Ethics series — 4

Mental health emergency transport: the pot-holed road to care

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Historically, police have had powers under successive mental health legislation to apprehend people with mental illnesses without a warrant. This is a widespread practice around the world and in all Australian states. Further, police are frequently the first point of contact for people with a mental illness in the Australian community, particularly after hours when mental health crisis team resources are limited.[1] However, people living with mental illness are increasingly recognised as a vulnerable population with high rates of exposure to traumatic life events;[2] and many are exposed to distressing experiences within mental health care systems. Being transported in handcuffs in a police vehicle has recurrently been reported as particularly distressing[3] (see also John's experience in the fictional scenario[4]). A submission to the Australian Human Rights Commission's "Not for Service" inquiry summed up the experience within the context of perceived mental health service failures:

> Because intervention comes so late, consumers and families report that once the police are involved and no matter how the police are, there is still a sense of not being treated with dignity . . . "I know when I get sick that I quickly lose insight and will resist treatment but I am sick and there I am being handcuffed by police. No other groups of people with an illness are treated like this. Why are we? Surely there can be a better way. I think it starts with me being able to say, I'm becoming unwell and clinicians taking me seriously".[5]

Recent changes to legislation in New South Wales sought to reduce police involvement in mental health by expanding state coercive powers to paramedics and registered mental health practitioners. While paramedics are taking on more emergency mental health responsibilities, police involvement does not appear to have been substantively reduced. New ways of thinking about community mental health responses are required. The primary aim of this discussion is to explore factors that may contribute to ongoing reliance on police involvement in transporting people affected by mental illness, by examining the Mental Health Act and the ensuing interagency response to mental health incidents.

Summary

- Police have, historically, been the first point of contact for people experiencing a mental health crisis in the Australian community.
- Changes in the NSW *Mental Health Act 2007* extended the powers and responsibilities for involuntary transport to paramedics and accredited mental health practitioners.
- The Mental Health Act also allows for police assistance to other agencies during transport of people living with mental illness if there are serious safety concerns.
- Involuntary intervention for people living with mental illness is based on risk-of-serious-harm criteria under the Mental Health Act, implying serious deterioration before the Act may be invoked.
- At the point of risk of serious harm, police involvement may be more frequently required according to the acuity of the situation.
- If the legal basis of non-consensual treatment under the Mental Health Act was lack of capacity, it would provide a more comprehensive legal and ethical basis for early intervention.
- Police contact is intensified in rural and remote regions, particularly after hours, where crisis assessments and intervention by health services are further stretched.
- Further reducing police involvement using strategies that increase access to consensual pathways of care for people living with mental illness, particularly for people in regional and remote areas, is desirable but not likely in the foreseeable future.

Current mental health legislation

Under the current *Mental Health Act 2007* (NSW), police may apprehend and transport a person to a declared mental health facility (DMHF) for psychiatric assessment if the officer believes the person: is committing or has recently committed an offence; has recently attempted or is probably going to attempt to kill himself or herself or someone else; or will probably attempt to cause serious physical harm to himself or herself or someone else (s. 22(1)(a)); *and* that it would be "beneficial to the person's welfare" to be dealt with under mental health, rather than criminal, legislation (s. 22(1)(b)). This is in keeping with the enacted mission statement of the NSW Police Force, which provides for "the protection of persons from injury or death . . . whether arising from criminal acts or any other way" (*Police Act 1990* (NSW), s. 6(3)(b)). The Mental Health Act allows police to divert people whom they suspect have a mental illness to health system, rather than justice system, end points.

The remarkable revisions enacted in the 2007 Mental Health Act extended state coercive powers to NSW Ambulance paramedics (s. 20) and other accredited NSW Health practitioners (s. 19 and s. 23), authorising them to detain and transport people living with mental illness to a DMHF for assessment. Paramedics and mental health practitioners were given powers to use "reasonable force" (s. 81(2)(a)) and physical restraint (s. 81(2)(b)), and trained paramedics could administer sedation (s. 81(3)). Paramedics were given authority to request police involvement where there were serious concerns for safety (s. 20(2)), and both paramedics and mental health practitioners could request police assistance, where practicable (s. 21(1)).

