

TRANSPORT OF PATIENTS WITH  
A MENTAL ILLNESS  
IN QUEENSLAND

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## **EXECUTIVE SUMMARY**

Recent legal judgements in Queensland and overseas have held hospitals liable for the safety of their patients, especially in transfer situations. The Australian Council for Safety and Quality in Health Care has flagged projects concerned with safety as a high priority in its current round of funding allocation, with emphasis on the area of risk management.

Movement of any patient within or between health facilities, or from their home in the community carries risk at every step and requires the integration of a number of support agencies, working harmoniously to achieve a safe outcome for all participants. However, there is no overarching body imparting universal governance to a transport and transfer system that is extensive, expensive and overextended.

The advent of a new Mental Health Act in Queensland (*MHA 2000*) prompted a review of the transfer of patients with acute mental illness.

Acute specialist services for the mentally ill in Queensland are centralised in major coastal cities, but patients are widely spread. Many must of necessity be transferred over varying distances which can be vast. Road and air are the available transport options, with air traditionally employed when distances to an authorised mental health service are greater than 200 kilometres. However, some rural centres situated outside the 200 km limit have established local systems that achieve road transfer as the first option.

The aviation environment is inherently dangerous and therefore highly regulated. Many of the binding aviation regulations do not align with the *MHA 2000*. Similarly, the Act does not provide a general authority for ambulance officers to administer treatment or apply restraint, one or both interventions sometimes being necessary during transport by road. However, to ensure the safety of the patient and response personnel, each transfer must take into account the individual circumstances surrounding the transfer. Consequently, after extensive review and consultation, the committee proposes that the following protocols and recommendations be endorsed.

	<b>URBAN / SEMI-URBAN</b>	<b>RURAL / REMOTE</b>
<b>VOLUNTARY M-H PATIENT</b>	<b>ROAD</b> - Taxi, private	<b>ROAD</b> – Taxi, private, QAS or QH vehicle. <b>RFDS</b> regularly carries small numbers of voluntary patients also
<b>INVOLUNTARY M-H PATIENT NEEDING</b> <ul style="list-style-type: none"> <li>• <i>ESCORT (and/or)</i></li> <li>• <i>SEDATION (and/or)</i></li> <li>• <i>RESTRAINT</i></li> </ul>	<b>ROAD</b> – QAS vehicle	<b>ROAD</b> – consider QAS vehicle for shorter distances and; <b>AIR</b> – RFDS aircraft if road impractical for any reason and for longer distances
<b>M-H PATIENT</b> <ul style="list-style-type: none"> <li>• <i>NEEDING RESUSCITATION (or)</i></li> <li>• <i>WITH PHYSICAL COMORBIDITIES</i></li> </ul>	<b>ROAD</b> – QAS vehicle	<b>AIR</b> – RFDS aircraft

It is noted that some patients who are acutely ill are capable of giving consent to transport and are therefore treated as a voluntary patient.

It is understood that transport decisions will be made on a case-by-case basis. Consequently, it is expected that variances to the above framework will occur.

It is expected that all agencies involved in the transfer process will be flexible in their decision making and that clinical imperatives will guide that decision making process.

It is acknowledged that Clinical Coordination will provide the over-arching authority for the transfer process. However, it is understood that transfer may occur following extensive and lengthy negotiations between the patient, carers and referring health care workers and the receiving mental health unit.

## RECOMMENDATIONS

- That the boundaries defining acceptable practice of transferring mental health patients be developed through the process of integrated and collaborative training for QAS, RFDS and QH personnel
  - to ensure local treatment is optimised before transfer
  - and retrieval teams are appropriately trained and resourced to respond when capacity for local treatment is exceeded.
- That bed shortage in an AMHS does not delay the timely transfer of a patient, and that the relevant AMHS should prioritise the finding of an acute bed.
- That the recommendations put forward by QCAG in their submission be considered where possible.
- That use of the PTSS be maximised for the transfer of patients and carers, while recognising the limitations of the service.

## **1. FORWARD**

In 2001, the Queensland Emergency Medical System (QEMS) Committee for the combined Central and Southern Zones requested that a working group be established to review issues associated with the transport of patients with a mental illness within Queensland. This request was based on the fact that a new Mental Health Act was commencing in Queensland on the 28<sup>th</sup> February 2002 and its advent necessitated a review of current practice.

The working group was asked to provide combined Central/Southern QEMS with a report which, if accepted could be developed into standardised and consistent protocols for the transport of mental health patients in Queensland. They would focus primarily on the transport of mental health patients by service providers external to Queensland Health. However, it is acknowledged that in some parts of the state and in some facilities, QH does provide personnel and vehicles for the transport of patients of all categories and acuity.

There are a number of stakeholders involved in the transport process and all were consulted and have contributed to this final document. The stakeholders come from government, private and community groups. Despite different operating procedures based on legislative and organisational imperatives, close collaboration between stakeholders exists to provide high quality pre-hospital and interhospital care to people with a mental illness.

## **2. INTRODUCTION**

Health service in Queensland is delivered in a diversity of locations, from metropolitan areas to regional, rural and remote communities. The challenge facing health professionals in providing seamless service delivery for patients/clients is complicated by the decentralised nature of the population in Queensland in areas where many services are not locally available.

