

Introductory Guideline to the Substance Addiction (Compulsory Assessment and Treatment) Act 2017

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Please note that these guidelines are not intended as a substitute for informed legal opinion. Any concerns you may have should be discussed with your legal advisors.

The ways in which the Substance Addiction (Compulsory Assessment and Treatment) Act 2017 (the Act) is interpreted will change over time and will be guided by case law and practice. Consequently, this guideline will be revised as necessary and following the review of the Act as required by section 120.

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MANATŪ HAUORA



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Use of the word ‘patient’

The preferred language for referring to someone receiving addiction treatment is ‘person’. The Act uses the word ‘person’ to refer to an individual prior to a compulsory treatment certificate being issued.

Once a compulsory treatment certificate is issued, the Act uses the word ‘patient’.

This guideline uses the language of the Act, while acknowledging that people who use or provide addiction treatment services rarely use the term ‘patient’.

Introduction

This guideline is intended to support the effective and lawful use of the Substance Addiction (Compulsory Assessment and Treatment) Act 2017 (the Act). The purpose of the Act is to:

Enable persons to receive compulsory treatment if they have a severe substance addiction and their capacity to make decisions about treatment for that addiction is severely impaired, so that the compulsory treatment may –

- (a) protect them from harm; and
- (b) facilitate a comprehensive assessment of their addiction; and
- (c) stabilise their health through the application of medical treatment (including medically managed withdrawal); and
- (d) protect and enhance their mana and dignity and restore their capacity to make informed decisions about further treatment and substance use; and
- (e) facilitate planning for their treatment and care to be continued on a voluntary basis; and
- (f) give them an opportunity to engage in voluntary treatment.¹

The Act is not a comprehensive framework for addictions treatment, and it is not the preferred way for people to access addiction treatment services. Compulsory treatment under the Act provides an opportunity for addiction treatment services to work intensively with an individual to meet the intent of the Act. The period of compulsory treatment should be regarded as a ‘window of opportunity’ for intervention in the lives of a group of people who are severely ill due to the nature of their substance addiction, rather than a solution for all persons with substance addiction.

If there is uncertainty as to the ‘correct’ interpretation of the Act, any action should be taken in good faith, be consistent with the spirit and intent of the Act, and reflect best clinical practice.

The Ministry of Health (the Ministry) has issued a range of guidance material to assist addiction treatment providers and administrators to fulfil their statutory roles and to assist in the appointment of suitable candidates to statutory roles. The following documents should be read in conjunction with this guideline:

- Guideline on the role and function of Directors of Area Addiction Services appointed under the Substance Addiction (Compulsory Assessment and Treatment) Act 2017
- Guideline on the Role and function of Authorised Officers appointed under the Substance Addiction (Compulsory Assessment and Treatment) Act 2017
- Guideline on the role and function of Approved Specialists and Responsible Clinicians appointed under the Substance Addiction (Compulsory Assessment and Treatment) Act 2017
- Guideline on Assessing Capacity to make Decisions about Treatment for Severe Substance Addiction
- Criteria for Approved Providers designated under the Substance Addiction (Compulsory Assessment and Treatment) Act 2017.

¹ Section 3 of the Act.

1 Definitions and criteria for compulsory assessment and treatment

Section 4 of the Act defines the key terms that are used in the Act. It also refers the reader to the more detailed definitions of certain terms such as ‘severe substance addiction’, ‘criteria for compulsory treatment’ and ‘compulsory status’.

Severe substance addiction

‘Severe substance addiction’ is defined in section 8 of the Act (see below). The addiction must be 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:

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 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:
 - (d) use of the substance despite suffering harmful consequences.²

The definition of ‘severe substance addiction’ focuses on a degree of addiction that is clearly beyond problematic substance use and mild to moderate substance use disorders. The features of severe substance addiction can be assessed against internationally recognised criteria and are measurable over time.

The definition of severe substance addiction within the Act does not include posing a risk of ‘harm to others’. While the actions of persons with severe substance addiction can cause harm to others, the most significant harm is to themselves.

It is anticipated that most of the people who are likely to come within the scope of the Act will have a long history of attempts to engage in treatment. Despite incentives to undertake treatment, individuals subject to the Act will not have been able to be engaged, or remain, in treatment or maintain changes to their addiction.

² Section 8 of the Substance Addiction (Compulsory Assessment and Treatment) Act 2017.

‘ ... such severity that it poses a serious danger to the health or safety of the person

The following elements may be useful in assessing whether the risk presented by the person comes within the scope of ‘serious danger to the health or safety of the person’:

- nature of the harm
- magnitude of the harm
- imminence of the harm
- frequency of the harm
- situational circumstances and conditions that affect the likelihood of harm occurring
- balancing the potential for harm against the nature of the proposed intervention.

The nature and magnitude of the potential harm posed by a person’s substance addiction may be low, but the frequency with which this harm is exhibited may be high enough to amount to serious danger if, for example, the person is engaging in repetitive harmful behaviour as a result of their addiction. This may also include the possibility of a person’s argumentative or confrontational behaviour when under the influence of alcohol or drugs, resulting in the person having been victimised.

This definition would, for example, include:

- a person who, because of their severe substance addiction is unable to regularly take medication needed for the control of diabetes
- someone who suffers repeated serious injuries while under the influence of substances
- a person who regularly consumes methylated spirits to become intoxicated or continues to drink alcohol despite having cirrhosis or other serious alcohol-related health problems.

‘... seriously diminishes the person’s ability to care for himself or herself

This issue is addressed in the *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Those guidelines note that self-care is not limited to the basic necessities of survival, but includes the:

‘multiplicity of other needs such as achieving financial security, maintaining proper social relations, maintaining stable accommodation and seeking out ... the assistance of others concerning health and lifestyle. Self-care has been said to embrace all of ‘the higher complexities of modern living and the ability to cope adequately in the community’.

Self-care can also be regarded as those essential functions that can be reasonably readily provided or addressed by others. It may include the security of relationships and the ability to access support as required.

‘Substance’ is defined as:

- a) any alcohol; or
- b) any drug; or
- c) any psychoactive substance (within the meaning of section 9 of the Psychoactive Substances Act 2013); or
- d) any volatile substance; or

- e) any substance declared by regulations made under this Act to be a substance for the purposes of this Act.³

Capacity to make informed decisions

Section 9 of the Act sets out the conditions that constitute severe impairment of a person's capacity to make informed decisions about treatment for a severe substance addiction. Under section 9, a person's capacity to make informed decisions 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 purpose of assessing capacity is to determine, by a clinical interview, whether the person is unable to make a legally effective decision to consent to or refuse treatment for their severe substance addiction. The 'test' is **not** an assessment of general capacity.

The Act does not apply to persons who are acutely intoxicated, even if they temporarily lack capacity to consent to treatment. The process of applying for assessment requires that the applicant and the examining practitioner have reasonable grounds to believe that the person has a severe substance addiction and severely impaired capacity. A practitioner cannot determine whether a person has severely impaired capacity when they are intoxicated as this will be incapable of being assessed.

