**In Confidence**

Office of the Minister of Health

Chair, Cabinet Business Committee

# Proposed Government Response to the Review of the Substance Addiction (Compulsory Assessment and Treatment) Act 2017

## Proposal

1 This paper seeks your agreement to a proposed government response to a review of the Substance Addiction (Compulsory Assessment and Treatment) Act 2017 (the Act).

## Relation to government priorities

2 This proposal relates to government's priority of wellbeing for all New Zealanders. It aligns to the transformation of the mental health and addiction system as described in *Kia Manawanui Aotearoa – Long-term Pathway to Mental Wellbeing (Kia Manawanui)* [CBC-MIN-21-0063 refers].

## Executive Summary

3 The Substance Addiction (Compulsory Assessment and Treatment) Act 2017 (the Act) enables people to receive compulsory assessment and treatment if they have a severe substance addiction and their capacity to make decisions about treatment for that addiction is severely impaired, while safeguarding their human rights. This compulsory assessment and treatment aims to protect those individuals from harm and stabilise their health.

4 The use of compulsion in the health system at any time warrants extreme caution, which the Act and its implementation are intended to provide. The Act therefore contains a specific provision requiring its operation and effectiveness to be reviewed after its first three years of operation.

5 The review has been completed, and the Act requires it be tabled in Parliament as soon as practicable. It raises a number of issues that require response. I therefore propose that we release a government response alongside it. This approach makes clear that we have listened to the reviewers and that we are committed to making improvements in this part of the mental health and addiction system, alongside improvements in other parts such as access to primary mental health and addiction services and supports.

6 The attached draft government response has been prepared by the Ministry of Health, which is responsible for the administration of the Act and service delivery supporting it. The response includes commitments to address issues raised in the review and situates them in the broader context of our mental health and addiction reforms.

## Background

7 The intent of the Act is to enable people with a severe substance addiction, and severely impaired capacity to decide on treatment for that addiction, to be committed to a place where their addiction could be assessed and have the opportunity to begin to engage in treatment. The purpose of compulsory assessment and treatment is to protect those individuals from harm and stabilise their health. The Act is also intended to protect and enhance their mana and dignity and restore the capacity to make informed decisions about further treatment and substance use.

8 Compulsory assessment and treatment is considered with the assistance of an Authorised Officer, who will investigate an application and ensure that there are reasonable grounds to believe that criteria are met. An application can come from anyone but is usually a whānau member, or health practitioner.

9 The Act contains a provision requiring its operation and effectiveness to be reviewed after its first three years of operation. This provision was inserted due to concerns expressed to the Select Committee considering the Substance Addiction (Compulsory Assessment and Treatment) Bill about potential breaches of human rights.

10 The Ministry of Health commissioned Allen and Clarke to conduct the review. The period of time to be considered for the review was from commencement of the Act in February 2018, to the end of December 2020. The purpose of the review was to:

10.1 provide the Ministry with information on the operation and effectiveness (outcomes) of the Act, including a focus on what is working well and what could be improved, and

10.2 identify areas where improvement can be made to the operation of the Act and outcomes for applicants, people and whānau.

11 Allen and Clarke structured the review around the following research questions:

11.1 How well is the Act pathway for assessment and treatment of people being implemented?

11.2 How well are the key principles of the Act being applied?

11.3 How well are the principles applying to exercise of powers (section 12 of the Act) being applied?

11.4 What health and wellbeing outcomes have people and whānau experienced as a result of the Act?

11.5 How can the Act and its delivery be optimised to ensure positive outcomes for people and their whānau?

12 The review used a mixed methods approach, drawing on both qualitative and quantitative data. An important data collection method was exploration of delivery of the Act in four district health board (DHB) regions. This included in-depth interviews with clinicians in various statutory roles, DHB management and administrative personnel, judges and health and social service providers.

13 Additionally, the review undertook qualitative interviews with people who had been placed under the Act and their whānau to map their 'journey' through the pathway. The reviewers accessed and analysed quantitative data to describe the demographic characteristics of those placed under the Act, and to determine whether engagement with the Act was associated with changes to patterns of substance use and reported wellbeing. This was supported by a review of key documents related to the delivery of the Act.

14 The Ministry of Health provided feedback on the draft report. The final report has been accepted and officials consider it to be robust, fair and balanced.

15 During the period February 2018 to June 2020, there were compulsory treatment certificates (CTCs) issued under the Act for sixty individuals[1]. Forty-six of these individuals were European, nine Māori, and five were of other ethnicities. There were 26 females and 34 males. The peak age groups were 40-44 and 60-64, with nine CTCs in each. There were no CTCs in either the 15-19 or 70+ age groups.

16 The small numbers mean quantitative analysis is not robust, but it is very likely that Māori and Pacific and Asian people are under-represented in access to the Act. While the review report does not mention disabled people specifically, we consider it is likely that they are also under-represented, based on evidence from other sectors in New Zealand, and international evidence around addiction treatment.

## Analysis

### Findings of the Review

17 The key findings of the review are as follows:

17.1 The Act plays an important legislative function in offering a pathway to treatment for people with severe substance addiction.

17.2 Systemic factors are preventing the Act from reaching groups with demonstrated need.

17.3 The Act's capacity criterion is narrowly focused on cognitive functioning.

[1] The review report analyses characteristics of 62 individuals who were issued with CTCs. This represents what was identified in the Ministry's Programme for the Integration of Mental Health Data (PRIMHD) database as of 15 September 2020, when the data was provided to Allen and Clarke. Subsequent data cleansing has identified that two of these did not receive any compulsory treatment, so the number for this reporting period, as of 16 July 2021, is in fact 60.

17.4 The withdrawal management, medical stabilisation and judicial processes impact on the length of treatment.

17.5 Having only one gazetted treatment centre limits options for treatment.

17.6 The location of the treatment centre removes most people from whānau and other supports.

17.7 Lack of appropriate care options after discharge from the Act are undermining its effectiveness.

17.8 Checks and balances to support appropriate use of powers and protect human rights are central to the delivery of the Act.

17.9 The principle of mana enhancement is endorsed by the sector, but there is little evidence of this being operationalised in practice.

17.10 The majority of people placed under the Act relapse into substance use within a year of discharge.

18 The Executive Summary of the Allen and Clarke report is attached unedited as an appendix for your information.

**The proposed government response**

19 The proposed government response accepts these findings and contains a number of actions to be taken to address the issues. In summary, the view in the proposed government response is:

19.1 We accept the findings that the Act is performing well in achieving its purposes in relation to protection from harm and assessment of addiction and stabilising health, but is less effective at achieving its purposes of mana enhancement, restoring capacity, ongoing care planning and voluntary treatment. We are pleased to see that checks and balances to support appropriate use of powers and protect human rights are central to the delivery of the Act. However, the review highlights, and we accept, that there is room to improve the systems and services that support the Act.

