GUIDELINES FOR MEDICAL PRACTITIONERS USING SECTIONS 110 AND 110A OF THE MENTAL HEALTH (COMPULSORY ASSESSMENT AND TREATMENT) ACT 1992

1 April 2000

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While every care has been taken in the preparation of the information in this document, users are reminded that the Ministry of Health cannot accept any legal liability for any errors or omissions or damages resulting from reliance on the information contained in this document.

It is important readers note that these guidelines are not intended as a substitute for informed legal opinion. Any concerns that individuals may have should be discussed with appropriate legal advisors.

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FOREWORD

Section 130(a) of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Act) states that the Director-General of Health may from time to time issue guidelines for the purposes of the Act. The following guidelines are intended to provide users of the Act with some guidance on issues of its interpretation and practical application when the urgent sedation of a person is required.

The need for guidelines to the Act was identified by the Law Commission's report on *Community Safety*: *Mental Health and Criminal Justice Issues* (1994) and the *Inquiry under Section 47 of the Health and Disability Services Act 1993 in Respect of Certain Mental Health Services 1996* (the Mason Report; Ministry of Health 1996). Both reports stated that workable guidelines were required to address different understandings of the Act.

For general guidance on the use of the Act please refer to the *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992* (Ministry of Health 2000). For other more specific information regarding District Inspectors, the roles and functions of Duly Authorised Officers (DAOs) and Directors of Area Mental Health Services (DAMHSs), the following Ministry of Health guidelines should be consulted:

- *Guidelines for District Inspectors Appointed under the Mental Health (Compulsory Assessment and Treatment) Act 1992* (April 2000)

- *Guidelines for the Role and Function of Duly Authorised Officers under the Mental Health (Compulsory Assessment and Treatment) Act 1992* (April 2000)

- *Guidelines for the Role and Function of Directors of Area Mental Health Services* (April 2000).

These guidelines are effective from 1 April 2000. On 1 July 2000, after a period of three months, the Ministry of Health will seek written submissions on errors, omissions, and points requiring clarification in these guidelines. The submission period will be for six weeks, therefore submissions will close on 14 August 2000. Should you wish to make written submissions before 1 July please do so.

Submissions should be sent to:

Dr Janice Wilson
Director of Mental Health
Ministry of Health
PO Box 5013
WELLINGTON

The guidelines will be revised accordingly and will be distributed by the end of December 2000.

Karen O Poutasi (Dr)
Director-General of Health

CONTENTS

1. INTRODUCTION

Under section 110 of Act, a medical practitioner who has medically examined a person and concluded that that person may be mentally disordered and needs to undergo an assessment examination urgently, applies to the Director of Area Mental Health Services (DAMHS) for this to happen. A flowchart showing the key points of compulsory assessment and treatment is appended to these guidelines (see Appendix 1).

Section 110A the Act provides powers for the medical practitioner to sedate the person urgently before the assessment examination occurs, if the medical practitioner considers the person presents a significant danger to the person themself, or any other person. In recognition of the fact that these procedures occur in situations of urgency and risk, sections 110 and 110A of the Act provide mechanisms for the medical practitioner to request police assistance while he or she carries out a medical examination, and/or to administer a sedative drug.

Any medical practitioner who believes he or she may use these powers in the future is advised to familiarise himself or herself with the relevant parts of the Act, in particular sections 8, 8A, 8B, 38, 110, 110A and 110C.

A medical practitioner intending to act under sections 110 and 110A of the Act must make every reasonable effort to first obtain the advice and assistance of a Duly Authorised Officer (DAO). If at all possible, before using the power (under section 110A of the Act) to sedate a person, the medical practitioner should discuss the situation with a psychiatrist.

It is anticipated that urgent sedation under section 110A of the Act will mainly be used in rural settings, when the medical practitioner considers that transporting a very mentally unwell person to an assessment examination poses a considerable risk that cannot be lessened in any other practical way.

In urban settings it may be possible to have a nominated medical practitioner (usually a psychiatrist) attend the person to conduct the assessment examination. This and the fact that transport times are much shorter means that the power to sedate under section 110A of the Act should only be used on rare occasions in urban areas.

