

Legal criteria for involuntary mental health admission: clinician performance in recording grounds for decision

In enacting mental health laws, parliaments empower doctors and other health professionals to detain patients and coercively administer treatment in defined circumstances. These laws have been informed by the United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (1991).¹ These principles include requirements that patients be treated in the least restrictive environment (principle 9), and that every effort be made to avoid involuntary admission (principle 15). Laws made in recent years also purport to give effect to the articles in the 2006 United Nations Convention on the Rights of Persons with Disabilities.² Australia is a signatory to this convention.

Principle 16 of the 1991 UN catalogue requires that, when involuntary admission occurs, the grounds of the admission be communicated to the patient without delay, and the fact of the admission and the grounds for admission be communicated to the patient's personal representative, the patient's family (unless the patient objects) and a legal review body.¹

In South Australia, the grounds for involuntary admission were previously recorded on the initial detention form, as required by a regulation of the *SA Mental Health Act 1993*. The form had space for a brief statement of the grounds for detention. It was expected that, if practicable, a psychiatrist would then examine the patient within 24 hours. It was not required that a copy of the form be given to the patient.

In 2010, the *Mental Health Act 2009* came into operation. This new Act requires the order for involuntary admission to be given to the patient, together with a statement of their rights. It was expected that by receiving a copy of the order, patients, carers and the tribunal would

Abstract

Objectives: Mental health laws set criteria that limit the use of involuntary admission to specific circumstances, and clinicians are expected to justify the lawfulness of such detention by referral to these criteria. The South Australian *Mental Health Act 1993* required grounds to be documented on the detention form, specifically with respect to the presence of a mental illness, risk to self or others, and a need for immediate treatment. This investigation sought to determine whether the grounds provided for detention met legislative requirements.

Design and setting: 2491 consecutive forms authorising the initial detention of involuntary patients in South Australia between July 2008 and June 2009 were rated to determine whether criteria stipulated by legislation were addressed.

Results: Only 985 forms (40%) addressed all the legal requirements for detention. 1471 forms (59%) did not comment on a requirement for immediate treatment, 540 (22%) did not state the presence of mental illness, and 359 (14%) did not discuss risk to self or others. Given the particularly poor performance of clinicians in addressing the need for immediate treatment, the data was reanalysed with respect to the presence of mental illness and risk only; 1697 forms (68%) addressed both these criteria.

Conclusions: This low compliance rate with legal requirements is concerning. It may reflect clinical decision making, the attention given to the form by the physician filling it, or a combination of both. Stating the grounds for involuntary admission should provide protection for the rights of patients, and the requirement to do so reflects the gravity that the loss of liberty entails for the patient. Our findings are relevant to jurisdictions that are currently reviewing mental health legislation and the need to document the grounds for involuntary treatment, including South Australia.

be informed of the specific grounds for their detention, as this had previously been included in the order. However, the Minister for Mental Health had removed the requirement for grounds to be documented on the form.

In 2014, the SA Office of the Chief Psychiatrist published a review of the operation of the Act in which the requirement for the inclusion of written reasons on orders was reconsidered. It was recommended that reasons for detention not be included in the form.³ The SA Government is currently considering the outcomes of this review.

In the context of the current policy and legal debate about requiring doctors and other medical practitioners to succinctly document

grounds for involuntary treatment on a form, our study examined how effectively doctors have complied with this legal requirement in the past. This has been done by rating forms for inpatient detention completed by medical practitioners under the former *Mental Health Act 1993* for compliance with legislative criteria.

Methods

We analysed 2491 consecutive forms authorising the initial detention of involuntary patients. These forms had been faxed to the Guardianship Board of South Australia from hospitals that admitted involuntary patients during the period 17 July 2008 – 15 June 2009.

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One of us (K R), a legal researcher, reviewed the forms to assess compliance with the requirements of the *Mental Health Act 1993*. An initial trial rating of 250 forms was completed before undertaking the analysis of all the documents.

The grounds for detention were defined in section 12(1) of the *Mental Health Act 1993*:

- (1) If, after examining a person, a medical practitioner is satisfied—
 - (a) that the person has a mental illness that requires immediate treatment; and
 - (b) that such treatment is available in an approved treatment centre; and
 - (c) that the person should be admitted as a patient and detained in an approved treatment centre in the interests of his or her own health and safety or for the protection of other persons, the medical practitioner may make an order for the immediate admission and detention of the person in an approved treatment centre.

The *Mental Health Act 1993* “Order for admission and detention in an approved treatment centre” (Form 1; reproduced in the Appendix) cites these legislative criteria and allows space for the examining physician to enter the reasons for detention.

