AmbulanceVictoria

Clinical Insights

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Mental Health

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Welcome

A message from David Anderson

Medical Director

By **Assoc. Prof. David Anderson**

Most of us pursued a career in paramedicine because we wanted to do three things – help people, be exposed to a wide variety of illnesses and injuries and respond to emergencies. Thankfully, by and large paramedicine is a profession that allows us to do those three things – but like everything in life, there's a catch. There are always going to be types of calls that are more common than others, and we won't always be attending the types of calls that we personally enjoy the most.

Over time, the prevalence of illnesses in the community will change as public health measures take care of some illnesses while environmental and other factors increase the incidence of others. When I started as a volunteer ambulance officer in the 90's, I probably attended a cardiac arrest every second or third shift, I saw lots of very sick children with meningococcal disease, and we went to lots of high velocity motor vehicle crashes with fatalities. Now, thanks to effective prevention of ischaemic heart disease, paramedics see less than two patients in cardiac arrest per year; thanks to vaccination and other public health measures, critically ill children with meningococcal sepsis are a rare presentation; and, thanks to many road safety initiatives, the vast majority of car crashes involve only relatively minor injuries.

> Mental health is now our most frequent call type (11 per cent), having overtaken chest pain (10 per cent) and breathing problems (10 per cent).

We all went through a period in 2021 when a large proportion of the patients we saw were suffering from COVID-19, now it is an uncommon presentation. Now, in the post-pandemic world, the frequency and type of presentations we see is changing again. As people struggle with cost of living pressures and access to primary care becomes challenging, patients call ambulances with conditions that may have been preventable with timely access to primary care and, as addressed in a number of the articles in this issue of Clinical Insights, the incidence of mental health and behavioural presentations in the population has risen dramatically. Mental health is now our most frequent call type (11 per cent), having overtaken chest pain (10 per cent) and breathing problems (10 per cent). So as paramedics, regardless of what we anticipated at the start of our career, mental health care has become a major part of our day-to-day work.

This means that we all have a responsibility to ensure that the care we provide to patients suffering from mental illness and behavioural disturbance is as safe and effective as the care we provide to any other patient group. As an emergency service and a health service, Ambulance Victoria (AV) has a responsibility to ensure that you are well trained, equipped and supported to deliver the highest standard of care. You, as a registered health care professional, have a responsibility to ensure that your knowledge and practice in the area of mental health are up to date.

Most patients under the mental health umbrella who we encounter are suffering from an acute deterioration of a chronic mood disorder like depression or anxiety (which together affect up to one quarter of the population at some point in their lives), a psychotic disorder like schizophrenia or a personality disorder like borderline personality disorder. We are also seeing an increasing number of younger patients presenting with behavioural symptoms related to ADHD and autism and an increasing number of older patients presenting with behavioural symptoms of dementia. We also commonly encounter patients with so-called "dual diagnosis" who have a mental illness, and a substance use disorder such as alcohol or opioid dependence.

A tiny proportion of these patients will be experiencing acute behavioural disturbance and present a potential or actual danger to themselves, you, and others on the scene. I increasingly think that these are both the highest risk and

most vulnerable patients that we encounter. There is the very real risk for them to harm us through their actions, and for us to harm them with the physical restraint and sedation that is required to safely assess and manage them. The safe management of sedation in this patient group will be a large focus of continuing education this year and I hope that many of you have already come across the *if you plan to sedate, plan to resuscitate* campaign being led by our Clinical Support Officers. The cases in this issue's feature article on mental health are confronting, but reflective practice is an important part of continuing professional development. It is vital that we all work to improve the care of patients in the future by reflecting on cases that didn't go as planned.

We also all have a responsibility to look after our own mental health. The job that we do isn't normal. Paramedics, first responders, triage practitioners, retrieval physicians and nurses, patient transport officers, and many of you who support us behind the scenes are all exposed on a regular basis to traumas that regular members of the public would encounter rarely, if ever. We cannot pretend that this doesn't have an impact on us. I strongly encourage you to read the articles in this issue on paramedic mental health and specialist mental health services for first responders.

Last year I started seeing a psychologist. I was strongly encouraged to go by my excellent GP who I had seen because I wasn't sleeping. He asked a few simple screening questions to make sure I wasn't drinking a double espresso before bed and didn't have obstructive sleep apnoea, looked me in the eye and said, "I think you're just really stressed." I dreaded the first appointment, but on reflection it was the best thing I have done for my health in a long time — and it's something I should have done a long time ago. I'm sure many of you are in a similar situation. Unfortunately, mental illness still carries a significant stigma, even among healthcare professionals, which can prevent us from seeking the help that we need.

For patients' sakes and our own sake, we need to have a much greater awareness of mental illness and mental health than we have previously. We are seeing more patients with mental health presentations than ever before. The *Mental Health and Wellbeing Act 2022* (Vic) is being gradually rolled out and gives us a much greater role, and eventually greater powers, in the management of this complex and vulnerable group of patients. We will keep you informed as this process evolves. In the meantime, please enjoy this mental health focused issue of Clinical Insights and as always, get in touch with any feedback you might have and any suggestions for future issues.

Quality and Clinical Innovation update

Welcome to the first edition of the Clinical Insights for 2025

By **Tegwyn McManamny** Executive Director Quality and Clinical Innovation

This edition will focus on mental health, an area of critical importance in both clinical practice and patient care.

Mental health challenges continue to impact individuals and communities across various settings, and it is essential that we stay informed about emerging trends, evidence, and best practices in this field.

In this issue, we'll delve into key topics related to mental health, including new research, evolving clinical practices, and initiatives aimed at improving outcomes for patients experiencing mental health issues. We will also explore how these developments can inform our daily clinical work and patient interactions, providing valuable insights that will help shape better care.

As always, we encourage your engagement and feedback on the topics covered, as your perspectives are crucial in driving improvements in clinical practice and patient safety. We hope this edition sparks meaningful discussions and provides you with useful information that can be applied in your work to support mental health care.

Thank you for joining us as we kick off another year of Clinical Insights, and we look forward to continuing to share knowledge and foster collaboration across the clinical workforce.

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Best Care, Everywhere refresh

At Ambulance Victoria, our clinical governance is guided by the Best Care Framework, *Best Care, Everywhere*. This framework outlines the organisational systems and structures that support our workforce in delivering consistent, high-quality, safe, effective, person-centred, and connected care for every patient, every time.

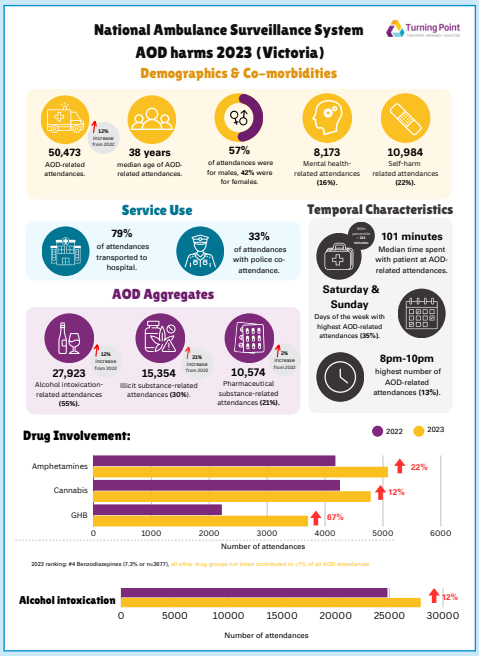
We are excited to share a refresh of the Best Care Everywhere framework, further reinforcing our commitment to these principles.

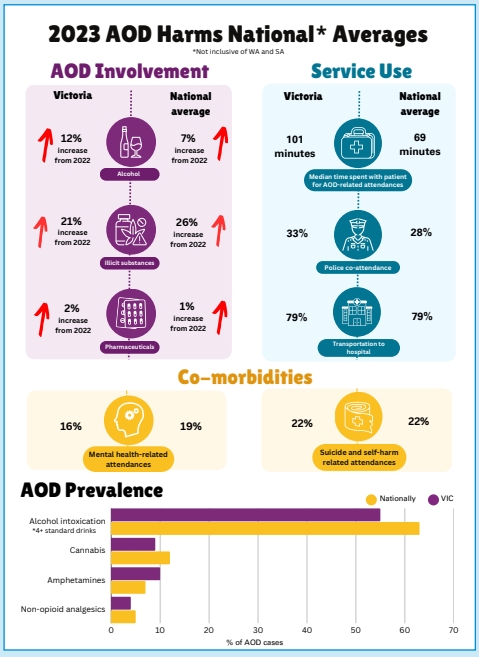
The Best Care Framework defines what Best Care means for both us and the community, how it is delivered, and how our people contribute to achieving our shared vision.

