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Characteristics and outcome of patients brought to an emergency department by police under the provisions (Section 10) of the Mental Health Act in Victoria, Australia

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ABSTRACT

Objective: The aim of this study is to describe the characteristics and outcome of patients brought to an emergency department by police under Section 10 of Mental Health Act (Victoria, Australia).
Methods: Retrospective medical record review. Patients referred under Section 10 provisions treated in calendar year 2009 were identified from ED database. Data collected included demographics, incident details, patient management, final diagnosis and disposition. Primary outcomes of interest were ED diagnosis and disposition. Secondary outcomes were length of stay in ED and use of restraint or sedation.
Results: One hundred and ninety seven presentations by 164 patients were identified. Patients were predominantly male (58%) with median age of 35 years (IQR 22–44, range 16–69). The most common presenting complaint (65%) was threat of self harm. No sedation or restraint was used in 61%. Sixty seven percent were deemed safe for discharge home while 26% were admitted to a psychiatric ward (equally divided between voluntary and involuntary admission). The predominant discharge diagnosis was self harm ideation or intent (35%). Median ED length of stay was 156 min (inter-quartile range 79–416).
Conclusion: Most patients brought to ED by police under Section 10 provisions were for threat of self harm and did not require sedation or restraint. The majority are discharged home. Further work exploring less restrictive or traumatic processes to facilitate psychiatric assessment of this group of patients is warranted.

1. Introduction

Under Section 10 of the Mental Health Act (Victoria) 1986 (the Act) (State of Victoria, 1986), a member of the police force may apprehend a person who appears to be mentally ill if they have reasonable grounds for believing that the person has recently attempted suicide or attempted to cause serious harm to themselves or to another person; or is likely by act or neglect to attempt suicide or to cause serious harm to themselves or another person. The member of the police force is not required to exercise any clinical judgment as to whether the person is mentally ill, but needs only to make a lay judgment that the person 'appears to be mentally ill', based on his or her behavior and appearance.

The Act as amended in August 2010 (State of Victoria, 2010) provides options for assessment of the person. Police may either arrange for an examination of the person by a 'registered medical practitioner'; or assessment by a 'mental health practitioner'. The place of these assessments is not specified. Additionally, some patients may be exhibiting physical features or injuries prompting police to request an ambulance to transport them for concurrent medical assessment. When this is not the case however, the application of Section 10 not infrequently results in the person being placed in the locked section of a police van and transported to an emergency department (ED) in order for these assessments to occur. This method is very restrictive of personal freedom and potentially traumatic, both physically and emotionally.

It was our clinical experience that many patients transported under Section 10 provisions were assessed and discharged home from ED and that some were psychologically traumatized by the experience. Other clinicians expressed perceptions that a high proportion of these patients required restraint and involuntary psychiatric admission and that they spent long periods of time in the ED. There were no published data against which we could assess the validity of these opposing perceptions. In fact, little is known about the characteristics and outcomes of this client group. The aim of this project was to determine the

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characteristics and outcomes of patients brought to an ED by police under the powers provided by the Act. Our questions were:

- What are the reasons given for police using Section 10 powers?
- What are the characteristics of these patients?
- What proportion requires sedation or restraint?
- What is the ED disposition for this cohort?
- How long do they spend in ED?

2. Materials and methods

2.1. Study design

This was a retrospective study conducted by explicit medical records review methodology (Gilbert, Lowenstein, Koziol-McLain, Barta, & Steiner, 1996) of patients brought to a community teaching hospital ED in Melbourne by police under the provisions of Section 10 of the Act during the calendar year 2009.

2.2. Setting and social context

The study site is an 'adult only' ED in a community teaching hospital treating approximately 34,000 patients per year. It has 18 h/day emergency physician coverage (registrar/specialist in training cover overnight) and mental health clinician (Emergency Crisis Assessment and Treatment (ECAT) clinicians) coverage 24 h/day for 5 days per week and 18 h/day for the remainder. The ECAT team at Western Hospital is made up of two clinical psychologists, two psychiatric nurses and a social worker all trained in the assessment of mental illness. Western Hospital does not have an inpatient psychiatric unit and has limited access to psychiatric registrars/specialists. It is not an approved mental health service under the provisions of the Act. In other words it is not a facility where a person may be involuntarily treated as an inpatient for their mental illness.