In particular, people with a mental illness in Queensland may require transfer from their place of presentation, whether it is in the community or a hospital, to a centre specifically equipped to manage their condition. It is well known and recently restated that transfers are associated with risks<sup>1</sup>.

### **3. KEY PRINCIPLES**

- The concept of equity of access underpins planning of delivery of health services in Queensland<sup>2</sup>.
- Queensland Health (QH) provides a range of mental health services, delivered by specialist mental health professionals. The private sector also provides primary, secondary and tertiary mental health services.
- The transport of people with a mental illness should be provided by the least restrictive means possible and conducted in a manner that ensures the safety of the person and others. During transport, the person's privacy, dignity and self-respect must be given full consideration.
- Whether a person requiring mental health treatment is a voluntary or involuntary patient, a range of options is available for the transportation of the person to a health facility.
- Private road transport should be considered first. Alternate transport options are provided by Queensland Ambulance Service (QAS), the Royal Flying Doctor Service (RFDS) and the Queensland Police Service (QPS). Their use will depend upon the person's medical and mental condition, and resource availability.
- Queensland Health, Queensland Ambulance Service, Queensland Police Service and RFDS recognise that the optimal provision of services to the people of Queensland relies upon the seamless professional interaction of their services.

## **4. THE LEGAL FRAMEWORK**

Local legal opinion, supported by judgements from overseas, is that hospitals are liable if they fail to properly supervise and treat mentally ill patients.<sup>3</sup> A recent judgement found a QH hospital and the State of Queensland liable for not ensuring that a safe system of transfer for a mentally ill patient was adopted.<sup>4</sup> It is considered legally insufficient to have documented policies without provision for applying them operationally.

Many pieces of State legislation impact on the treatment and care of persons with a mental illness. There are also applicable National and State Policies and Standards (appendix 3). The following points are specific to the Terms of Reference of this report.

### **4.1 Mental Health Act 2000**

The Act deals specifically with the management of involuntary mental health patients in Queensland and provides for the assessment and treatment, and protection, of such persons (whether adult or minor) while at the same time safeguarding their rights. The Act also mandates that examination and assessment is to take place in an authorised mental health service. The Act requires that patients with a mental illness be regarded in the same way as patients with any other illness.

### **4.2 Authorised Mental Health Service (AMHS)**

The Act states, *inter alia*, that:

- a public hospital in a rural or remote area may act as an authorised mental health service (but only for the purpose of assessment and not treatment) if no such service is available locally (section 15) and
- the Director of Mental Health may, for the Act declare a health service, or part of a health service providing treatment and care of people who have mental illnesses, to be an authorised mental health service (section 495).

### 4.3 Queensland Ambulance Service and the *Mental Health Act 2000*

The Act makes provision for an ambulance /police officer to take a person to an authorised mental health service (or its designated equivalent) for:

- assessment (section 25)
- emergency examination initiated by an ambulance /police officer (sections 33, 34, 35) and
- emergency examination initiated by a psychiatrist (section 39).

An ambulance officer may also assist a health practitioner or administrator to:

- take a person to an authorised mental health service if the person has not complied with treatment (section 117)
- take a person between sites within an authorised mental health service (section 163)
- take a person from an authorised mental health service to another (section 168) and
- return a person absent without permission from an authorised mental health service (section 508).

Ambulance officers provide transport to persons in need of attention at a medical or health care facility under the **Ambulance Service Act 1991**, (section 3D. c) and the **QAS Clinical Practice Manual**. Conditions of this transport are outlined in **Ambulance Service Regulation 1991**, (section 6). Also, the Act gives powers to authorised ambulance officers to protect persons from any dangers ... associated with an emergency situation (section 38.1.a) and gives powers to protect themselves ... from danger or assault from other persons (section 38.1.c). In exercising these powers, ambulance officers may use “reasonable measures”.

The Act does not provide a general authority for ambulance officers to administer treatment or apply restraint, (which are issues separate to the right of ambulance officers to be protected from danger and assault from others). The caveat to this is the need for ambulance officers to intervene to save or preserve life when clinically necessary. However, this action is not referable to a power described in *MHA 2000*.<sup>5</sup>

#### **4.4 Queensland Police Service and the *Mental Health Act 2000***

A health practitioner or QAS officer can make a **Request for Police Assistance** under the Act (sections 25, 30, 117, 119, 163, 168, 507, 541). Police (like ambulance officers) may initiate emergency examination orders when necessary (section 33, 34, 35).

The police also have specific roles detailed in the **Police Powers and Responsibilities Act 2000**. Sections 376 and 377 outline police powers to use force against an individual and in critical situations. The role of police in relation to other Acts is outlined in section 10, while section 14.3 details their role in helping public officials exercise powers under other Acts. Legal opinion has concluded that a “public official” includes a health practitioner detaining a person under an emergency examination order, and section 516 of the *MHA 2000* is sufficient in itself to permit police to respond to a request for assistance in appropriate circumstances <sup>6</sup>.