19.2 We are particularly concerned that the Act is does not appear to be accessible to some key populations including Māori, Pacific peoples, disabled people, and those who use substances other than alcohol (though noting that the very small numbers mean we need to treat quantitative analyses with caution).

20 The response document sets the findings and government's response within the context of ongoing work to improve the mental health and addiction system, particularly the repeal and replacement of the Mental Health Act and the development of a mental health and addiction system and service framework.

21 The document outlines the importance of a focus on equity, which is still relevant despite the small numbers of people affected by the Act. It commits to a number of operational changes that will be put in place by the end of June 2022, including:

21.1 *Increasing capacity for treatment under the Act*. The only gazetted treatment centre has been operating at 100 percent capacity in recent months. Bearing in mind the concerns raised about the appropriateness of focussing treatment in a single geographical region, the Ministry of Health will also investigate opportunities to develop and gazette new providers, potentially via the development of a community of practice model whereby sector leaders are provided with support to in turn support their peers.

21.2 *Testing ways of providing continuing care post-discharge from the Act*. Continuing (post-discharge) care is not part of the treatment delivered under the Act, which is a gap in the provision of a recovery approach for people treated under the Act. In addition, the only gazetted treatment centre is located in Christchurch, which is not where the majority of people who access it are from. The Ministry of Health will design a pilot to develop and test one or more approaches to the provision of continuing care. At least one will be physically based in the Auckland or Northland regions, as this is where there is significant demand for treatment.

21.3 *Workforce training and support for mana-enhancing practice and capacity testing.* The Director of Mental Health and Addiction Services (the Director) provides a series of guidelines outlining the obligations of health professionals and others who are responsible for implementing the Act. The Director will initiate a review of relevant clinical guidance, for example, touching on capacity testing and mana-enhancing practice, to ensure that it is as broad and enabling as possible under the current legislation. The Ministry will also commission at least one workforce training module or course for the whole workforce engaged in delivering the Act, with more to follow over time.

21.4 *Investigating, using a range of methods including kaupapa Māori research, the pathways Māori and Pacific individuals and whānau experiencing severe substance addiction take towards accessing support,* whether through the Act or through alternatives. It is essential that there is equitable access to care under the Act. However, it is important to understand and potentially support alternative options for those who do not wish their family or whānau members to undergo compulsory treatment.

21.5 *Reviewing and updating information available to tangata whai ora and whānau and how this is delivered, so they are well informed about the Act and potential outcomes.* This includes ensuring that verbal and written information is available in appropriate languages, including New Zealand Sign Language, and formats such as Easy Read.

22 I expect this combination of changes will address the most pressing issues raised by the review, while supporting the overall transformation of the mental health and addiction system that is underway.

23 I note the review includes findings, and a specific recommendation, relating to the judicial processes under the Act. The response document states that, as an independent branch of government, the review and recommendation will be referred to the judiciary for its consideration. The Ministry of Health and the Ministry of Justice will work with the judiciary as appropriate to support any subsequent actions it wishes to take.

*Related work*

24 The above actions will not be enough to reduce or address the need for specialist treatment for those with severe addictions. For that, we need to look to the significant activity underway to strengthen New Zealand's approach to mental wellbeing, including preventing and minimising harm from substance use, set out in *Kia Manawanui.*

25 *Kia Manawanui* describes a continuum of activities to support mental wellbeing from promotion and early intervention to specialist services. It references other government strategies and work programmes that address the wider determinants of mental wellbeing; for example, the Child and Youth Wellbeing Strategy, the family violence and sexual violence work programme, work on a national plan of action against racism and the Homelessness Action Plan.

26 Within the mental health and addictions system specifically, *Kia Manawanui* includes several initiatives that may influence the need for and operation of the Act:

26.1 A Mental Health and Addiction System and Service Framework (currently under development). It will set guidance and expectations for the spectrum of mental health and addiction services that should be available at national, regional and local levels (including service types and integration with other mental wellbeing supports).

26.2 The development of a replacement for the Mental Health (Compulsory Assessment and Treatment) Act 1992 provides us with the opportunity to consider how legislation should best enshrine, and support the implementation of, concepts such as mana-enhancement and capacity-testing consistently across the mental health and addiction sector.

26.3 A medium-term action to consider wider reform that may follow on from the short-term review of the 2019 amendments to the Misuse of Drugs Act 1975.

27 The Law Commission is undertaking a review of laws related to adults with impaired decision-making capacity. We anticipate the outcome of this review

to be relevant to any reconsideration of how capacity is defined in the Act. We are coordinating with the Law Commission as they undertake this review to ensure that any policy development related to the concept of decision-making capacity aligns with their findings.

28 The review report also makes clear that partnering with Māori using a Treaty of Waitangi approach, embedding a whānau ora approach and ensuring mana-enhancing care are essential to making meaningful improvements to the operation of the Act and the services that support it. These changes cannot be implemented in the time period we have adopted for the immediate actions proposed in response to this review, and in my view, are not required only for the operation of this Act but for the whole mental health and addiction system. I am therefore committed to driving this approach through the medium and longer-term work to promote wellbeing and transform the mental health and addictions system and services.

**Financial Implications**

29 There are no immediate financial implications of tabling these reports as the commitments made in the government response can be delivered within baseline funding. Some of these activities may increase demand and therefore require additional funding in future. In this case resources would be sought through standard Budget processes.

**Legislative Implications**

30 There are no legislative implications of tabling these reports. The government response states that any amendments to the Act will be considered in the context of legislative work already underway to replace the Mental Health Act (Compulsory Assessment and Treatment) 1992.

**Population Implications**

31 Alcohol and other drug use is common in New Zealand. The 2019/20 New Zealand Health Survey found that men, Māori and those living in more deprived areas were more likely (twice as likely for Māori vs non-Māori) to have reported using cannabis or amphetamines recreationally in the past 12 months, though the findings for amphetamines were not statistically significant. Prevalence is higher in younger age groups for both drugs.

32 The mental health and addiction module of the 2016/17 New Zealand Health Survey also found that men and Māori were substantially more likely than other groups to have problematic or risky alcohol, cannabinoid, amphetamine, cocaine and hallucinogen use (all findings statistically significant).

33 The 2020 Alcohol Use Survey found that almost 30% of men reported experiencing harm from their own drinking in the past 12 months (as against 26% for the total population). Men, Māori and Pacific people and people living in more deprived areas were all somewhat more likely to report this. Notably, Māori women were more than twice as likely as non-Māori women to report this.

34 Nationwide consultation with Pacific communities across New Zealand to develop the *Pacific Aotearoa Lalanga Fou* report in 2018 heard that Pacific communities saw the level and spread of mental health issues were severe and widespread and the main contributing factor was harm from alcohol and other drugs. Communities also emphasised that these issues were becoming more problematic especially with the growing use of illicit drugs.

