

Guideline on Assessing Capacity to Make Decisions about Treatment for Severe Substance Addiction

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Purpose of this guideline

The purpose of this guideline is to provide a legal and practical guide for health professionals who are assessing and treating people with severe substance addiction under the new legislation, the Substance Addiction (Compulsory Assessment and Treatment) Act 2017 ('the SA(CAT) Act' or 'the Act').¹ It is specifically aimed at addiction practitioners such as authorised officers² and approved specialists³, who will be designated under the Act and required to consider or carry out capacity assessments of people who may become subject to compulsory status under the new legislation. (In this guideline, we use the term "assessor" to refer to both authorised officers and approved specialists). The advice in this guideline will be regularly reviewed and updated to reflect evolving best practice and legal opinion about implementing the new law.⁴

A copy of the Act can be found at:

<http://www.legislation.govt.nz/act/public/2017/0004/latest/DLM6609057.html>

A complete guide to the new legislation can be found on the Ministry of Health website:

<http://www.health.govt.nz/our-work/mental-health-and-addictions/preparing-commencement-substance-addiction-compulsory-assessment-and-treatment-act-2017>

¹ This guideline is based on a practical legal and clinical toolkit developed for medical practitioners and other health practitioners when assessing the capacity of adults to make decisions within the New Zealand healthcare setting: A Douglass, G Young and J McMillan, *Toolkit for Assessing Capacity*, www.alisondouglass.co.nz/.

² SA(CAT) Act, s91.

³ SA(CAT) Act, s95.

⁴ The Ministry of Health convened a Reference Group that wrote this guideline. See Appendix 1

Introduction

Background

The Substance Addiction (Compulsory Assessment and Treatment) Act 2017 (SA(CAT) Act or the Act) comes into force on 21 February 2018. The Act replaces the Alcoholism and Drug Addiction Act 1966. People with substance addiction are currently excluded from the Mental Health (Compulsory Assessment and Treatment) Act 1992 (Mental Health Act).⁵ The SA(CAT) Act aims to balance the rights of a person with severe substance addiction (referred to as a ‘patient’ in the Act once a compulsory treatment certificate has been issued) to make their own decisions about their health and wellbeing against the (occasional) need to provide compulsory treatment for their addiction and to protect the person from serious harm. The SA(CAT) Act has specific sequential threshold criteria, based on clinical and legal requirements, which must be met for a person to be subject to compulsion. A further purpose of the compulsory treatment regime is to enable the person to restore their capacity to make informed decisions about their treatment for substance use.⁶

Principles

When assessing a person, the assessor should be guided by the following principles related to exercising powers under the Act:⁷

- the level of coercion used on patients should always be the least restrictive possible to enable effective treatment
- the assessor should take into account the views of the patient and of their principal caregiver, welfare guardian and nominated person (if applicable)
- interferences with the rights of patients should be kept to a minimum, including the right not to be arbitrarily detained⁸
- the interests of patients should remain at the centre of the assessor’s decision-making
- there should be proper recognition of the importance and significance of the patient’s ties with their whānau and family group, including recognition of these ties for the patient’s wellbeing and cultural and ethnic identity.

The Act uses much of the same language and similar procedures as the Mental Health Act. The main differences are that the SA(CAT) Act’s threshold test requires that the person has a severe substance addiction and severely impaired capacity to make informed decisions about treatment for that addiction.⁹ The Act therefore includes the need to assess the person’s capacity to make informed decisions about accepting or rejecting treatment for severe substance addiction. Capacity assessment is a relatively new concept within the addiction sector, although the aged care and disability sectors are more familiar with the concept, especially in the context of determining if people with impaired capacity need to have their financial affairs managed, or care and welfare

⁵ Mental Health (Compulsory Assessment and Treatment) Act 1992, s4.

⁶ SA(CAT) Act, s3 sets out the purpose of the new legislation.

⁷ This is a summary only of the principles that apply. See SA(CAT) Act, s12 (a)–(e)

⁸ S22 of the New Zealand Bill of Rights Act

⁹ Capacity or incapacity to consent to treatment is not a criterion for compulsory assessment and treatment under the Mental Health Act (Compulsory Assessment and Treatment) Act 1992 (refer s2, definition of ‘mental disorder’).

decisions made by a representative under the Protection of Personal and Property Rights Act 1988 (PPPR Act). The Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (IDCCR Act) is another compulsory care law, where people with impaired capacity become eligible for compulsory care and rehabilitation because of their intellectual disability and having committed a criminal offence.¹⁰

Option of last resort

The SA(CAT) Act clearly states that compulsory treatment is the option of last resort.¹¹ The necessity criterion, that is, whether compulsory treatment is ‘necessary’, will be met only if voluntary treatment is unlikely to be effective in addressing the severe substance addiction.¹² In practice, this means that it is likely that all other options without compulsion have been exhausted. It is not sufficient to state that ‘efforts to engage the person in treatment have failed’ or that the person has ‘committed to treatment based on one or two previous episodes of care’. To meet the compulsory status criteria, assessors will need to be able to demonstrate, from their own knowledge and/or clinical records, that a range of options (and providers) to engage the person in treatment for addiction has been explored. These options may include, for example, community support or programmes to address co-existing problems, homelessness, coping skills etc.

The key criteria for compulsory assessment

Sections 7 to 9 of the Act set out the key criteria for compulsory assessment and treatment under the Act. All assessors need to be familiar with these provisions, which are discussed in more detail below as part of the assessment process.

Section 7 states:

A person may be subject to compulsory treatment under this Act only if–

- (a) the person has a severe substance addiction; and
- (b) the person’s capacity to make informed decisions about treatment for that addiction is severely impaired; and
- (c) compulsory treatment of the person is necessary; and
- (d) appropriate treatment for the person is available.

