**Mental Health Act 2016**
Chief Psychiatrist Policy

# Managing involuntary patient absences

## Contents

# General

Arrangements may be made under the *Mental Health Act 2016* (the Act) for particular patients who are absent without approval (AWA) to be returned to an authorised mental health service (AMHS) or a public sector health service facility (PSHSF).

Patients who are AWA may represent a risk to their own life, health or safety, or the safety and wellbeing of others. All AMHSs must ensure governance and reporting structures are in place to facilitate the oversight of AWA events within their service.

This Policy promotes:

- preventing and reducing the risk of patients becoming AWA from an AMHS or PSHSF as part of the clinical governance of the relevant service or facility
- implementation of evidence-based, recovery-oriented strategies to reduce the risk of patients becoming AWA from the AMHS or PSHSF and working towards a least restrictive model of care, and
- the active inclusion of patients, their families, other support persons and service providers, in comprehensive care planning, problem solving and identifying strategies to reduce the risk of patients becoming AWA from an AMHS or PSHSF.

See the 'Absent without approval' pathway | Queensland Health for further information outlining the steps when responding to an AWA event.

# Scope

This policy is mandatory for all AMHSs. An authorised doctor, authorised mental health practitioner (AMHP), AMHS administrator, or other person performing a function or exercising a power under the Act **must** comply with this policy.

Staff should work collaboratively and in partnership with individuals in their care to ensure their unique-age related, cultural and spiritual, gender-related, religious and communication needs are recognised, respected and followed to the greatest extent practicable. This should include the timely involvement of appropriate local supports and a recovery-oriented focus.

This policy **must** be implemented in a way that is consistent with the objects and principles of the Act.

> This policy does not apply in relation to a person who absconds while being detained under the Emergency Examination Authority provisions of the *Public Health Act 2005*. For further information see the *Public Health Act 2005* website.

**This policy is issued under section 305 of the *Mental Health Act 2016***

**Dr John Reilly**
**Chief Psychiatrist, Queensland Health**

# Policy

## 1 Minimising risk and responding to patient absence

A risk assessment **must** be conducted on a patient's initial contact with a service or facility and be reviewed at regular intervals throughout the service episode.

Individual patient strategies must be based on assessment of the patient's risk of becoming AWA.

Particular attention must be given to patients who may be at increased risk of becoming absent without approval, for example:

- recently admitted patients
- patients voicing thoughts about wanting to leave
- patients with repeated AWA events
- patients with a history of violence
- patients with a history of trauma
- young patients, and
- patients who, because of their ethnic, social or cultural background, are at increased risk of becoming AWA.

## 2 AWA Prevention and Response Plan

An AWA Prevention and Response Plan (Prevention and Response Plan) is a locally developed plan that sets out the clinical strategies to mitigate the risk of an absence and the actions to be taken by the service if the patient becomes AWA.

Consideration should also be given to whether a Police Advice and Intervention Plan (PAIP) is required for the person.

## Key points

- The initiation of any process to return a patient following an AWA event must have regard to the strategies outlined in their Prevention and Response Plan.
  - A Prevention and Response Plan is intended to supplement clinical judgement at the time of an AWA event.
- A Prevention and Response Plan is **mandatory** for involuntary patients on an inpatient category order/authority.
  - It is recommended for involuntary patients being treated in the community.
- The plan must be developed by the treating team in consultation with the patient's treating psychiatrist.
- The Prevention and Response Plan must be incorporated into general mental health care planning and review processes.
- The treating team must ensure the plan is accessible in CIMHA to ensure ready access by clinicians, along with any other relevant clinical record.

The patient and their support person/s **must**, to the greatest extent practicable, be involved in the development of the Prevention and Response Plan and assisted to understand the actions that will be taken if the patient becomes AWA.

# 3 Application of the absent patient transport provisions

## Key points

The absent patient transport provisions of the Act may be applied when an involuntary patient is AWA from an AMHS or a PSHSF. An involuntary patient for this purpose means a person:

- detained under a Recommendation for Assessment or detained for the purposes of making a Recommendation for Assessment
- subject to:
  - an Examination Authority
  - a Treatment Authority
  - a Treatment Support Order (TSO)
  - a Forensic Order (FO)
  - a Judicial Order, or
- detained for the purposes of making arrangements to return the person to an interstate mental health service.

