Safe transport of people with a mental illness

Queensland interagency agreement

Queensland Health (including Queensland Ambulance Service) and Queensland Police Service

2014
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Foreword

Transport is a key part of healthcare, enabling access to assessment and treatment for people experiencing general health or mental health problems, and also providing an important point of care provision in and of itself.

Transport to, from or between health facilities can present certain challenges for patients, family members, carers, health service staff and emergency services. This is perhaps especially the case when a patient is experiencing an acute episode of mental illness, with or without a concurrent physical illness or injury.

Queensland currently faces a number of significant statewide challenges in ensuring the safe transportation of people with a mental illness. Of particular importance is the need for consistent decision making pathways and communication processes between agencies. In rural and remote areas, transport issues are further complicated by large travel distances and limited resource availability across agencies.

This statewide agreement is the result of considerable collaborative work between Queensland Health (in particular the Mental Health Alcohol and Other Drugs Branch, the Hospital and Health Services and the Queensland Ambulance Service), the Queensland Police Service and the Public Safety Business Agency. The agreement is in accordance with the National Safe Transport Principles and the National Safety Priorities in Mental Health.

It is anticipated that the agreement will facilitate the development and review of tailored agreements between services in local areas across Queensland, supporting interagency collaboration in ensuring the safe transport of people with a mental illness.

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1. **Purpose**

This agreement has been developed by the Department of Health (including Queensland Ambulance Service, QAS), in collaboration with the Queensland Police Service (QPS) and Hospital and Health Services (HHSs), and in consultation with patients\(^1\), carers and other key stakeholders.

This agreement aims to:

1. define a statewide interagency approach to the safe transport of people with a known or suspected mental illness who require, or may require, mental health assessment, treatment or care
2. clarify the roles and responsibilities of each agency involved
3. provide a broad framework to guide the development of local interagency agreements, and
4. facilitate collaboration and coordination between key agencies in providing transport and treatment/care that address the safety of individuals, service providers and the community.

2. **Scope**

This agreement pertains to the transport or transfer of people with a known or suspected mental illness, including (but not limited to) people under the *Mental Health Act 2000* (Qld) (the MH Act). Transport may be:

- from the community to a Queensland Health (QH) facility
- from a QH facility to the community
- between health facilities, including between private and public health facilities
- between a court or custodial facility (including a watch house) and a health facility.

Note that additional or separate guidelines will apply:

- where transport arrangements cross state or international borders
- for transport with specific providers such as:
  - corrective services
  - private hospitals
  - aeromedical retrieval services
  - commercial airlines
  - local hospital-based ambulance services
  - local non-emergency community transport services.

\(^1\) For the sake of clarity, a person with a known or suspected mental illness who may require transport to, from or between health facilities is generally referred to in this document as a *patient, person or individual*. The term *consumer* is not used because it is not understood or commonly used by all parties to this agreement.
This agreement is not legally binding and does not supersede the directives or protocols of any agency. The agreement is not intended to dictate the operational management of mental health patient transport in local areas, but rather to act as a broad guide. It is the role of local agreements and protocols, used in conjunction with professional judgement, to establish in detail how patient transport is managed in practice. It is expected that operational details will vary according to location and resourcing, but that all parties will endeavour to follow the principles set out in this agreement.

3. **Principles**

This agreement is underpinned by the following principles:

1. Ensuring the safety of patients, significant others, service providers and the public is of paramount importance.
2. Individuals should be treated respectfully, without discrimination or stigma, and in a manner appropriate to the cultural and language needs of the individual.
3. Individuals should receive holistic care that includes attention to the needs of children and significant others.
4. Individuals should have access to timely and effective healthcare, including specialist mental health assessment and treatment/care, and safe transport to an appropriate health facility when needed, based on the individual’s clinical needs.
5. Wherever possible, an individual should be treated in their own community.
6. Transport enables access to healthcare, and is also a point of care provision in and of itself.
7. Transport should be provided in the least restrictive and least intrusive manner possible, with due regard for the safety of the individual being transported and others; the clinical needs of the individual; and the available resources.
8. To the extent possible, patients and significant others should be involved in and given choices about decisions regarding their transport and care.
9. Transport and care should be provided in the context of cooperative and coordinated action between agencies, with the development of mechanisms to ensure clear role expectations, communication and appropriate sharing of information.
10. Appropriate training, information and support should be available to service providers, regardless of agency and geographic location.
The agencies agree that:

1. Cooperative work and communication between agencies are key in ensuring the safety of the patient, significant others, service providers and the public.
2. Agencies will work together to coordinate the safest and most appropriate form of transport for a patient, to the nearest clinically appropriate hospital or health care facility, as agreed by local interagency agreements and by negotiation on a case-by-case basis.
3. Ultimate responsibility for decisions made about management of the patient during transit rests with the agency providing the transport, taking into account the expertise and specialist knowledge of the other agencies.
4. With due regard for the clinical needs of the patient and the capacity of the local health facility to manage those needs, preference will be given wherever possible to transportation between facilities within business hours.

4. Relevant legislation and agreements

4.1 Acts

Mental Health Act 2000 (Qld)
Ambulance Service Act 1991 (Qld)
Police Powers and Responsibilities Act 2000 (Qld)
Civil Aviation Act 1988 (Cth)
Hospital and Health Boards Act 2011 (Qld)
Guardianship and Administration Act 2000 (Qld)
Information Privacy Act 2009 (Qld)

4.2 Memoranda of Understanding

Memorandum of Understanding between the State of Queensland through Queensland Health and the State of Queensland through the Queensland Police Service – Mental Health Collaboration (2011)

Memorandum of Understanding between the State of Queensland through the Queensland Police Service and the State of Queensland through the Queensland Ambulance Service – Mental Health Collaboration (2007)

Memorandum of Understanding between the Chief Executive of Queensland Health and the Queensland Police Service – Confidential Information Disclosure (2013)

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2 Note that this is not intended to be an exhaustive list.
3 Note that this is not intended to be an exhaustive list.
5. **Lawful sharing of confidential information**

The sharing of relevant confidential information between police, ambulance, air transport and health service personnel may be sanctioned under legislation that applies to each particular agency or entity when it is necessary for the treatment or care of a person, or for maintaining the safety of that individual, other persons or the public.

Staff of all agencies are encouraged to familiarise themselves with the relevant sections of the legislation, agreements and protocols under which they work that allow for disclosure of confidential information.


6. **Agency descriptions and roles**

6.1 **Queensland Health**

QH is comprised of:

- the Department of Health, including QAS, Retrieval Services Queensland (RSQ) and Queensland Emergency Medical System Coordination Centres (QCC)
- HHSs.

6.1.1 **Department of Health and Queensland Ambulance Service**

The Department of Health, through the Director-General, is responsible for statewide public healthcare policy and planning, performance monitoring, service purchasing, and the management of statewide health functions and services.

For the purposes of this agreement, the Department of Health is responsible for:

- at a statewide level, managing internal stakeholder relationships, and relationships with QPS and other transport partners and stakeholders
- providing guidance to HHSs regarding the safe transportation and care of mental health patients
- monitoring HHS compliance with relevant legislation, policy and Health Service Directives.

[^4]: Currently under review
Queensland Ambulance Service

As of 01 October 2013, QAS joined QH, operating as a discrete unit within the Department of Health, and continuing to work in accordance with the Ambulance Service Act 1991. The QAS Commissioner reports to the Director-General of QH.

QAS is comprised of

- fifteen geographical Local Ambulance Service Networks across Queensland
- seven QAS Operations Centres in key locations across the state. These are responsible for:
  - emergency and non-emergency ambulance call-taking, dispatch and resource coordination
  - coordination of rotary and fixed-wing aeromedical responses involving QAS resources through the QCC.

The QAS role in relation to transport is defined within the Ambulance Service Act 1991, section 3D(c), as being to ‘provide transport for persons requiring attention at medical or health care facilities’.

QAS has a core responsibility to provide pre-hospital emergency patient care and non-emergency health-related transport and clinical care to the community. The service responds to emergency mental health situations in the community and provides clinical risk assessment, preliminary mental health assessment, clinical stabilisation and safe transport to the nearest clinically appropriate hospital or health care facility.

As the interfacility transport of patients is undertaken within the context of maintaining pre-hospital emergency coverage to the community, patients requiring emergency care must be prioritised first.

Retrieval Services Queensland

Retrieval Services Queensland (RSQ) is a unit within the Department of Health that provides clinical coordination for aeromedical retrieval and transfer across the state. RSQ is part of the QCC (see below).

RSQ oversees both primary and interfacility aeromedical transfers, as well as coordinating the return of patients from tertiary or larger facilities to their referring centre when aeromedical resources and a clinical escort are required.

RSQ utilises the services of multiple government and non-government organisations to achieve the required aeromedical coverage of Queensland. RSQ has Service Agreements or contractual arrangements with the Royal Flying Doctor Service Queensland Section and with helicopters within the Emergency Helicopter Network.

