatrist applies to the Mental Health Review Board for the patient to remain an involuntary patient. If the patient is no longer an involuntary patient (there is no longer an apprehension power), police will treat the patient as a general missing person.

If the patient is not located within 60 days or when otherwise believed necessary, police will seek the relevant medical records, dentals and DNA samples (such as hair brush or toothbrush). Health services should hold personal patient items as per service policy and procedure guidelines.

## Children

In the case of a child or young person who is missing from a Department of Human Services placement, the existence of a Children's Court search warrant does not replace the requirement for police to take a missing person report.

## References

Sections 3, 9B, 42 and 43, *Mental Health Act 1986*  
Missing persons investigations guidelines, *Victoria Police Manual*  
Escapees and absconders guidelines, *Victoria Police Manual*

## Conducting welfare checks

When an AMHS has serious and significant concerns about the current welfare of a patient, but checking on the person poses a risk to the clinician or to any other person present (such as ambulance paramedics), the service may request police support via the callout procedures for non-urgent requests.

In requesting police support, the clinician should advise:

- the name and address of the patient, to enable police to conduct a records check,
- the nature and urgency of the welfare concerns, giving as much notice as possible,
- the attempts made to contact the patient, including the contacting of family or friends,
- the known current risks that the patient presents,
- the type of premise involved, and
- who is, or will be, present onsite, including the contact phone number of the attending clinician.

Police and the clinician will then arrange a time and a location at which to meet. It is not appropriate for police to conduct a welfare check without a clinician also present.

During the welfare check, the clinician is responsible for assessing the mental health needs of the patient and for making any arrangements necessary to link the patient into the appropriate service (for example transport and admission to an inpatient facility). Police are responsible for the safety of all persons present, which may involve making the operational decision to enter a premise. This decision is ultimately a police decision and existing police procedures for the reporting of any property damage and the reimbursement of costs apply.

## Reporting incidents to police

People with mental illness have the right to treatment equal to that of any other Victorian. At times, this may involve providing additional or specialised support in order to protect this right when such individuals are involved with the criminal justice system as a victim, witness or suspect.

### Principles for reporting an incident to police

Victoria Police encourages the reporting of all crime. In deciding whether to report an incident, clinicians should consider the following:

- the best interests of the victim,
- the nature and seriousness of the alleged incident, and
- the duty of care to the alleged victim, other persons and the broader community.

If unsure about whether to report an incident to police, clinicians can contact police and discuss particular concerns. Police can then advise of the options available, including making a formal report, referral options (including counselling) and civil pathways.

Police will support victims throughout the reporting process. Specialist police units can provide assistance and advice to clinicians and patients on more complex matters such as family violence, sexual assault and child abuse.

To report an incident, clinicians should call Police Communications ('000'). To seek advice, clinicians should call their local police station and speak to the duty sergeant or senior member in charge at the time.

### **Physical and sexual assault**

Assault is an offence under the *Summary Offences Act 1966* and assault causing injury and sexual assault are indictable offences under the *Crimes Act 1958*.

Once police commence an investigation into an alleged assault, they will interview the victim and any witnesses, obtain statements, collect evidence and finally determine whether there is sufficient evidence for a prosecution. Clinical staff can assist police during the early stages of this process by providing support to the persons involved and minimising any contamination of evidence. Early preservation of evidence (such as clothing, personal belongings and furniture) is crucial to ensure there is no loss of evidence.

Clinical staff, where possible, can help preserve potential evidence by considering the following:

- The clothing of the victim and/or offender may be required as exhibits for forensic testing.
- Try not to disturb the scene/s of the alleged incident (for example: kitchen, bedroom, inpatient bed).
- If possible, separate the victim, witnesses and suspect/s.
- Do not engage in repeated questioning of the victim, witness or suspect as this may contaminate the accuracy of the person's recall of the event.
- Take notes of the incident (especially times and dates) and include observations and conversations.

### **Sexual assault**

The Chief Psychiatrist's Guideline on the response of AMHS to sexual assault in adult inpatient units sets out the relevant legislation and policy, and establishes a minimum standard for prevention and clinical management of sexual activity and the appropriate staff response to patients who report inappropriate sexual activity.

The first priority for police in sexual assault cases is the care of the victim. When police receive a report of a sexual assault, they will refer the case to a Sexual Offences and Child Abuse Investigation Team (SOCIT). These units comprise specialist police trained to investigate child abuse and sexual assault. When responding to a report of sexual assault, police follow specific procedures for medical examinations, timeframes and collection of evidence to ensure the best outcome for the victim. They work closely with the Victorian Institute of Forensic Medicine and the Centres Against Sexual Assault (CASA).

If police identify that the victim has a mental illness or is a patient of an AMHS, police may contact the case manager or support worker if the victim wishes. After hours, police may liaise with the local Mental Health Triage service. This support is in addition to the advocacy and support provided by CASA. The CASA counsellor/advocate provides the primary support to the victim during this process.

Where the victim has, or police suspect they have, a cognitive impairment, police will arrange for an Independent Third Person to be present, but not for any forensic medical examination that the victim may undergo. Police will take the statement from a victim believed to have a cognitive impairment by way of a Visual Audio Recorded Evidence (VARE) statement.

### **Visual audio recorded evidence (VARE)**

The purpose of VARE interviews is for police to produce electronically recorded statements that are admissible as evidence. VARE interviews spare vulnerable witnesses from having to repeat their evidence to various professionals or to give evidence-in-chief in open court and provide a verbatim account of the crime contemporaneous to the incident. Only qualified police can take a VARE statement.

Police may take a VARE statement instead of a written statement from a child or a person with a cognitive impairment who is:

- a victim of, or witness to, a sexual offence, an offence of sexual servitude, or an indictable offence involving injury or threat of an injury, or
- involved in a serious investigation, such as a coronial inquiry.

Police can only take a VARE statement with the person's consent and must arrange for an Independent Third Person to be present during the interview. It may also be appropriate for a mental health service clinician to sit in on the interview for the sole purpose of providing emotional support to the victim. If this occurs, the clinician must clearly state the following at the start of the interview:

*'My name is ..., I am a case manager from ... I am in this room solely to provide support to ... I will not be answering any questions or providing any advice and I am not present as an independent third person'.*

### **Physical assault**

Health services should refer to their internal policies on physical assault and occupational violence. There are also other sources of advice and guidance on this matter, referred to below.