A ‘severe substance addiction’ is defined in section 8 as:

(1) A severe substance addiction is a continuous or an intermittent condition of a person that–

- (a) manifests itself in the compulsive use of a substance and is characterised by at least 2 of the features listed in subsection (2); and
- (b) is of such severity that it poses a serious danger to the health or safety of the person and seriously diminishes the person’s ability to care for himself or herself

(2) The features are –

- (a) neuro-adaptation to the substance:
- (b) craving for the substance:
- (c) unsuccessful efforts to control the use of the substance:

¹⁰ The IDCCR Act only applies to people who meet the criteria for Intellectual disability under s7 of that Act and who have been charged or convicted of an imprisonable offence.

¹¹ SA(CAT) Act, s10.

¹² SA(CAT) Act, s10.

- (d) use of the substance despite suffering harmful consequences.

If a person is assessed as having a severe substance addiction and that they are at risk of serious danger, and all other options have been exhausted, it is then appropriate to consider if the person has impaired capacity to make informed decisions about treatment for the addiction.

The functional test set out in section 9 of the Act is used to assess whether a person has the capacity to make an informed decision about treatment for severe substance addiction.¹³

Section 9 of the Act states:

For the purposes of section 7(b), a person's capacity to make informed decisions about treatment for a severe substance addiction is severely impaired if the person is unable to –

- (a) understand the information relevant to the decisions; or
- (b) retain that information; or
- (c) use or weigh that information as part of the process of making the decisions; or
- (d) communicate the decisions.

The general principles that an assessor should keep in mind for every capacity assessment are:

- a person is presumed to have the capacity to make a decision unless there are good reasons to show otherwise
- the assessment is not an assessment of global capacity, rather it is about capacity to make a specific decision(s) at a specific time
- the assessment is of a person's ability to *make* a decision, not the decision itself – a person is entitled in law to make unwise or imprudent decisions, provided they have the capacity to make the decision
- cultural considerations, and, in particular, consideration of tikanga when assessing Māori tāngata whaiora,¹⁴ need to be taken into account prior to and during any capacity assessment.¹⁵

Capacity assessment

The purpose of assessing capacity is to determine by clinical interview whether the person is unable to make a legally effective decision to consent to, or refuse, treatment. Capacity to consent to treatment requires consideration of whether the person can understand:

- the nature and effects of the proposed treatment
- the purpose for which the treatment is needed
- the likelihood of success and any alternative forms of treatment.

An integral aspect of this process is the need for the assessor to explain to the person the possible consequences of receiving, or not receiving, the proposed treatment.

¹³ This is similar to the functional test set out in the Mental Capacity Act (England and Wales) 2005, s2, without the diagnostic threshold set out in section 2 of that Act (impairment of function of the brain or mind). This functional test has been recognised in New Zealand case law, see for example, *Chief Executive of the Department of Corrections v Canterbury District Health Board and All Means All* [2014] NZHC 1433 and is similar to the legal threshold used in section 5 of the PPPR Act (whether the person understands the nature and can foresee the consequences of decisions in respect to his or her personal care and welfare).

¹⁴ Mental health consumers.

¹⁵ See sections 21-24 of A Douglass, G Young and J McMillan, *Toolkit for Assessing Capacity*, www.alisondouglass.co.nz/ for more information.

A capacity assessment for the SA(CAT) Act is based on the assessment of a person's **'capacity to make informed decisions about treatment for a severe substance addiction'**.¹⁶

The assessment of capacity, which in this context should only be carried out with a person for whom compulsory treatment of addiction is appropriate and necessary, is an assessment of the four issues outlined in section 9 of the Act.

When do capacity assessments need to be carried out?

Appendix 2 of this guideline includes a timeline of the SA(CAT) Act process. A capacity assessment will need to be carried out every time there is consideration or reconsideration of whether the patient meets the compulsory status criteria during the initial assessment and throughout the 112-day maximum¹⁷ period of compulsory assessment and treatment. The critical points in time are:

- the initial screening/brief assessment by the authorised officer (section 16 of the Act) resulting in a medical certificate or memorandum (sections 17 and 18)
- the assessment by an approved specialist resulting in a compulsory treatment certificate (section 22)
- the review of compulsory treatment status¹⁸ within 10 days (Judges can extend this by up to 20 days if unable to make an initial determination) by a Family Court Judge (s29, s31 and s75)
- if there is evidence of ongoing impaired capacity and possible 'brain injury' at the end of week 5, the responsible clinician may apply to the Court to extend the Compulsory Treatment Order for an additional 56 days for the purpose of further assessment (sections 45 and 46)
- a patient, or other people specified in section 34, may at any time apply to the Court for an urgent review of the patient's status (section 34).

¹⁶ SA(CAT) Act, s9.

¹⁷ The 112-day maximum period of compulsory assessment and treatment is made up of two discrete 56-day periods of assessment and treatment, SA(CAT) Act, s32.

¹⁸ If the application is unable to be considered and reviewed within 10 days of being signed, the application is dismissed and the patient released from compulsory status, s31.

Considerations prior to carrying out a capacity assessment

As mentioned above, capacity assessments only need to be carried out if the person meets the other criteria for use of the Act, that is:

- they have severe substance addiction
- they are at serious risk of harm
- all other options have been exhausted.

Although applicants may be very distressed when making an application for compulsory assessment and treatment for a person, this does not mean that authorised officers should believe they need to respond immediately – unless there is a medical crisis. The SA(CAT) Act is not intended to be used as a response to crises. It is important when considering relying on a law like the SA(CAT) Act to uplift people from their homes to provide compulsory assessment and treatment, that these decisions are carefully considered and appropriate. Authorised officers will first need to consider if the person meets the criteria above (as explored in more detail below) and then consider if there are reasonable grounds to believe the person also has severely impaired capacity to make informed decisions about treatment for severe substance addiction. Only if a medical practitioner and/or authorised officer are satisfied that all of the criteria are met will an authorised officer need to consider making an appointment for a specialist assessment of the person.