The absent patient transport provisions also apply to classified patients (involuntary) and classified patients (voluntary).

The absent patient transport provisions also apply if:

- a person becomes subject to a Treatment Authority, FO, TSO or Judicial Order requiring detention in an AMHS and the person is not in an AMHS when the authority or order is made, or
- a person subject to Chapter 4, Part 2 of the Act (request for psychiatrist report) or an order of the MHRT does not attend a scheduled appointment.

For involuntary patients and classified patients (voluntary), the provisions encompass the following circumstances:

- absconding or leaving:
  - an inpatient mental health unit or facility without approval
  - a community mental health facility without approval
  - an emergency department, non-mental health unit or facility, or a PSHSF without approval, where the patient has been detained under the Act

- absconding or not returning from limited community treatment including where the limited community treatment has been suspended or revoked
- absconding while being transported (i.e. during a transfer or while moving between units)
- not returning from an approved temporary absence, including when approval has been revoked
- not attending an AMHS or PSHSF as required (e.g. attending a scheduled appointment or review, to comply with conditions of an order or authority, or due to a change in category from community to inpatient).

# 4 Process for returning patients who are AWA

If a patient is AWA, the least restrictive option appropriate to the level of risk should be exercised to return the patient.

## Key points

Unless there is a risk that the patient may harm themselves or others, reasonable attempts must be made to contact the person and encourage them to return to the AMHS voluntarily prior to completing an *Authority to Transport Absent Person* (ATAP) form.

In all cases, the treating psychiatrist (or on-call psychiatrist) must be notified without delay of the patient's absence. The purpose of this is to ensure the treating psychiatrist is aware of the absence.

- This requirement does not prevent another health practitioner taking action to return the patient

Notification of relevant support persons (e.g. nominated support person, guardian, parent) should also occur consistent with clinical appropriateness and local processes.

If a patient is on a community category order or authority, there is no automatic requirement to change the category to 'inpatient' prior to authorising the patient's return.

- If the patient is on a community category order when they present or are taken to an AMHS following the AWA event, an authorised doctor must review the patient to determine whether the category of order should be changed to inpatient.

## 4.1 Authorisation to transport patients who are AWA

If the patient is unable to be located or returned voluntarily, or there are concerns regarding risk of harm to the patient or others, an ATAP form **must** be initiated.

- The ATAP form is required for all AWA events where the patient cannot be returned voluntarily.

### Key points

The return of an absent person to an AMHS or PSHSF can be authorised by a responsible person using the ATAP form. A responsible person in this context is:

- an AMHS administrator
- an authorised doctor
- an AMHP, or
- a person in charge of a PSHSF.
    - The person in charge may delegate this power to an appropriately qualified health service employee.

A responsible person may:

- authorise an authorised person, other than a police officer, to transport an absent person to a stated AMHS or PSHSF, or
- ask a police officer to transport an absent person to a stated AMHS or PSHSF (act alone or assist another authorised person with the transport of an absent patient).
    - An authorised person in this context is:
        - an AMHS administrator,
        - an ambulance officer,
        - a health practitioner,
        - a police officer,
        - a corrective services officer, if a person is to be transported to or from a corrective services facility or court,
        - a youth detention employee if the person is to be taken to or from a youth detention centre or court.
    - The administrator of an AMHS may appoint, in writing, an employee of the AMHS as an authorised person.

### 4.1.1 Administrator responsibilities

The AMHS administrator **must** ensure that, where appropriate, health service employees are appointed as authorised persons to enable them to return patients who are AWA.

In rural and remote AMHS, it is particularly important that the administrator or person in charge of a PSHSF ensures that processes are in place to enable action to be taken in response to an AWA event.

- These processes **must** ensure, at all times, that there is an authorised doctor or AMHP available to commence an ATAP process if required.

## 4.2 Authorising transport of an absent person

### Key points

The ATAP form must include:

- the name of the AMHS or PSHSF where the patient is to be transported
- the category or categories of authorised person able to return the patient
- a summary of risk issues relevant to the patient and others
- any actions taken to locate the person, and
- where a PAIP is in place, the checkbox on the ATAP form must be marked and the form should include any relevant information from the PAIP.