The study site is one of three ED operated by Western Health, a public health care service funded by government. Western Health serves a population of 650,000 people in the western suburbs of Melbourne. This population is both ethnically and socioeconomically diverse; however, the area has a higher rate of socio-economic disadvantage and drug and alcohol problems than other areas of Victoria. It is one of 18 ED serving the population of greater Melbourne (approx. 4 million) (ABS, 2010).

In Victoria, mental health care has been de-institutionalized; care is provided as often as possible in the community, co-ordinated by area mental health services. Area mental health services are run separately from public health services, although some of their facilities are co-located with selected acute hospitals. For adults in crisis (as would apply to Section 10 patients), assessment is usually performed by the crisis assessment and treatment (CAT) service. During office hours, this service may be accessed via community mental health centres. This service also provides follow-up in the community of people needing close short term support. In addition, mental health clinicians are based in a number of ED; known as ECAT clinicians. They provide assessment and plan treatment for patients attending ED with acute mental health issues. For patients arriving at ED under the provisions of Section 10, assessment by a senior emergency medicine clinician and an ECAT clinician working in collaboration is usual practice.

2.3. Legislative environment

Section 10 of the Act reads: *'A member of the police force may apprehend a person who appears to be mentally ill if the member of the police force has reasonable grounds for believing that—*

(a) *the person has recently attempted suicide or attempted to cause serious bodily harm to herself or himself or to some other person; or*

(b) *the person is likely by act or neglect to attempt suicide or to cause serious bodily harm to herself or himself or to some other person.*

A member of the police force is not required for the purposes (of this section) *to exercise any clinical judgment as to whether a person is mentally ill but may exercise the powers conferred by this section if, having regard to the behavior and appearance of the person, the person appears to the member of the police force to be mentally ill.*

For the purpose of apprehending a person .... a member of the police force may with such assistance as is required—

(a) *enter any premises; and*
(b) *use such force as may be reasonably necessary.*

A member of the police force exercising the powers conferred by this section may be accompanied by a registered medical practitioner or a mental health practitioner.

A member of the police force must, as soon as practicable after apprehending a person under subsection (1), arrange for—

(a) *an examination of the person by a registered medical practitioner; or*
(b) *an assessment of the person by a mental health practitioner.*

The mental health practitioner may assess the person, having regard to the criteria in Section 8(1) and—

(a) *advise the member of the police force to—*

  (i) *arrange for an examination of the person by a registered medical practitioner; or*
  (ii) *release the person from apprehension under this section; or*

(b) *complete an authority to transport the person to an approved mental health service in accordance with Section 9A(1)* (involuntary admission)'.

If the mental health practitioner assesses the person and advises the member of the police force to arrange for an examination of the person by a registered medical practitioner the member of the police force must do so as soon as practicable.

If the mental health practitioner assesses the person and advises the member of the police force to release the person from apprehension under this section the member must do so unless the member arranges for a personal examination of the person by a registered medical practitioner.

If an arrangement is made under this section to have a person examined by a registered medical practitioner, a registered medical practitioner may examine the person for the purposes of Section 9. (involuntary admission)'

In practical terms, police options under Section 10 vary depending on availability of services, the behavioral condition of the client and evidence of self harm or injury. During office hours, if the person of interest does not have significant behavioural issues or injuries, review by a medical practitioner or the CAT clinician of an area mental health service is often possible. Outside of these hours or if the person of interest is agitated, violent or injured, ED provides access to registered medical officers and mental health clinicians and resources for safe sedation or restraint, if required.

2.4. Participants

Patients were identified from the ED patient management database. All patients with a triage assessment containing the words 'Section 10' or similar were eligible for inclusion. It is standard practice in the study ED for cases to be identified as 'Section 10' in the triage description. We attempted to identify patients who might have been missed by cross-checking with the records maintained by the ECAT clinicians working in the ED and with police. ECAT had incomplete handwritten logs and police had no system in place at the time for logging Section 10 transfers to hospitals so full verification was not possible.

2.5. Data collection

Data collected included demographics, day of week and time of day, incident details, use of sedation or physical restraint, time spent in ED, ED diagnosis and disposition. 'Office hours' were defined as 8 am to 5 pm Monday to Friday. Use of physical restraint was determined from the case notes; the study ED did not have a restraint log at the time of the study. Recognizing the limitations of retrospective case review methodology for determining the circumstances surrounding use of chemical agents, we chose to simply record if chemical agents were used and did not attempt to determine whether they were taken voluntarily or used for the purposes of restraint. ED diagnosis was as assigned in the medical record (including formal psychiatric assessment) by the treating clinician/mental health clinician. Data was collected by a single researcher (KA), who was not blinded to the study's aims. Inter-rater reliability testing was undertaken on a sample of 20 patients for the data items of age, gender and disposition.