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Statewide statistics concerning people taken to a mental health facility under the *Mental Health Act 2007* (NSW)[7]

Financial year	Police (s. 22),* no. (%)			Ambulance (s. 20),* no. (%)			Total no. presentations‡
	Admitted	Not admitted	Total†	Admitted	Not admitted	Total†	
2008–09	2712 (80%)	682 (20%)	3394 (22%)	263 (99%)	4 (1%)	267 (2%)	15 496
2009–10	2536 (74%)	889 (26%)	3425 (23%)	494 (85%)	88 (15%)	582 (4%)	15 199
2010–11	2293 (71%)	940 (29%)	3233 (22%)	669 (69%)	301 (31%)	970 (7%)	14 566
2011–12	2150 (69%)	968 (31%)	3118 (20%)	742 (73%)	272 (27%)	1014 (6%)	15 765

* These data refer to the Mental Health Act ss. 20 (paramedics) and 22 (police) only and do not include mental health transports by police under other sections of the Act, including police assistance to ambulance (s. 21), doctors and accredited persons (s. 19), carers (s. 23 and s. 26), courts (s. 33), breach of Community Treatment Orders (s. 142 and s. 58), nor voluntary or informal transports by police or paramedics. † Proportion of total agency (police or ambulance) transports (under schedule) to total presentations at mental health facilities (NSW Health). ‡ Does not include people reclassified from informal to involuntary. ◆

Evaluating the outcomes of changes to the Mental Health Act

Statewide statistics provided by the NSW Mental Health Review Tribunal (MHRT)[6] suggest that transport by police (under s. 22 of the Mental Health Act) has remained stable, at about 20% of all presentations to DMHFs. In contrast, transport by paramedics (under s. 20) has increased to 6% (Box). These data do not include transport by police under other sections of the Act.

The Ambulance Service of NSW has estimated that of all occasions of transporting people affected by mental illness in an ambulance, only about 2% per year involve involuntary transport (personal communication, Kevin McLaughlin, Manager Mental Health, Ambulance Service of NSW). This low scheduling rate may reflect NSW Ambulance policy that decisions undertaken by paramedics to transport a person against his or her will should be viewed as an option of last resort. Further, it may reflect people's preference to be taken to the nearest health facility that has the resources to provide care, which may not necessarily be a DMHF if people agree to be transported voluntarily.

The NSW Police Force estimated that they responded to about 34 000 mental health-related incidents statewide in 2009.[7] In 2012, there were 38 534 such incidents, with about two-thirds resulting in a designated police function under the Mental Health Act (eg, transfer from court, interhospital transport) and including about 12 000 occasions of police detaining people under s. 22 (data obtained by M I). In the 6 months to May 2013, police detained 6149 people under s. 22 of the Mental Health Act across NSW, according to the NSW Police database (Computerised Operational Policing System [COPS]; data obtained by M I). Police do not necessarily transport all people detained under s. 22. Increasingly, people detained by police are then transported by ambulance to a DMHF; however, no records of this are kept. Further, there is a significant discrepancy between the number of people detained involuntarily by police in 2012 recorded by NSW Police and the number recorded by the MHRT (12 000 v 3000, respectively) that challenges the veracity of the available data. High-quality baseline data are required for accurately estimating the extent of police and ambulance involvement in the transport of people with mental illness across regions, and for evaluating outcomes resulting from changes to policy.

Problems with the current legislation

Risk of serious harm is the guiding principle

Under the Mental Health Act, a mentally ill or mentally disordered person is a person who is suffering from mental illness (s. 14) and/or whose present behaviour is "so irrational" (s. 15) that immediate care, treatment or control is necessary to protect the person or others from serious harm. "Risk of serious harm" is the guiding principle in any decision by mental health practitioners, paramedics and police to invoke a non-consensual intervention under the Mental Health Act.

The most significant implication of the sole reliance on this criterion is that a person's mental health must deteriorate to the point that they become a serious harm risk before intervention through non-consensual action is legitimate. At the point where a person living with mental illness reaches a point of risk of serious harm, the probability of police involvement appears to increase according to the severity of risk.

Lack of capacity is not taken into account

Decisional capacity refers in this context to the mental competence of a person to make his or her own health care decisions. Legally and ethically, it is argued that competence is essential for autonomy, as only competent decisions reflect a person's free will.[8] Two important assumptions regarding decisional capacity should be noted: first, capacity is not necessarily global to the person but may be relative to a situation or decision; and second, it is a threshold concept, perhaps best understood in terms of a degree of capacity.[9] The formal assessment of capacity must be made by a trained clinician, but carers and people living with mental illness may become attuned to signs that a period of diminishing capacity may be approaching.

A strong proponent for the use of capacity as a criterion in mental health legislation, Ryan, argues that the loss of capacity is not an all-or-none phenomenon, and suggests that a range of supported decision-making processes, including advance directives, could be instigated.[10] This may help fill the apparent gap in service provision between when a person loses decisional capacity and when they pose a risk of serious harm. Ryan and others have argued that using capacity to determine the threshold for non-consensual treatment would provide a legal and ethical justification for earlier intervention.[10] Doctors, carers, mental health practitioners and people living with mental illness could activate a legal mechanism for non-consensual intervention for assessment before the onset of high-

risk behaviour. In principle, this has the potential to increase the capacity of mental health services to assist people living with mental illness, and may reduce the necessity for emergency responses.