### **Child abuse and neglect**

For child protection purposes, the Children, *Youth and Families Act 2005* defines a 'child' as a person less than 17 years of age or, if a protection order exists, a person who is under the age of 18 years. In the case of an alleged offender, a 'child' is a person aged 10 years but less than 18 years at the time of the offence.

Victoria Police is the lead agency for investigating suspected criminal matters that arise in child abuse and neglect cases. As with sexual assault, police will refer cases to the specialist SOCIT. Not all cases of child abuse and neglect involve a criminal investigation; however, they will generally involve an aspect of joint response by child protection and police. Victoria Police has a statutory requirement to report protective concerns to Child Protection, while for AMHS it is best practice.

## Family violence

The *Family Violence Protection Act 2008* defines 'family violence' as behaviour towards a family member that is: physically or sexually abusive; or emotionally or psychologically abusive; or economically abusive; or threatening; or coercive; or controls or dominates the family member and causes them fear for their safety or well-being or that of another person.

This also includes exposing a child to the effects of the above behaviour. It is important to note that behaviour can constitute family violence even if it is not a criminal offence.

The definition of a family member now covers persons with a disability and/or mental illness who are in a family-like relationship with their carer. For example, this definition may extend to informal (ie. voluntary) and involuntary community-based clients and their carers. In circumstances where a relationship does not fit under the definition of family member, the provisions of the *Personal Safety Intervention Order Act 2010* may apply.

## Protection from family violence

Options are available to protect a person from family violence or stalking.

**Family Violence Intervention Orders:** An application for a Family Violence Intervention Order can be made by a person involved in a current or past family relationship under the provisions of the *Family Violence Protection Act 2008* or an application for an Intervention Order can be made under the *Personal Safety Intervention Order Act 2010*. Police, the affected family member or person, the affected family member's (or person's) guardian may make an application for an intervention order to any Magistrates' Court.

**Family Violence Safety Notices:** Police can issue Safety Notices for use outside of court hours. The notices make it easier for victims of family violence to remain in their homes and have the perpetrators of family violence (respondents) excluded. If police suspect a perpetrator has a cognitive impairment, they may not issue a notice but consider an alternative resolution, such as a complaint and warrant for an intervention order. Police may consult with AMHS staff to address issues around crisis accommodation and follow-up support for victims, witnesses and/or perpetrators, who are clients of the service.

**Formal and informal referrals:** Police will make a formal referral to a local family violence service where they have serious concerns for the physical, mental or psychological health or welfare of the affected family member. Police may make an informal referral (provide contact information) to mental health services.

## References

- Section 5, *Family Violence Protection Act 2008*
- Division 5, Part 8.2, *Criminal Procedure Act 2009*
- Section 3, *Children, Youth and Families Act 2005*
- Victoria Police *Code of Practice for the Investigation of Family Violence*
- Victoria Police *Code of Practice for the Investigation of Sexual Assault*
- Victoria Police Ready Reckoner: *Responding to a person who may have a cognitive impairment Protecting children: Protocol between Department of Human Services and Victoria Police Violence*
- Worksafe 'Prevention and management of aggression in health services: a handbook for workplaces' Ed 1 2008
- <http://www.health.vic.gov.au/nursing/promoting/noviolence>
- Chief Psychiatrist's *Guideline: Promoting sexual safety, responding to sexual activity and managing allegations of sexual assault in adult inpatient units* 2009
- Interviewing specific categories of person guidelines, *Victoria Police Manual*
- Family violence guidelines, *Victoria Police Manual*
- Protecting children guidelines, *Victoria Police Manual*
- Assault investigations guidelines, *Victoria Police Manual*
- Sexual offence investigations guidelines, *Victoria Police Manual*

## Victim support

Mental health clinicians and police should work together to ensure that victims receive appropriate support in order to participate in police investigations as fully as possible, including using communication aids and/or involving an independent third person, where necessary.

The *Victims' Charter Act 2006* sets out the obligations on police for providing support to victims. This involves:

- providing the victim with a copy of the Notice to Victim form, which includes details of the investigating officer and information about support services and entitlements available to them. If requested, police will assist in referring the victim to these services. Mental health clinicians may assist police in communicating with the victim effectively
- ensuring the victim is aware of their right to complete a Victim Impact Statement. Mental health clinicians may assist victims in completing a Victim Impact Statement
- advising the victim that they can be notified of the progress of the case, including information about the court process and court results
- considering any concerns expressed by the victim about their safety and welfare in any application for bail or contact with the accused in court
- providing all such information to the victim in a format that meets their communication needs. This may involve doing so when a carer or guardian is also present.

Victims are also eligible for a copy of *The Victim's Guide to Support Services and the Criminal Justice System*. A copy of the guide is also available at [www.justice.vic.gov.au/victimsofcrime](http://www.justice.vic.gov.au/victimsofcrime).

The Chief Psychiatrist's Guideline concerning sexual assault also provides advice regarding support for the person reporting an assault.

## Civil action

Police will investigate all reports of alleged crimes. In some cases, there will be insufficient evidence to take the matter to court. Police will advise the victim of options to take civil action if they so desire. Further information is also available in *The Victim's Guide to Support Services and the Criminal Justice System*.

## Victim impact statements

A Victim Impact Statement explains how a crime has harmed the victim. It is a written statement signed by the victim and presented to court during the sentencing of the defendant.

Police will ensure that a victim is aware of their right to complete a Victim Impact Statement but cannot assist the victim in preparing their statement. Clinical staff may assist a victim in completing a Victim Impact Statement. For further information and assistance, both police and clinicians can refer the victim to the Victims Support Agency or *The Victim's Guide to Support Services and the Criminal Justice System*.

## References

Victim support guidelines, *Victoria Police Manual*

Chief Psychiatrist's Guideline: *Managing persons required to attend police interview or court*, January 2005

## **Deaths involving a person with mental illness**

### **Reportable deaths**

The *Coroners Act 2008* requires health services to notify of a 'reportable death' and to provide information to police as part of the investigation into the death on behalf of the Coroner. Hospitals and AMHS must report any death that occurs in care to police immediately via Police Communications ('000').

All deaths (from any cause) of persons who are involuntary, security or forensic patients must also be reported to the Chief Psychiatrist.

