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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.