Sedation is not without significant medical risk and the forced inappropriate use of sedative medication is a serious impingement of a person's rights. Sedative medication should only be used in situations of extreme urgency, where there are no appropriate alternatives available. Sedating a person will cloud their mental state and may make a subsequent assessment examination difficult to perform. A medical practitioner using the Act's provisions for sedation must, therefore, be very sure of the necessity for using these powers.

2. PROVISOS

2.1 Mental disorder

Any medical practitioner who conducts a medical examination under section 110 of the Act must be fully aware of the statutory definition of mental disorder in section 2 of the Act:

> 'Mental disorder', in relation to any person, means an abnormal state of mind (whether of a continuous or intermittent nature), characterised by delusions, or by disorders of mood or perception or volition or cognition, of such a degree that it-
> (a) Poses a serious danger to the health or safety of that person or of others; or
> (b) Seriously diminishes the capacity of that person to take care of himself or herself;-
> and 'mentally disordered', in relation to any such person, has a corresponding meaning.

A full discussion of this definition is provided in the *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992* (Ministry of Health 2000).

2.2 Respect for cultural and personal beliefs

Medical practitioners must also act in cognisance of section 5 of the Act:

> **Powers to be exercised with proper respect for cultural identity and personal beliefs -**
>
> 5. (1) This section applies to-
> (a) A court, tribunal, or person exercising a power under this Act in respect of a person; and
> (b) A court or tribunal conducting proceedings under this Act in respect of a person.
>
> (2) The power must be exercised, or the proceedings conducted,-
> (a) With proper recognition of the importance and significance to the person of the person's ties with his or her family, whanau, hapu, iwi, and family group; and
> (b) With proper recognition of the contribution those ties make to the person's wellbeing; and
> (c) With proper respect for the person's cultural and ethnic identity, language, and religious or ethical beliefs.

A full discussion of this definition is provided in the *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992* (Ministry of Health 2000).

3. USING SECTIONS 110 AND 110A OF THE ACT

The use of these sections of the Act should only be contemplated in situations of particular emergency, after wherever possible discussing the situation with a DAO to establish the timeframes for subsequent assessment and possible management alternatives other than sedation. Sedation should only be contemplated after discussion with a psychiatrist if reasonably practicable.

3.1 Conducting the medical examination

The process for conducting this examination is described in section 110 of the Act:

> **110. Powers of medical practitioner when urgent examination required -**
>
> (1) Subsection (2) applies to a medical practitioner who -
> (a) Conducts a medical examination of a person who is acting in a manner that could give rise to a reasonable belief that he or she may be mentally disordered; and
> (b) Concludes that -
> (i) There are reasonable grounds for believing that the person may be mentally disordered; and
> (ii) It is desirable for the person to have an assessment examination urgently in the person's own interests or the interests of any other person.
>
> (2) The medical practitioner must, as soon as possible, -
> (a) Issue a certificate under section 8B(4)(b); and
> (b) Make an application under section 8A.
>
> (3) A medical practitioner acting under this section must make every reasonable effort to get the advice and assistance of a duly authorised officer.
>
> (4) A medical practitioner who needs assistance to conduct a medical examination under subsection (1)(a) may call for police assistance under section 110C.

3.2 Sedation in an emergency

Section 110A of the Act allows a medical practitioner to sedate a person when sedation is urgently required:

> **110A. Power of medical practitioner who issues certificate to sedate when sedation urgently required -**
> (1) This section applies to a medical practitioner who
> (a) Issues, under section 110(2)(a), a certificate under section 8B(4)(b); and
> (b) Has reasonable grounds for believing that the person presents a significant danger to himself or herself or any other person; and
> (c) Has reasonable grounds for believing that it is in the interests of the person to receive a sedative drug urgently.

(2) The medical practitioner may immediately administer an appropriate sedative drug to the person, by injection if necessary, in accordance with any relevant guidelines and standards of care and treatment issued by the Director-General of Health under section 130.

(3) A medical practitioner who administers a sedative drug under subsection (2) must, as soon as practicable,
    (a) Record the circumstances in which the drug was administered; and
    (b) Give a copy of the record to the Director of Area Mental Health Services.

(4) A medical practitioner acting under this section must make every reasonable effort to get the advice and assistance of a duly authorised officer.

(5) A medical practitioner who needs assistance to administer a sedative drug under subsection (2) may call for police assistance under section 110C.

