CHIEF PSYCHIATRIST
of Western Australia

Chief Psychiatrist's Community of Practice Session 30/03/2023 – Questions in the Chat

Duty of care and restraint in mental health and emergency– legal and clinical perspectives

Thank you for your questions. The answers to the questions below were provided by Dr Nathan Gibson and Michelle Wolstenholme General Counsel, Office of the Chief Psychiatrist (OCP).

1. **Question:** *"Our reality is having to make these decisions whilst the patient is actively trying to leave and 'holding' them to allow the time to make an informed decision is the question. How do you buy time without restraint that may be considered illegal*?". **Emergency Doctor**

Comments:

- Assessments in these situations must often, by nature, be rapid.
- A referrer under the MHA 2014 (i.e. complete a Form 1A, if relevant), is only required to suspect that the person meets the criteria for involuntary treatment.
- This can be based on, and highlights the importance of, available 3rd party information from family, police, ambulance, GP to assist the assessment.
- Any doctor or authorised mental health practitioner (AMHP) can make a referral for assessment under the MHA 2014 under a 1A and it can be revoked later by a medical practitioner or AMHP if not needed.

Case-by-case basis: If an individual has a sore bunion, and wants to leave, it is unlikely there will be any grounds to consider they might either meet the criteria for MHA referral or any other legislative pathways to detention. Whereas if a person has had a serious overdose and wants to leave, and there is suspicion that the person may also have a mental illness, while you should ideally carry out a full assessment, a very brief assessment may be all you are afforded to make an urgent decision to detain that person if they suddenly want to leave.

2. **Question:** *"When a 3A is placed on a patient, who then absconded, where can security lawfully detain that person? Is it in the hospital only or can then immediately pursue the patient and detain them outside – i.e. 200 metres down the road?".* ***Security Staff***

Comments:

- A Form 3A allows a person to be detained to take the person to the place of examination.
- When a person is on a 1A and 3A, it is important to act to prevent them from absconding.
- If the person has left the place of detention and is down the road, it is unlikely they could be detained without the use of force- WA Police should be notified.
- Once the person arrives at the place of examination, the Form 1A allows the person to be detained for 24 hours from the time the person is received at the place of examination.
- During this period, reasonable force may be used to restrain the person to detain them.

3. **Question:** *"Is it the organisation that can be responsible for unlawful detention or does it implicate the security staff- they are significantly stressed. ".* ***Nurse Coordinator***

Comments:

- The organisation has a responsibility to ensure its staff are appropriate trained.
- Staff have a responsibility to ensure they follow up with any training required by the organisation.
- The Chief Psychiatrist, Department of Health and the Health Service Providers will work promptly to develop training resources to assist staff, and the HSPs will develop policies to guide also.
- Under the Mental Health Act 2014 (MHA 2014), section 584 provides some protection from liability for individuals in circumstance when they are undertaking a function under the MHA 2014.
- Further advice from HSP Legal Team may be necessary.
- The roles of clinicians and security staff in these medical services where restraint may occur are absolutely crucial - no-one should stop providing the services they provide.

4. **Question:** *"Slightly off topic as my question pertains to patients without long standing mental health issues. What's the legal framework for restraining patients with delirium (drug, sepsis or trauma or any other reason) with medical problems who need to be restrained to be managed safely? It's not uncommon to restrain patients (physically or with medications) who are intubated to prevent accidental extubation.".* ***Emergency Doctor***

Comments:

- Delirium is a physical condition and the MHA 2014 can't be used here.
- The exception: placing a nasogastric tube and providing refeeding for a person with Anorexia Nervosa is considered treatment for mental illness under the MHA 2014.
- Other constructs such as the doctrine of necessity, Criminal Code or the Guardianship and Administration Act 1996 may potentially apply in non-mental health care situations like delirium.

5. **Question:** *"Outside of the MH Act, only common law principal "doctrine/defence of necessity" permits restraint/detain. We need absolute CLARITY on what "imminent peril" &/or "irreparable evil" is defined as. "Interval of Time" also seems hugely important. For example, a patient says "I am going to go kill myself later tonight" but is not yet on 1A & 3A forms. does this example meet the defence of necessity?".* ***Security Staff***

Comments:

- Based on this scenario, immediacy is not clearly being described, however there is not sufficient information to provide an answer.
- Where the situation is believed to be high-risk is and immediate, it is possible the doctrine of necessity could be used.
- Clinical staff should, wherever possible, provide advice to security officers in advance, on whether it is appropriate to restrain a patient, and under what statute.
- Security Officers should check with clinical staff before restraint where possible (of course, this is not always possible).

Essentially, if the matter is unfolding too rapidly for adequate discussion, this principle may assist: if any staff member, in their personal judgement, believe the risk is high and immediate if a patient leaves, it is sensible

to restrain, and then try to clarify the ongoing need for restraint after that. Where there are reduced staff numbers or capacity to restrain or when there is heightened risk, such as weapons involved, it may be more appropriate to allow the person to leave, track their direction and call the WA Police.

6. **Question:** *"Where there is a doctrine of necessity, but the MHA cannot be applied, can the police provide any additional powers to detain to clinicians who are ordinary citizens?"* **Clinical Director**

Comments:

We understand that, in the absence of criminal conduct, the police may only use reasonable force, in dealing with a person who is mentally unwell, in accordance with the provisions of the MH Act.

- The MH Act allows a police officer to "use reasonable force" in dealing with a person who is mentally unwell in the following specified circumstances:
  - To carry out an apprehension and return order – MH Act section 99.
  - To carry out a transport order – MH Act section 149.
  - To apprehend a person the police officer suspects has a mental illness and needs to be apprehended to protect the health or safety of the person or others or to prevent the person damaging property – MH Act section 156.

7. **Question:** *"In a private hospital - and a patient is attempting to harm themselves - we would consider it reasonable to intervene and stop them doing so, potential safehold - would this be deemed as an emergency intervention? As we wouldn't be providing treatment.".* **Private Hospital Staff**

Comments:

- Attempting to harm oneself in a private psychiatric hospital, if it's likely to lead to imminent serious injury or death, the doctrine of necessity might potentially apply or, the person might meet the criteria for referral under the MHA 2014 - detaining would likely be defensible.
- Where someone has low-level self-harm (often repetitive) such as making minor cuts or scratches on themself, where significant harm is neither serious nor imminent, there would often not be grounds for restraint.

We thank you for all your comments. We acknowledge that this is a very complex area from both a legal and clinical perspective and are aware that there is still a lot of confusion. The Chief Psychiatrist, Department of Health and the Health Service Providers (HSPs) are working together to develop training resources to assist staff, and the HSPs will develop policies to guide also.

The information cannot be considered as legal advice but rather, outlines the broader legal context and parameters. If legal advice is required, processes may be sought via health services.

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