### **Inquest investigations and brief preparation**

Police will investigate the circumstances surrounding a person's death and compile an inquest brief for the Coroner. In all cases once the person is pronounced dead, police will initially treat the death as a crime scene. If the death occurs on the premises of a health service, clinicians should leave the scene undisturbed and assist police with information on the client's history, circumstances prior to their death, and interactions with any potential witnesses. The Director of Clinical Services in the AMHS is the key contact for police in these enquiries.

As part of their investigation, police may contact the Mental Health Triage nearest to where the deceased person resided to determine whether the deceased person had been a client of a mental health service. If the person was at any point a client, Triage will refer police to the authorised psychiatrist or their delegate to obtain the information required.

Under sections 39 and 40 of the *Coroners Act 2008*, a Coroner may authorise in writing a member of the police force to enter, inspect, copy and/or take possession of specified documents or items, including medical records, reports or opinions on behalf of the Coroner. Section 103 makes it an offence for any person to hinder or obstruct a Coroner or a person acting under a Coroner's authority (ie. police) in exercising powers under this Act.

### **References**

Sections 4, 39, 40 and 103, *Coroners Act 2008*  
Deceased persons guidelines, *Victoria Police Manual*  
Inquests guidelines, *Victoria Police Manual*  
*Chief Psychiatrist's Guideline: Reportable deaths* Dec 1999 – Revised 2004

## 4. Transport

### Basis for transport

A person with mental illness may require transport to a hospital emergency department or mental health service for psychiatric assessment, examination or treatment. The basis for such transport includes:

- under a *Recommendation for Involuntary Treatment* (Schedule 2)
- under an *Authority to Transport without Recommendation* (Schedule 4)
- under an Involuntary Treatment Order (Schedule 6)
- apprehension by police under section 10 of the *Mental Health Act 1986*
- the revocation of a Community Treatment Order or Restricted Community Treatment Order
- apprehension and return of an involuntary patient absent without leave.

Consistent with the objectives in the *Mental Health Act 1986*, in all instances, **transport should be by the least restrictive means possible** and in a way that provides for the care of the person with a mental illness and the protection of the public and minimises interference with the person's privacy, dignity and self-respect. This means that the first option for transport should be family, friends or mental health staff using an agency vehicle.

Ambulance Services Victoria is responsible for providing emergency transport for people with mental illness. An ambulance must transport:

- a person who has been sedated for the purpose of safe transport to a psychiatric inpatient service for admission
- a person with co-occurring serious physical health needs.

Under the *Ambulance Fee Guidelines 2008*, ambulance transport in these circumstances is at no charge to police or the mental health service.

For medium or high acuity patients, a registered medical practitioner must approve all referrals to a Non-Emergency Patient Transport service.

### Transport without a recommendation

Under section 9A of the Act, a mental health practitioner may complete an *Authority to Transport without Recommendation* if a registered medical practitioner is not available within a 'reasonable' period to consider making a *Recommendation* and the person meets the criteria for involuntary treatment (section 8 of the Act). The provision allows for the person to be taken to an approved mental health service for examination by a registered medical practitioner to make a *Recommendation*.

What is reasonable will vary from case to case. If, for example, a person becomes increasingly disturbed because of the wait, it might be reasonable to authorise transport without further delay. The reasonableness of any decision will be judged against the clinical needs and the safety of the person and others, together with the availability of a registered medical practitioner (including consideration of contacting a local GP or a forensic physician).

## Use of restraint

The client may be extremely agitated, fearful, or angry at the time of transport to a mental health service in an ambulance or other vehicle. The most important consideration in transporting the person is safety, and where it will maintain the safety of the person and of others involved, the *Mental Health Act 1986* allows for the use of restraint. A prescribed person may use only such restraint as is reasonably necessary for the safe transport of the person.

Any health service or police personnel who use a form of restraint must document its use according to their respective agency's procedures.

## Police involvement

### Limits

Police involvement in the transport of a person with mental illness is appropriate when:

- the person is in police custody, or
- the person poses a risk of harm to themselves or to others.

Police involvement can take several forms:

- accompanying the person in another vehicle (eg. an ambulance, mental health agency vehicle),
- escorting another vehicle (such as. an ambulance, mental health agency vehicle), or
- conveying the person in a police vehicle.

Clinicians are responsible for determining whether to request police involvement. The decision should reflect a clinical risk assessment of both the person's current and previous behaviour.

Police are responsible for determining the most appropriate form of police involvement, mindful that police cannot delegate their custody (for example: for a person they apprehend under section 10).

### Requesting ambulance/police assistance

Either a mental health professional or an ambulance/MICA paramedic officer may request police involvement in the transport of mental health patients via Police Communications ('000').

If a mental health professional wishes to request both police involvement and ambulance attendance, the mental health professional will contact the police and ambulance service concurrently and arrange to meet at a common location. The ambulance communications centre will coordinate meeting arrangements.

### Transport options

Where police, with advice from the attending clinician/s, determine that transport in a police vehicle is necessary, they will:

- ensure a minimum of two police are involved,
- use handcuffs only when necessary,
- be mindful of the risk of positional restraint asphyxia,

- **never** transport a person who is under sedation or who has serious physical health needs, and
- transport the person to the nearest hospital or inpatient psychiatric service, unless notified by Mental Health Triage of the appropriate destination prior to their arrival at the nearest service. Police are not responsible for transport between hospitals or inpatient services; mental health clinicians should maintain care of the person until an ambulance or agency vehicle can transport them.

Wherever possible, police will notify the nearest Mental Health Triage via Police Communications of their estimated time of arrival and the gender of the client.

If the hospital is on bypass, the Mental Health Triage will advise police of an alternative arrangement, mindful that it is not in the best interests of the client to remain restricted in police custody any longer than is necessary.

### **Arrival at the hospital or area mental health service**

On arrival, police will liaise with the staff member responsible for arranging assessment and, with appropriate assistance from staff, move the person from the vehicle to a place where hospital staff can manage them safely. Police will hand over the *Mental Disorder Transfer form* outlining the circumstances in which police encountered the person.

If a bed is not available, police are not responsible for providing transport between health services.

### **Review**

Emergency Services Liaison Committees should review all police transports of patients, rather than transport by ambulance or other means, to assess the appropriateness of the decision.

