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ORIGINAL RESEARCH

Supporting equitable care of patients transferred from police watch-houses to the emergency department: A qualitative study of the perspectives of emergency doctors

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Abstract

Objective: People detained in short-term police custody often have complex health conditions that may necessitate emergency care, yet little is known about their management in EDs. The present study aimed to understand ED doctors' experiences and perceptions regarding the appropriateness and management of detainee transfers from police watch-houses to the EDs.

Methods: A qualitative descriptive study, using semi-structured interviews undertaken with ED doctors working in five purposively sampled EDs across Queensland, Australia. Data were analysed using inductive content analysis.

Results: Fifteen ED specialists and trainees participated. Participants reported that their overarching approach was to provide equitable care for watch-house detainees, as they would for any patient. This equitable approach needed to be responsive to complicating factors common to this population, including presence of police guards; restraints; complexity (physical/mental/social) of presentation; reliance on police to transport; ED doctors' often limited understanding of the watch-house environment; justice processes and uncertain legal disposition; communication with the watch-house; and detainees misreporting symptoms. Thresholds for assessment and treatment of detainees were contextualised to the needs of the patient, ED environment, and imperatives of other relevant agencies (e.g. police). Participants often relied on existing strategies to deliver quality care despite challenges, but also identified a need for additional strategies, including education for ED staff; improved communication with watch-houses; standardised paperwork; extended models of watch-house healthcare; and integrated medical records.

Conclusions: Providing equitable healthcare to patients transported from watch-houses to the EDs is

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challenging but essential. Numerous opportunities exist to enhance the delivery of optimal care for this underserved population.

Key words: *custody, emergency department, equity, police, qualitative.*

Key findings

- Emergency doctors caring for detainees from police watch-houses use an equitable approach that is responsive to circumstances common to this population, including the presence of police guards; requirement for restraints; and complex presentations.
- Emergency doctors reported successfully using various existing strategies to respond to detainee circumstances, but also identified gaps and suggested additional strategies.
- Enhancing quality and continuity of care for this population requires improved communication, shared electronic health records, and a better mutual understanding of the watch-house and ED environments.

Introduction

In Australia, police 'watch-houses' are custodial facilities designed for short-term detention: overnight or for 24 hours or longer.[1] People detained in watch-houses (i.e. detainees), might be under arrest awaiting charges or court outcome (remand or bail), or temporarily transferred from prison for a court appearance.[2] Detainees may experience acute health problems that require transfer to an ED, especially related to alcohol or other drugs, injury, chest pain, mental health problems, altered level of consciousness, diabetes, or seizures.[3,4]

Equitable healthcare for detainees is a requirement in the UN Mandela Rules,[5] but there are many challenges to healthcare provision in custodial settings. Unlike for prisons,[6–9] there is little public information on healthcare needs or healthcare provision in watch-houses. Of the limited research that does exist, it is evident that watch-houses have varying structures and processes underpinning healthcare approaches, and transfer to the ED is common.[2,10–12] Although it has been estimated that people brought in by police (inclusive of watch-house transfers) account for less than 1% of Australian ED presentations,[3,13] this population warrants attention as it is highly vulnerable, complex, and reliant on police services for access to care.[2,4]

Some research on the provision of healthcare in short-term custody settings has been completed internationally,[11,12,14,15] but there is a paucity of information about the management of detainees once transferred to the ED.[4,16] The present study aimed to understand ED doctors' perceptions of the appropriateness of detainee transfers from police watch-houses to the ED, and to explore their experiences and perceptions of management of detainees in the ED.

Methods

Design, sample and setting

The present study used a qualitative descriptive design.[17] A purposive sample[18,19] of ED physicians and trainees working in five EDs (two metropolitan, two regional and one rural/remote) in Queensland, Australia was recruited. Medical officers who had informed healthcare management decisions in the ED for at least one watch-house detainee in the past 12 months were eligible to participate.

Data collection and analysis

Data were collected using semi-structured interviews undertaken by CB and JC between April and November 2021. Interview questions were developed by the research team and piloted with one of the ED specialists on the research team (see Appendix S1 for interview guide). Interviews ranged from 20 to 40 min, and were audio recorded and transcribed verbatim. Data analysis was performed by a single researcher (CB) using inductive content analysis with the conventional approach, in which codes are derived from the data then organised into categories and themes.[20] Discussion of the various iterations of the coding framework and emerging themes with the other interviewer (JC) and broader research team assisted with the refinement of themes. The study is reported in accordance with the consolidated criteria for reporting qualitative research (CORE-Q,[21] see Appendix S2).