Repeating capacity assessments

A central feature of the 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.⁴ 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.⁵ In practice, this means that repeated capacity assessments will need to be carried out when the person is a patient in a treatment centre.

Detailed guidance for health professionals on capacity testing is provided in the document ***Guideline on Assessing Capacity to Make Decisions about Treatment for Severe Substance Addiction***.

Criteria for compulsory treatment under the Act

Section 7 of the Act sets out the criteria for compulsory treatment under the Act. In order to be compulsorily treated under the Act, a person must meet **all** of the following criteria:

- have a severe substance addiction (section 8); **and**
- have severely impaired capacity (section 9); **and**
- compulsory treatment is necessary (section 10); **and**

³ Section 4 of the Substance Addiction (Compulsory Assessment and Treatment) Act 2017.

⁴ Section 35 of the Substance Addiction (Compulsory Assessment and Treatment) Act 2017: '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.'

⁵ Section 43 of the Substance Addiction (Compulsory Assessment and Treatment) Act 2017.

- appropriate treatment must be available.

Section 7(d) sets out an important factor to be considered when determining whether a person should be subject to the Act. This section recognises that, for some people, treatment designed to address addiction may not be appropriate, either because of age or serious physical illness that would not be ameliorated by treating the addiction (eg, terminal liver disease), and the person would be more appropriately treated in an environment offering end-of-life care.

Furthermore, section 7 should be read in the context of section 10, which requires that compulsory treatment should be the option of last resort.

Compulsory treatment to be option of last resort

Section 10 states that compulsory treatment is necessary only if voluntary treatment is unlikely to be effective in addressing the severe substance addiction.

For example, in some cases a person may agree to attend treatment voluntarily, but this has been a pattern observed before without any follow-through or behaviour change. In such a case, voluntary treatment is unlikely to be effective for this person.

Participation in treatment for addiction is considerably more complicated than accepting or declining treatment. A person may move through different stages: being open to participating in treatment; relapsing and remaining in treatment; or choosing not to continue in treatment.

It is anticipated that most people coming within the scope of the Act will have been previously engaged in, and recently offered voluntary treatment, but have been repeatedly unable to remain free from addiction and are currently at risk of serious harm.

The Act does not state that compulsory treatment may be automatically used in respect of persons who have *refused* voluntary treatment.

Compulsory status – when it starts and ends

Section 11 sets out when a person's compulsory status starts and ends. Compulsory status starts immediately after an approved specialist certifies that, in relation to the person, the criteria for compulsory treatment are met.⁶

Generally, the compulsory status lasts for a maximum of 8 weeks (56 days), but that period may be extended for a further 8 weeks in the case of patients appearing to suffer from a brain injury.⁷ Compulsory status may end before the maximum period is reached if the Court does not make an order for continuing compulsory status within prescribed times or the person is released by an order of a Judge or by a responsible clinician.⁸

⁶ S23 of the Substance Addiction (Compulsory Assessment and Treatment) Act 2017

⁷ S32 of the Substance Addiction (Compulsory Assessment and Treatment) Act 2017

⁸ S31 of the Substance Addiction (Compulsory Assessment and Treatment) Act 2017

Principal caregiver

The Act defines ‘principal caregiver’ (in relation to someone who is not a child or young person) as ‘the friend of the patient or the member of the patient’s family group or whānau who is most evidently and directly concerned with the oversight of the patient’s care and welfare’ (section 4).

In relation to a patient who is a child or young person, ‘principal caregiver’ means the person who has the primary responsibility for the day-to-day care of the child or young person’ (section 4).

For many people subject to the Act, there is no dispute as to who the ‘principal caregiver’ is. If there is doubt or disagreement, the viewpoints that need to be considered are those of:

- the patient
- their spouse, partner and other family/whānau
- the patient’s support persons
- health professionals engaged with the patient.

In cases of doubt or dispute, the Director of Area Addiction Services (Area Director) should take responsibility for the decision about the principal caregiver.

Nominated person

Section 49 of the Act gives the patient the right to nominate a person to protect their interests under the Act. The patient may make the nomination (or vary or revoke it) in writing or orally, to the Area Director or their delegate; the patient’s responsible clinician or the manager of the treatment centre or any person employed at the centre.

Any person who is notified orally, must promptly record the notification in writing and provide that written notification to the Area Director, the patient’s responsible clinician and the manager of the treatment centre where the patient is detained.

The patient may revoke or vary the nomination at any time.

The exercise of this right, and the choice of a nominated person is at the discretion of the patient. This means that the nominated person may be a friend of the patient, a family member, a health professional or someone else living with an addiction. The nominated person has no authority over the patient’s interests outside the scope of the Act; for example, the patient’s financial affairs or relationships.

If the patient nominates their responsible clinician or a person closely involved in their treatment, it will be necessary to discuss any challenges that this may present in terms of professional relationships and to act accordingly.

Children and young persons

The Act defines a child or young person as a person under 18 years of age (section 4). It is not anticipated that children or young people will generally be subject to the Act. Although it is not unknown for children and young persons to have a substance addiction, it is arguable as to whether they would meet the criteria for compulsory treatment in terms of the severity of their addiction, severity of capacity impairment or the requirement in section 10 that compulsory treatment should be the option of last resort.

Despite those factors, there may be instances in which children or young people (primarily the latter) will require compulsory treatment for severe substance addiction.

Section 13 sets out the principles that are particularly relevant to the exercise of powers under the Act, with respect to children or young persons. These principles, in addition to the general principles in section 12, affirm the need to regard the child or young person within the context of their family, whānau, hapū, iwi and family group and to act with understanding of the age, culture and maturity of the child or young person.

Assessing capacity in children and young people

The Care of Children Act 2004 states that people over the age of 16 can consent (or withdraw consent) to health-care procedures. However, the converse of this (that those under 16 cannot consent) does not hold. Children's competence to consent to treatment in New Zealand is regulated by the Code of Health and Disability Services Consumers' Rights 1996 and case law, most notably the *Gillick* case (House of Lords, 1985).⁹ Together these represent what the Ministry of Health (Ministry of Health, 1998)¹⁰ refers to as a 'maturity approach' to consent.

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. 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 and caregivers, desperate for their young person to get help.

Guidance to assist authorised officers and approved specialists in applying the Act to young people under the age of 16 years has been developed and forms part of the *Guideline on Assessing Capacity to Make Decisions about Treatment for Severe Substance Addiction* (Appendix 3).

⁹ *Gillick v West Norfolk & Wisbeck Area Health Authority* House of Lords [1986] AC 112 House of Lords.

¹⁰ Ministry of Health. 1998. *Consent in Child and Youth Health: Information for practitioners*.

2 Rights of patients

The rights of all patients are set out in Subpart 5 of the Act. They supplement the rights affirmed in the New Zealand Bill of Rights Act 1990 (NZBORA) and the rights enjoyed by all health service consumers under the Health and Disability Services Consumers' Code of Rights 1996 (Code of Rights). The powers for providing compulsory assessment and treatment under the Act should be read consistently with the rights in the NZBORA and the Code of Rights as far as possible.