35 Māori, Pacific and Asian people are almost certainly under-represented in the group accessing the Act, although we are not yet able to know this conclusively due to the small numbers receiving compulsory treatment under the Act.

36 The actions set out in the government response have a strong focus on equity, including a focus on partnership approaches with Māori and learning more about Māori and Pacific addiction journeys. Focussing more on mana-enhancing care may also make it more likely that families and whānau will be willing to nominate men for treatment under the Act.

37 The Ministry of Health does not collect data about the disability status of those accessing the Act. However, international evidence suggests that disabled people, particularly those with a moderate intellectual impairment are less likely to access “substance abuse” services they may be eligible for. It is therefore possible that disabled people are under-represented in those accessing the Act. This issue will be addressed in its broadest sense through the medium and longer-term work underway described in paragraphs 25-27.

## Human Rights

38 The review of the Act was largely motivated by a concern that human rights could be breached by the new Act. The findings of the review indicate that there is no evidence that this is happening. However, the government response is clear that this cannot be taken for granted and that we must maintain vigilance in this area, particularly by addressing risks associated with service delivery.

## Consultation

39 The Ministry of Health prepared this paper in consultation with the Ministries of Justice and Social Development, the Department of the Prime Minister and Cabinet, the Department of Corrections, the New Zealand Police, the Office for Disability Issues, the Office for Seniors, Te Puni Kōkiri and the Ministry for Pacific Peoples.

40 The judiciary has been informed of the report, and of my proposed approach to responding to the judicial process findings and recommendation. The Ministry of Health will work with agencies and the judiciary as appropriate on cross-system actions responding to the review's recommendations.

## Communications

41 I must table the review report in the House of Representatives as soon as practicable. If you agree to the proposals in this paper, I will release the government response and release a Press Release attaching both documents.

## Proactive Release

42 I intend this Cabinet paper to be released proactively within 30 business days of final Cabinet consideration man.

## Recommendations

The Minister of Health recommends that the Committee:

1 note that the Substance Addiction (Compulsory Assessment and Treatment) Act 2017 requires a review be conducted of its first three years of operation, and that this review be tabled in Parliament as soon as practicable;

2 note that this provision was inserted due to concerns expressed to the Select Committee considering the Substance Addiction (Compulsory Assessment and Treatment) Bill for potential breaches of human rights;

3 note that the review has been completed and I accept its findings;

4 note that the Ministry of Health, as the administrator of the Act, has prepared a draft government response to the review which includes a range of immediate actions and links to the longer-term work underway to transform the mental health and addiction system;

5 note that the review includes findings and a specific recommendation relating to the judicial processes under the Act and that the response document states that the review and recommendation will be referred to the judiciary for its consideration, as an independent branch of government;

6 approve the draft government response attached to this paper, subject to any final editing requirements;

7 agree that the government response be released, alongside the review report, as soon as practicable.

Authorised for lodgement

Hon Andrew Little

Minister of Health

# Appendix: Executive Summary, Substance Addiction (Compulsory Assessment and Treatment) Act 2017 Review, Allen and Clarke

This report describes the findings, evidence, and recommendations from a review of the *Substance Addiction (Compulsory Assessment and Treatment) Act 2017* ('the Act'). The review was conducted to fulfil the legislative requirement to review the operation and effectiveness of the Act within six months of the third anniversary of the Act's commencement date.

## Review purpose

The purpose of the review is to:

- provide the Ministry of Health ('the Ministry') with information on the operation and effectiveness (outcomes) of the Act, including a focus on what is working well and what could be improved
- identify areas where improvement can be made to the operation of the Act and outcomes for applicants, people, and whānau.

## Review methods

The review used a mixed methods approach, drawing on both qualitative and quantitative data. An important data collection method was exploration of SACAT delivery in four DHB regions. This included in-depth interviews with clinicians in various statutory roles, DHB management and administrative personnel, judges, and health and social service providers. The review undertook qualitative interviews with people who had been placed under the Act and their whānau to map their 'journey' through the SACAT pathway. The review also accessed and analysed quantitative data to describe the demographic characteristics of those placed under the Act, and to determine whether engagement with the SACAT Act was associated with changes to patterns of substance use and reported wellbeing. This was supported by a review of key documents related to the delivery of the Act.

## Key findings

### *The Act plays an important legislative function in offering a pathway to treatment for people with severe substance addiction*

A widely held view amongst clinicians, whānau, statutory officers, and judges is that the Act plays an important role, in that it offers a mechanism to provide compulsory treatment for those with severe substance addiction who are at risk of severe illness and death. The review found that the people who progress through the SACAT pathway are typically those that have a lengthy history of addiction-related hospitalisation and outpatient events. Patterns of alcohol and substance consumption reported by those placed under the Act are indicative of severe addiction. Qualitative information from clinicians, people and whānau indicates that the Act is being used only as a last resort when all other options have been exhausted.

### *Systemic factors are preventing the SACAT Act from reaching groups with demonstrated need*

Those placed under the Act have mainly been of Pākehā ethnicity. Use of the Act by Māori has been much lower than would be expected, given Māori are twice as likely as non-Māori to experience a substance use disorder. Discussions with whānau Māori, clinicians, kaupapa Māori health service providers, and statutory officers raised concerns that the SACAT Act is less accessible to Māori. Throughout the SACAT pathway, there was little evidence of a specific focus on Māori and their distinctive preferences and needs, nor any indication of Māori involvement in the design of services, and little involvement of Māori in service delivery roles.

Pacific peoples' access to the Act was also substantially lower than would be expected on a population basis and in the context of addiction rates amongst these communities.

***The Act's capacity criterion focuses on cognitive functioning***

While the legal test of capacity is set out clearly in the Act and guideline on assessing capacity, clinicians stated that making a judgement as to whether a person met this test was challenging. The review found that there is inconsistency between DHB regions and individual clinicians regarding assessment processes and the interpretation of results. The legal test of capacity provides for an assessment of the person's cognitive functioning related to understanding and retaining information, problem solving, focusing attention and communication. It is intended to ensure that the right to refuse treatment is only revoked in situations where the individual does not have the cognitive capacity to make an informed decision.

Some clinicians and addiction experts considered that the definition of capacity should be amended to include consideration of addictive compulsivity and the apparent inability of the person to avoid severely damaging substance use. They expressed concerns that focusing only on current cognitive functioning does not account for the fluctuating nature of addiction, and that those with addiction to other substances, such as methamphetamine, often do not meet the criteria for impaired capacity, despite exhibiting severe addictive compulsion.

