

Substance Addiction (Compulsory Assessment and Treatment) Act 2017

Prescribing Guidelines¹

This guide has been developed to support the appropriate use of medication for a person subject to compulsory treatment under the Substance Addiction (Compulsory Assessment and Treatment) Act 2017 (the Act).

The purpose² of the Act should be considered when a person is subject to compulsory treatment, and who may need to be prescribed medication. Included in the purpose is:

- the need to protect and enhance a person's mana and dignity
- to restore their capacity to make decisions about treatment and substance use
- to give them an opportunity to engage in treatment voluntarily.

The Act further identifies general principles when exercising power over 'patients'. Their interests should remain at the centre of any decision-making; the level of coercion used should be the least restrictive possible; and the views of the person and their principal caregiver, welfare guardian and nominated person is taken into account³.

In general, this means that prescribed medication is given with the person's consent, and if informed consent is not immediately possible due to impaired capacity, then it is given in the least restrictive (of dignity and cognition) way possible. Where medication is prescribed without informed consent, efforts should first be made to support the person to make informed decisions and that their support people's wishes have been taken into account.

Where possible, make decisions for prescribing medication in consultation with members of a multi-disciplinary team as part of treatment planning.

Where a person under 18 is subject to a Compulsory Treatment Certificate, it is strongly recommended that specialist advice is sought from a child and adolescent psychiatrist before medication is prescribed.

Treatment

In the Act, 'treatment' is defined as including:

'detoxification, care, counselling, rehabilitation, and interventions to alleviate or prevent the worsening of the symptoms or manifestations of severe substance addiction'⁴.

¹ SA(CAT) Act 2017 s116(2)

² SA(CAT) Act 2017 s3

³ SA(CAT) Act 2017 s11

⁴ SA(CAT) Act 2017 s4

Prescribing medication may be required to facilitate; ‘detoxification’ and ‘care’ and to ‘alleviate or prevent the worsening of symptoms’.

Withdrawal management

One of the primary objectives of compulsory treatment is to:

‘facilitate the stabilisation of the patient through medical treatment, including medically managed withdrawal’⁵

Provide detoxification or withdrawal management medications as described in the Substance Withdrawal Management Guidelines⁶, based on responses to objective withdrawal assessment tools, where available, and clinical judgement. As the majority of people who are subject to the Act are likely to be in acute alcohol withdrawal, familiarity with page 19 of the guidelines is recommended.

A proportion of people will be in withdrawal from methamphetamine and or other amphetamine type substances. While amphetamine type withdrawal symptoms are not life threatening, they are very distressing. Medications can help to manage severe agitation, irritability and anxiety.

Other substances that a person may be addicted to include GHB, benzodiazepines, inhalants, novel psychoactive substances, primarily synthetic cannabinoids, and opioids.

Medication for GHB and benzodiazepine withdrawal management is generally the same as for alcohol withdrawal as the risks are similar.

Novel psychoactive withdrawal management is an evolving area of knowledge, and what medications to use very much depends on the presentation and apparent symptoms of the person and what category of substance they have possibly been using.

Be aware that what people think they have been using may not be accurate and conservative symptom management is recommended to reduce the risk of potentially lethal interactions and or serotonin syndrome.

While the Act is rarely likely to be applicable to someone with solely an opioid use disorder, some people may present with coexisting opioid use disorders. Opioid withdrawal management is usually best managed through opioid substitution, using either buprenorphine or methadone.

As the Act only applies to people with severe substance addiction it is likely that many will be subject to protracted withdrawal symptoms. Primary among these are likely to be sleep disturbances, anxiety, low mood, agitation and cravings. Long-term prescribing of benzodiazepines or zopiclone to manage sleep disturbances is contraindicated. Explore alternative strategies and or medications including low dose quetiapine, melatonin and or tricyclic antidepressants. Medical management of other symptoms are discussed below as part of general management of physical and mental health needs and of addiction specific treatment.