2.6. Outcomes of interest and analysis

The primary outcomes of interest were ED diagnosis and disposition. Secondary outcomes were ED length of stay and use of physical restraint or sedation. Data analysis was by descriptive statistics performed using Analyse-It™ software with 95% confidence intervals (CI) (Analyse-It™, 2010). Inter-rater reliability was assessed using percent agreement and kappa analysis. This project was approved by the institution under the NHMRC quality assurance project ethics guidelines.

3. Results

Two hundred and six potentially eligible presentations were identified; 189 from the ED database and 17 additional patients from ECAT records. Records on seven patients could not be found, one patient had been transported under Section 10 provisions at a previous presentation but not the current presentation and one presentation was of a police officer injured by a person detained under Section 10 provisions. Thus the final sample studied was 197.

One hundred and ninety-seven presentations by 164 patients were studied. Eleven patients were transported to ED under Section 10 provisions twice, three three-times, three four times and one eight times. Ninety-five (57.9%) of patients were male. Median age was 35 years (inter-quartile range 24–44, range 16–69). The majority of presentations were outside 'office' hours (152, 77%, 95% CI 71–83%), with 26% (52, 95% CI 21–33%) presenting between 2200 and 0800 h. Fifty-five presentations were on the weekend (Saturday or Sunday) (28%, 95% CI 22–35%). One hundred and forty eight presentations (75%) had evidence of a Section 10 referral form completed by police. Note, these referral forms were introduced part way through the study period. Prior to this no formal documentation was required.

The most common reasons for presentation were threat of harm to self without threat to others (128, 65%, 95% CI 58–72%); (Table 1). Of note, in 19 presentations (10%, 95% CI 6–15%) there is no record of threat/risk to self or others.

Only five cases required physical restraint (2.5%, 95% CI 1–6%). Seventy-six patients (39%, 95% CI 32–46%) received sedation. In 52 cases these were taken orally, with 24 requiring parenteral medication (12%, 95% CI 8–18%). A diverse range of agents were used, including diazepam, olanzapine, midazolam and haloperidol. In 120 cases (61%, 95% CI 54–68%), neither physical restraint nor sedation was required.

The most common ED diagnosis was self harm ideation/intent (35%). The distribution of diagnoses is shown in Table 2. One hundred and thirty patients (67%, 95% CI 60–73%) were discharged to home, with only 26% requiring psychiatric admission equally divided between voluntary and involuntary admission (Table 3). Median ED length of stay was 156 min (inter-quartile range 79–416, range 8–1415).

Inter-rater agreement for age was 95% (age of one patient different by one year), Kappa statistic for gender was 1.0 and for disposition was 0.76. This is indicative of good agreement on data extraction.

Table 1
Reason stated for use of Section 10 powers (from police form or medical record).

Reason	Number	%, 95% CI
Threat of self harm alone	128	65%, 58–72%
Threat of harm to self and others	34	17%, 12–23%
Abnormal behavior without threat of harm to self or others	17	9%, 5–13%
Threat of harm to others only	16	8%, 5–13%
Other	2	1%, 0–4%

4. Discussion

Section 10 of the Act attempts to balance public safety issues and the responsibility of the community to provide appropriate and timely access to psychiatric care for people who appear to be mentally ill. It does so at some cost to personal freedom and with some physical and psychological risk associated with detention and involuntary transport. Utilization of ED to provide the assessment required under the Act, particularly outside business hours, is not surprising as ED affords access to medical practitioners and/or mental health clinicians 24 h a day, 7 days a week. ED also affords the opportunity for assessment of injuries or medical conditions and offer a relatively safe environment capable of sedation, if required. This approach can however stretch ED resources, be an inappropriate over-stimulating environment for disturbed patients and cause inconvenience and distress to other ED patients. The validity of the assumptions underlying this approach has not been formally assessed. This is the first study to investigate the characteristics and outcome of patients transported to an ED by police under powers provided by Section 10 of the Act. It showed that the most common reason for presentation was expression of self harm ideation/intent, most presented out-of-hours; most were discharged home with approximately 60% of cases not requiring sedation or physical restraint. A proportion of patients were diagnosed with drug and alcohol issues rather than psychiatric diagnoses. This likely reflects the complex interplay of psychological problems and drug/alcohol use. It also highlights the difficulty with initial assessment in the community of a patient who appears to be mentally ill to a member of the community or police force. Acute psychotic illness was uncommon (7%).