Severe substance addiction

The primary criterion for using compulsory assessment and treatment under the SA(CAT) Act is that the person has a ‘severe substance addiction’ as defined in section 8 of the Act. Such a finding requires:

- evidence of compulsive use (section 8(1)(a))
- two of the diagnostic features set out in section 8(2)¹⁹
- serious danger to self (section 8(1)(b))
- seriously diminished ability to care for self (s8(1)(b)).

It is therefore important that assessors have a clear and shared understanding of what exactly constitutes a ‘severe substance addiction’ and what the terms ‘compulsive use’, ‘serious danger’ and ‘seriously diminishes’ mean in this context. Generally, addiction practitioners have a shared understanding of what constitutes a severe substance use disorder as described in the DSM-5²⁰ – that is, a person meets at least six of the following 11 criteria within a 12-month period:

¹⁹ Neuro-adaptation to the substance, craving for the substance, unsuccessful efforts to control the use of the substance, use of the substance despite suffering harmful consequences.

²⁰ This is a modified set of diagnostic criteria set out in the same order as in DSM-5 Substance Use Disorder. *Diagnostic and Statistical Manual of Mental Disorders*, 5th Edition: DSM-5. American Psychiatric Association 2013.

- (1) The substance is used in larger amounts and over a longer time than intended.
- (2) There is a persistent desire or a history of unsuccessful efforts to cut down or control use.
- (3) A great deal of time is spent on activities to obtain, use or recover from the effects of the substance.
- (4) The person has craving, or a strong desire, to use the substance.
- (5) Recurrent use of the substance results in failure to fulfil major role obligations at work, home or school.
- (6) Use of the substance is continued despite persistent or recurrent social or interpersonal problems caused or exacerbated by use of the substance.
- (7) Important social, occupational or recreational activities are given up or reduced because of the substance use.
- (8) There is recurrent use of the substance in situations in which it is physically hazardous.
- (9) Substance use is continued despite knowledge of having persistent or recurrent physical or psychological problems likely to have been caused or exacerbated by using the substance.
- (10) The person has tolerance as defined by either:
 - (a) a need for markedly increased amounts of the substance to get intoxicated; or
 - (b) the desired effect or a markedly diminished effect with continued use of the same amount of the substance.
- (11) Withdrawal manifests by either:
 - (a) the characteristic withdrawal syndrome for that substance; or
 - (b) a closely related substance is used to avoid or relieve withdrawal symptoms.

Section 8 of the Act and the corresponding DSM-5 criteria are set out below:

Section 8: Meaning of severe substance addiction

- (1) A *severe substance addiction* is a continuous or an intermittent condition of a person that –
 - (a) manifests itself in the *compulsive use* (criteria 1,3,5,7 of the DSM-5) of a substance *and* is characterised by at least *2 of the features* listed in subsection (2); and
 - (b) is of such severity that it poses a *serious danger* to the health or safety of the person ***and seriously diminishes the person’s ability to care for himself or herself.***
- (2) The features are –
 - (a) neuro-adaptation to the substance (criteria 10 and 11 of the DSM-5)
 - (b) craving for the substance (criterion 4 of the DSM-5)
 - (c) unsuccessful efforts to control the use of the substance (criterion 2 of the DSM-5) and
 - (d) use of the substance despite suffering harmful consequences (criteria 6 and 9 of the DSM-5).

Section 8(1)(a), in the context of severe substance addiction, compulsion can be described as an ‘irresistible urge’ to use a substance.²¹

The Act requires that at least two of the features in section 8(2) are met for the person to qualify as having a severe addiction. Although this may seem like a low threshold, using both the criteria described in the Act and applying a clear understanding of ‘compulsion’, a person is only likely to be assessed as having a severe addiction if they meet many, if not most, of the DSM-5 criteria.

²¹ <https://en.oxforddictionaries.com/definition/compulsion>

Serious danger

The term ‘serious danger’ could be open to interpretation based on subjective judgement. Assessors and practitioners therefore need to be able to document how they have judged that the person is at risk of serious danger. (Note that the Act does not include danger to others.) Prolonged use of most substances has potentially serious health and safety consequences; however, many of these risks are not acute or likely to manifest for many years. In the context of the Act, ‘serious danger’ is understood to be likely to occur within a relatively short timeframe – that is, within the next six months at the most.

Examples of ‘serious danger’ may include:

- continued alcohol use despite having cirrhosis
- repeated episodes (within a short period of time) of:
 - opiate overdoses
 - admissions for methamphetamine-related psychosis
 - driving while intoxicated
 - cooking while grossly intoxicated
 - walking in traffic while intoxicated
 - severe withdrawal when unable to access alcohol, benzodiazepines or other substances.

Seriously diminishes the person’s ability to care for themselves

The phrase ‘seriously diminishes the person’s ability to care for himself or herself’²² is also open to interpretation based on subjective understanding and practitioners’ values and attitudes.

Practitioners are strongly encouraged to establish what the person’s previous ability to care for themselves has been before making a judgement about changed ability. For example, if the person has been homeless for a significant period of time, is this state due to diminished self-care or a life-style choice? Diminished ability to care for one’s self may be shown by, for example:

- consistently not eating, as all funds have gone on purchasing the substance
- repeatedly not paying rent
- apparent loss of control of bladder in living areas
- failure to care for injuries.