We adopted a generous rating approach, in that we accepted any evidence that each criterion had been addressed by the practitioner, without seeking to determine whether a threshold level for the criterion had been met (eg, assessment of the degree of risk). We rated a criterion as having been met if it was referred to in writing in the reasons given, or if the criterion printed on the form was clearly marked up (eg, with a circle, underlining or tick) to indicate that the practitioner had considered that criterion.

Mention of a current illness, such as depression, schizophrenia or psychosis, was accepted as the presence of a mental illness.

The Act required that treatment be available in a treatment centre. This criterion was not assessed, as, if a person had been detained, treatment would be made available; if a bed in a ward was not available, a patient would be accommodated in an emergency department.

In assessing the forms, an overall statement of their compliance with legal criteria was made. Forms were assessed as clearly meeting the criteria if they addressed all the criteria required by the legislation (the detainee has a mental illness; is a risk to himself or to others; and requires immediate medical treatment). In some forms, not all criteria were explicitly addressed, but what was written and marked up constituted a justification for detention, and the form was therefore classified as “otherwise meets criteria”.

Ethics approval

The project was undertaken with the approval of the South Australian Department of Health Research Ethics Committee (HREC/14/SAH/129).

Results

Of the 2491 forms reviewed, only 985 (40%) addressed all the necessary legal criteria for detention (Box 1). Specifically, 1471 forms (59%) did not refer to a need for immediate treatment, 540 forms (22%) did not refer to the presence of a mental illness, and in 359 forms (14%) there was no reference to risk to self or to others (Box 2).

With regard to risk, 1247 forms (50%) recorded risk to self but not to others, 718 (29%) risk to both self and to others, and 167 (7%) risk to others but not to self.

On some forms, it was possible to infer that all criteria had been addressed even though this was not explicitly stated. If forms that “otherwise met criteria” in this manner were included, the number of those assessed as addressing the legal criteria increased to 1249 (50%). This group included 193 forms in which the assessor made a note that a need for immediate treatment could be inferred from the other details recorded on the form, although the

1 Completion of the Mental Health Act 1993 Form 1 by medical practitioners (analysis of 2491 forms)

Specific legal criterion	Addressed on the form	Not addressed on the form
Mental illness	1951 (78%)	540 (22%)
Requires immediate treatment	1020 (41%)	1471 (59%)
Form refers to individual's health and safety and/or protection of others	2132 (86%)	359 (14%)
Form overall		
All necessary criteria explicitly addressed	985 (40%)	1506 (60%)
All necessary criteria either explicitly addressed or could be implied from the form (“otherwise meets criteria”)	1249 (50%)	1242 (50%)

2 Mental Health Act 1993 s. 12 criteria not addressed (analysis of 2491 forms)

Criterion not addressed	
One or more criteria missing	1506 (60%)
Requirement for immediate treatment missing	1471 (59%)
Statement regarding the presence of mental illness missing	540 (22%)
Statement regarding risk to self or others missing	359 (14%)

3 Reanalysis of the completion of *Mental Health Act 1993* Form 1 by medical practitioners, after removing the criterion “requirement for immediate treatment” (analysis of 2491 forms)

All necessary criteria explicitly considered	1697 (68%)
All necessary criteria either explicitly considered or could be implied from the form	1725 (69%)

need for immediate treatment was not specifically mentioned.

As the majority of practitioners did not refer to the need for immediate treatment, a further descriptive analysis was undertaken after removing this element, and this indicated that 1697 forms (68%) explicitly addressed the remaining criteria: the presence of mental illness and risk to self or others (Box 3).

Discussion

In providing written grounds for the detention and involuntary treatment of their patients, medical practitioners addressed all necessary criteria on only 40% of the admission forms. We view this very low completion rate as a significant problem in documenting evidence of compliance with the law and protecting the rights of the affected patient. However, when the criterion that was most poorly addressed (the need for immediate treatment) was removed from analysis, the rate of compliance with the remaining criteria increased from 40% to 68%. This is reassuring.

Nevertheless, these results raise a significant question about the legality of the involuntary admission of those for whom the criteria were not addressed on the form. Does the fact that criteria were not specifically addressed reflect the actual clinical circumstances of the patient, or simply an error of omission by the clinician when completing the form? To answer this question it would be necessary to compare the information on the form with other sources, such as case notes or patient interviews. This was not part of our study.

A strength of our analysis was the large number of forms assessed. In theory, the examined collection should represent every mental health detention in SA between 17 July 2008 and 15 June 2009. We are nevertheless aware that some hospital units may not have complied with the requirement to routinely fax forms to the Guardianship Board. The detaining medical officer was not responsible for faxing forms, however, so we do not believe that lapses in doing so by some units would bias the outcome of our analysis.

