

Regulatory Impact Statement: Substance Addiction (Compulsory Assessment and Treatment) Bill

Agency Disclosure Statement

This Regulatory Impact Statement has been prepared by the Ministry of Health (the Ministry).

It provides an analysis of the options to replace the Alcoholism and Drug Addiction Act 1966 (the ADA Act). The objective reflects the Government's and society's interest in ensuring that people with severe substance addiction have access to effective treatment, acknowledging that for some people, this may involve compulsory treatment. It also reflects the importance of ensuring that the rights of people subject to compulsion are protected.

The analysis in this Regulatory Impact Statement (RIS) considers the necessity of compulsory treatment for severe substance addiction, the means by which that could be achieved and the implications arising from the proposal.

The analysis is based on the assumption that the ADA Act needs to be repealed and replaced. The analysis is constrained by limited data on the number of people who could become subject to the proposed new legislation, and by a lack of international evidence on the effectiveness of compulsory treatment for severe substance addiction for people who have not offended.

The Ministry has attempted to identify and describe the benefits of implementing the proposal. In developing its policy proposals on 2010, the Ministry estimated that implementing the proposal could cost the health sector at least \$775,000 (excluding GST) annually. Evidence has shown that addiction treatment yields net economic benefits. The proposal is therefore expected to produce health, social and justice sector savings that will outweigh the costs over time.

The draft legislation has specific threshold criteria, based on clinical and legal requirements which must be met for a person to be subject to compulsion.

The Ministry considers that compulsory treatment for severe addiction is justified under certain circumstances. The draft legislation includes a rigorous framework to protect an individual's rights while they are undergoing compulsory treatment. The Ministry of Justice has reviewed the consistency of the new legislation with the requirements of the New Zealand Bill of Rights Act 1990.

Dr John Crawshaw
Director of Mental Health

Executive summary

1. This RIS sets out the background to the Substance Addiction (Compulsory Assessment and Treatment) Bill (the SACAT Bill), the options that have been considered in its development and the analysis that has been undertaken to ensure it meets its intended purpose.
2. The development of the SACAT Bill has been guided by a review of the legislation undertaken by the Law Commission and reported in *Compulsory Treatment for Substance Dependence: A Review of the Alcoholism and Drug Addiction Act 1966*, in October 2010 (the Law Commission Report). That review remains current in terms of the evidence considered and the conclusions reached.
3. The Law Commission report examines the operation of the ADA Act, discusses the circumstances in which compulsory treatment may be justified, considered how this issue has been managed in other jurisdictions and makes recommendations for a new compulsory treatment regime for New Zealand. The Ministry and the Law Commission worked together in developing the proposal for new legislation, considered by Cabinet in 2010.
4. Since the original policy proposals were agreed in 2010, the Ministry has worked with Parliamentary Counsel to refine the SACAT Bill, and to ensure that it reflects modern legislative structures, and is consistent with other legislation. The fundamental principles of the legislation have not been changed, however, and continue to focus on a high threshold for compulsory treatment, limited duration for compulsion, the protection of patients' rights and the role of compulsory treatment as part of a 'treatment pathway' for addiction.

Status quo and problem definition

Current situation

5. The ADA Act allows for compulsory treatment of people suffering from substance addiction in New Zealand. It is out-of-date and presents practical, clinical and legal challenges to those wishing to use it. The language, definitions and approach to alcohol and drug treatment do not reflect modern human rights-based approaches to compulsory treatment neither are they consistent with changes to the health sector or to other relevant legislation.
6. Alcohol and other drug use falls along a continuum from occasional use to problematic use or abuse, to dependence or addiction. The *Diagnostic and Statistical Manual of Mental Disorders* (fifth edition) sets out the criteria for diagnosing both substance abuse and substance dependence disorders. Substance abuse generally refers to use which either causes some physiological damage or incapacity, or which causes people to behave in socially unacceptable ways. International evidence increasingly supports a view of substance dependence or addiction as being similar to other serious psychiatric disorders. A substance dependent person has permanently altered brain cells and their ability to make informed decisions about their substance use and welfare may be erodedⁱ.
7. People with alcohol and drug problems do not represent a homogeneous group. They differ substantially on a variety of dimensions such as age, length and severity of

substance use, various co-existing mental and physical health problems, the extent and type of criminal involvement, their psychosocial functioning, the social strata to which they belong, their treatment history and their reasons for using drugs and alcoholⁱⁱ. People who enter specialist addiction treatment services are distinguished by:

- significant personal vulnerability
 - greater problem severity than other substance users
 - higher rates of legal problems related to substance abuse
 - higher rates of physical and mental illness
 - greater personal and environmental obstacles to recoveryⁱⁱⁱ
8. People are often reluctant to admit to substance use problems and may avoid treatment. Consequently, one of the most difficult populations to get into treatment, to retain in treatment, and to attain stable recovery is people with addictions^{iv}. People entering alcohol and drug treatment are usually ambivalent about altering their relationship with alcohol and drugs. The longer a person remains in treatment or connected to treatment, the greater the chance of success. Coercion or compulsion can bring people into treatment but it cannot force them to actively participate and engage in treatment in the medium to long term.
9. Specialist addiction treatment for people with severe substance use disorders involves a mixture of evidence-based interventions and services, often delivered at intervals over a number of years. In New Zealand the addiction treatment sector encompasses a spectrum of treatment types and services, both mainstream and culturally specific in primary and specialist settings. Specialist alcohol and drug services are provided by specialist teams spread across the 20 district health boards (DHBs) and 16 large non-government organisations (NGOs). There are also alcohol and drug treatment practitioners in kaupapa Māori and specialist services catering for young people.