Although the rights in Subpart 5 of the Act specifically apply to 'patients' under the Act, they should be interpreted as applying wherever practicable to all people subject to the Act, including those who are not yet subject to a compulsory treatment certificate.

Patients under the Act have rights to:

- nominate a person to protect the patient's interests
- be informed of their rights
- be dealt with in accordance with the objective of compulsory treatment and with the principles set out in sections 12, 13 and 35 of the Act
- treatment
- be informed about treatment
- be informed in case of visual or audio recording
- independent advice from an approved specialist
- legal advice
- company
- receive visitors and make and receive telephone calls
- receive and send mail and electronic communications.

The patient's principal caregiver, welfare guardian, and nominated person have the right to be informed of events affecting the patient (section 51).

Section 53 Right to treatment

Patients have a right to receive medical treatment and other health care appropriate to their condition, and to receive general treatment and care that they would be entitled to if they were not subject to the Act.

Section 54 Right to be informed about treatment

Every patient is entitled to receive an explanation of the expected effects of any treatment they are offered, including the expected benefits and the likely side effects, before treatment starts. Because people with severe substance addiction are likely to have reduced capacity to understand and retain information about their treatment, information may need to be repeated at intervals throughout the compulsory treatment period.

The quantity and quality of the information given will depend on the nature of the situation.

Matters to be discussed with the patient should include:

- the reasons for the treatment and its intended effects
- likely course of the treatment

- details of the medication, dose and method of administration (in the case of pharmaceuticals)
- any other relevant information including the plan for continuing care.

Patients are entitled to effective communication in a form, language and manner that enables them to understand the information provided and in an environment that enables open, honest and effective communication (Right 5, Code of Rights). Information should be repeated as appropriate. Information provided in written form should also be explained verbally. Under Right 6(4) of the Code of Rights, ‘every consumer has the right to receive, on request, a written summary of information provided’.

Section 55 Rights in case of visual or audio recording

Every patient is entitled to be informed if it is intended to make or use a visual or audio recording of an interview with the patient, an aspect of the treatment or care of the patient. Furthermore, an audio or visual recording of the patient cannot be made without the consent of the patient or their guardian, or if the patient is dead.

Section 56 Right to independent advice from approved specialist

Every patient is entitled to seek a second opinion from an independent approved specialist, chosen by the patient. If the approved specialist agrees to the consultation, they must be provided access to the patient and must provide their opinion on the patient’s condition as soon as practicable.

Section 57 Right to legal advice

Every patient is entitled to request a lawyer to provide the patient with advice on their legal status and rights as a patient, or on any other legal matter. If the lawyer agrees to act for the patient, they must be given access to the patient and must provide their advice as soon as practicable.

The Area Director should ensure that satisfactory arrangements have been made with the local branch of the New Zealand Law Society to ensure that a patient can obtain the services of a lawyer if they do not already have a lawyer. The Law Society can provide a list of names of counsel suitably experienced and trained in providing legal advice to people who are subject to compulsory assessment and treatment.

If a patient asks to see a named lawyer, that person should be contacted without delay.

Section 58 Right to company

Every patient is entitled to the company of others. This means that patients cannot be placed in seclusion or otherwise isolated from others.

Section 58 can be also interpreted more widely, reflecting the importance of supporting pro-social behaviour and building and restoring relationships with family and whānau.

Section 59 Right to receive visitors and make and receive telephone calls

Every patient is entitled to receive visitors and make and receive telephone calls, at reasonable times and at reasonable intervals.

This right can be limited if, in the opinion of the responsible clinician, a visit or telephone call would be detrimental to the patient or to their treatment. This could include, for example, restrictions on a visitor bringing alcohol or drugs into the treatment centre, or a visitor who encourages the patient to provide drugs to other patients.

Consultations with an approved specialist (section 56) or a lawyer consulted under section 57 are not subject to the restrictions in this section.

Section 60 Right to receive and send mail and electronic communications

Every patient is entitled to send and receive mail and electronic communications in a manner that safeguards the patient's privacy. This section only applies if the patient has access to a computer or other device that enables electronic communication; the treatment centre is not required to provide the equipment or mechanisms for this to occur.

Section 61 Checking and withholding mail and electronic communications

The threshold for restricting patients' communications must be high. "[D]etrimental' to the interests and treatment of a patient or of other persons in the treatment centre" does not include nuisance or inconvenience but must be considered in terms of harm to individuals.

If there are reasonable grounds to consider that mail or electronic communications could be detrimental to the interests and treatment of the patient or others in the treatment centre, their responsible clinician may direct that the mail or electronic communication be checked. To carry out such checks, the responsible clinician may direct that any computer or device in the patient's possession be taken from the patient.

The powers of a responsible clinician in relation to mail and electronic communication are further defined and limited by section 62 (see below).

A responsible clinician may direct that the patient not receive or send mail or electronic communication that could be detrimental to the interests and treatment of the patient or of other persons in the treatment centre. Alternatively, the responsible clinician may direct that the patient send or receive mail or electronic communications subject to conditions or under supervision.

The responsible clinician may also direct that any computer or device in the patient's possession be taken from the patient or that the patient's access to that device be restricted. Any device taken from a patient must be returned once the patient is released from compulsory treatment status.

Section 62 Approval required to check and withhold mail and electronic communications

Any direction restricting a patient's access to a computer or electronic device requires the prior approval of the Area Director. Before giving such approval, the Area Director must be satisfied that the patient has adequate means to communicate electronically with his or her lawyer, and with the individuals listed in section 63 of the Act.

Section 63 Mail and electronic communications not to be withheld if sent by or to certain persons

The Act does not allow a patient to be prevented from sending or receiving mail and electronic communications to or from the following:

- a member of Parliament
- a Judge or an officer of a court, or a member or an officer of another judicial body
- An Ombudsman
- the Privacy Commissioner
- the Health and Disability Commissioner
- a Human Rights Commissioner
- in the case of a patient who is a child or young person, the Children's Commissioner
- the Director-General of Health
- the Director of Addiction Services
- a district inspector
- a lawyer
- an approved specialist from whom the patient has sought a second opinion about their condition.

Section 64 Procedure where mail and electronic communications are withheld

If mail or electronic communications are withheld, the patient must be informed of the fact unless the responsible clinician is satisfied that to do so would be detrimental to the interests of the patient.

If an item of mail is not received by a patient, it must be returned to the sender (if the sender's address is known). If the sender's address is not known, the item of mail must be sent to the district inspector or given to the district inspector when they next visit the treatment centre.

If an electronic communication is not received by a patient the sender should, wherever practicable, be informed of the fact unless the responsible clinician is satisfied that to do so would be detrimental to the interests of the patient or to the interests of the sender.

Section 65 Child or young person entitled to have adult present

Every child or young person who is examined by a medical practitioner under section 17 or is assessed by an approved specialist, or interviewed by Judge, is entitled to have an adult present. That adult may be nominated for that purpose by the child or young person; or if it is impracticable for the child or young person to do so, by the Area Director or an authorised officer.

