

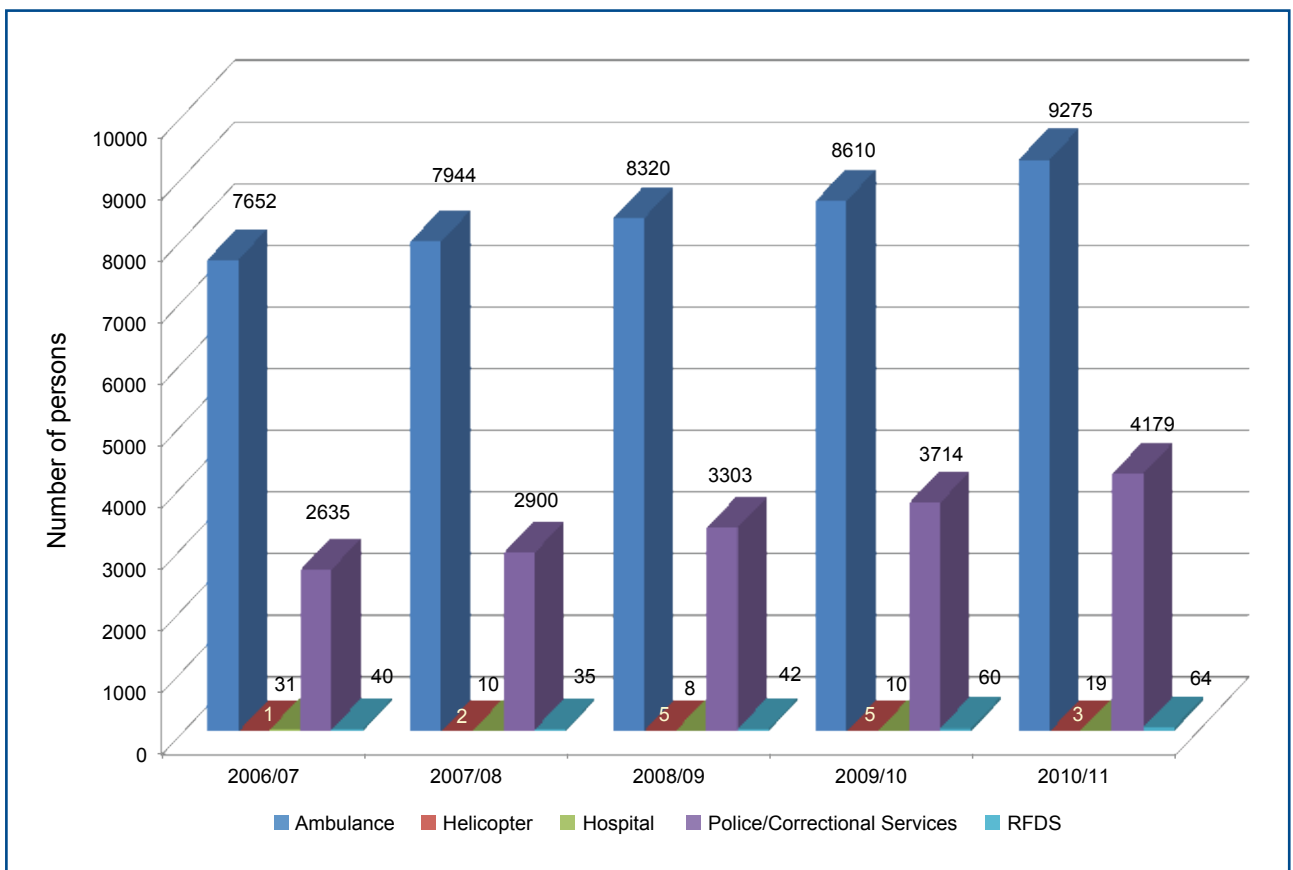
3.7 Transport

Patients with mental illness are transported to hospital by a number of modes including:

- private car
- taxi
- public transport
- hospital vehicle
- hospital transport services
- police
- ambulance
- Royal Flying Doctor Service (RFDS)
- rescue helicopter.