Problem definition – the Alcoholism and Drug Addiction Act 1966

10. The ADA Act is now almost 50 years old. It has been the subject of a number of reviews since at least the 1990s that concluded it does not fulfil its purpose of ‘making better provision for the care and treatment of alcoholics and drug addicts’. The use of committal procedures under the ADA Act is infrequent and has been declining steadily since the 1970s.
11. The ADA Act is widely regarded as reflecting an outdated treatment philosophy that has not kept pace with international human rights instruments. It is also inconsistent with modern approaches to compulsory assessment and treatment: a fact that was highlighted with the introduction of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MH(CAT) Act). A number of provisions in the ADA Act are no longer used and it is not widely understood.
12. Chapter two of the Law Commission Report outlines the key provisions of the ADA Act and identifies a number of significant problems with it. The main problems identified by the Law Commission are:
- although two medical certificates are required before a person can be committed, there is no requirement that either be issued by a specialist alcohol and drug practitioner, following a personal assessment

- the committal process begins with an application to the District Court; families find it difficult to make applications and there can be delays and problems satisfying the regulatory requirements for applications.
- the statutory period of detention is two years, which far exceeds what is normally necessary to undertake any programme of treatment
- the Act makes inadequate provision for review of the detention decision
- there are generally insufficient safeguards to protect the rights of people held under the Act
- few treatment facilities are certified to accept people under the regime and consequently there is little flexibility in the type of treatment programme available^V.

Objectives

13. The development of the SACAT Bill is consistent with the Government's focus on improved treatment for people with substance use problems (including addiction), set out in *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012-2017* (Ministry of Health, 2012).
14. The Government's *Tackling Methamphetamine: An action plan* (Policy advisory group, 2009) also requires new compulsory legislation for addiction, as part of reducing harm from methamphetamine use.

Options and impact analysis

15. The analysis in this RIS is constrained by several factors. Limited data exists on the number of people in New Zealand who have a severe substance addiction and may meet the proposed threshold for compulsory treatment. Based on the information available, the Ministry of Health tentatively estimates that approximately 200 people per year could become subject to the proposed new compulsory treatment regime. This is an increase from the current 70-80 people subject to the ADA Act 1966.
16. There is little international evidence on the effectiveness of civil compulsory substance addiction treatment in achieving good long-term outcomes for individuals. However, most experts agree that compulsion can be effective to get people into a position where they can more readily help themselves.
17. The Ministry has attempted to identify and describe the benefits of implementing the proposal. In developing its policy proposals, the Ministry estimated that implementing the SACAT legislation will cost the health sector at least \$775,000 annually. However, evidence has shown that addiction treatment yields net economic benefits. The proposal is therefore expected to produce health, social and justice sector savings that will outweigh the costs over time.
18. The draft legislation has specific threshold criteria, based on clinical and legal requirements, which must be met for a person to be subject to compulsion. In determining these requirements, the Ministry has sought expert advice.

19. The Ministry supports the view of the Law Commission that compulsory treatment for severe substance addiction is justified under certain circumstances. The draft legislation includes a rigorous framework to protect an individual's rights while they are undergoing compulsory treatment. The Ministry of Justice has undertaken a review to assess the consistency of the SACAT Bill against the New Zealand Bill of Rights Act 1990.

Effectiveness of alcohol and drug treatment

20. A number of studies have demonstrated that treatment for alcohol and drug dependence is effective across various treatment modalities, with reductions in substance use and improvements in health and wellbeing^{vi}. Addiction treatment is also cost effective. Reviews are consistently finding that most addiction treatment yields net economic benefits to society^{vii}.

It is estimated that for every dollar spent on addiction treatment programmes, there is a \$4 to \$7 reduction in the cost associated with drug-related crimes. With some non-residential programmes, total savings can exceed costs by a ratio of 12:1^{viii}.

21. The single best predictor of post-treatment outcomes across the spectrum of treatment types and services for people with severe substance addiction (residential and outpatient programmes) is the length of time in treatment. People who experience treatment following a managed withdrawal have much better long-term recovery outcomes than those who only undergo managed withdrawal^{ix}. Evidence indicates that effective intensive programmes are of at least three months duration, and outpatient treatment is recommended for most people^{x xi}. Inpatient treatment options are recommended for people with serious medical conditions and co-existing mental health problems.
22. Alcohol and drug treatment is aimed at reducing harm from alcohol and drug dependence rather than producing a cure. Factors outside of treatment such as housing, family support and employment can all have a significant impact on outcomes, and need to be incorporated into the treatment process. There are some people with severe substance addiction for whom treatment will not be effective in tackling their addiction. The likelihood is that they will not survive their problems with addiction.
23. Some people may have acquired brain injury as a result of substance addiction. However, it cannot always be ascertained whether brain injury is as a result of substance addiction, or has arisen from other causes, including certain medical conditions or injury. People with acquired brain injury and severe substance addiction are likely to have needs that continually cross the boundaries between mental health, addiction, dementia and older people services^{xii}. For these people it is important that, as far as possible, arrangements are made for their long-term support and care.

Effectiveness of compulsory alcohol and drug treatment

24. New Zealand has had legislation mandating compulsory residential alcohol and drug treatment for civilians for over a century. However, there is very little New Zealand research analysing the role of coercion in the treatment of alcohol and drug problems and the majority of that information is from a legal perspective.

25. In 2008 the Ministry contracted the Health Services Assessment Collaboration to undertake a Health Technology Assessment (HTA) on the ‘effectiveness of compulsory, residential treatment of chronic alcohol or drug addiction in non-offenders. The HTA noted that a number of international literature reviews have highlighted the scant research evidence on the effectiveness of civil commitment for addiction treatment and the numerous methodological challenges in assessing the evidence that does exist^{xiv}. The HTA concluded there is some evidence that civil compulsory treatment for short periods can be an effective harm reduction mechanism. There is little available evidence to support its effectiveness in rehabilitating people or achieving long-term behavioural change.

26. The Law Commission Report concludes:

While evidence of that nature is unavailable, many experts and many working in the alcohol and drug treatment sector consider that compulsory treatment can be effective in some situations for some people...most experts agreed that compulsion can be effective to get people to a position where they can more readily help themselves.^{xv}

When is compulsory treatment justified?

27. In developing the SACAT Bill, the Ministry has benefited from the view expressed in the Law Commission report, in which it is noted that compulsory treatment for alcohol and drug dependence is justified under certain circumstances. The right to refuse medical treatment is not an absolute right.