Queensland Emergency Medical System Coordination Centres

QCC is a multidisciplinary operational partnership between RSQ and QAS. Through two centres based in Brisbane and Townsville, QCC provides 24/7 statewide clinical coordination and logistical planning of all aeromedical retrieval operations and paediatric, neonatal and high risk obstetric retrieval operations (both road and aeromedical) in Queensland. RSQ provides the clinical coordination and retrieval services, while the transport logistics are managed by QAS.
6.1.2 Hospital and Health Services

HHSs are independent statutory bodies governed by Hospital and Health Boards. Each HHS is responsible for the operation and management of a network of public hospital and health services within a defined geographic or functional area.

For the purposes of this agreement, HHSs are responsible for:

- coordination of a transport episode from inception to clinical handover at the receiving facility, except where transport is initiated in the community by QAS, QPS or another agency or individual.
- appropriate clinical assessment and treatment for patients with suspected or known mental illness
- arranging support for family, carers and significant others of the person being transported
- providing relevant and necessary information and advice, including a risk assessment, to transport providers, the receiving facility and other service providers
- collaborating with transport partners to develop local interagency agreements or operational protocols for the safe transportation of mental health patients
- ensuring compliance with relevant legislation, policy and Health Service Directives.

Queensland Health public health facilities

Public health facilities range from large hospitals with multiple specialist inpatient treatment facilities and 24 hour emergency care availability, to small health clinics with limited staffing and opening hours.

Authorised mental health services

Authorised mental health services are health services with official authorisation under the MH Act to provide involuntary examination, assessment, treatment and care for persons with a mental illness, and also to provide care for persons with an intellectual or cognitive disability who are subject to a forensic order. The care of such persons includes the provision of rehabilitation, habilitation, support and other services. Authorised mental health services include both public and private sector health services. This agreement concerns public sector health services.

In declaring a health service as an authorised mental health service under the MH Act, the Director of Mental Health takes into account the professional expertise required in the assessment and treatment of people with a mental illness, and the need to ensure appropriate access to services across Queensland.

In most instances, authorised mental health services comprise both inpatient and community components. Inpatient facilities are generally based in metropolitan and regional centres, while community components may be established in rural and remote locations as well as major centres. Where a service is declared as an authorised mental health service, an emergency department is considered to be part of the authorised mental health service.

In addition, section 15(b) of the MH Act provides that a public hospital or health clinic may be an authorised mental health service for the purposes of a person’s examination or assessment (but not treatment) under the MH Act if there is no authorised mental health service readily accessible, for example in rural and remote areas of the state.
Availability of mental health care

The level and mode of emergency mental health care available will vary across individual health facilities according to the resources available to each facility within a HHS or geographical region. Facilities located in areas with larger populations generally have greater access to specialist staff, more on-site staff presence, and greater capacity to manage behaviourally disturbed persons and persons under the MH Act. Community-based clinics and rural or remote health facilities may not be staffed 24 hours, and/or may not have access to on-site mental health trained staff.

6.2 Queensland Police Service

QPS is comprised of 15 districts covering five geographical regions across Queensland. Corporate and business support functions for QPS are provided through the Public Safety Business Agency.

The role of the QPS in responding to and managing situations involving people with mental illness is to preserve peace and good order, and to support and protect the Queensland community. Police provide initial on-site response to incidents in the community that pose a serious risk to the safety of individuals or the public.

Police presence should be requested by health service staff or ambulance officers only if there is an assessed risk relating to the safety of the individual or other persons that cannot be safely managed otherwise (refer to the Multi Agency Risk Information and Assistance (MARIA) Guideline at Appendix 2). Note that all agencies may contribute to an assessment of the risk posed by an individual.

When requested under the MH Act, police have obligations to assist as soon as reasonably practicable in the transport of a person to a health care or custodial facility (refer to section 7 Transport under the Mental Health Act 2000 below).

Police assistance may be required by ambulance personnel or air transport personnel in the pre-hospital emergency setting to safely manage and transport patients deemed to be at high risk to themselves or others. In these instances, police presence is required to reduce the safety risks to the patient, ambulance/air transport officers, and the public.

Additionally, police may transport a person to a health facility in a police vehicle under an Authority to Return or an Emergency Examination Order (EEO) under the MH Act (see section 7 Transport under the Mental Health Act 2000 below), or provide an escort to an ambulance transporting the person.

Regardless of the site, police retain responsibility for the detention of people who are in police custody for reasons other than their mental health, for example where criminal charges may be (or have been) laid.
6.3 Mental Health Intervention Program (MHIP)

The Mental Health Intervention Program (MHIP) is a collaborative program that was established in 2006 between QPS, QAS and QH (prior to QAS joining QH). The program is designed to prevent and safely resolve incidents involving persons with a mental illness who are experiencing a mental health crisis, particularly those who may come into contact with emergency services.

Mental Health Intervention Coordinators (MHICs) were appointed in local regions across Queensland in all three agencies. With the aim of increasing the capacity of local services to prevent and respond to mental health crisis situations, MHICs provide consultation and liaison to stakeholders within the program and help to coordinate training. With a strong emphasis on training and interagency collaboration, MHIP has been instrumental in improving local relationships between agencies and increasing the knowledge and skills of police, ambulance and health service personnel in preventing and resolving crisis situations involving individuals with mental illness.

MHIP utilises the Mental Health Collaboration MoUs between QH and QPS (2011) and between QAS and QPS (2007) which guide interagency coordination when responding to people with a mental illness who are in crisis.

6.4 Operational Liaison Committees

Operational Liaison Committees are local interagency committees jointly established between police, ambulance and health services. Attendees may include police, ambulance officers, MHICs and clinicians from local emergency departments. The committees are designed to strengthen communication and collaboration between agencies by providing a regular forum for:

- reviewing incidents involving individuals with mental illness in crisis, where mental health and emergency services were also involved
- resolving issues
- improving processes
- discussing complex cases, with a view to preventing or safely resolving potential future incidents.

7. Transport under the Mental Health Act 2000 (Qld)

Most people with a mental illness are able to make decisions about their assessment, treatment and care. However, there are times when a person does not have full insight into their assessment or treatment needs due to the nature of their mental illness. In these cases, involuntary assessment and/or treatment may be warranted. The MH Act provides the legislative framework for the involuntary examination, assessment, treatment and protection of people with a mental illness, while safeguarding their rights and freedoms and balancing these with the rights of others.
The MH Act contains provisions for the transport of a person under the MH Act without their consent to an authorised mental health service, and within or between authorised mental health services, in a range of different circumstances.

The requirements under the MH Act in relation to transport vary according to the specific provisions under which transport is allowed. The MH Act requirements must be complied with when transporting a patient who is an involuntary patient under the MH Act, including a patient for whom an EEO or involuntary assessment documents are in force.

7.1 Requests for police assistance

Where it is considered necessary, a health practitioner or ambulance officer may contact police to request assistance with transport. Where appropriate, this can be done under the MH Act, which provides that ‘if asked by a health practitioner or ambulance officer, a police officer must, as soon as reasonably practicable, ensure reasonable help is given’ (s25; see also s30, s508 and s568). In practice, requesting assistance from police under the MH Act involves:

- providing a clear indication to police about what assistance is required and the circumstances (especially risks to the life or safety of the patient or others)
- negotiating with police regarding how and when assistance is to be provided.

7.2 Where an authorised mental health service is not readily accessible

As previously mentioned, the definition under the MH Act of an authorised mental health service can include a public hospital if an authorised mental health service is not readily accessible (for example in a rural or remote area of the state). This means that a person under an EEO or involuntary assessment documents can be examined or assessed (but not treated) without their consent in a public hospital or health clinic.

If it is determined that the person meets criteria for an Involuntary Treatment Order (ITO) and requires inpatient treatment, the person must be transferred to a gazetted authorised mental health service (a service that has been officially declared by the Director of Mental Health to be an authorised mental health service). If the person is placed under an ITO (community category), it has been determined that the person does not currently require inpatient treatment. The person may be treated as an outpatient by attending a QH community mental health service in their local community, where that service is a component facility of a gazetted authorised mental health service.

7.3 Transport to an authorised mental health service under involuntary assessment documents

Section 25 of the MH Act authorises a health practitioner or ambulance officer to take a person who is subject to a Request for assessment and a Recommendation for assessment (involuntary assessment documents) to an authorised mental health service for involuntary assessment.
The health practitioner or ambulance officer may take the person to the health service with the help that is needed and may use the minimum force that is necessary and reasonable in the circumstances.

The person may be transported by a family member, carer or friend where the health practitioner or ambulance officer determines that the person can be safely conveyed, and where it is considered to be in the person’s best interests to be transported by someone other than a health practitioner or ambulance officer.

The health practitioner or ambulance officer may request police assistance if it is required to safely transport the person.

In accordance with QH Director of Mental Health policy, where police assistance is requested by health service personnel, a health practitioner must still accompany the person to the health service. Where practicable, this should be in the same vehicle as police.

