Queensland Interagency Agreement for the Safe Transport of People Accessing Mental Health Assessment, Treatment and Care 2019

Queensland Health (including the Queensland Ambulance Service and Retrieval Services Queensland)

Queensland Police Service

Queensland Government

Queensland Interagency Agreement for the Safe Transport of People Accessing Mental Health Assessment, Treatment and Care 2019

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1.0	June 2019	• Initial version
1.1	November 2023	• Change name of Police and Ambulance Intervention Plan to Police Advice and Intervention Plan (PAIP) • Removal of QAS participating in the development and application of PAIPs. • Formatting of links

Contents

Foreword

Transport is a key factor in the provision of healthcare. Transport provides essential pre-hospital patient care and enables access to facilities that provide assessment, treatment, and care.

Transport to, from, or between health facilities can present challenges for patients, family members, carers, health service staff and emergency services, particularly when a person may be experiencing an acute episode of mental illness. The challenges increase in rural and remote areas where transport issues are further complicated by large travel distances and limited resource availability across agencies. Additionally, safely transporting people in need of mental health assessment, treatment and care predominantly requires input and coordination from multiple agencies.

To ensure we continue to provide accessible and safe transport, all agencies party to this agreement must be acutely aware of their role and their responsibilities when transporting people for assessment, treatment and care and the agreed process for working together.

The first iteration of the statewide interagency agreement, the *Safe Transport of People with a Mental Illness 2014*, articulated the roles and responsibilities of the agencies involved in transport and the agreed processes for working together. The first iteration has been successfully implemented around the state.

The second iteration of the statewide interagency agreement, the *Queensland Interagency Agreement for the Safe Transport of People Accessing Mental Health Assessments, Treatment and Care 2019*, builds on the first agreement and incorporates the legislative requirements of the *Mental Health Act 2016* and the *Public Health Act 2005* and has been expanded to include Retrieval Services Queensland.

It is anticipated that the revised agreement will facilitate the review and update of current local agreements in place between services in areas across Queensland, supporting interagency collaboration in ensuring the safe transport of people requiring assessment, treatment, and care.

Michael Walsh
Chief Executive
Queensland Health

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Commissioner
Queensland Ambulance Service

1. Overview

This agreement has been developed by the Department of Health (including Queensland Ambulance Service (QAS) and Retrieval Services Queensland (RSQ)), in collaboration with the Queensland Police Service (QPS), Hospital and Health Services (HHSs), the Royal Flying Doctor Service (RFDS), and the Queensland Emergency Department Strategic Advisory Panel (QEDSAP) and other key stakeholders.

This agreement:

- defines the statewide collaborative approach to the safe transport of people with a suspected or known mental illness who require, or may require, mental health assessment, treatment or care,
- details the legislative framework under which people can be transported,
- clarifies the roles and responsibilities of each agency involved,
- provides a framework to guide the development of local interagency agreements, and
- facilitates collaboration and coordination between key agencies providing transport and treatment and care that upholds the safety of individuals, service providers and the community.

2. Scope

This agreement is for the transport or transfer of people with a suspected or known mental illness, including (but not limited to) people under the *Mental Health Act 2016* (Qld) (the MHA 2016) and the *Public Health Act 2005* (the PH Act). The agreement applies to employees or contractors in Queensland Health (QH), the QPS, the QAS, RSQ who provide services under the context of this agreement.

Transport may include:

- from the community to a QH facility,
- from the community to a location considered clinically appropriate,
- from a QH facility to the community,
- between health facilities, including between private and public health facilities, or
- between a court or custodial facility (including a watchhouse) and a health facility.

Additional or separate guidelines will apply:

- where interstate or international transport arrangements are required,
- for transport with specific providers, such as:
  - corrective services
  - private hospitals
  - commercial airlines
  - local hospital-based ambulance services
  - local non-emergency community transport services.

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 best practice guide. Local agreements and protocols should be established around the state and used in conjunction with this agreement and with professional judgement to establish in detail how patient transport is managed. 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 principles of the MHA 2016 and the following principles:

- Ensuring the safety of patients, significant others, service providers and the public is paramount.
- Individuals should be treated respectfully, without discrimination or stigma, and in a manner appropriate to the cultural and linguistic needs of the individual.
- Individuals should receive holistic care that includes attention to the needs of children and significant others.
- 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.
- Wherever possible, an individual should be treated in their own community.
- Transport enables access to healthcare and is also a point of care provision in and of itself.
- Transport should be provided in the least restrictive and least intrusive manner possible, giving due regard to the clinical needs and safety of the individual being transported, the safety of others, and the available resources.
- To the extent possible, patients and significant others should be involved in and given choices about decisions regarding their transport and care.
- 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.
- Appropriate training, information and support should be available to service providers, regardless of agency and geographic location.

4. Agreed interagency principles

The agencies agree that:

1. Cooperative work and communication between agencies are crucial to 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 consideration 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.
5. Where appropriate, the relevant Chief Psychiatrist Policies and Practice Guidelines will be adhered to when organising patient travel.

4. Agency descriptions and roles

Queensland Health

For the purposes of this agreement, QH is comprised of:

- the Department of Health, including QAS, RSQ, and
- HHSs.

Department of Health

The Department of Health, through the Director-General, is responsible for statewide public health care 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.

Queensland Ambulance Service

As of 1 October 2013, QAS became part of QH as an operational unit within the Department of Health, continuing 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
- eight QAS Operations Centres in key locations across the state. These are responsible for:
  - emergency and non-emergency ambulance call-taking, dispatch and resource coordination
  - collaborating with RSQ, who coordinate all rotary and fixed-wing responses.

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 road based 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

RSQ is a unit within the Department of Health that provides clinical coordination for aeromedical retrieval and transfer from parts of northern New South Wales to the Torres Strait.

RSQ is responsible for the statewide clinical and operational leadership and governance structure for QH's specialised and contracted retrieval services and aeromedical transport across the state, ensuring

whole of system performance monitoring and subsequent policy and system enhancement and development. RSQ provides a multidisciplinary operational partnership between QH and the QAS.

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. Currently, RSQ has Service Agreements or contractual arrangements with the following organisations to provide this service:

- QAS
- RFDS, Qld
- Queensland Government Air
- Lifeflight Retrieval Medicine
- Capricorn Helicopter Rescue Service
- CQ Rescue Helicopter Service
- Babcock International.

