Case Report

Detention of patients in rural hospitals: Can we hold the patient awaiting transfer to a psychiatric facility?

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INTRODUCTION

Physicians working in rural hospitals are frequently the frontline care providers for mental health in their communities. When a patient is deemed a risk to self or others, they require transfer to a psychiatric facility to be assessed by a psychiatrist. Unfortunately, those transfers may be delayed due to congested patient flow at accepted facilities or limiting transport factors, such as weather or resources.[1] There are misconceptions and areas of legal ambiguity around the legal mechanisms that allow for such patients to be detained in these situations. Understanding what the law currently allows for is important for family physicians to be able to appropriately inform patients of their rights, as well as to mitigate the medico-legal risk posed by these situations.

CASE REPORT

A 28-year-old female presented to a rural emergency department following an intentional overdose of venlafaxine. The patient had a history of major depressive disorder and had presented during an acute situational crisis after having an argument with a family member. At the time of her presentation, the patient was deemed at risk to herself and the patient was placed on a Form 1 under Section 15(1) of Ontario's Mental Health Act (MHA)[2] by the emergency physician. She was admitted later that day to the intensive care unit for the management of her overdose and to await transfer to the Schedule 1 psychiatric facility. During her stay, the patient's most responsible physician completed two subsequent Form 1 documents, separated by 72 h, and after 7 days, the patient was accepted at a psychiatric facility outside of the associated referral hospital due to congestion at the designated psychiatric facility. The patient spent 7 days in the community hospital awaiting transfer.

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DISCUSSION

This case presents the challenging but not uncommon situation of a patient in a community hospital who meets Form 1 criteria to be transferred to a psychiatric facility for assessment but for whom transfer is delayed by the receiving facility. As described in the Ontario Hospital Association (OHA) publication 'A Practical Guide to Mental Health', the Form 1 allows for detention of patients in a psychiatric facility but does not give specific grounds for detaining patients in the community hospital. [3] The guide clearly states that 'Public hospitals that are not designated psychiatric facilities do not have the authority to detain a person under the MHA'. Instead, the ability to detain a patient in a community hospital while awaiting transfer to the psychiatric facility comes from common law. This common law duty is further supported in the Health Care Consent Act (HCCA) that explicitly states that the HCCA 'does not affect the common law duty of a caregiver to restrain or confine a person when immediate action is necessary to prevent serious bodily harm to the person or to others'.[4]

Ontario is not unique in that the detention of patients in community hospitals for mental health reasons takes place under a common law duty rather than an explicit statute. A review of other provinces' MHAs, or equivalent legislation conducted for this case report, confirmed that all other provinces, with the exception of Quebec, rely on the common law duty for detention in community hospitals before transfer to a psychiatric hospital. Quebec's judicial system is regulated by the Civil Code of Quebec, but the detention in community hospitals ends up being similar to the common law duty of the other provinces.

Physicians practising in Canadian community hospitals are placed in a difficult position when psychiatric facilities are not immediately able to accept these patients. While there is no explicit limit on how long the common law duty can be used to detain a patient in Ontario, the OHA guide advises that it should be 'confined in time to the immediate emergency and that it cannot be extended indefinitely'. In addition, the MHA[1] dictates that the transfer from the community hospital to the psychiatric facility for someone placed on a Form 1 must happen 'forthwith', which case law has suggested means 'as soon as reasonably possible'.[3]

It is important for community hospital physicians in this situation to understand that their ability to detain the patient in their facility comes from common law and not the MHA and that, therefore, the 72-h time limit for the assessment of a patient on a Form 1 does not apply. The Form 1 is not providing the grounds for holding the patient in the community hospital but is documenting the patient's need and requirements under the MHA for transfer to and assessment at a psychiatric facility. If the situation changes and the patient no longer meets the requirement for detention in the community hospital by common law, the physician has no legal authority to detain the patient.

Knowing that, in our current hospital environment, there will often be delays in psychiatric facilities accepting transfers from community hospitals, there should be legislative measures to dictate a formal mechanism under which patients who meet Form 1 criteria and common law duty can be held in community hospitals awaiting transfer. This would better protect the rights of patients by clarifying what their rights are to challenge their detention in the community hospitals and what physicians' obligations are in terms of on-going assessment and efforts to expedite transfer. Community hospitals should also consider engaging with their psychiatric referral centres about policies to expedite the transfer for these patients.

CONCLUSION

As things stand now, physicians who detain patients who have met criteria for a Form 1 in community hospitals must be aware that their ability to detain them is from common law and not the Form 1 itself. When situations arise where transfer is delayed, the sending physicians should engage with any available psychiatric facility and should carefully document their efforts to facilitate immediate transfer.

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