CHIEF PSYCHIATRIST
of Western Australia

3 &10 August 2022

Chief Psychiatrist's Community of Practice

Working with imminent risk in a non-authorised setting – legal context

Acknowledgement of Country

I acknowledge the Traditional Custodians of the lands on which each of us meet today, throughout Western Australia, and here in Perth, the Whadjuk Nyoongar people, I pay my respects to their Elders past and present.

Recognition of Lived Experience

In recognition of people with lived experience, I acknowledge their individual and collective expertise of mental health, alcohol and other drug issues.

Juliette Stevens, Principal Officer Reviews, Office of the Chief Psychiatrist

Chief Psychiatrist's Introduction

Today's session provides the legal context for future sessions, on managing risk in what are complex day-to-day clinical situations. Firstly, we acknowledge the challenge of the cohorts we work with, and the expert work done by staff. And, that the value of risk management is when it is collaborative with consumer and carers.

We hear that there are mixed views across the sector about the value of risk assessment tools, and we know, through our reviews, that there are inconsistencies in their use and practice is variable. There is value in the use of these tools in a consistent way. It is how they are applied, documented, and communicated in a plan going forward that is vital, especially when working with imminent and changing risk.

Dr Nathan Gibson, Chief Psychiatrist

When working with imminent risk, it is important to note that the legal considerations are different in an authorised setting and non-authorised setting. Non-authorised settings are those less controlled settings such as home visits, community service, emergency departments.

We acknowledge the commitment of staff to provide high quality care and uphold rights, whilst managing risks to staff, consumers and carers and the expectations of the public more broadly. We recognise that staff navigate this issue with great care and thought and compassion.

Dr Emma Crampin, Deputy Chief Psychiatrist

Key Messages: Michelle Wolstenholme - General Counsel, OCP

Personal liberty has been described as the most basic freedom and one of the most fundamental of all rights. Interference with a person's liberty will only be permitted where it is justified, authorised, or excused by law.

In WA, if a person restrains another person without legal authority to do so, it may be found to be an assault or deprivation of liberty under the Criminal Code.

Under what circumstances might a clinician be permitted to restrain someone in a non-authorised setting?

- There are very limited circumstances where clinicians may restrain a person in a non-authorised setting. Situations where there is a very immediate need to do something, there is an emergency or danger: in circumstances where it seems like there are no other options available at that precise moment.
- Section 25 of the Criminal Code allows restraint to occur where you believe that circumstances of sudden and extraordinary risks exist.
- **In these circumstances it is the doctrine of necessity that applies, not the duty of care**. Courts have determined there may be a defence available to a person who restrains someone if there is imminent peril and it is for the protection of the person or others.

Legal concepts and Questions to Michelle Wolstenholme - General Council, OCP

Duty of Care:

Duty of care does not provide the power to restrain a person in a non-authorised setting. It is a legal obligation to take reasonable steps to not cause foreseeable harm to a person or their property.

- A clinician's obligation of duty of care is to inform a patient of risks of treatment, and provide care that is appropriate in the circumstances
- **Duty of care does not provide clinicians with the power to, for example, prevent a person from leaving a ward of a hospital if the person indicates a desire to do so, or to treat a person who does not consent to or who refuses treatment.** Rather, it is the Criminal Code and the doctrine of necessity that may allow such conduct.

Doctrine of Necessity:

The doctrine of necessity is a common law doctrine, meaning it has been developed by the courts on a case-by-case basis. Whether the circumstances of a case will satisfy the elements of the doctrine of necessity or fall within the provisions of section 25 of the Criminal Code **depends upon the specific circumstances of the case**.

- Courts have determined there may be a defence available to a person who restrains someone if there is imminent peril, and it is for the protection of the person or others.
- In the leading Canadian Supreme Court case of *Perka v the Queen*, Justice Dickson explained the rationale behind the defence of necessity - the act was wrong, but it is excused because it was realistically unavoidable. He was careful to restrict the defence to situations of imminent peril "where compliance with the law is demonstrably impossible".
- Necessity, as it has generally been applied, may provide protection from criminal and/or civil liability for **the very short-term use of restraint (and detention) in situations akin to an emergency**.

The **doctrine of necessity** been applied where the following 3 elements can be established:

1. The restraint was done to **avoid an irreparable evil** (e.g. imminent peril to life or serious injury)
2. The persons carrying out the restraint believed **the individual was placing him or herself or others in a situation of imminent peril (**if there is an **interval of time** between the threat and the restraint, it is unlikely that a defence of necessity could apply).
3. The restraint was **proportionate** to the 'evil' or harm about to occur.

It's time critical: While temporary restraint and detention may be justified under the defence of necessity in situations of imminent danger to the person or others, **extended periods, would not be permitted**.