#### **4.5 The use of medication under the *Mental Health Act 2000***

The *Mental Health Act 2000* allows for medication to be given in the transfer process:

- when taking a person to an authorised mental health service for assessment (section 26)
- when taking a person between sites within an authorised mental health service (section 164)
- when returning a person who is absent without permission from an authorised mental health service (section 509).

Medication can only be given by a doctor or a registered nurse under the instruction of a doctor.

#### 4.6 The Royal Flying Doctor Service (Queensland Section)

The RFDS works under various guiding Federal and State legislation and regulations to provide both interhospital transfers, primary retrievals and primary health care services to rural and remote Queensland.

The RFDS must comply with the **Civil Aviation Act 1988** (section 28) to maintain its Air Operators Certificate.

Aviation safety requirements apply to all persons who may pose a potential danger to themselves and others during a flight. **Civil Aviation Regulation 256AA** states that a person in an aircraft must not behave in an offensive or disorderly manner. This is linked to **Civil Aviation Regulation 309** that states, *inter alia*:

“the pilot in command of an aircraft, with such assistance as is necessary and reasonable, may

- take such action, including the removal of a person from the aircraft or the placing of a person under restraint or in custody, by force, as the pilot considers reasonably necessary to ensure compliance with the Act or the Regulations in or in relation to the aircraft
- detain the passengers, crew and cargo for such period as the pilot considers reasonably necessary to ensure compliance with the Act or those Regulations in or in relation to the aircraft”.

**Civil Aviation Order Part 20, Section 20.16.3, subsection 14.1 and 14.2** refers to the carriage of sick and injured persons. It states that, *inter alia*, stretcher cases must be secured by approved standard safety harness (but notes that psychiatric or special restraint in itself is not an approved harness). Consequently, when special restraint is used, it is in addition to approved safety harness. Also, it should be noted that approved safety harness is restrictive for the recumbent patient, so preventing easeful posture changes.

Special requirements apply to the transportation of a person who exhibits a mental illness or is regarded as posing a danger to him/herself and others in flight. The Mental Health Act allows a mentally ill person to be treated as a voluntary or involuntary patient. The Act intends that if possible, patients be treated on a voluntary basis.

With these stipulations in mind, **RFDS Clinical Practice Guideline WI 3.10** states *inter alia*:

- All psychiatric patients are a potential threat to aviation safety.
- The requirements for aviation safety are as follows:
  - **The patient is to be appropriately sedated and/or restrained.**
    - The minimum amount of sedation necessary to ensure the safe transfer of the patient should be used.
    - The form of physical restraints approved for this purpose are RFDS ankle and wrist straps. Patients are more likely to accept the use of strap restraints if their purpose is explained and assurance given that they will be removed on safe landing.
    - The use of a straight jacket is not permitted.
    - Intubation and ventilation should be avoided. Alternative management such as road transfer or delayed transfer should be considered.
  - **There must be reliable IV access.**
  - **A Medical Practitioner and/or police officer (or additional person trained in restraint) must accompany.**
  - **Only one patient is to be transported per flight.**
  - **Night flights are to be avoided** due to :
    - The disorientating effect of night flying
    - Limited available landing sites should a problem occur

Under the *MHA 2000*, RFDS is bound to treat mental health patients in the least restrictive way. As civil aviation regulations do not differentiate between voluntary or involuntary status of patients, the in-flight requirements of restraint, sedation, etc cannot be utilised unless the voluntary patient specifically consents. If the patient does not consent, alternative transport may be necessary.

#### **4.7 The use of mechanical restraint under the *Mental Health Act 2000***

The Mental Health Act 2000 authorises the use of restraint on an involuntary patient in an AMHS if it is deemed clinically appropriate to prevent injury to the patient or others (sections 141-147).

If restraint is deemed to be clinically necessary in settings outside an AMHS, then authorisation must be obtained from other legislation. The committee feels that the respective Acts under which the QAS and QPS operate do not prevent the use of mechanical restraints in particular circumstances in the transfer process of patients with mental illness.

#### **4.8 Interstate transfer**

A small number of patients require transport across state borders. This is legally complex and before occurring requires consultation with senior mental health administrators in the relevant states. These requirements are over and above normal considerations given to patients, parents and guardians.

### **5. TRANSPORT OPTIONS**

The clinical condition of patient, their location and distance to the nearest appropriate AMHS and their status under the *MHA 2000* influence the choice of transport. Also, availability of transport options varies from time to time and is a further determinant when decisions are made.

#### **5.1 Road**

Ideally, road options should always be considered first. However, in remote western and northern parts of the State, this is rarely if ever practical. The options include:

- private vehicles driven by family member, carer or friend
- taxi cabs in metropolitan areas and /or public transport
- QAS vehicle with appropriate crew mix if the patient cannot be safely transported by other means for any reason, or urgency is imperative
- QH –operated ambulances or QH vehicle in those parts of the State which are not serviced by QAS)
- police vehicle.

The use of road transport will always have a severe impact on local resources, especially in rural settings. Provision of escorts and disruption to duty rosters (ambulance, police and hospital) cause difficulties that hinder the initiation and timely completion of the task. QAS require prior notification of at least 24 hours to arrange transport except for Code 1-category patients.

