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## POLICY AND SERVICE DELIVERY

### Protective jurisdiction, patient autonomy and paramedics: the challenges of applying the NSW Mental Health Act

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#### Abstract

Paramedics form part of the frontline response to mental health care in the community. Changes to mental health laws across the country have seen an increase in the role and responsibilities paramedics have in assessing, treating and managing mental health patients. The increasing complexity of the paramedic role associated with these changes requires a clear understanding of the legal, ethical and organisational requirements that accompany them. This paper will examine the relevant legislative principles and ethical dilemmas that are raised by these changes and will demonstrate the need for further research to assist in the development and implementation of strategies to assist paramedics in providing optimal patient care to a vulnerable section of the community.

**Keywords:** *education; ethics; law; mental health, paramedics, policy*

There has been much written about the potential of paramedics in an expanded role that goes beyond responding to trauma.<sup>1-5</sup> Paramedics already respond to non-traumatic calls and are often the first to respond to calls for assistance in mental health case.<sup>6</sup> In acknowledgement of this, the New South Wales (NSW) government altered the *Mental Health Act 2007* (NSW) to make provision for paramedics to transport patients directly to a mental health facility in order to relieve some of the burden on emergency department services. Similar provisions have already been made in other jurisdictions.<sup>7,8</sup> However, mental health patients often have complex and difficult histories and can be challenging to treat and manage. In addition, paramedics are often restricted in their decision making by protocols that limit treatment options for patients. For example, a patient that presents with threatened self harm is to be transported to hospital.<sup>9</sup> Immediate transport may be an appropriate option in some circumstances, but to be consistent with the principles of the *Mental Health Act* it should not be the *only* option available to paramedics. Furthermore, there is evidence of a misunderstanding of the legal and ethical issues that surround decision making in mental health treatment. As the paramedic role continues to expand beyond the traditional emergency role, legal and ethical challenges in decision making are likely to increase. Gathering further

research to inform the provision of sound organisational and educational support may help to deal with these challenges.

### **Protective Legislation**

Protective jurisprudence arose from ancient common law doctrine that led to the Court developing a role as an overarching protector of individuals who could not be otherwise protected.<sup>10</sup> This philosophy has been codified in law and is evidenced in all Australian Guardianship and Mental Health statutes. This type of legislation is considered to be strongly paternalistic because it offers protection in the form of care and treatment to those individuals who fall within its jurisdiction even to the point of detaining someone against their will under the premise of it being in the individual's best interest to do so.

### **Autonomy vs Protectionism**

There has been an increasing move away from paternalism in health care and shift towards encouraging patient autonomy even when decisions made by the patient have the potential to harm them. There has been a long history of alternating philosophical views on the rights and status of the mentally ill. Care has moved from a philanthropic approach to those 'afflicted', to the perception that community needs protection from them, as suggested by Plato; "*the offspring of the inferior, or of the better when they have the chance to be deformed, will be put away in some mysterious, unknown place, as they should be*",<sup>11, p.157</sup> back to the protection of the rights of the individual.<sup>12</sup> Mental health patients throughout the ages have experienced abuse, restriction of civil liberties and persecution. They have been feared, demonised, patronised and relinquished of rights; not for reasons of malevolence, but rather a paternalistic benevolence. Not only were changing community values responsible for a move away from institutionalised care, but advances in pharmaceuticals also enabled treatment to move from institutional care to community settings.<sup>13, p.279</sup> This had the dual effect of reducing demand on limited institutional resources and associated costs. It also led to the development of 'community treatment orders' - a less restrictive option for the patient which better recognises the patient's right to physical liberty, even if they were mentally restrained to some extent by their illness. However, the unintended consequence of this shift from institutions to community based care has been that it has contributed to an increase in the number of mental health presentations to emergency departments,<sup>14</sup> which Eppling suggests is a result of a corresponding decrease in funding for community mental health resources.<sup>15</sup>

The increase in presentations was a contributing factor in altering the NSW *Mental Health Act* to allow paramedics to transport directly to a mental health facility rather than the emergency department. The powers were written to enable paramedics to make these decisions independently of other members of the health care team. Whether or not this occurs in practice, the power for paramedics to transport directly to a mental health facility is available to them under the *Act* and therefore data about the effectiveness, or otherwise, of its use should be gathered at least for educational purposes. The changes to the *Act* also give paramedics additional powers that include the use of reasonable force, restraint and sedation for the purposes of transport and authority to carry out a search.<sup>16</sup> During the reading of the *Mental Health Bill* in the NSW Parliament, the then Assistant Minister for Health, Paul Lynch said of the proposed changes to the *Act* that:

