

The following tables provide guidance to clinicians considering using coercive treatments for patients under the care of the CDHB's Older Persons Health Specialist Services.

Coercive treatments are defined in this document as restrictive or invasive treatments used without a patient's consent. Coercive treatments will only be used with patients who have an illness that causes impairment to their insight and judgement to a degree that there is a significant threat to their interests, their safety, or the safety of others.

The legal frameworks that are considered in these guidelines include the Mental Health Act, the protection of Personal and Property Rights Act and the Health and Disability Service Users' Code of Rights.

Protection of Personal and Property Rights Act (PPPR Act)

The PPPR Act can only be applied if the patient lacks capacity to make decisions in respect of the treatment being considered, as defined in various ways in the Act depending upon the issue at hand. Any coercive treatments given under the authority of an Enduring Power of Attorney (EPOA) for Personal Care and Welfare may only be given if:

1. The EPOA has been "activated" by an appropriate medical assessment letter - updated in the case of important decisions even if a prior letter states that activation is permanent;
2. The EPOA has not been revoked since it was written (the attorney-designate should sign a certificate of non-revocation); and
3. The EPOA does not specifically exclude the attorney from making the specific decision being taken.

Any coercive treatments given under the authority of a Welfare Guardian assume that the Welfare Guardian Order does not specifically exclude the decision being made. Some decisions (such as consenting to take part in an experiment, to have ECT or decisions regarding life and death treatments) are outside of the authority of Welfare Guardians or of attorneys no matter what the person who wrote the EPOA stated. The person who wrote an EPOA or the Court may also stipulate other particular things that they wish to place outside the authority of the person chosen. These will be clearly outlined on the legal document.

The Code of Health and Disability Service Consumers' Rights (Code of Rights)

The Code of Rights falls under the Health and Disability Commissioner Legislation. Specifically, Right 7 (4) enables treatment to be provided if it is in the best interests of the individual and steps have been taken to determine the patient's views (as far as they can be obtained) and there has been discussion with the patient's family/caregivers. However, where the PPPR Act or the MH Act are relevant to the situation, these are preferred for using coercive treatments outside of true unanticipated emergency situations because they protect the patient's rights more strongly. Emergency treatment under the Code of Rights (or indeed the Common Law) should not continue to be routinely given without moving to a more definite legal basis when its necessity could reasonably be anticipated.

The Mental Health (Compulsory Assessment and Treatment) Act 1992 (MH Act)

The MH Act can only be used if the patient is “mentally disordered” as defined in the Act and if they pose a significant risk to others, themselves, or if they are significantly unable to care for themselves.

Coercive Treatment	Can a person holding EPOA for Personal Care and Welfare or a Welfare Guardian consent to the treatment on a patient's behalf?	Can the treatment be used with the consent of family / caregivers even though there is no PPPR Act authority?	Can the Mental Health Act authorise the use of the treatment?	What is best practice in the OPHSS?
<p>Admission to and remaining within an inpatient ward — locked or unlocked</p>	<p>A Welfare Guardian has the authority to consent to admission if it is necessary for the promotion and protection of the welfare and best interests of the patient.</p> <p>A person with an EPOA for Personal Care and Welfare can make decisions with the same effect as a competent patient's, therefore if the attorney consents to admission that consent is valid.</p> <p>This authority is not affected by the ward being locked / unlocked.</p>	<p>Yes, if the clinician believes this is in the best interests of the patient, irrespective of the ward being locked / unlocked.</p>	<p>The MH Act applies to admissions if the Act's criteria are met. It is not affected by the ward being locked / unlocked.</p>	<p>If the patient cannot give informed consent but gives assent or does not resist admission or remaining on the ward, then best practice is to work with the patient to develop their competence and gain their consent for admission; to consider and document what the patient was likely to have wanted were they competent; to gain agreement from the patients' family or key caregivers; and to regularly review whether ongoing admission is required. If there is a Welfare Guardian or a person holding an EPOA for Personal Care and Welfare then they must be consulted and give their proxy consent.</p> <p>If the patient resists admission or cannot be persuaded to remain on the ward all the above still hold, but if no Welfare Guardian or EPOA for Personal Care and Welfare exists then the Mental Health Act should be invoked if the patient has a mental illness and the admission is for the treatment of that illness. The Family Court can be approached for an urgent Treatment Order under the PPPR Act in some other settings and the CDHB legal team need to be involved in this decision.</p> <p>Occasionally a Welfare Guardian or person holding an EPOA for Personal Care and Welfare is technically able to make the decision but does not wish to accept that responsibility, in which case the Mental Health Act should be invoked if the patient resists admission or cannot be persuaded to remain on the ward.</p>
<p>Seclusion*</p>	<p>N/A</p>	<p>N/A</p>	<p>Seclusion may only be implemented for patients under the MH Act.</p> <p>(The legal basis for seclusion is set out in s71 of the Act)</p>	<p>Seclusion should only be used to prevent or contain behaviour compromising safety during situations in which other methods of clinical management cannot safely be used or have been used without success.</p> <p>Seclusion only occurs in an approved and designated seclusion room. Except in emergencies seclusion shall only ever be implemented with the authority of the responsible clinician under the MH Act. The use of seclusion must be subject to strict review. Refer to Ministry of Health Guidelines 'Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992'.</p>

