Chief Psychiatrist's Community of Practice Summary

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

Acknowledgment of Country

I would like to acknowledge the Traditional Custodians of the lands on which each of us is meeting today, throughout Western Australia and for us here in Perth, the Whadjuk Nyoongar people. I pay my respects to their Elders past and present. A warm welcome to Aboriginal colleagues here today. *Facilitator*

Welcome - Dr Nathan Gibson, Chief Psychiatrist

The purpose of the Community of Practice is to share learning, ideas and strategies. This session is designed to be a helpful and robust discussion on duty of care, doctrine of necessity and restraint to assist further discussions and resources. However, this is not formal legal advice, and it will not cover all potential legal principles and situations that can arise. Because this topic is so important, we're running it again, and are pleased to have emergency and security colleagues with us today.

We acknowledge the systemic issues impacting on our work – the focus today is on the clinical and legal factors to consider when making clinical decisions at the coal face. Work is being done by this Office, health service providers and the State Solicitor's Office to provide clarity on the issues and to develop further resources.

Our aim is for us to work collaboratively with our colleagues in the emergency departments and security staff - with the patient at the forefront. We are all part of the same team. *Dr Nathan Gibson, Chief Psychiatrist*

Recognition of Lived Experience

I would like to recognise the contributions of people with lived experience of mental illness, alcohol and other drugs and the contributions of the people who care for and support them. That their voices and insights are essential in the development of safe, high quality mental health services at every stage of the journey.

Key Messages

Emergency departments are non-authorised settings – the legal position for restraint in the non-authorised settings is different from authorised. To restrain in a non-authorised setting there must be imminent risk, immediate danger to the person or others.

Clinical situations are complex and specific to the person, place and time – there is not one legal answer for all situations. Clinical decisions are complex and nuanced, but the law is clear on what factors need to be considered.

Doctrine of necessity – it is necessary to consider whether it would be unreasonable to not act (e.g. to detain or restrain) in the circumstances. Action must be proportionate to the seriousness of risks posed. **Duty of care is an obligation not to cause harm.**

Balance the rights and safety of the patient. It's a moral and ethical dilemma in a system with limited beds and alternatives. Choose the **least restrictive option** in legal, policy, staffing and place constraints.

Clinicians must document the situations and the reasons for the decisions and actions taken at that moment.

Collaboration between Emergency Dept and mental health is key with the patient's best interest at the forefront.

Shared decision-making is needed and seek support from experienced MDT team members.

Escalate-up the increasing risks or delays.

High risk, changeable presentations, including intoxication, require rigorous, repeated clinical assessment. If there is just a suspicion that the person has a mental illness any doctor or authorised mental health practitioner may refer under a Form 1A for a psychiatric examination. And it can later be revoked by any AMHP or doctor.

Contact: clinicalreviews@ocp.wa.gov.au
GPO Box: A5, Perth Business Hub WA 6849
T: (08) 6553 0000 | F: (08) 6553 0099

A simulated video was shown, using emergency department (ED) staff and an actor, showing admission to the Emergency Dept at RPH (2018), a long wait for a mental health bed, escalating frustration, wanting a cigarette, challenging behaviour, restraint and sedation. We are grateful to Professor Daniel Fatovich for the video.

"The restrictive environment of an ED could not be a worse place for our most vulnerable mental health patients. It is noisy and busy - these patients are held in a 3 x 3 cubicle without natural light for many days awaiting a secure mental health bed. What are our legal options here?". *Dr Jessamine Soderstrom, Emergency Physician*

Authorisation Status: In WA, Emergency Departments are all non-authorised units.

Referral to ED: If a person, is referred to an ED on a Form 1A for an examination by a psychiatrist, the person is **received** once they reach that ED. The person may be detained in the ED for up to 24 hours from the time the person is received, and reasonable force may be used to detain the person to prevent them from leaving the ED. If the person has not been examined by a psychiatrist by the end of the 24hour period, the referral expires. The Mental Health Act does not prevent another Form 1A being written if the person is still requiring examination by a psychiatrist. This is not ideal, but not uncommon.