***The withdrawal management, medical stabilisation and judicial processes impact on the length of treatment***

The Act's provisions state that the first compulsory treatment order (CTO) expires 56 days after the compulsory treatment certificate (CTC) is signed. Any time spent on medically managed withdrawal or waiting for a hearing reduces the time available for treatment. During the medically managed withdrawal period, capacity tends to fluctuate meaning that a person may have capacity by the time the hearing takes place or period at the treatment centre begins. An appraisal stage has been suggested to provide for ongoing assessment of capacity.

While the judicial process is currently able to meet the statutory timeframes, it is unlikely this would be tenable if the caseloads increase. Clinicians, treatment centre personnel, judges, and whānau of people placed under the Act raised concerns about this, with anecdotal information suggesting that people are spending as little as 30 days at the treatment centre. They considered that this timeframe undermines the effectiveness of the treatment. It was suggested that the 56-day compulsory treatment period should begin once a CTO has been issued by a judge.

### *Having only one gazetted treatment centre limits options for treatment*

At present there is only one designated treatment centre under the Act. The centre does not accept people who it considers will not respond well to treatment, typically due to comorbidities such as mental health issues. As a high proportion of people that meet the SACAT criteria have comorbidities, there is a need for treatment options that cater to their needs.

### *The location of the treatment centre removes most people from whānau and other supports*

At present, most people placed under the Act are from the North Island and have to travel for treatment. The person being placed under the Act is likely to already be in a vulnerable state and undertaking a long trip can be distressing. The location also removes people from their community and any support mechanisms they have and makes it more difficult for whānau to visit. While there is financial assistance available to whānau, this is intended to fund one person to visit fortnightly and does not cover all costs associated with visiting.

Concern was raised about the limitations that having one gazetted treatment centre places on the ability to offer kaupapa Māori models of care. The distant location of the treatment centre is seen as a barrier to Māori whānau entering the SACAT process due to a reluctance to send their loved ones outside their region and away from whānau support. Whānau Māori noted that supporting only one person to visit is at odds with Māori perspectives of whānau support, which is provided by a group rather than an individual.

### *Lack of appropriate care options after discharge from the Act are undermining its effectiveness*

The review found that discharge planning is currently disjointed and limited by the lack of pathways of care for those returning from the Act. There are few beds available in supported residential accommodation, and service providers often require abstinence from substances as a condition of entry which is not seen as feasible for those discharged from SACAT. There is also little involvement of kaupapa Māori services to support the provision of culturally responsive continuing care. As a result, people are being discharged from the Act without an appropriate discharge plan. The Act's intent to restore people's capacity to make decisions about voluntary treatment is undermined by the lack of suitable continuing care options.

The Act does not provide any mechanism for services or statutory officers to engage with a person beyond the period of their compulsory treatment. The ability of DHB alcohol and drug services to continue engaging with people upon their return, or for people to engage in their plan for future treatment or care, relies on the person initiating this. In the context of a lack of suitable services, few people pro-actively engage with any services upon their return.

### *Checks and balances to support appropriate use of powers and protect human rights are central to the delivery of the Act*

Clinicians are cognisant of the power and removal of rights that SACAT entails. In response to an enquiry about beginning a SACAT application, clinicians state they always explore other options first, including voluntary or community-based treatment.

Throughout the application process and treatment, clinicians focus on the person, their history, and the best treatment options for them.

The SACAT pathway has multiple checkpoints that provide an opportunity to ensure the person's human rights are being protected. The judicial process is an important safeguard, ensuring that the range of views and evidence are weighed by an independent body and a decision made based on the balance of probabilities that compulsory treatment will protect the person. District Inspectors also play a fundamental role in the protection of human rights, ensuring that people are aware of their rights and have access to legal representation. The short and time-bound nature of the compulsory treatment also helps protect a person's human rights.

***The principle of mana enhancement is endorsed by the sector, but there is little evidence of this being operationalised in practice***

The review found that there is widespread support for the concept of mana protection and mana enhancement, and a focus from the workforce on treating all people with respect and dignity. However, the review also found that there has been limited workforce training, poor Māori representation within the workforce, little focus on operationalising mana enhancing practice, lack of robust cultural supervision and no formal accountability mechanisms established to ensure mana enhancement is a core part of the SACAT process.

***The majority of people placed under the Act relapse into substance use within a year of discharge***

The data on outcomes for people placed under the Act are sparse and often inconsistent. However, analysis of the available data show that the majority of people that have been placed under the Act experience a short-term reduction in substance use immediately after treatment. However, patterns of consumption (including reported frequency of substance use, average number of days per month alcohol was consumed and average standard drinks per typical drinking day) began climbing again around a year after treatment, and at 24 months post-discharge were at a similar level to that prior to being placed under the Act. Qualitative information from clinicians and whānau supports this finding.

**Recommendations**

Based on the findings described above, the review makes the following recommendations:

1. Consider whether the legal definition of capacity in section 9 remains fit for purpose.
2. Amend the Act to provide for a three-stage process to enable ongoing assessment of capacity and ensure people can access the full 56-day treatment programme.
3. Strengthen the provision of continuing care services for people and their whānau.
4. Gazette additional treatment provider(s) under the Act.
5. Partner with Māori on the design, delivery and monitoring of the SACAT pathway, under a Treaty of Waitangi framework.

6. Embed a Whānau Ora approach within the SACAT pathway.
7. Amend the purpose statement set out in section 3 (d) to separate capacity restoration from mana enhancement.
8. Strengthen mana enhancing practice in the SACAT pathway.
9. Establish an advisory group to the Ministry on how best to strengthen mana enhancing practice in the SACAT pathway.
10. Amend the Act to include a provision to recognise the right for people to be treated in a culturally safe way.
11. Ensure cultural safety within the SACAT pathway.
12. Enhance workforce development mechanisms for clinicians in statutory roles under the Act.
13. Ensure the judicial hearing component of the SACAT pathway is able to respond to demand.
14. Improve the collection of data in relation to the Act.

# Government Response to the Review of the Substance Addiction (Compulsory Assessment and Treatment) Act 2017

## Purpose

1. This report accompanies the report of the review of the Substance Addiction (Compulsory Assessment and Treatment) Act 2017 (the Act). It contains government's response to the review, including making commitments for immediate and longer-term action. It was prepared by the Ministry of Health.

## Summary

2. The Act was passed by Parliament on 21 February 2017. Its purpose is to enable people to receive compulsory assessment and treatment if they have a severe substance addiction and their capacity to make decisions about treatment for that addiction is severely impaired, while safeguarding their human rights.

3. The purpose of the compulsory assessment and treatment is to protect those individuals from harm and stabilise their health. The Act is intended to protect and enhance their mana and dignity and restore their capacity to make informed decisions about further treatment and substance use. The use of compulsion in the health system at any time warrants extreme caution, which the Act and its implementation are intended to provide.

