

# Part 2: Challenges in Paramedic Practice

## Chapter 7

### Paramedics and the mentally ill

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#### Objectives

This chapter will explore an emerging challenge in paramedic practice – managing mental illness in the pre-hospital care setting. Building on earlier chapters examining evidence-based practice and clinical judgment, it will explore the contemporary and emerging issues confronting paramedics and their assessment and management of mental illness in the emergency primary healthcare setting. It examines the literature relevant to paramedic clinical judgment and decision-making of mental illness and the emerging role for paramedics and their care and management of the mentally ill, which is informed by contemporary research. Finally, it provides clinical practice guidelines for paramedics managing the mental illness in the emergency pre-hospital care setting.

On completion of this chapter, you will have:

- examined the contemporary mandate for quality and safety in mental healthcare in Australia
- reviewed mental illness as a contemporary health priority and challenge for systems of healthcare in Australia
- explored the contemporary mental healthcare agenda, including contemporary standards, definitions and principles of mental healthcare and to the emerging role for paramedics in contemporary mental health care
- overviewed contemporary research examining the role of paramedics in mental healthcare service delivery
- explored clinical practice guidelines for the management of the mentally ill
- considered future challenges for paramedics with regard to mental healthcare in the pre-hospital emergency care setting

## Quality and Safety in Healthcare: A Contemporary Challenge

The quality and safety of healthcare is an issue that dominates the Australian healthcare system and its agenda. Clinical judgment and decision-making of healthcare professionals and their ability to understand and diagnose clinical problems are fundamental to the delivery of quality health and medical care (Groves, 2002, de Dombal, 1993). In an environment of ever-increasing demands for quality and safety in healthcare, few could dispute the direct relationship between the quality of the clinical judgment and decision-making of healthcare professionals and the quality and safety of healthcare they are then able to provide. Thus, individuals and the organisations they operate within are being called to account for the quality and safety of their clinical judgment and decision-making today more than ever before (de Dombal, 1993, White and Stancombe, 2003). Society demands greater transparency in the decisions taken on its behalf by policy-makers and professionals charged with interpreting and delivering the policies of central governments (Thompson and Dowding, 2002, Higgs, 1993).

Central to our efforts to improve the quality and safety of healthcare is the philosophy of evidence-based practice (National Institute of Clinical Studies, 2006) and its aim in closing what is commonly referred to as the 'evidence-practice gap'. Evidence-practice gaps in healthcare are, at the most basic level, the difference between what is known about how care is provided and how care should be provided as informed by a program of sound and systematic research. In many settings, this gap is substantial (National Institute of Clinical Studies, 2006). In recent times, much energy and resources have been devoted to closing evidence-practice gaps in pursuit of providing high-quality and safe healthcare. The reality is however that much of the care provided by emergency healthcare professionals such as paramedics and emergency nurses lacks an evidence-base. This is because in part of the relative infancy of ambulance practice as a profession (Lord, 2003), and that fact that providing high quality and safe healthcare in emergency settings and contexts is a complex business, and in many instances very difficult to achieve. Paramedics and emergency nurses have an array of competing priorities in their routine everyday practice. We expect a registered nurse in an overcrowded emergency department to care for a newly presenting patient with vague symptoms using "best-practice". We expect a paramedic who manages a patient having an acute myocardial infarction who suddenly deteriorates into cardiac arrest to use the best available "evidence". In reality however, there often is no "evidence", and the priorities for the nurse and the paramedic would not entirely be focused on looking for the evidence, or on closing the evidence-practice gaps by undertaking research. The nurse and the paramedic would primarily be concerned with providing the best possible care given the resources available in very difficult, uncontrolled, and unpredictable settings. Everyday, these and other healthcare professionals go about their ordinary but complicated business of making sense of the symptoms and troubles of their patients and clients the best way they know how (White and Stancombe, 2003, p. ix).

The ways in which paramedics and other healthcare professionals make sense of their patients, their symptoms and their troubles, can loosely be described as their clinical judgment and decision-making. In a general sense, clinical judgment and decision-making describes 'an assessment of the alternatives in treatment from which decisions or choices between alternatives for optimal treatment are made' (Dowie, 1993, p. 8). Given the contemporary mandate for quality and safety in health care, making quality clinical judgments are 'intrinsic and inescapable imperatives' (White and Stancombe, 2003, p. ix) for all healthcare professionals. Higgs and Jones (2000b) assert that 'health professionals need to be able to reason effectively, to make sound and defensible decisions, and to learn through their clinical experiences and other avenues in order to continually develop their knowledge as the basis for making effective clinical decisions to the knowledge of the field.' (Higgs and Jones, 2000b, p. xiii)

Although making quality clinical judgments are 'intrinsic and inescapable imperatives' (White and Stancombe, 2003, p. ix) for all healthcare professionals, the process is far from simple. Making decisions about 'which diagnosis, whose version or account of the troubles they find most convincing, or morally

robust' (White and Stancombe, 2003, p. ix), no matter how routine and fundamental they seem, is challenging in many contexts. Sometimes, the clinical judgments and decisions of healthcare professionals are insufficient or inaccurate, and sometimes they get it wrong. Contemporary media, particularly in western societies and cultures, is dominated with discourse highlighting "failure" and "mistakes" in healthcare. Surprisingly, there has been until relatively recently little impetus within the medical or health professions to study or question the ways in which its decisions are made (Wilson et al., 1995). In Australia, a ground-breaking study published in 1995 in the *Medical Journal of Australia* examined the *Quality in the Australian Healthcare System*. The study presented disturbing findings that 'seared patient safety into the public's psyche' (Wilson and Van Der Weyden, 2005, p. 1), and subsequently crystallised the quality and safety in healthcare agenda in Australia.