Ethics approval

Ethics approval was received from health service (HREC/2020/QGC/63816) and university (GU2020/645) Human Research Ethics Committees, and relevant site approvals from each health service, Queensland Police Service, and Queensland Ambulance Service. Participants provided informed, written consent.

Results

Fifteen doctors (eight female, seven male) were interviewed. Eight were emergency medicine specialists (i.e. Fellow of the Australasian College of Emergency Medicine [FACEM]) and seven were trainees. The median age of ED specialist doctors was 40 years (IQR: 39–42.5), median years working as a doctor was 14 (IQR: 11.5–18), and median years in their current role was 3 (IQR: 2–6). The median age of trainee doctors was 32 years (IQR: 28.5–37.5), median years working as a doctor was 5 (IQR: 4–5.5), and median years in their current role was 4 (IQR: 2.5–5). Analysis resulted in seven themes: one on participants' views on the appropriateness of detainee transfers to the ED, and six related to participants' experiences and perceptions of management of detainees once in the ED. Each theme is elaborated on below, with exemplar quotes for theme 1 provided in Table 1; for themes 2, 3, 4, 5 and 7 in Table 2; and for theme 6 in Table 3. A map of the latter six themes is shown in Figure 1.

TABLE 1. *Exemplar participant quotes associated with Theme 1: appropriateness of transfers*

1. Appropriateness of transfers
   - 'I personally don't see a lot of transfers from the watch-house that seemed inappropriate. I think it's better that they come and get assessed and then we can always discharge them back there when we're happy with things' (Dr 3)
   - 'I've never had an inappropriate transfer- they're all so high risk' (Dr 10)
   - 'I think the police are in a hard place. I don't think we should expect police to make medical decisions to be honest. So I don't think we should be harsh on them for bringing stuff in' (Dr 14)
   - 'We would see patients with far less concerning symptoms from the community all the time' (Dr 2)
   - 'I feel that the watch-house staff probably should have a low threshold for transferring in all honesty and patients that come in, while we might go, they probably didn't really need to be here, as we do unfortunately with a lot of ED presentations. In my mind it's better to be safer and have a much lower threshold to bring somebody in so we can assess them and make a decision' (Dr 7)

Theme 1: appropriateness of transfers

Participants generally considered detainee transfers from watch-houses to the ED to be appropriate, given the lack of medical training of police, limited in-house healthcare access, complexity of the patients and potential consequences of inaction (Table 1).

Theme 2: baseline approach of equity

All participants were consistent in saying that they did not assess or treat detainees differently to any other patient. When explored further, this approach was more akin to equity than equality, in which the particular circumstances of detainees informed justifiable variations in care.

Theme 3: particular circumstances of detainees that may impact management in the ED

Participants noted a number of circumstances unique or common to detainees that could influence management in the ED setting.

Police guard

Participants felt that detainee care in the ED could be both positively and negatively impacted by the presence of mandatory police guards (usually two police officers).

Many participants felt that police presence impacted detainee privacy, sometimes hampering information-gathering needed for medical assessment. Other negative impacts were that police could take up extra room, and distress other patients in the ED, including patients with mental health-related problems. These were considered minor issues in the overall ED context.

Participants reported sometimes using the police guard's knowledge to add useful collateral information about the lead-up to the detainee's ED presentation, but emphasised that they were conscious that this information may be biased, incomplete, or second-hand. The police guard was also seen as a useful extra security resource. Similarly, in some cases participants felt that the rapport the police had established with detainees was useful for behaviour management. Participants reported that in regional/rural locations, police may even be well-acquainted with some detainees and able to provide helpful information to inform care.

Restraints

Detainees are required to wear restraints (usually handcuffs and sometimes leg chains) while in the ED. Participants felt that most of the time these restraints did not hinder a normal assessment, but may occasionally need to be removed for specific examinations. Some participants also spoke about removing handcuffs (in some situations) to facilitate building rapport and support the patient's dignity.