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, and
- ensuring compliance with relevant legislation, policy and Health Service Directives.

Queensland Police Service

QPS is comprised of 15 districts covering five geographical regions across Queensland. 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 14). Note that all agencies may contribute to an assessment of the risk posed by an individual.

Police assistance may be requested under the PH Act or the MHA 2016 depending on the situation. More information on police assistance and transport is provided at section 17.

Queensland Health public sector health service facilities

Public sector health service facilities (PSHSF) 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. PSHSFs are included in the definition of treatment and care place and include authorised mental health services.

Authorised mental health services

Authorised mental health services (AMHS) are health services, with official authorisation under sections 329, 330 and 331 of the MHA 2016, 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. AMHS include both public and private sector health services. This agreement concerns public sector health services.

In rural and remote areas, AMHS may be authorised under section 331 of the MHA 2016 as an AMHS (rural and remote). As at the date of publication of this Agreement, there are no AMHS declared as an AMHS (rural and remote).

In most instances, AMHSs 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 AMHS, an emergency department is considered to be part of the AMHS.

5. Relevant legislation

Acts[1]

Mental Health Act 2016 (Qld)

Public Health Act 2005 (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)

[1] Note that this is not intended to be an exhaustive list.

6. Interagency agreements and programs

Memoranda of Understanding

MOU for Mental Health Collaboration – QH and QPS

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

The MOU for Mental Health Collaboration enables effective, timely information sharing between QH and the QPS when preparing mental health intervention strategies and responding to mental health incidents or situations involving vulnerable people (this includes the development of police and ambulance intervention plans).

A mental health incident or situation involving a vulnerable person means situations that:

- involve a series of events or a combination of circumstances in which a person is demonstrating behaviour that is indicative of a mental health problem,
- may involve a serious risk to the life, health, or safety of the person or of another person, and
- requires communication and coordination between QH, QPS and/or the QAS at the earliest opportunity and ongoing communication as required.

MOU for Confidential Information Disclosure – QH and QPS

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

The MOU for Confidential Information Disclosure enables information to be shared between QH and the QPS relating to suspected criminal conduct and missing persons.

Local interagency agreements

All agencies party to this agreement are encouraged to establish local interagency agreements to facilitate safe transport for people accessing mental health assessment, treatment, and care. Local interagency agreements should align with this agreement and be tailored to suit the region to which they apply, and include:

- the principles and objectives of interagency collaboration,
- the role of each agency, which will vary according to service availability and resourcing,
- agreed channels of communication and identified contacts for requesting police and ambulance assistance,
- an agreed escalation process for requests for assistance and requests for other agencies to work alone,
- an outline of agreed local fees and/or charges that may be applied for transporting and/or escorting staff and/or patients, and
- a mechanism for regular follow up and feedback on the collaborative working arrangements.

Mental Health Intervention Program (MHIP)

The Mental Health Intervention Program (MHIP) is a tri-agency program that was established in 2005 between QPS, QAS and QH (prior to QAS becoming part of QH). The objective of the MHIP is to prevent

and safely resolve mental health incidents and situations involving vulnerable people, particularly those people who may come into contact with emergency services.

Mental Health Intervention Coordinators (MHICs) are a key part of the MHIP and have been appointed in local regions across Queensland. MHICs provide consultation and liaison to stakeholders within the program and help to coordinate training, with the aim of increasing the capacity of local services to prevent and respond to mental health incidents or situations involving vulnerable people. With a strong emphasis on training and interagency collaboration, the 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.

The MHIP utilises the Mental Health Collaboration MOUs between QH and QPS, and between QAS and QPS which guide interagency coordination when responding to a mental health incident or situation involving a vulnerable person.

Operational Liaison Committees

Operational liaison committees are local interagency committees jointly established between QPS, QAS and health services. Attendees may include police officers, 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:

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

7. Lawful sharing of confidential information

The sharing of relevant confidential information between QPS, QH and QAS is authorised under legislation, and memoranda of understanding, that apply 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 general public.

This interagency agreement is not an authority to share confidential information or personal information about patients. Section 6.1 of this Agreement details the relevant agreements that provide the authority for agencies to share information.

Staff in all agencies should be aware of the relevant sections of the legislation, agreements, and protocols under which they work that allow for disclosure of confidential information, and must not disclose confidential information outside of an authority to do so.

QH staff should be aware of the information on confidential health records and personal information (http://www.health.qld.gov.au/privacy/) and the guideline on *Information sharing between mental health staff, consumers, family, carers, nominated support persons and others* https://www.health.qld.gov.au/__data/assets/pdf_file/0026/444635/info_sharing.pdf).

The Police Advice and Implementation Plan

The MOU for Mental Health Collaboration allows the sharing of information to establish mental health intervention strategies and when responding to mental health incidents or situations involving vulnerable people. One of the tools to assist the development of a mental health intervention strategy is the Police Advice and Implementation Plans (PAIP). The PAIP is developed by a mental health clinician, ideally in conjunction with the consumer, to plan strategies to support both the consumer and emergency responders to safely prevent or resolve a mental health incident in the community. The PAIP is to be developed as outlined in the *PAIP Resource Guide* and once completed, shared with the QPS.

8. Transfers and transport under the MHA 2016

The MHA 2016 allows for the transfer of an involuntary patients and classified patients from one AMHS to another AMHS. Requirements for approving and ordering the transfer differ depending on the patient's status under the MHA 2016.

Administrator approval

The following patients may be transferred to another AMHS by agreement of the administrators of the referring AMHS and the receiving AMHS:

- a person detained in an AMHS under an examination authority,
- a person detained in an AMHS for the purposes of an involuntary assessment,
- a patient on a treatment authority,
- a patient on a treatment support order, or
- a classified patient (voluntary).

In agreeing to the transfer, the administrators must have regard to the transfer considerations and must complete the patient transfer form. The administrator may delegate this function to an authorised doctor or a clinical director within an AMHS.

Chief Psychiatrist approval

Chief Psychiatrist approval is required to transfer:

- forensic patients,
- patients subject to a judicial order ,
- patients subject to a treatment authority who are not classified patients who need to be transferred to a high security unit, or
- a patient who is a minor.