Since then, some have suggested that most patients in Australia's healthcare system receive good care, and do not largely suffer preventable harm (Wilson and Van Der Weyden, 2005). However, recent events such as the *Royal North Shore Inquiry* (NSW Legislative Council, 2007), the *Bundaberg Hospital Commission of Inquiry* and subsequent *Queensland Public Hospitals Commission of Inquiry* (Davies, 2005), and the *Queensland Health Systems Review* (Forster, 2005) paint a very different picture. These investigations have often revealed the chronic and systematic failure of individuals, organisations and governments in health service delivery (Forster, 2005, Davies, 2005). Such events reflect increasing public expectations for quality and safety in healthcare (Higgs, 1993, Higgs and Jones, 2000a, Groves, 2002). One area of healthcare that has been the subject of sustained national and international scrutiny is that of mental illness.

## **Mental Illness: A problem for quality and safety in healthcare**

Mental illness is a well-recognised global health problem (World Health Organization, 2005). Generally speaking, a mental illness is a condition associated with clinically significant disturbances of thought, mood, perception or memory (Fontaine and Fletcher, 1999). There are many types of mental illness. Some are transient and relatively mild; others are chronic and significantly debilitating. In western countries, mental illnesses are diagnosed according to a classification system outlined in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition Text Revision (DSM-IV-TR)* (American Psychiatric Association, 2003) and the *International Classification of Diseases Tenth Revisions (ICD-10)* (World Health Organisation, 1992). The DSM-IV-TR provides a classification system for all mental health disorders in both children and adults, where the assessment of the mental illness occurs across five different axes. It provides key diagnostic criteria and other information such as epidemiological data, guidelines for management, and key research findings.

Mental illnesses such as those listed in table 7.1 are a significant cause of global morbidity and mortality. The World Health Organization reports that 450 million people worldwide are affected by mental, neurological or behavioural problems at any time. Mental and behavioural disorders constitute 12 percent of the global burden of disease, a burden that far exceeds other disease such as cancer, heart disease, or AIDS, tuberculosis and malaria combined (World Health Organization, 2001b). Approximately 873,000 people around the world die by suicide every year. Nationally, mental illness is one of the seven designated national health priorities of the Australian Government (Department of Health and Ageing, 2007), and providing appropriate mental health services to Australians is an the forefront of the needs of Australians (Council of Australian Governments [COAG], 2006, Department of Health and Ageing, 2007). Almost one in five (18%) Australians suffers from a mental disorder, and three percent of the total population live with a serious psychiatric disorder at any one point in time (Commonwealth of Australia, 2005, Groom et al., 2003, Queensland Health, 2004). Mental illness and mental disorders are associated with significant levels of disability (World Health Organization, 2001a). The economic and social burden for families, communities and countries and the associated stigma and violation of human rights and freedoms of people with mental illness are substantial. The mentally ill are systematically subjected to social isolation, have a poor quality of life, and have increased mortality, all of which have staggering

economic and social consequences (World Health Organization, 2005). Many cases of mental illness go unreported, unmanaged, or are concealed for a variety of social, political, and economic reasons.

**Table 7.1 - DSM-IV-TR Axis System and Related Classifications of Mental Illness**

<p><b>DSM-IV-TR Axis</b></p> <ul style="list-style-type: none"><li>• Axis I: Clinical Syndromes</li><li>• Axis II: Developmental Disorders and Personality Disorders</li><li>• Axis III: Physical Conditions</li><li>• Axis IV: Severity of Psychosocial Stressors</li><li>• Axis V: Highest Level of Functioning</li></ul> <p><b>Classifications</b></p> <ul style="list-style-type: none"><li>• Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence</li><li>• Delirium, Dementia, and Amnesic and Other Cognitive Disorders</li><li>• Mental Disorders Due to a General Medical Condition</li><li>• Substance-Related Disorders</li><li>• Schizophrenia and Other Psychotic Disorders</li><li>• Mood Disorders</li><li>• Anxiety Disorders</li><li>• Somatoform Disorders</li><li>• Factitious Disorders</li><li>• Dissociative Disorders</li><li>• Sexual and Gender Identity Disorders</li><li>• Eating Disorders</li><li>• Sleep Disorders</li><li>• Impulse-Control Disorders Not Elsewhere Classified</li><li>• Adjustment Disorders</li><li>• Personality Disorders</li></ul>
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The consequences of the global pandemic of mental illness and the challenges it creates for the quality and safety of mental healthcare have long been known. Barriers to the provision of effective mental healthcare and the treatment and management of mental illness are complex, but include a fundamental lack of recognition of the seriousness of the problem, and its chronic and pandemic consequences (World Health Organization, 2005). Perceptions of mental illness as a modern day pandemic have contributed to the growing national and international attention afforded to mental healthcare reform. Global reforms in the 1950s and 60s were to be the answer for the problems of mental healthcare. A key feature of these reforms that gained traction in the late 50s and early 60s was deinstitutionalisation, which saw psychiatric care away move away from dedicated institutions towards integrated and co-located mainstream general health services and community settings. Mainstreaming of mental healthcare services was a central feature of this policy agenda. Large in-patient psychiatric hospitals and facilities were closed down and patients were moved and subsequently managed in home and community care settings. This new found agenda for quality and safety in healthcare was based on the imperative to redress human rights violations associated with traditional models of psychiatric care. This agenda, along with the discovery of new psychotropic medications and sciences of psychiatry, spearheaded mental health care reforms nationally and internationally. The launch of the *National Mental Health Policy* by the Australian Health Ministers in 1992 signalled these reforms in Australia, providing the stimulus for significant changes to psychiatric services within the Australian healthcare system (Wand and Happell, 2001, Sharrock and Happell, 2000, Salkovkis et al., 1990).