Unless there is serious and imminent risk to the individual or others, or it is clearly unsafe for an authorised person other than police to return the patient, an ATAP form should at first instance authorise a health practitioner or appointed health service employee to return the patient.

The person completing the ATAP form must provide a copy to all categories of persons authorised under the form.

- Phone contact **must** also be made, particularly if ambulance officers or police are to be involved in the transport.

A copy of the ATAP form **must** be recorded on CIMHA.

Where there is a change in risk status or patient whereabouts, consideration should be given to completing a Request for Police Assistance or a new ATAP form to enable police to act alone (See sections 4.3.2 and 4.3.3 below).

## 4.3 Determining least restrictive method of transport

Decisions regarding who should be authorised to transport a person who is AWA should be made, as far as possible, in consultation with the patient's treating psychiatrist or on-call psychiatrist.

The *Queensland Interagency Agreement for the Safe Transport of People Accessing Mental Health Assessment, Treatment and Care between Queensland Health, Queensland Ambulance Service and the Queensland Police Service* outlines factors that should be taken into account when considering the mode of transport required.

Consideration should be given to the least restrictive means for safely transporting the patient. Transport options include, but are not limited to:

- a health practitioner, including an ambulance officer, returning the patient without police assistance
- a health practitioner returns the patient with the assistance of police, or
- the police acting alone to return the patient.

Although the least restrictive method should be used to transport a patient who is AWA, in some cases it may be necessary for police to act alone to ensure the safe transportation and return of the patient.

### 4.3.1 Requesting ambulance assistance to transport an absent person

The primary role of the Queensland Ambulance Service (QAS) is to assist the community with acute healthcare emergencies; this includes emergencies related to mental illness.

QAS are a less restrictive transport option in situations where circumstances prevent transport by the mental health service (e.g. co-morbid physical health concerns).

## Key points

- QAS assistance can be requested by health service staff or police where there is a healthcare emergency requiring ambulance transport.
- Health service staff should request ambulance assistance by calling '000'.
- When requesting ambulance assistance to transport an absent patient, the ATAP form should be completed and the 'Authorised person other than police' box should be selected in section 5 of the form.
- If an ambulance officer has been authorised to transport a person who is AWA, regular liaison by the AMHS with the ambulance officers should occur to provide updated information if required and to coordinate joint action.
- A copy of the ATAP form should be provided to QAS in person or as locally negotiated.

QAS do not provide a search and rescue service and as such, are unable to assist in locating consumers whose whereabouts are unknown.

### 4.3.2 Requesting police assistance (AMHS clinician attending)

A health practitioner or appointed employee who has been authorised to act under an ATAP form may request police assistance for transporting a patient who is AWA.

Requesting police assistance allows the health practitioner or appointed employee and police officer/s to work together to return a person who is AWA.

## Key points

When requesting police assistance, the Request for Police Assistance form must be completed.

- The form must include a statement outlining why it is necessary for police to assist with the transport.
    - Generally, police should be involved in transport only where their assistance is required for the management of serious risk to the individual or others.
- Local police must be contacted by phone if being requested to assist in transporting a patient who is AWA to establish collaborative transport arrangements.
- A health practitioner must attend with police when using the Request for Police Assistance process.
    - When requesting assistance, the police do not require a copy of the ATAP form.
    - A copy of the Request for Police Assistance form must be sent to the AMHS administrator and kept on the patient's clinical record in CIMHA.

A QCAD (Queensland Computer-Aided Dispatch) number (police communications ID) is **not required** where a Request for Police Assistance is being made under local arrangements agreed to by the relevant QPS district (and not via the regional police communications centre).

A QCAD number **must** be obtained by the AMHS when a Request for Police Assistance is being made via the relevant regional police communications centre (e.g. where local processes are not in situ or outside business hours).

The QCAD number **must** be recorded on the Request for Police Assistance form before it is provided to police.

- See section 4.3.3.1 below for full requirements for issuing of QCAD numbers.