*Seclusion is defined as “Where a consumer is placed alone in a room or area, at any time and for any duration, from which they cannot freely exit”. Care must be taken to ensure that consumers who are being physically restrained are not left alone out of line of sight during the restraint episode, for example in bedrooms, as this would equate to seclusion.

<p>IM injections of psychoactive drugs</p>	<p>Both a Welfare Guardian and a person holding an EPOA for Personal Care and Welfare can consent on behalf of a patient.</p>	<p>Yes, if the clinician believes this is in the best interests of the patient.</p>	<p>The MH Act allows compulsory treatment and restraint including for IM injections but only for the treatment of the patient’s mental disorder.</p>	<p>In a true unanticipated emergency the use of IM medication for non-consenting people is a nursing and medical decision and should be supervised by staff who are skilled in persuading people to take oral meds and skilled in providing the necessary restraint for this process to be safe. K1/2 nurses are usually available to assist with this process in a true emergency. If possible, attempts should be made to contact the relevant person holding an EPOA for Personal Care and Welfare or Welfare Guardian or key family member / carer in an emergency to gain their agreement.</p> <p>When IM injections are likely to be used (including if they have been used in an emergency situation more than a small number of times) then formal proxy consent from the relevant Welfare Guardian or person holding an EPOA for Personal Care and Welfare must be gained. Where these are not in place, the MHA should be used and key family / carers consulted.</p>
<p>Giving oral medications, sometimes covertly</p>	<p>Both a Welfare Guardian and a person holding an EPOA for Personal Care and Welfare can give consent.</p>	<p>Yes, if the clinician believes this is in the best interests of the patient.</p>	<p>The MH Act can be used to require patients to take oral medication for the treatment of a mental disorder (not other conditions) but it is inadvisable to administer medicine covertly as this is unlikely to comply with the requirement that the patient is informed about his/her treatment.</p>	<p>It is best practice to work with the patient to develop their competence and gain their consent to taking the required medicine; to consider and document what the patient was likely to have wanted were they competent; to gain agreement from the patients’ family or key caregivers; and to regularly review whether ongoing administration of the medicine is required.</p> <p>If there is a Welfare Guardian or person holding an EPOA for Personal Care and Welfare then they must be consulted and give their proxy consent.</p>
<p>Invasive or risky investigations</p>	<p>Both a Welfare Guardian and a person holding an EPOA for Personal Care and Welfare can give consent.</p>	<p>Yes, if the clinician believes this is in the best interests of the patient.</p>	<p>Procedures associated with assessment and treatment of mental disorder can be performed (e.g. lumbar punctures in some circumstances, CT scans with contrast) but procedures for general medical care are not authorised by MH Act. There is also doubt about the legal status of such procedures when under a Community or Inpatient treatment order (i.e. when assessment is completed). In these cases, when there is significant risk from the investigation, a personal order should be obtained under the PPPR Act.</p>	<p>It is best practice to work with the patient to develop their competence and gain their consent for having the procedure; to consider and document what the patient was likely to have wanted were they competent; and to gain agreement from the patients’ family or key caregivers.</p> <p>If there is a Welfare Guardian or person holding an EPOA for Personal Care and Welfare then they must be consulted and give their proxy consent.</p> <p>If there is no such person and the investigation carries a significant risk but is refused by the patient and the situation is a true emergency, it should go ahead. If the situation is not a true emergency, an application to the Family Court for a Personal Order to cover the procedure should occur.</p>