These reforms of the mental health system, though well founded, have not been without their problems. Healthcare workers have been widely reported as perceiving themselves as lacking the skills and expertise to provide appropriate care and treatment to this client group (Commonwealth of Australia, 2005, Wand

and Happell, 2001, Sharrock and Happell, 2000, Green, 1999, Kalucy et al., 2004). Managing individuals' mental health is a complex business, and requires higher order cognitive skills, expert knowledge, and finely tuned problem-solving skills (Crook, 2001). Many studies have reported the difficulties faced by healthcare professionals, such as doctors, nurses, and social workers, and non-healthcare professionals, namely police officers in assessing and managing the mentally ill (Schmidt et al., 2001, Spooen et al., 1998, Spooen et al., 1996, Pajonk et al., 2001, Doyle, 1999, Torrey, 1971, Nordberg, 1999, Green, 1999). An increasing emphasis and preference for community models of mental health care has meant that healthcare professionals, particularly community health and emergency personnel, are increasingly required to manage individuals with mental illness, particularly those with chronic mental illness.

The problems associated with mental healthcare reforms, or more specifically their implementation, have come under intense scrutiny (Senate Select Committee on Mental Health, 2006). In recent times, two Australian reports, *Not for Service: Experiences of injustice and despair in mental healthcare in Australia* (Mental Health Council of Australia, 2005) and *Out of Hospital, Out of Mind!: A report detailing mental health services in Australia in 2002 and community priorities for national health policy 2003-2008* (Groom et al., 2003), table systematic failures of the mental healthcare service provision. In particular, when discussing community-mental healthcare service delivery, Professor Hickie (Mental Health Council of Australia, 2005, p. 7) asserts that:

'Since the late 1990s, however, there have been persistent and disturbing reports of fundamental service failures. These reflect disorganised and dislocated health and welfare systems and a lack of commitment to the provision of quality mental healthcare, particularly in the public sector. Community-based care depends not only on organised health services but coordination of welfare, housing, police, justice and emergency care services. Multiple state-based inquiries have been conducted by health departments, coroners, auditor-generals, parliamentary committees and non-government organisations. The Brain and Mind Research Institute has now worked with the Mental Health Council of Australia on two national reports '*Out of Hospital, Out of Mind*' was published in 2003 and now '*Not for Service*' in 2005. Both have been based on a combination of qualitative and quantitative methods. Fundamentally, they rest on extensive consultations with persons with mental illness, their families and carers. Additionally, they include the perspectives of those healthcare professionals who provide services at local level. Tragically, the themes from all these investigations converge. When any of us seeks mental healthcare we run the serious risk that our basic needs will be ignored, trivialised or neglected.'

Other reports and commissions of inquiry have painted an equally bleak picture. The *Palmer Report* (Commonwealth of Australia, 2005) uncovered systematic failures of Queensland and Commonwealth government departments when an individual, Ms Cornelia Rau, was imprisoned for 10 months while suffering an acute schizophrenia without adequate medical help or treatment (Department of Parliamentary Services, 2005, Commonwealth of Australia, 2005). Serious and systematic failures of mental healthcare systems have also been uncovered in Queensland. *The Ward 10B Inquiry*, *Burdekin Report on Mental Illness* and the *Criminal Justice Commission Inquiry into Basil Stafford* all provide accounts of systemic neglect, abuse, and failure of healthcare institutions to provide safe and quality mental healthcare (McMurdo, 1998). The reasons for this are complex, but include poor institutional administration and accountability, a lack of ongoing government commitment to genuine reform, and failure to support the degree of community development required to achieve high-quality mental healthcare outside institutions at a local, state and national level (Mental Health Council of Australia, 2005). 'The discrimination between physical and mental problems by policy makers, insurance companies, health and labour policies, and the public at large all contribute to the failure of individuals, communities and societies in achieving mental health' (World Health Organization, 2005, p. 1). These problems of mental healthcare are reported to be a result of a lack of funding and mental health services in the community, rather than the model of de-institutionalisation (Senate Select Committee on Mental Health, 2006). Whatever the event, there still remains today a clear and unmistakable demand for quality and safety in mental healthcare.