### 4.3.3 Requesting police to act alone

Prior to making a request for police to act alone, every reasonable attempt to locate the person **must** be made, and detailed actions and outcomes are to be recorded on the ATAP form.

Circumstances in which it may be appropriate for police to act alone to transport a patient include, for example:

- for the management of serious and imminent risk to the individual or others, and/or
- where it is unsafe for the patient to be returned by an authorised person other than a police officer.

Using the ATAP form, a police officer may be requested to transport a patient who is AWA to an AMHS or PSHSF without a health practitioner.

## Key points

If requesting police to act alone, the ATAP form must include:

- a statement outlining why it is necessary for police to transport the person including the serious and imminent risk to self or others
- the name of the AMHS or PSHSF where the patient is to be transported
- a summary of risk issues relevant to the patient and other persons, including risk to the authorised person transporting the patient, and
- all actions taken to locate the person, and
- any relevant information from a patient's PAIP

The ATAP form should be completed electronically on CIMHA or, if this is not practicable, completed in hard copy and uploaded to CIMHA.

- the police must be contacted to be notified of the AWA event. Where a situation is assessed as urgent, consideration should be given to informing police via a '000' call.

A QCAD number **must** be obtained by the AMHS by contacting the relevant regional police communications centre. The QCAD number must be recorded on the ATAP form before it is sent to the local police and Warrant Bureau. See section 4.3.3.1 below for full requirements for issuing of QCAD numbers.

The ATAP form **must** be sent to:

- Regional police communications centre, and/or
- Local police station (if required by local protocol), and
- Police information centre (Warrant Bureau) once QCAD provided and ATAP accepted by the regional police communications centre.

Where an ATAP form has been accepted by QPS, ongoing communication and information sharing should be maintained to facilitate patient return.

Information sharing should be as per the *Memorandum of Understanding between The State of Queensland acting through Queensland Health and The State of Queensland acting through the Queensland Police Service Mental Health Collaboration 2017.*

#### 4.3.3.1 QCAD number (police communications ID number)

A QCAD number is the police communications ID number issued by the QPS and must be obtained by contacting the relevant regional police communications centre (dependent on local protocols).

If adequate information is not provided to establish that police involvement is required, a QCAD number will not be issued.

Forms without a QCAD number will not be actioned by the police and must not be sent to the local police and Warrant Bureau.

To determine whether involvement of police is required the police communications centre will request the following information:

- whether the clinician considers there is:
    - a recent history of violence towards self or others
    - a history of violence or vulnerability when not taking medication or engaging in treatment
    - threats to self or others when the Queensland Health staff contacted the patient
    - a history of vulnerability which may put the patient or others in imminent danger, and
- what the clinician considers to be the current level of these risks.

Assessment of risk should be based on the most recent examination of the person, collateral information and/or longitudinal historical information including from the patient's clinical record.

If historical risks are identified, these should be conveyed to the police in the context of the person's current situation.

> Where police advise that their involvement is not required and decline to provide a QCAD number, the escalation process detailed at section 4.3.4 should be followed.

### 4.3.4 Escalation of matter where police have indicated their involvement is not required

If the request meets the threshold for police attendance and the local communications centre have advised that their involvement is not required, the treating psychiatrist (or on-call psychiatrist) should be notified to review the circumstances of the absence and the ATAP documentation.

- The psychiatrist should consider whether the risks can be managed without the involvement of the police, and
- if the risks can be safely managed without the involvement of police, then further attempts by a health practitioner to return the patient should be made.

If the psychiatrist considers the involvement of the police is required, phone contact with the Duty Officer, Brisbane police communications centre should be made by the treating psychiatrist/ psychiatrist on call to clarify the current risk issues for the matter to be reconsidered.

**QPS Duty Officer, Brisbane Communications Centre**
Available 24 hours 7 days per week
Contact details are available to Queensland Health staff via Mental Health Act 2016 (MHA2016) on QHEPS | Queensland Health Intranet.

Where police continue to advise that their involvement is not required, the matter is to be referred to the AMHS Clinical Director (or appropriately delegated person) for resolution at a local level.

In circumstances where the Clinical Director is unable to resolve the matter locally and the AMHS require police involvement to return a patient, the Clinical Director (or appropriately delegated person) may contact the Office of the Chief Psychiatrist.