Limits on this right may be justified when:

- *the objective achieved is of sufficient importance to warrant the limitation*
- *a rational connection exists between the limiting measure and its objective*
- *the limits go no further than is necessary; and*
- *the overall effects are beneficial*^{xvi}

28. An important public interest is served by intervening to protect people who are severely dependent on alcohol or other drugs when their capacity to care for themselves is substantially impaired and they are at risk of serious harm.

29. There is a clear and rational connection between interventions such as detoxification and taking steps to stabilise a person’s medical condition, and the objective of protecting a person from serious harm by restoring his or her capacity to make ongoing informed decisions in relation to substance use and treatment.

30. There is also evidence, mainly anecdotal, that short term treatment of this kind is effective in achieving that objective.^{xvii} Proportionality requires that the limits imposed on a person’s right to refuse treatment go no further than is necessary. The benefits of those limits must outweigh the harm arising from the infringement on their rights.

31. For most drug and alcohol dependent people, the acute risks of harm tend to be short-lived. Therefore, only a relatively short period of detention to restore capacity, during which detoxification and supporting treatment is undertaken, can be justified. Once

capacity has been restored, and there has been an opportunity to engender motivation, people must be free to determine for themselves whether to undertake ongoing treatment on a voluntary basis.

Estimated demand for compulsory treatment in New Zealand

32. Estimating the demand for a new compulsory alcohol and drug treatment regime in New Zealand is difficult because of a lack of data on how many people with a severe substance dependence disorder would meet the threshold criteria and require committal for treatment.
33. The Ministry estimates that there are 60,500 people in New Zealand with a substance dependence disorder.^{xviii} However, the vast majority of this group are not likely to require compulsory alcohol and drug treatment. Instead, some will:
 - attend treatment voluntarily
 - attend treatment as a consequence of informal coercion (for example family pressure), or formal coercion (for example, as a condition of ongoing employment)
 - be compelled to attend treatment by the criminal justice system (for example, as a condition of sentencing)
 - refuse treatment but compulsory treatment would not be appropriate (for example, their capacity to make informed decisions has not been compromised)
 - refuse treatment but will not benefit from civil commitment (for example, they have reached a point in their illness where alcohol and drug treatment can no longer help)
34. The Ministry considers that it can be safely assumed that only a very small proportion of the estimated 60,500 people with a substance dependence disorder would require or meet the criteria for compulsory treatment.
35. Based on the available information, the Ministry estimates that the annual numbers of patients committed into compulsory alcohol and drug treatment will increase from 60-70 orders per year under the ADA Act to approximately 200 orders per year under a new compulsory treatment regime.
36. Those who would meet the threshold for compulsory alcohol and drug treatment represent the most severe end of the substance use continuum and are chronically unwell. They are people who are unable to stop drinking or taking drugs, for whom less restrictive means of intervention have not proven effective and who lack the capacity to consent to treatment. Without intervention, their health is likely to further deteriorate, requiring increasingly intensive health and social services. Ultimately, serious harm or even death may result. With intervention many will improve significantly and with good after-care and support are likely to enjoy a much improved quality of life.

The objectives of the legislation

37. The SACAT Bill provides for the compulsory assessment and treatment of individuals who are considered to have severe substance addiction as it is defined in the Bill, and

who do not have the capacity to participate in treatment, as recommended in Chapter 5 of the Law Commission Report; :

- *to provide for compulsory treatment of persons with severe substance dependence for the purpose of protecting them from harm and restoring their capacity to make their own decisions about their future substance use;*
- *to stabilise their health through the application of medical treatment (including supported withdrawal);*
- *to facilitate a comprehensive assessment of their dependence*
- *to facilitate the planning of ongoing voluntary treatment and aftercare for them and*
- *to give them an opportunity to engage in voluntary treatment.*^{xix}

Principles

38. The following principles are included in the legislation and apply to all decision-making within the SACAT Bill.
- i. detention and compulsory treatment of a person under the SACAT regime should only be considered when less restrictive options will not enable effective treatment;
 - ii. wherever possible a person should be given the opportunity to engage with treatment on a voluntary basis
 - iii. where compulsion is necessary, the level of coercion used should always be the least restrictive possible to enable effective treatment
 - iv. interferences with the rights and dignity of a person are kept to minimum
 - v. the interests of the person under compulsion should remain at the centre of any decision-making in respect of that individual.

Options analysis

39. This report examines several options that have been considered in relation to five key 'big picture' policy considerations on compulsory alcohol and drug treatment.
- threshold criteria
 - maximum time limit for compulsory treatment
 - place of treatment
 - treatment orders made with patients' consent
 - legislative vehicle
40. The following sections also discuss operational aspects of the SACAT Bill, including the application process, the assessment process, patient safeguards, enforcement provisions and a number of other recommended provisions.

Threshold criteria

41. Unlike the ADA Act, the SACAT Bill includes explicit threshold criteria that must be met while a person is subject to compulsory assessment or treatment. The Law Commission proposed that a person should only be committed for treatment under the new legislation when all of the following criteria are satisfied:
- (a) a person's substance dependence is so severe that it substantially impairs his or her capacity to make informed choices about ongoing substance use and treatment; and
 - (b) care and treatment is necessary to protect the person from significant harm; and
 - (c) the person is likely to benefit from treatment for his or her substance dependence; and
 - (d) the person has refused treatment; and
 - (e) no other less restrictive means are reasonably available for treating the person
42. The Ministry considers that criterion d) from the Law Commission's report is sufficiently covered by criterion e) 'no other less restrictive means are reasonably available for treating the person' and by the proposed principles to be included in the legislation and applied to all decision-making under the legislation.
43. Removing criterion d) also avoids possible confusion with criterion a). For example, if a person meets criterion a) and has severely impaired capacity to make informed choices about ongoing substance use and treatment, then it could be argued that they cannot properly refuse (or consent to) treatment.
44. Given the technical complexity involved in defining 'severe substance dependence' (including the meaning and practical testing of 'severely impaired capacity') the Ministry has sought expert advice to ensure the definition of severe substance dependence in the legislation satisfies both clinical and legal requirements.

