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Feature Article

Mental health nurses: *De facto* police

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ABSTRACT: *This paper examines the consequences for nursing staff and patients when police bring to hospital a person they assess to have a mental illness who exhibits violent or criminal behaviour. In particular, the impact on the nurse–patient relationship and the occupational health and safety of patients and staff is explored. Tensions between the conflicting roles for nurses of controlling the behaviour of this small minority of patients, while providing care and therapy, are examined within the context of health policy, bed shortages, and staffing problems. Recent Australian government and non-government reports are examined to assess the capacity of current health services in the State of New South Wales, to adequately and safely control behaviour while also provide therapeutic care for patients who are seeking help for their mental illness and emotional distress.*

KEY WORDS: *health policy, mental illness, nurses, occupational health and safety, police.*

INTRODUCTION

The title for this paper comes from the report of the New South Wales (NSW) Senate Inquiry into Mental Health Services. Section 3.60 of that report is titled '*De facto* Mental Health Services – NSW Police' and outlines the difficulties police face when implementing their powers under Section 24 of the NSW *Mental Health Act 1990* (Select Committee on Mental Health 2002; p. 29). Section 24 allows the police to take a person suspected of having a mental illness or being mentally disordered to a health facility for assessment if the person is committing or has recently committed an offence, or recently attempted to kill himself or herself or attempted to cause serious bodily harm to himself or herself (NSW Institute of Psychiatry 1998; p. 20).

In their submissions to the Inquiry, both the NSW Police Service and Police Association of NSW were concerned that police were becoming a *de facto* after-hours mental health service. They claimed that 'what was once the institution's mental health problem now becomes a police problem', and were 'alarmed' at the increasing proportion of patients presented by police under Section 24 of the *Mental Health Act 1990* (Select Committee on Mental Health 2002; p. 30). They argued police were being used by Area Health Services 'to ensure occupational, health and safety requirements for hospital staff . . .' because they were required to provide restraint of persons awaiting mental health assessments in health-care settings (Select Committee on Mental Health 2002; p. 235). The police were also frustrated that the lack of security in hospital facilities meant that persons brought in by police could easily abscond from the facility and become a policing problem again (Select Committee on Mental Health 2002). Interestingly, the report overlooked the implications for nursing staff. If police can be described as *de facto* mental health workers, it could be argued that mental health nurses become *de facto* police when they are expected to control the violent behaviour of people presented by police under Section 24 of the *Mental Health Act 1990.*

In recent years, numerous media, government and non-government reports have highlighted the problems inherent when people with a mental illness are inappropriately taken into criminal custody (Butler & Allnutt 2003; Carrick 2001; Council of Social Services 2004; McLeish 2003; Mental Health Coordinating Council 2003; Mitchell 2003). The contraposition when people exhibiting dangerous or criminal behaviour are

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hospitalized instead of being arrested also has problematic consequences. This paper seeks to examine the implications of Section 21 (involuntarily detention in a hospital on the certificate of a general practitioner) and Section 24 of the NSW *Mental Health Act 1990* on the ability of mental health nurses to provide therapeutic nursing care, to practice their professional duty of care to both patients and other staff and maintain their own occupational health and safety.

NURSING RESPONSIBILITIES AND POLICE POWERS UNDER THE NSW *MENTAL HEALTH ACT 1990*

According to the NSW *Mental Health Act 1990* (revised in 1997), a 'mental illness' is defined as a condition, which seriously impairs, either temporarily or permanently, the mental functioning of a person and is characterized by the presence in the person of any one or more of the following symptoms:

(a) delusions
(b) hallucinations
(c) serious disorder of thought form
(d) a severe disturbance of mood
(e) sustained or repeated irrational behaviour indicating the presence of any one or more of the symptoms referred to in paragraphs (a)–(d) (NSW Institute of Psychiatry 1998; p. 3).