7.4 Transport to an authorised mental health service under an emergency examination order

Under sections 33-40 of the MH Act, police officers, ambulance officers and psychiatrists are empowered to act in emergency circumstances to take a person to an authorised mental health service for examination. The purpose of the examination is to decide if involuntary assessment documents should be made for the person.

An EEO (police or ambulance) authorises a police or ambulance officer to take a person to an authorised mental health service for examination. An EEO (psychiatrist) authorises a psychiatrist (usually a private psychiatrist), a police officer or an ambulance officer to take the person to an authorised mental health service for examination.

7.5 Moving and transfer

The MH Act (Chapter 5 Part 1) establishes processes to move a patient between facilities within an authorised mental health service, to transfer patients from one authorised mental health service to another and to transfer between authorised mental health services and the forensic disability service. Requirements relating to the move and transfer of patients differ depending on the patient’s MH Act status.

In general, once a transfer has been authorised, a health practitioner may take the patient to the receiving service, using the minimum force that is necessary and reasonable in the circumstances. Assistance from police may be requested where it is necessary in order to move the patient safely.

For moving and transfer of patients out of Queensland, the MH Act allows for persons to be taken to, and detained in, an interstate mental health service. An agreement must exist between Queensland and the corresponding state before this can occur.

7.6 Return to an authorised mental health service of patients absent without permission

The MH Act (Chapter 14 Part 1) contains provisions to enable a patient who is absent without permission to be returned to an inpatient facility of an authorised mental health service for assessment, treatment or care. These provisions are referred to as the ‘return provisions’. The phrase ‘absent without permission’ is not used in the MH Act. It is used in QH resources such as the Mental Health Act 2000 Resource Guide to assist understanding of the return provisions.

In practice, patients are considered absent without permission in the following circumstances:

- a patient detained for assessment, treatment or care (for example, a patient under an ITO (inpatient category), a forensic patient or a classified patient):
  - leaves the authorised mental health service without approval
  - absconds while being transported during the period of detention (for example, during transfer to another service)
  - absconds while on escorted limited community treatment during the period of detention.

- a patient authorised to have limited community treatment:
  - does not return to the health service at the end of the period authorised
  - is required to return to the inpatient facility before the end of the period authorised due to a change to the patient’s limited community treatment plan

- a patient whose ITO is changed from community category to inpatient category
- a patient whose temporary absence is revoked by the Director of Mental Health, or who does not return to the service at the end of the temporary absence period.

The process for returning patients absent without permission will differ depending on the patient’s status under the MH Act and the individual circumstances. In general, when a patient is absent without permission, an authorised doctor will issue a Requirement to return. The Requirement to return authorises a health practitioner to take the patient to an inpatient facility of the authorised mental health service. The health practitioner may exercise the authority with the help that is needed and may use the minimum force that is necessary and reasonable in the circumstances. The health practitioner may request police assistance with a Request for police assistance form or an Authority to return form. An Authority to return authorises police to act alone in locating and returning the patient, though this should occur in the context of ongoing liaison between police and health service staff.
For detailed information about the requirements for returning patients subject to different orders under the MH Act who are absent without permission, refer to the Chapter 14 Part 1 of the MH Act and to the Mental Health Act 2000 Resource Guide (www.health.qld.gov.au/mha2000). Health services staff should also refer to the AWOP (absence without permission) Checklists (http://qheps.health.qld.gov.au/mentalhealth/mha/mha.htm).

Note that the return provisions of the MH Act do not apply in the following circumstances:

1. When a person is subject to involuntary assessment documents but the involuntary assessment period has not yet commenced. Refer to section 7.3 Transport to an authorised mental health service under involuntary assessment documents above.

2. When a person leaves the authorised mental health service while being detained under an EEO.

In this case, where there is ongoing concern about the person’s mental state, an application for a Justices Examination Order may be appropriate. In more urgent circumstances, where it is considered that there is an imminent risk to the patient or others, health service staff may notify police in accordance with section 147 of the Hospital and Health Boards Act 2011.

3. When a patient is subject to an ITO (community category) and, due to non-compliance with their treatment plan, needs to be taken to the authorised mental health service to receive treatment.

In this case, where there is a significant risk of deterioration in the patient’s mental or physical condition because of non-compliance, the MH Act sets out a number of steps aimed at giving the patient appropriate opportunity to respond before being returned to the service to receive treatment. If a patient fails to respond to these steps, a health practitioner is authorised to take the patient to the health service for treatment, and may do so with the help that is needed, and using the minimum force that is necessary and reasonable in the circumstances. Where necessary, the health practitioner may request police assistance in taking the patient to the service. Note that a health practitioner must be involved in transporting the patient, even where police assistance is provided.

Following the provision of treatment at the authorised mental health service, the patient must be returned to the place from which they were taken or to another place the patient reasonably asks to be taken. Even where police have provided assistance in taking the patient to the authorised mental health service, requests for police assistance with returning the patient home should be made only where it is determined that police involvement is necessary for the safety of the patient or others.

7.7 Custodial transport

Transport of patients with a mental illness or suspected mental illness between court or custodial facilities (including watch houses) and authorised mental health services may require negotiation involving a number of agencies such as police, corrective services and prison mental health services.

Patients requiring transport between court or custodial facilities and authorised mental health services fall into two main categories:

1. **Patients subject to involuntary assessment documents under the MH Act**

   Upon being released from custody, a person subject to involuntary assessment documents will require immediate transport from the court or custodial facility to an authorised mental health service for assessment. Transport of these patients may be undertaken:
   - by clinicians in a health service vehicle (with a police escort where necessary)
   - by police in a police vehicle or aircraft (with a health escort where necessary)
   - by ambulance where appropriate (with a police and/or health escort where necessary).

2. **Classified patients under the MH Act**

   The classified patient provisions under the MH Act apply when a person who is an involuntary patient under the MH Act is:
   - appearing before a Court in relation to a simple or indictable offence
   - detained in a watch house, correctional facility or youth detention centre as a result of being charged with or convicted of an offence (including a Commonwealth offence), or
   - held in lawful custody or lawfully detained without charge under an Act prescribed under a regulation.

   Transport of patients in custody must adhere to relevant legislation, and should follow agreed local protocols. Under section 68 of the MH Act, the patient must be taken to an inpatient facility of an authorised mental health service, and this may (where appropriate) be undertaken by a police officer, a correctional officer or a detention centre officer acting alone. In practice, transport of these patients is typically undertaken:
   - by corrective services, if the person is being transported from a prison or youth detention centre (with an appropriate escort where needed)
   - by police in a police vehicle or aircraft, if the person is being transported from a court or watch house (with an appropriate escort where needed)

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5 Note that the classified patient provisions do not apply to a person detained under the *Migration Act 1958* (Cth) who requires involuntary assessment. In this case, the person must be assessed under the provisions in chapter 2 of the MH Act.

6 *e.g.* *Mental Health Act 2000*, *Police Powers and Responsibilities Act 2000*, *Civil Aviation Act 1988*
where it is deemed necessary, by ambulance with an appropriate escort (note that the patient remains in the custody of police or corrective services).

Transport undertaken by corrective services is out of scope for this agreement. However, regardless of which agency undertakes transport, it is considered best practice for the transport planning process to include relevant mental health clinical input, particularly with regards to:

- comprehensive risk assessment
- determining the patient’s clinical needs
- determining the patient’s fitness for travel.

Decisions about the most appropriate authorised mental health service for the admission of a prisoner who requires transfer from a custodial facility are determined on a case-by-case basis by Queensland Corrective Services and the relevant authorised mental health service administrator, taking account of:

- the clinical needs of the patient
- risk assessment and community safety (including potential risk to other inpatients of the proposed receiving service and whether admission to a high or medium security unit is required)
- proximity of the receiving service to family and other supports
- continuity of care.


8. Managing behavioural disturbance to allow safe transportation

8.1 De-escalation strategies

De-escalation strategies are non-invasive techniques that should be the first resort for preventing and managing agitated or aggressive behaviour. These techniques are designed to calm a person and prevent further escalation in aggression.

Staff of all agencies are encouraged to refer to the relevant policy or procedure documents under which they work that outline measures for safely managing people exhibiting disturbed behaviour. These should include strategies for maintaining personal safety and the safety of others in the situation, and utilising de-escalation techniques before other more invasive strategies such as sedation or restraint are employed.

Basic de-escalation techniques include the following:

- Adopt a non-threatening stance with arms by your sides and open palms facing outwards.
- Allow the individual as much personal space as is reasonable and possible under the circumstances while allowing you to maintain control of the situation.
- Remain near an exit, but avoid standing between the patient and the exit.
Present yourself as being calm and in control. This is a powerful de-escalation skill. Consider self-calming techniques to help yourself in the situation, such as slowing your breathing and counting to three.

Avoid prolonged eye contact as this can be threatening, but do not turn your back on the patient.