### **References**

Sections 9, 9A, 9B and 10, *Mental Health Act 2009*

Preventative Action guidelines, *Victoria Police Manual*

Taking persons into police care or custody guidelines, *Victoria Police Manual*

Department of Human Services guidelines: *Ambulance transport of people with a mental illness*, February 2002

Department of Human Services Non-emergency patient transport services – *clinical practice protocols manual* (February 2006)

## 5. Disclosure of information

Consent is the key issue in relation to privacy. If a person provides informed consent for personal information to be disclosed, then the disclosure is permitted only to the extent of the consent.

Staff should document the disclosure of personal or health information in the appropriate record.

There is an existing framework to protect against the unlawful or inappropriate disclosure of personal information. The framework also facilitates disclosure where it is lawful to do so in order to prevent injury or risk to the client or another member of the public.

### Information that mental health clinicians can disclose

A clinician who discloses information to police in any of the circumstances below must document the disclosure on the client's clinical record, including the reasons for disclosure. Where clinically advisable and at an appropriate time, the clinician should communicate the disclosure to the person.

#### ***Mental Health Act 1986***

Section 120A of the *Mental Health Act 1986* is the principal law regulating the disclosure of information to police concerning clients of mental health services. Although the *Health Records Act 2001* is the principal law governing the collection and use of health information by clinicians, it does not override the legislative regime in section 120A of the *Mental Health Act 1986*.

Section 120A(3)(a) permits the disclosure of information with the consent of the client. It is good practice to seek the consent of the patient before disclosing information wherever reasonable and practicable (involving the patient in case planning with mental health and emergency services).

**However, the Act also provides for the disclosure of information to police without patient consent in specified circumstances.**

Section 120A(2) permits a mental health service to disclose information to police if the information is reasonably required to carry out the functions or exercise powers under the *Mental Health Act 1986* or any other Act.

Subsection 120A(3)(b) allows the "giving of information to a court in the course of criminal proceedings" that have already commenced and only under subpoena.

Subsection 120A(3)(ea) links to the Health Privacy Principles in the *Health Records Act 2001*, which allow the disclosure of information to police in specific circumstances:

- Health Privacy Principle 2.2(h) permits a mental health service to use or disclose information to reduce or prevent:
  - a serious and imminent threat to a person's life, health, safety or welfare, or
  - a serious threat to public health, safety or welfare.

The information disclosure must only be to someone who can act to prevent or lessen the threat, such as the police, and only be the information necessary to achieve that purpose.

- Health Privacy Principle 2.5 permits the disclosure of health information to police:
  - if a patient is suspected to be or is deceased
  - is suspected to be missing or is missing, or
  - has been involved in an accident or other misadventure and is incapable of consenting to the disclosure.

The disclosure of information in these circumstances should only be to the extent reasonably necessary to identify the individual, to ascertain the identity and location of family members for compassionate reasons, or to assist in the identification of the person. If the individual is missing or has been involved in an accident or misadventure, the disclosure should not be contrary to any wish expressed by the individual before going missing or becoming incapable of consenting. However, if police know or suspect the individual is deceased, the wishes of the individual expressed prior to their disappearance should not prevent clinicians from disclosing the health information under HPP 2.5.

To request such information, police should contact their nearest Mental Health Triage and outline the information they require and the purpose. Based on this outline, the Triage clinician will determine whether it is appropriate for them to provide the information directly to police (in an emergency or to provide referral details such as the name of the treating practitioner) or to refer the request to the authorised psychiatrist or their delegate (in order to provide or discuss client information).

### **Firearms Act 1996**

Under section 183 of the *Firearms Act 1996*, a health professional is immune from civil and criminal liability if they notify police that they believe that a client who has a firearms licence or intends to apply for a licence is not a fit and proper person to possess, carry or use a firearm. This provision overrides s.120A of the *Mental Health Act 1986*, section 39 of the *Disability Act 2006* and section 141 of the *Health Services Act 1988*.

Any health professional defined in s.183(4) of the Act can notify police by either contacting Police Communications or advising attending police.

The notified police member will:

- obtain details of the patient (name and address), other persons at risk and/or address at which risk may occur (where relevant), firearms, (type, quantity, location and source where known), circumstances or risk/threat and factors related to the client's condition
- assess the urgency of the police attendance required, and inform the caller of same
- decide on the most appropriate type of police unit to attend, taking into account any concerns expressed by the caller (for example plain clothes members in unmarked vehicle)
- arrange the dispatch of a police unit to speak directly to the health professional and provide the above details to the attending police unit.

The responsibilities of the attending police are to:

- obtain full details of the patient, including the circumstances meeting the criteria for notifying police. Health professionals may provide internal documents with these details, however police must still check and confirm the details with the caller
- obtain all possible information regarding the patient's access to firearms
- where appropriate, take action to prevent the client from obtaining or retaining access to firearms, or causing harm to themselves or others; and/or where appropriate complete a Person Warning Flag and send a report to the Manager, Licensing Services Division for consideration of firearms licence suspension or cancellation
- advise the notifying health professional of the decision on the patient's licence and firearms access so that the health professional can update the patient record and make informed future risk assessments.

## Information that police can disclose

The following two Victorian privacy acts apply to Victoria Police:

### ***Information Privacy Act 2000***

This Act regulates the collection and handling of personal information. Personal information means information or an opinion (including information or an opinion forming part of a database), that is recorded in any form, about an individual whose identity is apparent, or can reasonably be ascertained but does not include information to which the *Health Records Act 2001* applies. Examples include the information that police collect through performing their law enforcement or community functions, such as names, dates of birth, addresses, contact details, and criminal histories.

Generally, police only use or disclose personal information in order to carry out policing functions. However, IPP 2.1(d) of the Act provides police with an exemption where they believe that the use or disclosure of personal information is necessary to lessen or prevent:

- a serious and imminent threat to an individual's life, health, safety or welfare, or
- a serious threat to public health, public safety or public welfare.

This is not a blanket exemption. Police must base each decision to disclose on the specific circumstances of a situation. For instance, police may consider it appropriate to disclose to mental health clinicians information that would inform the assessment of a person apprehended under section 10 of the *Mental Health Act 1986* (for example for previous attempts at suicide or self-harm) or assist with the safe management of the person (warning flags for violence). The disclosure of criminal history information will generally be inappropriate.