You will start to notice updates across AV, as well as through our various systems and communications.

Turning Point: Alcohol and Other Drugs (AOD) harms 2023 – Victoria

Turning Point has released a bulletin on alcohol and other drugs from the National Ambulance Surveillance System, providing valuable insights into alcohol and other drug-related harms. The report includes key demographic data and co-morbidities, offering an overview of trends and impacts.





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Commendation

A warm acknowledgment for the exceptional care our paramedics are providing to support the community, highlighted by the following remarks from a member of Victoria Police. Their dedication and commitment continue to make a meaningful difference.

"We were dealing with a particularly difficult patient who has extensive history with both police and AV. Police were at somewhat of an impasse as the patient needed to be removed. However, if police were going to do so, it would've involved the patient becoming extremely agitated and violent. The patient was already very heightened having already assaulted emergency service workers that day. Any further involvement from police or PSO's would've likely involved further assaults from the patient.

The AV crew arrived and did not hesitate to engage with the patient despite the patient still being in a heightened state and it became apparent that one of the AV members, was familiar with the patient.

Thanks to the prior knowledge, being compassionate and showing empathy, the AV crew were able to get the patient to become calm and compliant and as such, the patient agreed to be taken to the hospital. The patient was transported without issue and even more so, without having to be sedated, which often happens with this patient in particular. Given the history with the patient, it would've been very easy to simply dismiss and not engage with her.

I believe if we had a different AV crew attend, the outcome for the patient that day would've been significantly different and would've involved far more risk to multiple emergency service workers as well as the patient."

An outstanding example of effective communication and interpersonal skills by our paramedics, ensuring safety and positive outcomes for everyone involved, with the patient's wellbeing at the centre. Well done to everyone involved in this case!

Refreshed approach to Grand Rounds in 2025

In 2025, we are introducing a refreshed approach to our Grand Rounds, with some key changes aimed at enhancing the experience and value for all attendees.

The first Grand Round for 2025 has been scheduled for **Tuesday, 27 May** from **10am to 1pm**, with the option to attend in person at the AV Capability Hub at Victoria University Sunshine, or online.

- **Session structure:** There will be three Grand Round sessions throughout the year, each lasting three hours. This extended format allows for more in-depth discussions and engagement on the topics covered.
- **Topic focus:** While the sessions may be aligned with the Clinical Insights' theme, the content will also be selected based on what is topical and relevant to our clinical practice and patient safety initiatives.
- **Content highlights:** Based on your feedback, we are incorporating:
  - **Stronger focus on patient safety reviews** to highlight key lessons and areas for improvement.
  - **Short clinical updates** to keep everyone informed on the latest developments and trends.
  - **Masterclasses** that leverage the diverse expertise within our teams, providing valuable insights and hands-on learning.
  - **External speaker/s** who can offer fresh perspectives and knowledge from outside our organisation.
- **Format flexibility:** The format of each session may vary based on feedback and emerging trends to ensure that we continue to address the most pressing and relevant topics in clinical care.

We hope these updates make the Grand Rounds even more beneficial for everyone involved and foster greater engagement and knowledge sharing.

To watch Grand Round webinars at any time, simply search for Grand Round in the Learning Hub.

Remember to log your CPD

Don't forget to reflect on the Grand Rounds sessions you attend and log them as part of your annual Continuing Professional Development (CPD) hours for your Aphra registration! You can also log hours for reading and discussion related to Clinical Insights publications.

The poster provides guidance on options on how to meet your CPD requirements.

Patient Management Team

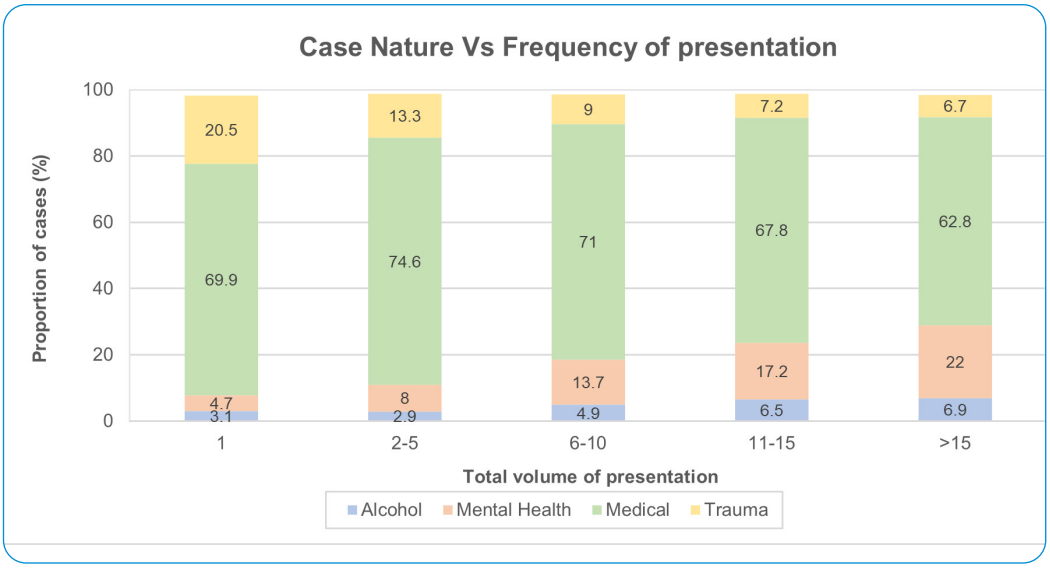
Patients with frequent complex mental health presentations

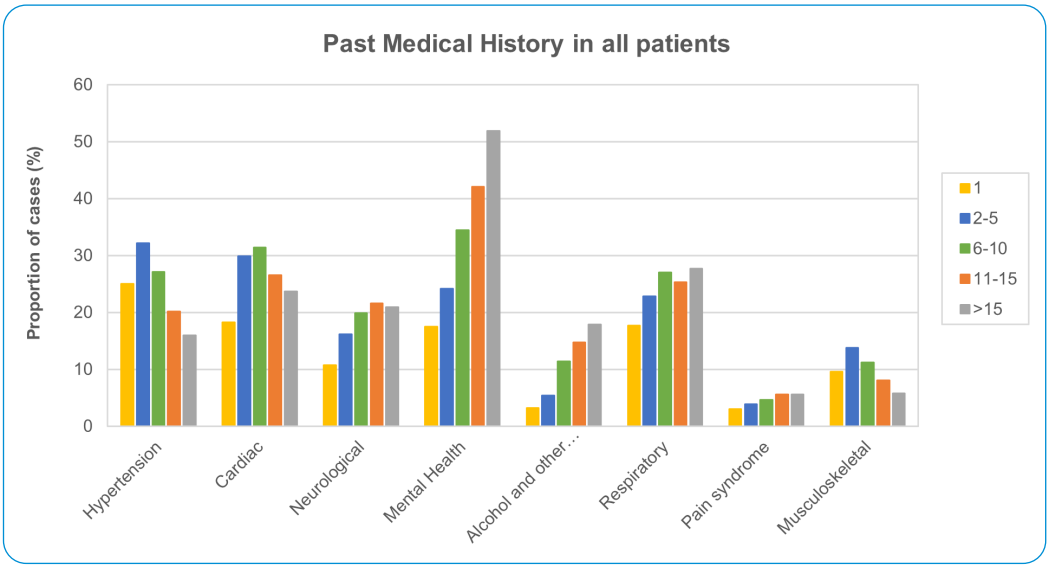
By **Ella Soydas** Patient Management Lead

Management plans

The management of patients with complex mental health conditions who frequently engage with the ambulance service can pose a unique set of challenges for paramedics. This includes issues with communication, resource and time constraints, accessibility of medical records, risk of occupational violence, and navigating coordination with other services.

The Patient Management Team seek to improve the care we provide patients with complex mental health conditions by engaging with the patient and their care team to develop Patient Management Plans and Mental Health Information Plans. These plans provide individualised management, as well as communication and de-escalation strategies, record known triggers and protective factors, and key contacts and support services involved in the patients care. These are crucial tools to support decision making and improve the care we provide to some of the most complex patients.





Did you know?

Data from the Centre of Research and Evaluation shows greater proportions of mental health related case natures in those who present more than 10 times within a 12-month period.[1] The data also shows greater proportions of past histories of mental health and alcohol and other drug related conditions in this cohort.[1]

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The benefits include:

- Individualised and patient-centred care.
- Continuity of care across services.
- Improved de-escalation and crisis management.
- Reduced restrictive practices.
- Reduced occupational violence incidents.
- Interdisciplinary collaboration.
- Patient empowerment.
- Improved patient experience and outcomes.
- Supported decision making.