4. The Act contains a specific provision requiring its operation and effectiveness to be reviewed after its first three years of operation. This provision was inserted due to concerns expressed to the Select Committee considering the Substance Addiction (Compulsory Assessment and Treatment) Bill about potential breaches of human rights.

5. The Ministry of Health (the Ministry) commissioned a review of the Act in 2020 to:
   a) provide the Ministry with information on the operation and effectiveness (outcomes) of the Act, including a focus on what is working well and what could be improved
   b) identify areas where improvement can be made to the operation of the Act and outcomes or applicants, people and whānau.

6. The review has now been completed, and in accordance with the Act, the review report must be tabled in Parliament. The Government considers the review report fair and balanced. It has highlighted both positives and negatives about the operation and effectiveness of the Act.

7. We accept the findings that the Act is performing well in achieving its purposes in relation to protection from harm, assessment of addiction and stabilising health, but is less effective at achieving its purposes of mana enhancement, restoring capacity, ongoing care planning and voluntary treatment. We are pleased to see that checks and balances to support appropriate use of powers and protect human rights are central to the delivery of the Act. However, the review highlights, and we accept, that there is room to improve the systems and services that support the Act.

8. We are particularly concerned that the Act does not appear to be accessible to some key populations including Māori, Pacific peoples, and those who use substances other than alcohol (though noting that the very small numbers mean we need to treat quantitative analyses with caution). While the review report does not mention disabled people specifically, we consider it is likely that they are also under-represented, based on evidence from other sectors in New Zealand, and international evidence around addiction treatment.

9. Equitable access to the Act is important because the treatment provided under it readies a person to receive specialist substance addiction treatment. People who need compulsory treatment are at high risk of very poor outcomes in the near future, including death. Māori and Pacific and disabled people appear under-represented in the group accessing the Act and, based on the data about substance use, we do not believe that this is because they are under-represented in the groups who could benefit from it. There is a possibility that this inequitable access could drive further inequitable health and wellbeing outcomes. The government is committed to preventing this.

10. We are taking immediate action to improve equitable and timely access to care, to promoting a harm reduction and recovery approach and to upholding Te Tiriti o Waitangi as follows. The Ministry of Health will initiate the following actions by the end of June 2022:

    a) *Increase capacity for treatment under the Act.*

    b) *Test ways of providing continuing care post-discharge from the Act.*

    c) *Workforce training and support for mana-enhancing practice and capacity testing.*

    d) *Learn more, using a range of methods including kaupapa Māori research, about the pathways Māori and Pacific individuals and whānau experiencing with severe substance addiction take towards accessing support, whether through the Act or through alternatives.*

    e) *Review and update information available to whānau, and how this is delivered, so they can have realistic expectations about the Act and outcomes.*

11. The Act is in place for people who are in need of intensive care and support for substance addiction and who do not have capacity to make a decision to engage in treatment. Treatment under the Act is the option of last resort. We anticipate that the broad work programme that this Government has underway to enhance mental wellbeing and improve the mental health and addiction system will influence the demand from people who need the intensive level of care and support that the Act is in place to make available to them. There are many activities underway described in *Kia Manawanui – Long-term Pathway to Mental Wellbeing (Kia Manawanui)* that may affect the need for treatment and support under the Act and how the Act is applied.

12. Two key actions we are already undertaking are the repeal and replacement of the Mental Health Act (Compulsory Assessment and Treatment) 1992 (the Mental Health Act) and the collaborative development of a Mental Health and Addiction System and Service Framework to set guidance and expectations for the spectrum of mental health and addiction services that should be available at national, regional and local levels (including service types and integration with other mental wellbeing supports).

## Background

13. The Substance Addiction (Compulsory Assessment and Treatment) Bill (the Bill) was developed to replace outdated legislation and address concerns that people with addictions were not receiving the treatment to which they had a right.
14. Before the Bill, the legislation that governed compulsory treatment for addiction, the Alcoholism and Drug Addiction Act 1966, was focused on detention rather than a comprehensive approach to treatment and recovery. The 1966 Act was infrequently used and poorly understood both within the addictions treatment sector and among the judiciary. It failed to protect the rights of people subject to committal, and difficulties in making applications under the Act caused significant distress for families and whānau trying to use it.

15. In 2010 the Law Commission considered whether New Zealand needed to have legislation governing the compulsory treatment of people with substance addiction. It concluded that such legislation was necessary but that it should be narrowly focused. Those conclusions included:

    - the need for compulsory treatment to be applied only to people who have severe substance addiction and have severely impaired capacity to consent to treatment for the addiction
    - the need for treatment to be applied for a limited period of time
    - the importance of protecting the rights of patients, and
    - a preference for compulsory treatment to be the option of last resort.

16. The intent of the Bill was to enable people with a severe substance addition and severely impaired capacity to decide on treatment for that addiction, to be committed to a place where their addiction could be assessed and have the opportunity to begin to engage in treatment. The purpose of compulsory assessment and treatment was to protect those individuals from harm and stabilise their health. It was also intended to protect and enhance their mana and dignity and restore the capacity to make informed decisions about further treatment and use.

17. The conclusions reached by the Law Commission are reflected in the Substance Abuse (Compulsory Assessment and Treatment) Act 2017 (the Act). The Act includes a number of world-leading features for addiction legislation. Principally, these are the creation of the principle of “mana-enhancing” services, and the concept of a decision-making capacity assessment” – this is the assessment of the person’s “capacity” to make informed decisions about treatment for a severe substance addiction.

## What the Act is intended to do and for whom

18. The Act is an option of last resort for people who are seriously unwell, to assist them to recover their capacity to decide whether or not to engage in treatment. There is a clear intention that any measure to be taken in response to such severe harm from alcohol and other drugs should be the least restrictive of the rights of the person. To that end, the period of time for which a person can be subject to the Act can be extended beyond 56 days, but not indefinitely.

19. Supported decision-making is an integral part of the suite of options available before revocation of the right to refuse treatment. This should include the provision of information in appropriate languages including New Zealand Sign Language, and Easy Read versions of written information, to both tangata whai ora and their whānau.

20. For tangata whai ora, assessment and treatment under the Act is intended to stabilise and improve wellbeing (physical and mental). Long term recovery is possible. However, given the significant harm experienced by people by the time that they are being treated under the Act, this period of care is not a 'cure', but rather is intended to be a turning point and an opportunity to facilitate planning for their treatment and care that can be continued on a voluntary basis.

21. Knowing that relapse is frequent does not mean we accept it as inevitable, which is why it is critical to have continuity of care services in place to support the person before and after a community treatment order (CTO) expires. These supports may need to be in place long-term. Diminished capacity may not be restored within weeks and may never be restored. Support services may be needed for whānau as well as the individual, to enable the person to live in the community. The Act cannot prevent the myriad pressures and trauma that contribute to the person's substance use in the first place. Our ongoing work to transform our approach to wellbeing and improve mental health and addiction services is the best place to address this. This transformation is discussed in the next section.