Over the past five years, there have been 25.13 per cent more ambulance arrivals and 77.41 per cent more Royal Flying Doctor Service arrivals (see Figure 18). Most people arrive by private transport. In 2010–11, 18,485 arrived by private car, an increase of 2500 since 2006.

Figure 18 Patient’s mode of arrival by transport services (excluding private and community transport) to WA emergency departments, 2006–11



Source: The ED Data Collection, data from all HCARE sites and data for all EDIS (ED information system) sites, (i.e. metropolitan, including Joondalup Health Campus, excluding Peel Health Campus and Bunbury Hospital) as received up to 9 March 2012. Private vehicle, walking and bus/taxi modes of arrival are excluded from this table.

Sometimes patients suspected of having or diagnosed with a mental illness require transport to hospital by police or ambulance, the RFDS or hospital transport services. Such occasions include incidents in the community where the person with mental illness is in danger of hurting themselves or others and requires a psychiatric assessment. In addition, emergency services are deployed to move a patient from one hospital to another. In such instances, the Commonwealth and State guidelines, the National Safe Transport Principles and the National Standards for Mental Health Services (Standard 10.3.7) guide transport to occur in the safest and most respectful manner possible.

In the context of WA's vast geographical expanse, the most efficient and expedient mode of transport depends on the patient's location in relation to the destination ED or mental health service. As a rule, all patients transferred from above the 26th parallel latitude are transported by the RFDS and those below are transported by ambulance or car.

3.7.1 WA Police

The *Mental Health Act 1996* authorises Western Australia Police to apprehend a person and arrange their health and/or mental health examination when a person is suspected of having a mental illness and to protect the health and safety of that individual and any other person or to prevent serious damage to property (*Mental Health Act 1996* Pt 10 Div 2 s 196).

The police service is frequently required to intervene in situations that involve persons with mental illness who may be placing themselves, others, and the police themselves at risk of harm. It is an important acknowledgement of the work of the police that families, carers and hostel licensees informed this Review that police demonstrate a great deal of respect when dealing with and transporting patients. In addition, clinicians reflected that police respond quickly when asked to assist patients who display behaviours related to methylamphetamine use or are otherwise considered in need of restraint.

There are numerous occasions when mental health services rely on police to assist them in their work, including:

- mental health staff in imminent danger
- planned back-up to manage clinician or client risk
- police assistance with transporting a patient into protective custody or to a mental health facility
- high-risk situation involving trained police negotiators
- request for urgent police attendance at an inpatient facility—in relation to violence or threat of violence
- locating a missing person
- apprehension and transport of an involuntary person absent without leave from an authorised mental health service or in breach of a community treatment order (OCP undated b).

WA Police confirmed their role in the transport of patients with mental illness with this Review, noting that the initial interception of a person with mental illness in the community often involves the police where there are issues of community safety. Police understand that their uniform and manner enables transfers with little need for restraint and that dealing with mental illness is not an incident of criminality. The emphasis of their intervention is always on the health issue, emphasising that if the incident involved criminality, police do not charge the individuals until they are medically and psychiatrically 'cleared'.

In the case that a person requires emergency health or psychiatric assessment, the police will escort the patient to an ED. Police will stay with the patient to ensure their safety and the safety of others until the patient receives assessment and required medical or psychiatric attention.

Police are not compelled to wait with the patient if cooperative arrangements can be made with the health services ‘whereby given the condition of the patient, immediate attendance by the police is not required’ (OCP undated b). Such arrangements are rarely possible in hospitals that do not have hospital security staff.

Police are also requested to transport patients by GPs, ED staff, courts and mental health facilities and services. Guidelines based on the OCP (undated b) framework for dealing with psychiatric crises and high-risk situations involving a person who has a mental illness inform the referrer about assessing urgency (triage) and the roles of community services who can assist instead of, or as well as, the police.

These include the community emergency response teams (CERTs), forensic nursing staff and local Aboriginal medical services. The referrer must make a clinical judgement about the need for police escort; involving the police in transfer should not be common practice (OCP undated a & b). When police assistance is required, a transport order (Form 3) can authorise the police to apprehend the person and take them to a place for examination.