Risk of significant harm to others

45. The Mental Health (Compulsory Assessment and Treatment) Act 1992 includes 'risk of harm to others' as a relevant consideration for committal for treatment. A number of stakeholders have argued that the threshold criteria should also address the risk posed to others by people with severe substance use problems.
46. In light of this, the Ministry considered whether it would be appropriate to include a criterion of significant harm to others, in the Bill. The Ministry has concluded that this would not be appropriate in this legislation. Existing legislation directed at child protection, family violence and other criminal behaviour is available to deal with situations where behaviour arising from the substance addiction results in a risk of serious harm to others.
47. Alternative processes, such as immediate police intervention, will better protect those at serious risk, rather than waiting for a civil committal application to be determined. The Law Commission Report does not support the inclusion of the 'harm to others'

criterion because it changes the focus of the legislation from protecting people from significantly impaired capacity to one of protecting others from harm. It also risks compulsion becoming a means for social control rather than an approach to restore health. The equivalent legislation for Victoria and New South Wales also excludes 'harm to others' as a criterion for compulsory treatment.

Maximum time limit for compulsory treatment

Two week maximum period

48. In developing its policy proposals, the Ministry considered the *Severe Substance Dependence Treatment Act 2010* (the Act), which was under development in Victoria, Australia. The Act allows for a brief period of detention and compulsory treatment of people where this is necessary as a matter of urgency to save the person's life or prevent serious damage to their health. Detention and treatment is limited to a maximum of 14 days.
49. The Ministry believes that although compulsory managed, medical withdrawal will be lifesaving in many cases, the period of treatment provided for in the Victorian legislation is inadequate. Managed withdrawal alone does not address the underlying disorder that compels severely dependent people to drink or take drugs. People who are severely substance dependent require more than just managed withdrawal to restore their capacity to make informed decisions about their substance use and treatment.
50. The Victoria model risks a 'revolving door' situation where patients repeatedly go through managed withdrawal without any long-term improvement in managing their addiction. Even when people become motivated to change, they will often be ill-prepared and unlikely to maintain change without ongoing treatment.

Fifty six days with extension (preferred option)

51. The Law Commission's consultation identified a distinct group of people who will initially come under the regime but have brain damage as a result of chronic alcohol or drug use. They will respond more slowly to treatment and take longer to improve. Some individuals may have permanent brain damage and will, after they have recovered to the extent they can, be unlikely to benefit from further alcohol and drug treatment. Provision is needed for extensions in such cases to allow for a slower recovery or (where a person has an enduring brain injury) for arrangements to be made for ongoing care and protection (e.g. an order under the Protection of Personal and Property Rights Act 1988).
52. The SACAT Bill enables the compulsory assessment and treatment of people with severe alcohol or drug dependence (with a requirement that a person be released sooner if capacity is restored).
53. For most individuals a treatment order will be for a maximum of 56 days with a requirement that a person be released sooner if capacity is restored. The Family Court will have the power to extend an order by a further 56 days where this is necessary because a person is considered to have a brain injury and additional time is needed to complete assessment and treatment or to plan the person's discharge from compulsory status.
54. In reaching this decision, the Ministry also considered the following option.

Twenty four week maximum period (rejected)

55. In determining the maximum period of compulsory treatment, the Ministry also considered whether there was a need for a further 12-week extension, for a small group of people who have significant and/or permanent impairment cognitive damage. Additional time will be needed for adequate comprehensive neuropsychological assessment and/or to make arrangements for the long term care of the person.
56. However, following targeted consultation with alcohol and drug experts, front line clinicians and psychiatrists, the Ministry concluded that the maximum compulsory treatment period proposed of up to 24 weeks was insufficient to deliver demonstrable additional benefits over and above the maximum period weeks proposed by the Law Commission. Moreover, the additional administrative requirements arising from the two extension periods would not be justified in light of the first point.

Place of treatment

Approved treatment centres (preferred option)

57. Treatment under the SACAT regime is intended to be provided at treatment centres, intended to be a specialised residential alcohol and drug treatment centre or a medical detox facility (usually an inpatient hospital bed) and operated by an approved provider. Approved providers will be designated by the Director of Addiction Services and must meet certain requirements.

Patient's usual place of residence

58. The Ministry has considered the option of enabling the Family Court to make an order for compulsory treatment that would include a period of compulsory treatment at the patient's usual place of residence, such as in their own home.
59. This option was considered for people who, towards the end of their committal period, could undertake intensive treatment at their usual place of residence with the support of family, whānau or other support people. To manage patients under compulsion in such circumstances, the Ministry considered that the treatment order would need to specify certain conditions that the patient must adhere to, such as abstinence from drugs, place of treatment, and the requirement to accept treatment as prescribed. There would be an expectation placed on treatment providers to assertively follow-up patients to pre-empt any potential disengagement from treatment.
60. If a patient breached a condition specified under the treatment order, the patient's responsible clinician would be required to review the patient's condition and, where appropriate, apply to the Family Court for an alteration of the patient's management plan. A breach of a condition may result in more intensive patient management and if necessary, admission or readmission to a residential treatment facility. This option was initially considered useful because it:
- fulfils the objective of the least restrictive intervention
 - enables the patient to move from residential treatment into community-based treatment while still under compulsion
 - reduces the disruption to individuals' lives and the lives of their families/whanau
 - ensures that alcohol and drug treatment services establish and maintain sufficient support for community-based patients

61. However, the cases where this option would be applicable would be very rare. For instance, there would be very few people who meet the criteria for compulsory treatment (ie, chronically unwell with impaired capacity) and who would have the necessary supports in place in their usual place of residence to continue to undertake intensive treatment and remain abstinent.
62. The Law Commission was not persuaded during its consultation process that people detained under the regime could be adequately accommodated and treated without being required to reside in a certified facility. The criteria for compulsory treatment are such that only people who are severely impaired by substance dependence could come within the regime. The Law Commission Report also notes that people covered by the SACAT legislation are extremely unlikely to be suitable for treatment in their usual place of residence. Furthermore, the inclusion of community-based treatment has the potential to extend the catchment for the regime beyond that which can be justified under the New Zealand Bill of Rights Act 1990.