**Office of the Chief Psychiatrist, Mental Health Act Liaison Service**
8:30am – 4:30pm Monday – Friday
Phone: 07 3328 9899
After hours/public holidays contact details are available to Queensland Health staff via Mental Health Act 2016 (MHA2016) on QHEPS | Queensland Health Intranet.

# 5 Transportation

## Key points

If authorised to transport a patient following an AWA event, the authorised person may take the patient to the AMHS or PSHSF stated in the ATAP form.

- If it is not reasonable or practicable to transport the patient to the stated AMHS, the patient may be transported to the nearest AMHS or PSHSF.
- In determining where the patient should be transported to, the authorised person should consult the treating or on-call psychiatrist.

While acting to transport a patient who is AWA, the authorised person may act with the help, and using the force, that is necessary and reasonable in the circumstances.

- This includes the ability to detain the person if required.

While transporting a patient following an AWA event, an authorised person must comply with the *Chief Psychiatrist Policy Transfers and Transport*.

# 6 Notifications

All AWA events and ATAP forms **must** be recorded on CIMHA.

The AMHS administrator or person in charge of a PSHSF **must** ensure the AMHS or PSHSF has clearly established notification processes for patients who become AWA.

## 6.1 Notification of AWA events

### 6.1.1 AWA events – Inpatient category, classified patients and Judicial Order

**Key points**

A copy of the ATAP form must be provided to the treating psychiatrist and the Clinical Director (or appropriately delegated person) at the time of issuing for all AWA events involving patients subject to a:

- Treatment authority (inpatient)
- TSO (inpatient)
- FO (inpatient)
- Classified Patients, and
- Patients subject to a Judicial Order (excluding non-attendance for an Examination Order).

Notification to the Clinical Director is mandatory for all of the above patients, regardless of the type of AWA event.

Email notification to the Clinical Director must be followed with a phone call for all Forensic patients (inpatient), classified patients, or Judicial Order patients (excluding non-attendance for an Examination Order).

#### 6.1.1.1 Clinical Director responsibilities

**Key points**

The Clinical Director (or appropriately delegated person) must notify the Chief Psychiatrist, by phone call and email, as soon as practicable of AWA events involving:

- Forensic patients (inpatient)
- Classified Patients, and
- Patients subject to a Judicial Order (excluding non-attendance for an Examination Order).

A copy of the ATAP form must be provided to the Chief Psychiatrist at the time of the notification.

Notify the Chief Psychiatrist **during business hours** by calling 3328 9899 **and** email MHA2016@health.qld.gov.au.

Notify the Chief Psychiatrist **after hours or on public holidays** by calling and emailing the on-call Chief Psychiatrist. Contact details are available on QHEPS at Mental Health Act 2016 (MHA2016) | Queensland Health Intranet (Queensland Health staff access only).

### 6.1.2 AWA events - Patients other than inpatient category, classified and judicial order

This section includes AWA events involving patients subject to any of the following authorities or orders:

- An Examination Authority
- detention under a Recommendation for Assessment, or detained for the purposes of making a Recommendation for Assessment
- Treatment Authority (community)
- TSO (community)
- FO (community), and
- individuals subject to:
    - an Examination Order, who have failed to attend an appointment,
    - chapter 4, part 2 of the Act (request for psychiatrist report initiated by the Chief Psychiatrist), or
    - an order of the MHRT and who have not attended for an appointment.

#### 6.1.2.1 Clinician responsibilities

## Key points

Where the treating psychiatrist (or on-call psychiatrist) considers there is a significant risk related to an AWA event involving a patient identified in section 8.1.2, they should notify the Clinical Director (or appropriately delegated person) as soon as practicable.

Factors that may be relevant for notifying the Clinical Director include for example:

- clinically significant risks
- serious or controversial events
- known victim issues, and
- events that may attract media attention.

If an AWA matter is escalated to the Clinical Director, a copy of the ATAP form must be emailed to the Clinical Director and must be followed with a phone call.

#### 6.1.2.2 Clinical Director responsibilities

If required, the Clinical Director may notify the Chief Psychiatrist as soon as practicable of AWA events involving patients identified in section 6.1.3.