*This aims to provide a more structured approach to admission and transport...Training and support for ambulance officers will be critical to ensure that they can safely and effectively perform this role.*<sup>17, p.2</sup>

The recognition of the need for training and support has been echoed by others. In Queensland, where similar changes to the *Mental Health Act* occurred in 2000, paramedics voiced concerns regarding their ability to comply with the legislative changes due to poor mental health education, particularly with respect to patient assessment.<sup>16</sup> Claiming that there is a distinct lack of research in the area of paramedic knowledge, judgement and clinical decision making, with respect to mental health care,<sup>16</sup> Shaban conducted a study to determine how paramedics managed decision making when faced with mentally ill patients. His study demonstrated that paramedics rely on intuition and experience to assist them with decision making, and when faced with non-specific symptoms, they tended to transport their patients for fear of being charged with negligence and sustaining damage to their personal and professional well being. Paramedics also considered transport to hospital as the only treatment they could offer anyway, and that consequently not transporting was considered as non-treatment. Paramedics reported transporting not as a way of providing good patient care, but as a way of meeting their formal obligations to their employer (in this case, Queensland Ambulance Service). This research is supported by others including a study in South Australia<sup>9</sup> that found there was an emphasis placed on the 'load and go' philosophy with respect to mental health patients. As noted by Shaban,<sup>18</sup> Roberts<sup>6</sup> stated that she believed this was partly due to a lack of education. Given that South Australia has recently amended its *Mental Health Act* to include greater powers for paramedics similar to those provided in NSW, then it is reasonable to conclude that similar difficulties in implementation may be encountered.

In NSW, paramedics are also obliged to transport patients if they request it, irrespective of the paramedic's assessment of the patient's need for hospital treatment.<sup>19</sup> Staff have commented that they were not encouraged or supported to make clinical decisions about patient care and expressed concern at the prospect of being subjected to disciplinary action if they diverted from clinical protocols.<sup>20, p.37</sup> Staff have also expressed concern at not being adequately trained to deal with acutely mentally ill patients,<sup>21-23</sup> which is also mimicked within the police service.<sup>1</sup> The consequences of the conflict between legal and ethical obligations and organisational expectations is, as Shaban has suggested, likely to result in the inability of staff to meet governmental policy initiatives on the provision of mental health care. In addition, a failure to fully understand the ethical and legal implications of the role of the paramedic in providing care to the mentally ill, may result in a breach of the paramedic's legal or ethical duty. For example, the determination of whether a patient is mentally ill as defined under the *Mental Health Act* is necessary in order to make the decision to give protection to those who require it, or to respect the autonomous decision of a competent individual. The failure to make this decision correctly may contribute to a breach in the paramedic's legal standard of care or may result in an assault being committed against a patient.

English research examining the ability of paramedics to make an assessment of the needs of patients who do not require transport to an emergency health facility indicated that there was very little evidence to suggest that they are able to do this without carrying a clinical risk to the patient.<sup>24, p.212</sup> There have been attempts made by ambulance services to improve decision making and to discourage individualism in the process by restricting paramedics to the use of protocols and clinical procedural texts that prescribe treatment. The intention of these documents is to standardise care and the mechanism used in reaching clinical treatment decisions. Shaban et al<sup>25</sup> suggest that protocols designed to assist paramedics in their

assessment and treatment of the mentally ill are confined by their narrow applicability and as such are not reflective of the broad spectrum of mental health disorders that a paramedic may encounter. It has been suggested that clinical guidelines attempt to oversimplify what are often complex problems and do not provide the single answer that they espouse.<sup>26, p.25</sup>

However, other studies demonstrate that protocols do provide some measure of protection for patients. An American study found that where paramedics relied on protocols to determine the need for patient treatment and transport, they would have transported all but one patient who required further treatment. Where they did not follow their protocols, they grossly under triaged their patients resulting in 21% of patients who required further treatment according to the protocols not being transported to definitive care.<sup>27</sup> Victoria recognised the need to align protocols to the public policy position of ‘least restrictive’ care option when their *Mental Health Act* was amended.<sup>28</sup>