Limited understanding of watch-house environment

Detainees are (typically) discharged back to the watch-house. Participants usually had a limited understanding of the watch-house environment, including uncertainty about what healthcare was available onsite, the role of Forensic Medical Officers (or other medical staff supporting the watch-house), access to other specialists, and how medical follow-up post detention could be facilitated. Participants also had limited knowledge of how police make decisions regarding healthcare/transfer, and about the watch-house environment in general (e.g. access to bathroom/shower, cell capacity), which could be important for discharge planning.

Justice process and uncertain legal disposition

Participants felt that the lack of predictability of 'legal disposition' (i.e. how long the detainee would be in the watch-house, and where they were going afterwards [prison or released]), as well as other elements of the justice process, could impact care and discharge planning.

Reliance on police to access care

Detainees are dependent on police for healthcare access and transport to the ED. Participants expressed that this was a key concern in discharge planning, as it may be difficult (for the detainee, if released) or resource-intensive (for police) if a

TABLE 2. *Exemplar participant quotes associated with Themes 2, 3, 4, 5 & 7*

2. Baseline approach of equity

- 'My approach really is no different to any other patient… We have to treat everyone with the same quality of care' (Dr 1)
- 'I treat the detainee in the same way that I'd treat a non-detainee' (Dr 2)
- 'I again advocate treating everyone the same and basing on triage need and clinical need' (Dr 2)
- 'The fundamental principles of being a doctor are…to provide equal health care for all to the extent that we can' (Dr 2)
- 'I just treat them as any other patient to be honest' (Dr 15)

3. Particular circumstances of detainees that may impact management in the ED

Police guard	• 'The patient doesn't really want to tell you much information 'cause they've got the police sitting there next to you. So it's really hard to get a detailed history' (Dr 7) • 'I was getting second hand information- the guards that were with me weren't the ones that had seen what happened' (Dr 7) • 'I see them as an extra sort of safety net…if the patient is abusive…they've been with the patient a while and have developed a bit of a rapport with them' (Dr 3)
Restraints	• 'You can actually do quite a good examination with the cuffs on. It's just really that specific type examination' (Dr 5) • 'Seeing if they are safe to come out of their restraints so we can at least try to gain some sort of rapport with the patient for one and also facilitate investigations and assessments' (Dr 3)
Limited understanding of watch-house environment	• 'Really we're clearing these people, or we're saying these people are stable to send them into a place that we have absolutely no idea of what can be [provided], how they can be cared for' (Dr 8) • 'Most people should transition into someone else's care, be that into a specialist team or back to their GP…I'm not 100% what people go back to' (Dr 6)
Reliance on police to access care	• '[Detainees] haven't got the freedom to then call up their own liver specialist or their own GPs and say I need this, I need that. They're reliant on other people to do such things' (Dr 11) • 'I would have a lower threshold both for admission to the ward and for keeping in the ED because your follow up plans change based on how likely the patient is to come back…It's not fair to then ask the police to, or the prison or whoever, to bring them back' (Dr 5)
Justice process and uncertain legal disposition	• 'What's always challenging is that follow up. So often we'd like to see these people after they've got an injury, 48 h later, but we don't know if they're still going to be in the watch-house, we don't know if they're going to be transferred to [prison in a town hours away]' (Dr 11)
Communication with watch-house	• 'It's really hit and miss as to whether you get actual written information, sometimes it's non-existent, and so that makes it really hard' (Dr 7) • 'You gotta go through switch [to talk to the watch-house] and then you go this person, and this person you get has probably been on a shift handover and has no idea what's gone on…sometimes you don't get any more information by the time you spend 20 min getting hold of this person' (Dr 7)
Complex presentation	• 'The level of illness of their detainees is extreme. They've basically all got chronic disease' (Dr 10) • 'They're all high risk! Whatever has happened to lead them to be in custody, will have its own risks and some of that demographic will be health literate and some won't be, and they'll have other medical comorbidities, so I would view all of them as a vulnerable population' (Dr 5)
Misreporting of symptoms	• 'Sometimes with this population group they're not very forthcoming with the correct information, or you feel sometimes you're being misled with information, so it's a little bit difficult to interpret the situation' (Dr 3) • 'They were only really in there with the complaint because they were concerned that they were having their court hearing the following day, and this was probably a way for them to get around attending that' (Dr 7)