Written approval must be provided by the Chief Psychiatrist on the patient transfer form. The referring AMHS must seek the agreement of the receiving AMHS prior to seeking the approval from the Chief Psychiatrist. Once agreement has been reached, approval of the Chief Psychiatrist is sought by sending a copy of the patient transfer form to the Office of the Chief Psychiatrist and must include collateral material, or ensure that it is clearly available on CIMHA, to support the request.

Patient transfers should be determined on a case by case basis, taking account of the transfer considerations; legislative authority; individual clinical needs; the wishes of the patient; local arrangements and support available for the patient.

All patient transfers should be carried out in a way that is the least restrictive of the rights and liberties of the person who has the mental illness. This means that the person's rights and liberties should be restricted only to the extent required to protect the person's safety and welfare and the safety of others.

An authorised person can act under an agreement or approval for a patient transfer to transport the patient to, and from, an AMHS.

The *Chief Psychiatrist Practice Guidelines for Transfers and Transport* (the Guidelines for Transfers and Transport) (appendix 1) must be referred to when planning transfers and transport for a mental health patient. The Guidelines for Transfers and Transport should be read in conjunction with the relevant provisions of the MHA 2016 – chapter 11, parts 5 and 6, and chapter 12, parts 2, 3, and 10. The Guidelines for Transfers and Transport provide detailed direction on:

- patient transfers and transport between authorised mental health services,
- patient transfers and transport to, and from, the Forensic Disability Service,
- patient transport after an involuntary examination or assessment,
- requests for police assistance,
- administration of medication,
- use of mechanical restraint,
- warrants,
- notifications, and
- interstate transfers.

Transport for involuntary patient absences

The absent patient transport provisions of the MHA 2016 (chapter 11, part 6, division 3) come into effect when an involuntary patient is absent without approval from an AMHS or a public sector health service facility.

This includes a person:

- detained under a recommendation for assessment or detained for the purposes of making a recommendation for assessment,
- subject to:
    - an examination authority made by the Mental Health Review Tribunal (MHRT),
    - a treatment authority,
    - a treatment support order,
    - a forensic order,
    - a judicial order, or
    - detained for the purposes of making arrangements to return the person to an interstate mental health service.
- The absent patient transport provisions also apply to classified patients (involuntary) and classified patients (voluntary).

If authorised to transport a patient following an absent without approval event, the authorised person or a police officer, may take the patient to the AMHS or the public service health service facility (PSHSF) stated in the *Authority to Transport Absent Person* form.

While acting to transport a patient who is absent without approval, the authorised person or police officer may act with the help, and using the force, that is necessary and reasonable in the circumstances, including the ability to detain the person if required.

Where it may not be possible to transport the patient to the stated AMHS, the patient may be transported to the nearest AMHS or PSHSF.

When determining where the patient should be transported to, the authorised person must consult the treating or on-call psychiatrist.

The *Chief Psychiatrist Policy for Managing Involuntary Patient Absences* (the Managing Involuntary Patient Absences Policy) (appendix 2) must be complied with when transporting a patient absent without approval. This Policy provides detailed direction on:

- authorisation to transport patients who are absent without approval,
- authorising the transport of an absent person,
- determining the least restrictive method for transport,
- requesting QPS assistance – AMHS attending with police officers, and police officers acting alone, and
- escalation of matters where police have indicated their involvement is not required.

The *Chief Psychiatrist Policy: Managing Involuntary Patient Absences* (appendix 2) should be read in conjunction with chapter 11, part 6, division 3 of the MHA 2016.

Generally, QPS should only be involved in transport where their assistance is required for the management of serious risks to the individual or others.

The Guidelines for Involuntary Patient Absences do not apply to a person who absconds while being detained under the emergency examination authority provisions of the *Public Health Act 2005* (refer below to *Transfers and transport under the Public Health Act 2005 – Emergency Examination Authority*).

9. Transfers and transport under the *Public Health Act 2005* - Emergency Examination Authority (EEA)

Section 157B of the PH Act allows an ambulance officer or a police officer to detain and transport a person under the following circumstances:

- the person's behaviour or communication leads the officer to believe the person is at immediate risk of serious harm, and
- the risk appears to be the result of a major disturbance in the person's mental capacity, whether caused by illness, disability, injury, intoxication, or another reason, and
- the person appears to require urgent examination, or treatment and care for the disturbance.

A police officer may consider advice from a health practitioner as to whether the person's behaviour indicates imminent risk of injury.

The transport of the person being placed under the emergency examination authority (EEA) can occur without the person's consent, with the help and force necessary and reasonable for the circumstances.

An ambulance officer or police officer may detain and transport the person to a treatment or care place. The person will, in most cases, be taken to an emergency department or PSHCF. Where the treatment or care place is a PSHSF that is not an inpatient hospital, approval from the person in charge of the facility must be sought before a person is transported to the facility.

Under section 157D of the PH Act 2005, an EEA must be made immediately if the person is being taken to a public sector health service facility. Please see the Queensland Health Clinical Guideline for EEAs for HHSs (appendix 4).

Doctors and authorised mental health practitioners may ask for assistance from QPS when completing examination authorities. Section 16 of the *Police Powers and Responsibilities Act 2000* requires police officers to assist public officers to exercise their powers under other Acts. This applies when a doctor or authorised mental health practitioner is carrying out their power under the MHA 2016 to complete an examination authority (MHA 2016, section 32 and 34).

If a person absconds while being detained under an EEA (including while the EEA is being made by a police officer or ambulance officer at the facility), the least restrictive option appropriate to the level of risk should be exercised to return the person.

A health service employee who has been authorised to act under an *Authority to Transport Person who Absconds* form may request QPS assistance to transport a person who has absconded.

Generally, police officers should only be involved in transport where their assistance is required for the management of serious risk to the individual or others, or where the person is detained by the QPS (for example where criminal charges may be or have been laid).

The QH Guideline for the *Powers and Responsibilities of Police Officers* (appendix 3) provides detailed information on the powers and responsibilities of police officers under the MHA 2016 and the PH Act.

10. Transport and the Guardianship and Administration Act 2000

The *Guardianship and Administration Act 2000* (Qld) (GAA) applies to adults with impaired capacity, and comes into effect if, prior to transport, a guardian has been appointed to a mental health patient. Health practitioners must consult a person's guardian, regarding planning treatment, care, and transport.