4. SEDATION

4.1 Emergency use of sedation

After completing a certificate under section 8B(4)(b) of the Act, the medical practitioner contacts a DAO at the service where the person will undergo an assessment examination, and the DAO arranges where and when the assessment examination will take place. If they are unable to contact a DAO, the medical practitioner should attempt to contact the DAMHS to make the arrangements.

In rare circumstances the medical practitioner may consider the person to be so disturbed that they will pose significant danger to themselves or another person in the time before the assessment interview takes place. In such circumstances the medical practitioner may consider the emergency use of sedation.

Before deciding to use emergency sedation the medical practitioner needs to assess the situation both from a medical and psychosocial perspective, to see if there are any appropriate alternatives to sedation.

4.1.1 Medical considerations

A medical practitioner must have assessed the person for the presence of any medically treatable causes of agitation such as hypoglycaemia and hypoxia (absolute contraindications to sedation and requiring specific management), drug and alcohol intoxication and withdrawal, pain or delirium. If any of these or other causes of agitation are present, the practitioner should attempt to manage these conditions in their own right where practicable, with or without the use of sedation.

Particular care must be taken to assess the person for the presence of delirium, manifest in impairment in orientation and concentration. While not always a contraindication to

sedation in an acute situation, delirium necessitates urgent treatment of the underlying cause of the delirium if at all possible.

4.1.2 Psychosocial considerations

The medical practitioner should:

- attempt to contact family/whānau and/or other key support people if they are not present, and if possible enlist their help in managing the person's distress
- work with the DAO, if they are present, and other available health professionals to engage with the person, explain what is happening and try to alleviate their distress
- use de-escalation techniques.

In some instances, police assistance may be required. If police assistance is required, this is requested by the DAO or, if they are not present, the medical practitioner.

The roles and responsibilities of the police, the DAO and medical practitioner in these circumstances are specified in the revised Memorandum of Understanding dated 23/3/2000 between the New Zealand Police and the Ministry of Health (see Appendix 2).

4.2 General principles of sedation

It is only after assessment of the medical and psychosocial factors outlined above, and finding no appropriate way of managing the person's distress that a decision to proceed with urgent sedation should be taken.

Medical practitioners should only use minimum effective doses of medication for sedation. Small doses should be used and repeated if an adequate effect is not obtained.

At all times, practitioners must balance the risks and potential benefits of using sedative medication.

4.3 Process of sedating the person

The following steps are expected to be followed when a medical practitioner decides it is necessary to sedate a person:

- the medical practitioner should attempt to discuss their intention with a psychiatrist at the service where the person will be undergoing the assessment interview

- the medical practitioner should ensure he or she has adequate assistance to administer the medication intramuscularly (IM), if required, before initiating negotiations about the use of medication with the person

- the person should always be told of the medical practitioner's intention to use medication, the reasons for doing so, possible side effects, and be given the option of taking medication orally

- where appropriate, family/whānau support should be sought for the person to take medication orally (with family/whānau support, medication may not be needed)

- even if medication is to be given IM, it remains imperative that the medical practitioner explains to the person what is happening and why it is happening, and gives the person the chance to take the medication orally. If present, the family/whānau should also be aware that medication may be given IM.

4.4 Choice of medication

Choice of medication should be determined by the medical practitioner's familiarity with usage and side effects. There is no clearly superior sedative regime.

Medical practitioners need to be aware that use in acute sedation is not an approved indication for any benzodiazepine in New Zealand at present. However, under section 25 of the Medicines Act 1981, medical practitioners can prescribe and administer unapproved medicines to a particular patient under their care. The Ministry of Health considers that there is satisfactory evidence for medical practitioners to consider using benzodiazepines for urgent sedation.

The only benzodiazepine widely available in New Zealand that can appropriately be given intramuscularly and has a rapid onset of predictable sedation is clonazepam. If a medical practitioner were to consider using clonazepam in this context he or she needs to be aware that clonazepam carries a small risk of causing respiratory depression.

THREE SUGGESTED PHARMACOLOGICAL APPROACHES:

High-potency neuroleptic

HALOPERIDOL 5–10 mg orally (PO) *or*
2.5–5 mg IM

Repeat at 30 minute intervals to maximum of 30 mg PO, or 20 mg IM

First dose should accompanied by anticholinergic cover (benztropine 2 mg PO/IM or procyclidine 5 mg PO) unless person suspected of being delirious.