Treatment orders with the patient's consent

63. Under section 8 of the current ADA Act a person can make a voluntary application to the Family Court for an order requiring his or own detention for treatment. Once such an order is made it has the same effect as any other order and the person is constrained by it. Some front line clinicians have advised the Ministry that these voluntary orders are useful for engaging a patient in treatment.
64. The Ministry considered an option of enabling the Family Court to make a treatment order in circumstances where the patient expresses a desire for treatment and still meets the criteria for compulsory treatment. For example, the patient wants further alcohol and drug treatment but has impaired capacity and is assessed as being incapable of undertaking continued treatment without compulsion.
65. However, the Ministry considers that the provision of 'voluntary treatment orders' is a confusing concept and is unnecessary. The Law Commission also opposed this concept and notes that they do not think it is possible to justify a regime that recognises consent for the purposes of opting in but not enabling a person to 'opt out'.

Legislative vehicle

66. Four possible legislative vehicles were considered for the proposed regime:
- inclusion in the Mental Health (Compulsory Assessment and Treatment) Act 1992
 - inclusion in a new legislative framework developed to replace the Misuse of Drugs Act 1975
 - inclusion in the Protection of Personal and Property Rights Act 1988
 - a new, stand-alone Act

New stand along legislation (preferred option)

67. The Ministry has identified that new stand-alone legislation has the following advantages.
- it is a more straightforward and expedient approach than incorporating the policy into other legislation

- it allows the development of legislation designed specifically to support a treatment pathway for people with severe alcohol and drug dependence
68. Similarly, the Law Commission Report concludes that the most straightforward option is to enact a new, stand-alone legislation dealing solely with civil compulsory treatment for severe alcohol and drug dependence.

Incorporate policy into the Mental Health (Compulsory Assessment and Treatment) Act 1992

69. The MH(CAT) Act excludes 'substance abuse' as a sole reason for compulsory assessment and treatment. However, incorporating new regulation into the MH(CAT) Act is attractive for the following reasons:
- substance dependence is a mental disorder
 - the MH(CAT) Act contains an applications process, rights protections and mechanisms such as the district inspector regime, which could be extended to civil commitment for alcohol and drug dependence
 - an estimated 30% of people who present in crisis to mental health services have co-existing mental health and substance use problems
 - mental health services and addiction treatment services recognise the importance of providing a seamless treatment process for people with co-existing mental health and substance use problems
70. The Ministry does not recommend this approach. The MH(CAT) Act, unlike the SACAT Bill, places limits on the rights of competent adults to refuse medical treatment and allows for the making of indefinite compulsory treatment orders.
71. The treatment pathway for people who are chronically unwell because of their severe alcohol and drug dependence is very different to that of people with a mental disorder being treated under the MH(CAT) Act. There is also evidence that it is not helpful for people with very different needs to be treated in the same facility.
72. While coordination between mental health and addiction treatment services is very important, maintaining a distinction in terms of the provision of compulsory treatment has benefits, as it allows services to specialise and provide more patient-centred services.

Incorporate policy into a reformed Misuse of Drugs Act

73. There are some advantages in incorporating the proposed compulsory treatment approach into a new, broader legislative framework for regulating drugs. This approach would:
- help to reinforce harm minimisation as the key plank of drug policy
 - recognise the risks posed by alcohol even though it is not an illicit drug
 - signal a consistent approach if a reformed Misuse of Drugs Act included the option of compulsory assessment as an alternative to criminal sanctions for personal use and/or social supply of drugs

74. However, there are number of possible disadvantages with this approach.
- compulsory treatment is inconsistent with legislation that focuses on prohibiting the use of illicit drugs and establishing offences
 - the approach may deter people from seeking help (including using compulsory treatment) because of the stigma of using legislation primarily concerned with drug prohibition and offences

Inclusion in the Protection of Personal and Property Rights Act 1988

75. The Protection of Personal and Property Rights Act 1988 enables the court to appoint a welfare guardian for a person who is incapacitated to make decisions about their care and welfare and to act on those decisions. The Ministry agrees with the Law Commission's analysis on this option (below) and so does not support inclusion of compulsory treatment policy into the Protection of Personal and Property Rights Act 1988. The Law Commission Report states:

Substance dependence is a long-term relapsing condition causing intermittent and fluctuating impairment of capacity rather than continual ongoing loss. The guardianship regime in the Protection of Personal and Property Rights Act is appropriate for managing cases where there is ongoing brain impairment cause by long term alcohol use, but it would be too cumbersome for dealing with cases of severe substance dependence where the loss of capacity is of a temporary or fluctuating nature.

Operational aspects of the proposal

76. Having determined the preferred options in relation the policy questions above, the Ministry has also considered the options for managing the operation of the new legislation.
77. Aspects of the mental health framework have been adapted for the SACAT Bill, including the application and assessment processes, patient safeguards and enforcement provisions. Despite being enacted in 1992, the Mental Health (Compulsory Assessment and Treatment) Act 1992 remains a modern, human rights-based compulsory treatment framework that is well-understood and used. These are further outlined below.

Application process

78. The SACAT Bill enables any person over 18 years to apply to have a person compulsorily assessed. Applications must, wherever practicable be accompanied by a certificate issued by a medical practitioner. The certificate confirms that the medical practitioner has examined the person and has reasonable grounds to believe that the person is likely to meet the criteria and should be assessed by a specialist for compulsory treatment.
79. If a medical practitioner cannot sign the required certificate, an authorised officer (namely, a designated person with specialist knowledge of addictions treatment, but not necessarily a medical practitioner) can sign a memorandum in support of the application. Applications are to be made to the Director of Area Addiction Services (the Area Director), appointed by the Director of Addictions.