The Public Guardian must take into consideration the General Principles and the Health Care Principle contained in Schedule 1 of the GAA, when making healthcare decisions in relation to adults with impaired capacity, including mental health treatment and care.

The principle underpinning the decisions regarding a health matter state that power for a health matter should be exercised in the way least restrictive of the adult's rights and that power should only be exercised if it is necessary and appropriate to maintain or promote the adult's health or wellbeing; or if it is in the adult's best interests.

In an emergency, health care of an adult may be carried out under the GAA without consent if the adult's health provider reasonably considers that the adult has impaired capacity for the health care matter concerned; and either the health care should be carried out urgently to meet imminent risk to the adults life or health; or the health care should be carried out urgently to prevent significant pain or distress to the adult and it is not reasonably practicable to get consent from a person who may lawfully give consent (section 63 GAA).

The Office of the Public Guardian has established the Policy on the *Consent to mental health treatment and care by the Public Guardian* (http://www.publicguardian.qld.gov.au/__data/assets/pdf_file/0003/510177/jag-3608848-v1a-opg-pol-20170118-position-statement-on-consent-under-mh....pdf). The policy clarifies the position of the Public Guardian and applies to adults for whom the Public Guardian is providing consent to mental health treatment and care. The policy assists guardians and attorneys with their consideration and provision of consent for mental health treatment and care in the performance of their roles.

11. Transport considerations for mental health patients with acute behavioural disturbance

Sometimes mental health patients with acute behavioural disturbance will require the administration of sedation before being transported to ensure the safety of themselves and others. Any decisions to sedate a mental health patient under these circumstances should be guided by the principles of least restrictive, patient centred care, and by the relevant Queensland Health guideline for managing patients with acute severe behavioural disturbance (refer to appendices 7, 8 and 9).

If aeromedical transport is being considered for a patient with acute behavioural disturbance, please refer to the RSQ Standard Operating Procedure – Clinical Decision-Making Framework for the Transfer of Patients with Acute Behavioural Disturbance RG4002 (appendix 13).

Decisions about the 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, and
- 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.

12. Ensuring safe transport – de-escalation, sedation and mechanical restraint

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, providing a quiet environment, offering distractions and where possible having a family member or carer accompany the patient in transit, may help calm an agitated patient. Recommended de-escalation techniques for adults, adolescents and children are provided in:

- the QH Guideline for the Management of Patients with Acute Severe Behavioural Disturbance in Emergency Departments (appendix 5)
- the QH Guideline Pharmacological management of acute behavioural disturbance management (ABDM) in Queensland Mental Health Alcohol and Other Drugs (MHAOD) Inpatient Services (adults and older adults) (appendix 6), and
- the QH Guideline for Acute Behavioural Disturbance Management (including acute sedation) in Queensland Health Authorised Mental Health Services (children and adolescents) (appendix 7)

If de-escalation techniques are unsuccessful and the patient's agitation continues, options for sedation and mechanical restraint may be investigated.

13. Sedation, mechanical restraint and transport

Sedation

The transport of patients who have been sedated increases the risk to the patient and potential risk to staff. Vigilance is required to maintain patient safety and protect staff.

The following principles of safe transport of the sedated patient must be adhered to:

- The safety of patients, significant others, service providers and the public is paramount.
- Reassessment of any ongoing need for restraint (sedation or physical) is required prior to transport.
- Individuals should have access to timely and effective healthcare, including specialist mental health assessment and treatment and care, and safe transport to an appropriate health facility when needed, based on the individual's clinical needs.
- Wherever possible, an individual should be treated in their own community.
- 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.
- Early advice from RSQ should be sought if an aeromedical means of transfer may be required.

If required, medication may be provided to transport an involuntary patient (but not a classified patient (voluntary)) under the MHA 2016. This includes patients who are detained in an AMHS for the purposes of an involuntary assessment.

Administration of medication may, for example, be required when the patient is being moved from a rural or remote area, to a regional PSHSF, to access inpatient treatment in an AMHS.

Medication may only be administered by a doctor or registered nurse acting under a doctor's instruction, and only if there is no other reasonably practicable way to protect the patient or others from harm.

If medication is required, it should be administered in a suitable time frame prior to confirmed transportation, or during transportation. All instances of medication for transportation must also comply with the *Chief Psychiatrist Policy – Clinical Need for Medication* (appendix 8).

Where possible, consent for treatment (sedation) should always be sought. Where consent is unable to be provided, dependent on the situation, the authority to administer treatment may be found in provisions under the GAA, the MHA 2016 or the *Criminal Code Act 1899*.

For more information regarding the legal requirements for the urgent treatment of patients with acute severe behavioural disturbance please see section 4.3 of the Queensland Health Guideline for the *Management of Patients with Acute Severe Behavioural Disturbance in Emergency Departments* (appendix 5).

Mechanical restraint

Mechanical restraint can only be used by an authorised person to transport an involuntary patient once the Chief Psychiatrist has given approval, and only if there is no other reasonably practicable way to protect the person or others from physical harm.

The Chief Psychiatrist's approval to use mechanical restraint must be sought prior to the transportation occurring and should only be utilised for the planned transportation of an involuntary patient.

Mechanical restraint may not be used to transport a classified patient (voluntary).

Guidance on the requirements for an application for approval to use mechanical restraint are provided at item 3.7 of the Guidelines for *Transfer and Transport* (appendix 1, pages 11 and 12).

Sedation by an ambulance officer

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. For more information see the *QAS Clinical Practice Manual* at www.ambulance.qld.gov.au/clinical.html and the QAS Clinical Practice Procedure: Behavioural disturbances/Sedation – acute behavioural disturbance (appendix 11).

Aeromedical transport and the use of sedation and mechanical restraint

In certain circumstances patients will require air transport, particularly in rural and remote areas. RSQ coordinate aeromedical transport for mental health patients around the state and support the clinical coordination of these patients by road in rural areas.

When planning aeromedical transport and sedation and mechanical restraint are being considered, please refer to the RSQ Standard Operating Procedure – Clinical Decision-Making Framework for the Transfer of Patients with Acute Behavioural Disturbance RG4002 (appendix 13) for guidance.

When arranging air transport, the *Civil Aviation Act 1988,* and the relevant air transport provider's policies regarding risk assessment and risk management, should also be taken into account. This may include physical restraint and/or sedation being required during air transportation.