### ***Health Records Act 2001***

This Act regulates the handling and management of health information. Health information means information or opinion about:

- the physical, mental or psychological health (at any time) of an individual,
- a disability (at any time) of an individual,
- an individual's expressed wishes about the future provision of health services to him or her, or
- a health service provided, or to be provided, to an individual

that is also personal information. Health information also includes other personal information collected in providing a health service. There is no general law enforcement exemption in the *Health Records Act 2001* as there is in IPP 2.1(d) of the *Information Privacy Act 2000*.

However, specific provisions in other Acts (such as section 120A of the *Mental Health Act 1986*) take precedence over these privacy provisions.

To request such information, mental health clinicians should contact the duty sergeant or senior member in charge at the time of their nearest police station and outline the information they require and the purpose. Based on this outline, police will determine whether it is appropriate for them to provide the information. Police may request that the clinician follow-up this conversation with a faxed written request.

## Factors to consider when deciding to disclose

The decision to disclose information will require individual judgement, based on professional expertise and consideration of the following factors:

- Is the disclosure authorised under law? If not, the information must not be disclosed.
- What is the purpose for disclosing the information?
  - Can you serve the purpose by providing de-identified information?
- What is the minimum information necessary to serve the purpose?
- What is in the best interests of the patient and the community?
  - Is it possible to obtain patient consent to disclose the information?

A decision to disclose that takes into account these factors and made in good faith will be consistent with the *Victorian Charter of Human Rights and Responsibilities Act 2006*.

### References

- Section 120A, *Mental Health Act 1986*  
Section 3 and Schedule 1, *Health Records Act 2001*  
Section 183, *Firearms Act 1996*  
Section 3 and Schedule 1, *Information Privacy Act 2000*  
Obtaining information from external organisations guidelines, *Victoria Police Manual*  
Use and disclosure of information policy rule, *Victoria Police Manual*  
Regulatory responsibilities guidelines, *Victoria Police Manual*  
Department of Human Services: Program Management Circular: *Confidentiality under the Mental Health Act*, November 2008

## 6. Liaison

Effective liaison between police, mental health services, ambulance and hospital emergency departments at all levels, is fundamental to delivering the objectives in the Act. This protocol provides the framework for liaison.

### Local - Emergency Services Liaison Committees

#### Description

There are 21 Emergency Services Liaison Committees (ESLCs) operating across the state, based on the AMHS catchment areas. These committees comprise senior staff from the local police, ambulance, hospital emergency department and mental health services, as well as consumer and carer representatives.

The role of the committees is to:

- develop and update local protocols for inter-agency service cooperation and coordination,
- address operational service issues, including any use of force, restraint or police transport,
- agree on joint case plans for shared patients, particularly those who present frequently and/or who have multiple and complex needs,
- arrange inter-agency training and information sessions to share knowledge and skills, including induction sessions and ride-alongs, and
- inform the corporate Inter-departmental Liaison Committee of ongoing or systemic issues requiring attention, local initiatives and achievements, and recommendations.

Each local Emergency Services Liaison Committee is responsible for developing terms of reference to fulfil the role of the committee described above. Committee members are responsible for communicating to their respective staff the process for submitting issues to their emergency services liaison committee.

#### Local protocols

Each committee is responsible for translating this state protocol into a local protocol that reflects their particular communities, services and clientele. The local protocols should document agreed matters such as:

- contact details and processes
- callout criteria
- service responses and standards
- case planning
- meeting schedules
- dispute resolution.

Committee members are responsible for ensuring their respective staff are aware of, and can access a copy of, their local protocol.

Committees are required to submit the minutes of their meetings to the Inter-departmental Liaison Committee on a quarterly basis in order to advise of any matters requiring inclusion in the state protocol.

## Case planning

Joint planning of the responses to a shared patient, a person who presents frequently to services, or to a vulnerable person, enables appropriate, collaborative and timely interventions. It also allows the pooling of knowledge about a person's risks, behaviours and effective communication strategies in order to make informed decisions intervene early and minimise any harm to the person or to others. However, the information shared should be the minimum required for operational response and must still comply with privacy regulations.

Where possible, the patient should participate in the case planning so that they are aware of the responses put in place. Support people (such as family members, guardians or carers) may also be involved.

Committees should review the relevance and content of a case plan regularly. The local police mental health liaison officer should file the case plan and record its existence on a Mental Disorder LEAP Flag.

## Local dispute resolution

Disputes should be resolved in a manner that ensures:

- the rights of the person with mental illness are protected and promoted,
- differences are resolved at the most immediate level and as soon as they arise,
- local management decision-making is used when immediate level processes have not resolved the dispute, and
- the process is documented in accordance with the requirements of each organisation.

When a dispute arises, staff should in the first instance endeavour to clarify expectations, capacity and objectives. Where necessary, staff may need to raise the issues with their local management, including the police Mental Health Liaison Officer, for resolution. In finding a resolution, staff should refer to respective agency operational policies and the guidelines provided in this protocol.

If the service delivery issues still cannot be resolved, or the problems are ongoing, staff should refer them to their Emergency Services Liaison Committee for formal discussion, resolution and documentation in the minutes. If the issue has policy implications, the Emergency Services Liaison Committee should bring the matter to the attention of the Inter-departmental Liaison Committee.

## Corporate – Inter-departmental Liaison Committee

The Inter-departmental Liaison Committee is a forum where senior representatives from Victoria Police, the Department of Human Services, the Department of Health, Ambulance Victoria and consumer and carer stakeholders meet quarterly to improve system responses involving police, ambulance, mental health and disability services to people with complex needs.