TABLE 2. *Continued*

4. Existing strategies that support equitable care	
General strategies	• 'In the ED that's just the nature of the beast isn't it? You get patients that come in that you don't know what their history is and you just have to treat based on what the person's in with' (Dr 7) • 'We have lots of problems and we have lots of patients, and so from an ED perspective, they are another patient' (Dr 6) • 'I just treated them like normal so same quality of care, same approach to chest pain, same questions but they seemed a bit, little bit intoxicated so their responses weren't that clear. But again we have so many patients like that anyway, so we just did the normal history exam' (Dr 1) • 'It's just the nature of ED these days is serving vulnerable populations…its just a necessary- I mean who else is going to do it?' (Dr 9)
Communication with police	• 'I normally ask if it's OK for the handcuffs to be removed. I understand that the person's in detention, but for the purpose of a medical assessment…100% of the time when I've asked for them [restraints] to be removed, they [the police] have always taken them off' (Dr 2) • 'Things that are going through my mind are is this a patient that I can ask the police to at least step a little bit away so that I can ask questions that I know they're not going to answer accurately with that person standing there' (Dr 7) • 'The police officers here actually do a truly superb job…I do think they are in an incredibly difficult position because they have [responsibility for] the most medically vulnerable people' (Dr 11)
Other	• 'My question on discharge and follow up is, are you still going to be [in the watch-house] because I need to organise these tests for you' (Dr 15) • 'They can't go to ambulatory care, because there isn't enough space for them and the police officers who are bringing them in. So they go to usually a bed space' (Dr 15)
5. Gaps and risk of inequitable care	
Continuity of care	• 'Most people should transition into someone else's care, be that into a specialist team or back to their GP…I'm not 100% what people go back to' (Dr 6)
Information sharing	• 'The level of communication- you know its that Chinese whispers issue- the information just doesn't flow through from department to department. I mean, to be honest, it's bad enough in the hospital sometimes, let alone across different services' (Dr 7)
Watch-house healthcare services	• 'If it was a 24 h nurse [in the watch-house]…And it would also make a difference whether she was a Registered Nurse and what kind of training that she had. Whether she's got the ability to do observations' (Dr 12)
7. Outcome of equitable care	
Thresholds for assessment and treatment	• 'So two patients, one's going home one's not, then I would possibly keep the custody patient overnight when I wouldn't have otherwise… maybe doing extra testing [as well]' (Dr 5) • 'My assumption and my understanding is that there's minimal medical care, and they have to be at a community level discharge and also well enough that they shouldn't need to have to re-attend hospital within an acute period…'cause I know there's going to be a delay from them getting recognised as unwell to getting to hospital' (Dr 9) • 'Sometimes…it's a benefit for them being in custody because they've got someone to keep an eye on them…in some ways it's a safety net, which makes it easier for us and we know they're probably going to take their medication' (Dr 4) • 'You try and get the testing done all at once…so they're x-rayed earlier, they get CTed earlier, more blood tests are probably done as a result, but that applies

(*Continues*)

TABLE 2. *Continued*

	exactly the same as someone on a [cattle] station…three hours away [who would have difficulty re-presenting]' (Dr 10)
Impact on police resources	• 'I feel like you might have a lower threshold to have them admitted, but then on the other hand, sometimes I feel like I'm swayed the other way that if I think they would manage more in the watch-house…You'll have a nurse there keeping an eye on you, you can get your two QPS officers back to doing other things…I try not to let their presence of them being in detention sway it, but sometimes it probably does…Verse if he was- that same situation living alone and then just bring him for observation wouldn't take up all those other resources, so it probably does sway you in some situations. Just thinking about a resource allocation' (Dr 3) • 'The poor police have to sit there for 100 years while changing shifts, but obviously we try to get them back if we can' (Dr 14)
Level of comfort with equitable approach	• 'I think I provided the same care that I would provide to any other patient. If anything I provided more investigation based on the specific circumstances of that patient being a detainee' (Dr 2) • 'The person who might be quite behaviourally challenging on the ward, have lots of code Black's and get a lot of resources involved. So you'd want to have a good reason for them to be in hospital. Does that makes sense? Does that sound bad?' (Dr 3) • 'If I'm totally honest in my personal practice I probably tend to over-investigate…if they don't meet the Ottowa ankle criteria for an x-ray…I would probably x-ray 100% of the watch-house people' (Dr 11)

detainee needed to re-present to the ED.