The numbers

We know that paramedics see a small cohort of patients more often, with two per cent of patients receiving 14 per cent of all emergency ambulance attendances in Victoria.[1]

Accessing a plan

In field paramedics are alerted that a patient has a plan via an alert (SPPT) if the patient is calling from their primary address. Paramedics can access these plans by calling Field Referral and speaking to a triage practitioner or alternatively a mental health nurse if utilising Teleprompt.

References

1. Pellegrini M. Characterising high frequency presenters to Ambulance Victoria: Briefing Report. Melbourne: Ambulance Victoria; 2024. 27p.
2. Broadbear, JH; Ogeil, RP; McGrath, M, et al. Ambulance attendances involving personality disorder – investigation of crisis-driven re-attendances for mental health, alcohol and other drug, and suicide-related events, *Journal of Affective Disorders Reports*. **2025**, ***20***, 100882.

Did you know?

Requiring repeat ambulance attendances is more common in individuals with personality disorder (70 per cent) than those with other mental disorders (37 per cent).[2]
Of all ambulance attendances relating to personality disorder, a small proportion of just 8.3% of this group, accounted for almost half of attendances (49.6 per cent).[2]

Cultural awareness in clinical practice

The power of identity for Aboriginal and Torres Strait Islander people

By **Michelle Crilly**, Program Lead Aboriginal & Torres Strait Islander

Did you know that Aboriginal and Torres Strait Islander people have a life expectancy gap of nearly 10 years compared to non-Indigenous Australians? This significant disparity highlights the importance of understanding cultural backgrounds in healthcare.

In December 2024, AV completed the implementation of our first Reconciliation Action Plan (RAP), laying the foundation for better patient care for Aboriginal and Torres Strait Islander communities. This is the first step of our ongoing commitment to achieve reconciliation and demonstrates how we can play our part in reducing inequality in healthcare and disparity in health outcomes for Aboriginal and Torres Strait Islander peoples.

The role of cultural identification in clinical practice

Recognising a patient's cultural identity is essential to improving health outcomes. When we ask each patient, "Do you identify as Aboriginal and/or Torres Strait Islander?" we create the opportunity to provide culturally safe and relevant care. Without this awareness, we risk offering care that may not align with the patient's cultural needs, potentially leading to poorer health outcomes.

On the other hand, having a clear understanding of a patient's cultural background empowers us to make more informed decisions, deliver culturally sensitive treatments, and foster better communication. This awareness plays a crucial role in supporting patients throughout their healthcare journey and addressing health disparities.

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CASE STUDY

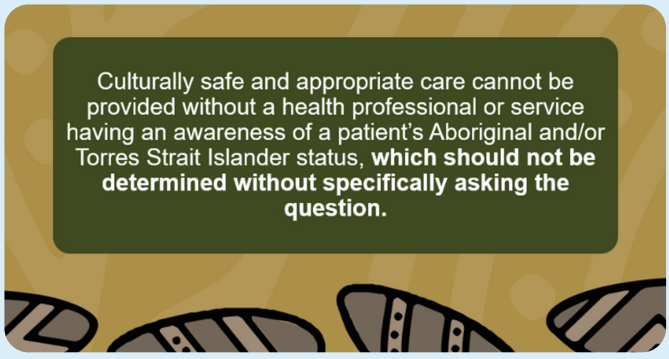
Please note: *This case study is entirely hypothetical and is intended to demonstrate how asking the question, "do you identify as Aboriginal and/or Torres Strait Islander?" can inform clinical decisions and enhance patient care. While fictional, this scenario mirrors real-life experiences for many Aboriginal and Torres Strait Islander people seeking ambulance care.*

Consider the case of Sarah, a 34-year-old Aboriginal woman who was taken to hospital in by paramedics after a fall. Initially, her medical history was unclear, and her injuries were compounded by underlying health issues related to her diabetes.

During the assessment, the paramedics asked Sarah if she identified as Aboriginal. After a brief hesitation, she confirmed that she did. This simple question opened the door for a more in-depth conversation about her cultural background and health history. Sarah shared that she had a strong preference for certain traditional healing methods alongside conventional treatments.

By recognising her cultural identity, the paramedics were able to connect Sarah with Aboriginal community health services, offering culturally safe support and resources. This not only improved her recovery experience but also helped ensure her care was more personalised and respectful of her cultural values.

This case highlights the importance of asking the question and how it can lead to better health outcomes, improved patient-provider communication, and a more inclusive care environment.



Asking the question

As of August 2023, only about 13 per cent of AV's workforce consistently asked patients about their Aboriginal and Torres Strait Islander status. The good news is that this has increased to 30 per cent as of March 2025, but there is still more we can do! We've launched the 'Asking the Question' project with two main goals:

1. **Increase the rate of enquiries** about the Aboriginal and/or Torres Strait Islander status of patients.
2. **Enhance education** for our workforce on the importance of these enquiries for delivering high-quality, culturally safe care.

We recognise that asking this question can be challenging. Feedback from our workforce has highlighted several common concerns:

- Making visual assumptions about Aboriginal and Torres Strait Islander identity.
- Forgetting to ask.
- Uncertainty about the relevance to the question to patient care.
- Concerns about negative reactions from patients.
- Not knowing how to phrase the question appropriately.

To address these barriers, we're launching an education initiative to empower our clinical staff with practical strategies for confidently navigating this important conversation. The training will cover why these questions matter for patient care, culturally sensitive approaches to build trust, techniques for addressing concerns, documentation best practices, and guidance on respectful communication

A call to action

As we progress with the 'Asking the Question' project, we encourage every clinical staff member to fully embrace this initiative. Together, let's make cultural awareness a key part of our clinical approach.

By incorporating cultural awareness into our clinical practice, we can improve health outcomes for Aboriginal and Torres Strait Islander patients and take significant steps toward reducing health disparities. Together, let's make this essential question a routine part of our approach to care.

Mental health-related cases in paramedicine

By **Bart Cresswell**, Lead Patient Review Specialist and **Ben Meadley**, Director, Paramedicine

Introduction

Across Australia, mental health-related cases represent a significant portion of paramedics' workload. Estimates suggest that 10 to 20 per cent of all ambulance presentations are related to mental health concerns.[1] Internal Ambulance Victoria data indicates that mental health cases make up approximately nine to 11 per cent of all cases, compared to 6.8 per cent of cases requiring MICA intervention. On average, a paramedic is at least twice as likely to attend a patient with a mental health-related presentation, compared to one requiring prehospital critical care interventions.

Case exposure provides real-time learning opportunities for clinicians and informs future practice through practitioner reflection and ongoing professional development.[2] For example, low exposure to certain clinical skills (e.g. airway management or sedation for acute behavioural disturbances) can challenge skill maintenance and real-time execution. This challenge is not unique to paramedicine, it is evident across healthcare.

At AV, a paramedic working in Edenhope (Loddon Mallee) will have vastly different case exposure compared to one working in East Ringwood (Metro 1). To illustrate this, the total 12-month caseload for mental health-related cases in Loddon Mallee matches the number seen in a single month in Metro 1. The challenge for all of us is to ensure that the same standard of care is provided to the community in both settings.

While simulation training, procedural reviews, and professional development play essential roles in maintaining clinical competency, vicarious learning—learning through others' experiences—is another critical tool.[3] In this article, we share insights from recent adverse events to encourage discussion, enhance professional practice, and enhance clinical judgment when managing mental health presentations.

Acute behaviours of concern

When responding to acute mental health crises, paramedics may administer sedation to manage severe agitation and unpredictable behaviour. This can pose risks to both healthcare workers and to patients. In the hospital setting, sedation occurs in a controlled resuscitation environment, involving critical care staff, physicians, and access to necessary airway and resuscitation equipment. In the out of hospital environment, paramedics must strive to replicate this preparedness, and our recent patient safety data indicate a need for increased vigilance and careful planning.

Over the coming months, clinical leaders at AV will emphasise the message **"if you plan to sedate, plan to resuscitate."** This is part of a statewide initiative aimed at improving sedation safety and builds on recent updates to clinical practice guidelines for managing patients with acute behavioural disturbances.