It is noted that road vehicles, including QAS vehicles are not optimal for the transport of patients with an acute mental illness over distance in summer. Such vehicles offer confined space, can induce travel sickness and passengers are exposed to the inherent dangers of road travel generally.

## **5.2 Air**

### **5.2.i Fixed Wing**

(a) RFDS in Queensland is the principal preferred provider of fixed wing aviation assets for the transport of sick and injured patients within the State. The aircraft used in acute retrieval tasks are configured as flying intensive care units, having all resuscitation and life support equipment on board. Suitably trained nursing and medical staff is in attendance. These aircraft are used for transport of patients with an acute mental illness.

RFDS also provide “clinic” or General Practice services to the more remote parts of the State on a regular timetable. The aircraft used in this activity are configured differently and are generally not used to provide advanced levels of medical intervention.

The aviation environment is claustrophobic and noisy. Turbulence, hypothermia, dehydration, relative hypoxia, barotrauma and the potential for airsickness are realities. However, these demerits are offset by the obvious advantage of rapid response times (generally) and speed of completion of task once initiated. Also, the RFDS aircraft comes with medical and nursing crew, so mitigating the depletion of local health and ambulance personnel.

**(b)** Commercial aviation options are limited in rural Queensland, with recent contraction of scheduled services to major centres. Unlike RFDS, local resources would be needed for escort duties in the transfer to an AMHS if this option were considered. Consequently, it is felt that commercial aviation has little to offer the patient with an acute mental illness who needs transport. However, there is a place for this option in the return journey of these patients and their carers, which can be accessed using the Patients Travel Subsidy Scheme. Return flights generally occur at least 24 hours later.

### **5.2.ii Rotary Wing**

It is considered that helicopters are unsuited for transporting patients with acute mental illness. Also, as helicopters have a range that is congruent with motor vehicles, road transport can sometimes be substituted in these situations. The exception is expected to be remote or isolated communities such as the Gulf, Channel Country and Island communities. In these circumstances if helicopters are deployed, the same provisions as stated in RFDS Clinical Practice Guidelines W1 3.10 will apply.

### **5.3 Boat / Water taxi**

This option may be needed on rare occasions. The offshore islands (Whitsundays, Moreton Bay, others) would be the source of this activity. The use of a boat would generally be linked to one or more of the other options outlined above.

### **5.4 Patients Travel Subsidy Scheme (PTSS)**

This is not an option for transport of patients seeking treatment for an acute mental illness, with occasional exceptions. However, the PTSS should be considered when possible for returning these patients and their carers to their home at the completion of treatment.

## **6. THE TRANSPORT PROCESS**

Transfers become necessary when local resources or expertise is incapable of providing definitive care. All acute patient movements are conducted as a primary (direct from the community to a hospital) or as an inter-hospital transfer. Private and public facilities are included.

The acute retrieval service from rural and remote Queensland is activated by the referring hospital, health facility or medical practitioner ringing a dedicated central telephone number for their area and requesting assistance.

### **6.1 Clinical Coordination**

Clinical coordination is the process that links specialist medical advice to patient transport.<sup>7</sup> Clinical coordinators (CC) can be experienced QH or RFDS medical officers. Coordinators arrange appropriate transport, a task-specific crew, a receiving hospital, and offer clinical advice and assistance until the retrieval team arrives. All transport options are available to the CC. The process can be complicated with negotiations between QAS communications centres, local medical officers or hospital superintendents and (mental) health services, receiving hospitals, and the RFDS and community providers of aviation assets.

Patients with acute mental illness who require transport must be triaged with the neonatal, paediatric, obstetric and adult casemix prevailing at the time. The lack of a universal triage tool to accommodate all presentations on equal terms creates difficulties for the clinical coordinator responsible for the transfer.

### **6.2 Urban – Rural Delineation**

The interface between urban and rural areas will determine where road transport is not negotiable (urban) or otherwise. There are a number of ways to define it, all of them roughly congruent. For the purpose of this report, a working definition can be derived from one or more of the following:

- The **2-hour / 200-kilometre rule** was developed some years ago. The rule is practically attractive but operationally difficult to employ universally, because of geographic considerations and organisational pressures prevailing in some areas
- **“Tasking Guidelines for the RFDS Fixed Wing and DES Helicopters”**<sup>8</sup> state that a helicopter should respond to destinations that are less than 90 nm (167 km) with some exceptions. Fixed wing aircraft should undertake tasks to destinations in excess of 115 nm (213 km). In these shorter distances, road and rotary wing transport are interchangeable for patients presenting with an acute mental illness
- traditional geographic considerations suggest that “urban” areas end at the Great Dividing Range. This applies in the southeast corner of Queensland, but further north, the definition is less easy to apply.

### **6.3 Rural Hospitals Experience**

Medical superintendents of several large rural hospitals were canvassed for their experience in the transfer of patients with acute mental illness.<sup>9</sup> They indicated there are no rules and no protocols to which they can refer for guidance. Consequently, they treat each case individually with respect to transport, and there is no consistent outcome following negotiations. Negotiations can be extensive and indeed tortuous, involving RFDS, QAS, QPS, and the receiving AMHS. They indicate that the bed situation in the receiving AMHS is frequently critical and this can delay timely transfer by forcing the patient to remain at scene until a bed is found.