The objectives and functions of the committee are:

- to strengthen cross-portfolio communication at the local, regional and statewide level by:
  - reporting initiatives, strategies and legislative proposals from within each portfolio
  - fostering cross-portfolio training and education initiatives

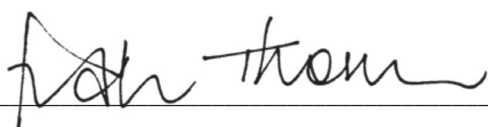
- identifying good practice, local practice that is inconsistent with this state protocol and the Ambulance Guidelines, and sentinel events (eg. by reviewing the minutes of the Emergency Services Liaison Committees)
- disseminating good local practice and agreed cross-portfolio service responses to frontline personnel (for example: via feedback to the Emergency Services Liaison Committees).
- To improve system responses and outcomes to complex patients by:
  - monitoring system performance against existing indicators (for example: via service datasets, research, Emergency Services Liaison Committee minutes, and stakeholder consultation)
  - identifying changes required to policy and/or practice at a system level to address interface issues
  - monitoring the implementation and outcomes of initiatives developed to action interface improvements
  - establishing sub-committees to research, develop and advise of responses to specific themes and issues.
- To contribute to long-term system planning and development by:
  - exploring research opportunities
  - contributing advice and information to portfolio and cross-portfolio planning.

Staff can raise matters for consideration by the committee via their local Emergency Services Liaison Committee.

## 7. Execution of this schedule

Signed by the organisations this \_\_\_\_\_ day of \_\_\_\_\_ 2010

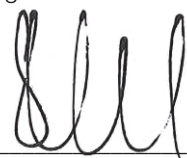
Signed for and on behalf of the **Department for Health**



Fran Thorn

Secretary, Department of Health

Signed for and on behalf of **Victoria Police**



Simon Overland

Chief Commissioner, Victoria Police.

### Review date

Either party may terminate this schedule by giving 30 days written notice to the other party.

The next joint review of this document will be conducted by June 2013.

### Document owners

There shall be no changes to this document unless approved by:

- Executive Director, Mental Health , Drugs & Regions Division, Department of Health
- Deputy Commissioner, Public Safety and Community Engagement, Victoria Police.

Requests for amendment will be coordinated by:

- Manager, Adult and Older Person's Mental Health, Mental Health, Drugs & Regions Division Operations, Department of Health.
- Manager, Mental Health Strategy Unit, Victoria Police.

### **Grievance procedures regarding the application of the protocol**

Any organisation claiming that a dispute has arisen under this schedule will immediately inform the other organisation. Upon being informed of a dispute, the organisations will enter into good faith discussions and use all reasonable endeavours to resolve the dispute through negotiations and if necessary, mediation.

The Secretary, Department of Health and the Chief Commissioner of Police, should be informed of issues that arise with policy, organisational or other significant consequences; the process for resolution; and the outcome; or be involved as per the final dispute resolution procedures under the overarching Memorandum of Understanding.

### **Disclaimer**

This schedule is not intended to represent comprehensive analysis of the law, and should not replace the exercise of professional judgment on a case-by-case basis.

Nothing in this schedule should replace the seeking of appropriate legal advice by services where this is considered appropriate.

Nothing in this schedule is intended, or does, create any legally binding obligation on any party.

## 8. Glossary

### **Acute mental illness**

Significant symptoms of a serious mental illness requiring immediate treatment. This may be the person's first experience of mental illness, a repeat episode, or the worsening of symptoms of a continuing mental illness. A person's ability to think, communicate and behave appropriately may be so impaired that it significantly interferes with his or her ability to deal with ordinary demands of life. Without effective treatment and support, the outcome for the person may be a significant disability and/or disadvantage.

### **Approved mental health service**

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

### **Area mental health service (AMHS)**

A geographic catchment in which triage, acute and community mental health services are delivered. Each Area Mental Health Service has a gazetted mental health inpatient unit in a public hospital. Other facilities may include Community Care Units, a Prevention and Recovery Care service and a Secure Extended Care Unit. The varying functions of community mental health services are Crisis Assessment and Treatment (CAT), Continuing Care (CC), Mobile Support & Treatment (MST) and Primary Mental Health & Early Intervention (PMHEI). These public services are provided free of charge by the state and include child and adolescent, adult and older person's mental health services and specialist statewide services. Mental health services may request police assistance and referral to a mental health service by police should go through triage.

### **Authorised psychiatrist**

A qualified psychiatrist appointed as the 'authorised psychiatrist' for an approved mental health service by the governing body of that service. The authorised psychiatrist has specific powers, duties, functions and immunities under the *Mental Health Act 1986*. The authorised psychiatrist can delegate any of these powers, other than the power of delegation to another qualified psychiatrist. Consultant psychiatrists in the Area Mental Health Service are delegated routinely and carry out the responsibilities of the authorised psychiatrist.

### **Chief Psychiatrist**

The Chief Psychiatrist is a psychiatrist appointed by the Secretary, Department of Human Services (now Department of Health) with responsibilities under the *Mental Health Act 1986* for the medical care and welfare of persons receiving treatment or care for a mental illness within the state of Victoria. The Chief Psychiatrist's responsibilities include monitoring the clinical standards of psychiatric practice and treatment provided by public mental health services and responding to complaints from consumers, carers and others.

### **Cognitive impairment**

'Cognitive impairment' refers to the possible adverse effect of a mental disorder on a person's ability to understand and process information. It can present in a person with mental illness, intellectual disability, acquired brain injury, neurological disorder or personality disorder. Not every person with

a mental disorder is necessarily cognitively impaired (for example: their form of disorder maybe episodic or does not affect their capacity to understand and process information). Equally, a person with a physical disability (such as cerebral palsy) may not necessarily have a cognitive impairment.

### **Community care units (CCU)**

CCUs provide 24-hour medium to long-term accommodation, clinical care and residential rehabilitation to people with severe mental illness and associated disability who are unable to be supported in available less intensive community options. Located in residential areas, CCUs provide a 'home like' environment where people can learn or re-learn everyday skills necessary for successful community living.

### **Community treatment order (CTO)**

Community Treatment Orders enable involuntary patients to receive treatment for their mental illness while living in the community. A CTO is made by an authorised psychiatrist and offers a less restrictive treatment option than inpatient treatment. A person subject to a CTO has the legal status of an involuntary patient.

### **Crisis assessment and treatment (CAT) service**

This service is a component of an Area Mental Health Service which is available 24 hours a day to provide community-based assessment and treatment for people experiencing psychiatric crisis. CAT services aim to prevent unnecessary hospitalisation, by providing treatment in the person's own environment such as in their home. CAT services provide urgent assessment and will arrange inpatient admission if this is the most suitable treatment option. Although CAT services will always give top priority to urgent referrals from police, they are not an emergency service and can only provide assistance as soon as practical. Not every Area Mental Health Service has a separate CAT service. In some services, particularly in regional areas, this function is undertaken by community mental health teams.