Avoid sudden gestures, and do not corner or stand over the patient.

Do not touch the patient without their consent unless necessary.

Only one person at a time should speak to the patient.

Allow the patient to verbally express anger and distress.

Emphasise your desire to help.

Use the patient’s name to personalise the interaction.

Listen to the patient.

Use plain language and speak in a calm, confident and non-threatening manner.

Ask open-ended questions - try to identify the problem and seek a solution.

Avoid the use of words such as ‘no’ and ‘but’. For example, use statements such as ‘hospital policy doesn’t allow me to do that, however I can offer you other help…’ or ‘I’ll see what I can do’.

Where possible, reduce stimuli in the immediate environment (for example, remove or move away from other sources of stimulus such as people, loud music or machinery).

Seek collaboration and cooperation rather than making threats (for example, offer a quiet environment or medication rather than threatening to seclude or medicate the person).

Where possible, offer courtesies such as a drink of water, a place to sit down, and a chance to attend to personal needs (for example, accessing a toilet).

Where appropriate, encourage the patient to speak with or sit with a family member, carer or other support person.

### 8.2 Administering medication to ensure safe transport

#### 8.2.1 Sedation for safe transport to an authorised mental health service under the *Mental Health Act 2000*

In addition to a clinical assessment, a comprehensive assessment of risk should inform the preparation of a patient for transport. Amongst other things, this should include consideration of the patient’s level of distress, agitation or aggression prior to transport and the potential for associated risks in transit. Using de-escalation techniques (see section 8.1 *De-escalation strategies*), providing a quiet environment, offering distractions and (where possible and appropriate) having a family member or carer accompany the patient in transit can help to calm an agitated patient. These strategies should be tried prior to making the decision to administer medication.
A patient’s informed consent to the administration of medication for the purpose of safe transport should always be sought in the first instance, regardless of the patient’s status under the MH Act.

Where sedative medication is considered necessary for safe transport and the patient refuses consent, or lacks the capacity to give informed consent, section 26 of the MH Act may apply if the person is an involuntary patient. Section 26 provides that a doctor, or a registered nurse under the instruction of a doctor, may administer medication to an involuntary patient without the patient’s consent immediately prior to or during transport to an authorised mental health service, if the doctor believes it is necessary to ensure the safety of the patient or others during transport. The doctor or nurse may administer the medication with the help, and using the minimum force, that is necessary and reasonable in the circumstances. A list of all medications administered before and during transport must accompany the patient, including the medication name, and the time, route, dose and frequency of administration.

In certain circumstances where a mental health assessment is not appropriate or is impractical, or there is insufficient time to complete the assessment process (for example, where the level of violence exhibited by the person may cause an imminent risk to the safety of the person or others), the provisions of the Guardianship and Administration Act 2000 may be considered.

Note that there will be circumstances in which neither the MH Act nor the Guardianship and Administration Act 2000 applies. In these cases, medication for the purpose of safe transport cannot be administered by health service personnel without the informed consent of the patient, unless acute sedation is necessary to save the person’s life or prevent serious and imminent harm to the patient or others. Refer also to section 8.2.2 Sedation by an ambulance officer for safe transport.

Decisions about mode of transportation and the need for medical monitoring in transit should be informed by a clinical assessment that takes into account, among other things, the likely effects on the patient of:

- any medication, alcohol or illicit substances that the patient may have taken
- medication that has been administered to the patient
- physical illness or injury.

As a general rule, patients who have been sedated for the purpose of safe transport should be transported by ambulance. As an exception, minimal sedation that reduces agitation and distress but does not affect the patient’s level of consciousness, airway reflexes or respiration, will usually not result in the need for ambulance transport. However, patients may respond unexpectedly to medication due to side effects, drug interactions, physical illness or injury, and individual variations in dosage requirements. Where there is any doubt, the patient should be transported by ambulance (or air transport if necessary) for their own safety, with an appropriate escort to monitor the patient in transit (refer below to section 13.3 Escorts).
Depending on the level of sedation and any medical complications that may arise during transport, it may be necessary for the patient to be taken to the emergency department upon arrival at the receiving facility, even where approval has originally been given for direct admission to an inpatient unit. Wherever possible, the need or potential need for a patient to be taken to the emergency department should be discussed with the receiving facility prior to transfer occurring or, where necessary, in transit.


### 8.2.2 Sedation by an ambulance officer for safe transport

 Appropriately trained and authorised ambulance officers are able to carry and administer medication under a doctor’s orders to sedate behaviourally disturbed patients when it is considered necessary for the safe treatment and/or transport of the person. Sedation for safe transport may be considered necessary immediately prior to and/or during transport. Refer to the QAS Clinical Practice Manual at www.ambulance.qld.gov.au.

Note that for interfacility transfer, preparing a patient for transfer (including the management of distress or behavioural disturbance prior to transport) is the responsibility of the referring facility, and not of the ambulance crew members that may be conducting the transfer.

### 9. Transportation of children and adolescents under the age of 18

When transporting a child or an adolescent, care should be taken to ensure that:

- a parent or guardian is informed and wherever possible involved in the transport arrangements
- liaison occurs with child and youth mental health services where appropriate
- where possible, transportation is to an appropriate facility with access to specialist child and youth mental health services.

The requirements of the MH Act, including those relating to transport, apply to people of all ages. Transport of patients subject to an order or involuntary assessment documents under the MH Act must be in accordance with the MH Act.

Health service staff are encouraged to refer to the transport section in the *Guiding principles for admission to Queensland Health child and youth mental health acute inpatient units* (http://qheps.health.qld.gov.au/mentalhealth/).
10. Factors to consider in arranging transport

The transport needs of a patient should be carefully evaluated. Appropriate, timely and well-managed transport can contribute to recovery. Poorly managed transport, especially when a person is in crisis, can cause additional trauma that may delay recovery, and adversely affect future transport experiences.

When a person requires transport from the community to a health facility, from one health facility to another, or back to their place of residence, decisions about the type and timing of the transport should be based on assessment of the:

- person’s physical and mental state
- person’s immediate treatment needs
- person’s legal status
- risk of harm the person poses to themselves and/or others
- likely effect on the person of the proposed mode of transport
- expressed wishes of the person and/or their family or carer/s, where practicable
- availability of the various modes of transport, and the relative risks and benefits of each
- distance to be travelled
- person’s need for support, monitoring and/or treatment during the period of travel, taking into account potential complications or issues during transport
- information from other service providers, family and carers
- the capacity and limits of both the referring facility and the receiving facility to manage the needs of the patient
- availability of appropriately trained and authorised staff for assessment, treatment and escorting, particularly in regional, rural and remote areas.

Wherever possible, the transport option chosen should be the least restrictive and least intrusive option appropriate to the clinical situation.

As far as practicable, transport should occur to the health facility most appropriate to the patient’s clinical needs (and not simply the nearest facility). However, transport via police vehicle will generally be to the nearest authorised mental health service or public hospital, except where agreed otherwise.

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7 Note that cultural and other factors may affect how a person responds to particular modes of transport or particular escorts. For example, some refugees may be terrified of police due to traumatic experiences in their country of origin.
11. **Transport timing**

There is often pressure to arrange immediate transport of patients presenting with a mental illness. However, allowing time to address clinical or psychosocial needs prior to transportation may reduce patient distress and contribute to transport safety. For example, it may be beneficial to:

- delay transport until a doctor has reviewed a patient prior to transfer to another facility, especially where specific treatment or care may be needed prior to or during transport (including the management of behavioural disturbance or significant distress that may place the person or others at risk during transport)
- delay transport until an appropriate mode of transport (such as an ambulance) is available
- wait until a family member or carer is present to provide support for the person
- allow time for a person to secure their property or animals before being taken to hospital.

Transportation carries its own risks. With due regard for the clinical needs of the patient and the capacity of the local health facility to manage those needs, preference should be given wherever possible to transportation between facilities within business hours. If the patient cannot be transported safely at the current time, the patient should be stabilised at the current location and not transferred until it is safe to do so.

12. **Police involvement in transport**

Police should be involved in transport only where their assistance is required for the management of serious risk to the individual or others, or where the person is detained by police (such as where the person is subject to an EEO or the return provisions of the MH Act, or where criminal charges may be or have been laid).

As mentioned previously, police are obligated to respond when their assistance is requested under the MH Act by a health practitioner or ambulance officer. In practice, this process involves negotiation between police and the requesting agency. The requesting agency should clearly indicate to police the type of assistance needed and the relevant circumstances, with particular regard for risks to the safety of the patient or others. QPS will prioritise requests for transport assistance and determine the most appropriate response based on the nature of the situation, safety considerations and the availability of operational resources.

Police involvement in transport may take several forms:

- police officer/s accompanying the patient in an ambulance or health service vehicle
- police vehicle escorting an ambulance or health service vehicle
- police officers conveying the person in a police vehicle.