Assessment process

80. When an application is received, the Area Director must arrange for the person to be assessed by an approved specialist. An approved specialist is a health professional with significant experience in the treatment of severe substance addictions, and approved by the Director to fulfil that role.
81. If the person requires compulsory treatment, the approved specialist can issue a certificate of compulsory treatment, requiring the person to attend a treatment centre and receive treatment. If an individual does not meet the criteria for compulsory treatment, he or she must be provided with information about alternative options for treatment.

Placement in a treatment centre

82. If the approved specialist issues a certificate of compulsory treatment, the Area Director must appoint a responsible clinician for the patient. The responsible clinician must prepare a treatment plan for the patient, arrange to place the patient in a treatment centre and apply to the court for a review of the compulsory status of the patient, to be heard in the Family Court to within 10 days (with a possible extension to 20 days).
83. In arranging for a patient to be admitted to a treatment centre, the responsible clinician must obtain the agreement of the manager of the centre and must take into account the wishes and preferences of the patient and the views of others closely involved with the patient (principal caregiver, welfare guardian and nominated person).

Discharge planning and after-care

84. The SACAT Bill places strong emphasis on the ongoing management of the person undergoing compulsory treatment. As noted above, this starts when the patient is assigned a responsible clinician. The patient's responsible clinician must develop a discharge plan that may include, for example, options for the person to live in the residential care, a consideration of any orders that need to be made under the Protection of Personal and Property Rights Act 1988 and advice for family and whānau to assist in their support of the individual.

Patient safeguards

85. The SACAT Bill includes a number of important safeguards to protect the rights of patients who are subject to compulsory assessment and treatment. These rights apply throughout the assessment and treatment process, and include:
 - a general duty on the clinician responsible for the patient's treatment to discharge the patient if he or she no longer meets the criteria for compulsory treatment
 - the right of patients to seek an urgent review of compulsory status from the Family Court
 - family and whānau involvement, through making provision for the patient to nominate a support person and by identifying a principal caregiver

- people subject to the SACAT legislation will have the right to information, to respect for their cultural identity, the right to a second opinion from an independent specialist and the right to legal advice and representation
 - access to district inspectors, appointed to ensure the maintenance of patients' rights and to investigate breaches of those rights.
86. To ensure that New Zealand fulfils its commitments under the *Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (OPCAT), the Office of the Ombudsmen and the Office of the Children's Commissioner as the designated National Preventive Mechanisms in respect of health and disability services are empowered to monitor the treatment centres under the legislation.

Children and young persons

87. The SACAT Bill also includes specific provisions to protect the rights and needs of children and young persons. Those provisions are supported by the requirement that a compulsory treatment certificate can only be signed if appropriate treatment cannot be given to the child or young person under the relevant provisions of the Children, Young Persons, and their Families Act 1989. The Ministry considers it unlikely that children will be subject to the legislation due to the high admission threshold, but acknowledges that there may be a small group of young people who need intensive addiction treatment under the legislation.
88. Further provisions in respect of children and young people who are under the care of Child Youth and Family have also been included in the Bill, to ensure that the agency is kept informed of matters affecting that child or young person.

Enforcement and offence provisions

89. Police are empowered to assist in certain circumstances under the legislation, where a person is not willing to cooperate. However, it is undesirable both for the patient and for Police, to routinely engage members of Police at the beginning of the compulsory assessment process. Because of the high threshold of the Bill, it is likely that people considered for compulsory assessment will be acutely unwell, will often be in hospital for treatment of medical complications associated with their addiction.
90. Unlike the ADA Act however, absconding from a treatment centre will not be an offence. The risk of absconding will be managed by the development of management plans for each individual, and the SACAT Bill contains provisions to facilitate the return of a person to a treatment centre.
91. The SACAT Bill also creates offences relating to the ill-treatment or neglect of a patient, for staff at a treatment centre to permit or assist a patient to be absent without leave or to obstruct an inspection by a district inspector, the Director or an Area Director.

Other recommendations

92. The SACAT Bill contains provisions to enable patients to leave the treatment facility for a period of time in appropriate circumstances, such as for medical appointments, for compassionate reasons or as part of their management plan.

Consultation

93. The Law Commission undertook extensive public consultation in the preparation of its 2010 report. The main elements of its recommended regime were proposed in the issues paper *Controlling and Regulating Drugs*. The Law Commission received 51 submissions specifically on its compulsory treatment proposals. It also held 22 consultation meetings with the addiction treatment sector that covered aspects of the recommended scheme.
94. Since then, the Ministry convened consultation meetings on the policy proposals in Auckland and Wellington with alcohol and drug clinical experts and sector leaders, front-line clinicians and relevant government-sector agencies. Written comment was also provided from sector experts in Christchurch, after a meeting had to be cancelled due to the 2010 earthquake.
95. Almost all feedback supported the need for a modern, rights-based, compulsory alcohol and drug treatment regime.
96. Throughout the development of the SACAT Bill, the Ministry has worked with the addiction treatment sector and has encouraged district health boards to consider the services they need to have in place (including contracted services) to meet the needs of people subject to the legislation.
97. The Ministry of Justice, New Zealand Police, Ministry of Social Development and Te Puni Kōkiri have also been consulted with during the development of the Bill. The Chief Ombudsman and the Office of the Privacy Commissioner have offered comment on the draft Bill.

Conclusions and recommendations

Conclusions

98. The key components of the draft compulsory treatment legislation for people with severe substance addiction are outlined below.

Criteria for compulsory assessment treatment

99. Further to the consideration of the Law Commission's recommendations (see paras 41, 42). It is proposed that a person would only be liable for treatment under the SACAT Bill when all the following criteria are satisfied.
- the person has a severe substance addiction as defined in the Bill, and
 - the person has a severely impaired capacity to make informed decisions about treatment for their addiction, and
 - compulsory treatment is necessary, and
 - appropriate treatment for the person is available.

Maximum time limit for compulsory treatment

100. The proposed legislation would enable the compulsory assessment and treatment of people with severe substance addiction, with a maximum period of detention for treatment being 56 days.. The Family Court will have the power to extend this by up to a further 56 days if the person is considered likely to have a acquired and enduring brain injury

Place of treatment

101. The SACAT Bill gives the Director the power to designate a person as an approved provider, with the authority to operate treatment centre. In doing so, the Director must be satisfied that the person is certified under the Health and Disability Services (Safety) Act 2001 to provide mental health services, and has the capacity and resources to treat patients under the SACAT legislation and to comply with the legislation.