### **Custodial Risk Management Unit**

The Victoria Police Custodial Risk Management Unit coordinates the welfare of people in police cells. The unit:

- provides on-call nursing care and assessment services for persons in custody
- provides on-call medical care and assessment for persons in custody through a network of medical officers
- provides medical opinions on fitness to be detained
- advises on the management of people with mental illness or disability in custody
- delivers prisoner health care training programs for police, at all levels
- promotes public awareness of prisoner health care.

### **Emergency services**

Emergency services are publicly funded services available 24 hours a day across the state to respond to crises in the community. They include the police, fire and ambulance services, but not mental health services.

### **Emergency Services Liaison Committees**

Local committees that include mental health carer and consumer representatives as well as designated representatives from Victoria Police, hospitals, the Area Mental Health Service and Ambulance Victoria. The role of the committees is to review issues arising from crisis or emergency responses involving mental health, ambulance and police services, to generate cross sector working relations and improve service responsiveness.

### **Forensic Medical Officer**

Forensic Medical Officers are responsible for the collection of medical evidence from victims and offenders, and the presentation of expert evidence in court. Forensic Medical Officers are also available 24 hours a day for advice and assessment of whether a person in custody is fit for interview.

### **Forensic patient**

A forensic patient is a person:

- remanded in custody in an approved mental health service or committed to custody in an approved mental health service by a supervision order under the *Crimes Mental Impairment and Unfitness to be Tried Act 1997* (CMIA Act)
- detained in an approved mental health service under section 30(2) or 30A(3) of the CMIA Act
- deemed to be a forensic patient by section 73E(4) or 73K(8) of the CMIA Act
- detained in an approved mental health service under 20BJ(1) or 20BM of the *Commonwealth Crimes Act 1914*, or
- transferred from a prison to an approved mental health service under section 17 of the *Mental Health Act 1986*.

### **Forensicare**

Forensicare is the trading name for the Victorian Institute of Forensic Mental Health. Forensicare provides inpatient services through Thomas Embling Hospital and community services to offenders with mental illness in Victoria, including psychiatric assessment of prisoners and forensic psychiatric reports for court.

### **Health services**

Refer to [www.health.vic.gov.au/hospitals/](http://www.health.vic.gov.au/hospitals/) for a list of metropolitan and rural hospitals and health services.

### **Independent third person**

Where police need to interview a person they believe has a cognitive impairment, police must arrange for an independent third person to be present. This may be a close relative or friend not associated with the police inquiry or a volunteer trained by the Office of the Public Advocate. The requirement for an independent third person applies whether the person is a witness, victim or suspect.

### **Indicators for mental health referral**

A person with mental illness will generally exhibit a significant disturbance in thought, mood, or behaviour. They may also have disturbances in perception or memory. Specific symptoms and signs will vary depending on the type of mental illness and the person's age.

A person with mental illness may exhibit:

- bizarre or unusual thinking
- hallucinations
- significant changes of mood (. pronounced depression, anxiety, or pronounced elevation in mood)
- restless, agitated and disorganised behaviour, or a pronounced decrease in activity
- significant impairment of social functioning, occupational functioning, or self-care
- suicidal thoughts or acts of self harm
- destructive or high risk behaviour
- significant memory impairment
- confusion and disorientation.

Police do not have to make any clinical judgement when exercising powers under the *Mental Health Act 1986*.

#### **Involuntary admission**

Involuntary admission is the admission to an approved mental health service without the person's consent for the treatment of a serious mental illness. For an involuntary admission to an approved mental health service, a person must meet all five of the criteria set out in section 8 of the *Mental Health Act 1986*.

#### **Involuntary treatment order – persons in the community**

A registered medical practitioner within an approved mental health service or a mental health practitioner can assess a person and believe that the person fits the conditions of an involuntary patient. The practitioner can recommend the person's placement on an involuntary treatment order, requiring the person to receive treatment in an approved mental health service, such as a hospital. Once the order is made, the person must be reviewed by an authorised psychiatrist within 24 hours to decide whether the person should be:

- taken off the order
- treated in the community and released on a community treatment order, or
- cared for in an approved mental health service on an involuntary order.

#### **Mental health liaison officers**

The liaison officers are police located across the state who have responsibility for the mental health and disability portfolio, as part of their normal duties. The functions of these officers are to:

- foster good communication and collaboration with local service providers,
- maintain an awareness of current policy and procedures, sources of information and advice, local initiatives and protocols, and referral agencies,
- support local members with mental health-specific advice, information and education;
- report issues and suggestions to the local Emergency Services Liaison Committees,
- develop and promote prevention, early intervention and other response strategies,
- provide a first point of contact for members of the community wishing to discuss mental health-related issues, and
- represent the work area in internal and external forums.

Contact the nearest police station to identify the local liaison officer.

### **Mental health clinician**

Mental health clinicians, for the purposes of this document, are staff employed by approved mental health services with professional training and qualifications, and experience in working with clients who have mental illness. Mental health clinicians include social workers, registered nurses, psychiatrists, medical officers, occupational therapists and psychologists.

### **Mental health practitioner**

Mental health practitioners, as defined in the *Mental Health Act 1986* and Mental Health Regulations, are:

- registered nurses
- psychologists registered under the *Psychologists Registration Act 2000*
- social workers
- occupational therapists

employed by an approved Area Mental Health Service to provide acute psychiatric assessment and treatment services in the community. In practice, mental health practitioners are often employees of community-based mental health services, such as Crisis Assessment and Treatment services.

### **Mental Health Review Board**

An independent tribunal established under the *Mental Health Act, 1986* to hear appeals from and periodically review the involuntary legal status of involuntary inpatients and people on community treatment orders.

### **Police stations**

Refer to [www.police.vic.gov.au](http://www.police.vic.gov.au) for a list of police stations and Police Service Areas.

### **Prescribed person**

Defined in section 7 of the *Mental Health Act 1986* as:

- a member of the police force
- an ambulance officer
- a person who is a member of a class prescribed for the purposes of this section, including
  - registered medical practitioners
  - registered nurses
  - psychologists registered under the *Health Professions Registration Act 2005*
  - social workers
  - occupational therapists

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

### **Prevention and recovery care (PARC) service**

PARC services complement other acute services in the mental health service continuum and are located within a supported community residential setting. They are designed to meet the treatment needs of eligible clients who are 'stepping down' relatively early from inpatient beds as well as being responsive to eligible consumers who are 'stepping up' from the community. This assists in diverting admission or readmission to inpatient beds and represents a less restrictive treatment setting.