Case discussion: Mr. H

Paramedics were dispatched to a supported accommodation facility for Mr. H, who was presenting in an acute mental health crisis with self-harming behaviour. He was reported to be armed with a knife and was actively cutting himself, with significant blood loss reported. Police Critical Incident Response Team members restrained Mr. H before paramedics were permitted to assess him. Upon contact, he was handcuffed and in a lateral position. Three minutes after first contact, he was administered 10 mg of intramuscular droperidol. Over the next 10 minutes, he rapidly deteriorated

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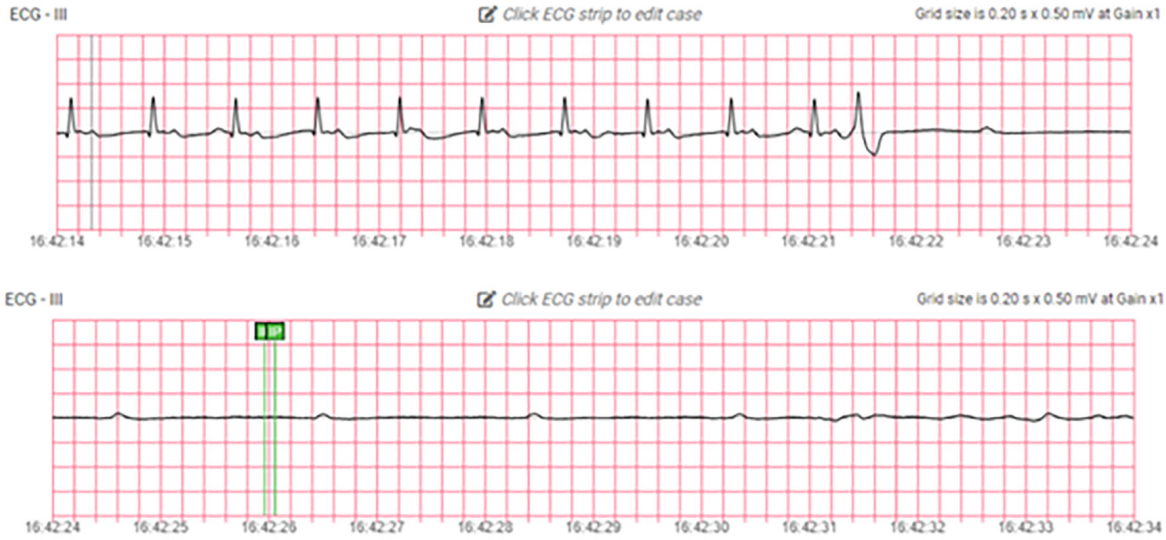

Figure 1: Electrocardiogram showing change of cardiac rhythm (Zoll Online)

into asystole. Very sadly, despite resuscitation efforts, he could not be revived. Potential medical causes of death include hypovolemic shock and droperidol toxicity.

This case highlights the dangers of enacting a treatment plan with only limited clinical information. Key assessments—such as estimating blood loss, obtaining vital signs, and considering comorbidities—were not prioritised before sedation was administered. The diagnostic momentum generated by the dispatch details and police involvement may have influenced decision-making, limiting consideration of alternative or concurrent diagnoses.

Assess

- Potential / correctable causes
  - Head injury
  - Infection / sepsis
  - Metabolic derangement
  - Hypoxia
  - Hypoglycaemia
  - Post ictal
  - Alcohol Withdrawal Syndrome
  - Exposure to toxins
  - Drug induced hyperthermia
  - Unmet needs (e.g. pain)
- Establish
  - Past history
  - Usual care plan
- SAT score
- Frailty

Image 2: Assessment of potential/correctable causes (AV CPG A0708 Acute Behavioural Disturbance)

Case discussion: Mr. S

Mr. S was found in a front yard with an obvious open tibia-fibula fracture. He was consuming alcohol when paramedics arrived. After being assisted onto a stretcher and into the ambulance, his behaviour quickly escalated, and he became agitated when a traction splint was applied to his injured leg. The crew retreated and requested police assistance. Whilst agitation can stem from various causes, it may be noted here that this includes inadequate pain management during splinting and movement, or the distress of being moved into a confined space.

Following police intervention, Mr. S was administered 10 mg of intramuscular droperidol. During transport, he became apnoeic, and he experienced a cardiac arrest. Resuscitation was initiated after pulling over on the freeway, but very sadly Mr. S could not be revived.

This case underscores the importance of considering all potential causes of agitation before administering sedation and being prepared to resuscitate if sedation is chosen as an intervention. One of the keys to successful resuscitation is not just identification of the equipment that may be required, but the coordination and planning regarding roles and responsibilities. In this case, the lack of a second paramedic in the ambulance during the transfer made ventilation and resuscitation very challenging.

In both cases, sedation was initiated without first obtaining vital signs and with limited consideration for differential, or indeed concurrent, diagnoses. While this is sometimes the pragmatic approach required, it should not be one we make lightly.

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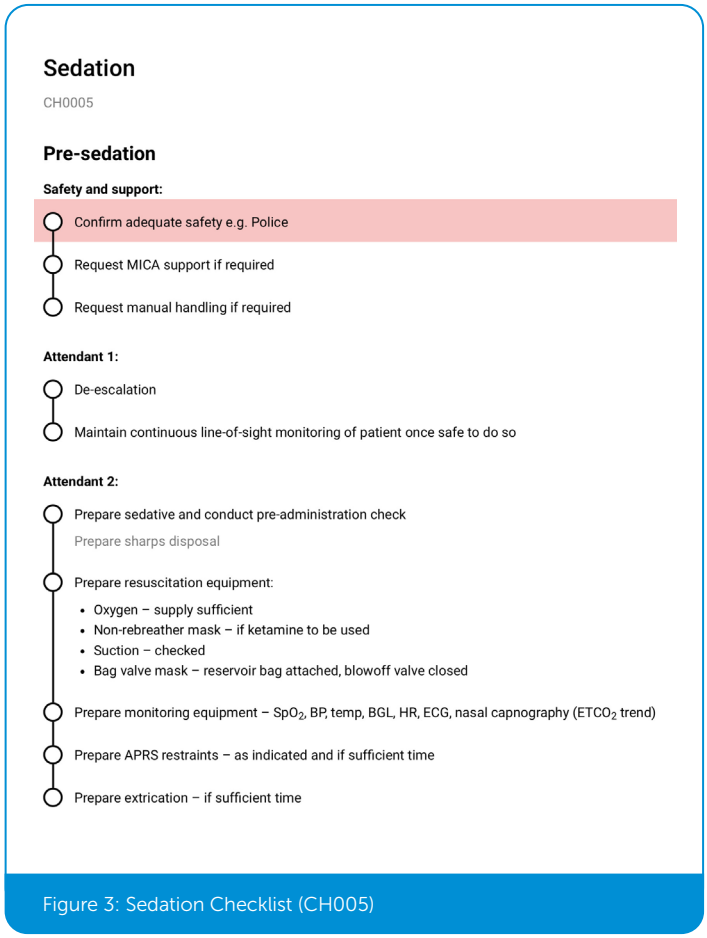

Sedation

CH0005

Pre-sedation

Safety and support:

- ○ Confirm adequate safety e.g. Police
- ○ Request MICA support if required
- ○ Request manual handling if required

Attendant 1:

- ○ De-escalation
- ○ Maintain continuous line-of-sight monitoring of patient once safe to do so

Attendant 2:

- ○ Prepare sedative and conduct pre-administration check
  Prepare sharps disposal
- ○ Prepare resuscitation equipment:
  - Oxygen – supply sufficient
  - Non-rebreather mask – if ketamine to be used
  - Suction – checked
  - Bag valve mask – reservoir bag attached, blowoff valve closed
- ○ Prepare monitoring equipment – SpO_2, BP, temp, BGL, HR, ECG, nasal capnography ($ETCO_2$ trend)
- ○ Prepare APRS restraints – as indicated and if sufficient time
- ○ Prepare extrication – if sufficient time

Figure 3: Sedation Checklist (CH005)

These events reinforce the role of structured clinical planning and clear role allocation, which can be consistently achieved with the use of a checklist.

Lessons and considerations

We encourage paramedics to reflect on the following questions:

1. Have you ever experienced a similar case in which patient deterioration was unexpected, and preparedness was limited?
2. Based on these outcomes, what changes would you make to your clinical approach?
3. What does **"if you plan to sedate, plan to resuscitate"** mean for your practice?
4. Do you consistently use the sedation checklist to structure communication, assign roles, and assist with team preparedness for potential complications?
5. Do you initiate out of hospital sedation without first obtaining baseline vital signs?
6. What do you consider the minimum standard of clinical monitoring when providing prehospital sedation? Why?