Additional factors should always be considered, such as the potential distress for the patient, the MHA 2016 requirements, and the need for safe extubation of an anaesthetised patient at the receiving hospital.

When the person being transported by air is a patient of an AMHS, the patient's treating psychiatrist should always, where possible, be involved in the planning and decision-making process regarding the air transfer. This should also involve the referring doctor and the treating psychiatrist at the receiving AMHS.

For all aeromedical transport, in accordance with section 224 of the *Civil Aviation Regulations 1988,* the pilot has the final authority as to the disposition of the aircraft while he or she is in command and for the maintenance of discipline by all persons on board. This applies whether a patient is being treated and transported voluntarily; is being transported under the PH Act under an EEA; is a patient under the MHA 2016; or has a guardian appointed under the GAA.

All organisations transporting mental health patients via air must take into consideration the objects of the MHA 2016 and make every attempt to transport the person in a way that safeguards the rights of the person, in a way that is the least restrictive of the person's rights and liberties.

All HHSs are mandated to follow the requirements of the Health Service Directive for the *Use of Retrieval Services Queensland* (appendix 9) when organising aeromedical transfers. The standard operating procedures and guidelines for RSQ can be found at https://qheps.health.qld.gov.au/rsq/sops-guidelines.

14. Transfers for patients in custody

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

Safety is the priority when transferring patients in custody. Clinical considerations should be taken into account when deciding the mode of transport to be used to transfer a patient from a corrective services facility, watch house, court or between AMHSs.

Air travel should be considered for journeys that take more than two hours by road (one way).

Transport for classified patients subject to a recommendation for assessment or treatment authority under the MHA 2016

Upon release from custody, a person subject to involuntary assessment orders will require immediate transport from the court or custodial facility to an AMHS for assessment. Transport may be undertaken:

- by clinicians in a health service vehicle (with a police escort where necessary)
- by police in a QPS vehicle or aircraft (with a health escort where necessary)
- by ambulance where appropriate (with a police and/or health escort where necessary).

Under section 65 of the MHA 2016 a person may be transported to an AMHS and become a classified patient (involuntary) if:

- the person is subject to a recommendation for assessment made under Chapter 2 of the MHA 2016,
- an administrator consent has been made for the person, and
- a custodian consent has been made for the person.

Under section 66 of the MHA 2016, a person may be transported to an AMHS and become a classified patient (involuntary) if:

- the person is subject to a treatment authority, treatment support order or forensic order (mental health),
- a transfer recommendation has been made for the person,
- an administrator consent has been made for the person, and
- a custodian consent has been made for the person.

Under section 67 of the MHA 2016, a person may be transported to an AMHS and become a classified patient (voluntary) if:

- the person consents to being treated in an AMHS,
- a transfer recommendation has been made for the person,
- an administrator consent has been made for the person, and
- a custodian consent has been made for the person.

Further information for HHSs on transfers for sentenced prisoners, prisoners on remand and transfers after the person is released from custody, is provided in the Chief Psychiatrist Practice Guidelines for *Transfers and Transport* (appendix 1, page 6 and 7).

Consistent with the broader policy objectives regarding the provision of treatment and care to persons in custody as set out in the Chief Psychiatrist Policy: *Classified Patients*, decisions to transfer a patient's involuntary status on reception to, and discharge from, custody should be determined on a case by case basis.

The responsibilities of the AMHS which held responsibility for the patient's involuntary status immediately prior to imprisonment (i.e. the AMHS of origin) do not cease upon the patient's imprisonment (Section 5.3 of the Chief Psychiatrist Policy for *Classified Patients*).

Planning for transfers and relevant treatment and care places - AMHS for patients in custody

Transport undertaken by Queensland Corrective Services (QCS) is out of scope for this agreement. However, regardless of which agency undertakes transport, the transport planning process should always include relevant mental health clinical input, particularly with regards to:

- a comprehensive risk assessment,
- determining the patient's clinical needs, and
- determining the patient's fitness for travel.

Decisions about the most appropriate AMHS for the admission of a prisoner who requires transfer from a custodial facility are determined on a case-by-case basis by QCS and the relevant AMHS administrator, taking into consideration:

- the clinical need of the patient,
- the 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 support, and
- continuity of care.

If a person was admitted to an AMHS that was the closest, or next closest, AMHS to their custodial facility, due to being unfit to travel, and it is later determined that the patient is fit to travel, the patient may be transported to the AMHS that would otherwise be determined as their relevant AMHS, if clinically appropriate.

Relevant AMHS

In accordance with the *Chief Psychiatrist Policy for Classified Patients*, the following criteria are used to determine the relevant AMHS a person in custody must be transferred to.

Where a person requires admission to The Park Centre for Mental Health – High Secure Clinical Program (the HSIS), the HSIS is the person's relevant AMHS.

When the person does not require admission to the HSIS, other criteria will influence which AMHS is determined to be the person's relevant AMHS. This includes:

- If the referring service determines the person is not fit for travel, the closest, or if in South East Queensland, the next closest AMHS is the relevant AMHS.
- If the person has a treatment authority, a forensic order (mental health) or a treatment support order, the person's relevant AMHS is the AMHS responsible for the treatment authority, forensic order (mental health) or treatment support order.
- If the person has an open service episode at an AMHS, that hasn't been initiated by the prison mental health service or court liaison service, the relevant AMHS is the AMHS with the open service episode.
- The relevant AMHS may be the AMHS:
    - in the locality the person resided, or the person's last known residential address prior to arrest, or
    - the AMHS where the person has recent or strong links.

If none of the above criteria apply, or the person is homeless, other considerations need to be taken into account, for example:

- location of the court where the person was processed,
- location of key supports in the community,
- geographical distance to a proposed service, and
- the patient's fitness for travel.

Where there is no preferred AMHS based on the above criteria, admission should be negotiated with the nearest, most appropriate, AMHS.

Classified patients and the 72 hour requirement

If a classified patient is not transported to an AMHS within 72 hours of a recommendation for assessment or transfer recommendation being made, a doctor or authorised mental health practitioner in the referring service must notify the Chief Psychiatrist (section 72, MHA 2016).

The Chief Psychiatrist may consent to a classified patient being transported to an AMHS after receiving a notice from a doctor or practitioner, or if the Chief Psychiatrist otherwise becomes aware a classified patient has not been transported to a service (4.1 CP Consent – Chief Psychiatrist Policy *Classified Patients*).