Legislative vehicle

102. New stand-alone legislation has been developed, as consideration of amending other legislation indicated that the desired goal could not be achieved through that means. As a result, the SACAT Bill is legislation designed specifically to support a treatment pathway for people with severe substance addiction and severely impaired capacity.

Mental health framework adapted

103. Aspects of the MH(CAT) Act have been adapted for the new regime. This includes the application and assessment processes, patient safeguards and enforcement provisions. The concept of national and local statutory oversight and responsibility through the Director of Addiction Services, Area Directors, authorised officers and district inspectors is similar to the structure set out in the MH(CAT) Act, and provides an effective structure for managing statutory responsibilities.
104. The Ministry considers that these roles may often be filled by officials already appointed under the MH(CAT) Act, thereby reducing the risk of establishing a further layer of bureaucracy.

Implementation issues

Implications for the addiction treatment sector

105. The Ministry expects addiction treatment services to prioritise treatment to the people who are most in need, including individuals subject to compulsory treatment. These patients are chronically unwell and represent the most severe end of substance use continuum. The patient numbers predicted to require compulsory substance addiction treatment is difficult to quantify, but is estimated to be up to 200 orders each year.
106. Additional resources have been made available to district health boards for medically managed withdrawal beds. Further resources are about to be rolled out to district health boards to provide long-term rehabilitation. The Ministry is working with addiction treatment services to support them in developing models of care, particularly around people with severe substance addiction, some of whom may be subject to the SACAT processes.

Implications for the Ministry of Health

Directors of Area Addiction Services

107. The SACAT Bill requires the Director-General of Health to appoint Directors of Area Addiction Services ('area directors'). These officials will be responsible for:
- the civil commitment process in their respective areas
 - receiving applications and arranging for compulsory assessment
 - assigning an 'approved specialist' to review the patient
 - approving responsible clinicians and assigning such to each patient
 - approving people to act as 'authorised officers'
 - arranging police assistance where necessary
 - providing advice on the function of the legislation
108. This role is similar to that which is included in the MH(CAT) Act. Given the small number of patients expected to be committed under the new legislation, it is possible that existing Directors of Area Mental Health Services and duly authorised officers appointed under the MH(CAT) Act can be asked to take on these additional functions, with some initial training.

District inspectors

109. The SACAT Bill provides for the Minister of Health to appoint district inspectors to investigate complaints and help safeguard the rights of patients. That role will be similar to the role of district inspectors under the MH(CAT) Act and the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (the IDCCR). Existing district inspectors may be asked to be appointed.

Financial implications

110. The SACAT legislation provides a more effective compulsory addiction regime than the current ADA Act, and is therefore likely to be used more extensively. It will increase costs to the Ministry of Health, DHBs and addiction treatment services, but is also likely to provide health, social and justice sector savings on the long term. The Ministry is seeking to minimise the regulatory costs by using existing addiction treatment services to implement the new regime and by using existing officials wherever practicable, including directors of area mental health services and district inspectors.
111. The Ministry has previously estimated that there will be set-up costs of \$350,000 (excluding GST) to equip the clinical and justice sectors to undertake their statutory roles in accordance with the new regime. Ongoing operational costs are estimated to be at least \$775,000 annually (excluding GST). The Ministry is working with DHB and NGO addiction treatment services to ensure that the new legislation can be effectively implemented, and to identify whether the predicted costs need to be reconsidered.

Implications for the justice sector

112. Given the relatively small number of patients expected to be assessed under the proposed legislation, the impacts on the justice sector – the New Zealand Police and the Family Court – are not expected to be significant.
113. Even though the number of treatment orders is expected to be relatively small, there is likely to be a percentage of patients who abscond from treatment centres and require the involvement of police to facilitate their return. This will need to be reflected in the

existing memorandum of understanding between Police and the Ministry and in service level agreements at DHB and Police districts.

114. The Ministry of Justice has not indicated any concern about possible cost implications to courts.
115. Under the ADA Act, the Minister of Corrections has the power to order the transfer of any prisoner into a 'certified institution' (for addiction treatment). It is not proposed to replicate this power in the SACAT Bill, as addiction treatment is provided through the Department of Corrections' health service, in prison.
116. The Ministry of Health will work with those agencies most likely to have roles in the administration of new legislation, to ensure that the impacts are identified and managed through the implementation process.

Transitional arrangements

117. The SACAT Bill includes provisions for people held under the ADA Act at the time of the new legislation coming into force. These provisions require that the person be assigned a responsible clinician and that clinician should prepare a treatment plan for the patient, arrange for the patient to be admitted to a treatment centre and apply to the court for a review of compulsory status. Pending applications for committal under the ADA Act will be required to be withdrawn.

Risks

Pressure to extend the criteria for compulsory treatment

118. The Ministry considers it likely that there will be a body of public opinion that seeks to extend the criteria for compulsory assessment and treatment. This is likely to involve the families of people who are regular drug users and who are looking for ways to compel their family members to attend treatment. There may also be calls to significantly extend the period of compulsory treatment.
119. The threshold criteria are deliberately set high, to protect people from being detained and treated unnecessarily when other, less-restrictive avenues exist. There is also insufficient evidence that long-term compulsory treatment is effective in treating addiction. Broadening the threshold criteria and extending the period of compulsion would increase the likelihood that the Bill would be found in breach of human rights framework.
120. The Ministry will ensure that the compulsory addiction treatment regime is implemented in a manner that responds to the desire of families to seek help for their family members. This will include a requirement that services provide families with advice and assistance, irrespective of whether the person comes within the scope of the legislation. Family inclusive practices are also an important part of the legislation's implementation, particularly as some people who will be under the legislation will have become estranged from their families over time.
121. It should be understood that compulsory treatment is not effective for everyone who meets the threshold criteria. While compulsory treatment will provide a real opportunity

for intervention in the lives of people who are seriously ill as a consequence of their addiction, there will be some who do not recover from their addiction. For these people, the provision of palliative and supportive care by non-medical staff in a safe environment, is appropriate. It is likely that such care would be provided in a rest-home environment, and that the Protection of Personal and Property Rights Act 1988 will be used as a further safeguard.