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8 This section has been adapted from Safe transport of people with a mental illness – Chief Psychiatrist’s Guideline (Department of Health, Victoria, 2011).
Transport in a police vehicle should be an option of last resort, and should be restricted to short distances wherever possible. Transport in a police vehicle can cause heightened distress and agitation for the patient and family members, and can contribute to stigma. Additionally, an acutely unwell, agitated patient travelling in a police vehicle may require restraint by police. While necessary at times to ensure the safety of the individual and others, restraint may pose additional risks, especially when occurring in the context of a patient’s drug or alcohol intoxication and/or travel in a police caged truck where monitoring of a patient during transit is difficult. Wherever possible, alternative means of safe transport should be arranged.

Where police are transporting an acutely mentally ill person from a rural or remote area, who is likely to require admission to an authorised mental health service a considerable distance away, all agencies have a responsibility to consider alternative transport options to ensure the best outcome for the patient. By negotiation between police and the relevant health facility, transport by police to a local health facility for initial examination and medical care may be required. This may be followed by interfacility transport by ambulance or aircraft, with health and/or police escorts as required.

Where police are required to attend a health facility to ensure the safety of the patient or others at the facility itself (separate to transport), this can be arranged:
- in an emergency, by calling 000 and asking for police
- outside of emergency situations, via established local protocols.

13. Transport options

Refer also to the Transport Options chart at Appendix 1.

13.1 Modes of transport

Consideration should be given to non-emergency transport options in the first instance, where clinical and safety needs allow, as these may offer accessible transport that is least restrictive for the patient concerned. This is most appropriate for patients without urgent medical needs, who do not present a significant risk of harm to themselves or others, and where the distance to be travelled is not excessive. Options may include:
- a private vehicle driven by a family member, carer or friend
- public transport such as taxi, bus, train or ferry, accompanied by a family member, carer, friend or clinician (if needed)
- a non-emergency hospital or community transport service, where available
- a health service vehicle driven by a health or mental health worker, with an additional health escort where needed. A police escort may be negotiated for transport via a health service vehicle, where it is considered necessary for the safety of the patient and/or others.

Refer to Appendix 3 for further considerations in relation to non-emergency transport.
Where a patient cannot be transported safely by other means, or is in police custody, one of the following will be necessary:

- ambulance or aeromedical transport, with a health or police escort where required;
  or
- as an option of last resort, a police vehicle, with a health escort where appropriate (police may request that an escort be provided).

A person should be transported by ambulance or aeromedical transport:

- when there is an urgent need for medical monitoring or treatment
- when a person has been sedated for the purpose of safe transport to an authorised mental health service\(^9\) (except where the relevant senior clinician determines that the level of sedation and any additional considerations do not warrant medical monitoring of the person in transit)
- when it is determined that a person is sufficiently affected by medication, alcohol, illicit substances or physical illness or disability to warrant medical monitoring in transit.

### 13.2 Air transport

The decision to use air transport will depend on clinical considerations, distance to be travelled, accessibility of the receiving facility by road, and transport availability. As a general rule, air transport is used for journeys that would take more than two hours (one way) by road, however local protocols may vary.

When arranging air transport, the *Civil Aviation Act 1988* and the relevant air transport provider’s policies regarding risk assessment and risk management should be taken into account. This may include physical restraint and/or sedation being required during air transportation. Additional factors should also be considered, such as the potential distress for the patient, the MH Act requirements, and the need for safe extubation of an anaesthetised patient at the receiving hospital. The director of the receiving facility should be involved in the planning of transport where aeromedical transport will be required.

Should transport via a commercial flight be deemed appropriate, this will be subject to the flight provider’s policies, including *Fitness to fly* requirements.

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\(^9\) Refer to section 8.2 *Administering medication to ensure safe transport* above.
13.3 Escorts

An escort is someone other than the driver of a vehicle who accompanies a patient during transport to provide monitoring, support or treatment. Escorts typically include a family member, carer or close friend, a health worker (usually a nurse, doctor or allied health professional), an ambulance officer or a police officer. An escort is not always needed. Where required, one or more escorts may be necessary or desirable to ensure the health and safety of the patient and others. An escort should have the appropriate skills relevant to the needs of the patient during transit. Where an escort is used, the roles and responsibilities of each agency should be clarified prior to transport.

Escorts for transport from the community to a hospital are usually determined by negotiation between the attending agencies with, where possible, input from the patient and their family or carer.

Escorts for interfacility transport are usually determined:

- for air transport – by the air transport provider in consultation with the referring agency, RSQ and the patient and/or carer (where possible)
- in a QAS vehicle - by the senior referring doctor with input from QAS and the patient and/or carer (where possible)
- in a police vehicle – by negotiation between police and the health service with input from QAS (where applicable) and the patient and/or carer (where possible)
- in a health service vehicle – by the health service in consultation with relevant agency personnel (such as police), with input from the patient/carer (where possible)
- in a private vehicle – by negotiation between the vehicle driver, the patient and/or carer, and the relevant agency personnel (for example the attending doctor, mental health professional, ambulance officer or police officer).

Health escorts for interfacility road transfers are usually arranged by the clinical staff at the referring hospital in consultation with the transport provider. Decisions should be made by the most senior referring clinician on the basis of the individual needs of the patient, taking into account relevant agency policies and specific requests by police, ambulance or other transport personnel.

In rural and remote areas, special consideration of escort issues may be required due to the long distances to be travelled, increased safety risks associated with transport at night, and the limited availability of staffing and resources across agencies. For example, QAS may be unable to provide a two officer crew for a transport request, or a local health facility may have difficulty arranging an appropriate clinical escort, especially at short notice, without significantly affecting the capacity of the facility. Where difficulties occur ensuring an appropriate clinical escort, RSQ can be consulted.

Local transport protocols should clearly outline escort arrangements, including options for the return of escorts to the referring facility. QH personnel are encouraged to refer to the Queensland Health Authorised Transports (QHAT) Operational Standards10 (http://qheps.health.qld.gov.au/iptu/html/qhat.htm).

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10 The QHAT system is currently under review.
14. Transport contexts

Safe transport of people with a mental illness can be considered to occur in a number of broad contexts.

<table>
<thead>
<tr>
<th>CONTEXT</th>
<th>TRANSPORT PROVIDERS</th>
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</table>
| Community to facility          | - QAS, QPS, health service staff and aeromedical crews as first responders  
                                 | - Private transport by family, carers or friends  
                                 | - Non-emergency hospital or community transport services (where available)  
                                 | - Public transport  |
| Transport between health       | - QAS and aeromedical retrieval services  
                                 | facilities                          | - Health service staff in a health service vehicle  
                                 | - Non-emergency hospital or community transport services (where available)  
                                 | - QPS where needed (generally as an escort rather than a primary provider)  
                                 | - Private transport by family, carers or friends  |
| Return transport              | - Private transport by family, carers or friends  
                                 | (Health facility to community)      | - Non-emergency hospital or community transport services (where available)  
                                 | - Public transport  | - QAS  
                                 | - Health service staff in a health service vehicle  | - Aeromedia transport (subject to availability) |
| Return of patients absent      | - Corrective services (custodial transport only)  
                                 | without permission                 | - QPS  
                                 | (return to an authorised mental health service of patients absent without permission under the MH Act) and custodial transport (transfers between courts or custodial facilities and authorised mental health services)  
                                 | - Health service staff in a health service vehicle  
                                 | - QAS where appropriate |
14.1 Community-to-facility transport

Ambulance officers, police officers and health or mental health clinicians are often first responders in crisis situations involving a person who is, or appears to be, experiencing a mental health crisis. Where required, transport to a health facility may be arranged or provided by staff of one or more of the attending agencies. Family members, carers and friends also commonly provide transport to a hospital or health facility for someone needing assessment or treatment for a mental illness.

For patients who do not require urgent medical care, and who pose a low risk of harm to themselves and others, transport from the community to a health facility may be via private vehicle, public transport or a non-emergency hospital or community transport service (where available).

Patients who do not require urgent medical care but who require support or monitoring of their mental state or behaviour during transit may be transported in a health service vehicle, with an additional health escort where needed. At times, a police escort may be requested where it is necessary to ensure the safety of the patient and/or others.

Patients requiring urgent medical care or medical monitoring during transit should be transported by ambulance or aeromedical transport. Cases requiring aeromedical transport will be coordinated by QCC.

Police should be called directly when their assistance is needed to ensure the safety of the patient or others at the scene and/or during transport from the community to a health facility. Where appropriate, police assistance should be requested under the MH Act using the approved form.

Where ambulance, an aeromedical crew or police are called to attend the scene and/or transport a person to a health facility, staff of the requesting agency should provide sufficient information to enable the attending agency to prioritise the case and make informed decisions reflective of their primary roles. This information should include:

- the patient's full name, date of birth, gender and address details
- the address to be attended
- destination facility
- a physical description of the patient (if staff of the requesting agency will not be on site when emergency services arrive)
- current mental state and behaviour of the patient
- urgent medical needs (known or suspected)
- current risk of harm to self or others, taking both risk history and current risk factors into account
- additional risk factors such as weapons or dogs kept on the property, potential aggression from a family member, dark or isolated location
- who is on site (e.g. family or carers including children; emergency services; other agencies)
- triggers likely to escalate the crisis
- communication and de-escalation strategies likely to be effective with the patient
• the contact details of the most appropriate person to provide advice about the patient, should a call-back be necessary
• any other information considered necessary for planning and conducting safe transport of the patient.