Police use the most suitable vehicle available, including Department of Health vehicles, ambulance services, police cars, police division vans or private vehicles. Families informed the Review that police seemed very thoughtful and often choose a private or unmarked car, which reduces the stigma in their neighbourhood.

The CERT clinicians at Osborne Park reported that police most often accompany the mental health nurse in the hospital vehicle unless safety requires the services of an ambulance. In addition, police call on the CERT team directly to obtain assistance with mental health issues in the community.

WA Police data demonstrates that the number of police interventions in community incidents has doubled and escorts have increased by 169 per cent in the past six years and the time taken to complete escorts is 261 per cent longer than five years ago (excludes forensic incidences) (See Figure 19).

Figure 19 Table of incidents and escort WA Police

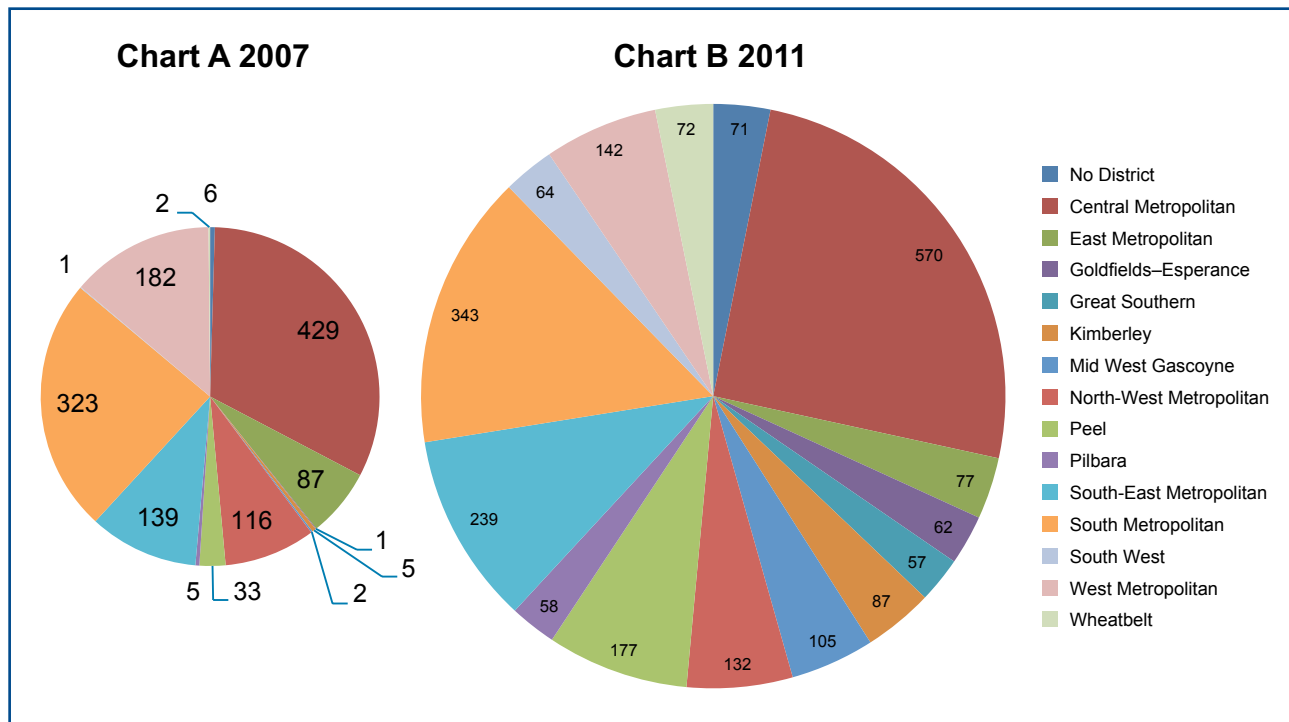
Year	Mental health escorts	Escort hours	Police attended incident
1/12/2006–1/12/2007	1331	2248	339
1/12/2010–1/12/2011	2256	5860	677

Note: Mental Health in these figures does not necessarily infer a psychiatric diagnosis of mental illness.