Intoxication and withdrawal

It is highly likely that many people referred for an assessment under the SA(CAT) Act will be either intoxicated or in mild to moderate substance withdrawal when visited by an authorised officer to investigate if there are grounds for an application, and if assessed by an approved specialist. Both intoxication and withdrawal are considered to impair capacity, as described above, and as such could potentially skew responses to questions designed to explore whether a person has severely impaired capacity to make decisions about addiction treatment. For this reason, it is strongly recommended that when investigating applications and carrying out specialist assessments, practitioners should endeavour to ensure that people are not grossly intoxicated (as evidenced behaviourally), or in significant withdrawal. As this may be a narrow window of opportunity for someone with a severe substance addiction, the authorised officer and approved specialist will need to be prepared to be flexible about the timing, and potentially place, of capacity assessments. They will also need to document steps taken to ameliorate and/or take into account the impact of both intoxication and withdrawal when assessing the person’s capacity to make treatment decisions.

²² SA(CAT) Act, s8.

Comprehensive assessment

Carrying out a comprehensive assessment (see Matua Raki 2016²³ is considered a minimum requirement prior to carrying out a capacity assessment. Components of a comprehensive assessment that may require greater attention in the context of compulsory assessment under the SA(CAT) Act include:

- current and recorded physical health issues, especially those that may have an impact on cognition and self-care; for example, urinary tract infections (UTIs), strokes (CVAs), diabetes, chronic pain, delirium, and so on
- history of brain injuries and/or learning disability; for example, motor vehicle accidents (MVAs), assaults, autism spectrum disorder (ASD) and so on
- current and recorded mental health issues, especially those that may have an impact on cognition and self-care; for example, psychosis, schizoaffective and schizotypal disorders, major depressive disorder
- current medication
- the person's personal history and recall of their engagement with mental health and addiction services and treatment, including peer-group involvement
- family and whānau view of substance use history and impact, and engagement with mental health and addiction services and treatment.

Existing comprehensive assessments and file notes will be an important source of information to consider as part of a comprehensive assessment for the purposes of the SA(CAT) Act. It is recommended that approved specialists ensure they have access to all existing file notes before seeing a person for a specialist assessment.

²³ Matua Raki. 2016. *Mental Health and Addiction Screening and Assessment*.

Carrying out a capacity assessment

Preparing for the assessment

A significant component of assessing a person's capacity to make informed decisions about treatment for severe substance addiction is having access to the relevant background information, including:

- the person's history of treatment for substance use and any previous assessments
- the person's history of mental health treatment and/or involvement with mental health services
- the person's physical health and medical history, including history of head injuries and visits to emergency departments (EDs)
- the person's family and whānau viewpoints of their substance use history
- any available information about family and whānau dynamics
- collateral information from social agencies, including the Police.

Where the person is from a different culture from the approved specialist or the authorised officer, it is important to consider whether there are cultural considerations that need to be taken into account when having conversations with the person about accepting treatment or not, such as:

- whakamā (shame)
- having a support person or nominated person present for the interview, or a professional interpreter (eg, for people from refugee or deaf communities).

If the authorised officer has visited the person in their home (normal place of residence), and they consider that the person will not attend the specialist assessment, then where practicable and safe, the specialist assessment should be carried out in the person's home. This is especially the case where involving the Police to get the person to the assessment is likely to be counterproductive.

The capacity assessment

Starting the assessment

The capacity assessment is part of a larger assessment, started by the authorised officer and then completed by the approved specialist. As such, the general introductions, whakawhanaungatanga (the process of establishing relationships and relating well to others)²⁴ and other culturally appropriate steps will have been completed by both the authorised officer and the approved specialist. The assessment should first confirm that compulsory assessment under the SA(CAT) Act is appropriate for this person. That process will include a conversation about the reasons for the application and the person's perspective on their addiction and treatment options. The focus should primarily be on the severity of the addiction and the problems associated with the addiction (risks, deterioration of self-care, and so on) and the possible treatment options. It will be necessary to ensure that the person has all the information relevant to the decision, before assessing their capacity to make the decision.

For example: 'Hello John. I am Joe Bloggs and I am an approved addiction specialist. My role here today is to decide if you have a severe [insert relevant substance] addiction and if you can make decisions about accepting treatment for that or not. If I consider you are unable to make informed decisions about accepting treatment, I will arrange for you to receive compulsory treatment for up to 56 days.'

Providing information

As the capacity assessment is focused on the person's capacity to make informed decisions about treatment for severe substance addiction, it is important that the approved specialist has:

- disclosed all the information a reasonable person would require to make an informed decision about the treatment
- discussed the information with the person
- given the person a reasonable opportunity to ask questions about any aspect of the treatment
- given the person a reasonable opportunity to discuss the treatment with the person's principal caregiver, and/or welfare guardian (if the Court has appointed one)
- informed the person that, if the approved specialist finds the criteria for compulsory treatment are met, the person is entitled to seek independent advice from another approved specialist,²⁵ (which is a right to a second opinion).²⁶

Disclosing the information about the severe substance addiction will include discussing the evidence (usually other people's observations and reports) that supports the criteria for severe addiction and harm. As it is very likely the person will disagree with much of the evidence

²⁴

<http://maoridictionary.co.nz/search?idiom=&phrase=&proverb=&loan=&histLoanWords=&keywords=whakawhanaungatanga>

²⁵ SA(CAT) Act, s22.

²⁶ SA(CAT) Act, s 56.

presented, it is important that the evidence is reliable, especially as it may be debated in Court at a later stage. It will probably be necessary to agree to disagree with the person about this evidence. The justification for this will rest on the severity of harm arising from the addiction, and the inferred severity of impaired capacity.

It is likely that many people who will be subject to an application will have some degree of cognitive impairment. Communication strategies – such as plain language, written information, repetition and so on, that take the person’s impairment into account – will be necessary to support the person to have the information to decide about treatment if they have the capacity to do so.