## Paramedics and the mentally ill

Paramedics are one group of healthcare professionals facing increasing challenges in the care of the mentally ill (Shaban, 2004a, Roberts, 2007). The decentralisation of mental health services has resulted in increased attendance of individuals with mental health problems illness presenting to emergency departments and emergency medical services by patients something well documented in Australia and around the world (Kalucy et al., 2004). Some facilities have reported a ten-fold increase of the number of patients presenting to the emergency department with mental health problems in the past 10 years (Sharrock and Happell, 2000, Anstee, 1972, Salkovkis et al., 1990, Bell et al., 1990, Commonwealth of Australia, 2005). It is clear that emergency personnel come into contact with patients experiencing mental health problems more than ever before (Sharrock and Happell, 2000). Such events and factors have meant that healthcare workers, particularly community health and emergency personnel, are increasingly required to manage a variety of patients' mental health problems, often complex and chronic in nature. As a consequence, paramedics more than ever manage and are expected to manage patients with mental illness in the pre-hospital care setting, and their participation is warranted (Shaban, 2004a, Mental Health Council of Australia, 2005, Mental Health Evaluation and Community Consultation Unit, 2006, Commonwealth Department of Health and Aged Care, 2000, Council of Australian Governments (COAG), 2006). They require mental health skills that allow them to recognise and manage mental illness in ways that collaboratively value-add to patient care. They are also expected to provide high-quality, safe and effective healthcare. Providing care in a community context presents many challenges for quality and safety in healthcare for professionals working in emergency medicine is well documented (Driscoll et al., 2001, Vincent, 2001, Lipsedge, 2001, Mental Health Evaluation and Community Consultation Unit, 2006). Paramedics like other emergency healthcare workers face particular challenges when it comes to providing high-quality, safe and effective healthcare. In some jurisdictions in Australia such as Queensland, an unprecedented population growth coupled with an ageing work force and changes to the model of ambulance services delivery has made providing timely and high quality ambulance services difficult. Australian paramedics like other primary healthcare professionals are taking on new roles and performing increasingly complicated and invasive procedures, assessing health risks, delivering health promotion and disease prevention interventions—in many cases with increasing autonomy and independence' (Thompson and Dowding, 2002, p. 5). Paramedics are one group of community healthcare professionals under increasing pressure to expand their scope of practice to meet the needs of a more complex array of health and medical conditions (Raven et al., 2006).

Globally, reform of mental healthcare systems advocate for increased participation of a wide range of health, welfare, and disability professionals and organisations in providing services to people with mental disorders (Commonwealth Department of Health and Aged Care, 2000). Healthcare professionals across all disciplines require increased skills to better equip them to recognise and manage mental illness, along with improved coordination of consumer of mental health services, and increased community interest and involvement in mental health issues (Commonwealth Department of Health and Aged Care, 2000). Yet, how paramedics have dealt with such events and how they are able to contribute, or otherwise, to the care of the mentally ill in the emergency primary health context has not been the subject of sustained systematic research or inquiry. Little is known about paramedic clinical judgment and decision-making (Snooks et al., 2005), and even less is known about paramedic clinical judgment and decision-making of mental illness (Shaban, 2006). Generally speaking, research that examines paramedic clinical judgment and decision-making is rare. Snooks and her colleagues (2005, p. 251) assert that:

'Little is known about how ambulance personnel make decisions on whether to take patients to hospital or to leave them at home, how they feel about adopting guidelines or protocols to leave patients at scene, or about the potential impact of introducing such protocols on crews. Without an understanding of this context, initiatives within ambulance services to address concerns about quality and appropriateness of care [sic] may fail'.

There are few published works that examine the mental healthcare provided by paramedics or emergency medical service personnel (Shaban, 2006). It is of no surprise that research into clinical judgment and decision-making of mental illness is centred in medicine, psychiatry, psychology, nursing and, interestingly, police and the law. While much research has been undertaken to investigate mental health assessment practices in these domains, research into practices in the ambulance or paramedic setting is

limited. In fact, research into paramedic judgment and decision-making of mental illness is rare. The warrant for such research and its importance in informing quality practice and clinical care have been established elsewhere (Shaban, 2003, Shaban, 2004c, Shaban, 2004b, Shaban, 2004a, Shaban et al., 2004, Commonwealth Department of Health and Aged Care, 2000, Roberts, 2007).

## Contemporary Research: What do we know?

Two recent Australian studies have sought to address this deficiency in research. In one study Shaban (2005) undertook examined how paramedic were expected to and actually do account for their clinical judgment and decision-making of mental illness, and the factors paramedics report as influencing this aspect of their professional work in the pre-hospital care setting. This work revealed the situational and contextual factors paramedics reported as influenced their enactment and accomplishment of clinical judgment and decision-making of mental illness in the Queensland pre-hospital care setting.

Paramedics in Shaban's study reported working under considerable uncertainty and both professional and personal distress in the pre-hospital care setting when it came to managing the mentally ill. This uncertainty and stress was due to a number of factors including: rapid role expansion, poor education and training; increasing exposure to the mentally ill; increasing complexity of mental illness; lack of integration with wider mental health services and infrastructure; significant unmet mental health services needs among the mentally ill; and a failure of community mental health services to manage those with chronic mental illness. To cope, paramedics reported relying almost exclusively on their intuition and experience, and their clinical judgment and decision-making of patients with mental illness was centred on their physical assessment of their patients' condition. Patients presenting with vague symptoms without clear physical signs or symptoms brought about considerable personal and professional distress for the paramedics due to the uncertainty of their condition. To mitigate this, paramedics in this study reported practicing a policy of "taking them all to hospital", in which all patients presenting or suspected of having a mental illness were transported to the emergency department, regardless if believed their condition did not warrant such action. Because clinical policy explicitly required paramedics to transport all patients to hospital, almost all patients went to hospital. There were few exceptions to these policy because do so invoked considerable professional and personal distress for the paramedics, for fear of negligence and the threat to their personal and professional wellbeing. What also compounded their distress was their significant concern over threats to their own physical safety from the mentally ill, and threats to their personal safety from fears of litigation from patients who were not transported subsequently self-harming or sustaining injury when the official policy states that all patients are to be transported to definitive medical care. As a consequence, paramedics in this study reported having to convince patients to go to hospital using what Standcombe and White (2003, p. 3) might call 'artful rhetoric and persuasion'. Interrelated with this was the participants' fear of "judging" patients. Paramedics in Shaban's study saw their role as caring for patients, rather than being there to judge them. To the paramedics, the term "judgment" is laden with moral connotations. They saw their role as assessment and treatment, which translated invariably into "care" and "transport". In fact, for the participants in this study, transport to medical care was the sole treatment. The act of driving the patient to definitive medical care was considered as treatment for the patient—often the only treatment provided by the paramedic other than reassurance and psychological support. As such, the act of not transporting a patient to hospital was viewed by paramedics as a failure in treatment of the patient. This was further compounded by a rigid clinical policy and practice framework that focused almost exclusively on patients with psychotic illness, rather than those with the far more prevalent conditions such as anxiety and depression. Paramedics reported a lack of education about mental illness, and an insufficiency of existing clinical practice policy and guidelines that focused on the uncommon mental illnesses such as psychoses rather than far more prevalent conditions such as anxiety and depression. As such, paramedics reported not knowing how to manage these patients, who made up the majority of those that they attended to, other than to transport to hospital or the emergency department. They cited a profound lack of general practice services, in particular after hours and in rural and remote settings, which meant that they transported patients to overcrowded emergency departments even when they believed their conditions did not warrant presentation to the emergency department. Typically paramedics reported having to transport patients to hospital so as to be seen to comply with clinical policy that requires all patients to be transport to definitive medical care, even in instances where they considered in inappropriate. The consequence of