Referrals under Section 10 provisions made up a very small proportion of overall ED workload (0.6%). Although on occasion these cases can be dramatic, noisy and labour intensive, the perception held by some clinicians that they were common is refuted by this data.

In nineteen cases (1.6%) there was no evidence in the documents of threat/risk to self or others associated with the referral. These cases would appear to fall outside the provisions of the Act. Our data collection and ethics approval did not allow us to investigate the circumstances of these cases in depth. That said, possible explanations for these cases include liberal interpretation of risk in persons of interest where there was genuine concern for welfare without identified imminent risk and lack of alternative services for this group.

Eighteen presentations (9%) were of patients who presented more than once in the calendar year under Section 10 provisions. There are a variety of patient types who are frequent ED users and current best practice is to identify them and, in suitable cases, to develop tailored managed plans in partnership with community health care providers to identify deterioration in their condition earlier so that intervention to prevent ED attendance can occur and, if deterioration has occurred, to facilitate care in the most appropriate location avoiding the ED where possible (Newton et al., 2011; Skinner, Carter, & Haxton, 2009). Expansion of similar approaches to mental health clients are probably worth exploration.

Table 2
ED diagnosis.

Diagnostic group	No. (%)	Discharge to home (N)	Involuntary admission for treatment (N)
Self harm ideation/intent	69 (35)	37	11
Drug/alcohol effect	22 (11.2)	18	0
Schizophrenia	18 (9.1)	8	3
Behavioural disturbance/anger/attention seeking	15 (7.6)	14	0
Social or situational crisis	15 (7.6)	14	1
Psychosis	15 (7.6)	5	7
Depression	10 (5.1)	8	1
Bipolar disorder	8 (4.1)	4	2
Anxiety/adjustment disorder	5 (2.5)	5	0
General review/welfare check	4 (2)	4	0
Delusional/paranoid	4 (2)	3	1
Organic	2 (1)	0	0
Other	10 (5.1)	10	0
Total	167	130	26

The provisions of Section 10 of the Act are in line with those in other Australian and European jurisdictions with perceived danger to themselves or others being the common criteria for detention by police (Clifford, 2010; Zinkler & Priebe, 2002). Little is known about patients brought to ED by police with suspected psychiatric illness under the powers provided by mental health acts or similar regulations. They appear to make up a small proportion of the mental health-related ED workload in Australia; estimated by one Victorian study to be 17.6% (Knott, Pleban, Taylor, & Castle, 2007) and in a NSW study to be 19.7%. (Lee, Brunero, Fairbrother, & Cowan, 2008). Data from the United States reports the proportion of mental health presentations referred by police ranging from 10 to 53% (Way, Evans, & Banks, 1993). Our data suggests that as a proportion of overall ED caseload, Section 10 referrals are a tiny proportion. Like our study, Lee et al. (2008) found police referrals more likely to be male, have drug and alcohol issues and present out of hours. Unlike our study, they were more often admitted to hospital. The incidence of psychotic illness was similar between the studies if our categories of psychosis and schizophrenia are considered together. Similar characteristics have also been reported in overseas studies (Fahndrich & Neumann, 1999; Redondo & Currier, 2003), but the proportion admitted to psychiatric care was lower in our study. The proportion of patients with self harm ideation/threat of self harm is higher in our study than other reports but the proportion threatening harm to others is similar (Skeem & Bibeau, 2008). Our findings contrast somewhat with the characteristics of patients transported by police to specialist psychiatric services as emergency cases. While also commonly male with a high rate of drug and alcohol problems, psychosis and hospital admission were more common and patients were often known to psychiatric services (Kneebone, Rogers, & Hafner, 1995). This difference is probably explained by differences in referral procedures between jurisdictions.

Jurisdictions in other places employ other models for assessment of people who are potentially mentally ill. In the United Kingdom, there are several examples of assessment processes based at police stations utilizing the skills of community psychiatric nurses/psychiatrists (Moore, 2010). Some US jurisdictions employ transfer directly to a specialized psychiatric emergency facility (Way et al., 1993). This latter approach avoids the need for a secondary transfer if hospital admission is required. The exact type of place is probably less important than the key processes: recognition of potential mental illness by police, a safe environment for assessment, prompt access to assessment by a clinician trained in mental health and, if necessary, timely access to an appropriate treatment pathway.