Key messages

- Always consider **alternative causes** of agitation before pursuing sedation.
- Implement the **structured communication checklist** to guide decision-making, preparation and crew resource management.
- Ensure appropriate **monitoring** is in place before and after sedation and that it is not removed during extrication.
- **Plan for resuscitation** whenever administering **sedatives** in the out of hospital setting. (e.g. IV access, functional suction, BVM, end-tidal capnography, appropriately positioned personnel).

It is important to remember that the paramedics caring for Mr H and Mr S all came to work with the intent of providing the highest level of prehospital care. The Patient Safety Team is focused on improving the systems that support paramedic practice at AV. We are extremely privileged to have the opportunity to learn from the experiences of those directly involved in sentinel events and the permission of those involved to share the learnings. In this way, we can enhance patient safety and clinical outcomes when managing people with mental health crises in paramedicine.

Listen to the Clinical Conversations podcast

Spotify

https://open.spotify.com/show/03gWpFDyiuJFh88KDrp4qy?si=55af16e1446644dd

Apple Podcasts

https://podcasts.apple.com/au/podcast/clinical-conversations/id1557773702

References:

1. Emond K, Mnatzaganian G, Savic M, Lubman DI, Bish M. *Paramedic perceptions of decision-making when managing mental health-related presentations: a qualitative study.* BMC Medical Informatics and Decision Making. 2024 Nov 19;24(1):348.
2. Heydari S, Beigzadeh A. *Medical students' perspectives of reflection for their professional development.* BMC Medical Education. 2024 Nov 29;24(1):1399.
3. Horsburgh J, Ippolito K. *A skill to be worked at: using social learning theory to explore the process of learning from role models in clinical settings.* BMC Medical Education. 2018 Dec;18:1-8.

Use of care and control powers

By **Clarissa O'Connell**

When the *Mental Health and Wellbeing Act 2022* (the Act) commenced in September 2023, it provided the legislative foundation required for the reforms recommended by the Royal Commission into Victoria's Mental Health System.

In response to feedback the Commission heard from consumers, carers, families and supporters, the Commission proposed transitioning to a health led response for mental health crises. AV paramedics were to be given care and control powers under section 232 to support this transition.

However, subsequent legislation, the *Mental Health and Wellbeing Amendment Act 2023*, removed these powers from paramedics until such a time that these could be safely and effectively implemented.

Current care and control powers

Under the Act, there are **two** types of care and control powers (sections 232 and 241):

Section 232: Taking a person into care and control in a mental health crisis

- Under the *Mental Health Act 2014*, this was known as section 351 or apprehension.
- Section 232 can only be utilised if the following conditions have **both** been met:
  - the person **appears to have mental illness**; and
  - because of the person's apparent mental illness, it is necessary to take the person into care and control to prevent **imminent** and **serious harm** to the person or to another person.
- Only police and protective services officers (PSOs) can use this power, and they need to be satisfied the criteria for section 232 has been met.
- As police and PSOs are the only authorised persons able to use section 232, the need to clearly articulate how the criteria have been met is crucial.
- If police use this power for a patient who requires transport, police must be in the vehicle transporting them, until they transfer care and control at the health service (i.e. to a registered medical practitioner, an authorised mental health practitioner or a registered nurse).
- Paramedic safety is paramount, and AV fully supports all crews in requesting police assistance if there are safety risks on scene and/or during transport that require additional support.

Section 241: Taking a person into care and control for the purposes of transport

- Both paramedics and police can utilise this power if required to enable safe transport of a patient with an **inpatient assessment or treatment order**, such as an interhospital transfer. Paramedics can use this power as the patient has already been assessed by an authorised mental health practitioner.
- Unlike section 232, there is no specific criteria that must be met in order for this power to be used by paramedics or police.
- This power can also be transferred between AV crews as required, such as multi-leg transfers when transporting a patient long distance, or between paramedics and police (and vice versa). This is enabled by section 242.
- As noted earlier, you are encouraged to request police assistance if there are safety risks on scene and/or during transport that require their support.

TelePROMPT can also provide mental health expertise and advice – please follow CPG A0107 - Mental Health Conditions.

Requesting police support with care and control

In line with the health-led principle of the Act, police should seek health advice before exercising care and control powers when reasonably practicable. This advice can come from health professionals including paramedics, registered medical practitioners and authorised mental health practitioners (via PACER or Area Mental Health and Wellbeing Services triage). On-scene paramedics can also consult TelePROMPT clinicians for additional guidance to relay to police.

The Transport of Mental Health Patients fact sheet from the Department of Health aims to assist mental health clinicians and paramedics to understand how the Act relates to transport.

Next steps

AV continues to engage with the Department of Health to progress work on consultation, design and implementation approach of care and control powers. We will share relevant updates when they become available.

In the interim, we encourage you to keep recording as much information as possible in VACIS regarding mental health cases to support continuous improvement.

For more information, check out the Mental Health Crisis Reform page on OneAV, which includes FAQs and a flowchart outlining care and control powers. Additionally, the Mental Health Reform Series Part A and B learning packages are available on the Learning Hub.

Paramedic mental health

Key implications from AV's 2024 Psychosocial Survey

By **Kaitlyn Harrington**, Senior Clinical Psychologist

AV's Psychosocial Survey 2024 (PSS2024)

Ambulance Victoria's Psychosocial Health and Wellbeing Survey is a biennial survey of all AV staff and volunteers.

The PSS2024 was developed and delivered by AV's Psychology team, which is embedded within the Wellbeing and Support Services department.

The survey's aims were twofold:

- To further our understanding of the mental health and wellbeing issues impacting our people.
- To identify changes over time via comparisons with previous surveys completed in 2016, 2019 and 2021.

To meet these aims, participants were invited to complete an online, anonymous survey which assessed the following domains:

- Demographics and employment information.
- Mental health including mood, resilience, burnout and post-traumatic stress.
- Relationships, sources of stress and coping.
- Support seeking behaviours.
- Organisational commitment.

Of our workforce, 22.8 per cent of staff completed the survey, which was more than double the previous participation rate of 11 per cent in 2021. Most respondents (81.9 per cent) were operational employees, with 48.2 per cent of respondents working from metropolitan locations, 37.8 per cent from regional areas and 14 per cent not specifically classified as working from either a metropolitan or regional area.

Summary of key findings

As the PSS2024 was completed in-house, we were able to publish the full report for the first time; we encourage you to read it on OneAV.

While not an exhaustive list, some of the key findings of the PSS2024 include:

- Average levels of anxiety, depression and stress were lower than all previous PSS. However, the percentage of respondents reporting severe or extremely severe levels of anxiety, depression and stress were higher than the 2016 and 2019 surveys. While this may suggest that prevention and early intervention support is working, it also highlights a proportion of individuals experiencing significant distress who require more targeted treatment.
- 17.7 per cent of respondents reported post-traumatic stress symptoms that indicated a likely diagnosis of post-traumatic stress disorder (PTSD). This is consistent with previous PSS, as well as a recent large-scale systematic review of paramedics worldwide, which found a 20 per cent twelve-month prevalence rate of PTSD, compared to 3.1 per cent in the general population.[2]
- Almost one third (29.6 per cent) of respondents endorsed at least one item related to suicidality, e.g. experiencing suicidal ideation, which was an increase from 2021. Encouragingly, the majority of respondents that endorsed an item related to suicidality also reported that they had sought support for this, although there was a minority that did not.
- An increased number of respondents reported seeking support through Victorian Ambulance Clinicians' Unit (VACU) psychologists, and more than one in three respondents reported accessing a psychologist within the last 12 months. More respondents also reported that their needs were 'very' or 'extremely' met by AV Wellbeing and Support Services compared to 2021.
- Concerns regarding confidentiality and impact on career continue to be reported as key barriers to accessing support, consistent across previous PSS.
- Analysis of group differences found that single responders in regional areas were at greater risk of reporting high levels of post-traumatic stress, depression, anxiety and stress symptoms, when compared to non-single responders in regional areas and single responders in the metropolitan area.
- Group differences were also found between ALS paramedics in metropolitan areas versus regional areas, with the former more likely to report high levels of anxiety compared to the latter.

Next steps and available support

PSS2024 results are already helping to inform the priorities and initiatives of the Mental Health and Wellbeing Action Plan 2025–2028.