this was often overcrowding on the emergency department and a breakdown in professional relationships with staff at that facility. Shaban argues that in summary paramedics' clinical judgment and decision-making of mental illness are primarily anchored in satisfying the professional and personal needs of the paramedic themselves, and their formal obligations to the Queensland Ambulance Service than it is about satisfying the clinical and healthcare needs of the patient.

In another study, Roberts (2007) examined the implications of mental health reforms in South Australia and the effects they had on the ambulance service in South Australia, and the way in which paramedics deal with mental health cases. Her study explored the implications of paramedics attending mental health patients, and examined how paramedics perceived their role when dealing with patients presenting with disturbed behaviour. Roberts found that paramedics were frustrated working in an environment where the workload of mental health cases was significant, and that the wider mental healthcare system is under considerable stress. Participants reported being poorly prepared professionally to attend an individual with a mental illness, and expressed concern for their own safety when it came to managing the mentally ill. The organisational and professional culture placed emphasis on the practice of 'load and go'. Interestingly, Roberts found that a culture existed within that setting where some paramedics viewed mental illness as not being as important as other types of cases, so much so that some officers were labelled by their peers as 'social workers' when they did spend time with a patient with a mental illness. The clear emphasis was on transportation and 'load and go', which was reinforced by the lack of education and the limited assessment, treatment or referral options open to them.

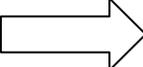
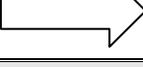
Other than these, there has been little sustained or systematic research examining the role and practice of paramedics with respect to mental illness in the prehospital care setting nationally, and indeed internationally. This has meant that the impact of the reform to mental health services on the care of the mentally ill in emergency and pre-hospital care settings have occurred unexamined. The complexity of clinical situations faced by paramedics where, for example, multiple contexts exists with significant levels of uncertainty, risk, and time criticality, most of which make clinical judgment process difficult, has not been examined. The identification of strategies from research to support more effective paramedic clinical judgment practices has not been attempted in the context of paramedic practice. Additional programs of research that focus on paramedic clinical judgment and management of mental illness in pre-hospital emergency care settings are required so as to explore further the contributions paramedics make to the care of the mentally ill and the wider mental healthcare systems. One recent intervention conducted by the National Institute of Clinical Studies (NICS), a division of the National Health and Medical Research Council, involved a novel project to improve care for people with mental health problems presenting to emergency departments. Commissioned by the Victorian Department of Human Services through the Emergency Care Community of Practice, NICS undertook a six-month project to implement the Victorian Emergency Department's Mental Health Triage tool across 14 metropolitan and 5 regional hospitals in Victoria. The tool used was based on the South East Sydney Area Health Service (SESAHS) triage tool developed in 1999, and is regarded as best practice for Emergency Department Mental Health Triage by both the New Zealand Guideline Group and the NHS National Institute for Clinical Excellence (NICE) (National Institute of Clinical Studies, 2006). This project sought to close the evidence-practice gap in mental healthcare in emergency departments, and is one that paramedics and the ambulance professionals could benefit from greatly in the emergency primary healthcare context. The NICS study highlighted the insufficiency in practice standards and guidelines for the care of the mentally ill in the emergency department context. The introduction of a mental health triage scale into paramedic practice in the pre-hospital care setting could greatly assist in reducing the demand for services in heavily overcrowded emergency departments, and provide more appropriate care to the mentally ill by referring them to more appropriate health care services based in the community. The roles of paramedics, and the impact their work within the wider mental health agenda requires further examination in national and international contexts. Such work would make significant contributions to improving the preparedness of paramedics to recognise, assess and manage mental illness in everyday practice, and the sufficiency of education and training programs, clinical standards, policy and legislation for ensuring quality and accountability in the care of the mentally ill.

