LEGISLATION NOTE: THE SUBSTANCE ADDICTION (COMPULSORY ASSESSMENT AND TREATMENT) ACT 2017

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I. INTRODUCTION

The Substance Addiction (Compulsory Assessment and Treatment) Act 2017 (the SA(CAT) Act) received the royal assent on 21 February 2017. The Act replaces the Alcoholism and Drug Addiction Act 1966 (the 1966 Act), which was considered outdated and inconsistent with modern approaches to compulsory treatment based on human rights.

The new Act provides for the compulsory assessment and treatment of people with severe substance addiction who lack the capacity to make treatment decisions. Writing in *New Zealand's Mental Health Act in Practice*, Warren Young and Val Sim note that legislation allowing compulsory detention and treatment of people addicted to alcohol and drugs is primarily protective in nature and depends mainly on the incapacity of such people to make decisions for themselves. Such legislation is justified:[1]

> because such addiction can substantially interfere with comprehension and decision-making and substantially diminish the capacity of addicts to care for themselves or make informed choices about the treatment that would be required to enable them to do so.

Compulsion in the treatment of those addicted to alcohol or drugs is thus justified for the sole purpose, and to the extent that it enables, the restoration of capacity.[2]

The new legislation draws substantially on the review of the 1966 Act produced by the New Zealand Law Commission in September 2011.[3] In its report the Law Commission acknowledged the need for a more effective structure and coherent framework for delivering alcohol and drug treatment services.[4] A particular concern in developing a new framework was how to manage the use of compulsion in requiring people to take treatment. The Law Commission noted that over the years various provisions in the 1966 Act had fallen into disuse and that the overall framework of the Act had not kept pace with changes in allied legislation like the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the MH(CAT) Act). Reform was therefore considered long overdue.

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[1] Warren Young and Val Sim, "Reform of the Alcoholism and Drug Addiction Act", in John Dawson & Kris Gledhill (eds) *New Zealand's Mental Health Act in Practice* (Victoria University Press, Wellington, 2013) 376. The chapter, chapter 21 in the book, provides a valuable account of the theory behind, and the problems associated with, the compulsory treatment of alcoholics and drug addicts.

[2] Young and Sim, above n 1.

[3] See Law Commission *Compulsory Treatment for Substance Dependence – A Review of the Alcoholism and Drug Addiction Act 1966* (NZLC R118, 2010) (Report).

[4] At [1].

The Law Commission report identified a number of significant problems with the earlier legislation.[5] These included the fact that while medical certification was required before committal could occur, there is no requirement that such certification be undertaken by specialist alcohol and drug practitioners. The committal process itself required an application to be made to the District Court, which often led to delay and problems for families meeting regulatory requirements for applications. In addition, the statutory two-year period of detention was considered to be far longer than was necessary for treatment purposes, and there was inadequate provision for review of the detention decision.

Important in the Law Commission's review was the question of the public interest that is served by long-term compulsory treatment. It concluded that while it was debatable whether reducing substance dependence was a sufficiently important objective to justify intervention, nevertheless in the case of people who were severely dependent on alcohol or drugs there was an important public interest to be served by intervening to protect them where they had, as a result of severe substance dependence, a substantially reduced capacity to care for themselves or to make treatment decisions and, therefore, were at risk of serious harm.[6] In the Law Commission's view, protecting such people from immediate harm by restoring the capacity to make treatment decisions was a sufficiently important objective to justify intervention. The Commission offered the following limited justifications for compulsory treatment for alcohol and drug dependence:[7]

> - a person's dependence and seriously reduced capacity to make choices about ongoing substance use and personal welfare;
> - care and treatment is necessary to protect the patient from significant harm;
> - no other less restrictive means are reasonably available for dealing with the person;
> - a person is likely to benefit from treatment;
> - a person has refused treatment.

II. Assessment and Court Review Model

The SA(CAT) Act is formulated around a model of an initial committal decision being made by a specialist clinician which is then subject to review by the Family Court. In this regard it appears to follow the model of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (the ID(CCR) Act) whereby an initial care and rehabilitation plan made by a care manager may, or may not, issue in the making of a compulsory care order.