## The future wellbeing vision the Act is expected to contribute to

22. The Act is one part of a significant series of changes in New Zealand mental health and addiction legislation, policy and services. For example, Budget 2019 invested $69 million over four years in alcohol and other drug (AOD) services, including for specialist AOD services ($42 million over four years), and primary and community AOD services ($14 million over four years). This Budget provided new funding each year to be invested in services.

23. A key area that we know the mental health and addiction sector needs to improve in is the promotion of equity. In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes.

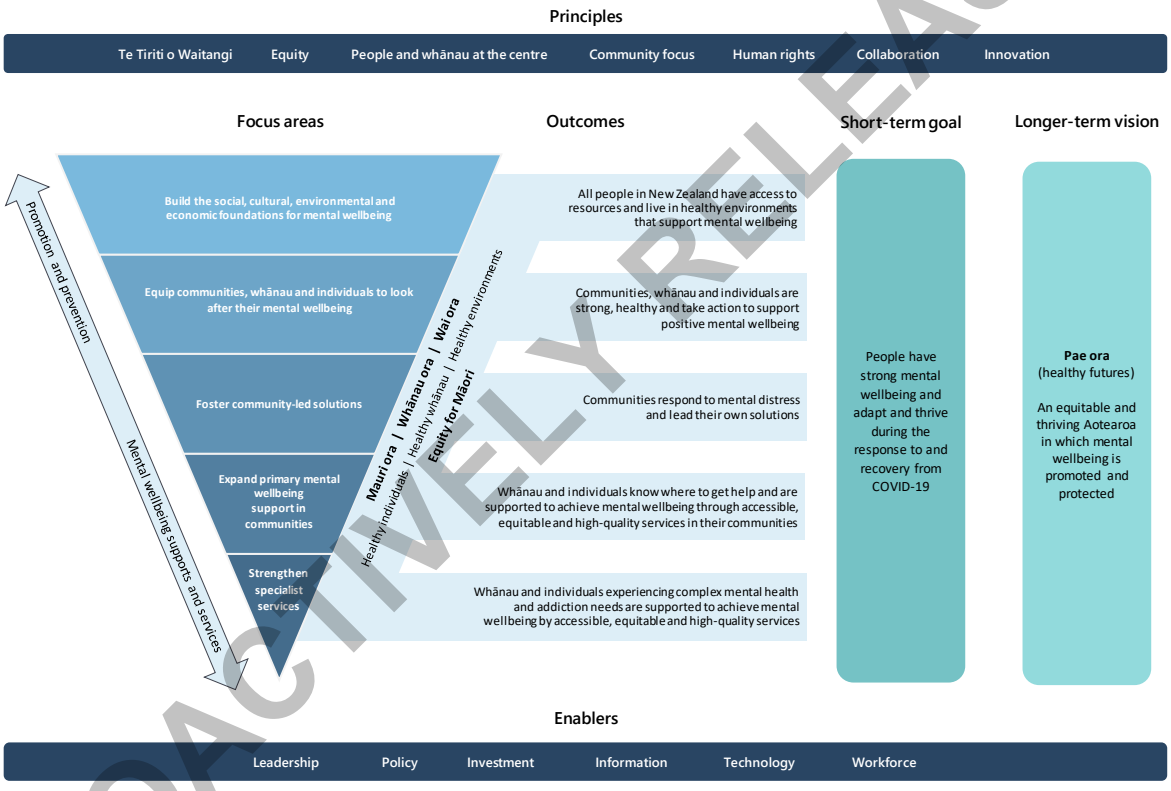
24. Inequities are not random; they are typically due to structural factors present in society and the local community that cannot be explained by biomedical differences between population groups. This means their causes are often complex and multifaceted and are outside the scope of the health system to address on its own.

25. This is very relevant in the case of this Act, because we know that Māori and Pacific people are overrepresented in the population who experience harm associated with substance use, but underrepresented in treatment and care, likely including that delivered under the Act. Inequities in any part of the system strike at the heart of our vision of wellbeing for all. The actions we will take to address these issues in the implementation of the Act are discussed in the following sections of this report.

26. The review report makes clear that partnering with Māori using a Treaty of Waitangi approach, embedding a whānau ora approach and ensuring mana-enhancing care, are essential to making meaningful improvements to the operation of the Act and the services that support it. These changes are required not only for the operation of this Act but for the whole mental health and addiction system. Government is therefore committed to driving this approach through the medium and longer-term work to promote wellbeing and transform the mental health and addictions system and services.

27. *Kia Manawanui – Long term pathway to mental wellbeing (Kia Manawanui)* is this government's approach to system transformation for the mental health and addiction sector. It recognises the nature of the transition we need to make to improve equity, by attending to the broad suite of determinants, from the environments people live in to the specialist health and addiction services available. It sets out a broad vision of a transformed shift from a focus on mental illness to a focus on mental wellbeing, which includes people being free from harm from substance use (their own, or others'). The system-wide goal of *Kia Manawanui* is Pae Ora: Healthy Futures. Pae Ora is made up of three interconnected elements – wai ora (healthy environments), whānau ora (healthy families) and mauri ora (healthy individuals).

28. This government has adopted the following mental wellbeing framework in *Kia Manawanui* for the whole mental wellbeing system, including mental health and addictions services and supports. It shows what is needed to support Pae Ora and describes the continuum of mental wellbeing needs and responses for the whole population.




29. The services and settings for the population mostly affected by the Act fit into the bottom of the triangle, "strengthen specialist services". The Act itself contributes to the outcome *that whānau and individuals experiencing complex addiction needs are supported to achieve wellbeing by accessible, equitable and high-quality services* by supporting individuals to make informed choices about the treatment they receive.