## Managing the mentally ill: Practice Guidelines

Despite the lack of research that examines current practice, there is much that paramedics currently do and can do to provide the best possible care to those suffering mental illness in the pre-hospital care setting. Considerable work has been undertaken in the community mental health care arena with respect to the work of nurses, doctors, social workers, psychologists and others actively involved in the care of those with mental illness. Much of what has been learned in those settings is relevant and applicable to paramedic practice in the pre-hospital care setting. Paramedics can learn much from their specialist mental healthcare professional colleagues, particularly registered mental health nurses and psychiatrists with expertise in community care. Paramedics undertake their assessments of patients in community settings. This is most often in the patient's home, at a public place such as shopping centres or parks, on the roadside at a road traffic crash, or in the back of the moving ambulance. Thus, in addition to relevant education, training and clinical practice standards of the particular ambulance service, a useful practice guide for paramedics is available from the work of Professor Peter Yellowlees (Yellowlees, 1997). Regardless of where in the community healthcare professionals (such as paramedics) are called to assess and manage individuals suspected of having mental illness, Yellowlees (1997) provides four salient points that all health care professionals should remember.

1. First, the success of any mental health assessment or treatment in the community setting depends largely on the ability to 'engage with the patient's major concerns, develop rapport, win their trust, and lay the foundation for more formal assessment of diagnosis and treatment later' (Yellowlees, 1997, p. 1). For paramedics, assessment the patient's mental state is a vital part of all clinical health assessments, and their assessment practice should be systematic and reliable. Few if any mental illnesses are remedied after a single intervention or interaction. Long term care and interventions are most often required, with more formal assessment of diagnosis and treatment later, and ongoing care. Thus the actions of paramedics are vital to the ongoing care provided to the patient within the broader health care system. Tables 12.2 and 12.3 provide clinical practice guidelines that are useful to paramedics in pursuit of this aim.
2. Second, paramedics should take note of important information such as evidence of the patient's living skills and social connections, and other environmental factors, during their assessment. Information, such as evidence of the patient's living skills and social connections, is crucial to the ongoing diagnosis and management of the patient and is otherwise readily available to other health care professionals such as psychiatrists and mental health nurses unless provided by paramedics. These are crucial to the ongoing diagnosis and management of the patient, which subsequent health care professionals such as psychiatrists often do not have ready access to.
3. Records that are objective and comprehensive yet concise are invaluable to other health care professionals. Inter-related with this is the importance of active engagement and collaboration with allied services and mental health professionals such as community mental health care teams, community outreach teams, community mental health liaison personnel, and the patient's own GP or mental healthcare team, is vital to the health and wellbeing of patients.
4. Finally, managing mental illness in the community is often challenged, stressful, and even dangerous. Paramedics should also ensure they are supported at every case by other ambulance or emergency personnel such as police, and take reasonable measures to care for their own physical and psychological welfare during difficult cases. Activities such as operational debriefing, peer support, and employee assistance services such as confidential counselling are critical activities if paramedics are to provide optimal mental healthcare services in the pre-hospital care setting.

**Table 7.2 – Mental Health Assessment Decision and Assessment Guide**

<b>Mental Health Assessment Decision Tree and Assessment Guide</b> <small>Adapted from Yellowlees P. 1: Psychiatric assessment in community practice. MJA 1997; 167: 149-156. © Copyright 1997.                      The Medical Journal of Australia - reproduced with permission</small>		
<p><b>Step 1:</b> Is there evidence of altered consciousness or cognitive impairment? <i>e.g. Altered level of consciousness; evidence of alcohol or drugs use</i></p>		<p>Is so, suspect possible physical illness or substance-related disorder</p>
<p><b>Step 2:</b> Is there evidence of perceptual abnormality or thought disorder? <i>e.g. Is there evidence of hallucinations or delusions in any of the five senses?</i></p>		<p>If so, suspect possible psychotic illness</p>
<p><b>Step 3:</b> Is there evidence of a disturbed or abnormal mood or behaviour? <i>e.g. Is the patient depressed, manic, or anxious?</i></p>		<p>If so, suspect possible mood or affective disorder</p>
<p><b>Step 4:</b> Are there other symptoms or evidence? <i>e.g. psychiatric medications, psychiatric history, odd or bizarre behaviour</i></p>		<p>If so, suspect other mental illness, or no psychiatric diagnosis</p>
<b>Individual Mental Health Assessment Guide</b> <small>Adapted from Yellowlees P. 1: Psychiatric assessment in community practice. MJA 1997; 167: 149-156. © Copyright 1997.                      The Medical Journal of Australia - reproduced with permission</small>		
<p><b>Appearance</b></p> <ul style="list-style-type: none"> <li>Describe the patient's physical appearance and presentation, giving due attention to cultural diversity: What are wearing? Is it appropriate? What is their standard of personal hygiene?</li> </ul> <p><b>Behaviour</b></p> <ul style="list-style-type: none"> <li>Briefly describe the patient's behavioural: Are they agitated? Is there evidence of inappropriate or unusual behaviour?</li> </ul> <p><b>Conversation</b></p> <ul style="list-style-type: none"> <li>Describe the content and form of the conversation: What is the patient saying? What is the rate of their conversation and logic, or otherwise, of thought processes? Provides some verbatim quotes in your clinical record.</li> </ul> <p><b>Affect and mood</b></p> <ul style="list-style-type: none"> <li>Assess the individual's mood level, variability, range, intensity and appropriateness.</li> </ul> <p><b>Perception</b></p> <ul style="list-style-type: none"> <li>Are there any perceptual abnormalities, such as hallucinations or delusions, or other psychotic symptoms? Assess for the presence of these in any of the five senses.</li> </ul> <p><b>Cognition</b></p> <ul style="list-style-type: none"> <li>Describe the individual's cognitive orientation, their memory and attention, and ability to concentrate, using such tools as a Mini Mental State Examination.</li> </ul> <p><b>Dangerousness</b></p> <ul style="list-style-type: none"> <li>Is there evidence of suicidal or homicidal ideas, beliefs or feelings? Is there evidence or a threat of self-harm or harm to others?</li> </ul> <p><b>Insight</b></p> <ul style="list-style-type: none"> <li>Does the patient display insight into the current physical or mental state?</li> </ul> <p><b>Judgement</b></p> <ul style="list-style-type: none"> <li>What the patient's level of judgement, in particular regarding safety issues.</li> </ul> <p><b>Rapport</b></p> <ul style="list-style-type: none"> <li>Record how you consider the interaction was between yourself and the patient, and in particular how he patient made you feel.</li> </ul>		