Source: WA Police (2012).

The state distribution of incidences and transports across the police regions are illustrated in Figure 20.

Figure 20 **WA Police mental health escorts by districts: Chart A, 2007 and Chart B, 2011**



Source: WA Police Reports (2012).

As with other services, the police do not have limitless capacity or resources and must prioritise service. Police prioritise community safety and promptly attend; the escorting of patients from one hospital to another is a lower priority. At times, patients may wait days until police are available to assist with their transfer.

Planning and backfilling of WA Police roles is necessary in order for police to transport patients, particularly from rural and remote areas, to metropolitan hospitals.

Tyranny of distance means that some transports to treatment centres are measured in days. This is the case for transports such as from Karratha to Perth. The low level of staffing in rural areas at times requires police to be flown from Perth to country towns to escort a patient. On some occasions, the police auxiliary officers provide escorts. Delays are lengthened when RFDS are deviated to medical emergencies. As these preparations and arrangements are made, the patient continues to wait in hospital.

WA Police representatives drew the attention of this Review to the Mental Health Intervention Team in NSW that has trained a number of frontline police and ambulance staff in mental health (NSW Health, Ambulance Services of NSW & NSW Police Force 2007).

These multiformed teams with training in mental health are able to de-escalate situations and, when necessary, use soft restraints and will transport patients between hospital facilities and from community situations. The ambulance officers have been trained to use Velcro model restraints and, while police maintain presence until paramedics arrive, they do not need to be present during patient transfers. The program aims for police assistance at initial contact and for paramedics to provide transport without police escorts. A model along similar lines is likely to be of benefit to patients and may contribute to an improved patient transport system in WA.

The introduction of a metropolitan-wide mental health transport service staffed by mental health trained escorts in an appropriate vehicle would do much to reduce waiting times (usually in EDs) for patients being transported between mental health facilities. This is a major recommendation.

Note: Police were concerned that on the occasions when they must use the police division van to take a patient to ED, they have to 'ramp' with the ambulances. Police officers cautioned and were concerned that they are not able to provide the patient with adequate assistance in this situation, suggesting that these patients 'jump the queue' and be triaged into the ED as soon as possible.

3.7.2 Royal Flying Doctor Service

Clinicians commented that the RFDS transfers severely ill patients promptly.

The WA Royal Flying Doctor Service has been involved in the air transport of patients with psychiatric conditions since 1982. Combinations of physical restraint, sedation and health professional escorts enabled safe air transport for restless and agitated patients, ensuring the safety of pilots, passengers and aircraft. Standardised sedation requirements for transporting patients with mental illness were established in 1982 (Western Australian Therapeutics Advisory Group 2006). The standardised requirements meets the obligations of aircraft operators and pilots to comply with CASA (Civil Aviation Safety Authority) safety regulations in regard to carriage of violent or disturbed individuals and with health providers' obligations in accordance with the *Mental Health Act 1996*.

In the financial year 2010/11, 342 acutely disturbed patients were transported on 418 flights in WA. The RFDS is generally only involved in transfer of acutely disturbed 'referred' patients who are not willing to travel voluntarily and where there are no other reasonable means of transfer. Both Form 1 (referral) and Form 3 (transport orders) are completed. Form 3 requires that police ensure the conveyance of the patient to the authorised hospital.

These patients are escorted by a nurse, police officer, and often a doctor.