If delirium is suspected an anticholinergic agent should also be used to treat EPSE.

Risks

- Extrapyramidal side effects (EPSE): especially in young males, can include laryngeal spasm, and ocular gyric crises.
- May cause impaired thermo-regulation: caution on hot days.

Benzodiazepine

DIAZEPAM 5–10 mg PO
OR
CLONAZEPAM 2 mg IM

Repeat at 30 minute intervals until control achieved.

Risks

- Respiratory depression and CO_2 retention possible.
- Disinhibition occurs in less than 1% of cases.
- Should be avoided in inebriated patients as may compound alcohol-induced sedation.
- Flumazenil reverses sedation and respiratory depression but repeat doses may be needed. Should be available if IM Clonazepam is being used.

Benzodiazepines–neuroleptic combined

HALOPERIDOL 2.5 – 5 mg PO, or IM
AND
CLONAZEPAM 2 mg PO, or IM

Repeat at 30 minute intervals to maximum of three doses.

Risks

- Effect is **MORE RAPID** than with either drug alone.
- May use **LOWER DOSES** of each drug.
- Can **TITRATE** individual doses for desired effect.
- **FEWER EPSEs** than with neuroleptic alone.

As previously stated there is no superior sedating regime. However, there are some general principles:

- if the person has a clear past history of schizophrenia and/or a past good neuroleptic response, use of haloperidol should be considered

- if the patient has a history of mania and appears manic, a benzodiazepine is probably the most appropriate option

- if there is suspicion of drug or alcohol withdrawal, a benzodiazepine should be used if possible, as neuroleptics can lower the seizure threshold

- combination benzodiazepine–neuroleptic provides a rapid and effective sedation in most cases.

4.5 Monitoring

As soon as is practicable, blood pressure, pulse, respiration and temperature should be checked by the medical practitioner. These should be rechecked at 15 minute intervals by a suitably qualified health professional until the person undergoes an assessment examination. under sections 10 or 110B of the Act.

4.6 Transport

While the sedated person is being transported to and awaiting the assessment examination under sections 10 or 110B of the Act, he or she must be accompanied by either the medical practitioner or a suitably qualified health professional, usually a registered nurse or an ambulance officer.

Once sedated, a person must be accompanied by a medical practitioner during transportation if the medical practitioner considers it likely that further sedative medication will be required in transit. Section 110A of the Act does not allow delegation of the power to administer the sedative medication from the medical practitioner to another health professional.

If a person who has been administered clonazepam is not accompanied by a medical practitioner, the accompanying health professional must have flumazenil available for treating potential respiratory depression, and must be competent to administer flumazenil intravenously.

If the person has been administered a neuroleptic, the accompanying health professional must have access to benztropine for treating acute extrapyramidal reactions.

4.7 Documentation

The medical practitioner who administered the sedative medication must record the circumstances of its use and submit that record to the DAMHS in accordance with section 110A(3) of the Act.

The medical practitioner must ensure that the symptoms leading to the use of sedation are well documented as the person may still be significantly sedated when seen by the nominated medical practitioner for the assessment examination.

APPENDIX 2

MEMORANDUM OF UNDERSTANDING DATED 23/3/2000 BETWEEN NEW ZEALAND POLICE AND THE MINISTRY OF HEALTH

MEMORANDUM OF UNDERSTANDING

23/3/2000

BETWEEN THE NEW ZEALAND POLICE
(hereinafter referred to as "the Police")

AND THE MINISTRY OF HEALTH
(hereinafter referred to as "the Ministry")

RECITAL

IN recognising that the Police and the Ministry have separate missions and standards,

AND acknowledging that each party brings to its respective tasks valuable expertise and resources,

AND acknowledging full co-operation between both parties at all levels as essential to ensure the co-ordinated, effective and efficient delivery of services to meet the needs of individuals who may require compulsory assessment and treatment under the Mental Health (Compulsory Assessment and Treatment Act) 1992:

BOTH PARTIES DECLARE AND AGREE TO THE FOLLOWING

1 INTRODUCTION

1.1 The following matters are agreed in principle between the Police and the Ministry of Health to give guidance to Police staff and health professionals administering the provisions of the Mental Health (Compulsory Assessment and Treatment) Act, 1992, (hereinafter referred to as ‘the Act’).

1.2 This memorandum should form the basis of local agreements made at Police region and district level with Mental Health Services.