Screening for cognitive functioning and contributing factors

Both the authorised officer and the approved specialist will need to assess the person’s current cognitive functioning. Impairment in cognitive functioning in this context may be caused by delirium, intoxication or withdrawal, and assessment itself may be difficult if the person is not willing to cooperate with the assessment. A minimum level of cognitive assessment should include observations of:

- level of consciousness
- ability, as observed, to focus, sustain and switch attention
- ability to communicate
- orientation to time, place and person
- short-term memory
- problem-solving ability.

Using components of a mental state examination will help to establish if the person has cognitive impairment, that may be enduring (eg, due to brain injury) or transitory (eg, due to intoxication, withdrawal, psychosis or an organic confusional state), that is likely to be affecting their capacity to make decisions about treatment. If the person is intoxicated or in withdrawal, as discussed above, the use of a formal cognitive impairment screen, such as the Montreal Cognitive Assessment (MoCA), is not recommended. In this situation, orientation in time and place and simple delayed recall can probably provide a proxy indication of current cognitive impairment. The value of using a structured assessment, if possible, is that cognitive impairment is critical to impaired capacity, and a good baseline assessment will allow much better judgement of what treatment is needed and whether the treatment is likely to be effective.

Documenting the aspects of a mental state exam that are used, and responses to the questions may also be useful to support the application to the Family Court for a compulsory treatment order. Where other contributing factors are thought to be contributing to the person’s apparent cognitive impairment, as is the case in organic confusional states, these need to be addressed appropriately.

Capacity assessment

Once the above steps have been followed, the approved specialist should explore the legal test of capacity as set out in the Act. The following four criteria need to be addressed by questions in the interview.

- 1. Is the person able to understand the information about their treatment options and/or the consequences of not accepting treatment for severe substance addiction?**

The approved specialist should directly ask the person what they understand about the information shared with them earlier and what the consequences are likely to be of continued substance use. It would be best to approach this in a methodical way. Ask first about whether the person knows and understands:

- Why they are considered to be addicted to the substance?
- Why the addiction is considered severe?
- Why this treatment option is being considered now?
- What this treatment option entails?
- Why voluntary treatment is not being considered now?
- What would happen if they had no treatment now?

2. Has the person remembered what they were told about their substance addiction and the treatment options?

The approved specialist should directly ask the person to repeat back what they have been told about their substance addiction and what the treatment recommendations were. It would only be necessary to check that they remember what is being recommended and why, not all of the options that have been discarded. Note, some people with extensive histories of involvement with addiction services, have a good grasp of the language of the sector and can readily talk about diagnoses and treatment needs, so assessors need to listen for specific elements of the current information shared with the person.

3. Is the person able to use the information about their substance addiction and treatment options, and use and weigh this up when making decisions about accepting the recommendations or not?

The approved specialist should ask the person questions such as:

- You have tried to control your substance use many times before, what will be different this time?
- What are your reasons for not accepting treatment?
- What do you think people are saying about your situation?
- Do you know you have a problem?
- What do you think will happen if you do not stop using the substance?
- What do you think would help you control your substance use?

The approved specialist should be alert to:

- superficial or apparently facile answers
- factually incorrect answers
- positive assurances of willingness to change behaviours and engage in treatment in the face of repeated evidence to the contrary in the recent past
- lack of awareness of short-term consequences
- unrealistic expectations of particular treatment options
- lack of recognition of the extent of the impact of substance use on family and whānau and/or self-care and wellbeing
- incongruent affect.

It is important to note that a person cannot be considered to lack capacity because they are considered to be making an 'unwise or imprudent' decision about accepting the need for treatment

for severe substance addiction. The test of impaired capacity is that the person genuinely does not understand or acknowledge the risks or seriousness of the situation, or the improbability of their preferred course being effective.

4. Is the person able to communicate their decisions about accepting or not accepting treatment for severe substance addiction?

In practice, it is likely that most people referred under the SA(CAT) Act will be able to communicate their decisions about addiction treatment, either verbally, in writing or drawing, or in gestures and actions. If the person is so grossly intoxicated that they are unable to communicate, this is clearly an indication that an assessment should be carried out at a later time. It is possible that people referred for assessment under the SA(CAT) Act may have communication difficulties such as aphasia. Approved specialists may therefore need to get advice about appropriate means of communicating with people with specific issues before making a judgement call about their capacity based on perceived ability to communicate their decisions.

After the capacity assessment

At this stage, the approved specialist will need to decide if they have enough information on which to base a judgement on the person's capacity to make addiction treatment decisions. If they do not have enough information to decide one way or the other, what other sources of information are needed, such as physical health and/or blood screens? Is a second appointment necessary with the person?

If the approved specialist can make a capacity assessment and finds the person meets the criteria for a compulsory treatment certificate and signs the certificate, the approved specialist then needs to notify the Area Director, who must inform the patient and other people specified in the SA(CAT) Act.²⁷ This includes the patient, the applicant, the patient's principal caregiver, the patient's welfare guardian (if the court has appointed one), the patient's nominated person, the medical practitioner who usually attends the patient, the district inspector and any person who is a guardian of a child of the patient²⁸. They must be provided with a copy of the compulsory treatment certificate and a written statement of the patient's rights and other entitlements under the Act.²⁹ The Area Director must then assign a responsible clinician to the patient.³⁰ Although the responsible clinician has responsibility for completing a treatment plan,³¹ the approved specialist has a duty of care to arrange withdrawal management and/or medical care if urgently required.³²

Assessing a person's capacity to make decisions about treatment for severe substance addiction is part of a legal process. The approved specialist therefore needs to clearly document their reasons why the person meets, or does not meet, the criteria for severely impaired capacity to make decisions about treatment for severe substance addiction.