15. Transport of children and adolescents

When transporting a child or 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, and
- where possible, transportation is arranged to an appropriate facility with access to specialist child and youth mental health services.

Children, adolescents and the 72 hour requirement

If there is a situation where a child or adolescent is taken to a high security unit or an inpatient unit of an AMHS, other than a child and adolescent unit, the administrator of the AMHS must, within 72 hours after the minor is admitted, give the Public Guardian written notice of the admission (section 231, MHA 2016).

The administrator of an AMHS may enter into arrangements with the Chief Psychiatrist for the giving of notices, on behalf of the administrator, to the public guardian.

Further detail regarding the transport of children and adolescents is provided in section 7 of the *QH Guideline – Admission of children and adolescents to acute mental health inpatient units* (appendix 10).

The requirements of the MHA 2016, including transport requirements, and the requirements of the *Chief Psychiatrist Practice Guidelines for Transfers and Transport* (appendix 1) apply to children and adolescents.

16. Factors to consider when 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[2],
- 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 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, and
- 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 the least intrusive option appropriate to the clinical situation.

When a patient is absent without approval, in accordance with the Chief Psychiatrist Policy for *Managing Involuntary Patient Absences* (appendix 2), transport should be conducted in a way that least restricts a person's rights and liberties. Options for transporting an absent person should be considered, where possible, in the following order:

- a health practitioner (AMHS, QAS or other agency) returning a patient without QPS assistance,
- a health practitioner returning the patient with the assistance of the QPS, or
- the QPS acting alone to return the patient.

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), unless the patient is a classified patient, whereby the criteria

[2] 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.

for ‘relevant AMHS’ should be applied when deciding which AMHS the patient should be transferred to.

Transport via a QPS vehicle will generally be to the nearest AMHS or public hospital, except where agreed otherwise.

17. Transport timing[3]

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, or
- 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.

18. Police involvement in transport

Police officers should only be involved in transport where their assistance is required for the management of serious risk to the individual or others, or where a person is detained by the QPS (where the person is subject to an EEA or the return provisions of the MHA 2016, or where criminal charges may be or have been laid).

A health practitioner or QAS ambulance officer may request QPS assistance to transport a person under the MHA 2016. The requesting entity should clearly articulate to police officers the type of assistance needed, and the relevant circumstances, with regard given to accurately communicating the current level of risk the patient poses to themselves and others. The 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.

Where a PAIP has been established for a patient, the information in the PAIP should be proactively shared with the QPS.

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, or
- police officers conveying the person in a police vehicle.

Transport in a QPS 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

[3] This section has been adapted from *Safe transport of people with a mental illness – Chief Psychiatrist’s Guideline* (Department of Health, Victoria, 2011).

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 officers. 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 officers are transporting an acutely mentally ill person from a rural or remote area, who is likely to require admission to an AMHS 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 QPS and the relevant health facility, transport by police officers 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 officers 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, or
- outside of emergency situations, via established local protocols.

For detailed guidance on arranging police assistance or requesting the police to act alone to transport a patient please see the Chief Psychiatrist Practice Guidelines for *Transfers and Transport* (appendix 1) or the *Chief Psychiatrist Policy for Managing Involuntary Patient Absences* (appendix 2).

19. Request for ambulance transport

A QAS ambulance officer (paramedic) has the authority to transport a person who is a patient under the MHA 2016, and to detain and transport a person to a PSHSF under an EEA (PH Act).

A QAS ambulance officer may transport people to, or from the following places:

- authorised mental health service (AMHS),
- public sector health service facility,
- a place of custody,
- a court, or
- the community.

Details on the powers and procedures for QAS ambulance officers transporting people under the MHA 2016 are provided in the *QAS Clinical Practice Procedures: Behavioural disturbances/transportation of persons under the MHA 2016* (appendix 11).

20. Transport options

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, or
- 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 occurring via a health service vehicle, where it is considered necessary for the safety of the patient and/or others.

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).

Circumstances in which a person should be transported by ambulance or aeromedical transport include:

- 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 AMHS[4] (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), or
- 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.

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 planning aeromedical transport please refer to the RSQ Standard Operating Procedure – Clinical Decision-Making Framework for the Transfer of Patients with Acute Behavioural Disturbance RG4002 (appendix 13) for guidance.

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 MHA 2016 requirements regarding the least restrictive option, and the need for safe extubation of an anaesthetised patient at the receiving hospital. The senior medical officer (or equivalent), or the most senior doctor available at the receiving facility, must 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.

All HHSs are mandated to follow the requirements of the Health Service Directive: *Use of Retrieval Services Queensland* (appendix 9) when organising aeromedical transfers. The standard operating procedures and guidelines for RSQ can be found at https://qheps.health.qld.gov.au/rsq/sops-guidelines

It's important to note that when a patient of an AMHS is being transported by air, the patient's treating psychiatrist should, where possible, be involved in the planning and decision-making process regarding

[4] Refer to section 8.2 of the agreement *Administering medication to ensure safe transport* above.

the air transfer. This should also involve the referring doctor and the treating psychiatrist at the receiving AMHS.

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 aeromedical transport – by RSQ in consultation with the air transport provider, the referring agency, 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 QPS 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 QPS), with input from the patient/carer (where possible), and
- 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 QPS, QAS 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 local HHS documents and the relevant Health Service Directive – *Ambulance Services Purchasing* QH-HSD-002:2012 and the *Medically Authorised Ambulance Transports (MAAT) Operational Standard* (https://qheps.health.qld.gov.au/acmsu/maat).

Community-to-facility transport

Ambulance officers, police officers and health or mental health clinicians are often the first responders to a mental health incident or situation involving a vulnerable person. 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, may be transported by ambulance or aeromedical transport. Cases requiring aeromedical transport will be coordinated by RSQ.

QPS 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 MHA 2016 using the approved form.

Where QAS, RSQ or QPS 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),
- any other information considered necessary for risk mitigation and planning, including, if the person is a mental health patient and has a PAIP, sharing the information recorded in the PAIP,
- 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 (or other animals) 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),
- communication and de-escalation strategies likely to be effective with the patient, and
- the contact details of the most appropriate person to provide advice about the patient, should a call-back be necessary.