Completion of forms

Given that mental health laws seek to limit the use of coercion to defined situations, the requirement to succinctly state the grounds for taking this action should protect the rights of patients if the defined grounds are not present. The discipline of completing the form, a skill that requires the integration of clinical findings with legal requirements, can, arguably, assist with this clinical decision making. The legal requirement to complete the form also accurately reflects the gravity of the loss of liberty for the patient, which is comparable with other forms of custody, including police arrest.

Variability in decision making

It is worrying that decisions to make orders may be made for extra-legislative rather than legal reasons. Variability in decision making about the need for an order can be attributed to the level of training of clinicians and to the individual clinician's attitude to risk.⁴ Some extra-legislative factors may be clinically relevant, such as non-compliance of the patient and their lack of insight,^{5,6} although they ultimately influence

the assessment of risk within the context of the defined criteria.

There is also a potential for clinicians to substitute their own moral judgement for what the law requires. This has been discussed in the context of experts who testify in forensic matters “... in accordance with their own self-referential concepts of ‘morality’ and openly subvert statutory and caselaw criteria that impose rigorous behavioral standards as predicates for commitment”.⁷

A recent report of in-depth interviews with 10 Norwegian psychiatric clinicians about how legal criteria are interpreted suggested that an ideal rational deliberation can lapse into paternalism, with assumptions made about lack of insight and the pointlessness of attempting to provide voluntary care for people with severe mental illness.⁸ Another author identified the risk of applying a false “ordinary common sense” to decision making in the law; this can nurture irrational, unconscious, bias-driven stereotypes and prejudices.⁹

Whether a requirement for clinicians to succinctly document grounds for involuntary admissions would rectify the problem of extra-legislative decision making is not known. It is still possible to apply extra-legislative criteria in making a decision, and to then retrospectively justify it by correctly citing the law in recording the decision.

In SA, patients are no longer provided with grounds for their detention. It must now be very difficult to detect whether criteria for detention under the *Mental Health Act 2009* have been addressed. Patients would be better protected by a requirement that the grounds be recorded at the time of detention.

Other jurisdictions in Australia have a variety of laws regarding the completion of forms and the notification of involuntary patients. All except the Australian Capital Territory and SA require a form that includes the grounds for detention. New South Wales, the Northern Territory, Queensland, Victoria, Tasmania and Western Australia require

that people who are involuntarily detained be informed either of the fact of their detention and their rights, or of the reasons for their detention.¹⁰⁻¹⁵ The manner in which they must be informed, however, differs. In the NT, involuntary patients may be informed orally or in writing, although a record of the notification must be made.¹¹ In Queensland,¹⁶ Victoria¹³ and NSW,¹⁰ involuntary patients are informed in writing; in Tasmania, the legislation provides a right to be informed, but does not specify how involuntary patients are to be informed.¹⁷

We do not have a uniform system of counting and reporting inpatient detention rates.¹⁸⁻²⁰ The Australian Institute of Health and Welfare refers to general trends (eg, 29.0% of public hospital admissions of patients with psychiatric symptoms in Australia during 2011–12 were involuntary), but it cautions that direct comparisons between service settings can be affected by differences in data collection standards and methods.¹⁹ In SA, statistics on the number of involuntary orders in emergency departments and wards are now available,²¹ but there is no usable denominator that would allow the calculation of rates and accurately

attribute meaning to yearly fluctuations.

Light and colleagues²² highlighted a similar problem with respect to involuntary community treatment orders, noting the lack of a comprehensive, uniform national dataset and the need for rigorous and publicly accessible policy on their use. The same can be said for the reasons for inpatient compulsion. The collection of this information would allow links between rates of compulsion and the practices and culture related to documenting the grounds for detention to be explored.

Should admission forms include the grounds for involuntary treatment?

On the one hand, the poor performance of medical practitioners in completing legal forms, as described in our article, might support the argument that specifying the grounds for involuntary treatment on such forms should be abandoned. However, we suggest not only that the recording of reasons be required, but also, given the concerns discussed in this article, that the reasoning on the forms be regularly monitored for quality assurance and

that clinicians be supported to improve their performance. This would ensure rational deliberative decision making based on law and good practice.

The UN mental health principles stipulate that the grounds for involuntary treatment be communicated to the patient and to a legal review body. Giving a patient a form that includes the reasons for their detention may help them understand what is happening to them, and this transparency will, in itself, provide a quality check on the accuracy of information recorded and on the reasoning on the form. Further, if tribunals routinely received these forms, they would be better able to evaluate the appropriateness of detention and to provide constructive advice to practitioners on best practice.

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