Wherever possible, a child or young person should be supported to nominate an adult. Only as a last resort should an authorised officer or Area Director make that decision. Instances in which this might occur include:

- the child or young person may refuse to nominate an adult
- the nominated adult is unable to attend.

- the nominated person is prohibited from contact with the child or young person (for example, a parent, guardian or other who is not permitted to have contact with the child or young person under the Care of Children Act 2004).

Section 66 Parents and other to be informed of decisions

A person who takes any action or makes any decisions under the Act that affects any patient who is a child or young person, must, where practicable and as soon as practicable, let the following persons know of the action or decision and the reasons for it:

- the parent, guardian or any other person who has the day-to-day care of the child or young person
- the child or young person.

Where a child or young person is in the custody, guardianship or care of the Chief Executive or another person under the Oranga Tamariki Act 1989 when the compulsory treatment order is made, the information must also be given in writing to the Chief Executive or that other person. It is not necessary to inform a child or young person of the action or decision if they are incapable of understanding it or it is plainly not in the child or young person's interests to be informed.

The information must be given orally and, where practicable, in writing. It must also be given in a manner and language that is easily understood.

Patient to be kept informed of their rights

The patient must be informed of their rights and other entitlements under the Act. This includes both the rights statement approved by the Director-General of Health (sections 26(1)(b) and 26(3) of the Act) and an oral explanation, which must be available in other languages if the patient is unable to communicate adequately in English (section 26(4) and section 26(5)).

Others who must also be informed are:

- the applicant
- the patient's principal caregiver
- the patient's welfare guardian (if the Court has appointed one)
- the patient's nominated person (if the patient has nominated one)
- the medical practitioner who usually attends the patient
- the district inspector and
- any person who is a guardian of a child of the patient.

Informing the patient about their rights is not a one-off event. Section 50 states that every patient has the right to be kept informed of their rights and in particular, of:

- their legal status
- their right to apply for a review of their compulsory status
- the functions and duties of district inspectors.

Patients (or a person acting on behalf of the patient) can complain to a district inspector if they are concerned that there has been a breach of their rights.

3 Guidance on other sections of the Act

Section 12 Principles applying to exercise of powers over patients

Section 12 sets out the principles by which persons and courts exercising powers under the Act over patients must be guided. These principles include that the level of coercion used on patients should always be the least restrictive possible to enable effective treatment, that interferences with the rights of patients should be kept to a minimum and that the interests of patients should remain at the centre of any decision-making.

The view of the patients, their principal caregiver, welfare guardian (if appointed) and nominated person, should be ascertained and taken into account before the power is exercised unless it is not ‘reasonably practicable’ or in the best interests of the patient.

Powers under the Act should also be exercised with proper recognition of the importance and contribution to the patient of ties with family, whānau, hapu, iwi and family group; and respect for the patient’s cultural and ethnic identity, language, and religious or ethical beliefs.

“Reasonably practicable”

The term ‘reasonably’ brings a measure of objectivity to a decision: with knowledge of the same facts, would a reasonable, responsible health professional make the same decision?

The term ‘practicable’ has been considered in mental health jurisdictions, particularly in relation to the involvement of family and whānau with care. It acknowledges that, for various reasons, there are circumstances in which we must be content with less than the ideal, and the degree of compromise calls for judgement and common sense.

Thus, when considering whether it is reasonably practicable to ascertain the views of the parties listed in section 12(b), the health professional needs to consider objectively whether consultation is feasible. They may consider:

- whether the situation is urgent
- the time it will take to contact family and whānau as well as the time required for family and whānau and others to form their views
- any other disadvantage.

Individuals making decisions need to balance the disadvantages of consultation with the potential benefits to the patient.

Neither time of day nor resource constraints should be used to justify a decision that it is not reasonably practicable to consult. Urgency combined with resource constraints may limit the time available for consultation but will not, in most cases, make it ‘not reasonably practicable’.

‘Best interests’ of the patient

The importance of the ‘best interests’ concept in section 12 is that the interests of the patient are prioritised over anybody else’s interests.

The interests of a patient and their family and whānau may conflict. The ‘best interests’ assessment means the responsible clinician must resolve any conflict in favour of the patient about or for whom they are making a decision.

To determine a patient’s best interests, a responsible clinician must consider all relevant clinical and personal information, which includes:

- the mental state of the patient
- the patient’s competence to make decisions about their care (whether the patient has ‘*severely impaired capacity*’)
- any advance directives the patient may have
- the patient’s clinical and family and whānau history
- any previous contact the patient has had with other addiction treatment and/or mental health providers
- the likelihood of family or whānau having information that is not available from other sources.

If family and whānau will be providing the ongoing care of someone once they are no longer subject to compulsory status, it will normally be in the patient’s best interests that family and whānau be consulted and have relevant treatment information disclosed to them.

Even if the patient does not want their family and whānau to be involved, this does not preclude family and whānau from providing information or seeking information about the patient.

Section 12(e) of the Act recognises the importance of family and whānau relationships to the wellbeing of each individual. Family and whānau should be encouraged to provide information about the person and about changes they notice during the treatment period.

The relationship between family and whānau and the person may change over time. Persons with severe substance addiction often have fractured relationships with family and whānau and compulsory treatment may provide an opportunity to start the process of healing those rifts.

Note that the Privacy Act 1993 does not preclude information being provided by family and whānau members and does not always prevent family and whānau members and other caregivers from being provided with information about the person. For example, it may be appropriate for information to be shared if:

- disclosure was one of the purposes for which the information was collected
- there is a serious threat of self-harm by the person
- the person is being discharged into the care of family and whānau.

Health professionals should take the opportunity to ensure that family and whānau are informed about the nature of substance addiction and its impacts on the wellbeing of the individual and their family and whānau, both in the short term and over time. They should also be provided with information about the person’s other health needs, and about any behaviour that may be cause for concern.

Proper respect for the patient’s cultural and ethnic identity, language and religious or ethical beliefs

Section 12(e)(iii) of the Act is reinforced by Right 1(3) of the Code of Rights, which is the right to respect for the patient’s cultural and ethnic identity, language and or ethical beliefs. It should be incorporated into the assessment and management of the individual by ensuring that cultural assessment is a key component of assessment.

Section 13 Additional principles applying to exercise of powers over children or young

Section 13 specifically relates to children or young persons (that is, those under 18 years) who may be subject to the Act.

The concept of ‘capacity’ is particularly challenging in children and young persons, not necessarily because of substance addiction, but because of their developmental stage. See section above on ‘Assessing capacity in children and young people’ (page 9).

Section 24 further clarifies the role of the Act in treating children or young people with severe substance addiction, limiting the use of the Act to situations where appropriate treatment for the severe substance addiction cannot be given in accordance with an order or other determination under the Oranga Tamariki Act 1989.

Section 14 Application for assessment

Section 14 allows any person who is 18 years or older and who believes that another person has a severe substance addiction to apply to the Area Director to have that person assessed.

Section 15 Application requirements

Section 15 sets out the requirements for an application for assessment. These include that an application must be accompanied by a medical certificate or by a memorandum that is completed by an authorised officer.