Communication with watch-house

Participants reported rarely receiving written information from the watch-house, and were sometimes unsure about how to best prepare discharge information so that it could be used by watch-house staff to support continuity of care. Participants seldom felt that they needed a direct line of communication with the watch-house, but described not knowing how or who to contact when they did.

Complex presentation

Participants highlighted factors more common in the detainee population that meant they were often more complex than most other ED presenters. These factors included poor overall health, acute intoxication, aggression/mental health issues, addiction, poor health literacy, and status as a vulnerable population and/or Indigenous Australian.

Misreporting of symptoms

Participants perceived that some detainees were motivated to under-report or over-report health issues in order to be transferred to and/or stay in the hospital rather than returning to the watch-house. Other perceived impediments to disclosure included mistrust of authority, presence of police guard, drug-seeking, avoiding court appearance, and evading criminal charges (e.g. for drug activity).

Theme 4: existing strategies that support equitable care

General strategies

Participants stated that in the ED context, many of the aforementioned circumstances were not unique to detainees, although they were considered more common and more frequently co-occurring in this population. ED doctors noted that they routinely encountered people: brought in by police/in restraints, exhibiting behavioural disturbances, with unknown medical histories, with potential legal implications, who misreport/provide biased information, and who require communication regarding their care needs with another institution (e.g. nursing home, prison). Because of their familiarity in managing these issues, participants reported they were often able to use their existing skills and strategies to mitigate negative impacts and ensure equitable, person-centred care while the detainee was in the ED.

Communication with police

One specific strategy that participants considered important for mitigating a number of challenges for providing care to detainees was communication with police. Participants described good teamwork with police, in which they respected each other's role and needs. Participants spoke positively about strategies such as asking police guards to: provide information on the detainees' presentation, legal disposition, or the watch-house environment in general; make contact with the watch-house; remove restraints; and step away for

TABLE 3. *Exemplar participant quotes associated with Theme 6: Suggested strategies to support equitable care of watch-house detainees in the ED*

Suggested strategy	Exemplar quote	Description
Education for ED staff	'Key would be [education on] what is a watch-house? What facilities do they have there? How are they observed and what's the level of training of these people observing them' (Dr 7)	Many participants felt brief education (1 h, 2–4 times/year) for ED staff would be an appropriate target for improving emergency doctors' knowledge of the watch-house context, and improving care. Suggested content of education included the topics: Detainees: • General profile of detainees (e.g. complexity/social determinants); • How long detainees are typically in the watch-house. Watch-house structures: • Purpose and function of watch-house; • What are the facilities for detainees in the watch-house (e.g. sleeping, toileting, showering arrangements, how many people to a cell); • Availability of healthcare in the watch-house (e.g. personnel, level of training, hours of availability, facilities/equipment). Watch-house processes: • Nature of police observation of detainees (e.g. how frequently, what kind of observation [in-person, on camera], how open/visible are the cells); • How health screening is undertaken for detainees; • What are the triggers for police to access healthcare. ED structures: • Understanding the term 'fit for custody' and associated forms; • Understanding rules around use of restraints in the ED. ED processes: • Optimal methods of communicating with watch-house; What information needs to be in patient discharge letters; • Information about how follow up care can be arranged (e.g. fracture clinic, specialist referral, GP).

(*Continues*)

TABLE 3. *Continued*

Suggested strategy	Exemplar quote	Description
Improved communication with the watch-house	'It's always good to have an open line of communication or know who to call and who is referring them because you'll get way more information' (Dr 3)	Participants felt that accessible contact numbers for the watch-house nurse or officer-in-charge would be useful to overcome communication challenges. Some participants also spoke about the idea of a better liaison in general between the hospital and watch-house (e.g. regular meetings).
Standardised paperwork	'What would be really useful is having like a transfer sheet or transfer information filled in by the watch-house officers' (Dr 7)	Some participants stated that receiving incoming paperwork, in addition to the standard paramedic paperwork if they were transported by ambulance, would be useful. However, others felt that they were used to working with limited information and that additional paperwork was likely to get lost. Some participants felt it would help to have some standardised discharge paperwork, or suggested changes to existing proformas in regions where this already existed.
Extended models of watch-house healthcare	'I would love to see better health care services provided to people in custodial care…it would be far better if they could be managed in place. It's safer for them, it's cheaper for everybody…its less disruptive for the person' (Dr 6)	Participants in the two regions with a health-service employed watch-house nurse felt that this was a successful model, and generally reported better understanding of and communication with their local watch-house, but suggested that hours be expanded. Participants in regions that had a community nurse or no nurse desired a watch-house based nurse. Participants had mixed opinions about the utility of other models of care, like tele-health, medical officers in the watch-house, or more health training of watch-house staff. Some participants also felt that custody in the watch-house was an opportunity for expanded public health outreach for a population of medically vulnerable people who may not regularly access healthcare.
Integrated medical records	'The key to detainee healthcare here is the integration of their health records from various sites' (Dr 10)	A few participants spoke about the usefulness of having electronic access to integrated medical records. One noted that this worked well for sites which used nurses from the local health service, as they had better access to health service records than community nurses.