Chair/Bed/Hands-on restraint	Both a Welfare Guardian and a person holding an EPOA for personal care and welfare can give consent.	Yes, if the clinician believes this is in the best interests of the patient.	The MH Act should not be initiated solely for the purpose of using restraint and its use is not required for the use of restraint when clinically indicated and in accordance with the CDHB's restraint policies.	<p>The restraint use must fully comply with CDHB policy and OPHSS schedules / procedures.</p> <p>Restraint is a clinical decision used in the context of preventing harm to the patient, others or property. Restraint must only be used as a last resort for the least amount of time possible. Use of restraint should be a shared team decision when it is non-urgent or anticipated. If possible, attempts should be made to contact the relevant person holding an EPOA for Personal Care and Welfare or Welfare Guardian or key family member / carer in an emergency to gain their agreement.</p> <p>When some form of restraint is likely to be used then formal proxy consent from the relevant Welfare Guardian or person holding an EPOA for Personal Care and Welfare must be gained.</p> <p>Where these are not in place but the restraint is going to be used regularly and is for the treatment of a mental disorder, key family / carers should be consulted and the MH Act may be considered.</p>
Limiting visitors / phone contact	Both a Welfare Guardian and a person holding an EPOA for Personal Care and Welfare can give consent if this is truly required for treatment and recommended by the treating team.	Yes, if the clinician believes this is in the best interests of the patient	s72 MH Act applies. A patient should not be placed under the Act simply for the purposes of enabling these limits to be used. The MH Act may offer an extra legal framework for these measures but it does not negate other best practice advice in this situation.	<p>It is best practice to work with the patient to increase their competence and negotiate agreed boundaries on contacts. The people likely to be contacted should also be involved in the process and be encouraged to limit phone calls and visits themselves.</p> <p>If limits need to be enforced by clinicians, especially on an inpatient ward, this should be done with the consent of the Welfare Guardian or person holding an EPOA for Personal Care and Welfare; or if these are not available, with the agreement of key family / carers. Such limits should be regularly reviewed to ensure they are necessary.</p>
Attending clinical reviews	Both a Welfare Guardian and a person holding an EPOA for Personal Care and Welfare can give consent.	Yes, if the clinician believes this is in the best interests of the patient	A Community Treatment Order under the MH Act could enable this but Duly Authorised Officers or Police should be used to transport a non-consenting patient.	In practice it is very difficult to require people to attend clinical reviews. Best practice is to use persuasion and enhance the person's capacity. If any significant coercion such as family, staff or Police presence to ensure that the meeting takes place, then PPPR or MH Act authorisation should be in place and clearly documented.

<p>Entering residential care</p>	<p>Both a Welfare Guardian and a person holding EPOA for Personal care and Welfare can give consent unless this is specifically stated not to be one of their authorities on the legal document involved. The Court may also make a Personal Order for placement.</p>	<p>No. The Code of Rights is not an appropriate framework for people to enter or remain in residential care against their will, but note comments about situations where people cannot give informed consent but do not oppose living in care.</p>	<p>The MH Act is not able to be used as the primary framework under which patients enter residential care.</p>	<p>If the patient does not give informed consent but does not resist entering residential care or regularly attempt to leave, then consent should be sought from the Welfare Guardian or person holding an EPOA for Personal Care and Welfare if they exist, or agreement should be sought from key family / caregivers under the Code of Rights.</p> <p>If the patient refuses to enter care or persistently expresses the desire to leave or attempts to leave, consent must be gained from a Welfare Guardian or person holding an EPOA for Personal Care and Welfare if they exist, or a personal order for placement under the PPPR Act should be obtained. Whilst this is being sought, key family / carers should also give their agreement.</p> <p>For people already under the MH Act for assessment and treatment on an inpatient ward, at the point when the assessment period is complete and the only reasonable management is to discharge the patient into care but the patient will not accept this, the responsible clinician should apply for an Inpatient Treatment Order specifically requesting in advance that the Judge authorise an ITO plus subsequent placement of the patient "on leave" to a specified residential care facility, so long as the placement is a legitimate treatment for the mental disorder in question. A PPPR Act process that will scrutinise this placement and validate it in terms of a Welfare Guardian appointment or a personal order for placement must also be initiated. The MHA will lapse after the PPPR process is completed. <u>Note that the cost of residential care falls to the CDHB whilst the person is in care under section 31 of the MH Act (Inpatient Treatment Order on leave).</u></p> <p>For outpatients who will not accept placement when this is the only reasonable option, for whom all relevant family / carers and PPPR authorities are in agreement, and for whom persuasion has not proved successful, admission under the MH Act (if the Act's criteria are met) to an inpatient unit for formal assessment to review the necessity of placement and the potential for capacity to be enhanced should occur. This may lead on to the joint PPPR / MH Act process above.</p>
<p>Receiving services into the home</p>	<p>Both a Welfare Guardian and a person holding EPOA for Personal care and Welfare can give consent.</p>	<p>Yes if the clinician believes this is in the best interests of the patient</p>	<p>A Community Treatment Order under the MH Act could enable this provided it is services for the treatment of the patient's mental disorder. Any other services, including social support, would need consent or a personal order under the PPPR Act.</p>	<p>In practice, it is virtually impossible to require people to receive services into their homes. Best practice is to use persuasion and enhance the person's capacity. Sometimes services are provided covertly but this should be done with the consent of Welfare Guardian or person holding an EPOA for Personal Care and Welfare if they exist; or with agreement of the key family / carers.</p>