Section 16 Assistance in arranging medical examination for application

Section 16 enables an authorised officer to assist an applicant in arranging for a medical practitioner to examine the person whom the applicant seeks to have assessed where the authorised officer is satisfied that there are reasonable grounds to believe that a person has a severe substance addiction and their capacity to make informed decisions about treatment for that addiction are severely impaired.

Section 17 Medical certificate

Section 17 sets out the required contents of a medical certificate. A medical practitioner must not sign a certificate if they are a relative of the applicant or of the person whom the applicant seeks to have assessed.

Section 18 Memorandum by authorised officer

Section 15 sets out the required contents of the application for assessment. The application must be accompanied by a medical certificate or, where attempts to have the person examined by a medical practitioner have been unsuccessful, by a memorandum that is completed by an authorised officer and states the matters set out in section 18.

Authorised officers are required to be health professionals appointed by the Area Director, with appropriate training and appropriate competence in dealing with persons who have severe substance addictions (section 91 of the Act).

The information required in a memorandum from an authorised officer must include:

- a description of the attempts that have been made to have the person examined by a medical practitioner
- an explanation of why the attempts have been unsuccessful
- a statement that the authorised officer considers that there are reasonable grounds to believe that the person has a severe substance addiction and severely impaired capacity to make informed decisions about treatment for that addiction.
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Section 19 Arrangements for specialist assessment

Section 19 sets out the arrangements that are required to be made so that a person can be assessed by an approved specialist.

Testing for capacity is not a common skill in the addiction treatment workforce. However, the definition of capacity in section 9 has been adapted from the Code of Health and Disability Consumers' Rights and should be familiar to many health professionals.

The Ministry notes that the test in the Act concerns prospective patients' capacity to consent to treatment for addiction, rather than the wider scope of capacity that forms the basis of an application for an order under the Protection of Personal and Property Rights Act 1988.

Section 20 Certain approved specialists to undertake assessment of child or young person, if practicable

Section 20 recognises that children and young people have particular needs in relation to assessment and therefore specifies that specialist assessments of children or young people are to be conducted, wherever practicable, by approved specialists who practise in the field of child or adolescent psychiatry or psychology.

Section 21 Assistance in arranging specialist assessment

Section 21 enables assistance to be provided where a person refuses to attend a specialist assessment. In that case, an authorised officer may take all reasonable steps to take the person to the approved specialist and to ensure that the approved specialist is able to assess the person. The authorised officer may ask Police to assist.¹¹

¹¹ Section 105 of the Substance Addiction (Compulsory Assessment and Treatment) Act.

Section 22 Requirements for specialist assessment

Section 22 sets out how an approved specialist must conduct a specialist assessment. An approved specialist is a health professional who is designated as an ‘approved specialist’ by the Director of Addiction Services, based on their expertise and training in the treatment of persons with severe substance addiction.¹²

If the specialist assesses a person as having a severe substance addiction, the specialist must assess whether the person’s capacity to make informed decisions about treatment for that addiction is severely impaired. In making that assessment, the specialist must observe requirements relating to informing and communicating with the person. The specialist must then go on to assess whether compulsory treatment is necessary for the person and whether appropriate treatment for the person is available.

A request for a second opinion should not impact on an application for a compulsory treatment order. It would be impractical to delay an application until the person had received a second opinion, and could result in the patient being detained for an indefinite period.

Section 23 Compulsory treatment certificate

Section 23 provides for the completion of compulsory treatment certificates by approved specialists. A certificate takes effect as soon as it is dated and signed.

Section 24 Restriction on signing compulsory treatment certificate for child or young person under 18 years

Section 24 restricts compulsory treatment certificates for children and young persons who are under 18 years. Such a certificate may only be signed if the approved specialist has confirmed whether the department responsible for the administration of the Oranga Tamariki Act 1989 has any involvement with the child or young person and if the approved specialist is satisfied that appropriate treatment cannot be given to the child or young person under that Act.

Children and young people may be required to receive treatment if they are under the care of Oranga Tamariki/Ministry for Vulnerable Children. However, treatment cannot be compulsory and the needs of children or young people with severe substance addiction who require compulsory treatment may not be adequately met by the services available to that organisation.

Section 25 Approved specialist to notify Area Director

Section 25 requires an approved specialist who has signed a compulsory treatment certificate to notify the Area Director of the identity of the patient to whom the certificate relates.

Note that most people will initially need to be detained in a medical ward and/or in specialist withdrawal management wards, due to the seriousness of their physical health needs. Service providers will need to work together developing an integrated care pathway to ensure a smooth transition between services, particularly for patients who are confused or distressed.

¹² Section 95 of the Substance Addiction (Compulsory Assessment and Treatment) Act.

Section 26 Information to be given to patient and others

Section 26 entitles patients and specified persons concerned with the patient's welfare to certain information, which must be provided as soon as practicable after the Area Director has been notified of the patient's identity.

Section 27 If compulsory treatment certificate not signed, advice must be given

Section 27 applies where, after completing a specialist assessment, the approved specialist considers that the criteria for compulsory treatment are not met. The specialist who carries out the specialist assessment must, if that is appropriate, provide information about alternative options for treatment.

This advice is particularly important where family, whānau or other caregivers have made an application for assessment and may be frustrated at their lack of ability to require that the individual undergo compulsory treatment.

Section 28 Responsible clinician to be assigned

Section 28 states that the Area Director must assign a responsible clinician to every patient for whom a compulsory treatment certificate has been signed. This must be done as soon as practicable after the Area Director is notified of the patient's identity.

Section 29 Initial steps to be taken by responsible clinician

Section 29 requires the patient's responsible clinician to take certain steps within a period no longer than seven days after the patient's compulsory treatment certificate is dated and signed. These are to prepare a treatment plan for the patient, to arrange to place the patient in a treatment centre, and to apply to the Court for a review of the compulsory status of the patient.

Section 30 Detention and treatment in treatment centre

Section 30 requires a responsible clinician to direct that a patient be detained and treated in a treatment centre. The responsible clinician must obtain the agreement of the manager of the treatment centre and must consider the wishes and preferences of the patient and the views of the patient's principal caregiver, welfare guardian and nominated person.

Section 31 Patient must be released if review not determined within prescribed period

Section 31 sets a period of 10 days for determining an application for review of the compulsory status of a patient. That period may, in some cases, be extended by up to 20 days. If the application for review is not determined by the end of the period set by this section, the application is dismissed and the patient must be released from compulsory status.

Section 32 Court may make compulsory treatment order

Section 32 provides for the Court to determine whether the criteria for compulsory treatment are met. The Judge hearing the application may continue the compulsory status of the patient by making a compulsory treatment order if satisfied that the criteria for compulsory treatment are met in respect of the patient.

If that is not the case, the Judge must order that the patient be immediately released from compulsory treatment status. The effect of any compulsory treatment order is to continue the compulsory status of the patient until the close of the 56th day after the date on which the patient's compulsory treatment certificate was signed unless the order is extended under section 47, for a further 56 days.