In certain instances, people who have a mental illness require involuntary incarceration either for their own proper care or for the protection of others in the community. Section 21 of the Act allows a person to be involuntarily detained in a hospital on the certificate of a doctor. Section 24 of the Act allows the police to take a person suspected of having a mental illness or being mentally disordered to a mental health facility for assessment against their will if:

- The person is committing or has recently committed an offence, or
- The person has recently attempted to kill himself or herself or attempted to cause serious bodily harm to himself or herself.
- It would be beneficial if that person were admitted to a hospital rather than being dealt with under the criminal law (NSW Institute of Psychiatry 1998; p. 20).

Section 24 entails a judgement by police officers as to whether a person who may be about to commit an offence or has committed an offence, should be detained under the criminal justice system or the mental health system. If police deem a person criminally culpable, they are taken into custody, charged and either given bail and released, or kept in custody. If mental illness is subsequently considered a possibility, a mental health professional assesses the person and psychiatric treatment may be commenced in custody (Lamb *et al*. 2002). If, on the other hand, police deem a person to be mentally ill rather than criminally culpable, they are taken to a hospital under Section 24 of the Act and must be examined by a doctor within 12 hours. While the person is waiting for medical assessment, nursing staff have a responsibility to provide nursing care. If on medical assessment the person is found to have a mental illness or is mentally disordered, they may be detained in the health-care facility for compulsory treatment and become known as an 'involuntary patient' or a 'schedule patient'.

A memorandum of understanding between NSW Police and NSW Health Departments provides a framework for applying Sections 21 and 24 of the Act. Fourteen indicators are outlined to assist police when considering whether to refer a person to hospital or to charge them with a criminal offence. These indicators amount to a mental status examination including an assessment of mood, delusions, perceptual distortions, sleep and appetite disturbance, suicidality and behavioural disorganization (NSW Health 1998; pp. 36–37). NSW Police have expressed concern that they do not have adequate knowledge or training to perform this assessment (Mental Health Workers Alliance 2002). The memorandum of understanding also requires police to remain at the health facility until the health assessment is completed 'If the person is considered dangerous', but clarifies

> It is not the role of the police to restrain persons for the purposes of chemical sedation . . . within mental health in-patient facilities security measures should be available to address any situations involving serious threats to staff or patient safety. The involvement of police should only be used as a last resort (NSW Health 1998; p. 14).

When police leave the hospital, the responsibility for controlling behaviour shifts to hospital staff, frequently nursing staff. If the patient poses a threat to staff and patients, hospital staff may either try to restrain the person or allow them to leave the facility. A decision to restrain the patient requires several staff members (five are recommended in hospital policy documents) to hold the person still so that an intramuscular (IM) or intravenous (IV) injection of a rapid action sedative can be administered in dosages large enough to completely subdue the person (NSW Health 2002; p. 116).

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OCCUPATIONAL HEALTH AND SAFETY CONSEQUENCES FOR PATIENTS AND STAFF

The majority of studies on violence in acute mental health settings including emergency departments show a very small number of patients account for nearly all violent incidents (Barber *et al*. 1988; Ferguson & Smith 1996; Kennedy *et al*. 1995; Noble & Rodger 1989; Owen *et al*. 1998a; Owen *et al*. 1998b; Paterson *et al*. 2004). A recent review of the literature on the relationship between violence and mental illness found that violence in psychiatric settings did not necessarily result from the mental illness or even specific symptoms per se, as much as from the patients reaction to "the experience of admission . . . unwitting provocation by other patients or staff . . . lack of activities and staff patients interactions . . . or restrictions on liberty . . . " (Paterson *et al*. 2004; p. 42). The risk of violence was significantly increased when alcohol and other drugs were present (Paterson *et al*. 2004). Owen *et al*. (1998a, 1998b) in their American study of 1289 violent incidents recorded in five acute psychiatric settings over a 7-month period, found the majority of serious violent incidents (78%) were directed towards nursing staff and 18% were directed against fellow patients. Nurses responded to nearly all these serious incidents (99%) whereas police were involved in only 0.07% or five incidents.