When an involuntary patient, under the MHA 2016, is absent without approval, health service staff should make every reasonable attempt to locate the patient before requesting QPS assistance. Health service staff should then liaise directly with police officers when police assistance is needed to return the patient, and when police officers are required to locate and return the patient alone. Health service staff

must comply with the MHA 2016 and the *Chief Psychiatrist Practice Guideline for Involuntary Patient Absences* (appendix 2).

Where a patient in the community is to be transported in the first instance by QPS or QAS to a nearby community-based health clinic or other health facility with limited staffing (usually in rural or remote areas) or limited opening hours, the agency, wherever possible must liaise, prior to transport, with the relevant receiving 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 MHA 2016), access to specialist advice and/or patient assessment may be via telemedicine (refer to the *Specialist consultation and support* section below).

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, or
- 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, aeromedical 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, wherever possible, 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 the *Specialist consultation and support* section below). Confirmation should be sought that a bed will be available at the receiving facility. The senior medical officer (or equivalent) or the most senior doctor available at 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 Queensland Health Authorised Transports (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. Where there is a need for aeromedical transport, RSQ will coordinate this.

Interfacility transfers of patients under the MHA 2016, must be carried out in accordance with the MHA 2016. Health service personnel must ensure that interfacility transfers are made in accordance with the MAAT Operational Standards (for QAS transports) (QUEENSLAND HEALTH AUTHORISED TRANSPORT ORDERING GUIDE), and with relevant Health Service Directives including the Patient Centred Emergency Access Health Service Directive (www.health.qld.gov.au/directives/).

Please see appendix 12 – transport contexts.

21. 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/), and
- 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, and
- conducted in accordance with the principles underpinning this agreement.

22. Return of patients absent without permission and custodial transport

Refer to the Chief Psychiatrist Practice Guideline for *Involuntary Patient Absences* (appendix 2) and the Chief Psychiatrist Guideline for *Transfers and Transport* (appendix 1).

23. 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 AMHS).

Where the patient has been brought to the facility by QPS or QAS, health service staff may request that QPS or QAS 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[5] (unless otherwise agreed by negotiation between the relevant managers).

[5] Patient Centred Emergency Access Health Service Directive (https://www.health.qld.gov.au/directives/html)

Where appropriate, provide clear indicators to the QPS or QAS 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.

24. Specialist consultation and support

For rural, remote and regional health facilities, specialist consultation and support regarding patient management within the health facility and during transport, should be available via contact with the relevant AMHS and/or specialist statewide service (where relevant and available)[6].

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 may be conducted by an authorised doctor via audio-visual link (telemedicine) if it is considered clinically appropriate (section 795, MHA 2016).

25. 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.

26. 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.

[6] As per the *Clinical Services Capability Framework for public and licensed private health facilities* (www.health.qld.gov.au/cscf/default.asp)

27. Abbreviations and Acronyms

AMHS	Authorised Mental Health Service
CP	Chief Psychiatrist
EEA	Emergency Examination Authority
HHS	Hospital and Health Service
HSD	Health Service Directive
HSIS	The Park Centre for Mental Health – High Secure Program
MAAT	Medically Authorised Ambulance Transports
MHIC	Mental Health Intervention Coordinator
MHIP	Mental Health Intervention Program
PAIP	Police Advice and Intervention Plan
PH Act	*Public Health Act 2005* (Qld)
PSHSF	Public Sector Health Service Facility
RA	Recommendation for Assessment
RSQ	Retrieval Services Queensland
TA	Treatment Authority
QAS	Queensland Ambulance Service
QH	Queensland Health
QPS	Queensland Police Service

28. Glossary

The following definitions apply within the context of this agreement:	
Absent without approval event	An absent without approval event is an event that meets one of the situations prescribed/described under section 363 of the MHA 2016.
Ambulance officer	Under Schedule 3 of the MHA 2016, an ambulance officer is defined as 'an ambulance officer appointed under the *Ambulance Service Act 1991* (Qld), section 13.
Authorised mental health service (AMHS)	Authorised mental health services are health services with official authorisation under the MHA 2016 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.
Clinician	This term does not have a legal meaning but is used in this agreement to refer to any medical practitioner, nurse, psychologist, social worker or occupational therapist employed by a Hospital and Health Service.
Confidential information	Confidential information has the same meaning as at section 139 of the HHB Act.
Escort	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.
Examination authority	An examination authority gives a doctor or authorised mental health practitioner authority to enter premises to detain and involuntarily examine a person to decide if a recommendation for assessment should be made for the person. Examination authorities are issued by the Mental Health Review Tribunal.
Emergency examination authority	Police officers and ambulance officers may detain and transport persons under the emergency examination authority provisions of the *Public Health Act 2005* to a public sector health service facility in emergency circumstances. The emergency examination authority provisions apply if a police officer or ambulance officer reasonably believe that: a person's behaviour indicates the person is at immediate risk of serious harm, and the risk appears to be the result of major disturbance in the person's mental capacity caused by illness, disability, injury, intoxication or other reason, and the person appears to require urgent examination, treatment or care.

Forensic order	A forensic order is made under the MHA 2016 primarily by the Mental Health Court for persons charged with a serious offence who are found of unsound mind at the time of an alleged offence or unfit for trial. Persons on a forensic order may be treated or cared for without consent and, if necessary, detained in an AMHS or the Forensic Disability Service. There are two types of forensic orders – • Forensic order (mental health) – made if the person is found to be of unsound mind or unfit for trial due to a mental condition other than an intellectual disability, or the person has a dual disability (mental illness and intellectual disability) and needs involuntary treatment and care for their dual disability. • Forensic order (disability) – made if the person is found to be of unsound mind or unfit for trial due to an intellectual disability and needs care for the intellectual disability but does not need treatment and care for any mental illness.
Health facility	A facility that provides health care. This includes hospitals, authorised mental health services, clinics, outpatient care centres and specialised care centres.
Health practitioner	Under the *Mental Health Act 2016*, a health practitioner is a person registered under the Health Practitioner Regulation National Law.
Health service directive	Health service directives are formal documents that contain mandatory outcomes to be achieved by a hospital and health service and may also contain required actions to be completed. Health service directives are issues by the chief executive to hospital and health services under section 47 of the HHB Act.
Health service staff (or health service personnel)	Employees of Hospital and Health Services.
Interfacility transport or *transfer*	Interfacility transport (or interfacility transfer) refers to the provision of transport for moving a patient between health facilities.