Where a patient who is subject to an order or involuntary assessment documents under the MH Act is absent without permission, health service staff should liaise directly with police when police assistance is needed to return the patient, and when police are required to locate and return the patient alone. Health service staff must comply with the MH Act and the Director of Mental Health’s policies. Health service staff should refer to the Director of Mental Health’s guidelines, including the Mental Health Act 2000 Resource Guide and the Absent Without Permission (AWOP) Checklists (www.health.qld.gov.au/mha2000).

Where a patient in the community is to be transported in the first instance by police or ambulance to a nearby community-based health clinic or other health facility with limited staffing (usually in rural or remote areas) or limited opening hours, it is considered best practice to liaise prior to transport with the relevant facility to confirm that the facility will be able to provide initial examination, assessment or care. For facilities without specialist mental health trained staff on site (particularly doctors authorised under the MH Act), access to specialist advice and/or patient assessment may be via telemedicine (refer to section 17 Specialist consultation and support below).

### 14.2 Interfacility transport

Interfacility transport or transfer refers to the provision of transport for moving a patient between health facilities. This may be:

• to obtain further assessment or treatment not available at the referring facility (this is often, though not always, urgent)
• non-urgent transport for an inpatient of a higher level health facility moving to a lower level health facility
• non-urgent transport to allow treatment in a facility closer to the patient’s home or family, when the original admission may have been to a facility in a different city or geographical region.

Interfacility transport is often via ambulance or air transport but may also, where appropriate, be via private or public transport, a non-emergency hospital or community transport service, a health service vehicle or (in exceptional circumstances) a police vehicle.

Prior to transport occurring, the referring facility should liaise with the receiving facility regarding the patient’s needs, risk issues, current management, planned mode and timing of transport and any other relevant factors. This may include conducting a telemedicine assessment (refer to section 17 Specialist consultation and support below). Confirmation should be sought that a bed will be available at the receiving facility. The director of the receiving facility should be involved in the planning of transport where aeromedical transport will be required.
Transfer of a patient by ambulance between health facilities should be arranged via QHAT processes. All relevant information about the patient’s physical and mental state and any risk issues should be provided to QAS. QAS will prioritise the request and determine the appropriate response based on the patient’s clinical needs, safety considerations and the availability of operational resources at the time.

Transport may be coordinated by QCC where there are complicating factors such as the need for aeromedical transport, or for both ambulance (by road) and aircraft.

Transfers of patients subject to an order or involuntary assessment documents under the MH Act must be in accordance with the MH Act. Health service personnel must ensure that interfacility transfers are made in accordance with the QHAT Operational Standards (for QHAT transports) (http://qheps.health.qld.gov.au/iptu/html/qhat.htm), and with relevant Health Service Directives including the Patient Access and Flow Health Service Directive (www.health.qld.gov.au/directives/).

**Arranging police assistance with interfacility transport**

The decision to involve police in interfacility transfer should be made on the basis of a clinical and risk assessment. Where health service personnel determine that police assistance is required to safely transfer a patient with a mental illness between facilities, this can be arranged:

- through QAS, or
- by contacting police directly.

**Arranging police assistance through QAS**

As the primary interfacility transport provider, QAS can act as the main contact in negotiations with health service personnel and police about the timing and mode of interfacility transfer.

Health service personnel must ensure that the need (or likely need) for police assistance with transport is clearly communicated to QAS, along with the relevant risk information. Sufficient information must be provided to enable both QAS and police to make informed decisions reflective of their primary roles.

Note that where health service staff have not requested police assistance, QAS can contact police independently if they believe police assistance is required. Where this is the case, QAS will discuss the issue with the referrer.

**Arranging police assistance directly**

Health service personnel may prefer to contact police directly:

- where the clinician arranging transport wishes to liaise directly with police to provide information, or to make specific arrangements regarding transport
- where local arrangements are in place between the health service and police.

If police attendance at the facility is urgently required, police should be contacted directly by calling 000.
14.3 Return transport (health facility to community)

In most instances, patients and their families bear responsibility for arranging transport from the health facility to the patient’s place of residence. Health service staff should:

- discuss options for transport with the patient and family or carers
- provide information about relevant services such as public transport, local non-emergency patient transport services (where available) and the Patient Travel Subsidy Scheme (www.health.qld.gov.au/ptss/)
- assist the patient to make appropriate transport arrangements (where assistance is needed).

Where return transport is to be provided by the health service, QAS, aeromedical transport (where available) or QPS (in exceptional circumstances), this should be:

- discussed with the patient and family or carers
- arranged via QHAT processes (for return transport via QAS)
- arranged in accordance with transport provider policies and local protocols
- conducted in accordance with the principles underpinning this agreement.

14.4 Return of patients absent without permission and custodial transport

Refer to section 7 Transport under the Mental Health Act 2000 above.

15. Addressing safety upon arrival at a health facility

Upon arrival at a health facility, there may be concerns that a patient:

- presents a risk of harm to themselves or others in the facility, or
- may abscond prior to being seen by a health professional (where the patient can be or is required to be detained in an authorised mental health service).

Where the patient has been brought to the facility by police or ambulance, health service staff may request that police or ambulance personnel remain with the patient until alternative arrangements can be made such as allocating appropriate staff to the patient, taking the patient to a more secure setting within the facility, or arranging assistance from hospital security (where available).

Local interagency agreements should address the safe management of such patients, with particular reference to the roles of different agency staff, including hospital security. Small health facilities and those in rural and remote areas typically do not have access to secure settings or security personnel. It is particularly important that local services work collaboratively in these circumstances to ensure safety for all involved.
Every effort should be made by staff at the health facility to ensure that where QAS or QPS personnel are asked to remain with the patient following arrival at the health facility, this is for the minimum possible time. For patients transported by QAS, health facilities are required to ensure a Patient Off Stretcher Time of no more than 30 minutes\(^\text{11}\) (unless otherwise agreed by negotiation between the relevant managers).

### 16. Local interagency agreements

Staff in each agency are encouraged to be proactive in the collaborative development of local interagency agreements and/or operational protocols at district or facility level to facilitate safe transport of persons with mental illness. Such agreements should:

- be tailored to suit the region to which they apply
- clearly outline the roles of each agency, which may vary according to service availability and resourcing in different locations
- where appropriate, provide clear indicators to service partners as to the capacity and limits of each health facility to manage mental health presentations. This will help to ensure appropriate assessment and care, and avoid unnecessary multiple assessments and transfers.

Refer to Appendix 4 for further suggestions about developing local operational protocols and interagency agreements.

### 17. Specialist consultation and support

For rural, remote and regional health facilities, specialist consultation and support regarding patient management within the facility and during transport should be available via contact with the relevant authorised mental health service and/or specialist statewide service (where relevant)\(^\text{12}\). Higher level services with specialist mental health trained staff and on-call authorised doctors should be prepared to provide consultation and support to other facilities via audio-visual link (including patient assessment), telephone and/or written communication. This may include a telemedicine assessment conducted between the referring and receiving facilities to assist in assessing the patient, determining the appropriateness and/or urgency of transfer, safely managing the patient on-site, and commencing required therapy as appropriate.

Specialist mental health examinations and assessments under the MH Act may be conducted by an authorised doctor via telemedicine. Refer to MH Act sections 19, 46, 50 and 112. Refer also to the *Queensland Health Guideline on Safe Transport/ Transfer of People with a Mental Illness* (2014, in draft).

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\(^{12}\) As per the Clinical Services Capability Framework for public and licensed private health facilities (www.health.qld.gov.au/cscf/default.asp)
18. Transport contact officers

All agencies are encouraged to nominate a position as a contact officer for mental health patient transport at district or health facility level to assist in transport coordination and negotiation. This should include a position for after-hours contact.