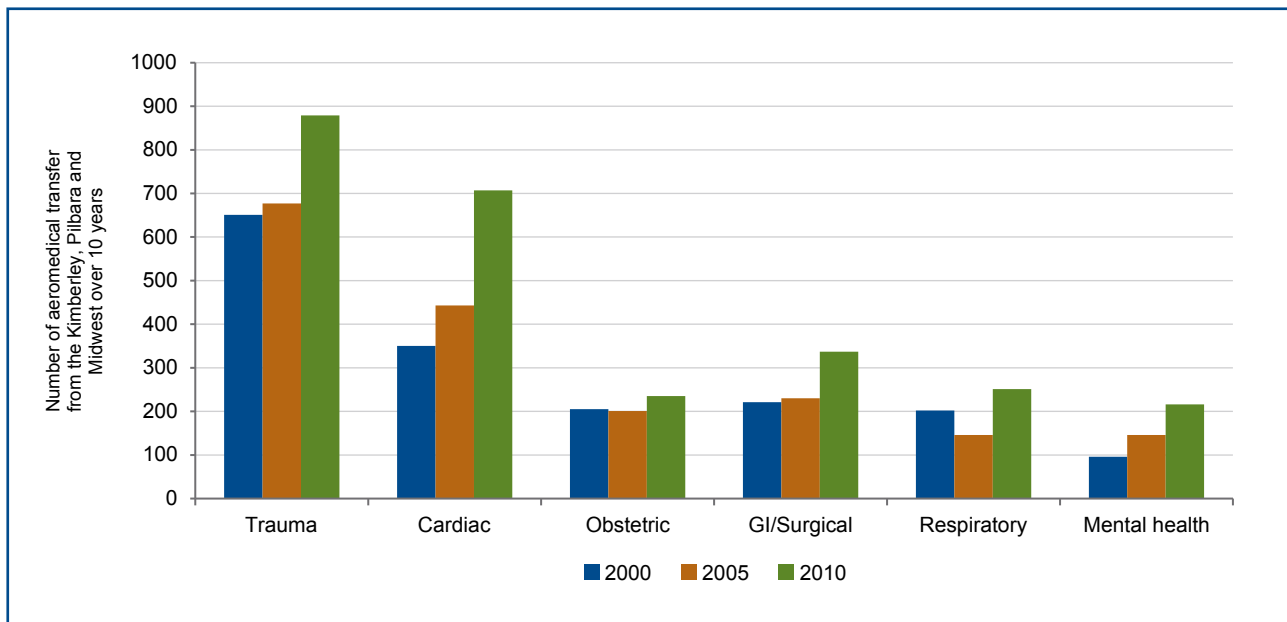
All patients are evacuated as quickly as possible and the RFDS applies a three-tier national system for allocating priorities to patients. Priority 1 is life threatening; 2 is urgent medical transfers (heart attacks, major trauma); and 3 is routine elective transfer.

It can take up to 24 hours to transport the patient from the referral point to their destination. Response times to a request for transfer averages 24 hours. However, it can take as long as 78 hours in the north-west.

Flight times can take 10–12 hours at times. In some cases, multiple flights with multiple aircraft and crew are required to cover the distances involved. A cited example is a transport of a patient from Kununurra to Derby, Derby hospital overnight, Derby to Port Hedland, handover to another crew, Port Hedland to Meekatharra, handover to another crew, then Meekatharra to Perth. A flight from Kununurra is costly at some \$30,000 per flight. The outcome for patients is not ideal as they experience lengthy transport episodes and onerous periods of restraint.

There has been a marked rise in aeromedical transfers, with 70 per cent more transfers in 2010/11 compared to 2009/10 (see Figure 18).

Figure 21 **Aeromedical transfers from the Kimberley, Pilbara and Midwest, 2000–10**



Note: GI = gastrointestinal

Source: RFDS data (2012).

The new mental health facility in Broome is expected to alleviate the pressure on RFDS transfers of patients with mental illness in the north-west.

The RFDS expressed a number of concerns to the Review, including that:

- Mental health issues appear to be increasing in our community. It is an observation of RFDS personnel that substance abuse is exacerbating the behaviour of many patients and resulting in increased levels of violence.
- It can be difficult to obtain police escorts from country centres.
- Patients are transported a long way from their social networks.
- There is a ‘revolving’ door scenario in many cases, with patients receiving a brief period of treatment in the metropolitan hospital and are then discharged home to rural areas, only to present again a short time later.
- Physical restraint protocols and equipment need reviewing in country hospitals.
- There should be opportunities for commencing antipsychotic medication earlier with supportive expert psychiatric advice. Tele-psychiatry may have a role.
- The requirement of sedation and often intubation raises issues of increased risk to the patient.
- Increasing the capacity of rural hospitals could avoid some of the air travel.

