Submission - The Substance Addiction Compulsory Assessment and Treatment (SACAT) Bill

Submission to: Health Select Committee
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Submission from: Addiction Practitioners Association Aotearoa New Zealand (dapaanz)

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Susan Paton, Executive Director, Dapaanz requests the opportunity to make an oral submission to the Select Committee.

About dapaanz

The Addiction Practitioners' Association, Aotearoa-New Zealand, an Incorporated Society, was established in 2003 as a national body representing practitioners and others working in addiction treatment. Dapaanz's vision is to foster excellence in addiction practice. It does this by promoting and upholding competence, ethical practice and professionalism in addiction practice in Aotearoa.

Dapaanz has a current membership of 1,500, of which 533 are Registered Competent Addiction Practitioners and 147 are Provisionally Registered.

Consultation on this submission

Dapaanz members were consulted and provided feedback in the development of this submission. It was coordinated on behalf of the membership by a sub-committee of the Executive Board and the Executive Director.

Support for the Bill

Dapaanz welcomes the opportunity to comment on the Substance Addiction Compulsory Assessment and Treatment (SACAT) Bill.

In general dapaanz supports the aims and principles as set out in the SACAT Bill. We acknowledge the work of the Law Commission in laying the foundations for the development of the Bill. We agree that the Alcoholism and Drug Addiction Act 1966 is outdated, difficult to invoke and out of date in relation to developments in addiction treatment practice. We support the requirement for a new Act. We agree that there is a need to provide a workable, legislative framework for people considered to have severe substance addiction, who do not have the capacity to participate in treatment voluntarily. We believe that the Bill and the principles embedded within it, support that aim.

Dapaanz strongly supports the requirement for practitioners with specialist addiction knowledge and expertise to be involved in the decision to invoke compulsory treatment and in subsequent assessment and treatment processes.

Dapaanz also wishes to emphasise support for:

- Application of the principle of least restrictive intervention ie, the limits imposed on a person's right to refuse treatment should go no further than is necessary.
- The aim of protecting and enhancing the person's mana and dignity.
- The clarity the Bill provides in relation to a focus on the person's capacity to make an informed decision about whether to participate in addiction treatment and the specification of criteria by which capacity is to be assessed.
- Recognition of other key principles including: being client centred, recognising the importance of ties with family, whānau, hapū and iwi and proper respect for cultural and ethnic identity, language, and religious or ethical beliefs.
- Recognition of the needs for family involvement and consideration of age-related factors for young people.
- The requirement for assessment and treatment processes to meet an accepted best practice approach. This includes such provisions as the appointment of a specialist assessor, the appointment of a responsible clinician to coordinate and manage treatment based on a treatment plan that is regularly reviewed and the acknowledgement of the requirement for ongoing treatment and care coordination beyond the provisions of the Compulsory Treatment Order.

While dapaanz supports the Bill, we wish to note our recommendation for further consideration of the following key items:

- More emphasis on the concept of recovery.
- Stronger provisions for consideration of cultural needs.
- Inclusion of family and whānau or other support people in decision-making processes.
- Appoint a Director of Addiction Services
- Stronger mechanisms for ensuring officers and clinicians have addiction expertise.
- Sufficient resources to ensure effective implementation.

These items are discussed in detail in the remainder of this submission.
We suggest that without further consideration there is a risk that while the legislation may change, for those individuals, family and whānau who must rely on compulsory assessment and addiction treatment as a life saving intervention, in practice the status quo may prevail and there is further risk that resources will be spread more thinly thus reducing overall access to addiction treatment for the broader population.

1. More emphasis is required on the concept of recovery

Dapaanz recommends that the concept of recovery is included and given prominence within the Bill.

The concept of recovery is not evident within the SACAT Bill and in our view this is a significant omission. While recovery is not a new concept, it has broadened and strengthened over time and is a central philosophy or guiding principle in present-day addiction treatment.

Recovery is defined as "creating a meaningful self-directed life regardless of challenges faced, that includes building resilience, having aspirations and the achievement of these." (Midland, Northern Region Alliance and Te Pou 2014:5). Recovery is a key value underpinning the Addiction Competency Framework and is embedded as a foundation competency for addiction intervention.

Supporting recovery is also a core value in Blueprint II and Rising to the Challenge and in relevant competency frameworks within the mental health and addiction sector including Real Skills, the Takarangi Competency Framework, the Seitapu Competency Framework and Peer and Consumer Workforce competencies.