Seventy five percent of patients had Section 10 forms completed by police. These forms were introduced during the study year so this high proportion suggests good uptake of this form as a communication tool. We did not compare the groups with and without forms as this is likely due to form availability rather than other factors. The Section 10 referral form was developed and piloted at the study institution. Its aim was to improve communication between ED staff and police officers about the circumstances of the referral, to allow officers to leave the ED sooner and to improve documentation of referrals. No formal evaluation of the form or associated processes has been published.

While a proportion of patients might accept transport by police to ED willingly, for some that will not be the case. Transport without consent is a significant limitation of their freedom and the process of detention and transport is not without risk of injury, on rare occasions resulting in death (Otahbachi, Cevik, Bagdure, & Nugent, 2010). These may occur due to police actions to restrain patients or from patients injuring themselves due to agitation while in the police van. There is also a risk of psychological trauma.

Given that a minority of patients require restraint, sedation or hospital admission, a strong argument could be made for a less restrictive and traumatic process in selected cases. How that is achieved, balancing mental health and police resources and patient and community safety, is the challenge. One potential model would be for CAT staff to attend situations where police believe that there is a mental health-related crisis in order to supply specific information about known patients, de-escalate psychological crises and, in appropriate cases, perform mental health assessments on-site. To be successful, CAT staff would need specific training and procedures for working with police and clients in these high pressure situations. A model that has been successful in the United States is the Crisis Intervention Team (CIT) Model. Self-selected police officers undergo special training, including training in de-escalation techniques, and act as first responders for situations involving people with a mental illness who are in crisis (Compton et al., 2010). The model also involves partnership between police and mental health services to facilitate referral to mental health services and reduce incarceration (Compton et al., 2010). When compared to a mobile psychiatric assessment team model, the CIT had a higher proportion of cases with specialized on-scene response (92% vs. 40%), more direct transfers to a treatment location (75% vs 42%) and more situations resolved at the scene (23% vs 17%) (Steadman, Deane, Borum, &

Table 3
Disposition [two missing data].

Disposition	No.	%; 95% CI
Home	130	67%, 60–73%
Involuntary psychiatric admission	26	13%, 9–19%
Voluntary psychiatric admission	26	13%, 9–19%
Absconded	10	5%, 3–10%
Medical ward admission	5	2.5%, 0.1–6%

Morrissey, 2000). A number of Australian jurisdictions are proactively developing specific interagency agreements aimed at ensuring that, where possible, early intervention occurs to appropriately link mentally ill individuals with the assessment, support services and care required thus reducing the demand on specialist mental health services by avoiding escalating situations and harms (NSW, 2005; Victoria Police, 2008).

The issues of police resources and training have been widely recognized (Clifford, 2010; Moore, 2010) and attempts to address these are underway. Most are similar to the CIT model described above. Examples include the Queensland Police Service Mental Health Intervention Project and the Mental Health Intervention Team project in NSW (Herrington, Clifford, Lawrence, Ryle, & Pope, 2009). They include specialized training for selected front line officers focusing on communication, risk assessment and crisis intervention and inter-agency processes to streamline assessment and treatment. Similar work is underway in Victoria (Perez E, personal communication) in partnership with Monash University.

Limitations of study include those of retrospective medical records review methodology in particular potential issues with missing data (Gilbert et al., 1996). In particular, we were unable to determine accurately whether sedative agents were taken/administered voluntarily or used for the purposes of restraint. It is also possible that the use of physical restraint has been under-estimated because of under-documentation. Defining eligible presentations was challenging. We chose to take the most inclusive approach because the use of Section 10 forms was implemented during the study period, officers can forget to complete the forms or they may be lost. Even with this broad approach, we may have failed to identify some eligible presentations. We attempted to mitigate this by cross checking with ECAT and police records. Assigning an ED diagnosis is likely to have under-estimated the complexity of these presentations which often have a combination of psychiatric/psychological, drug and alcohol, personal and social/environmental factors. Balancing this limitation, to attempt to code for all the possible combinations using retrospective data would have likely resulted in data that was inaccurate and with too many categories for meaningful interpretation on a sample of this size. Generalisability to other sites cannot be assumed, particularly to other jurisdictions with different mental health acts and/or different referral processes.

5. Conclusion

Most patients brought to ED under Section 10 of the Mental Health Act (Victoria) had expressed intention to self harm and did not require sedation or restraint. The majority were discharged home. Further work exploring less restrictive or traumatic processes to facilitate psychiatric assessment of this group of patients is warranted.

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