It is implicit in the Act that treatment for addiction needs to be a long-term process and there is the need to ensure that there are effective pathways into ongoing treatment for people once they have completed compulsory treatment.

Section 33 Restriction on making compulsory treatment order in respect of child or young person under 18 years

Section 33 provides that a compulsory treatment order for children and young people who are under 18 years of age may be made only if the Court is satisfied that appropriate treatment cannot be given pursuant to an order or other determination under the Oranga Tamariki Act 1989.

Note that there is no provision in the Substance Addiction (Compulsory Assessment and Treatment) Act for prospective patients, including children and young persons, to be detained in Police custody. If a person is sufficiently unwell to be considered liable for compulsory assessment and treatment, that person should be managed within a health environment.

Section 34 Right to apply to court for urgent review of patient's status

Section 34 entitles a patient and other specified persons (such as the patient's nominated person, lawyer) to apply to the Court for an urgent review of the patient's status on the grounds that the criteria for a compulsory treatment order are not met, or where a compulsory treatment order has not yet been made, that the compulsory treatment certificate should not have been given. On review, a Judge must order the release of the patient from compulsory status if the Judge is not satisfied that the criteria for compulsory treatment are met.

Section 34 also allows the district inspector who is involved with upholding the patient's rights ('the responsible district inspector'), to apply to the Court for an urgent review.¹³

Section 35 Objective of compulsory treatment

Section 35 sets out the objective of compulsory treatment. This is to facilitate the stabilisation of the patient through medical treatment, including medically managed withdrawal, and, 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.

Section 36 Requirement to accept treatment

Section 36 requires a patient to accept treatment properly given under the Act and to comply with every lawful direction given by or on behalf of the responsible clinician or the manager of the treatment centre.

¹³ Section 43 of the Substance Addiction (Compulsory Assessment and Treatment) Act.

Section 37 Treatment given or authorised by responsible clinician

Section 37 authorises the responsible clinician to give or authorise any treatment, including medication (if that is in their scope of practice) that they think fit. The responsible clinician is required to give or authorise the minimum medication, consistent with proper care, to ensure that the patient is not prevented from communicating adequately with any person engaged in proceedings to represent the patient.

Section 38 Requirement to stay in treatment centre

Section 38 states that a patient must not leave the treatment centre in which they are detained without leave. Once released from compulsory treatment status, the patient must not be further detained.

The Act reflects a desire to minimise the involvement of Police as it is primarily the role of the health sector to administer the legislation and to manage people subject to the Act. Police powers are restricted to specified situations (eg, apprehending patients absent without leave) or their powers in relation to criminal offending.¹⁴

Section 39 Leave of absence on compassionate, medical or other grounds

Section 39 allows the responsible clinician to grant a patient leave of absence from a treatment centre.

Although the responsible clinician must be satisfied that the patient will not harm themselves, 'harm to others' is not included in relation to the leave criteria as this is inconsistent with the purpose of the Act; namely, its focus on the harm that an individual presents to themselves.

Section 40 Return of patient

Section 40 authorises an authorised officer to take a patient back to the treatment centre if the patient is absent without leave from the centre.

Section 41 Transfer to another treatment centre

Section 41 authorises the transfer of a patient from one treatment centre to another at the direction of the responsible clinician and with the agreement of the manager of the new treatment centre, and after consultation with the patient and the patient's principal caregiver, welfare guardian and nominated person.

Section 42 Condition of patient be kept under review

Section 42 requires clinical reviews, at regular intervals, of the patient's condition and any adjustments to be made to the patient's treatment plan that are appropriate in light of those reviews.

¹⁴ Sections 40 and 105 of the Substance Addiction (Compulsory Assessment and Treatment) Act.

Best practice expectations are that responsible clinicians should conduct regular reviews of the patient's condition and capacity at least every two weeks or on request of the treatment centre manager.

Section 43 Release from compulsory status

Section 43 requires the responsible clinician to order the release of a patient if the responsible clinician is satisfied that the criteria for compulsory treatment are no longer met or that no useful purpose would be served by the further compulsory treatment of the patient.

Section 44 Plan for future treatment and care

Section 44 requires planning for a patient's voluntary treatment and for care after their release from compulsory status.

Section 44 has a relationship with the requirements in section 29(a), in which the patient's responsible clinician must prepare a treatment plan for the patient. The treatment plan should include a focus on future treatment and care, and can be expected to change as the patient progresses through treatment. It also requires that the plan be shared with any agency involved in providing relevant services to the patient; this would include the patient's usual health practitioner.

Section 45 Review where patient appears to suffer from brain injury

Section 45 requires a patient's responsible clinician to review the patient's condition if, at any time within 21 days before the date of the expiry of the patient's compulsory treatment order, the responsible clinician considers that there are reasonable grounds to believe that the patient appears to suffer from a brain injury (as defined in section 4 of the Act). The responsible clinician must record the findings of the review in a report.

Section 46 Application for extension of compulsory treatment order

Section 46 provides that, if the responsible clinician considers, after completing a review under section 45 of the Act, that the criteria for compulsory treatment continue to be met and that the patient suffers from a brain injury, the responsible clinician may apply for an extension of the compulsory treatment order. The responsible clinician must apply within 14 days before the date on which the compulsory treatment order is to expire.

The definition of brain injury in section 4 of the Act refers to 'acquired brain injury'. This definition deliberately does not require that the origin of the brain injury be determined, other than it has been acquired (that is, it was not present at birth) in acknowledgement of the difficulty in determining the extent to which brain injury is caused by the substance that has been used, or because of accident or injury that may or may not be related to the addiction.

Section 47 Court may extend order

Section 47 provides that the Court may extend the patient's compulsory treatment order for a further 56 days if it is satisfied that the criteria for compulsory treatment continue to be met and that there are reasonable grounds to believe that the patient suffers from a brain injury.

Section 48 Steps to be taken after extension of order

Section 48 requires the responsible clinician of a patient whose compulsory treatment order has been extended, to, within 28 days after an order is made under section 47, to:

- prepare an updated treatment plan for the patient
- investigate whether an actual brain injury can be confirmed or excluded
- prepare a plan for ongoing care on the patient's release from compulsory status.

If the responsible clinician considers that there are no reasonable grounds for believing the patient suffers from a brain injury, the patient must be released from compulsory status.

Section 49 Right to nominate person to protect patient's interests

Section 49 entitles a patient to nominate a person who is 18 years or older to protect their interests under the Act.

Other than the proviso that this should be a person who is 18 years or older, the patient can choose anyone they like. Some people might nominate another person with an addiction.

It should also be noted that the role of the nominated person is to *protect the patient's interests under this Act*. This does not extend to financial or other personal interests.

Section 50 Patient to be informed of his or her rights

Section 50 requires a patient to be kept informed of their rights, including:

- their legal status as a patient
- their right to apply for a review of their compulsory status
- the functions and duties of district inspectors.

Section 51 Principal caregiver, welfare guardian, and nominated person to be informed of events affecting patient

Section 51 entitles the patient's principal caregiver, welfare guardian, and nominated person to be informed of certain key events. Those events include:

- the patient's absence from the treatment centre without leave
- the patient's release from compulsory status
- their transfer to another treatment centre
- applying to extend the duration of their compulsory treatment order.