If the person has been assessed as having the capacity to make decisions about treatment for severe substance addiction and has chosen not to accept advice about treatment options, then a duty of care remains to ensure that the person, and their family and whānau, continue to be supported as far as is possible to reduce harms and enhance their wellbeing. Examples of this include nutritional

²⁷ SA(CAT) Act, s25, s26.

²⁸ SA(CAT) Act, s 26(2).

²⁹ SA(CAT) Act, s26(1).

³⁰ SA(CAT) Act, s28.

³¹ SA(CAT) Act, s29(1)(a).

³² SA(CAT) Act, s25(1)(b).

supplements such as thiamine, Meals on Wheels, home visits, supported housing, treatment for co-existing physical and mental health problems, family and whānau counselling (eg, 5-step method³³) and self-help groups.

Ongoing capacity assessment

A central feature of the SA(CAT) Act is the expectation that treatment under the Act will contribute to restoring the person's capacity to make informed decisions about treatment for severe substance addiction, with an emphasis on engaging the person in voluntary treatment if possible.³⁴ The Act is clear that once a person's capacity is restored they can no longer be held for compulsory assessment and treatment under the Act and must be discharged from the Act.³⁵ In practice, this means that repeated capacity assessments will need to be carried out when the patient is in a treatment centre. It will be the role of a responsible clinician to carry out or organise repeated capacity assessments. As a person can initially only be detained in a treatment centre for a maximum of 56 days,³⁶ it is recommended that capacity is reviewed on the request of treatment centre staff and/or if the patient asks to discharge themselves from the treatment centre.

As capacity to make informed decisions about treatment for severe substance addiction may be temporarily restored or fluctuating, it is important to establish if capacity has been restored over time. Practically speaking, this is likely to mean that capacity assessment should be repeated every couple of days, and that the person should be discharged from the Act if it is demonstrated that capacity has been restored over time. At this stage, the responsible clinician will need to discuss and explore with the person their options and decisions about accepting treatment for severe substance addiction.

Note: As stated above, if capacity to make informed decisions about treatment for severe substance addiction is restored and the person chooses not to accept treatment recommendations, this is not an indication of impaired capacity as such. A duty of care remains with the responsible clinician to ensure that the person receives appropriate ongoing support when they return to their normal place of residence or treatment as a voluntary patient.

If capacity to make informed decisions about treatment for severe substance addiction remains impaired, then a formal cognitive impairment screening should be carried out, for example using the Montreal Cognitive Assessment (MoCA). Evidence of significant cognitive impairment is grounds to apply for an extension of the duration of compulsory assessment and treatment for a further 56 days.³⁷ During the second period of 56 days, capacity assessment will inform treatment planning and the ongoing care plan, including the possible use of the PPPR Act, for the person at the end of that time.

³³ <https://www.matuaraki.org.nz/news/the-5-step-method-for-working-with-families-and-whanau/1033>

³⁴ SA(CAT) Act, s35: 'Objective of compulsory treatment ... (b) if possible to restore the patient's capacity to make informed decisions about the patient's treatment and to give the patient an opportunity to engage in voluntary treatment'.

³⁵ SA(CAT) Act, s43.

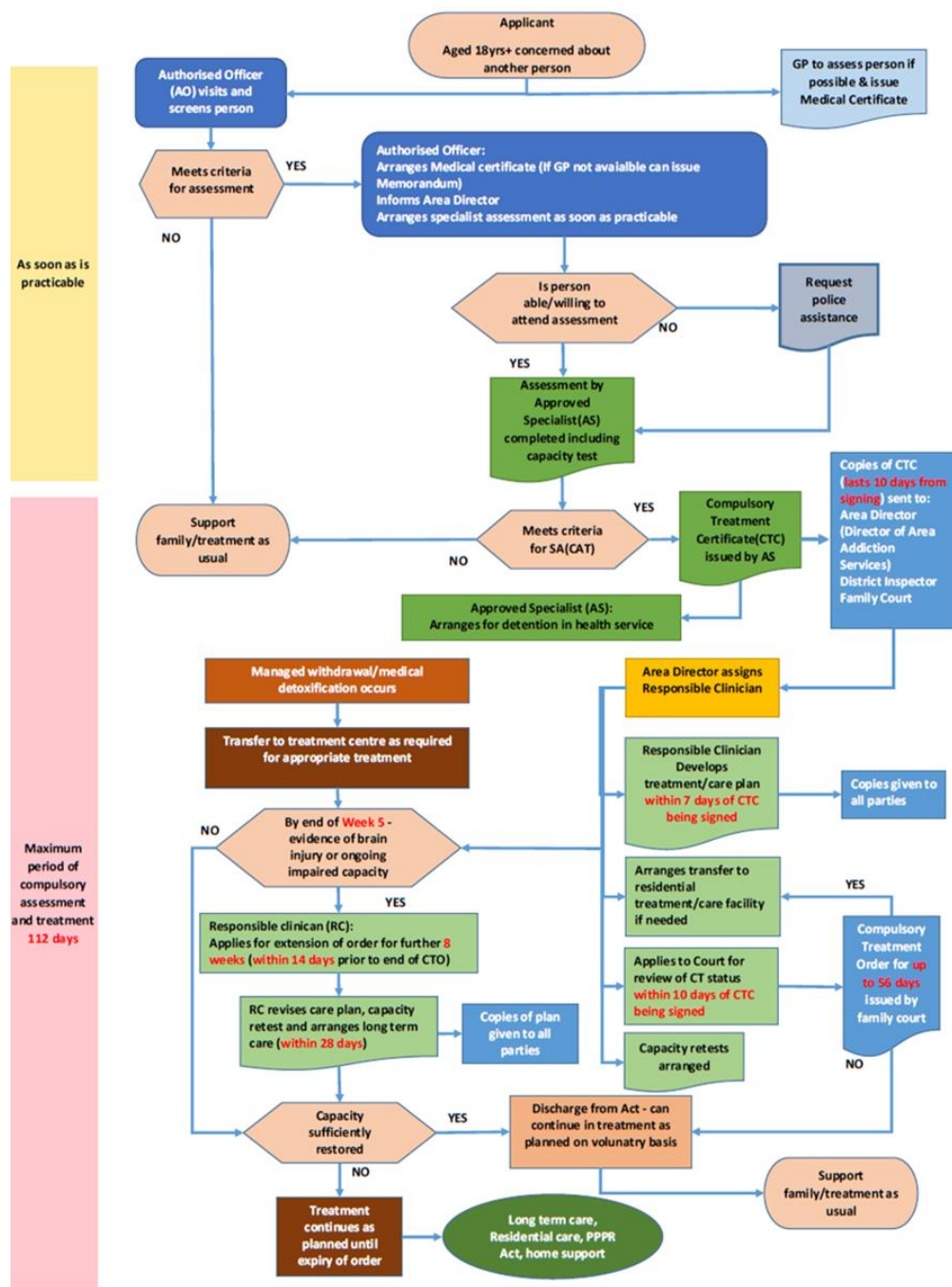
³⁶ SA(CAT) Act, s32.