Key areas of focus for the AV Psychology team include:

- Continuing to deliver Skills fOr Life Adjustment and Resilience (SOLAR) an online early intervention program building stress management and resilience skills, which has been shown to significantly reduce symptoms of post-traumatic stress, burnout, depression and anxiety.[3]

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- Ongoing rollout of Suicide Intervention and Response Engagement Network (SIREN), an AV-specific suicide education and intervention program available through the Learning Hub. Additional face-to-face training will also be offered to identified areas of the business that work with at-risk staff, such as Peer Support. SIREN, which was not widely available at the time of the PSS2024, has been found to significantly improve participants' knowledge and confidence in suicide prevention and intervention amongst colleagues. Encouragingly, over 50 per cent of the workforce has now completed SIREN, and it is hoped that this significant uptake will help destigmatise suicidal ideation across AV and empower people to reach into personal and professional support.
- Designing and delivering a randomised controlled trial for treatment of post-traumatic stress using Eye Movement Desensitisation and Reprocessing (EMDR) in operational staff, with a focus on recruiting single responders in regional areas due to their increased levels of reported symptoms.
- Partnering with Monash University to deliver compassion-focused training, a program shown to reduce burnout and empathic distress in healthcare workers, following a successful pilot in 2023.
- Increasing collaboration and business unit support to partner more effectively with other parts of the organisation supporting identified at-risk groups, including providing needs analysis, identification of risks and protective factors, and tailored wellbeing support as required.
- One-on-one clinical treatment will continue to be offered by AV Psychology and VACU as business as usual, with ongoing and reactive support also available through Peer Support and Pastoral Care.

To contact Wellbeing and Support Services regarding any of these programs, or to access support and consultation, all AV staff and volunteers can call 1800 MANERS, option 1 for Peer Support and general enquiries. Alternatively, please email vacu@ambulance.vic.gov.au for support options.

References

1. Dobbie, M., Bond, A., Harrington, K., McCourt, L., Tyler, M., Egan, R., Ridgway, E., Lee, J., & Tzefronis, J. (2024). *Ambulance Victoria Psychosocial Health & Wellbeing Survey*. Report prepared by Ambulance Victoria Psychology Team for Ambulance Victoria. Ambulance Victoria: Melbourne.
2. Hoell A, Kourmpeli E and Dressing H (2023) *Work-related posttraumatic stress disorder in paramedics in comparison to data from the general population of working age. A systematic review and meta-analysis*. Front. Public Health 11:1151248. doi: 10.3389/fpubh.2023.1151248.
3. Lee, J. & Dobbie, M. (2023) *Skills fOr Life Adjustment and Resilience (SOLAR) Pilot Outcomes*. Briefing Note. Ambulance Victoria – Melbourne. November.

Mental health treatment services for those who care for our community

By **Shelley Cooper,** Registered Nurse, Director of Clinical Services, St John of God Langmore Centre

Those who work in emergency services play an essential role in our community.

Caring, supporting, and protecting people in need can be incredibly rewarding but can also be challenging and can have a compounding impact when a person has repeated exposure to stressful events.

It is important to understand that psychological trauma can impact anyone, and not dealt with, can have an impact on your well-being and on the wellbeing of those around you. This can exhibit as anxiety, depression, and/or PTSD and can lead to alcohol and drug use as a coping mechanism.

Mental health issues often come on gradually, and it is important to ensure that early signs are recognised and acted upon to prevent worsening of symptoms and decreased quality of life. The key thing is to seek support from available services early.

Individuals experiencing PTSD may have:

- Distressing memories, flashbacks, or nightmares.
- Negative changes in thinking or mood.
- Feelings of irritability, anger, guilt, helplessness, or intense sadness.
- An exaggerated startle response, feeling constantly on edge.
- Avoidance of people or social situations.
- Disturbed sleep patterns.
- Difficulty relaxing and enjoying daily activities.

Trauma can also trigger other mental health conditions, including:

1. Anxiety.
2. Alcohol and drug misuse.
3. Depression.
4. Anger and other challenging behaviours.

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Treatment programs

Employers of front-line workers such as AV, Victoria Police and Fire Rescue Victoria prioritise the mental health and wellbeing of their members, offering education and early access to a wide range of services to support employees and their families.

There are times where mental health issues can require more acute intervention.

At St John of God Langmore Centre, we identified a growing need for evidence-based treatments for frontline workers and defence in our south-east Melbourne community, allowing people to access hospital and day patient services delivered by experienced clinicians, close to their family, in a trusted environment in Berwick, Victoria.

In February 2025, following extensive consultation and service design, we opened our 12-bed mental health unit, dedicated to the treatment and mental health recovery of Emergency Services and Defence personnel.

Key considerations in our service design included timely access to services, evidence- based treatments, access to physical activity, a space which allows treatment to occur in a confidential and private setting, and family and carer supports.

St John of God Langmore Centre's 12 bed Wexford unit is a welcoming and secure space designed for comfort and recovery. Our service features:

- Private rooms with ensuites, large windows, and natural light for a restful environment.
- A dedicated ward that ensures privacy, with restricted access to protect confidentiality.
- A well-equipped gym, with exercise physiologist support, and a walking group for physical rehabilitation.
- Art Therapy Studio.
- A sensory garden and outdoor deck, where individuals can participate in gardening and enjoy fresh air.
- Onsite café.
- Freshly cooked meals with onsite chef.
- Family and carer support.
- Tailored discharge planning to ensure continued recovery and community engagement.

Evidence based therapeutic programs offered at St John of God Langmore Centre include:

- Group therapy - talking therapy, art therapy, exercise physiology.
- Medication management.
- Repetitive Transcranial Magnetic Stimulation (rTMS).
- Electroconvulsive Therapy (ECT).
- Eye Movement Desensitisation and Reprocessing (EMDR).
- Alcohol and drug detoxification and treatment.
- Pain management support.
- Day programs.

Access to our services is simple, requiring a GP or psychiatrist referral and can be funded by private health insurance, WorkCover or DVA.

For more information email our intake team Langmore-Intake@sjog.org.au or call 03 9773 7000.

Support

Emergency service workers perform essential community service. While the work is incredibly rewarding, there is an increased risk of mental health issues as a result of repeated exposure to traumatic events. First responders need to care for themselves and take steps to maintain their mental health and wellbeing. There are many effective supports and evidence-based treatments available through employers, GPs and mental health services such as St John of God Langmore Centre.

Best Care case study

Paramedic activation of TelePROMPT for a 35-year-old with mental health concerns

By **Melissa Howell** TelePROMPT Mental Health Nurse and **Sam Peart** Alternate Service Lead

Case

Sophie*, 35-year-old woman with a history of complex post-traumatic stress disorder (CPTSD) and bipolar disorder type 1 (BPAD) is experiencing a mental health crisis.

Patient

Over the past few weeks, Sophie's mental state has declined, and she is now feeling overwhelmed, isolated, and tearful. Sophie has a history of trauma, including childhood sexual abuse, and is currently facing the stress of an upcoming court case. Additionally, she has been struggling with suicidal ideation (SI) over the past three weeks but has no plan or intent. Sophie's family is unsupportive, and she is living alone with minimal mental health support, though she has pets that serve as a protective factor. She has also sustained a non-self-inflicted hand injury. Sophie has reached out to paramedics for help.

Assessment

The paramedic crew responds to Sophie's call and assesses her mental and physical state. Although Sophie is in emotional distress, the paramedics determine that she does not have high risk symptoms as per the Mental Health Conditions CPG and that an emergency department (ED) visit is not necessary. Instead, paramedics activate TelePROMPT, a telehealth platform that connects them with a mental health clinician.

The clinician can provide remote support, ensuring that Sophie gets the mental health care she needs without the added stress of an ED visit. Using the dedicated field referral line, the paramedics provide the clinician with important information about Sophie's history, symptoms, and current condition.

Consultation

Upon connecting with Sophie, the TelePROMPT clinician conducts a thorough mental health assessment. The clinician evaluates Sophie's symptoms, including her intrusive thoughts, escalating suicidal ideation, and emotional distress. The clinician discusses Sophie's trauma history, current stressors, and protective factors, such as her pet rabbit. While the clinician acknowledges Sophie's increasing SI, they determine that she is not at immediate risk of harm, allowing for a tailored care plan.

Results

The clinician recommends that the paramedics assist Sophie in staying at home rather than transporting her to the ED. The clinician arranges immediate support through an Urgent Care Clinic for Sophie's hand injury, bypassing the crowded ED. Sophie is provided with resources for mental health support, including a local mental health and wellbeing hub, and instructions for seeking further psychological care through South Eastern Centre Against Sexual Assault and Family Violence (SECASA), an organisation that specialises in sexual assault and family violence services, providing counselling and advocacy for individuals who have been impacted.

The clinician guides the paramedics in supporting Sophie with coping strategies and developing a safety plan. They reassure Sophie that she can call mental health crisis services or go to the hospital if her situation worsens. The clinician also ensures that Sophie has resources for immediate help, including after-hours crisis support through her NDIS plan.