The medical superintendents are aware the aviation environment is not optimal for transporting mental health patients. Some have been able to achieve a timely transfer by road on occasions. However, the difficulties inherent in accessing road transport are great and these are explored in the following section (7).

## **6.4 Local treatment**

Optimising local treatment of any condition will enhance the transfer process and contribute to improved clinical outcomes. This principle becomes particularly important when transport is delayed for any reason. Given the nature of the retrieval service, delays are inevitable. The local management of acute mental illness in rural and remote centres requires staff skilled in this discipline, with expertise in resuscitation and other interventions, and occasionally the provision of an isolation area. Many facilities are unable to provide some or all of these.

## **6.5 Activity and Data Collection**

It has proved difficult to estimate how many patients with acute mental illness are transported in Queensland each year. Data on Emergency Examination Orders is being collected centrally since the *MHA 2000* commenced. However, the number of voluntary patients transferred between facilities is not known. This information may be included in clinical notes or in organisational databases, but is not easily accessible.

The demand on the adult retrieval service in the Central and Southern Zones is increasing by 10% per annum. The overall demand on the RFDS Brisbane base increased by 17% over the 1999-2001 financial years and this increase is expected to be sustained.<sup>10</sup>

## **7. DISCUSSION**

An acute mental health patient who has co-existing physical pathology that requires some level of resuscitation is always managed along conventional emergency lines in the first instance. It is unusual for the *MHA 2000* to be invoked in these situations i.e., prior to or during resuscitation. The concerns that prompted this report are based on the subset of patients who present solely with an acute mental illness and who require transfer. Many of these patients are unlikely to attend an AMHS in a voluntary capacity.

The transport of acute mental health patients in Queensland to an authorised mental health service takes place in two broad environments:

- firstly, within the **urban and outer-urban** areas where health resources are generally available and sufficient, and distances to an AMHS are short. Transport is invariably by road. Assistance from support agencies such as QPS and QAS under the terms of the *MHA 2000* is usually readily available
- the transfer process in the **rural and remote** sector poses a greater challenge because of the limited resources and mental health services available in these areas. The distances involved suggest transport by aircraft is the best option to achieve a speedy outcome to an acute clinical dilemma. However, some towns have achieved road transfer on occasions. The requirements of the *MHA 2000*, the conditions of carriage imposed on the RFDS by CASA, and local and remote factors have guided their medical superintendents to this end.

## 7.1 Queensland Ambulance Service

The QAS representatives on the committee have raised a number of issues based on QAS current experience:

- the “Patient Transport Guidelines” of the QAS did not specifically address transport of mentally ill patients when they were designed. The Guidelines do refer briefly to transport of psychiatric patients however, but only in the context of **aeromedical** transportation of **regulated** patients who are “low risk, sedated or have a police escort”<sup>11</sup>. If these provisions are not met, the Guidelines state “alternative transport” should be used
- some mentally ill patients only require **transport** (as distinct from **transfer** with the implication of medical and ambulance support.) These patients should be able to travel safely by means other than ambulance. This applies to voluntary and some involuntary patients
- there is no ambulance triage device that prevents the inappropriate use of an expensive QAS vehicle and crew
  - the ambulance triage tool ProQA is not an effective instrument for prioritising patients who exhibit mental illness. It is used to triage calls coming directly from the public and is only effective in the urban and semi-urban environment

- clinical coordinators use the 5-point National Triage Scale when requesting ambulance transport
- an appropriate level of escort to accompany patients during QAS transport should be provided by QH
- QAS is not responsible for the return transport of QH escorts but if operationally convenient, QAS will assist in the return process.

The Ambulance Communications Officer will allocate the appropriate QAS transport Code to the patient based on clinical information received (appendix 4). If the person requesting transport feels the allocated Code is inappropriate, they may request the case be referred to the Area Manager for QAS or the Assistant Commissioner for the Region in which the transfer is to take place.

In rural and remote areas, QAS resources, human and material, are limited. QAS must consider their broader responsibility to the community it serves. Consequently, communities can be left without emergency cover while QAS completes inter-hospital transfers that may take many hours to complete. QAS does have the capability to change vehicles and operational staff when ambulance district boundaries are crossed during a long road transfer, but QH escorts will not be returned by QAS in these situations.

## **7.2 Rural and Remote Mental Health Services**

A rural patient with an acute mental illness who cannot be managed locally requires transfer. The type of transport employed depends on distance, safety issues, level of care needed and the availability of resources. Allocation of staff to assist in this process imposes great demands on rural centres.

Air transfer makes the least demands on local resources. No nursing staff from the referring hospital are required as RFDS provides medical and nursing escort. Ambulance and police officers may be needed for some part of the journey, usually only the road component, but generally there is limited impact on local resources when air transfer is used. It should be noted that police are sometimes required as escorts in air transfers.

On the other hand, ambulance transport requires use of locally based vehicles and nursing, medical and police escort may be required. For shorter distances, this may

be more practicable and more efficient than air transport. Longer distances may necessitate local ambulance staff and vehicle being unavailable to the community, for extended periods of time. In some situations, this may exceed 24 hours when the return trip and rest time is factored in.