19. Dispute resolution

Where a dispute arises and agreement is not able to be reached at officer level, it is to be escalated for immediate resolution to the appropriate managers within each agency. Where a dispute requires further discussion between agencies, for example where policy or protocol clarification is sought or a complaint has arisen, the matter should be escalated through the relevant Operational Liaison Committee or other appropriate channels within each agency.
## Abbreviations and Acronyms

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>EEO</td>
<td>Emergency Examination Order</td>
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<tr>
<td>MH Act</td>
<td><em>Mental Health Act 2000</em> (Qld)</td>
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<td>MHIC</td>
<td>Mental Health Intervention Coordinator</td>
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<tr>
<td>MHIP</td>
<td>Mental Health Intervention Program</td>
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<tr>
<td>QAS</td>
<td>Queensland Ambulance Service</td>
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<td>QCC</td>
<td>Queensland Emergency Medical System Coordination Centres</td>
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<td>QH</td>
<td>Queensland Health</td>
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<td>QHAT</td>
<td>Queensland Health Authorised Transports</td>
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<td>QPS</td>
<td>Queensland Police Service</td>
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<td>RSQ</td>
<td>Retrieval Services Queensland</td>
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# Glossary

The following definitions apply within the context of this agreement:

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td><strong>Ambulance officer</strong></td>
<td>Under section 10 of the <em>Mental Health Act 2000</em>, an ambulance officer is defined as ‘an ambulance officer appointed under the <em>Ambulance Service Act 1991 (Qld)</em>, section 13.’</td>
</tr>
<tr>
<td><strong>Authorised mental health service</strong></td>
<td>Authorised mental health services are health services with official authorisation under the <em>Mental Health Act 2000</em> to provide involuntary examination, assessment, treatment and care for persons with a mental illness, and to provide care for persons with an intellectual or cognitive disability.</td>
</tr>
<tr>
<td><strong>Clinician</strong></td>
<td>This term does not have a legal meaning, but is used in this document to refer to any medical practitioner, nurse, psychologist, social worker or occupational therapist employed by a Hospital and Health Service.</td>
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<tr>
<td><strong>Escort</strong></td>
<td>An escort is someone other than the driver of a vehicle who accompanies a patient during transport to provide monitoring, support or treatment. Common escorts include a family member, carer or close friend, a health or mental health worker (usually a nurse, doctor or allied health professional), an ambulance officer or a police officer. An escort is not always needed.</td>
</tr>
<tr>
<td><strong>Health practitioner</strong></td>
<td>Under the <em>Mental Health Act 2000</em>, a health practitioner is: (a) a doctor, registered nurse, occupational therapist, psychologist or social worker engaged in providing health services; or (b) a person appointed under section 505A(1).</td>
</tr>
<tr>
<td><strong>Health service staff</strong></td>
<td>Employees of Hospital and Health Services.</td>
</tr>
<tr>
<td><strong>Interfacility transport or transfer</strong></td>
<td>Interfacility transport (or interfacility transfer) refers to the provision of transport for moving a patient between health facilities.</td>
</tr>
<tr>
<td><strong>Medical monitoring</strong></td>
<td>Medical monitoring during transport refers to the monitoring of the health of a patient by a nurse, doctor, ambulance officer or other appropriately qualified clinical escort.</td>
</tr>
</tbody>
</table>
MHICs are appointed across Hospital and Health Services, Queensland Police Service and Queensland Ambulance Service to help to coordinate training, and provide consultation and liaison to stakeholders within the interagency Mental Health Intervention Program. The main aim of this is to increase the capacity of local services to prevent and respond effectively to mental health crisis situations.

This term refers to a medical practitioner, nurse, psychologist, social worker or occupational therapist employed in a mental health service of a Hospital and Health Service.

The Mental Health Act 2000 (Qld) defines mental illness as ‘a condition characterised by a clinically significant disturbance of thought, mood, perception or memory.’

Operational Liaison Committees are local interagency committees jointly established between police, ambulance and health services to improve collaboration between services when responding to individuals with mental illness who are in crisis.

In this document a patient is a person with a known or suspected mental illness who may require transport to, from or between health facilities.

The QHAT system (currently under review) is the agreed system for arranging urgent and non-urgent patient road transports provided by Queensland Ambulance Service that have been authorised by a medical officer employed by Queensland Health.

QCC is an operational partnership between Retrieval Services Queensland and Queensland Ambulance Service. Based in Brisbane and Townsville, QCC provides 24/7 statewide clinical coordination and logistical planning of all aeromedical retrieval operations and paediatric, neonatal and high risk obstetric retrieval operations (both road and aeromedical) in Queensland. Retrieval Services Queensland provides clinical coordination and retrieval services, while Queensland Ambulance Service manages the transport logistics.

RSQ is a unit within the Department of Health that provides clinical coordination for aeromedical retrieval and transfer across the state.
References


Mental Health Alcohol and Other Drugs Branch (2014, in draft). *Queensland Health Guideline on the Safe Transport/Transfer of People with a Mental Illness*. Department of Health, Queensland.


Queensland Health (2010). *Guiding principles for admission to Queensland Health child and youth mental health acute inpatient units*. Department of Health, Queensland.


Safe transport of people with a mental illness – Queensland interagency agreement

## Appendix 1  Options for safe transport of people with a mental illness

### Community-to-facility, interfacility and return transport

<table>
<thead>
<tr>
<th>Private vehicle (family/friend) or public transport or non-emergency hospital or community transport service (where available)</th>
</tr>
</thead>
<tbody>
<tr>
<td>o person is cooperative with low identified risk to self/others</td>
</tr>
<tr>
<td>o person does not require medical care during transit</td>
</tr>
<tr>
<td>o for public transport or non-emergency hospital or community transport: where appropriate the person should be accompanied by a responsible family member or friend or a clinician.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health service vehicle (with additional health escort if needed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>o person poses low/medium risk to safety of self or others</td>
</tr>
<tr>
<td>o person does not require medical care during transit</td>
</tr>
<tr>
<td>o person may require monitoring of behaviour or mental state in transit.</td>
</tr>
<tr>
<td><strong>A police escort may be negotiated when transporting a person in a health service vehicle,</strong> where it is considered necessary to ensure the safety of the person and/or others.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ambulance/air transport</th>
</tr>
</thead>
<tbody>
<tr>
<td>o person requires active monitoring and/or medical care in transit</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ambulance/air transport with health escort where clinically indicated</th>
</tr>
</thead>
<tbody>
<tr>
<td>o medium risk to self/others</td>
</tr>
<tr>
<td>o where sedation has been administered</td>
</tr>
<tr>
<td>o person requires both medical and mental health support/monitoring in transit.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ambulance/air transport with police escort</th>
</tr>
</thead>
<tbody>
<tr>
<td>o serious risk to self/others</td>
</tr>
<tr>
<td>o where sedation has been administered</td>
</tr>
<tr>
<td>o and/or person is in police custody but requires immediate medical care</td>
</tr>
<tr>
<td><strong>and health escort where clinically indicated</strong></td>
</tr>
<tr>
<td>o person requires mental health care, support or monitoring in transit.</td>
</tr>
<tr>
<td><em>Police to determine firearm security</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Police vehicle, with or without additional escort</th>
</tr>
</thead>
<tbody>
<tr>
<td>o serious concerns relating to safety of person or others</td>
</tr>
<tr>
<td>o all other transport options have been considered</td>
</tr>
<tr>
<td>o no appropriate transport alternatives available</td>
</tr>
<tr>
<td>o transport cannot be delayed until alternative transport available.</td>
</tr>
</tbody>
</table>
MARI A Guideline (page 1)

Multi-Agency Risk Information and Assistance

a brief guide to assist in assessing risk and determining agency presence for mental health crisis situations in the community

This guideline is designed to be used by staff of Hospital and Health Services, Queensland Ambulance Service and Queensland Police Service in the community setting, to indicate:

- information that might be sought in assessing the situation and communicated between agencies prior to site visit or at site
- a common way to identify risk and the need for agency assistance in the community setting during events in which a person is thought to be suffering from a mental illness

THIS GUIDELINE DOES NOT REPLACE INDIVIDUAL AGENCIES’ ASSESSMENT TOOLS, OPERATIONAL PROTOCOLS OR CLINICAL PROTOCOLS.

Information sharing between agencies must be in accordance with relevant legislation and MoUs.

Risk Information

*assess* the situation

*communicate* with other agencies

Key questions

- What is the level of risk in the current situation?
  - Consider:
    - possession of weapons (or history of)
    - actual or threats of violence (or history of)
    - suicide attempts or thoughts (or history of)
    - drug or alcohol misuse (or history of)
    - recent traumatic event or loss (family member/friend/job/relationship/child custody/home)
    - acute physical illness or injury
- Is the person known to mental health or emergency services?
- Is the person subject to an order or involuntary assessment documents under the MH Act?
- Is the person absent without permission from a mental health or custodial facility?
- Is the situation escalating?
- Are there children or other dependants, and what are their needs?
- Is the notification or involvement of child services required?
- Is a trusted friend or carer present or able to be contacted?

Key sources of information

- Local mental health services
- QH mental health and emergency databases
- Police database
- Mental Health Intervention Coordinators (HHS, QAS or QPS)
- Crisis Intervention Plans - may be available on police and HHS mental health databases for individuals requiring frequent or repeated involvement of police and mental health services during a crisis.

Adapted from the New South Wales Memorandum of Understanding - Mental Health Emergency Response (2007)
**Assistance**

*determine agency presence* required

This table provides a brief guide to assist in assessing risk and the need for the attendance of agencies in the community. Note that the guideline suggests the **minimum agency presence**. Some instances **may require additional assistance**, especially where **multiple risk indicators** are present. This guide does not replace or override agency assessment tools or operational/clinical protocols.

