GAE: And not enough of that is done. What do you feel?

WBG: I think that it’s of great importance and I feel sorry for colleagues who have managed to get themselves into a situation in which they’re so loaded with work that they seem unable to step outside that at all. I have found it very helpful – for example, here – to talk with colleagues, to share experiences, puzzles, ideas in a situation, which one knows to be safe. Regrettably, some peer situations are not safe and one has to pick and choose people and a place with whom and where one can share joys, successes, anxieties, depressions, uncertainties, groupings and sudden insights. Someone in the same room is bound to be able to see a matter in a different light from the person who is temporarily lost or blind and, if one has chosen wisely, one’s vulnerabilities will be seen for what they are, accepted empathically and used, with everything else, in service of enlightenment.

GAE: It certainly doesn’t happen enough. At Westmead of which I’m fond and where I enjoy the relationship with the staff, we’ve not really developed in this way. There’s quite well-organized training for the more junior staff but at the senior level it has not yet developed, except for the Thursday case conferences and at times on an informal basis.

WBG: Peer supervision is not just for personal sustenance either but should aid the development of ideas and ways of working, and thus be of benefit to our patients. The safe place should not simply be a haven where the discipline of critical examination is accepted and expected. Since the possibility of having to change is always associated with some discomfort, one will feel uncomfortable sometimes in the presence of honesty.

GAE: Sometimes, thinking about my interactions with a patient, I ask myself “Did I really say that?” or “What was I thinking at the time” or…

WBG: …or “What would my colleagues think about this?”

GAE: (laughing)

WBG: So one sees a peer group which will assiduously examine one’s presentations, not allowing one to dodge issues, but doing it empathically.

GAE: Yes, and I think that what often gets in the road in professional groups is that somebody has a mission, with a patient I ask myself “Did I really say that?” or “What was I thinking at the time” or…

WBG: …or “What would my colleagues think about this?”

GAE: Any thought, Bill, about the future of psychiatry and psychotherapy?

WBG: Oh! I’m not a very good predictor. I believe that human nature won’t change. The Department of Health became the Health Commission and is now the Department of Health again, which facts seem to say something else. I hope that our training organizations develop well enough to allow people to confront, recognize and cope with the complexities and vagaries of the human condition and to put such experience to good use.

Meeting the call of the coroner: detention and release of patients under the Mental Health Act

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In a recent inquest into the death of a man discharged from a Sydney emergency department, the coroner commented that some of that staff of that hospital may have had “a less than satisfactory understanding of the provisions of the Mental Health Act 2007”.

He recommended that that Local Health Network review its training programmes and materials concerning the Act as to ensure compliance with its provisions. However, subsequent informal discussions around mechanisms for detention and discharge under the Act have suggested that there are many ambiguities about the provisions extend more broadly. This brief paper sets out to clarify some of these issues, particularly as they arise in the emergency department.

The CORONER’S INQUEST

The case concerned a 61-year-old gentleman with a past history of bipolar disorder who was brought to the emergency department by the police in compliance with s 22 of the Act. The police had found the man lying in the middle of a major road, attempting to assault anyone who tried to assist him and stating that he wanted to die. It was 12:15 pm.

Upon arrival in the emergency department, the patient was observed to be oppositional and aggressive. On initial assessment, the attending psychiatry registrar formed the belief the patient was a mentally ill person and, in a completed Form 1, noted a probable relapse of bipolar disorder. The registrar also directed a RMO to fill in a Schedule 1. The patient was given haloperidol and midazolam intramuscularly. When the patient refused it. In those circumstances emergency physicians – registrars and consultants - as AMOs, had a strong argument for nominating senior emergency physicians – registrars and consultants - as AMOs, under the Act, required urgent medical treatment, but refused it. In those circumstances emergency
physicians would be best able to assess the patient and determine appropriate treatment.11 DETAINING AND RELEASING PATIENTS UNDER THE ACT Patients may be brought to and detained in a declared EoA in accordance with the framework set out in section 12. The most familiar of these is the Schedule 1 that may be completed by any medical practitioner (s 19), but a range of other professionals can take a person whom they believe to be mentally ill or disturbed, to hospital for detention and treatment. These other professionals include: accredited persons (s 19), ambulance officers (s 20), police officers (s 22) and magistrates (s 23). A person, who is taken to hospital under one of these sections, must be detained (s 18) with no further need for a Schedule 1 to be completed. A person may also be detained in a declared EoA on a written request made to an AMO by the primary carer or a relative or friend of the person, though only in urgent circumstances where providing a Schedule 1 is not reasonably practicable (s 26).

If it becomes apparent that a patient, who attended the declared EoA voluntarily, now needs to be detained, any doctor or accredited person in the emergency department may detain them by completing a Schedule 1. Once a person is detained in a declared EoA, by any of the mechanisms above, a series of steps are required for their discharge or detention (s 27). First, a Form I must be completed by an AMO as soon as practicable (but not later than 12 hours) after the patient was detained. The AMO who performs the Form I assessment must not be the same medical practitioner who completed the patient’s Schedule 1 (s 28).