1.3 A spirit of co-operation should prevail in all dealings under the Act between Police and health professionals.

1.4 People being dealt with under the Act are **patients or proposed patients** and shall be treated with humanity and respect for the inherent dignity of the person. The responsibility for the provision of services under the Act to mentally disordered persons rests primarily with health services. It is further recognised that such persons, while being dealt with purely under the Act, have not necessarily broken any rule of law.

1.5 Police and health professionals must retain a flexible approach to any incident being dealt with under the Act and must be prepared at all times to change their course of action.

1.6 Nothing in this Memorandum limits or prevents the Police from carrying out any duties or exercising any powers under other enactments.

2 RESPONSIBILITIES

2.1 The Duly Authorised Officer is the official in charge at any incident that requires the invoking of the Act and a combined Police/Mental Health Services response. In the absence of a Duly Authorised Officer if sections 110, 110A, 110B, or 110C are being invoked the Registered Medical Practitioner is the official in charge.

2.2 The Police may be called upon to assist the health professionals but will continually review the appropriateness of the action requested of them. The Police will advise the health professionals if the actions requested of them are outside their powers or immediate ability.

2.3 Duly Authorised Officer should only request Police assistance when the particular powers and specific expertise of the Police are required.

3 TRANSPORTATION OF PATIENTS

3.1 Duly Authorised Officers have the responsibility for arranging for the transportation of patients, proposed patients, and patients absent without leave. Mental Health Services are responsible for ensuring that Duly Authorised Officers are adequately resourced to carry out this duty.

3.2 When the particular powers and specific expertise of the Police are required to assist with transportation, the decision as to the type of vehicle to be used should be made by the Duly Authorised Officer or Registered Medical Practitioner in charge in consultation with attending Police.

3.3 Matters to be taken into account in making that decision include:

- the clinical condition of the patient or proposed patient
- whether sedation has been administered to the proposed patient or patient
- the potential or actual violence of the patient or proposed patient
- the types of vehicle available
- the need for restraint and the type of restraint required
- the personnel available
- the distance to be travelled

3.4 Where Police have been called to assist a Duly Authorised Officer or Registered Medical Practitioner, the Duly Authorised Officer **OR** a suitable health professional will at all times PHYSICALLY accompany and monitor the patient or proposed patient. The definition of 'suitable health professional' should be negotiated at a local level and be contained in local memoranda of understanding.

4 USE OF FORCE

4.1 Section 122B of the Act allows the use of force in certain circumstances. Anyone who is exercising a power under the Act should be certain that these circumstances apply before using force.

4.2 Any taking, retaking or detention by force must only be in circumstances where it is likely the patient or proposed patient will be a danger to him or herself, or to others or will be likely to cause serious property damage.

4.3 Before using force the wishes of the patient or proposed patient and their caregivers should be sought wherever practicably possible and careful consideration should be given to their views. Every effort must be made to reduce the risk of violence before the patient is transported.

4.4 If it is necessary to use force to take and/or detain a patient or proposed patient the Duly Authorised Officer or Registered Medical Practitioner shall give a clear request to police to do so.

4.5 If it is necessary to use force to gain entry to property in an emergency the Duly Authorised Officer or Registered Medical Practitioner shall give a clear request to Police to do so. Police officers must be certain of the section of the Act they are acting under that authorises the entry. Where it is reasonably practicable to get a warrant, the Police must comply with section 41(7). In determining whether it is reasonably practicable to apply for a warrant, Police should consult with the Duly Authorised Officer or Registered Medical Practitioner. The appropriate Mental Health Service should usually assume responsibility for making good any damage caused by such action.

5 CHARGING FOR SERVICES

5.1 The Police and the respective Mental Health Services will not normally charge each other for the provision of assistance under the Act.

5.2 Consideration may be given to charging for pre-planned use of Police services by Hospitals and Health Services where it has been contractually agreed to at a local level or in instances of excessive and unreasonable demands on Police time.

6 AMENDMENT VARIATION

6.1 The parties agree that these understandings may be amended or varied by mutual agreement between partners. Such variations should be raised and addressed through the National Operations Manager for the Police and the Deputy Director of Mental Health for the Ministry of Health.

Signed by: ……..

On behalf of the New Zealand Police

Signed by: ……

On behalf of the Ministry of Health