TABLE 3. *Continued*

Suggested strategy	Exemplar quote	Description
Ongoing challenges	'Developing rapport, getting a reliable history can be difficult if there's already reasons not to trust the system' (Dr 6) '[Detainees are] a sub-demographic of a demographic that's already vulnerable, that is already in a demographic that's complicated that meets with a lot of resistance from medical and nursing' (Dr 5)	Participants outlined some ongoing challenges to detainee healthcare that would be more complex to address.

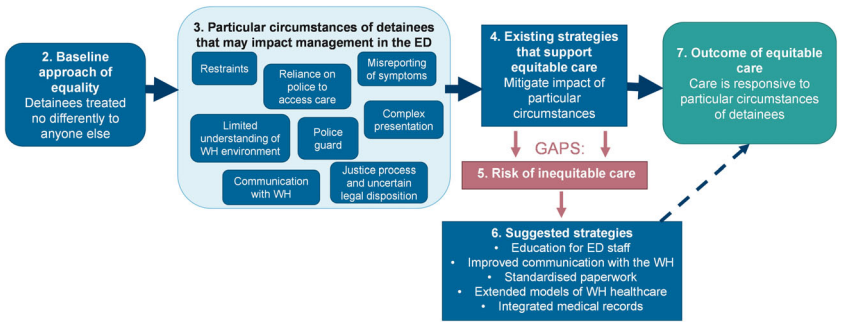

Figure 1. *A thematic map of themes 2–7. WH, watch-house.*

privacy during assessment. Participants noted the importance of remaining aware of limitations of the police's role and associated security risks when using these strategies. Participants also tried to mitigate impacts on police resources by expediting care where possible, and updating police about timelines.

Other strategies

Other specific existing strategies included asking the detainee themselves about their likely legal disposition, and detainees waiting or being seen in a different area than usual if space or other patients were an issue.

Theme 5: gaps and risk of inequitable care

Participants identified some gaps in existing strategies to support the outcome of equitable care provision to detainees.

Continuity of care

The most commonly mentioned gap was the challenge of providing continuity of care following ED presentation, reflective of many participants' limited understanding of healthcare available in the watch-house and how to facilitate follow-up care.

Information sharing

Another perceived gap related to information sharing. Participants described confusion about how to contact the watch-house, difficulties with existing incoming and outgoing health-related paperwork, and felt that their reliance on information from the police guard(s) was not ideal as it was not their role, and that information may be biased, incomplete, or second-hand.

Watch-house healthcare services

Gaps in the healthcare services provided in the watch-house were also identified, such as the services not being 24/7, limited training of nurses, and inability of healthcare staff to access detainees' medical records in the watch-house.

Theme 6: suggested strategies to support equitable care

Participants suggested a number of strategies to address the noted gaps, outlined in detail in Table 3. These included education for ED staff; improved communication with the watch-house; standardised paperwork; extended models of watch-house healthcare; and integrated medical records. Participants also identified some challenges they felt were unavoidable, or would require more complex strategies to address, but that were nevertheless important clinical considerations for ED staff. These included uncertain legal disposition, use of police resources during ED visits, and concerns that detainees may be less likely to access appropriate healthcare if released to the community. Some participants also spoke about the ongoing challenges of tackling negative preconceptions of ED staff and building rapport with detainees.

Theme 7: outcome of equitable care

Participants aimed for an equitable approach to care, in which decision making was responsive to the circumstances of the individual

detainee as well as the overall needs of the department (e.g. staff, other patients).