Next, a second Form I assessment must be completed “as soon as possible” by another doctor (s 27(d)). This doctor must be a psychiatrist, if the AMO who completed the first Form I was not a psychiatrist. If the second doctor disagrees with the first, and thinks the person is not a mentally ill person, then, in order for that person to continue to be detained, a third Form I assessment must be sought from another psychiatrist who must certify that the person is mentally ill or mentally disordered (s 27(c)). If the third opinion finds the person is not mentally ill or mentally disordered, the person must be released (s 27(d)). In the inquest, a question arose as to what should be done when the AMO, who completes the first Form I, ceases to be of the opinion that the person is mentally ill or mentally disordered. Can the person be discharged, or must the person be detained while a second, and possibly third Form I assessment is carried out by another doctor/s in accordance with the procedures in section 27? ACCORDING TO THE CORONER: “What section 27 would have required is that [the patient], having been assessed as mentally ill it must be examined by a second medical officer, this time a Consultant Psychiatrist who would either endorse the first opinion or not. If the Consultant Psychiatrist was unable to agree that the patient was mentally ill if … then a third opinion would be required.”12 13

This suggests, although it is not expressed as such in his findings, that the Coroner felt that once the section 27 process is started, another two medical opinions must be obtained stating that the person is not mentally ill, before the person can be released. Certainly, if two such medical opinions are obtained, the person must be released (s27(d)), but in our view, it is not clear that a patient, whom an AMO no longer believes to be mentally ill or mentally disordered, must or should be detained until the section 27 process is completed.

The issue of whether a duty exists to detain a person under the Mental Health Act 1990 (NSW), was considered by the New South Wales Court of Appeal in Hunter Area Health Service & Anor v Presland.5 In that case, Mr Presland was discharged from a psychiatric hospital after the attending psychiatric registrar failed to diagnose him with a mental illness and did not detain him under the 1990 Act. Six hours after his release, Presland killed his brother’s fiancée. He was later acquitted of murder on the grounds of mental illness and was detained for a period in a psychiatric hospital. Presland sued the hospital for negligently failing to restrain him and care for him.

The Court of Appeal held by majority, that while doctors owed patients a general duty to exercise reasonable care and skill in providing advice and treatment, the Mental Health Act 1990 enabled detention only as a “last resort”.6 7 Sheller JA noted that s 20 of the 1990 Act, “is not expressed as imposing a duty to admit or, detain in, or continue the detention in, a hospital … if the medical superintendent is of the opinion that the alternative care of a person who is not mentally ill and of a less restrictive kind is appropriate and reasonably available to the person. It is expressed as imposing a duty not to admit to, or detain in, or continue the detention in, a hospital of a person unless the medical superintendent is of that opinion.”8 9 The same could be said of section 12 of the current Act, which sets out much the same general restrictions on detention. Section 12 requires that:

(1) A patient or other person must not be involuntarily admitted to, or detained in, or continue in, a mental health facility unless an authorised medical officer is of the opinion that:

(a) the person is a mentally ill person or a mentally disordered person, and

(b) no other care of a less restrictive kind, that is consistent with safe and effective care, is appropriate and reasonably available to the person.

(2) If an authorised medical officer is not of that opinion about a patient or other person at a mental health facility, the officer must refuse to detain, and must not continue to detain, the person.

This appears to impose a positive duty to discharge a patient once no longer of the opinion that the person is mentally ill or disordered. The requirements of section 27 must be read against this duty.

Section 27, sets out the “[s]teps for medical examination requirements for ongoing detention in mental health facility” (emphasis added). This heading is a useful indicator that the section is intended to apply only where detention is continuing in accordance with the framework set out in section 12. Nothing in that section expressly requires that detention must continue, or that it should continue whenever the AMO is no longer of the opinion that a person is mentally ill or mentally disordered. Even so, while the Presland case may be useful precedent for the principle that there is no obligation to detain a person under the Mental Health Act 2007 where the AMO is not, or is no longer of the view that a person is mentally ill, the decision about whether or not a person is mentally ill must be made with care. We would caution that, in most instances, a registrar

Faculties, Sections & Interest Groups

SECTIONS FACULTY AND INTEREST GROUPS ARE INVITED TO CONTACT THE BRANCH OFFICE WITH INFORMATION RELATING TO THEIR MEETINGS SEMINARS ETC. SO THAT THIS MAY BE CONVEYED TO INTERESTED MEMBERS AND TRAINEES.

FACULTY OF CHILD & ADOLESCENT PSYCHIATRY

The NSW Branch of the Faculty of Child and Adolescent Psychiatry meets on the second Tuesday of every second month (although from time to time amendments may be made to accommodate for school holidays). This is an informal meeting in which a range of political, administrative and clinical concerns relating to child and adolescent psychiatry are discussed. The meeting is followed by a scientific presentation, Finger food and wine are served at meetings. All child and adolescent psychiatrists, psychiatry trainees, and other interested psychiatrists, are warmly welcome to attend.

Meetings are held at Madding House, 761 Darling St, Rozelle, from 7:30pm to 9:00pm. Attendance may contribute to your Continuing Professional Development.

The Faculty is particularly interested in engaging with colleagues who are working in the child and adolescent psychiatry field, both in private practice, and outside the Sydney metropolitan area.

If you are not on the Faculty mailing list and would like to be so, please contact Mr. Helen Mullins (administrative secretary) on 02 98457950, or by email at helen.mullins@health.nsw.gov.au.

Meeting dates for the rest of 2011 are:
- Tuesday 5 April 2011 (AGM).
- Tuesday 7 June 2011;