We believe that supporting recovery is consistent with the principles in the Bill and we recommend that the concept be given prominence throughout in order to ensure that the Bill better aligns with addiction-related best practice.

Specifically, the following are two examples where the concept of recovery could be included (see suggested additions in red):

Clause 3. The purpose of the Act:

The purpose of this 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 ***facilitate their engagement in their recovery***
(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 ***to support their recovery****.*

Clause 35. Objective of compulsory treatment:

The objective of compulsory treatment given to a patient is—
(a) to facilitate the stabilisation of the patient through medical treatment, including medically managed withdrawal; and
(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 ***to support their recovery****.*

2. Provisions for consideration of cultural needs require strengthening

Dapaanz recommends as a priority that a person's right to culturally appropriate services and support should be enshrined in the Act. We believe this would be best achieved via the addition of a distinct clause which requires all parties to the Act to exercise proper respect for cultural identity and personal beliefs and with further key additions (as set out below).

Strengthening the Act in regard to consideration of the cultural needs of the patient and whānau will ensure it reflects addiction treatment best-practice. Addiction and mental health professionals in Aotearoa New Zealand as part of their competency requirements must apply the principles of tino rangatiratanga (self-determination) and mana motuhake (autonomy) for Māori and actively protect the rights of Māori clients. While the Bill incorporates concepts of mana in its purpose, the provisions in the Bill do not extend far enough to achieve this purpose.

Enshrining the right to cultural advice throughout the Act would further assist, as follows: (see suggested additions in red)

Clause 22. Requirements for specialist assessment

(4) *The approved specialist may make the assessment described in subsection (3) only if the approved specialist has –*

(f) Given the person a reasonable opportunity to discuss the treatment with a cultural advisor.

(5) *If the approved specialist considers that the person's capacity to make informed decision about treatment for the person's addiction is severely impaired the approved specialist must assess whether –*

*(b) appropriate treatment for the person is available****; including proper consideration of the person's cultural needs.***

Clause 26. Information to be given to patient and others

Include provision that oral and written explanation to be provided in Māori if requested by the patient and/or whānau.

Clause 28. Responsible clinician to be assigned

(1)*…must assign a responsible clinician to the patient.* ***Wherever practicable the assignment of should account for the cultural needs of the patient.***

Clause 30. Detention and treatment in treatment centre

(b) take into account the wishes, ***cultural needs*** *and preferences of the patient and the views of the following persons:*

Clause 44. Plan for future treatment and care

(3) In preparing the plan, the responsible clinician must take all reasonably practicable steps to ensure that the following are consulted:
(a) the patient:
(b) the patient's principal caregiver:
(c) the patient's welfare guardian (if the court has appointed one):
(d) the patient's nominated person (if the patient has nominated one):
(e) any agency involved in providing relevant services to the patient
(f) ***a cultural advisor as required.***

A further recommendation relevant to cultural considerations relate to strengthening provisions for whānau involvement is outlined below.

3. Include family and whānau or other support people in decision-making processes

Dapaanz strongly recommends that, for adults, the inclusion of family and whānau in decision-making processes should mirror closely the provision made for young people. This would be more consistent with addiction treatment best-practice approaches and professional competency requirements, and would acknowledge and support Māori and Pasifika values, practices and professional competency frameworks.

The SACAT Bill acknowledges the importance of family and whānau as a principle. For young people under 18 years of age the principle extends to the family, whānau, hapū, iwi, and family group *"participating in the making of decisions affecting the child or young person and, accordingly, regard should be had to the views of the family, whānau, hapū, iwi, and family group"* **(Clause 13).**

The previous clause pertaining to adults **(Clause 12)** does not extend this far.

Family inclusive practice is well-recognised within addiction treatment as supporting better, more sustained treatment outcomes for an individual and their family (Kina Families & Addictions Trust, 2006; Matua Raki, 2010).

Generally a broad definition of family applies and includes friends and significant others as defined by the person themselves.

Working with families and whānau and supporting whānau ora is embedded in the Addiction Competency Framework and in Real Skills, the Takarangi Competency framework, the Seitapu Competency Framework and Peer and Consumer Workforce competencies.

4. Appoint a Director of Addiction Services

Dapaanz strongly recommends that the appointment of the Director of Addiction Services (*Clause 86*) is made as a separate appointment to that of the Director of Mental Health Services.