Use of compulsory treatment for people with severe methamphetamine dependence

122. Because of the high prevalence of alcohol dependence compared with that of other drugs, the Ministry anticipates that the majority of people committed under the SACAT regime will be people with a severe addiction to alcohol. However, the definition of 'substance' in the SACAT Bill covers a wide range of drugs, including methamphetamine, cannabis, alcohol and psychoactive substances.
- 123.. Although this initiative is expected to have a positive impact on reducing severe addiction to methamphetamine, the numbers committed with methamphetamine addiction are anticipated to be considerably lower than those for alcohol addiction. This may be perceived as a risk given that the initiative is part of the *Tackling Methamphetamine: An Action Plan*.
124. It should be acknowledged that *Tackling Methamphetamine: An Action Plan* is not the only driver for the development of the SACAT Bill. The addiction treatment sector and other stakeholders have for some time been calling for the ADA Act to be repealed or amended. The new legislation will also make an important contribution to the range of initiatives currently in place, designed to address drug-related harm.

Evaluation, monitoring and review

Reporting and monitoring

125. It is essential that the use of the new compulsory treatment regime is closely monitored and reported on. The SACAT Bill requires that the annual report of the Ministry of Health should disclose information about the number of people subject to the legislation, and various other matters.
126. Information about the use of the ADA is currently included in the Annual Report of the Director of Mental Health, and it is proposed that information about the new legislation and its impact be reported in that format.
127. The Ministry is currently developing a national mental health and addiction outcomes framework. It is likely that the framework will also provide high-level information about the impact of the SACAT legislation on a particularly vulnerable population.
128. Police have expressed some reservations about the impact of certain provisions on the Bill, on front-line staff, primarily as a result of practices that have emerged under the Mental Health (Compulsory Assessment and Treatment) Act. Although the Bill has been amended to reduce the involvement of Police with compulsorily treated patients, Police note that there is a need to monitor the level of Police involvement in the new processes established under the SACAT legislation.

Evaluation

129. The Ministry considers that there is benefit in evaluating the impact of the legislation and this will be further developed as part of the implementation planning process. Evaluation may include access to compulsory treatment, patient outcomes, cost-effectiveness and the impact on treatment services.

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- v Law Commission Report, pages 3 to 4
- vi Swan A, Alberti S. 2004. The Alcoholics and Drug-dependent Persons Act 1968: A Review. Turning Point Alcohol and Drug Centre Inc. Australian National Council on Drugs.
- vii National Committee for Addiction Treatment (NCAT). 2008. Investing in Addiction Treatment: A Resource for Funders, Planners, Purchasers and Policy Makers NCAT.
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- xii Cox, S., Anderson, I. and McCabe, L. (2004) A Fuller Life: Report of the Expert Group on Alcohol Related Brain Damage, University of Stirling and Scottish: Dementia Services Development Centre.
- xiii Webb M B. 2001. Addiction and the Law: a case-study of the Alcoholism and Drug Addiction Act. Master of Laws Thesis, University of Canterbury. Page 82.
- xiv There have been no evaluations of the effectiveness of programmes for people who have been committed for alcohol and drug treatment pursuant to the Alcoholism and Drug Addiction Act 1966.
- xv Law Commission Report, page 56
- xvi Law Commission Report, page 4-5.
- xvii An Australian review of the Inebriates Act 1912 found that there is an absence of robust evidence to support long-term compulsory interventions with the ultimate goal of 'rehabilitation'. However, relying on case studies and expert opinion, the review concluded that "compulsory treatment can be effective and therefore justified when its overriding purpose is to provide a short term, intervention to protect a person from immediate harm, restore their health and capacity, and enable them to make informed choices about moving on to longer term treatment." New South Wales Standing Committee on Social Issues (2004). Report on the Inebriates Act 1912. Sydney. New South Wales Parliament. (Page 4).
- xviii Te Rau Hinengaro – the New Zealand Mental Health Survey 2006 (Te Rau Hinengaro) estimated that, within New Zealand's adult population (16 years and over), over a twelve-month period, 1.3% have an alcohol dependence disorder, and 0.7% have another drug dependence disorder. The estimates are conservative because Te Rau Hinengaro did not include people living in institutions (such as prisons, sheltered accommodation, and hospitals) and homeless people. Using the conservative percentages from Te Rau Hinengaro and the estimated adult population as at 30 June 2009, an estimated 77,000 adults have an alcohol or other drug dependence disorder.

Annually, approximately 25,000 people in New Zealand (or 0.7% of the estimated adult population) with either a substance abuse or a substance dependence disorder receive some assistance from specialist alcohol and drug treatment services. This includes offenders in the criminal justice system receiving treatment.

There is a lack of data measuring the severity of the substance dependence disorders in people presenting for alcohol and drug treatment. However, based on the international literature, it is likely that the larger proportion of those receiving assistance from New Zealand specialist alcohol and drug treatment services have problems at the more severe end of the continuum.

For the purposes of estimating the demand for compulsory alcohol and drug treatment, the Ministry of Health has estimated conservatively that two-thirds of 25,000 people – or approximately 16,500 people – receiving specialist addiction treatment have a severe alcohol or drug dependence disorder.

Based on these estimates, the unmet demand for specialist alcohol and drug treatment by people with severe substance dependence is an estimated 60,500 people (77,000 people with substance dependence, minus 16,500 people already in treatment).

- xix Law Commission Report, page 70
- xx Law Commission Report, pages 97-99
- xxi New South Wales Standing Committee on Social Issues (2004). Report on the Inebriates Act 1912. Sydney. New South Wales Parliament. Page 41.
- xxii Gupta S, Warner J. 2008. *Alcohol-related dementia: a 21st-century silent epidemic?* The British Journal of Psychiatry 193(5): 351-3.