The Act embodies legal, not benevolent, paternalism

The current mental health laws have evolved from centuries-old English laws that originally served the purpose of protecting society (preventive detention).[11] Over time, the focus became care and treatment for the person — benevolent paternalism (*parens patriae*)[12] — by which "we decide for him as we assume he would decide for himself if he were of sound mind".[11]

Under the current Mental Health Act, however, paternalism is based on criteria other than the individual's own presumed choices. This legal paternalism, based on harm, is distinguishable from benevolent paternalism, which would be based on capacity. This is a disquieting ethical–legal contradiction deserving the attention of policymakers.

Implications for practice of the changes to the Mental Health Act

A memorandum of understanding (MOU) was developed between NSW Health, the Ambulance Service of NSW and the NSW Police Force to delineate interagency roles and responsibilities during a mental health emergency. It stipulates that police should be involved only in high-risk situations.[13] Nevertheless, the capacity of the MOU to cover the complexities of real-world mental health emergencies is limited by practicalities — for instance, mental health practitioners may not be available after hours; there may not be onsite interagency agreement on the person's presenting level of risk; nor may there be ready availability of an appropriate transport vehicle. Additionally, in the many regional and rural centres across NSW, the drive to the nearest DMHF may involve extreme distances and take a long time.

Advances in online technologies and the availability of videoconferencing call into question the transporting of people living with mental illness long distances for assessment. The Mental Health Emergency Care — Rural Access Program trialled the use of videoconferencing to provide rural and regional hospitals in western NSW with timely access to expert mental health assessments.[14] Among other positive outcomes, there was a significant reduction in the referral rate (ie, transport) to the distant DMHF, from 73% to 52% of all admissions by the end of the 20-month study. The program has continued as usual practice at the trial site and is being extended to neighbouring areas.

A number of other strategies are being developed with the aim of limiting the occasions when police are the primary providers of transport for people living with mental illness and reducing police involvement to an interagency support role. For instance, NSW Health has developed a fabric mechanical restraint device that is now used by paramedics when physical restraint is required. This reduces the use of police handcuffs and caged vehicles, and enables clinical monitoring of the person during ambulance transport.

For people living with mental illness, access to voluntary inpatient services is an important consensual pathway to care; however, access is not universal. Regional and rural areas in particular are poorly served. For the foreseeable future at least, the pathway to inpatient assessment for many people continues to involve emergency transport to DMHFs. Limiting the need for police attendance may be achieved by developing a model of care that aims to prevent situations where police are involved in mental health interventions.

Ethics in practice: case scenario

In the accompanying scenario[4] there is a point where John's parents and his caseworker, Kate, are all concerned that John is showing signs of serious deterioration. At the point where Kate advises John's parents that she cannot force John to receive care there may be strong ethical grounds for non-consensual intervention. It appears that John's decisional capacity has been reduced by his illness, perhaps beyond the point where he could be considered competent enough to be self-determining. At this point, Kate could arrange for a clinician who is qualified to assess capacity to visit John to determine whether his decisional capacity is critically compromised. If so, the Mental Health Act could be invoked to transfer responsibility for care decisions temporarily from John to the state, to provide the care that John would presumably choose for himself were he of sound mind.

Conclusions

The issue of ongoing police involvement in mental health services beyond high-risk situations is vexed. Two major contributors to ongoing reliance on police involvement are the enacted risk-of-serious-harm criteria and rural and regional resourcing issues.

There is an ethical imperative for earlier intervention in mental health situations. While police will always need to attend situations involving high risk for any member of the community, an earlier, more therapeutic intervention is required for a person living with mental illness who is losing the capacity to determine his or her own health care needs. A legal mechanism for non-consensual assessment based on decisional capacity could be explored. People living with mental illness could be supported, during periods of capacity, to identify indicators of diminished capacity as key intervention points, and doctors making clinical assessments in chronic and potential first-episode psychosis could give serious consideration to capacity. Thinking about capacity at an earlier intervention point may reduce the number of people requiring an emergency response. Further, making telehealth programs available in more rural and regional areas could help minimise long-distance transport. The establishment of reliable incidence statistics for emergency mental health transport would enable accurate assessment of the effects of policy changes on practice.

Ideally, people living with mental illness should be able to access quality mental health services voluntarily, long before non-consensual intervention is required. Once vol-

untary options have been exhausted, the point at which a person loses decisional capacity may represent an earlier, more benevolent juncture for non-consensual intervention. Reaching the point of emergency services intervention in a mental health incident should be the *last* option along the pot-holed road to care.

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