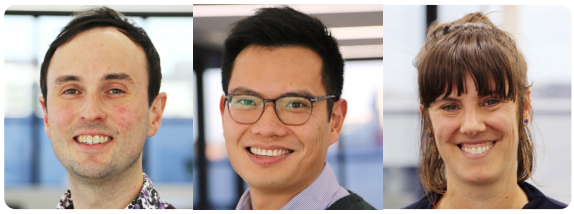
Outcome

This case highlights how TelePROMPT enables paramedics to efficiently support patients and manage mental health crises by providing remote clinical support and enabling patients to receive appropriate care while avoiding unnecessary ED visits. By implementing alternative care pathways and ensuring follow-up support, TelePROMPT improves patient outcomes, enhances system efficiency, and optimises paramedic resource allocation.

** Sophie is not the patient's real name.*

Emergency help-seeking for mental health-related harms

A community challenge



By **Dr Rowan P. Ogeil**[1], **Dr Anthony Hew**[2] and **Dr Natasha Hall**[3]

1. Strategic Lead, NAMHSU at Turning Point and Senior Research Fellow, Eastern Health Clinical School, Monash University **2.** Psychiatrist, PhD Candidate at Monash University **3.** Research Fellow at Turning Point and School of Public Health and Preventive Medicine, Monash University.

The community burden and cost of mental ill-health

Mental health issues are highly prevalent and costly for the Australian community, accounting for 15 per cent of the total burden of disease in 2024.[1] Approximately one in five Australians aged 16-85 years' experience a mental health disorder in any given year, the most common being anxiety and depression.[2] There are also significant mortality impacts, given that almost two-thirds of the people who die by suicide have a diagnosed mental illness,[3] with Australia ranking in the top third of developed countries for suicide rates.[4] Presentations for intentional self-harm to emergency services are significant, with more than 29,000 hospitalisations for intentional self-harm, and 309,657 mental health-related emergency department presentations in the 2020/21 financial year.[5] Together, these impacts of mental health and suicide-related harms highlight the importance of ensuring access to high quality mental health care and adequately supported systems.

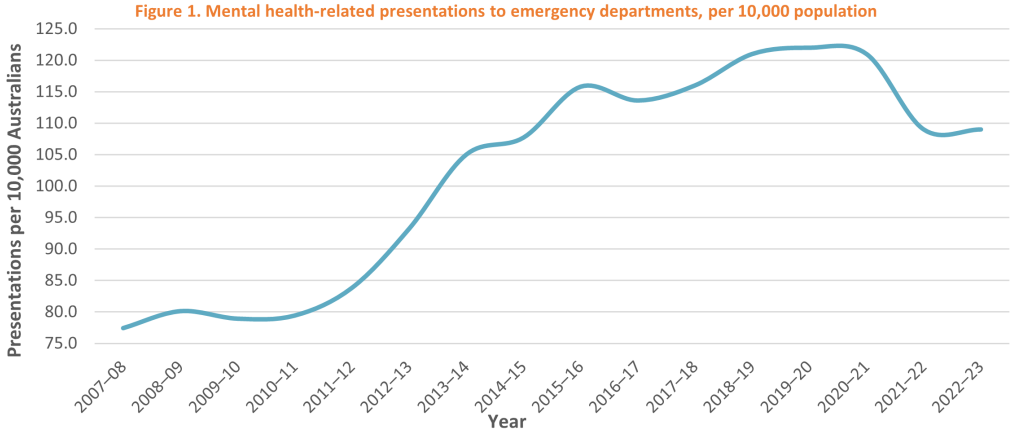
Despite a growing need for care in this sector, demand for mental health services currently outstrips service availability. Over 50 per cent of Australians with a mental health disorder did not receive professional treatment in the past 12 months,[6] and there has been a steady decline in available mental health beds over the past 30 years.[7] There has also been an increase in people presenting to EDs with more acute mental health issues, with 52 per cent of these individuals arriving via emergency services vehicles – double that of all ED presentations (see Figure 1).[7]

In addition to the enormous emotional burden placed on individuals, their families, and the community, the financial cost of mental ill-health and suicide to Australian society is significant. The 2020 Productivity Commission Inquiry into Mental Health estimated the cost of mental illness to the Australian community to be between $200 and $220 billion per year.[3] Given this, investment in mental health and suicide prevention has been a major priority for Australian governments over the past decade, with Commonwealth spending more than doubling between 2012/13 and 2022/23, and mental health now accounting for six and a half per cent of overall healthcare costs.[8]

Challenges with rapid population level measurement

Routine and accurate measurement of mental health and suicide-related harms in population datasets is often not

Figure 1. Mental health-related presentations to emergency departments, per 10,000 population



Adapted from: https://www.aihw.gov.au/mental-health/resources/archived-content?&page=9 and https://www.aihw.gov.au/mental-health/topic-areas/emergency-departments

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timely, non-representative, or geographically fragmented. While some survey data on the experience of these harms is available, there is often a significant time-lag in reporting, and methodologies may under-sample vulnerable populations including those with insecure housing or in custody, despite these groups likely having higher rates of mental-health harms.[9] An alternative to surveys is the use of routinely collected administrative data. In Australia, data on suicide deaths can be obtained from coroner's records, however, there can be lag times of many years rendering these sources unsuitable for rapid surveillance.[10] While hospital ED data have been described as a potential early warning system[11] to monitor intentional self-harm related presentations, ED data often relies on ICD-codes, which may not reliably capture, or distinguish between different types of self-harm.[12] The 2020 Productivity Commission report highlighted this gap in knowledge noting that there is a need for high-quality and fit-for-purpose data to inform decision-making and improve service delivery.[3]

At present a fragmented system ensues, where services and providers often work in isolation, hindering continuity of care for patients, and resulting in gaps in service delivery. For people with complex co-morbid conditions often involving mental health or self-harm presentations, this leads to poorer outcomes and represents a poor return on investment by governments.

Opportunities and challenges for paramedics and the impact of re-presentation

Investigating routine clinical data recorded by paramedics offers a novel avenue for assessing information related to mental health and self-harm trends across populations and overcomes some of the limitations inherent with other systems. Ambulance attendances for mental health and suicide-related harms comprise at least 10 per cent of all emergency attendances,[13] with mental health attendances increasing during COVID-19 lockdowns.[14] Given that paramedics are often the first (and sometimes only) health professionals to respond to acute mental health or self-harm presentations in the community,[9,13] understanding how to map, track, and evaluate these data are critical. A comprehensive source that captures mental health, suicide and self-harm presentations is the National Ambulance Surveillance System (NASS), an internationally unique multi-jurisdictional database that codes and reports on alcohol, other drug, mental health and suicide-related harms,[9,15] and forms a pivotal element of both national and state-based systems such as the National Suicide and Self-harm Monitoring System. Being able to accurately code and report on outcomes from the NASS is vital given the demand for ambulance services has exceeded the rate of population growth over the past 30 years.[16]

Contributing to high service burden includes individuals with repeated or frequent presentations to ambulance services. Frequent presenters have four to five times higher odds of a mental health diagnosis,[17] and typically have complex and unmet clinical needs.[18] Recent research into frequent presenters using the NASS has identified the considerable demands placed on ambulance services, with some individuals being attended over 100 times a year.[19] Frequent presenters often have multiple co-occurring physical, psychiatric and substance use issues and are socially disadvantaged with limited social supports. Given this, there is a need to investigate alternative models of care that can provide assertive and integrated care to reduce the reliance of frequent presenters on emergency services to address their unmet needs.[20] Options for consideration based on models in other jurisdictions may include provision or expansion of Police, Ambulance and Clinician Early Response (PACER) teams, specific mental health or social ambulances including peers and/or treatment in the home.

Conclusion

Mental health and suicidal behaviours contribute to significant public health and economic costs across the community including ambulance services. While population measurement and reporting of these outcomes is difficult, ambulance services contribute substantially to ongoing surveillance through the NASS. Future opportunities to further knowledge in this area include linking data from the NASS to hospital, community, and social services to better understand patient trajectories through these services and to identify opportunities for intervention to help individuals and enhance system responses.