The Chief Medical Officer of the RFDS said that over the past five years there seems to be an increasing number of patients transferred by air whose behaviour is violent, and the violence is more extreme. Often, the patient’s symptoms are precipitated by illicit drugs and sometimes mental health services are required for very short intervals. The population are more often teenagers and young persons and most referrals derive from medical consultants rather than psychiatrists.

The RFDS do not require all patients to be sedated and intubated. Clinicians from country regions told the Review that sedation is given orally if possible and the patient is monitored. It is rare that patients require intubation and this is only undertaken where the oral sedation is ineffective and intravenous sedation needs to be used. Patients are secured with Velcro to a trolley and the sedation is titrated [adjusted according to effect] according to the patients' level of aggression. If they are not aggressive, they are only lightly sedated. Nevertheless, all patients require constant supervision, resuscitation equipment and a capacity to attend to respiratory depression or obstruction during transportation and for a minimum of 48 hours post-dose (Western Australian Therapeutic Advisory Group 2006).

One in four patients is intubated before transport by the RFDS. Hospital psychiatric liaison clinicians explained to the Review that when the sedated and intubated patients arrive they are taken to metropolitan intensive care units (ICU) for extubation. The patient then waits in ICU until an authorised mental health bed becomes available.

Some patients may require continuous sedation until a bed is available and no psychiatric treatment is commenced until the effects of sedation have dissipated. Once the mental health bed becomes available, often within 36 hours, the patient requires police-escorted transport. Patients may also wait for long periods in the ICU while police and ambulance transport is coordinated.

During the period of waiting for transfer to an authorised bed, the ICU could be exposed to considerable disruption. The Department of Health's Chief Medical Officer suggested that it would make sense to transport such patients to an ICU in hospitals that have secure mental health beds, thereby avoiding the additional transfer to a mental health facility.

When patients have completed an inpatient episode of treatment, the RFDS is not able to provide the transport back to their area. That is, the patient or their family may be left in many cases to make their own arrangements for transport home.

This risk to patients is illustrated by information provided to the Review that highly agitated children are transferred from the Pilbara only to be assessed and discharged the following day and issues arise concerning the way they return home.

Broome clinicians informed this Review that the opening of the mental health beds in Broome may not be of advantage to patients in the Pilbara because while they may be transported by RFDS from say, Roebourne to Broome, their return home may mean a long wait for air travel as there are few services between north-west towns. Road transport is an alternative but may not always be wise for a patient discharged from mental health care. There is also a lack of supported hostel accommodation in Broome where patients could wait for transport.

This Review is concerned about the sedation and the transport of patients from rural and remote communities to Perth. Capacity building in local EDs is required to enable a local response to acute presentation of patients with symptoms of psychosis and aggression. This may require increased security and a State Protocol for Patient Management.

The transport of patients away from their network of family and friends, and the often-complex arrangements for their return, are added stress to already fragile situations. This is exacerbated when patients re-present in a similar state within a short time of discharge. Dislocation from the local environment and meeting different treatment teams may also be damaging the patient's continuity of care. Young people who present with first episode psychosis are only flown to Perth if there are overriding factors that cannot be managed locally such as high risk and containment issues.

3.7.3 St John Ambulance (Western Australia)

St John Ambulance (SJA) provides a first line of emergency care and transport for patients with mental illness. In 2010–11 SJA provided 9572 transports for mentally ill patients in WA, most of which were for emergencies (ED Data Collection). In the metropolitan area during 2011–12, SJA transported 702 persons on forms, with 421 of these as inter-hospital transfers (pers. comm. Principle Business Analyst, SJA 2012). In the context of the mental health system, the ambulance service is confronted by a number of issues on a day-to-day basis, while working in collaboration with WA Police and mental health services.

Specific procedural requirements when transporting disturbed patients means paramedics, who are not authorised to restrain patients physically, can use only chemical restraint.