Judicial order	A judicial order means –
	• A court examination order;
	• An examination order; or
	• Another order, requiring or permitting the detention of a person in an AMHS, made by a court under any of the following –
	  ○ Section 124(1)(b);
	  ○ Section 183(c)(ii);
	  ○ Section 193(2);
	  ○ Section 544 (4);
	  ○ Section 551(4)(b).

Medical monitoring	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.

Mental Health Intervention Coordinators (MHICs)	MHICs are appointed across hospital and health services, the 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 (MHIP). The MHIP enhances the capacity of local services to prevent and respond effectively to mental health incidents and situations involving vulnerable persons.
Mental health incident or situation involving a vulnerable person	This means situations that: • Involve a series of events or a combination of circumstances in which a person is demonstrating behaviour that is indicative of a mental health problem; • May involve a serious risk to the life, health, or safety of the person or of another person; and • Require communication and coordination between QH, QPS and/or the QAS at the earliest opportunity and ongoing communication as required.
Mental health professional	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.
Mental illness	The MHA 2016 defines mental illness as 'a condition characterised by a clinically significant disturbance of thought, mood, perception or memory.'
Open service episode	An open service episode is a continued period of contact for a consumer within a mental health service. The service episode is closed/stopped when the consumer no longer requires treatment or care by the mental health service.
Operational Liaison Committees	Operational Liaison Committees are local interagency committees jointly established between QPS, QAS and QH to improve collaboration between services when responding to individuals with mental illness who are in crisis.
Patient	For the purpose of this agreement, a patient is a person with a known or suspected mental illness who may require transport to, from or between health facilities.
Personal information	Personal information has the same meaning as at section 12 of the *Information Privacy Act 2009* (Qld).
Police officer	A police officer means a person declared under section 2.2(2) of the *Police Service Administration Act 1990* to be a police officer.

Queensland Emergency Department Strategic Advisory Panel (QEDSAP)	QEDSAP oversees all strategic matters relating to the delivery and advancement of emergency care services in Queensland. QEDSAP includes Queensland emergency departments, and draws on the combined knowledge, clinical and operational expertise to influence, progress, develop and reform emergency care in Queensland.
Medically Authorised Ambulance Transport (MAAT)	The MAAT system 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.
Recommendation for assessment	A doctor or authorised mental health practitioner may, after examining a person under section 31 of the MHA 2016, make a recommendation for assessment for a person if satisfied: the treatment criteria may apply to the person, and there appears to be no less restrictive way for the person to receive treatment and care for the person's mental illness. The recommendation for assessment must be made within 7 days after the examination and must be in the approved form.
Referring service	The referring service is the service responsible for making a recommendation for assessment or transfer recommendation for a person in custody.
Retrieval Services Queensland (RSQ)	RSQ is a unit within the Department of Health that provides clinical coordination for aeromedical retrieval and transfer across the state.
Service provider	For the purpose of this agreement, a service provider means Queensland Health (including QAS and RSQ), and the Queensland Police Service.
Treatment authority	A treatment authority is made under the MHA 2016 and authorises the treatment and care of a person for a mental illness without the person's consent.
Treatment support order	Treatment support orders are made by the Mental Health Court and the Mental Health Review Tribunal under the MHA 2016 for persons charged with a serious offence. A treatment support order authorises involuntary treatment and, if necessary, detention in an authorised mental health service. A treatment support order may be made if the Mental Health Court decides a person was of unsound mind at the time of an alleged offence or is unfit for trial. Treatment support orders are made by the Court to protect the safety of the community in circumstances where a forensic order is not warranted.

29. Appendices

Appendix 1 – Chief Psychiatrist Practice Guidelines for Transfers and Transport

Appendix 2 – Chief Psychiatrist Policy for Managing Involuntary Patient Absences Appendix 3 - Chief Psychiatrist Factsheet – Powers and Responsibilities of Police Officers, Mental Health Act 2016, Public Health Act 2005

Appendix 4 - Queensland Health Clinical Guideline for Emergency Examination Authorities, Public Health Act 2005

Appendix 5 - Queensland Health Guideline for the Management of Patients with Acute Severe Behavioural Disturbance in Emergency Departments

Appendix 6 – Queensland Health Guideline Pharmacological management of acute behavioural disturbance management (ABDM) in Queensland Mental Health Alcohol and Other Drugs (MHAOD) Inpatient Services (adults and older adults)

Appendix 7 – MHAOD Branch Guideline for Acute Behavioural Disturbance Management (including acute sedation) in Queensland Health Authorised Mental Health Services (children and adolescents)

Appendix 8 – Chief Psychiatrist Policy – Clinical Need for Medication

Appendix 9 – Health Service Directive for the Use of Retrieval Service Queensland

Appendix 10 - Queensland Health Guideline – Admission of children and adolescents to acute mental health inpatient units

Appendix 11 – QAS Clinical Practice Procedures: Behavioural disturbances/sedation – acute behavioural disturbance

Appendix 12 – Transport contexts

Appendix 13– RSQ SOP – Clinical Decision-Making Framework for the Transfer of Patients with Acute Behavioural Disturbance RG4002

Appendix 14 - Multi-Agency Risk Information and Assistance Guideline (MARIA Guideline)

Appendix 12 – Transport contexts

Safe transport of people accessing mental health services can be considered to occur in a number of broad contexts.

CONTEXT	TRANSPORT PROVIDERS
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 facilities	• QAS and aeromedical retrieval services • 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 (Health facility to community)	• Private transport by family, carers or friends • Non-emergency hospital or community transport services (where available) • Public transport • QAS • Health service staff in a health service vehicle • Aeromedical transport (subject to availability)
Return of patients absent without approval (return to an authorised mental health service of patients absent without approval under the MHA 2016) and **custodial transport** (transfers between courts or custodial facilities and authorised mental health services)	• Health service staff in a health service vehicle • QAS staff • QPS • QCS (custodial transport only) • RSQ where appropriate

MARIA Guideline (page 1)
Multi-**A**gency **R**isk **I**nformation and **A**ssistance

a brief guide to assist in assessing risk and determining agency presence for mental health incidents or situations involving vulnerable people 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 approval 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)
- Police and Ambulance 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.

MARIA Guideline (page 2)

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.

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

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)