If the patient has a child, any guardian of the child (for example, the child's other parent) is entitled to be informed of those key events as well. Any agency involved in providing relevant services to the patient (for example, Oranga Tamariki) is also entitled to be informed of those key events.

Section 52 Right to be dealt with in accordance with objective of compulsory treatment and with principles

Section 52 entitles every patient to be treated in accordance with the objective of compulsory treatment set out in section 35 and with the principles set out in section 12. In the case of a child or young person, the principles set out in section 13 also apply.

Section 67 Complaint of breach of rights

Section 67 requires complaints about any breach of a patient's rights to be referred to a district inspector for investigation. The district inspector must report the matter to the Area Director, who must take all steps that are necessary to rectify the matter.

Section 68 Application of Subpart 6 of the Act: Procedure

Section 68 provides that the procedural matters set out in Subpart 6 apply to applications to the Court under the Act, namely:

- applications by responsible clinicians for reviews of the compulsory treatment status of patients (section 29(c) of the Act)
- applications for urgent reviews of a patient's status by the patient and others (section 34(1) of the Act)
- and applications by responsible clinicians for extensions of compulsory treatment orders (section 46(1) of the Act).

Section 69 Meaning of party

Section 69 defines who is a party for the purposes of applying to the Court under sections 29(c) or 46(1), and under section 34(1) of the Act.

Section 70 Jurisdiction of Family Court

Section 70 requires that every application to the Court under the Act be dealt with by the Family Court. If it is not practicable for an urgent case to be determined by a Family Court Judge, any District Court Judge can determine the case.

Section 71 Persons entitled to appear and be heard

Section 71 sets out who may appear and be heard at a hearing of an application.

Section 72 Service where application made by responsible clinician

Section 72 requires a responsible clinician who applies for a court order to serve the application and certain documents on the patient and the district inspector and to take reasonable steps to provide the application and the documents to every other person entitled to appear and be heard on the application.

Section 73 Service where application made by, or on behalf of, patient

Section 73 requires a person who applies for an urgent review under section 34(1) to serve the application on the responsible clinician and the district inspector and to take reasonable steps to provide the application and the documents to every other person entitled to appear and be heard on the application.

Section 74 Responsibility of district inspector on application

Section 74 requires a district inspector to contact any patient who is the subject of an application to the Court to find out, if possible, whether the patient wants the district inspector to appear before the Court to be heard on the application. The district inspector must have regard to the views of the patient in deciding whether to appear on the application.

Section 75 Judge to interview patient before application for review heard

Section 75 provides for a patient to be interviewed by a Judge before an application under section 29(c) or 34(1) is heard. The Judge must order that the patient be immediately released from compulsory status if satisfied that the criteria for compulsory status are not met.

Section 76 Attendance of patient at hearing

Section 76 provides for patients to attend at hearing applications. A patient must attend a hearing unless the Judge who interviewed the patient in accordance with section 75 certifies that it would be in the patient's best interests to excuse the patient, the Court excuses the patient because of their condition, or the Court excludes the patient for causing a disturbance that makes it impracticable to continue with the hearing in their presence.

Section 77 Representation of persons entitled to be heard, and special rights of patient

Section 77 allows persons who are entitled to appear and be heard at hearings of applications to be represented by lawyers and to call witnesses.

Section 78 Court may call for report on patient

Section 78 enables the Court to request a qualified person to prepare a report on the patient.

Section 79 Evidence on report

Section 79 allows every party to the application to give evidence on matters covered in a report prepared under section 78.

Section 80 Court not bound by rules of evidence

Section 80 enables courts, in applications under the Act, to receive evidence that would not otherwise be admissible.

Section 81 Appointment of lawyer to represent child or young person

Section 81 requires the Court or the Registrar of the Court, in an application that relates to a child or young person under 18 years of age, to appoint a lawyer for the child or young person if the child or young person is not represented by a lawyer.

Section 82 Power of court to call witness

Section 82 enables the Court to call witnesses on the Court's own initiative.

Section 83 Court may dispense with hearing in certain circumstances

Section 83 enables the Court to determine an application under the Act without a formal hearing if it is satisfied that no person wishes to be heard.

Section 84 Interpreters to be provided

Section 84 provides that, where practicable, the services of interpreters must be available in applications involving patients whose first or preferred language is not English or who have a disability that prevents them from understanding spoken language.

Section 85 Appeals from decisions of Family Courts

Section 85 provides for appeals to the High Court from decisions of the Family Court made on applications under the Act.

Section 86 Director of Addiction Services

Section 86 provides for the appointment of a Director of Addiction Services. The Director of Addiction Services is responsible for the general administration of the Act under the direction of the Minister of Health and the Director-General of Health.

Section 87 Director may delegate functions, duties, and powers

Section 87 allows the Director to delegate their functions, duties and powers.

Section 88 Directors of Area Addiction Services in specified areas

Section 88 requires the Director of Addiction Services to appoint Directors of Area Addiction Services (Area Directors) for different areas.

Section 89 Area Director may delegate functions, duties, and powers

Section 89 allows Area Directors to delegate functions, duties, and powers in certain circumstances.

Section 90 District inspectors

Section 90 requires the Minister of Health to appoint lawyers as district inspectors for different locations.

District inspectors are lawyers, appointed as independent parties to protect the rights of patients and investigate any alleged breaches of those rights. They are not, however, the legal representative of a patient as that role would conflict with district inspectors' role as an independent mechanism to safeguard patients' rights.

The role and function of district inspectors under the Act is expected to be much the same as that currently outlined in the Mental Health (Compulsory Assessment and Treatment) Act:

Functionally, the role of District Inspector is similar to that of an ombudsman. This is consistent with the recognition that individuals who are subject to compulsory psychiatric treatment have lost a very important right to freedom, and that certain safeguards are required to ensure they are lawfully detained and not subject to abuse or ill-treatment.¹⁵

District inspectors are paid through Vote Health but operate independently of the Ministry.

Section 91 Authorised officers

Section 91 requires each Area Director to designate sufficient health professionals as authorised officers within the area for which that Area Director is responsible. To be designated, authorised officers must be appropriately trained and have appropriate competence in dealing with persons who have severe substance addiction.

Section 91 specifically requires that an authorised officer be appropriately trained and have expertise in the treatment of substance use disorders. It is the responsibility of the Area Director to ensure that appropriately qualified persons are appointed to the position based on their knowledge, skills and experience in the field of substance addiction.

Section 92 Designation of approved providers

Section 92 authorises the Director of Addiction Services to appoint approved providers for the purposes of the Act. Persons that are appointed under this section must be certified, under the Health and Disability Services (Safety) Act 2001, to provide residential disability care, and meet other requirements.

Section 93 Reporting duties of approved providers

Section 93 authorises the Director of Addiction Services and the Area Director to require approved providers to report on anything covered by the Act that has been done, or is required to be done, in a treatment centre operated by the approved provider.