Despite the reliance upon protocols for direction, there is evidence that paramedics struggle to make a determination of capacity in their patients even though it is a vital component of assessing a patient’s mental health status.<sup>29</sup> This issue is not restricted to paramedics. An examination of decisions made by medical personnel with respect to determining a patient’s capacity for the purposes of formalising Guardianship provisions demonstrated a need for improved education for both undergraduate and postgraduate health professionals in making such determinations.<sup>30</sup>

### **Least restrictive option**

A problem with mental health care and treatment decision making is the complexity inherent within the area including not only the legal and ethical issues, but also the clinical issues. In one case, *Hunter Area Health Service & Anor v Presland*,<sup>31, p.37</sup> a psychiatric registrar assessed and discharged a patient from James Fletcher Hospital because he believed that he was not acutely psychotic. Upon his release Mr Presland went home and killed his brother’s girlfriend. He sued the hospital for releasing him too early. Dr Nazarian is not the first doctor to make such an error, and Parker demonstrates that amongst ‘experts’ determining patient capacity, the rate of agreement between two or more experts may be as low as 43.5%.<sup>32</sup> Dr Nazarian defended his actions stating that he believed he had an obligation to place Mr Presland in the ‘least restrictive environment’ available and this was not the hospital.<sup>33</sup> This case is analogous to some experienced by paramedics. Shaban’s research demonstrates that some mental health patients attended by paramedics on a ‘regular’ basis have a “boy-who-cried-wolf” effect on paramedics. Subsequently the paramedics either transport, knowing that it is inappropriate; but believe it is an organisational or legal requirement,<sup>16</sup> or leave the patient at home because they are ‘regulars’ or ‘frequent flyers’ and are known to have a chronic condition.<sup>9</sup> While this decision may be made irrespective of whether the patient wishes to be transported or not, the situation creates the potential to undermine the legitimacy of subsequent mental health cases and also undermine the legal and ethical principles outlined in mental health law and policy.

The issue raised in *Presland* was whether or not the common law duty of care owed by Doctor Nazarian to Mr Presland was incompatible with the *Mental Health Act’s* statutory function. That is, that the doctor would feel that his duty of care to the patient would prevent him from releasing the patient *just in case* something went wrong and the duty was breached. This position would obviously restrict the options available to the doctor and thus promote the notion of defensive medical practice. It would also act to defeat the purpose of the statute, which is to afford the patient the opportunity to be cared for in the least restrictive

environment possible.<sup>33</sup> This policy is in direct conflict with ambulance protocols that deny paramedics the ability to make decisions regarding ‘least restrictive’ patient management options and limit them to transporting patients.

### **Defensive Practice**

The idea that health practitioners make health care decisions based on a fear of litigation is often misguided and results from a lack of understanding of the extent of the health practitioner’s liability. After *Presland*, the NSW government introduced legal reform<sup>32</sup> to provide a practicing ‘professional’ with legal protection against litigation in order to reduce the risk of unnecessary medical intervention, but this reform has been poorly understood within the medical profession.<sup>i</sup>

As such, defensive medicine is still practiced.<sup>29,33</sup> Research has identified the view amongst some paramedics that they believe they are not legally covered to leave patients at the scene rather than transporting them.<sup>34, p.253</sup> In a study conducted by Snooks et al, paramedics suggested that the decision to transport, or not, was influenced by several factors including how busy their shift had been and whether the job occurred close to the end of shift. One officer said,

*The easiest option is always to take them to hospital.*<sup>39</sup>

And another said,

*Management has said they’ll cover us if it fits the protocol. Now it might be only one aspect but, in law, one word means one thing to one person and another to another. You only have to fall over one word.*<sup>39</sup>

**Although this practice may be ethically justified as beneficence – acting for the good of the patient – this position may be misguided because it does not address the legal implications of transporting a patient who may not want or require hospitalisation.** This is defensive practice and costs the health care system time and money and has the potential to impact on the well being of a patient, as it may not offer the opportunity for patients to be cared for in the least restrictive environment.

### **Stuart v Kirkland-Veenstra**

The challenge for practitioners lies between respecting the patient’s right to autonomy and realising the duty of care that paramedics have to their patient’s under the protective jurisdiction of the *Mental Health Act* and at Common Law. In the High Court of Australia case of *Stuart v Kirkland-Veenstra*, Mrs Kirkland-Veenstra brought an action for breach of duty of care against two police officers who had attended her husband on the day he committed suicide, and at which time the officers did not detain Mr Veenstra because they did not believe that he was mentally ill when they saw him.