When physical restraint becomes necessary, usually because of violence, the ambulance paramedics call on police to assist with transferring the patient. In these cases, SJA operational staff report that police do assist and do physically restrain patients when necessary.

The Review was informed that police assistance with ambulance transfers is more difficult to obtain for inter-hospital transfers and that ambulance delays can result in difficulties of coordination of ambulance and police services. The key factor is that the ambulance service necessarily prioritises responses in accordance with urgency; transfers between hospitals are often delayed by one to four hours; in rural areas, transport can be delayed for days. If the ambulance has not arrived within 30 minutes of the police officer's arrival, the police must leave the ED to undertake other duties. This results in longer waits for the patient. When the ambulance arrives and the police are not present, they too must attend urgent calls if they occur while they wait for the police to arrive.

The Review was informed that in the ED environment, with pressure to discharge patients, the response may be to circumvent the formal procedural requirements related to the requirement of police assistance, resulting in SJA transporting patients without police assistance.

In rural areas, ambulances are crewed by trained volunteers. Volunteer ambulance transfers account for 10 per cent of all ambulance transports and include approximately 2000 mentally ill patients a year in rural areas. In the context of transporting mentally ill patients over long distances, operational managers expressed concern for patients who were sedated and restrained for long periods. This is an issue similar to the RFDS sedation of patients, including the risk to the patient and the transport personnel.

The Review revealed varying models and approaches to hospital transfers of mentally ill patients. For example, Swan District and Sir Charles Gairdner hospitals use police regularly while at Royal Perth Hospital transfers are undertaken with a nurse and companion security officer.

At Rockingham hospital, ED staff meet regularly with police to discuss issues. There is agreement that neither the ambulance nor police are always the appropriate mode of transfer for patients.

The ED and mental health staff who participated in this Review supported the concept of an inter-hospital transport team as outlined in section 3.7.1. They postulated that hospital-trained staff in a hospital vehicle would ease many problems involving patient transfer between hospitals and mental health services. Although patients may still wait, an assurance of a pick-up time would ease tension. In addition, it would reduce demands on police and ambulance services, enabling them to attend to other priorities. With a more certain time of departure, ED clinicians could provide more appropriate sedation and have a clearer understanding of the resources needed, such as the level of security.

Among comments by carers was a concern that authorised persons described in the Mental Health Bill 2011 should be well trained and not private security guards. In addition, clinicians suggested that using hospital security personnel to ensure safety might have an effect of reducing the ‘criminalising’ of mental health behaviours.

This Review considers that mental health services should develop a safe and quality transport system in the metropolitan area with hospital staff trained in mental health and soft restraint.

A need to ensure adequate mental health-focused training of security personnel is mandatory for such a system to be efficient and safe.

See Recommendation 1: Governance (1.3).

3.8 Specific issues

3.8.1 Mental health services in remote areas

Irrespective of geographic location, provision of regular patient assessment and care intervention, emergency response, and carer training and support are core aspirations of mental health services.

The capacity of the mental health system is directly affected by the effectiveness of a workforce strategy that results in securing and retaining a skilled and qualified workforce across WA. This Review was made acutely aware of workforce and MHS capacity issues in remote areas.

The tyranny of distance is a feature of WA that acts to reduce capacity to provide optimal psychiatric care to communities in remote regions such as the Kimberley, the Pilbara and the Goldfields.

The rural and remote population makes up 28 per cent of WA’s population and includes many Aboriginal persons who require special attention.

Mental health services in remote areas are intermittently provided by fly-in or drive-in practitioners and emergency responses include Rurallink telephone support, the RFDS and some volunteer-operated ambulance services.

Remote area mental health care is provided in a hub-and-spoke model. Clinics are based in larger towns and staff travel to smaller towns and communities for a number of days at a time at regular intervals. The scarcity of GPs and lengthy travel by clinicians create obstacles to timely mental health care and there are virtually no after-hour services. Mental health care tends to focus on acute illness management and relies on frequent and regular communication with the GPs.