### **Psychiatric disability rehabilitation and support services (PDRSS)**

PDRSS are a component of the comprehensive mental health services network and complement the assessment and treatment functions of clinical services. PDRSS provide psychosocial rehabilitation in a variety of ways to people with psychiatric disability to minimise stress, maintain recovery, and improve quality of life. Such services include home-based outreach support, structured day programs and informal drop in, residential rehabilitation services, respite care and consumer and carer support and advocacy services.

### **Registered medical practitioners**

A prescribed registered medical practitioner is:

- in general practice
- the registered medical practitioner who recommended that the person receive involuntary treatment from an approved mental health service
- the head of an emergency department of a hospital
- employed as a registered practitioner such in or by a psychiatric service within the meaning of section 106 of the Act
- a psychiatrist
- forensic physician.

### **Psychiatric assessment**

A thorough assessment of a client by a mental health professional which includes identifying a person's current mental state, personal history, social history, social situation and any relevant past psychiatric history. The psychiatric assessment enables selection of the most appropriate form of treatment for the client.

### **Restraint – physical and mechanical**

For mental health clinicians:

For the purposes of this protocol, restraints are applied with the minimum use of force consistent with the intentions of the *Mental Health Act 1986*. Physical restraint is defined as the skilled hands-on immobilisation or the physical restriction of a person who is suspected to have or has a mental illness to prevent the person from harming him/herself or endangering others or to ensure the provision of essential medical treatment. Mechanical restraint in relation to a person means the application of devices on the person's body to restrict his or her movement but does not include the use of furniture that restricts the person's capacity to get off the furniture.

For police:

The use of force by police members while fulfilling their duties must be in line with s.462A of the *Crimes Act 1958*, any other specific legislative provisions and the 10 Safety Principles.

### **Restricted community treatment order (RCTO)**

Similar to a community treatment order, but applies to an involuntary patient who is on a restricted involuntary treatment order under section 93 of the *Sentencing Act 1991*. It offers a less restrictive option than inpatient treatment.

### **Seclusion**

Seclusion is the sole confinement of a person at any hour of the day in a room with doors and windows that lock from the outside. Section 82 of the *Mental Health Act 1986* allows for the seclusion of patients receiving treatment for a mental illness in an Area Mental Health Service.

### **Secure extended care unit (SECU)**

SECUs provide secure inpatient treatment and care for people with severe symptomatology and associated behavioural disturbance who require an extended period of sustained treatment and rehabilitation in a contained environment. These services are provided on a regional basis, and are gazetted under the *Mental Health Act 1986* to provide involuntary treatment.

### **Triage**

Mental health triage is provided for all potential clients or people seeking assistance on behalf of a person thought to have a mental illness, as the first point of contact for mental health services. Triage may also be used for assessment of current and former clients who make unplanned contact with the mental health service. Triage is a clinical function. The role of the triage clinician is to conduct a preliminary assessment of whether a person is likely to have a mental illness or disorder, and the nature and urgency of the response required.

### **Voluntary patient**

A person who voluntarily requests and receives treatment by an approved Area Mental Health Service and is not subject to the involuntary provisions of the *Mental Health Act 1986*.

## 9. Contact details

AMHS triage contacts for adult (and covering child and adolescent and older persons) mental health services can be located at [www.health.vic.gov.au/mentalhealth/services/index.htm](http://www.health.vic.gov.au/mentalhealth/services/index.htm)

Victoria Police mental health liaison officers can be located by contacting the nearest police station and requesting the contact details of the appropriate liaison officer.

For queries relating to the application of this protocol, contact:

- Manager, Adult and Older Person's Mental Health  
Mental Health and Drugs Operations  
Department of Health  
50 Lonsdale St, Melbourne 3000  
Ph: 9096 8778
- Manager, Mental Health Strategy Unit  
Operations Coordination Department  
Victoria Police  
637 Flinders St, Melbourne 3005  
Ph: 9247 5443

# 10. Adult area mental health services

Adult AMHS	Geographic coverage by Local Government Area (LGA) or part LGA
<i>Metropolitan</i>	
Inner South East	Port Phillip, Stonnington and Glen Eira-Caulfield
Central East	Manningham, Monash-Waverley West, Whitehorse-Box Hill and Whitehorse-Nunawading West
Outer East	Maroondah, Knox, Yarra Ranges and Whitehorse-Nunawading East
Middle South	Bayside and Kingston
Dandenong	Greater Dandenong, Casey, Cardinia, and Frankston-East
Peninsula	Mornington Peninsula, French Island, Kingston-South and Frankston-West
Northern	Whittlesea and Darebin
North East	Nillumbik and Banyule
Inner West	Mooney Valley and Melbourne
Inner Urban East	Yarra and Boroondara
North West	Hume and Moreland
Mid West	Melton and Brimbank
South West	Wyndham, Hobsons Bay and Maribyrnong
<i>Rural</i>	
Barwon	Greater Geelong, Queenscliff, Surf Coast, Colac-Otway, Corangamite (part) and Golden Plains(part)
Glenelg	Glenelg, Southern Grampians, Moyne, Warrnambool and Corangamite-North
Grampians	Hindmarsh, West Wimmera, Horsham, Yarriambiak, Northern Grampians, Ararat, Hepburn, Pyrenees, Ballarat, Moorabool and Golden Plains-North West.
Goulburn	Greater Shepparton, Strathbogie, Mitchell, Murrindindi and Moira-East (part)
North Eastern Hume	Towong, Wodonga, Alpine, Indigo, Wangaratta, Benalla, Mansfield and Moira East
Loddon Campaspe/ Southern Mallee	Gannawarra, Buloke, Campaspe, Central Goldfields, Loddon, Greater Bendigo, Mount Alexander, Macedon Ranges and Swan Hill (part)
Gippsland	East Gippsland, Wellington, Baw Baw, Bass Coast, Latrobe and South Gippsland
Northern Mallee	Mildura, Swan Hill and Robinvale