References

1. Australian Institute of Health and Welfare. Australian Burden of Disease Study 2024. [Accessed March 12, 2025]. https://www.aihw.gov.au/reports/burden-of-disease/australian-burden-of-disease-study-2024/contents/interactive-data-on-disease-burden/burden-of-disease-in-australia.
2. Australian Bureau of Statistics. National Study of Mental Health and Wellbeing (2020-2021) Canberra: ABS; 2022.
3. Productivity Commission. Inquiry Report - Mental Health. Report no. 95. 2020. [Accessed March 13, 2025] https://www.pc.gov.au/inquiries/completed/mental-health/report.
4. Australian Institute of Health and Welfare. Suicide and self-harm monitoring data. 2022. [Accessed March 13, 2025]. https://www.aihw.gov.au/suicide-self-harm-monitoring.
5. Australian Institute for Health & Welfare. Emergency Departments - Mental Health (July 2022). [Accessed March 13, 2025]. https://www.aihw.gov.au/mental-health/topic-areas/emergency-departments.
6. Australian Bureau of Statistics. National Study of Mental Health and Wellbeing, 2020-2022 [Internet]. 2024. [Accessed March 13, 2025]. https://www.abs.gov.au/statistics/health/mental-health/national-study-mental-health-and-wellbeing/latest-release

CONTINUED OVER

7. Australian Medical Association. 2024 Public Hospital Report Card. Mental Health Edition. [Accessed March 13, 2025]. https://www.ama.com.au/clear-the-hospital-logjam/mhrc
8. Australian Government Department of Health. [Accessed March 13, 2025]. https://www.health.gov.au/sites/default/files/documents/2022/03/budget-2022-23-mental-health-treatment-pillar-3.pdf
9. Lubman DI, Heilbronn C, Ogeil RP, Killian JJ, Matthews S, Smith K, Bosley E, Carney R, McLaughlin K, Wilson A, Eastham M, Shipp C, Witt K, Lloyd B, Scott D. National Ambulance Surveillance System: A novel method using coded Australian ambulance clinical records to monitor self-harm and mental health-related morbidity. PLoS One. 2020; 15(7):e0236344. doi: 10.1371/journal.pone.0236344.
10. Studdert D, Walter S, Kemp C, Sutherland G. Duration of death investigations that proceed to inquest in Australia. Inj Prevent. 2016;22:314–20. https://doi.org/10.1136/injuryprev-2015-041933
11. Witt K, Robinson J. Sentinel surveillance for self-harm: Existing challenges and opportunities for the future. Crisis. 2019;40:1–6. https://psycnet.apa.org/doi/10.1027/0227-5910/a000583
12. Hedegaard H, Schoenbaum M, Claassen C, Crosby A, Holland K, Proescholdbell S. Issues in developing a surveillance case definition for nonfatal suicide attempt and intentional self-harm using International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) coded data. Natl Health Stat Report. 2018;108:1–19.
13. Roggenkamp R, Andrew E, Nehme Z, Cox S, Smith K. Descriptive Analysis Of Mental Health-Related Presentations To Emergency Medical Services. Prehosp Emerg Care. 2018;22(4):399-405. doi: 10.1080/10903127.2017.1399181.
14. Andrew, E., Nehme, Z., Stephenson, M., Walker, T., & Smith, K. The Impact of the COVID-19 Pandemic on Demand for Emergency Ambulances in Victoria, Australia. Prehospital Emergency Care, 2021:26; 23–29. https://doi.org/10.1080/10903127.2021.1944409
15. Lubman DI, Matthews S, Heilbronn C, Killian JJ, Ogeil RP, Lloyd B, Witt K, Crossin R, Smith K, Bosley E, Carney R, Wilson A, Eastham M, Keene T, Shipp C, Scott D. The National Ambulance Surveillance System: A novel method for monitoring acute alcohol, illicit and pharmaceutical drug related-harms using coded Australian ambulance clinical records. PLoS One. 2020 31;15(1):e0228316. doi: 10.1371/journal.pone.0228316.
16. Andrew E, Nehme Z, Cameron P, Smith K. Drivers of Increasing Emergency Ambulance Demand. Prehosp Emerg Care. 2020 24(3):385. doi: 10.1080/10903127.2019.1635670.
17. Soril LJ, Leggett LE, Lorenzetti DL, Noseworthy TW, Clement FM. Characteristics of frequent users of the emergency department in the general adult population: A systematic review of international healthcare systems. Health Policy. 2016 120(5):452-61. doi: 10.1016/j.healthpol.2016.02.006.
18. Krieg C, Hudon C, Chouinard MC, Dufour I. Individual predictors of frequent emergency department use: a scoping review. BMC Health Serv Res. 2016;16(1). doi: 10.1186/s12913-016-1852-1.
19. Hew A, Young JT, Rowland B, Scott D, Nehme Z, Arunogiri S, Lubman DI, Exploring the reliability and profile of frequent mental health presentations using different methods: An observational study using statewide ambulance data over a 4-year period. Aust NZ J Psychiat. 2024;59(1):74-85. doi:10.1177/00048674241289016.
20. Hall N, Mihalopoulos, C., Ogeil, R.P., Nehme, Z., & Lubman, D.I. Comparison and policy implications of ambulance duration and associated costs for suicidal presentations versus general presentations in Australia. [Manuscript under review, 18/10/24].

Research corner

By **Tegwyn McManamny**, Executive Director Quality and Clinical Innovation

At AV, we are proud of the outstanding work being done regularly by our Research and Evaluation Department, as well as across various other teams within AV. Combined efforts contribute to advancing knowledge, improving practices, and ultimately enhancing patient care.

Below, you'll find the abstracts and links to full articles for two of the recent research publications that are particularly relevant to the mental health theme for this edition. These publications highlight the valuable contributions being made in the field and offer insights into the ongoing efforts to improve mental health care within our services.

Qualitative exploration of health care professionals' experiences caring for young people with acute severe behavioural disturbance in the acute care setting

Abstract

Objectives: To describe the experience of health care professionals involved in the care of young people with acute severe behavioural disturbance across the acute care setting.

Methods: We used purposive and snowball sampling to recruit paramedics, nurses, doctors, and mental health clinicians caring for young people with acute severe behavioural disturbance in the prehospital and/or ED environments. We conducted one-to-one telephone-

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based semistructured qualitative interviews with each staff member. The audio recordings were transcribed verbatim, and participant pseudonyms were assigned. We iteratively developed a thematic coding structure. Data collection continued until thematic saturation was reached.

Results: We interviewed 31 health care professionals: 12 doctors, five nurses, seven mental health clinicians, and seven paramedics. Participants outlined factors they felt contributed to the young person's behavioural disturbance. They detailed the management strategies used. Participants spoke about their exposure to physical violence while managing these young people and the challenges of balancing patient and staff safety. There was a significant personal impact on participants through providing care to this cohort. Participants acknowledged the workflow, staff resource, and bystander impacts of these presentations.

Conclusion: Based on participants' experiences, health care staff aim to provide high-quality care to young people with behavioural disturbance in circumstances that present risks to their safety. There is variability in the way staff are currently managing these young people likely because of the limited high-quality evidence currently available, highlighting key areas for future research.

Qualitative Exploration of Health Care Professionals' Experiences Caring for Young People With Acute Severe Behavioral Disturbance in the Acute Care Setting - PubMed

Ambulance attendances involving personality disorder – investigation of crisis-driven re-attendances for mental health, alcohol and other drug, and suicide-related events

Abstract

Background: Mental health crises experienced by people with personality disorder often necessitate emergency service involvement. Ambulance services are frequently first responders. Acute crisis presentations of people experiencing personality disorder can be a source of anxiety and frustration for emergency workers, especially when they recur frequently. This study evaluated the utilisation of ambulance services for mental health, alcohol and other drug, and suicide-related events in association with personality disorder, to understand how system responses can be improved.

Methods: We conducted a retrospective study of coded electronic patient care records from the Victorian-arm of the National Ambulance Surveillance System between January 2012 and May 2019. Records where 'borderline personality disorder' or 'other personality disorders' was noted were assessed using patient demographics, presentation, outcome, and re-presentation frequency, in comparison with attendances for 'other mental health conditions'.

Results: 76,929 attendances for 9,632 people with borderline and/or other personality disorder were identified. Most presentations involved suicide attempts, suicidal ideation, non-suicidal self-injury, and drug and alcohol harms. Most attendances (87.9 per cent) were transported to emergency departments. Re-attendance was common; 8.3 per cent of people accounted for 49.6 per cent of all attendances involving personality disorder.

Limitations: The study data likely underrepresent the prevalence of personality disorder in ambulance attendances, as a diagnosis was noted by paramedics only if it was considered relevant to the attendance and volunteered at the scene.

Conclusions: Two-thirds of service users noted to have personality disorder required ambulance services three or more times per year, highlighting the need for evidence-based alternatives to reduce the incidence of mental health crises and reliance on emergency services. These findings are a valuable reminder to emergency clinicians that they are primarily seeing service users who have the most severe presentations and may serve as a bulwark against therapeutic nihilism.

Ambulance attendances involving personality disorder – investigation of crisis-driven re-attendances for mental health, alcohol and other drug, and suicide-related events