Physical and mental health treatment

The Act states that every ‘patient’ is entitled to:

‘(a) medical treatment and other health care appropriate to his or her condition; and

⁵ SA(CAT) Act 2017 s35(a)

⁶ Substance Withdrawal Management: Guidelines for Medical and Nursing Practitioners in Primary Health, Specialist Addiction, Custodial and General Hospital Settings, Matua Rāki, 2015

(b) the general treatment and care that the patient would be entitled to receive if he or she were not subject to compulsory status'.⁷

This places the onus on responsible clinicians and treatment centres to ensure that a person has their general health care met, whether related to their substance addiction or not. It is probable that they will have a range of unmet, undiagnosed and or poorly treated health conditions.

For many people 'stabilisation' and withdrawal management provides a unique opportunity for a full medical assessment that is not dominated by either intoxication and or withdrawal symptoms. While the assessment begins in the acute phase of withdrawal management, it will need to continue while the person is subject to compulsory status. This includes reviewing the need for and or impact of any medication that the person has previously been prescribed.

It must be assumed that a person can make informed decisions about other aspects of their lives and decisions about accepting or refusing treatment for other issues. It must be clearly documented where people clearly lack capacity to make decisions about medical treatment and, if treatment is provided, this must be justified⁸. Treatment must be carried out in the least restrictive and safest way possible⁹.

Addiction treatment

The responsible clinician appointed to develop a treatment plan is authorised to:

'...the giving of, any treatment (including any medication) that the responsible clinician thinks fit for the treatment of the patient's severe substance addiction' (if they are normally authorised to prescribe that treatment).¹⁰

The Act further states that due regard must be given to possible effects of medication and the responsible clinician must authorise/give the 'minimum medication, consistent with proper care' so that the person can communicate with any other person representing them.¹¹

Taken together, the parts of section 37 of the Act indicate any medication provided must not impair the person's ability to communicate and potentially regain capacity. Unless therapeutically indicated, such as briefly managing intense anxiety, keeping someone medicated, for example, on high-dose benzodiazepines or antipsychotic medication, to manage their behaviour post-acute withdrawal would be considered extreme and unacceptable practice¹². As well as being a breach of the person's rights, excessive use of medications is counterproductive to one of the primary goals of compulsory treatment. That is, to restore the person's capacity to make decisions about addiction treatment.

Medications that have an evidence base for ongoing addiction treatment may be considered as appropriate to prescribe over the course of treatment under the Act. These include naltrexone to help manage 'cravings' for alcohol, and nutritional supplements such as thiamine, magnesium and zinc, to address some of the physical risks associated with long-term heavy alcohol use.

Disulfiram should not be prescribed without the person's permission and informed consent. As the expectation is that the person will be detained in a treatment centre without access to alcohol, using an aversive medication is inappropriate. Disulfiram could be appropriate to prescribe to manage possible

⁷ SA(CAT) Act 2017 s53

⁸ HDCA Act 1994, Code of Rights, Right 7(4)

⁹ SA(CAT) Act 2017 s12

¹⁰ SA(CAT) Act 2017 s37(1),(3)

¹¹ SA(CAT) Act s37(2)

¹² NZS 8134.2:2008 New Zealand Standard Health and Disability Services (Restraint Minimisation and Safe Practice) Standards

alcohol use if on leave from the treatment centre. However, as the interaction between alcohol and disulfiram can be so extreme, this would need to be with the fully informed consent of the person.

The evidence base for other potential addiction treatment medications, apart from the opioid substitution medications, methadone and buprenorphine, is limited. Due to the risk of iatrogenic addiction to opioid substitution medications, prescribing either of these, apart from as opioid withdrawal management medications, without fully informed consent is inadvisable. The use of naltrexone as an opioid antagonist while on leave from a treatment centre without fully informed consent is also inappropriate.

Make smoking cessation therapies available to all tobacco and e-cigarette smokers from the signing of the Compulsory Treatment Certificate to the person's discharge, and beyond. Get the person's preferences in type or form of therapy, including nicotine replacement therapy where possible. They have the right to decline treatment. Prescribe symptomatic relief if people choose to abstain from tobacco and have nicotine withdrawal symptoms while subject to the Act.



HP6797

June 2018