It has been noted above that QAS may offset the demands on their service by changing vehicle and officers at district borders, so transferring the patient and escort to other vehicles. This may involve up to 3 or 4 ambulance changes in some instances. Queensland Health and the QPS are unable to work this way due to operational provisions and therefore have the responsibility of accompanying the patient for the entire journey. This can leave members of these professional groups with transport difficulties in returning to their local areas.

Rural health facilities face staff recruitment and retention issues, and consequently find it difficult to allocate staff for escort duty without affecting the provision of general services. Also, lack of training and expertise in working with people with mental illness has been identified and these factors may lead to reluctance by some staff to assist in transfers. It was identified that if staff training was enhanced, some transfers may become unnecessary.

Finally, the clinical impact on the patient may be adverse if a lengthy road journey in an ambulance is required, particularly in summer.

With these caveats in mind, it is noted that some rural facilities can achieve successful road transfer on occasions.

### **7.3 Queensland Mental Health Consumer Advisory Group (QCAG)**

The consumer group made a submission to the committee. They have important concerns with the transport of mental health patients and the methods that currently prevail. They made suggestions that include:

- patient to be kept fully informed about what is happening and included in the decision making process
- escorts to be trained in mental health issues
- family friend to act as escort when available
- no uniforms visible on escort staff
- use of unmarked vehicles for transport to avoid public scrutiny
- minimise sirens and flashing lights
- regular comfort stops when using road transport
- night-time transfer was preferred for road transfer, allowing patient to sleep, and when cooler temperatures prevailed.

Most of these requests are only applicable to road transport. Regarding the aviation environment, QCAG have not sighted the RFDS Clinical Practice Guideline WI 3.10 and so are unable to comment on the conditions of transport applied therein. However, QCAG does endorse the least restrictive manner by which mental health patients should be transported. They also acknowledge that a duty of care is required of all stakeholders and recognise that restraints are necessary in some cases.

### **7.4 Queensland Police Service**

A Memorandum of Understanding (MOU) between the State of Queensland through Queensland Health and the State of Queensland through the Queensland Police Service was agreed to and signed on 24<sup>th</sup> May 2001.<sup>12</sup> The MOU commits both agencies to work in full cooperation to promote a coordinated system of care to ensure effective and efficient delivery of services to meet the needs of people with a mental illness, who may from time to time require assistance from both services.

At the system level, both agencies agreed to develop formal arrangements to identify respective responsibilities and to resolve issues that may impede effective interventions.

At a local level, (Regional for QPS and District for QH), working arrangements have been developed throughout the State, which are both informal and formal. These arrangements are needed to achieve consistency across the State, while allowing for local variations. To progress this, a Protocols Framework Workbook has been developed and published.<sup>13</sup>

The Framework recommends that Local Monitoring Committees be set up to monitor and review any agreements and that Queensland Ambulance Service representatives be included.

## **8. ASSUMPTIONS**

The following protocols for the transport of patients with an acute mental illness are based on a number of assumptions:

- the retrieval/transfer service is an integral part of QEMS
- the level of acute mental illness presenting to rural and remote hospitals will not decrease
- acute psychiatric retrieval services to rural and remote hospitals and communities will not be readily achieved in the foreseeable future
- the rural medical and nursing staffing crisis will continue until Federal, State and Collegial initiatives to resolve it become effective
- consumer expectations and best practice requirements to access specialised technology in regional and tertiary centres are likely to increase
- clinical coordination will underpin all acute retrievals in Queensland
- the annual increase in aeromedical retrievals across Queensland is consistent with earlier estimates and is unsustainable without alternative or innovative transport options being explored
- conflict between providers and users as to best available transport options will continue, based on demands for cost containment and cost recovery by and from individual participating agencies

- road vehicles should be considered as the first transport option and discarded in favour of air transport if circumstances such as distance, staffing constraints and adverse service provisions dictate.

## **9. TRANSPORT PROTOCOLS**

These are derived from the provisions of the *MHA 2000* and the legal and operational requirements of the QAS, RFDS and QPS. They attempt to meet community expectations. They acknowledge the limited resources, both human and material to be found in many rural areas. They also acknowledge that transport of patients with an acute mental illness is essentially an exercise in risk management, irrespective of the distance involved.

The protocols are influenced largely by a number of related and unrelated factors, being:

- voluntary/involuntary status of the patient
- clinical condition and immediate treatment needs at presentation and during transport
- presence or absence of co-morbidities
- potential for self-harm or harm to others
- distance to nearest AMHS
- mode of transport best suited to the patient's physical and mental condition
- need for, and availability of, suitable escort(s)
- availability of local EMS resources including QH, QAS and QPS
- availability of transport options
- the dignity of the patient.

They are not formal Guidelines, which require extensive literature review and the rigour of an evidence-based evaluation to develop. (Such Guidelines are achievable but not operationally practical in the current retrieval climate). However, as Guidelines are "...tools to help informed decisions for individual patients and organisations by making clear the benefits, harms and costs of different treatment/transport options"<sup>14</sup>, the committee feels this process should be attempted at some time in the future.

This will take a significant investment of resources to hire expertise in guideline development, literature search and evaluation, information management and other skills, but should be considered as it would contribute to the evidence-based structure which the retrieval service in Queensland is assuming.