## Key points

Escalation to the Chief Psychiatrist for AWA events not involving a forensic patient (inpatient), classified patient or judicial order patient is at the discretion of the Clinical Director (or appropriately delegated person).

- Escalation should only include matters where the Clinical Director considers additional oversight beyond the AMHS governance structures is warranted.

Notifications to the Chief Psychiatrist must be made via phone and email. A copy of the ATAP form must be provided to the Chief Psychiatrist at the time of notification.

### 6.1.3 Notification of the return of patient absent without approval

**Key points**

The treating psychiatrist and Clinical Director (or appropriately delegated person) must be notified as soon as practicable of the return of a patient who, at the time of the AWA event, was:

- on an inpatient category authority or order, or
- a classified patient, or
- subject to a judicial order.

The Clinical Director must also be notified for any other matters that were significant either at the time of the AWA event, or on the patient's return.

If the Chief Psychiatrist is notified of any AWA event, they must be notified as soon as practicable, via phone and email, of the patient's return and any relevant issues.

For patients with repeated AWA events, or who are assessed as being high risk of further absences, the treating psychiatrist **must** provide the Clinical Director with relevant information about the patient including:

- an assessment of risk issues
- proposed future management to minimise risk, and
- actions or recommendations to address any systemic issues identified in relation to the patient's absence.

The Clinical Director has discretion to notify the Chief Psychiatrist in other circumstances where a patient's return from an AWA event is deemed to warrant additional involvement and oversight from the Chief Psychiatrist.

The Clinical Director may also determine that an Assessment and Risk Management Committee (ARMC) should be arranged to discuss the circumstances of the AWA event and review the patient's treatment and care (For further detail see *Chief Psychiatrist Policy Treatment and Care of Forensic Order, Treatment Support Order and other Particular Patients*).

### 6.1.4 Notifications to MHRT

**Key points**

The MHRT must be notified of a patient AWA event in the following circumstances:

- the patient is on a Treatment Authority or TSO and is absent within seven (7) days of their MHRT hearing, or
- the patient is on a FO and is absent within fourteen (14) days of their MHRT hearing.

Notification is provided on the Written Notice of Relevant Patient's Absence – Mental Health Review Tribunal Clinical Report template.

Once notified, the MHRT may determine whether to adjourn the hearing due to the patient's absence.

- The MHRT may proceed in the patient's absence (if for example, the patient wilfully absents themselves from the hearing).
- The treating psychiatrist's advice provided in the Written Notice of Relevant Patient's Absence - Mental Health Review Tribunal Clinical Report template will be used to inform the decision of the MHRT.

If the hearing is adjourned, the AMHS administrator will be advised by the MHRT.

The administrator **must** notify the MHRT as soon as practicable of the patient's return using the Written Notice of Relevant Patient's Return - Mental Health Review Tribunal Clinical Report template.

The MHRT must schedule a new hearing within **twenty-one (21) days** after receiving notification of the patient's return.

All Written Notices of Relevant Patient's Absence and Return must be uploaded to CIMHA as soon as practicable.

# 7 Ending an authority to transport absent person

## Key points

An ATAP even ends:

- when the patient returns or is returned to the AMHS; or
- after three (3) days if:
  - the patient was subject to a recommendation for assessment and absconded before the assessment period ended
  - the patient was being detained for a one-hour period to make a recommendation for assessment, or
  - the patient was subject to an Examination Authority; or
- when the person is no longer subject to an order or authority (e.g. their order or authority is revoked or ends).

A Revocation of Authority to Transport Absent Person form must be issued to end the effect of an ATAP form.

The Revocation of Authority to Transport Absent Person should be completed electronically in CIMHA or, if this is not practicable, completed in hard copy and uploaded to CIMHA.

When ATAP form has been issued to police (see section 4.5.3):

- if the patient returned without direct involvement of police, contact local police or relevant regional police communications centre to notify of the patient's return, and
- send a copy of the Revocation of Authority to Transport Absent Person form (by email preferably) to the police information centre (Warrant Bureau).

The Revocation of Authority to Transport Absent Person form must also be sent to:

- the authorised person/s who were authorised to transport the patient, and
- the relevant AMHS administrator.