Michelle Wolstenholme shared an example based on recent advice provided:

- A service queried whether a wheelchair could be used to restrain a person, in order to transport them back to a mental health ward from just outside the hospital, as they were refusing to return. In this instance, restraint would not be permissible because **there was no imminent danger present**. To clarify, if a person happens to use a wheelchair and satisfies the other elements above, it may be justifiable that they be restrained. The circumstance of each case requires consideration.

Question: ***Is there any difference those under 18 years of age and how this law applies?***

- The situation is generally not different. If there is no consent, the age of the person makes no difference. The danger may be greater for a child who does not understand the dangers they face.
- Generally, for a child, as opposed to a minor who has more say in their care, consent has been provided, by the parent or guardians before the child comes into the facility.

Community Question and Police Powers:

'What happens if the person, who is known to be at risk and on a Community Treatment Order, leaves the community clinic or home visit, while the clinicians are there - can they ask the Police to intervene and in what circumstances? Mental Health Transport are not always available, and police sometimes advise they cannot convey the person to an authorised facility for assessment. The practicalities are challenging.'

Despite their responsibility to ensure public safety, the police do not have the power to restrain a person without express legal authority to do so, especially in the absence of criminal conduct.

The *Mental Health Act 2014* (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 the person 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 and for the purposes of assessment by a medical practitioner or an authorised mental health practitioner. However, this is in circumstances where the person isn't currently receiving mental health treatment, according to police. – MH Act section 156

The more **general powers of police outside the MH Act are limited**, where they can become involved in restraining someone outside of potential criminal conduct. In the absence of criminal conduct, their ability to get involved, restrain a person, and take them elsewhere, is very limited. So, it's not always in their remit and negotiation may be beneficial.

Participants raised that clinicians often find they need to put people on forms so that they can be taken to hospital because they cannot be taken by the police under section 156 of the MH Act. There was agreement that a form 1A is most appropriate in these circumstances.

In relation to **section 156 of the MH Act,** the **police have to form their own view** that the person may have a mental illness. Where clinicians believe that someone has a mental illness, the police may not always have the same view.

'My concern is that, if a person is refusing entry to clinicians, the only people who can enter a property are police. There is no right of entry for the hospital officers.'

- Advised that in this situation, police would need to be the transporting officer as opposed transport officers. Sometimes it is not known at the time, when the Transport Orders are written, whether the person will grant entry to their property.

Pressures on both systems:

A significant proportion of transport is still done by police even though Mental Health Transport was intended to reduce reliance on police. Discussions recognised efforts made to address the need at a systemic level. Developing relationships, education, and negotiations with local police, where feasible, was encouraged and pressures on mental health and centralised police capacity were acknowledged.

'Police are sometimes used as security in mental health settings or hospitals- they are not let go after the assessment and stay for 3-4 hours when they could respond to several domestic violence calls in that time.'

Emergency Departments and negligence:

Question: ***What about situations in emergency departments where there is a concern that if you decide not to act that you could be considered negligent?***

- To clarify, **negligence falls under the duty of care**. Duty of care is not a power but an obligation to do no harm. Therefore, the decision to act would not be under duty of care but rather under the doctrine of necessity.
- The level of harm, the risk to the patient and the immediacy of the emergency needs consideration.

Question: ***Hypothetically, can we restrain somebody who is still settled, because some staff believe the person is likely to escalate due to previous unprovoked aggressive behaviour in the past?***

- **You cannot restrain in anticipation of certain behaviour by a person.**

Transport of a medically unstable person from community to hospital*:*

In situations where the person has an eating disorder, is both physiologically unstable and on MH Act forms, the GP was asking how they get them to hospital. Sometimes it is not clear whether Wilsons or St John's (because of their medical needs) would be more appropriate.

- The Mental Health Patient Transport Contract Overview outlines where Wilson's can conduct mental health transfers and that, in a medical emergency, St John's can be involved.

We recognise the level of interest in this kind of conversation, for future sessions. Also, as a reminder, our office can progress escalation of issues towards resolution, including the pragmatics and collaboration between agencies. The OCP Helpdesk is available to discuss the issues – we may not always available immediately but do get in contact.
We welcome suggestions for future sessions.

Dr Nathan Gibson, Chief Psychiatrist

The presentation by Michelle Wolstenholme is available on our website.

Fact sheets on duty of care and other legal information will be published in future by the Office of the Chief Psychiatrist. For updates, subscribe to our mailing list from our homepage.

For guidance regarding clinical situations contact:

OCP Clinical Helpdesk reception@ocp.wa.gov.au / **08 6553 0000**

To contact Community of Practice and suggest future topics email clinicalreviews@ocp.wa.gov.au

Note: The information within this session cannot be counted as legal advice as factors specific to each situation must be considered.