### TRANSPORT PROTOCOLS FOR PATIENTS WITH A MENTAL ILLNESS

	<b>URBAN / SEMI-URBAN</b>	<b>RURAL / REMOTE</b>
<b>VOLUNTARY M-H PATIENT</b>	<b>ROAD</b> - Taxi, private	<b>ROAD</b> – Taxi, private, QAS or QH vehicle. <b>RFDS</b> regularly carries small numbers of voluntary patients also
<b>INVOLUNTARY M-H PATIENT NEEDING</b> <ul style="list-style-type: none"> <li>• <i>ESCORT (and/or)</i></li> <li>• <i>SEDATION (and/or)</i></li> <li>• <i>RESTRAINT</i></li> </ul>	<b>ROAD</b> – QAS vehicle	<b>ROAD</b> – consider QAS vehicle for shorter distances and; <b>AIR</b> – RFDS aircraft if road impractical for any reason and for longer distances
<b>M-H PATIENT</b> <ul style="list-style-type: none"> <li>• <i>NEEDING RESUSCITATION (or)</i></li> <li>• <i>WITH PHYSICAL COMORBIDITIES</i></li> </ul>	<b>ROAD</b> – QAS vehicle	<b>AIR</b> – RFDS aircraft

It is noted that some patients who are acutely ill are capable of giving consent to transport and are therefore treated as a voluntary patient.

It is understood that transport decisions will be made on a case-by-case basis. Consequently, it is expected that variances to the above framework will occur. It is expected that all agencies involved in the transfer process will be flexible in their decision making and that clinical imperatives will guide that decision making process.

It is acknowledged that Clinical Coordination will provide the over-arching authority for the transfer process. However, it is understood that transfer may occur following extensive and lengthy negotiations between the patient, carers and referring health care workers and the receiving mental health unit.

## **10. CONCLUSIONS**

Patients with a mental illness make up a small proportion of the sick and injured who require acute medical transfer within Queensland each year. Despite the small numbers, mental health patients are transported under a strict legislative and regulatory framework. Each State has its own legal structure and there are requirements under Federal law also. Consequently, there is no single legal entity that provides protection to mental health patients.

Medical and transport infrastructure in the populous parts of Queensland is sufficient to meet the needs and expectations of patients with an acute mental illness. Appropriate road transport is the only option in these areas. History and practicalities have made air transport the preferred provider of transport as distance increases. However, road options should be explored first before resorting to air.

An alternative model of care, provided by specialist psychiatrists or their registrars at the scene, may negate the need for transfer, at least in the acute phase. This would overcome some practical impediments that this report has identified and it is felt important that this model be considered.

## **11. RECOMMENDATIONS**

- That the boundaries defining acceptable practice of transferring mental health patients be developed through the process of integrated and collaborative training for QAS, RFDS and QH personnel
  - to ensure local treatment is optimised before transfer
  - and retrieval teams are appropriately trained and resourced to respond when capacity for local treatment is exceeded.
- That bed shortage in an AMHS does not delay the timely transfer of a patient, and that the relevant AMHS should prioritise the finding of an acute bed.
- That the recommendations put forward by QCAG in their submission be considered where possible.
- That use of the PTSS be maximised for the transfer of patients and carers, while recognising the limitations of the service.

## **APPENDIX 1.**

### **TERMS OF REFERENCE**

#### **1. Role & Objective of the Working Group**

The Working Group is an advisory body to the QEMS Committee for Central and Southern Zone/Region.

The objective of the Working Group is to develop Guidelines to assist operational staff in the safe transport of patients with a mental illness, in line with the requirements of the Mental Health Act 2000. The Guidelines will seek to improve coordination and consistency in the management of transport services for these patients.

Issues associated with funding allocations and the purchase or provision of specific services are not within the scope of the Working Group.

#### **2. Key issues to be addressed**

Specific issues to be addressed by the Working Group in the development of operational Guidelines include:

*The requirements of the new Mental Health Act.*

*Transport safety issues.*

*The management of involuntary patients versus voluntary patients.*

*The use of escorts for people during transport.*

#### **3. Background**

The Queensland Emergency Medical System (QEMS) Committee for Central and Southern Zone/Region has requested that a Working Group be established to address issues associated with the safe transport of patients with a mental illness. The safe transport of these patients involves a number of key stakeholders including Queensland Health, Queensland Ambulance Service, Royal Flying Doctors Service, Department of Emergency Services and Queensland Police.

The Mental Health Act 2000, which commenced on 28 February 2002, relates principally to the involuntary assessment, treatment and protection of a person with a mental illness. The Act does not specifically address the voluntary treatment of mental illness, as this is to be regarded in the same way as treatment for any other illness with the protection of rights in other mainstream legislation.

Under the new Act, ambulance officers are now authorised to take a person to a health service for involuntary examination or assessment. A factsheet containing information about the new involuntary assessment provisions is attached.

The new Act also contains specific provisions for the transfer of involuntary patients between health facilities and the return of patients that are absent from a mental health service without permission.