Delaney *et al*. (1999) explored the incidence of violence against nursing staff in four psychiatric inpatient facilities in the State of NSW in Australia. They conducted both a survey and focus groups for all registered nurses working in these units to determine incidents of assault and injury. A random sample of 60 aggressive incident forms and corresponding patient files were also analysed. Information from the document review indicated that 12% of violent incidents occurred during the day of admission while the majority (52%) occurred between 1 and 5 days after admission. The response rate for the 95 surveys distributed was 62%. Eighty-eight per cent ($n = 52$) of nurses stated they had been assaulted, 37% of these assaults were within the previous 6 months. Seventy-three per cent of those who had experienced assault stated they had sustained physical and/or psychological trauma as a result of the incident. Ninety-seven per cent of patients who assaulted staff were involuntary patients (Delaney *et al*. 1999; p. 22).

Tragically, in NSW for the 3 years from 2000 to 2003, two mental health patients were murdered in facilities by other patients; there were eight suicide deaths of patients, and eight homicides were perpetrated by patients in contact with mental health services (NSW Mental Health Sentinel Events Review Committee 2003; p. v). Assaults on nurses working in mental health facilities include physical injuries such as broken noses, broken jaws, concussion, neck injuries, severe bruising, hearing loss, and weapons injuries (e.g. stabbing), as well as the concomitant psychological trauma both for the victims and for those witnessing the attacks (NSW Nurses Association 2002).

MENTAL HEALTH POLICY, BED SHORTAGES, AND STAFFING PROBLEMS

Government policy, lack of resources, bed shortages, and staffing problems compound this problem. The policy of 'mainstreaming' or re-locating mental health services within general health services has meant people with mental health problems are frequently admitted via general hospital emergency departments. The NSW *Mental Health Act 1990* does not require people whose behaviour is considered dangerous to be separated from other patients in the hospital environment. Emergency departments are known for their chaotic, stressful environments, long delays before medical assessment and treatment, and are not conducive for calming patients with problematic behaviour and/or mental illnesses.

The NSW Mental Health Sentinel Events Review Committee (2003) noted that the overall number of mental health beds had reduced in the last decade at the same time as demand had increased. If a bed is not available within the psychiatric ward, the patient brought to the hospital by police either remains in emergency or is admitted to a general ward until a bed becomes available. A survey of mental health nurses and doctors in NSW indicated that sometimes patients with a mental illness were kept in emergency departments for 5 days or more because of bed shortages. Prematurely discharging patients was the usual way of dealing with the bed shortage when the demand for beds was high (Mental Health Workers Alliance 2002). The National Association of Practicing Psychiatrists in their submission to the NSW Senate Inquiry into Mental Health Services explained it was not possible to keep patients in hospital long enough to ensure their illness had stabilized. Their submission asserted, 'Early discharge of patients in the acute phase of psychotic illness is now routine' (Select Committee on Mental Health 2002; p. 44).

A serious shortage of psychiatrists in the public health sector and problems in retaining and recruiting expert mental health nurses compound this problem. Nearly half of the mental health nursing workforce in Australia do not have specialist skills in mental health nursing (Australian

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Medical Workforce Advisory Committee 1999; p. 7; Commonwealth Department of Education, Science and Training 2002; Commonwealth Department of Health Services and Training 2001; Select Committee on Mental Health 2002). The NSW Mental Health Sentinel Events Review Committee (2003) noted that levels of staffing commensurate with the level of identified risk were not always available for patients on admission. The report continued:

> . . . the risk to the general public is higher, the risk to the patient is higher, the risk to the mental health clinician is higher, and the risk to Area Health Management being held responsible for not supplying the responsible level of care is also higher. (NSW Mental Health Sentinel Events Review Committee 2003; p. vi)

CONSEQUENCES FOR MENTAL HEALTH NURSING PRACTICE AND THE NURSE–PATIENT RELATIONSHIP

The impact of potential violence and criminal behaviour on the ward atmosphere, therapeutic relationships, and staff morale is considerable. The capacity for staff and patients to feel safe, to build trust and rapport, and to develop a therapeutic alliance may be seriously hindered. Other patients and their families may become distressed and frightened and similarly may have difficulty in forming a trusting and therapeutic alliance in an environment where they no longer feel safe. Reports from government, consumer and non-government organizations in Australia continue to confirm that patients with a mental illness frequently report feeling unsafe in hospital, are frequently critical of mental health nursing care, and find many mental health settings unhelpful and non-therapeutic (Human Rights and Equal Opportunity Commission 1993; Mental Health Council of Australia 2000; 2005; Select Committee on Mental Health 2002).