We believe this appointment is vital to provide the leadership necessary to ensure the effective implementation of the Act as intended. Further, the role of the Director of Addiction Services could be utilised beyond the specific tasks outlined in this legislation to fill a much needed leadership void in the sector.

We also believe this is an opportunity to strengthen the leadership of the mental health and addiction sector and provide additional support to the office of the Director of Mental Health.

5. **Ensure clinicians and officers are addiction experts**

Dapaanz recommendation is that a robust mechanism will be required to determine the addiction expertise of those practitioners who are not specifically **registered** on account of their addiction expertise. Currently in our view the Bill does not make sufficient provision to safeguard this.

As noted, dapaanz strongly supports the move to ensure practitioners with specialist addiction expertise are involved in the assessment and treatment of people under the provisions of the Bill. Critically, we wish to emphasise that a health professional is not necessarily an addiction specialist, and we believe that currently the Bill does not make this sufficiently clear.

We strongly contest the notion that all registered health practitioners and registered social workers have addiction related expertise sufficient to fulfil the requirements of the Bill.

We note that the Ministry of Health *Regulatory Impact Statement* on the SACAT Bill states:

> *Given the small number of patients expected to be committed under the new legislation, it is possible that existing Directors of Area Mental Health Services and duly authorised officers appointed under the MH(CAT) Act can be asked to take on these additional functions, with some initial training* (p.19).

Under the Bill, the Director of Area Addiction Services is responsible for appointing authorised officers, Approved Specialists and Responsible Clinicians. If the Directors themselves are not addiction experts this raises significant concern regarding their ability to effectively fulfil this responsibility.

We suggest that if it is intended that existing mental health officers will take on the officer's responsibilities under the SACAT legislation there is likely to be a significant workforce development requirement.

6. Ensure sufficient resources for implementation

Dapaanz recommends that resources are identified to ensure the effective implementation of the SACAT legislation.

The resources available to support implementation of the Bill are not clearly identified.

The Bill introduces significant changes in the compulsory addiction assessment and treatment pathway, these changes and an anticipated increase in demand for this pathway will impact across the AOD service continuum. Tentative estimates by the Ministry of Health suggest that approximately 200 people per year nationally, compared with the current 70 - 80 people, could become subject to the proposed new compulsory treatment

regimen. Unsuccessful applications will also create demand. Additionally, if the legislation is successful in providing a more accessible application process, demand could increase further.

Additionally, the Bill introduces a number of steps which rightly must be undertaken within specified timeframes. The application stage and initial assessment and treatment planning stages of the pathway are reliant on community-based Addiction Services having the capacity to provide mobile and intensive assessment and care-coordination as and when required. The compulsory treatment stage of the pathway relies on the ready availability of managed withdrawal facilities and an expanded range of treatment centres.

The overall context is important here. In the 2011/12 year 44,170 people attended an addiction treatment service. Despite this, we know that there is a significant unmet need for help. For example the Mental Health Commission (2012) reports that in 2007, the equivalent of approximately 50,000 people aged between 16 and 64 wanted but did not receive help to reduce their substance use. While the majority of people do not need a compulsory treatment pathway the services implementing the pathway will largely be the same services as those used by a majority of people seeking treatment. There is already significant pressure on managed withdrawal services, particularly those in medical or mental health wards and many addiction residential services have long waitlists. These issues will be compounded for those in smaller centres and rural areas where access to residential managed withdrawal services and residential treatment programmes is already limited and difficult to access.

A further consideration is the type and duration of care that may be required for those assessed as having an acquired brain injury. Expectations regarding who will provide ongoing care for this group have not been identified and it is likely that their needs will be significantly different from those who would benefit from the type of AOD residential treatment currently available.

The SACAT legislation will mandate a high priority for those requiring compulsory treatment. In the absence of sufficient resources there is a risk that existing resources will be diverted to compulsory treatment to the detriment of other groups seeking treatment.

Ministry of Health has estimated that implementing the SACAT legislation will cost the health sector at least $775,000 annually. It is unclear how this figure was arrived at and whether this level of funding will be applied in addition to current funding within the sector.

Given that there is an expectation signalled by the Ministry of Health that the range of treatment centres for people undergoing compulsory treatment will be extended these issues warrant further discussion to ensure services are sufficiently resourced to provide adequate and appropriate care. There will also be a need for monitoring and auditing of programmes to ensure resources are applied, as intended, to support this vulnerable group of service users.