The officers saw Mr Veenstra sitting in his car in a park with a tube running from the exhaust pipe into the window of the car. Upon interviewing him they discovered that he had been in the car for approximately 2 hours (they noted that the bonnet was cold and they observed no exhaust fumes in the vehicle), that he stated that he was contemplating doing “something

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<sup>i</sup> The term ‘professional’ is not defined in the Act but would be unlikely to include paramedics as they are unregistered health practitioners.

stupid” but did not use the word ‘suicide’. He stated he was in a “loveless” marriage but that he was an intelligent person and that there were other options available to him other than ‘suicide’. The officers stated he was “rational, cooperative and very responsible” and had no apparent “disturbance of thought, perception or mood” but did think that he was “depressed” which Mr Stuart defined as “unhappy” and as such did not consider him to be mentally ill as it is defined under the *Act*.<sup>35</sup> The officers checked the vehicle and found no alcohol, drugs or medication. Mr Veenstra stated that he would visit his doctor later. The officers asked if they could ring his doctor, or a number of other support people and agencies (including the Crisis Assessment Team as per their protocols) however, Mr Veenstra denied this help. Later that same day, Mr Veenstra was found dead, from his own hand, in his vehicle, near his home.

The Court agreed that the police were not expected to make a clinical diagnosis about Mr Veenstra’s mental health status, but should have been able to make a ‘lay persons’ determination as to whether Mr Veenstra was mentally ill as defined under the Victorian *Mental Health Act*.<sup>36</sup> The court also found that in determining that Mr Veenstra was not mentally ill, the officers were right to respect Mr Veenstra’s common law right to refuse assistance and to allow him to determine his own fate. For without reasonable grounds to believe that Mr Veenstra was mentally ill, the officers had no statutory power or duty to detain him and arrange for him to be assessed by a medical practitioner, and further, that the *Mental Health Act* would only permit this action if they had suspected that he was mentally ill. This was a vital piece of evidence on which the case turned. The court upheld the principle of self determination and found that if Mr Veenstra was not mentally ill at the time of deciding to kill himself, then he had a right to make the decision to do so, and for there to be no interference in the carrying out of that right; thus upholding a well recognised common law right for the individual to make decisions over his or her own body.<sup>37</sup>

### **When suicidal ideation is not mental illness**

The High Court noted research which supports the view that a patient who is suicidal is not necessarily mentally ill,<sup>38</sup> Depression is a recognised mental illness according to the DSM-IV, however CJ French stated:

*The fact that a person has decided to commit suicide may indicate deep unhappiness or despair. It does not mean that the person is mentally ill within the meaning of s8 (1A).<sup>44</sup>*

However, this does not mean that all suicidal patients are not mentally ill and herein lay the issues faced by frontline workers such as police and paramedics. Whilst the court determined that police are not expected to make clinical decisions regarding the state of mind of a person, they are still required to determine if the patient meets the criteria and definition of ‘mentally ill’ as outlined in the *Act*.

The same would be true of paramedics, and therefore the outcome would have been equivalent in this case. However, because paramedics make clinical health assessments of patients as part of their daily role, it would be expected that the standard of clinical assessment expected of them would be more advanced than that of the police because paramedics have expertise in health and health assessment, as opposed to the police, who are experts in law enforcement. Across the profession, the standard of care provided by a paramedic is that of the ‘reasonable’ paramedic who would be expected to make a clinical judgement of a patient’s mental health status and determine competence to that standard.<sup>39</sup> The standard of care is determined not only by the peer group, but also by policy, procedure,

protocols and guidelines developed by the industry to inform and instruct paramedics on appropriate care and treatment. It is likely therefore, that paramedics would have an onus to prove that they had undertaken a significant assessment of the patient to determine mental health status and competence to refuse treatment. The case of *Stuart v Kirkland-Veenstra* demonstrated the importance of establishing the existence of two elements before detention of a mentally ill patient can occur. First, the patient must satisfy the definition of being ‘mentally ill’ or ‘mentally disordered’, and secondly, the patient must be at risk of harm to self or others. It is not sufficient to detain a patient based on the assessment of risk of harm to self or others alone, **it must be accompanied by a determination of loss of competence or capacity that demonstrates that a patient is unable to make a legally valid informed choice regarding their actions. This can be accomplished by completing a mental health assessment which covers the criteria outlined in the Act’s definition of ‘mentally ill’ or ‘mentally disordered’.**

But what if the patient had commenced killing himself/herself when paramedics arrive?