Thresholds for assessment and treatment

Participants would sometimes have a lower threshold for ordering investigations or longer observation in ED for detainees. This was because of a perception of the watch-house as a place with limited health resources and more risks than a typical discharge home. Conversely, in other cases participants perceived the watch-house to be a controlled, supervised environment, thus a facilitator to earlier discharge compared to home. These different thresholds were driven by circumstances of the individual patient, but also sometimes the participants' variable understanding of the watch-house environment and its capabilities.

Impact on police resources

Potential impact on police resources also factored into participants' decision-making. In some cases, the threshold for investigations was lower, as it was considered more difficult and resource-intensive for a detainee to return to the ED from the watch-house if they deteriorated. Alternatively, keeping the detainee in ED for longer in order to complete investigations meant more police resources used for providing guard. One participant also mentioned legal implications as a reason for having a lower threshold for investigation (i.e. for evidence).

Level of comfort with equitable approach

Many participants were reflective, self-questioning, and expressed some unease when justifying their use of different thresholds, especially if they perceived it may be considered to be 'overtreatment' or 'over-investigation'. Other participants were more comfortable with their delivery of equitable (but not necessarily equal) care, that was responsive to the individual circumstances of the detainee and where possible took into account the needs of the whole ED and other agencies (e.g. police).

Discussion

ED doctors in the present study reported that their approach to care delivery for detainees was no different to that for other patients. Further exploration revealed that this meant that ED doctors tended to base their decision-making for all patients, including detainees, on care equity rather than equality (i.e. the delivery of person-centred care). This may entail different thresholds for management, as for other complex populations. These findings touched on concepts central to medical ethics, such as equity, justice and utility (i.e. doing the greatest good for the greatest number).[22–24] Participants felt compelled to ensure that police resources were used responsibly, so that they could be out on the road helping other citizens. This additional facet to the already complex decision-making required from ED doctors[25] warrants further investigation. Variations in care also have implications for resource use; as for other vulnerable populations, ED doctors may invest disproportionate time and resources with detainees, given their atypically complex needs and circumstances.[26]

Although participants usually felt that they could rely on the existing strategies developed as an ED clinician when tackling many of the challenges common to detainees, there were gaps. Suggestions for EDs to improve the management of watch-house detainees and equivalence of outcomes[27] included staff education and improved lines of communication. Participants also outlined more complex interventions like expanded models of care and integrated medical records. Our findings support early evidence within Queensland, suggesting that a Watch-House Emergency Nurse (WHEN) model may be of benefit in minimising the need for transfers to the ED, and be economically viable for both health and police services.[15,28] Coronial inquiries into deaths in police custody, some of which have occurred in Queensland watch-houses, have also highlighted a need for medically-trained staff to be posted in large watch-houses to assess and monitor detainees.[29] This has recently become more important in Queensland, as recent changes to legislation allow children to be detained in watch-houses for extended periods, with associated needs for healthcare access.[30]

Limitations

As for any qualitative research, our study findings reflect participants' individual experiences and opinions only, and it is possible that only those with interest in the topic consented to participate. However, participants/sites were sampled to reflect diversity, which may support transferability of results to structurally similar settings. Additionally, this research reflects perspective of ED doctors only, and did not capture the perspectives of other stakeholders in the ED setting (e.g. nurses, allied health professionals, detainees, health executive).

Conclusion

ED doctors suggested that transfers from watch-houses were mostly appropriate and described a care equity approach for watch-house detainees. This included tailoring their assessment and treatment in response to the individual circumstances of the detainee and, where possible, considering the needs of the ED more broadly, and needs of other agencies, including police. Strategies recommended to improve the provision of care to detainees attending EDs include education for ED staff; improved communication with the watch-house; standardised paperwork; extended models of watch-house healthcare; and integrated medical records.

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Competing interests

The authors disclose no conflicts of interest with respect to the research, authorship, or publication of this article. The views expressed are those of the authors or participants and not necessarily those of affiliated organisations.

Data availability statement

We are unable to share or make publicly available data used for the present study because of ethical and data privacy requirements.

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Supporting information

Additional supporting information may be found in the online version of this article at the publisher's web site:

Appendix S1: Semi-structured interview guide for ED Medical Officers who have cared for detainees from police watch-houses.

Appendix S2: CORE-Q Reporting checklist.