The transport of involuntary mental health patients has raised questions for staff about patient management, including transport safety issues and the use of restraint. A number of Queensland Health Service Districts have established local protocols and procedures in consultation with local Queensland Ambulance staff in an effort to address some of these issues. However, the development and accessibility of standardised and consistent Guidelines would provide benefits for operational staff across the State.

#### **4. Reporting Requirements**

The Working Group has been established to provide advice to the QEMS Committee for Southern and Central Zone/Region. Thus, the Guidelines will be forwarded to QEMS and if appropriate to the Queensland Emergency Medical System Advisory Committee (QEMSAC) prior to finalisation.

District/Zonal Managers and other key stakeholders will have the opportunity to comment on the draft Guidelines.

#### **5. Meetings**

The first Working Group meeting is scheduled for

9 May 2002

9.30-11am

17<sup>th</sup> Floor Conference Room, QH Building

It is expected that the work will be completed within a maximum of 3 months and that there will be approximately 3 Working Group meetings. The Working Group will delegate responsibilities to members of the group to complete the Guidelines.

**Ms Dianne Cameron, Senior Project Officer**, Southern Zone Management Unit, on telephone (07) 323 40155 will provide secretariat support for the group.

## **APPENDIX 2**

### **MEMBERSHIP**

- Dr. Peter Thomas, Principal Clinical Coordinator, Southern Zone, QH. Chair
- Ms. Dianne Cameron, Senior Project officer, Southern Zone Management Unit, QH. Secretariat
- Mr. James McLachlan, A/Asst Commissioner, QAS
- Mr. Rod Walz, Regional Executive Director, QAS
- Dr. Max Chalmers, Medical Superintendent, RFDS (Queensland Section)
- Ms. Maree Cummins, Senior Flight Nurse, RFDS, Brisbane Base
- Senior Sergeant Dan Willett, QPS, Charleville
- Ms. Julie Finucane, NPC Emergency Department, PAH
- Dr. Brett Emmerson, Director, Mental Health, RBH
- Ms. Robyn Bradley, Team Leader, Mental Health Unit, Charleville.
- Ms. Joanne King, Team Leader, Mental Health, Southern Zone Management Unit
- Ms. Annette Lindsay, Mental Health Act Liaison Officer, Mental Health Unit, QH
- Guest Presenter: Mr. Dean Lewin, Principal Project Officer, Mental Health Act Implementation Project, Mental Health Unit, QH.
- Senior Sergeant Bill Graham, QPS, Cunnamulla
- Mr. Aaron Matson, Mental Health Act Liaison Officer, Mental Health Unit, QH
- Ms. Bretine Curtis, Senior Project Officer, Southern Zone Management Unit, QH

### **APPENDIX 3**

- The Health Services Act 1991
- The Health Act 1937
- The Police Service Administration Act 1990
- The Weapons Act 1990
- The Criminal Code 1899
- The National Mental Health Policy 1992
- The National Mental Health Plan 1992
- The Mental Health Statement of Rights and Responsibilities 1991
- The Queensland Mental Health policy 1993
- The 10 year Mental Health Strategy for Queensland 1996
- The National Standards for Mental Health Services 1996
- The Second National Mental Health Plan 1998
- The Personal Information Privacy Principles for Queensland Health 1998
- The Queensland Health Administrative Access to Health Records Policy
- The Queensland Health Code of Conduct 2000
- The Queensland Police Service Code of Conduct
- The Police Powers and Responsibilities Code
- The Queensland Police Service Operational Procedures Manual
  - Chapter 6 Special Needs Groups
  - Chapter 10 Escorts and Extraditions
  - Chapter 13 Miscellaneous (S13.20.29 Mental Health Act)
  - Chapter 16 Custody

## **APPENDIX 4**

- Emergency. This response is an ambulance Code 1 time critical response using lights and sirens. For example, it is declared in cases of overdose or severe self-harm that require resuscitation. The person will be transported to the nearest appropriate emergency department or health facility for treatment and stabilisation
- Urgent response Code 2 is called if the patient exhibits agitation, distress impulsivity, unpredictability, propensity for destructive acts or who has attempted or threatened suicide and is unable to be cared for in a safe manner
- Routine ambulance Code 3 with the person transported to the nearest emergency department or AMHS. Transport other than ambulance should be considered in these cases.

## **REFERENCES**

1. Medical Journal of Australia, Editorial, February 5, 2001
2. Queensland Health Strategic Plan 2000-2010
3. (i) Drake v Pontefract Health Authority (1998) Lloyds Rep Med 425.  
(ii) De Jong v Owen Sound General and Marine Hospital (unreported, High Court of Ontario, 26 February 1996)
4. Batiste v State of Queensland (2001) QCA 275
5. Crown Law Document Number 845580
6. Crown Law Document Number 807248
7. QAS Patient Transport Guidelines, page 16
8. Tasking Guidelines for the RFDS Fixed Wing and DES Helicopters, (1998)
9. Longreach, St George, Roma, Charleville, Mungindi, Augathella, Dirranbandi, Injune, Miles, Goondiwindi
10. RFDS website
11. QAS ibid
12. Memorandum of Understanding, 24<sup>th</sup> May 2001
13. Protocols Framework Workbook, June 2002
14. New Zealand Guidelines Group – Tools for Guideline development and evaluation