### **Doctrine of Necessity**

In the *Stuart vs Kirkland-Veenstra* Appeal case, CJ Warren had stated that he believed that if the patient had already commenced the act of killing himself, the officers would not have argued that it “was reasonable not to intervene”. Such a situation would have led to the patient being incapacitated and therefore not able to give or refuse consent for treatment and thus officers could have acted under the Doctrine of Necessity to save his life. The Doctrine of Necessity is a strongly paternalistic principle that is enshrined in both common law and in legislation under the realm of protective jurisprudence.<sup>ii</sup> Under these laws, emergency care workers can provide care to a patient where it is necessary to:

- (a) save the patient’s life, or
- (b) prevent serious damage to the patient’s health, or
- (c) prevent the patient from suffering or continuing to suffer significant pain or distress.<sup>iii</sup>

This Doctrine can apply outside of an emergency or life-saving treatment, where a patient requires care but is unable to give consent. For instance, where there is a necessity to act when it is not possible to communicate with the patient, and where the action taken is reasonable in all the circumstances and is undertaken in the best interests of the patient irrespective of the cause of their inability to give or refuse consent for treatment.<sup>41,42</sup> If these conditions are met then no legal action should arise as a result of treatment and/or transport being undertaken without the patient’s permission. However, whilst ever the patient was competent to choose to live or die, the choice to do so remained with him and to override that choice would have been both legally and arguably, ethically wrong. This is also the case if there is an advanced care directive or enduring guardianship instrument which outlines the patient’s wishes and intentions.<sup>42-51</sup> It should be noted however, that differences between state *Mental Health Acts* can lead to confusion regarding authority to intervene as some states permit intervention if there is merely a ‘risk of harm to self or others’. This highlights a very real need to determine patient competence in order to avoid infringing on patient autonomy.

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<sup>ii</sup> For example, the *Guardianship Act 1997* (NSW) s37; *Mental Health Acts* and *Child Protection* legislation.

<sup>iii</sup> It should be noted that (c) does not apply in the case of special treatment which may be related to fertility or experimental medical treatment as per the *Guardianship Act 1987* (NSW) s 33.<sup>40</sup>

A reliance upon the Doctrine of Necessity by paramedics may generate complacency, conflict or uncertainty with regard to acknowledging the autonomous choice made by a patient. For example, Steer<sup>52</sup> reports that through his own research, paramedics have difficulty untangling the complexities of the legal and ethical issues surrounding the issue of consent. Many claim that such cases are far more challenging than the most extreme clinical presentation. Steer found that paramedics set assault as their default position rather than risk an intimation of negligence, that is, they transport the patient rather than not ‘*just in case*’. However a solid understanding of bioethics and law can assist in decision making and will help paramedics reconcile the conflict between upholding the autonomous decisions of the patient with the paternalistic protective jurisdiction.<sup>53, p.48;54, p.263</sup>

### **Conclusion**

The move to expand the scope of practice of paramedics is gaining momentum. With this expansion in practice comes the need to be able to function outside of restrictive protocols. Some paramedics have expressed uncertainty as to their legal and ethical obligations with respect to the treatment transport of the mentally ill, and some have cited fear of organisational reprisal if patients are not transported. All of these factors combine to promote defensive paramedical practice and impact on the quality and type of care able to be offered to mental health patients, clinically, legally and ethically. Patient autonomy is of paramount importance, however, it has been recognised that in some circumstances a paternalistic stance may be necessary for the welfare of the patient. It is essential that paramedics are clear about when paternalism can be legally and ethically applied. Paramedics may be encouraged to utilise a ‘shared’ decision making model when they are faced with decisions that invoke a conflict between paternalism and autonomy – a balance between pragmatism and idealism. There is very little research on the way in which paramedics deal with the clinical complexities of mental health assessment and treatment, and even less on the way in which paramedics understand and implement the *Mental Health Act* and the ethical dilemmas it can raise. Further research of paramedics and their application of the *Mental Health Act* is required to more accurately direct educational and organisational resources to ensure paramedics are adequately prepared to deal with these issues.

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