**Table 7.3 – Assessing and Managing Mental Illness - A Practice Guide for Paramedic**

<b>Assessing and Managing Mental Illness - A Practice Guide for Paramedics</b> <i>Adapted from Yellowlees P. 1: Psychiatric assessment in community practice. MJA 1997; 167: 149-156.</i> © Copyright 1997. The Medical Journal of Australia - reproduced with permission.
<p><b>Before the Case:</b></p> <ul style="list-style-type: none"> <li>• Attempt to predict the range of outcomes before attending, and collect as much information as possible. Discuss with your clinical or on-road colleagues who know the patient if possible.</li> <li>• Plan for the outcomes early, and check availability of patient's family, police and other health professionals such as community mental health team members</li> <li>• Do not go out alone if the situation sounds dangerous. At times, the scene may be dangerous, particularly when paramedics attended by are not invited, and the patient feels threatened. Ensure the safety of yourself, patients and bystanders. If there is any suggestion of dangerous, ensure Ambulance Communications are aware of your status and follow established protocols such as dispatch of secondary crews, police or other services such as fire officers if police are not readily available. Ensure portable or mobile communications are operational.</li> <li>• Ensure you are operationally prepared with the appropriate equipment, pharmacology, certification documents and a mobile communications devices</li> <li>• Identify local support teams and individuals you may call on for advice. This should include the psychiatric liaison service, community mental health teams, case managers, other health care professional with expertise in mental health, and relevant community organisations. Check availability of local services such as family or case managers to spend more time with the patient if admission to hospital can be avoided</li> <li>• Ensure you maintain clinical skills and authority-to-practice procedures and pharmacology consistent with your education and training as authorised by your ambulance service. Be fully informed of any statutory obligations required of you with respect to the care that you provide, such as requirements of state mental health legislation.</li> <li>• Plan how you intend entering a scene and how you might manage a case based on the information at hand. Ensure your plans are flexible, and are agreed to and shared amongst all attending staff. Develop routine and protocols with your on-road partner about entering patient for ensuring staff safety.</li> </ul> <p><b>During the Case:</b></p> <ul style="list-style-type: none"> <li>• Introduce yourself and explain why you are present. Remain courteous and non-threatening, but be honest and direct. Avoid confrontation at all costs; be prepared to "agree to differ" with the patient's perspective and to address what they see as the major issues first</li> <li>• Engage with the patient attentively and as early as possible. Be mindful and take respectful but careful note of the patient's surrounding; much can be learned about a patient from their environment.</li> <li>• Be mindful of your surroundings. Public places are usually quite safe, but consider safety seriously. Avoid interacting with patients in areas with poor access and egress; draw them out to more appropriate areas.</li> <li>• Explain to the patient what you are doing, and ensure your communication style and manner is therapeutic</li> <li>• Adopt systematic assessment and treatment practices. Assessment should not be limited to just the description of the patient's behaviour. It must take into account their historical, background information.</li> <li>• Pay attention to social, family, and cultural dynamics at the scene. Seek information from family members or the patient's friends or acquaintances, as appropriate. Be mindful that in many instances mental illness has a significant toll on family members, and may result in interpersonal tension or difficulties. While you are there to treat the patient, you also have an obligation to assess and treat family members and bystanders as appropriate.</li> <li>• Be prepared for it to take time to build rapport with some patients, particularly those who are anxious or those with psychotic symptoms.</li> <li>• Considering using other assessment tools such as the Mini Mental State Examination Assessment which are useful if you suspect the patient is suffering from dementia, delirium or other cognitive impairment..</li> <li>• Adhere to ethical and legal requirement for patient confidentiality and privacy, particularly when family, friends or bystanders are present.</li> <li>• Do not attempt to manhandle the patient, except to prevent serious assault, self-harm or suicide attempt.</li> </ul> <p><b>After the Case:</b></p> <ul style="list-style-type: none"> <li>• Write comprehensive case notes as soon as possible. Ensure your clinical records are comprehensive and complete. See advice and feedback from clinical support staff and other colleagues regarding your work.</li> <li>• Managing mental illness in the community is often challenging, stressful, and even dangerous, so be sure to care for self. Check yourself for your personal responses to the incident to ensure that you are not adversely affected. If the incident was traumatic, or you feel anxious or distressed, discuss these issues with a colleague or friend, or use a more formal debriefing process. Avoid denying the emotional impact of dealing with difficult and challenging cases. Allow yourself time and space to emotionally decompress after particularly difficult cases.</li> <li>• Seek out operational and personal debriefing as appropriate. Debrief with a trusted friend or colleague. Access confidential professional counselling through your employee assistance service.</li> <li>• Seek out a mentor or some clinical supervision in mental health. A local social work, psychologist, mental health nurse, or psychiatrist might be able to provide advice to you on managing patients.</li> </ul>