The dilemma for mental health nurses is the inherent contradiction within their role. On the one hand, ethical and professional guidelines state that mental health nurses are accountable for their clinical practice, should provide therapeutic care in the least restrictive environment, and include a duty of care to both staff and patient safety. On the other hand, under current legislation, mental health nurses are expected to enforce the detention of involuntary patients and control violent behaviour in hospital environments not necessarily conducive to managing extreme behavioural problems. Striking a balance between these contradictory roles is less problematic in adequately resourced, secure, and specialized environments where highly qualified staff can creatively formulate custody and control as part of therapy and care. Staff shortages and consequent problems in maintaining close supervision, preventing absconding, and ensuring the safety of staff, the individual patient and other patients, impair the ability of the mental health nurse to control possible violent behaviour and provide therapeutic care. In a minimally resourced environment, there are few options available to nursing and medical staff other than increasing chemical sedation (Delaney *et al*. 1999; Owen *et al*. 1998b).

The capacity of current health-care services to adequately and safely control patient behaviour is being questioned. The NSW Mental Health Sentinel Events Review Committee (2003) notes a lack of adequate hospital security, inadequate access to qualified and experienced senior psychiatric and mental health nursing staff, and poor communication in relation to transfer of care as increasing the risk of violence in health-care settings. The report recommends that all patients presenting to health services require immediate mental health assessment and that those deemed high-risk should not be managed in a non-psychiatric ward (NSW Mental Health Sentinel Events Review Committee 2003; pp. xvii, 65, 66, 76). Recognition of the need to separate and provide specialized care for patients who exhibit behavioural problems has resulted in the recommendation in 2002 from the NSW Senate Inquiry into Mental Health Services, that '*as a matter of urgency*' (emphasis added) the NSW Minister for Health construct maximum and medium security forensic mental health units in the community (outside prison) following the same model as the Thomas Embling Hospital in the State of Victoria, where patients are referred to the hospital through the courts, public mental health services, the police, and the prison system and justice agencies (Select Committee on Mental Health 2002; p. 268). To date, the recommendation has not been implemented; however, in an attempt to partially address these concerns, Psychiatric Emergency Care Centers have recently been established to provide mental health nursing care for people with problematic behaviour in some NSW emergency departments (Wong 2006; p. 11).

CONCLUSION

The NSW *Mental Health Act 1990* sets up complex and contradictory roles for front line workers such as police and nurses. In the current under-resourced environment, it is unreasonable to expect mental health nurses and other hospital staff to manage increasing incidents of violence unless they have recourse to specialist units designed for the purpose and specialist mental health staff

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with skills in managing antisocial behaviour that may or may not be triggered by mental illness.

Research cited in this paper shows it is a very small cohort of people with mental illness that exhibit potentially criminal behaviour through violent acts, that nursing staff are the most frequent victims of this violence, that the majority of these patients are involuntary, and that violent behaviour most frequently occurs either on the day of or within the first 5 days of admission to hospital. These facts indicate there is an urgent need to separate this small cohort of violent patients from other patients and staff in both general hospital settings and acute mental health units.

The vast majority of patients and their families who are seeking help for their mental illness and emotional distress rightfully expect the hospital and nursing staff to provide a therapeutic environment that is respectful of their needs, is peaceful and safe, and is conducive to providing therapeutic nursing care. They should not feel threatened and frightened by witnessing potential or actual violence, criminal behaviour, or attempts by nursing staff to enforce the detention of involuntary patients in hospital environments not conducive to this function. Nursing staff do not wish to hold the same level of power and authority for controlling behaviour as the police, and mental health nurses and other health-care staff should not be required to act as *de-facto* police officers to control violent and/or criminal behaviour in health-care settings.

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