30. The set of principles that Cabinet agreed to in 2019 with regard to the repeal and replacement of the Mental Health Act are relevant when we are thinking about how the Act should function:

    i. Human rights approach: Persons receiving mental health services and their whānau should have their rights, cultures, dignity and autonomy respected and protected. There is a presumption that the legislation will align with our international obligations including the

Convention on the Rights of Persons with Disabilities, and the Convention on the Rights of Children.

ii. Maximum independence; inclusion in society; and safety of individuals, their whānau and the community: State intervention into the lives of an individual and their whānau creates a positive duty to ensure any actions are done in a manner that promotes wellbeing, enhances the ability of the individual to participate as a full member of society, reduces stigma and discrimination, and ensures the safety of the individual, their whānau and the wider community.

iii. Te Tiriti o Waitangi: Recognition and incorporation of, and respect for, the spirit and principles of Te Tiriti o Waitangi is paramount. This means all stages of legislative reform must align with the principles of Te Tiriti o Waitangi, including working in partnership with Māori.

iv. Improved equity of care and treatment: Persons needing mental health services should have equitable access to quality care and treatment, and legislation should support equitable outcomes for all population groups. Legislation permitting state intervention into the lives of an individual and their whānau should be applied equitably across populations. Māori must be a prioritised population when considering how to improve equity and outcomes under legislation.

v. Recovery approach to care and treatment: Modern approaches to ethical care and treatment which emphasise a person and whānau-centred recovery approach should be embedded into new mental health legislation.

vi. Timely service access and choice: People with mental health needs, regardless of status under legislation, should be able to access appropriate, high-quality, culturally-responsive services and support when and where they need it. People should have their individual and whānau needs and preferences recognised and responded to. Services should act with an understanding of the age, culture and maturity of the individual.

vii. Provision of least restrictive mental health care: People will be provided with assessment and treatment in the least restrictive way possible.

viii. Respect for family and whānau: Support and inclusion of family and whānau in care and treatment can be critical to wellbeing and positive outcomes. Individuals, including children and young people, need to be seen in the wider context of their family and whānau.

## The Review

31. The review was mandated at the time the legislation was passed (as discussed above). The statutory requirement is: *The Ministry of Health must, within the period of 6 months beginning on the review date conduct a review of the operation and effectiveness of this Act since its commencement* (s120(1)(a)).

32. The Ministry of Health commissioned Allen and Clarke to conduct the review. The period of time to be considered for the review was from commencement in February 2018, to the end of December 2020. The purpose of the review was to:
    a) provide the Ministry of Health with information on the operation and effectiveness (outcomes) of the Act, including a focus on what is working well and what could be improved
    b) identify areas where improvement can be made to the operation of the Act and outcomes or applicants, people and whānau.

33. Allen and Clarke structured the review around the following research questions:
    a) How well is the Act pathway for assessment and treatment of people being implemented?
    b) How well are the key principles of the Act being applied?
    c) How well are the principles applying to exercise of powers (section 12 of the Act) being applied?
        i. How well is the Act upholding human rights?
        ii. How well is the Act delivering the principle of mana enhancing practice?
        iii. How well is the Act achieving its intended purpose, as stated in section 3 of the Act?
    d) What health and wellbeing outcomes have people and whānau experienced as a result of the Act?
    e) How can the Act and its delivery be optimised to ensure positive outcomes for people and their whānau?

34. The review used a mixed methods approach, drawing on both qualitative and quantitative data. An important data collection method was exploration of delivery in four district health board (DHB) regions. This included in-depth interviews with clinicians in various statutory roles, DHB management and administrative personnel, judges and health and social service providers. The review undertook qualitative interviews with people who had been placed under the Act and their whānau to map their 'journey' through the Act's pathway. The review also accessed and analysed quantitative data to describe the demographic characteristics of those placed under the Act, and to determine whether engagement with the Act was associated with changes to patterns of substance use and reported wellbeing. This was supported by a review of key documents related to the delivery of the Act.

## Who received treatment under the Act?

35. During the period February 2018 to June 2020, there were compulsory treatment certificates (CTCs) issued under the Act for sixty individuals[1]. Forty-six of these individuals were European, nine Māori, and five were of other ethnicities. There were 26 females and 34 males. The peak age groups were 40-44 and 60-64, with nine CTCs in each. There were no CTCs in either the 15-19 or 70+ age groups. The small numbers mean quantitative analysis is not robust, but it is very likely that Māori and Pacific and Asian people are under-represented in access to the Act.

## Key findings of the review

36. The review made the following findings:
    a) The Act plays an important legislative function in offering a pathway to treatment for people with severe substance addiction.
    b) Systemic factors are preventing the Act from reaching groups with demonstrated need.
    c) The Act's capacity criterion focuses on cognitive functioning.

[1] The review report analyses characteristics of 62 individuals who were issued with CTCs. This represents what was identified in the Ministry's Programme for the Integration of Mental Health Data (PRIMHD) database as of 15 September 2020, when the data was provided to Allen and Clarke. Subsequent data cleansing has identified that two of these did not receive any compulsory treatment, so the number for this reporting period, as of 16 July 2021, is in fact 60.

d) The withdrawal management, medical stabilization and judicial processes impact on the length of treatment.

e) Having only one gazetted treatment centre limits options for treatment.

f) The location of the treatment centre removes most people from whānau and other supports.

g) Lack of appropriate care options after discharge from the Act are undermining its effectiveness.

h) Checks and balances to support appropriate use of powers and protect human rights are central to the delivery of the Act.

i) The principle of mana enhancement is endorsed by the sector, but there is little evidence of this being operationalised in practice.

j) The majority of people placed under the Act relapse into substance use within a year of discharge.

## Recommendations

37. Based on the findings described above, the review makes the following recommendations:

i. Consider whether the legal definition of capacity in section 9 remains fit for purpose.

ii. Amend the Act to provide for a three-stage process to enable ongoing assessment of capacity and ensure people can access the full 56-day treatment programme.

iii. Strengthen the provision of continuing care services for people and their whānau.

iv. Gazette additional treatment provider(s) under the Act.

v. Amend the purpose statement set out in section 3 (d) to separate capacity restoration from mana enhancement.

vi. DHBs should partner with Māori on the design, delivery and monitoring of the Act's pathway, under a Treaty of Waitangi framework.

vii. Embed a Whānau Ora approach within the Act's pathway.

viii. Strengthen mana-enhancing practice in the Act's pathway.

ix. Establish an advisory group to the Ministry of Health on how best to strengthen mana-enhancing practice in the Act's pathway.

x. Amend the Act to include a provision to recognise the right for people to be treated in a culturally safe way.

xi. Ensure cultural safety within the Act's pathway.

xii. Enhance workforce development mechanisms for clinicians in statutory roles under the Act.

xiii. Ensure the judicial hearing component of the Act's pathway is able to respond to demand.

xiv. Improve the collection of data in relation to the Act.

## Government's response

38. We consider the review report fair and balanced and we intend to address the issues identified. We have already started developing responses and some will be in place before the end of the calendar year 2021.

39. We accept the findings that the Act is performing well in achieving its purposes in relation to protection from harm, assessment of addiction and stabilising health, but is less effective at achieving its purposes of mana enhancement, restoring capacity, ongoing care planning and voluntary treatment. We are pleased to see that checks and balances to support appropriate use of powers and protect human rights are central to the delivery of the Act. However, the review highlights, and we accept, that there is room to improve the systems and services that support the Act.