³⁷ SA(CAT) Act, s46 and s47.

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Appendix 2: Process for Substance Addiction (Compulsory Assessment and Treatment) Act 2017



Appendix 3: Capacity and consent in under-16-year-olds³⁸

Overview

The relevance of the SA(CAT) Act for the treatment of children and young people is likely to be minimal.

Those young people who have used substances long and heavily enough to develop severe addiction will, in almost all cases, have life experience, maturity and understanding, such that they can normally be assumed to have capacity to make decisions about treatment for addiction.

However, there is potential for confusion as the legal framework for capacity, and consent to treatment for children is not straightforward. Furthermore, it is understandable that parents and caregivers, who feel protective of a young person who is reliant upon them, will try to use whatever means they have access to, to get a young person into treatment. As such, authorised officers and approved specialists may find themselves in the situation of having to manage inappropriate applications for compulsory assessment and treatment from distressed parents or caregivers, desperate for their young person to get help.

The following information sets out the current legal and best-practice framework around issues of capacity, and consent to treatment, for ‘minors’ in New Zealand. This has been developed to provide clarification for families, authorised officers and approved specialists who may not be familiar with this area of health-care delivery.

Consent in children

The Care of Children Act 2004 states that people over 16 can consent (or withdraw consent) to health-care procedures. However, the converse of this (that those under 16 cannot consent) does not hold. Rather, children’s competence to consent in New Zealand is regulated by the Code of Health and Disability Services Consumers’ Rights 1996 and case law, most notably the *Gillick* case.³⁹

Together these represent what the Ministry of Health⁴⁰ refers to as a ‘maturity approach’ to consent. This contrasts with a ‘status approach’ that might use firm rules based on a child’s age or independence. Also relevant is the United Nations Convention on the Rights of the Child,⁴¹ which introduced the notion of diminishing parental responsibility with the evolving capacity of the child.

³⁸ The Act distinguishes extra steps for under 17 year olds, but this guideline is about capacity, hence referring to under 16 year olds as generally a person is assumed to have legal capacity at 16 years of age.

³⁹ *Gillick v West Norfolk & Wisbeck Area Health Authority* [1986] AC 112 House of Lords.

⁴⁰ Ministry of Health. 1998. *Consent in Child and Youth Health: Information for practitioners*.

⁴¹ United Nations General Assembly. 1989. Convention on the Rights of the Child.

The Code of Health and Disability Services Consumers' Rights 1996 (the Code of Rights) presumes all consumers of health care to be competent:

- Right 7(2) states: 'Every consumer must be presumed competent to make an informed choice and give informed consent, unless there are reasonable grounds for believing that the consumer is not competent'.
- Right 7(7) addresses refusal of consent by stating: 'Every consumer has the right to refuse services and to withdraw consent to services'.

Thus, the onus is on the clinician and/or practitioner to establish whether or not a person has the capacity to consent, and this includes young people and children under the age of 16. Case law forms the basis for this position as considered by the House of Lords in the *Gillick* case. The key legal principle clarified was that parental rights came from parental duty and existed as required for the protection of the person and property of the child. However, parental rights to decide on medical treatment for their child cease when the child has the understanding and intelligence to make an informed decision.⁴²

The Ministry of Health,⁴³ provides further clarification around this issue:

The court in *Gillick* did stress that practitioners should make every effort to encourage the child to involve his or her parents, in any medical decision. But if the child refuses to involve the parents, or if the parents refuse to give consent, the doctor can proceed to treat the child if satisfied that the treatment is in the child's best interests and provided that the practitioner is satisfied that the child/young person has the understanding and maturity to make the decision.

The implication is that children and young people can also refuse to consent to treatment 'provided the practitioner is satisfied that the child or young person has the understanding and maturity to make the decision'.

Assessing capacity in children and young people

The assessment of capacity in children and young people differs little from the capacity assessment process in adults. Capacity is task-specific, and not global. For instance, someone may have the capacity to provide informed consent for a blood test, but not have the capacity to provide informed consent for an irreversible surgical procedure. Developmentally, young people may have varying cognitive performance in specific areas (such as abstract reasoning). However, because capacity is *task-based*, the principles to establish capacity regarding a specific task (such as deciding about addiction treatment) remains the same in both adults and children.

The Ministry of Health report, *Consent in Child and Youth Health*, states that the provisions for a child to be deemed to have capacity (competent) include understanding 'that they have a choice (freedom from coercion), why they are being offered the "treatment", what is involved in what they are being offered, and what the probable benefits, risks, side effects, failure rates and alternatives are'.⁴⁴

⁴² C Drake. 2001. Review: Informed consent? A child's right to autonomy. *Journal of Child Health Care*, 5(3), 101-104.