Detention <u>before</u> being taken to ED: If a person is referred on a Form 1A for an examination by a psychiatrist in an ED, the person may be detained for up to 24 hours on a Form 3A Detention Order pending receival at the destination. This may be extended using a Form 3B. Please note in a non-metro setting, timeframes are different.

Clinically: It's weighing-up the relative risk from further detainment and sedation compared to the risk of absconding and likelihood of harm to self and others.

Can we allow a patient out for a cigarette in a situation where they are on Forms and not on Forms?

Policy context: There is a Health-wide policy that there is no smoking across all health services and that staff cannot accompany patients out for cigarettes. There are no safe smoking areas in public hospitals.

1. **On Forms, including referral under MH Act**- This clinical decision is made on a case-by-case basis. A clinical risk assessment is needed to determine whether the person could go safely outside to smoke. Levels of insight, impulse control, risk of absconding, risk to self and others and the safety of the immediate environment need consideration. And, of what is in the best interests of the patient including prevention of further escalation. This is subject to private and public hospital policy and spaces available.
2. **Not on MH Act Forms –** If an assessment indicates there is no suspicion of mental illness then there are no legal grounds for detainment and they can go out. If there later becomes a concern about risk of safety to the patient, they will require a reassessment.

Practically it's a case-by-case basis - balancing the rights and safety of the person in that specific situation.

Case 2 - 24-year-old brought in by police, intoxicated with alcohol, has suicidal ideation - wants to leave

- **What are the factors we need to consider, to determine risk, and capacity in the ED?**
- **If it was determined that he had capacity and allowed to leave, and an adverse event occurred, what are some of the legal concepts we need to consider?**

Dr Soderstrom - The experience of ED staff is that decisions need to be made quickly, based on limited information, while they are trying to leave so doing a Form 1A as a referral for further assessment, practically has problems.

OCP General Counsel - What is reasonable needs to be assessed on a case-by-case basis, at the time. There must be a cause and effect relationship in relation to duty of care. See the Hunter and New England Local Health District v McKenna [2014] for example.

Dr Gibson - Where there is a suspicion that there may be mental illness, or there is an acuity of risk, there are the legal pathways to hold that person while you're assessing them.

Dr Gibson cont. - Most people who are intoxicated shouldn't be under the Mental Health Act, but intoxication where there is suspicion of underlying mental illness doesn't stop you putting someone under the Mental Health Act. Intoxication is a known increased risk factor for completing of suicide.

- **Where risk is high, there must be very rigorous assessment.**

Determining capacity and risk in intoxication – If the patient presents as intoxicated in ED, the existence of the mental illness may not be clear. However, as a referrer, for an examination under the Mental Health Act, you only need to suspect that they meet the criteria involuntary treatment. Sometimes in an acute situation there will be very limited time to assess capacity (due to escalating risk) and a decision may need to be made with limited information. A Form 1A can also be revoked by a medical practitioner or AMHP if no longer required.

- There needs to be the ability in health services to have urgent advice from senior staff in these situations.

Section 583 clause of the MH Act - The in-good-faith clause. If you're using the Mental Health Act and you're trying to apply it properly, there are protections for staff.

Safety planning and follow-up needs work. From a health service perspective, a big area to work on across areas is follow-up and having safety-netting and planning with the family - that's what's missing. *Dr Soderstrom*

First and foremost, we have to be the patient's advocate. We must work together with our colleagues in psychiatry and ED and move away from working in silos.
And don't make these difficult decisions by yourself - do it collaboratively and document well.
Dr Jessamine Soderstrom

Resources

- A flow chart of MHA 2014 forms under which you can/cannot restrain and detain a person and links to relevant case law are all available in the PowerPoint of the session on our webpage. More resources will be developed.
- Answers to questions from at the session will be emailed to attendees. Email clinicalreviews@ocp.wa.gov.au

OCP Clinical Helpdesk
reception@ocp.wa.gov.au
Tel: 08 6553 0000

Dr Jessamine Soderstrom, Co-Deputy Head of Department, Emergency Department, Royal Perth Hospital, Emergency Physician, Clinical Toxicologist and Clinical Senior Lecturer University of Western Australia
Jessamine.Soderstrom@health.wa.gov.au