# 8 Monitoring AWA events

## Key points

All AMHS administrators must ensure there are sufficient governance and reporting structures in place to facilitate oversight of AWA events.

Regular case reviews to re-assess risk and, review attempts made to locate the patient, are essential to the governance of all AWA events. A number of AWA events will remain the sole responsibility of the AMHS.

Frequency of reviews will be determined based on clinical circumstances, with more regular reviews recommended for AWA events considered high risk and requiring notification to the Chief Psychiatrist.

Governance and reporting structures can be determined by the AMHS however must ensure:

- clinical and reporting oversight is provided for all AWA events that occur in inpatient or community settings and, if applicable, PSHSF where patients of the relevant AMHS are involuntarily detained
- reporting structures comply with notification and reporting requirements of the Chief Psychiatrist, and
- all AWA events are recorded in CIMHA.

Data relating to AWA events is auditable and published annually at a state and national level (in de-identified formats). AWA data is utilised by the Chief Psychiatrist and AMHSs to support continuous clinical improvement.

# 9 Further information

## Definitions and abbreviations

| Term | Definition |
|---|---|
| AMHP | Authorised mental health practitioner |
| AMHS | Authorised mental health service–<br>a health service, or part of a health service, declared by the Chief Psychiatrist to be an authorised mental health service. AMHSs include both public and private sector health services. While treatment and care is provided to both voluntary and involuntary patients, additional regulation applies under the Act for persons subject to involuntary treatment and care. |
| AWA | Absent without approval |
| CIMHA | Consumer Integrated Mental Health and Addiction application–<br>the statewide clinical information system and designated patient record for the *Mental Health Act 2016*. |
| NSP | Nominated support person–<br>a family member, carer or other support person **formally appointed** by a patient to be their nominated support person. NSP rights include:<br>• must be given all notices about the patient that are required under the Act<br>• may discuss confidential information about the patient's treatment and care<br>• may represent, or support the person, in any hearings of the Mental Health Review Tribunal, and<br>• may request a psychiatrist report if the person is charged with a serious offence. |
| PAIP | Police Advice and Intervention Plan. A PAIP is an information sharing tool. This plan is developed by a mental health clinician to provide specific information and strategies regarding a consumer which informs and assists the Queensland Police Service (QPS) to mediate a mental health event involving a consumer in the community. |
| Patient | • An involuntary patient, or<br>• A person receiving treatment and care for a mental illness in an AMHS, other than as an involuntary patient, including a person receiving treatment and care under and Advance Health Directive or with the consent of a personal guardian or attorney. |
| PSHSF | Public Sector Health Service Facility |
| QAS | Queensland Ambulance Service |

| | |
|---|---|
| QCAD | Queensland Computer-Aided Dispatch |
| Relevant AMHS Administrator | • Administrator of the AMHS currently providing clinical services to the person, or<br>• if the person is not currently receiving mental health services (i.e. no open service episode), the Administrator of the AMHS for the location where the person resides. |
| Support person/s | Includes, a Nominated Support Person or, if the person does not have a Nominated Support Person, a family member, carer or other support person. |

## Referenced policies and resources

### Chief Psychiatrist policies

Transfers and transport

Treatment and care of patients subject to a treatment support or forensic order or other identified higher risk patients

Classified Patients

### Mental Health Act 2016 forms and other resources

Guide: Police Advice and Intervention Plan (PAIP)

Form: Authority to Transport Absent Person (ATAP)

Form: Request for Police Assistance

Form: Revocation of Authority to Transport Absent Person

Clinical Report Template: Written Notice of Relevant Patient's Absence - Mental Health Review Tribunal

Clinical Report Template: Written notice of Relevant Patient's Return - Mental Health Review Tribunal

Agreement: Queensland Interagency Agreement for the Safe Transport of People Accessing Mental Health Assessment, Treatment and Care, Queensland Health, Queensland Ambulance Service and Queensland Police Service

Agreement: Memorandum of Understanding between The State of Queensland acting through Queensland Health and The State of Queensland acting through the Queensland Police Service Mental Health Collaboration 2017

### Legislation

*Mental Health Act 2016*

*Public Health Act 2005*

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