Decisions regarding the most appropriate mode of transport to a health facility may be guided by the Transport Options chart at Appendix 1.

<table>
<thead>
<tr>
<th>Risk situation</th>
<th>Assistance</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Siege situation or presence of firearm / lethal weapon (or history of use of)</td>
<td>Police presence indicated</td>
</tr>
<tr>
<td>□ Dangerous environment (e.g. dangerous dog; isolated site; late night)</td>
<td>Police presence indicated</td>
</tr>
<tr>
<td>□ Actual or threatening violence (self or others)</td>
<td>Police presence indicated</td>
</tr>
<tr>
<td>□ Ideas or hallucinations involving suicide / homicide, with impulsive or aggressive behaviour (or history of)</td>
<td>Police and Ambulance presence indicated; Mental Health presence or involvement desirable</td>
</tr>
<tr>
<td>□ Ideas or hallucinations involving suicide / homicide without behavioural disturbance (or history of)</td>
<td>Mental Health presence or involvement indicated</td>
</tr>
<tr>
<td>□ Acute physical illness or injury (actual or suspected)</td>
<td>Ambulance presence indicated</td>
</tr>
<tr>
<td>□ Overdose (drug / alcohol / medication)</td>
<td>Ambulance presence indicated</td>
</tr>
<tr>
<td>□ Under the influence of alcohol or drugs</td>
<td>Ambulance presence indicated</td>
</tr>
<tr>
<td>□ Highly distressed or acute mental health problems but no dangerous behaviour (or history of)</td>
<td>Mental Health presence or involvement indicated</td>
</tr>
<tr>
<td>□ Uncooperative or unwilling to accept help / care (in absence of other risk indicators)</td>
<td>Mental Health presence or involvement indicated</td>
</tr>
<tr>
<td>□ Shows little interest in, or comprehension of efforts made on their behalf (in absence of other risk indicators)</td>
<td>Ambulance or Mental Health presence indicated</td>
</tr>
</tbody>
</table>

**Dispute resolution:** If agencies differ in opinion as to the level of risk or requirement for attendance, the higher level of agency attendance is to apply. Where agreement is not able to be reached at officer level, it is to be escalated for immediate resolution to the relevant managers within each agency.

Adapted from the New South Wales Memorandum of Understanding - Mental Health Emergency Response (2007)
Appendix 3  Additional information about arranging non-emergency transport\textsuperscript{13}

Read in conjunction with earlier sections in this agreement such as section 10 Factors to consider in arranging transport, section 11 Transport timing and section 13.1 Modes of transport, this section provides further information about factors for health service staff, ambulance officers and police officers to take into account when considering non-emergency transport options for a patient.

Transport via private vehicle, taxi or other public transport, non-emergency hospital transport service or community transport service

On many occasions, the transport option most easily arranged and most acceptable to the patient may be a private vehicle driven by a family member, carer or friend; a taxi or other form of public transport; or a non-emergency transport service provided by a hospital or the local community (where available).

When deciding whether it is safe for a patient to be transported via one of the above options, agency staff should consider:

- the patient’s current mental state, especially the risk of erratic or unpredictable behaviour
- the patient’s understanding of the purpose and destination of the transport, and their degree of acceptance of this information
- the driver’s understanding of the purpose and destination of the journey; their knowledge of the patient to be transported\textsuperscript{14}; and their willingness and availability (for example, it would be unreasonable to expect a taxi driver to monitor the patient’s needs)
- the distance to be travelled and time of day
- the patient’s history of using this mode of transport and their willingness to engage with this transport option
- the patient’s relationship to the driver
- any risk issues that may impact on the safety of the patient, the driver, other passengers in the vehicle, and the general public.

Agency staff should not try to persuade a family member, carer or friend of the patient to transport the patient if they are reluctant to do so.

\textsuperscript{13} This section has been adapted from Safe transport of people with a mental illness – Chief Psychiatrist’s Guideline (Department of Health, Victoria, 2011).

\textsuperscript{14} Information should be provided to carers only with the consent of the patient, or in circumstances where it is required for the patient’s ongoing care, or to prevent a serious threat to the safety of the patient or others.
Transport by health service vehicle

Where a patient is known to the health service, and there is no clinical or safety need for an ambulance, a health service vehicle may be the preferred means of transport. When deciding whether to use a health service vehicle for transport, health service staff should consider:

- the patient’s current mental state, especially the risk of erratic or unpredictable behaviour
- the patient’s previous transport history
- the patient’s understanding of the purpose and destination of the transport, and their degree of acceptance of this information
- the patient’s willingness to be transported by the proposed driver
- the distance to be travelled and time of day
- the clinician’s knowledge of the patient and the patient’s history
- the placement of the patient in the vehicle (in the back seat, not directly behind the driver)
- the placement of an escort, where relevant (in the back seat, directly behind the driver and next to the patient)
- the safety needs of all those in the vehicle.

When transporting a patient in a health service vehicle it is generally safer to have an additional worker or an escort in the car in addition to the driver in case of any change of patient circumstances or the need to contact others for assistance.

Internal health service protocols should be in place to ensure additional safety considerations are met, such as:

- informing appropriate contacts of the details of the transport occurring, including the occupants of the vehicle, the destination, and the estimated time of arrival at the destination (and/or estimated time of return to the point of origin)
- actions to be taken in the case of the vehicle not arriving at the destination (or not returning to the point of origin).
Appendix 4 Tips for developing local operational protocols and interagency agreements

The development and review of local interagency agreements and clear operational protocols at district or facility level will assist in the safe transport of people with mental illness, and better outcomes for patients and their families, service providers and the community.

It is important to develop and maintain strong links between agencies. Where possible and appropriate, utilise existing networks such as Operational Liaison Committees. It may be useful to designate certain positions rather than people when arranging regular interagency liaison, to help to maintain interagency links over time. Discuss and put in writing agreed approaches tailored to your local services and community. Set regular interagency (and internal) meetings with a clear agenda. Discuss and resolve issues as they arise, and engage in planning for the future. Talk to other regions and share ideas and templates. Review your local agreements and protocols on a regular basis such as annually or biannually, and also when associated legislation, policies or agreements are released or updated.

The following suggestions may be of help when developing or reviewing local agreements and protocols (this is not an exhaustive list):

- Documents intended to be used by staff on the ground should be brief, to-the-point and easy to follow. Consider one-page checklists, flowcharts, numbered steps or tables. More detailed information can be included in a parent document.
- Discuss and use agreed terms when the document is for use by staff of more than one agency, and list operational definitions where needed.
- Clarify the purpose and scope of the agreement or protocol.
- Ensure compliance with relevant legislation, policy, agreements and protocols. Refer to these in your documents where appropriate.
- Clearly state the role of each agency. This may include specific arrangements tailored to local service availability and resourcing.
- It may be useful to list the capacity and limits of each relevant health facility to manage mental health presentations. This may be best achieved by simplifying the information and presenting it in a table.
- Outline transport options for your area, the circumstances in which to use them, and the agreed processes and contact details for arranging transport. A flowchart, list of steps or table may be of most use in summarising the information.
- Clearly list agreed local processes for arranging and conducting transport of patients with a mental illness, particularly those in crisis and/or with a high risk of harm to self or others, and patients subject to an order or involuntary assessment documents under the MH Act.
- Outline arrangements for transport escorts, including preferred options for the return of escorts to the referring facility. QH personnel are encouraged to refer to the QHAT Operational Standards (http://qheps.health.qld.gov.au/iptu/html/qhat.htm).
• HHSs are encouraged to develop and review processes for the provision of specialist consultation and support by trained and experienced staff at authorised mental health services to staff at lower-level health facilities\textsuperscript{15} regarding the assessment, management and transfer of patients with a known or suspected mental illness. This should include arrangements for specialist assessment of a patient via telemedicine, including patients requiring examination or assessment under the MH Act. Lower-level facilities should be able to access support from an authorised mental health service both within business hours and, for urgent situations, after-hours.

• Clearly state agreed procedures for managing the risk of harm to patients, the public and staff at a health facility in a crisis situation such as when a patient is aggressive or violent. Health service staff, security personnel (where available), local police and ambulance officers should have a shared understanding of their roles and the procedures to follow.

• Clarify arrangements for ensuring the security of a patient who can be, or is required to be, detained under the MH Act, if there is concern that the patient may abscond from a health facility prior to being seen by a health professional. This may involve health service personnel, police or ambulance officers, and where available, hospital security and the use of secure settings within the hospital.

• Ensure dispute resolution processes are clearly outlined, with relevant positions/ranks and contact details. This could be designed as a check list or flow chart if desired.

\textsuperscript{15} As per the Clinical Services Capability Framework for public and licensed private health facilities (\url{www.health.qld.gov.au/cscf/default.asp}), all health facilities should have access to consultation-liaison with higher-level mental health services, including statewide specialist services (where applicable).