⁴³ Ministry of Health. 1998. *Consent in Child and Youth Health: Information for practitioners*.

⁴⁴ Ministry of Health. 1998. *Consent in Child and Youth Health: Information for practitioners* - [page 4]

The Medical Council of New Zealand also provides guidance on the issue and describes a competent child as ‘able to understand the nature, purpose and possible consequences of the proposed investigation or treatment, as well as the consequences of non-treatment’.⁴⁵

Adults tend to underestimate the ability of children to understand quite complex matters. In a study which assessed the capacity to consent on a specific matter in groups of 9-, 14-, 18- and 21-year-olds, the 14-year-olds were as competent as the two adult groups.⁴⁶ Similarly, screening tools and frameworks that attempt to standardise the assessment of capacity, generally conclude that competence cannot be correlated with age.⁴⁷ In one study, the finding of the mean age of 10 years old for capacity (in a sample of children required to consent to psychiatric inpatient hospitalisation and treatment) suggests that capacity is acquired much younger than many adults might think.⁴⁸

While chronological age is a poor marker of the children’s competence, things such as life experience and previous experience of medical or psychological interventions do have influence on a child’s capacity for informed consent.⁴⁹ Furthermore, health-care providers have a responsibility to do things that are likely to enhance a young person’s competence, for example, by conducting assessments in non-threatening and youth-appropriate surroundings, using plain language that is understandable and providing time for comprehension and asking questions.

Further considerations

Clinicians, practitioners and families need to be mindful that attempts to alleviate suffering using coercive methods may be potentially harmful or have unintended consequences. In almost all cases, a collaborative approach is recommended and the process of gradually engaging a young person in a therapeutic alliance, working to achieve goals that the young person sets, and liaising with families to minimise risks and enhance supervision are likely to be more effective than compelling a young person into a situation and environment to which they are resistant.

Applications for assessment of young people under the SA(CAT) Act are likely to be unsuccessful in most, if not all, cases of youth addiction. Parents and caregivers enquiring about using the SA(CAT) Act should be informed of the legal requirements regarding capacity. Essentially a young person would need to be *unable* to understand what addiction treatment would entail and be unable to weigh up the potential outcomes of accepting or rejecting treatment. This is only likely to be the case if the young person has significant cognitive impairment of some kind. In these cases, care and protection or guardianship issues are likely to be more pertinent than the addiction.

The development of a severe addiction in a young person is often a care and protection issue, and a remedy (via notification or referral to the Ministry for Vulnerable Children, Oranga Tamariki) should be considered in every case. Children who are unsupervised or in an environment where they are unable to be protected from exposure to substances are at risk. If this exposure is extensive enough to allow the development of a severe addiction, this invariably highlights that there is insufficient care and protection. In most cases, Oranga Tamariki orders are likely to provide

⁴⁵ Medical Council of New Zealand, 2011. *Information, Choice of Treatment and Informed Consent*.

⁴⁶ L Weithorn, S Campbell. 1982. The competency of children and adolescents to make informed treatment decisions. *Child Development*, 53, 1589-1598.

⁴⁷ S Billick, W Burgert III, and G Friberg. 2001. A clinical study of competency to consent to treatment in pediatrics. *J. Am. Acad. Psychiatry Law*, 29(3), 298–302.

⁴⁸ S Billick, J Edwards, and W Burgert III. 1998. A clinical study of competency in child psychiatric inpatients. *J. Am. Acad. Psychiatry Law*, 26(4), 587 - 594.

⁴⁹ P Alderson. 2007. Competent children? Minors’ consent to health care treatment and research. *Soc Sci Med.*, 65(11), 2272-2283.

families with a wider variety of options in terms of levers to encourage attendance at addiction treatment than the SA(CAT) Act. Engaging and assisting a young person to consider longer-term (rather than shorter-term) outcomes (noting that young people may have variable abilities in this domain) could also be seen as falling under the auspices of care and protection.

The treatment available under the auspices of the SA(CAT) Act is also unlikely to be appropriate for young people, as the primary focus is on the person's safety, assessment, stabilisation and restoration of capacity to engage in voluntary treatment. While it is highly likely that these aims could be achieved in very brief periods of time with young people through managed withdrawal, coerced treatment is unlikely to lead to prolonged voluntary engagement in addiction treatment. Ongoing motivational work is likely to be more effective in the long term to engage young people in voluntary treatment.

Because the intent of the SA(CAT) Act is not to treat the addiction but to restore capacity, the implication of this is that, in most cases of cognitive impairment due to causes other than the substance use, capacity is unlikely to be returned in the timeframes allowed. While there is nothing in the SA(CAT) Act to state that the cognitive impairment should be due to substance use, there is the implication that it should at least be remediable. In other words, where the lack of capacity is long-term and unlikely to change (for example, intellectual disability), the Act is unlikely to be appropriate. In these cases, a care and protection order or using the PPPR Act is more appropriate.

Discussion with a psychiatrist or psychologist working predominantly in the field of youth addiction should occur before embarking on any SA(CAT) Act assessment process with a young person. If such a specialist is not available, cases should be discussed with a Child and Adolescent Psychiatrist.

Conclusions

- Use of the SA(CAT) would be appropriate for few if any young people.
- Assessing capacity in young people is similar to assessing capacity in adults.
- Age is a poor indicator of capacity. Almost all young people old enough to use substances will have the capacity to make decisions about treatment.
- In young people who do have cognitive impairment and severe substance addiction, taking time to engage and motivate them is usually the treatment of choice rather than compulsory treatment.
- Consult with a Youth Addiction Specialist or Child and Adolescent Psychiatrist if possible.

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