Section 94 Responsible clinicians

Section 94 requires the Area Director to ensure that a responsible clinician is assigned to every patient at all times. Section 94(2) stipulates that a responsible clinician must be given access to the patient and their records.

¹⁵ Ministry of Health. 2012. *Guidelines for the Role and Function of District Inspectors*.

Section 95 Designation of approved specialists

Section 95 requires the Director of Addiction Services to designate sufficient health professionals as approved specialists.

Section 95(4) sets out the circumstances in which a designation as an approved specialist can be suspended or revoked.

Section 96 Designation of bodies for purposes of definition of health professional

Section 96 enables the Minister of Health to designate bodies corporate that register certain practitioners for the purposes of the definition of health professional in the Act.

Section 97 Advice and assistance of general nature

Section 97 requires the Area Director and authorised officers acting with the Area Director's authority to respond to general enquiries from members of the public about the administration of the Act or about the availability of services.

Section 98 District inspectors to visit treatment centres

Section 98 provides for district inspectors to visit treatment centres in which patients are detained.

Section 99 Inspectors' access to persons and documents

Section 99 gives a district inspector access to every part of a treatment centre and to every person in it, and requires the manager of the treatment centre to present specified items, such as the patient's compulsory treatment certificate, to the district inspector on request.

Section 100 Reports on visits

Section 100 requires a district inspector, after a visit to a treatment centre, to report to the Area Director within 14 days after the visit.

The Act provides that copies of a district inspector's report can be provided to the manager of a treatment centre if the Area Director considers it appropriate.

Section 101 Inquiries by district inspector

Section 101 enables a district inspector to conduct an inquiry into conduct that occurs within a treatment centre and into any concern raised in relation to the care, treatment, or conduct of a patient. The district inspector has relevant powers under the Inquiries Act 2013.

Section 102 District inspectors to report monthly

Section 102 requires district inspectors to send the Director of Addiction Services written reports every month.

Section 103 No proceedings against district inspectors unless bad faith shown

Section 103 protects district inspectors from civil liability for anything done or said in the exercise or performance, or intended exercise or performance of their functions, duties, or powers under the Act, except where it is shown that they acted in bad faith. A person's right to apply for judicial review is not affected.

Section 104 Crimes of Torture Act 1989 not limited

Section 104 clarifies that the Act does not limit the investigative powers under the Crimes of Torture Act 1989. Part 2 of the Crimes of Torture Act 1989 provides for the designated National Protective Mechanisms (NPMs) to inspect, at regular intervals, the places of detention to make sure the human rights of those being detained are being upheld and to make recommendations for improvement. The NPM for treatment centres used for the purpose of the Substance Addiction (Compulsory Assessment and Treatment) Act will be the Ombudsman.

Section 105 Police assistance

Section 105 confers powers on constables to provide Police assistance, where assistance is requested by authorised officers performing specified duties. This section also sets conditions and limits on the exercise of those powers. A constable must, before exercising a power under this section, obtain a warrant if it is reasonably practicable to do so.

Police should only be engaged where their specific powers (particularly regarding the use of force) are required.

Section 106 Apprehension of patients not permitted to be absent from treatment centre

Section 106 provides for patients who are absent from their treatment centres without leave to be returned to those centres by persons holding certain offices, including authorised officers, responsible clinicians and constables. Before apprehending a patient under this section, a constable must obtain a warrant if it is reasonably practicable to do so.

Section 107 Judge or Registrar may issue warrant

Section 107 provides for the issue of a warrant authorising constables to take persons to places that they are required to go for assessments or for admission to a treatment centre, or to return patients to treatment centres if they are absent without leave.

Section 108 Certain sections of Crimes Act 1961 apply to powers to take and retake

Section 108 gives persons who are authorised to take patients to treatment centres and other places the same protection from liability that they would have under the Crimes Act 1961 as if they had made, or assisted with, an arrest under that Act.

Section 109 Use of force

Section 109 allows persons who are authorised under the Act to take or retake patients or to take and detain for examination purposes, to use such force as is reasonably necessary in the circumstances. Such force may also be used by a person treating a patient or giving a lawful direction to a patient in accordance with the Act. Force is to be used in emergency situations only.

If a person (other than a police constable) uses force, the circumstances in which force was used must be recorded and a copy of the record given to the Area Director.

Section 110 Neglect or ill-treatment of patients

Section 110 makes it an offence for the manager of a treatment centre or a person employed or engaged by the manager or the service that operates the treatment centre, and any other person performing any function or exercising any power in relation to a patient under the Act, to intentionally ill-treat or intentionally neglect a patient.

Section 111 Assisting patient to be absent from treatment centre without leave

Section 111 makes it an offence for the manager of a treatment centre or a person employed or engaged by the manager or the service that operates the treatment centre to intentionally permit or assist a patient to be absent without leave or to attempt to be absent without leave from the treatment centre. This section also provides that it is an offence to facilitate such an absence or attempted absence or to assist a patient to avoid, or attempt to avoid, being apprehended or taken back to a treatment centre.

Section 112 Obstruction of inspection

Section 112 makes it an offence for the manager of a treatment centre or a person employed or engaged by the manager or the service that operates the treatment centre to conceal, or attempt to conceal, anything from a district inspector, Director of Addiction Services, or Area Director or to wilfully obstruct, or attempt to obstruct, an inspection by a district inspector, Director of Addiction Services, or Area Director.

Section 113 False or misleading certificates

Section 113 makes it an offence to include anything in a certificate that is false or misleading.

Section 114 Further offences involving false or misleading documents

Section 114 makes it an offence to fail to include in documents particulars required by the Act or to include false particulars in documents.

Section 115 Matters of justification or excuse

Section 115 protects managers of treatment centres, responsible clinicians, authorised officers, and others from criminal responsibility if they act in good faith in reliance on a notice, certificate, or an order under the Act that they believe was lawfully given or made.

Section 116 Director-General may issue guidelines and standards

Section 116 authorises the Director-General of Health to issue guidelines and standards for the care and treatment of patients.

Section 117 Rules

Section 117 authorises the making of rules to regulate the practice and procedure of the Family Courts in proceedings under this Act.

Section 118 Regulations

Section 118 empowers the Governor-General by Order in Council to make regulations for specified purposes.

Section 119 Matters to be disclosed in annual report

Section 119 requires certain matters concerning the operation of the Act to be disclosed in every annual report of the Ministry of Health, including the numbers of people detained under the Act, the length of their detention and the number of discharged patients who chose voluntary residential treatment and outpatient services following discharge from the Act.

Section 120 Ministry must review the Act

Section 120 requires the Ministry to review the Act by August 2021.

Section 121 Provisions applying to delegations under section 87 or 89

Section 121 contains provisions relating to delegations of functions, duties, and powers made by the Director of Addiction Services and by Area Directors.

Section 122 Consequential amendments and repeal and revocations

Section 122 gives effect to Schedule 2, which makes consequential amendments to various Acts and legislative instruments, repeals the Alcoholism and Drug Addiction Act 1966, and revokes legislative instruments made under that Act.