40. We are particularly concerned that the Act does not appear to be accessible to some key populations including Māori, Pacific peoples, and those who use substances other than alcohol (though noting that the very small numbers mean we need to treat quantitative analyses with caution). While the review report does not mention disabled people specifically, we consider it is likely that they are also under-represented, based on evidence from other sectors in New Zealand, and international evidence around addiction treatment.

41. Equitable access to the Act is very important because the treatment provided under it readies a person to receive specialist substance addiction treatment. People who need compulsory treatment are at high risk of very poor outcomes in the near future, including death. Māori and Pacific and Asian people are almost certainly under-represented in the group accessing the Act, although we are not able to know this conclusively due to the small numbers receiving compulsory treatment under the Act. If this is the case, this inequitable access would have the potential to drive further inequitable health and wellbeing outcomes and we are committed to preventing this from happening.

## Immediate actions

42. Our response takes a themed approach based on Cabinet's principles for the new Mental Health Act as follows:
    - A human rights approach.
    - Te Tiriti o Waitangi.
    - Improved equity of care and treatment.
    - Harm reduction and recovery approach to care and treatment.
    - Timely service access and choice.

43. Some of the actions we have identified will be taken immediately, while others, for example, amendments to the legislation itself, will take longer. This will ensure our response is a stepping-stone to the broader wellbeing vision outlined above.

44. We are taking immediate action to improve equitable and timely access to care, to promoting a harm reduction and recovery approach and to upholding Te Tiriti o Waitangi as follows. The Ministry of Health will initiate the following actions by the end of June 2022:

    a) *Increasing capacity for treatment under the Act.* Nova STAR, the treatment provider, has been operating at 100% capacity in recent months. In view of concerns about the appropriateness of focussing treatment in a single geographical region, the Ministry will investigate opportunities to develop and gazette new providers, potentially via the development of a community of practice whereby sector leaders are provided with support to in turn support their peers.

    b) *Testing ways of providing continuing care post-discharge from the Act*. Continuing (post-discharge) care is not part of the treatment delivered under the Act. This is a gap in AOD

service provision in general, but particularly in the provision of a recovery approach for people treated under the Act. In addition, Nova STAR is located in Christchurch, which is not where the majority of people who access it are from (the majority being from the Northland district health board region). Taken together, this means that the responsibility for post-discharge care mostly lies with the discharged person. The Ministry of Health will design a pilot to develop and test one or more approaches to the provision of continuing care. At least one will be physically based in the Auckland or Northland regions.

c) *Workforce training and support for mana-enhancing practice and capacity testing.* The Director of Mental Health and Addiction Services (the Director) provides a series of guidelines outlining the obligations of health professionals and others who are responsible for implementing the Act. The Director will initiate a review of relevant clinical guidance, for example, touching on capacity testing and mana-enhancing practice, to ensure that it is as broad and enabling as possible under the current legislation. The Ministry will also commission at least one workforce training module or course for the workforce engaged in delivering the Act, with more to follow over time.

d) *Investigating, using a range of methods including kaupapa Māori research, the pathways Māori and Pacific individuals and whānau experiencing severe substance addiction take towards accessing support, whether through the Act or through alternatives.* It is essential that there is equitable access to care under the Act. However, it is important to understand and potentially support alternative options for those who do not wish their whānau to undergo compulsory treatment.

e) *Reviewing and updating information available to tangata whai ora and whānau and how it is delivered,* so they are well informed about the Act and potential outcomes. This includes ensuring that verbal and written information is available in appropriate languages, including New Zealand Sign Language, and formats such as Easy Read.

45. The review of the Act includes findings, and a specific recommendation, relating to the judicial processes under the Act. As an independent branch of government, the review and recommendation will be referred to the judiciary for its consideration.

## Longer-term actions

46. There is significant activity underway to strengthen New Zealand's approach to mental wellbeing, including preventing and minimising harm from substance use. *Kia Manawanui* sets out a continuum of activities that take a strong focus on wellbeing promotion, harm prevention, and early intervention across the systems that promote wellbeing. Within the mental health and addictions system specifically, there are two key initiatives that may influence the need for and operation of the Act: the replacement of the Mental Health Act and the development of a Mental Health and Addiction System and Service Framework.

47. For example, the development of a replacement for the Mental Health Act provides us with the opportunity to consider how legislation should best enshrine, and support the implementation of, concepts such as mana-enhancement and capacity-testing consistently across the mental health and addiction sector. The Law Commission is undertaking a review of laws related to adults with impaired decision-making capacity. We anticipate the outcome of this review to be relevant to any reconsideration of how capacity is defined in the Act. We are coordinating with the Law Commission as they undertake this review this ensure that any policy development related to the concept of decision-making capacity aligns with their findings.

48. *Kia Manawanui* also includes an action to strengthen the public health approach to regulation and enforcement in relation to alcohol and other drugs (for example, implementing the drug checking licensing scheme, reviewing the 2019 amendments to the Misuse of Drugs Act 1975, reviewing the Substance Addiction (Compulsory Assessment and Treatment) Act 2017.

## Acknowledgements

49. We would like to take this opportunity to acknowledge the tangata whai ora and their whānau who have been under the Act since its passing, those who worked for its development including the Law Commission, Allen and Clarke for its work, and those who were interviewed for the report.

## Appendix 1 – Key stages of the treatment process under the Substance Addiction (Compulsory Assessment and Treatment) Act 2017

| **Key stages of the treatment process under the Substance Addiction (Compulsory Assessment and Treatment) Act 2017** | |
|---|---|
| **Application** | **Section 14**<br>An applicant who believes that a person has a severe substance addiction may apply to the Director of Area Addiction Services to have the person assessed. |
| **Assessment** | **Section 22**<br>An approved specialist assesses whether a person has a severe substance addiction. If the approved specialist considers that the person has a severe substance addiction, they must then assess whether that person's capacity to make informed decisions about treatment has been severely impaired. |
| **Certification** | **Section 23**<br>After assessment, if the approved specialist considers that the person meets the criteria for compulsory treatment, they sign a compulsory treatment certificate. The person is detained at a health care service for a period of stabilisation while arrangements are made to admit them to a treatment centre. |
| **Treatment plan** | **Section 29**<br>The responsible clinician must prepare a treatment plan for the patient, arrange for the patient to be admitted into a treatment centre and apply to the court for a review. |
| **Detention** | **Section 30**<br>The responsible clinician must direct that the patient be detained and treated in a treatment centre. The primary treatment centre is Nova Supported Treatment and Recovery (Nova STAR) in Christchurch. |
| **Review** | **Section 32**<br>The court reviews the compulsory status of the patient. If the judge is satisfied the patient meets the criteria for compulsory treatment, then they can make a compulsory treatment order, which lasts 56 days. These orders may be extended for a further 56 days. |

(Source: https://www.health.govt.nz/system/files/documents/publications/office-director-mental-health-addiction-services-annual-report-2018-2019-apr21.pdf