## Looking Ahead: The Future

In this chapter we have explored contemporary professional and clinical practice issues relating to paramedics and the assessment and management of the mentally ill in the pre-hospital care setting. Paramedics are one group of healthcare professionals facing increasing challenges in the care of the mentally ill, but until recently have appeared to lack explicit involvement in mental health reforms or the mental healthcare agenda. Despite widespread international reform and much interdisciplinary collaboration, the roles of paramedics and the contributions they may make to the care of the mentally ill in the wider continuum of healthcare are yet to be realised. Traditionally, the work of paramedics has been limited to managing specific 'psychiatric emergencies' such as attempted suicide (Shaban, 2004a). There are, however, fundamental differences between what may be considered a psychiatric emergency warranting immediate intervention and other non-life threatening mental illness such as depression, anxiety and mood disorders that are far more common and prevalent within the community. Recent research by Shaban (2005) and Roberts (2007) indicates that paramedics are routinely called to attend to patients with anxiety and depression, but perceived themselves as lacking the skills to do so. We know from this research that paramedics in the Australian setting find it difficult to manage common, everyday mental illnesses such as anxiety and depression, for a variety of reasons. They themselves have called for better professional preparation, education and training to equip them to meet their demands of the expanding practice, and also call for better integration of their role into mainstream mental health care systems so as to make meaningful contribution to the mental health of their patients.

Paramedics are no longer regarded as peripheral health care workers when it comes to mental health. They, like all of their health care colleagues, are faced with both an unprecedented dynamic of change and growing emphasis on the wider social responsibility and social relevance of healthcare. Paramedics and the quality of the mental healthcare they provide in community and pre-hospital contexts will become increasingly important to the success of the wider health care system they operate in. In an environment where the demands of quality and safety in healthcare dominate the reform agenda, the clinical judgments and decisions of paramedics take on crucial importance. The importance of interdisciplinary integration of hospital and community services in areas such as ambulance services take on a new importance when considering the quality and safety of mental health care. The *National Mental Health Plan 2006-2011* (Council of Australian Governments [COAG], 2006) recommends increased participation of a wide range of health, welfare and disability professionals and organisations in the provision of services to people with mental disorders. Further, this plan calls for increased knowledge and understanding of mental health and mental disorders for all healthcare professionals, an awareness of additional needs with increased coordination of services provided to consumers and carers, and increased community interest and involvement in mental health issues. We know from existing research (Roberts, 2007, Shaban, 2005) that paramedics are well-placed and actively seek to make meaningful contributions to the national mental health reform agenda. To do so, paramedics must be provided with comprehensive education and training opportunities with particular focus on the assessment and management of mental disorders within appropriate professional practice, policy, and legislative frameworks. In addition, debate about extending the role and scope of practice of paramedics (Raven et al., 2006) must encompass the contributions they may make in the wider mental health agenda. The *National Action Plan on Mental Health 2006-2011* (Council of Australian Governments [COAG], 2006) in part seeks to address this, and includes an excellent initiative to improve the integration of police and ambulance service responsiveness to mental health incidents. This initiative is aimed at the prevention and resolution of mental health crisis situations by collaboration between the Queensland Health, the Queensland Police Service and the Queensland Ambulance Service, and is reported to include training for paramedics on how to conduct mental health assessments. Such interventions allow paramedics to make significant contributions to improving the mental health of the many individuals, families and communities suffering mental illness.

## Further study activities

1. Look up the legislation, clinical policies and procedures, and other official documents that govern the assessment and management of mental illness in your local ambulance jurisdiction. What types of mental illness are these focused on? What assessment, treatment or referral options are available?
2. Contact a local mental illness patient support group such as ARAFMI and find out more about specific mental illnesses listed in textbox 12-1 such as depression, anxiety, and personality disorders. Are any particular illnesses more prevalent than others in your area? What services are available? Is there any inter-departmental collaboration?
3. Contact mental health professionals within your local community mental health team and department of mental health at your local hospital. Attend any seminars and workshops they provide on the management and assessment of mental illness.

## Resources

- **Beyond Blue** <<http://www.BeyondBlue.org.au>>
- **World Federation for Mental Health** <<http://www.wfmh.org/>>
- **World Health Organization** <[http://www.who.int/topics/mental\\_health/en/](http://www.who.int/topics/mental_health/en/)>
- **Mental Health Council of Australia** <<http://www.mhca.org.au>>
- **Mental Health Foundation of Australia** <<http://www.mhfa.org.au/main.htm>>
- **Mental Health Fellowships of Australia Inc.** <<http://www.schizophrenia.org.au>>
- **Centres for Disease Control and Prevention** <<http://www.cdc.gov/mentalhealth/>>
- **HEALTHInSite** <[http://www.healthinsite.gov.au/topics/Mental\\_Illnesses](http://www.healthinsite.gov.au/topics/Mental_Illnesses)>
- **Multicultural Mental Health Australia** <<http://www.mmha.org.au/>>
- **Department of Health and Ageing (DoHA), Australian Government** <<http://www.health.gov.au>>
- **Council of Australian Governments – Mental Health** <<http://www.coag.gov.au/meetings/140706/index.htm#mental>>
- **Australian College of Mental Health Nurses** <<http://www.acmhn.org/index.html>>
- **ARAFMI - Mental Health Carers ARAFMI Australia** <<http://www.arafmiaustralia.asn.au/>>
- **SANE Australia** <<http://www.sane.org/>>

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