Under the SA(CAT) Act a similar approach is adopted. Provided a person meets the criteria for compulsory treatment, in that they have a severe substance addiction and lack capacity to make informed decisions, they may then be subjected to a process of assessment and treatment which may issue in a compulsory treatment certificate, which takes effect as soon as it is dated and signed (s 23). This authorises a person's detention and admission to a treatment centre under the oversight of a responsible

[5] At [4].
[6] At [9].
[7] At [12].

clinician (s 28). However, while detention and treatment in a detention centre is authorised upon appropriate execution of the compulsory treatment certificate, treatment must be terminated and the patient released from detention if an application for review of compulsory status has not been determined by the Court within 10 days of the date of filing the application in Court (s 31(2)).

Where a review does take place pursuant to subpart 6 of Part 2 the Court is required to determine whether, in relation to the patient, the criteria for compulsory treatment are met.[8] If so satisfied the court may, having regard to all the circumstances of the case, continue the compulsory status by making a compulsory treatment order (s 32(2)). A compulsory treatment order remains in force until the close of the 56th day after the date of the signing of the compulsory treatment certificate, although it may, subject to certain restrictions, be extended for a once only period of a further 56 days (s 32(3)).

Where a judge is not satisfied that the criteria for compulsory treatment are met, he or she may dismiss the application and order the patient's immediate release from compulsory status.

III. Defining Principles

Broadly speaking the Law Commission's recommendations align with what the new legislation now provides. Part 1 of the Act defines various preliminary matters, including the purpose of the Act (s 3), matters of interpretation (s 4), the criteria for compulsory treatment (s 7), and principles applying to the exercise of powers (s 12), including specific principles applying to the exercise of powers over children and young persons (s 13).

The purpose of the SA(CAT) Act as defined in s 3 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". The intended purpose of compulsory treatment is defined as being to:

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

These purposes in effect encompass the broad scope of the Act as expressed in the concept of compulsory treatment, the process of assessment, detention and treatment, the rights of patients, appeals and review, and the designation of approved providers.

[8] Substance Addiction (Compulsory Assessment and Treatment) Act 2017, s 7 [SA(CAT) Act].

The question of who is likely to become subject persons under this Act is, at this point, a matter of speculation. However, three factors will be determinative, namely, the nature and degree of the addiction, the subject's actual decision-making capacity, and the principle of parsimony (least restrictive intervention). While some well-known and chronic alcoholics might seem to be early candidates for compulsion, the philosophy of the Act appears to favour engagement in voluntary treatment wherever practicable. With a growing public de-stigmatisation of all forms of disability and appeals to inclusivity, it is to be hoped that the availability of the new regime, properly supported by adequate resourcing in the public sector, will encourage those struggling with addiction to seek the help they need.

IV. Assessment and Treatment

A. Application

Part 2 of the SA(CAT) Act outlines the process for assessment and treatment of persons suffering from severe substance addiction. For practitioners accustomed to the procedure for compulsory assessment and treatment under the MH(CAT) Act the regime for assessment in this legislation will seem familiar. The application requirements in s 15 are similar to those prescribed in s 8A MH(CAT) Act, as is the provision for assistance in arranging for a medical examination for the application defined in s 16. In addition to the medical certificate (again modelled on s 8B MH(CAT) Act) if attempts at examination of the subject person have been unsuccessful, an 'authorised officer' (ie a health professional designated under s 91 as a person with appropriate training and competence in dealing with persons with severe substance addictions) must outline in a memorandum attempts made to examine the person and why they were unsuccessful.

Once an application has been received by the Area Director (the equivalent to the Director of Area Mental Health Services under the MH(CAT) Act) that person must arrange for the person to be assessed by an approved specialist. The procedure specified in s 19 for making the necessary arrangements is virtually identical to the procedure in s 9(2) of the MH(CAT) Act. In defining the maximum time limits on compulsion, the SA(CAT) Act states seven events which signify when a person's compulsory status ends.[9] However, a compulsory treatment order expires eight weeks (56 days) after the signing of the compulsory treatment certificate (s 32 (3), contrary to the Law Commission's recommendation that the period be a maximum of six weeks.[10] While compulsory status begins when an 'approved specialist' has signed and dated a compulsory treatment certificate in respect of the person (see s 17) compulsory status only ends when one of the following events occur:[11]

> (a) The responsible clinician has, by the close of the seventh day after the date on which the patient's compulsory treatment certificate was dated and signed, failed to apply under s 29(c) for a review of the patient's status;

[9] Section 11(2).
[10] Report at [22].
[11] SA(CAT) Act, s 11(2).

(b) The court fails to make a compulsory treatment order within the period prescribed by section 31;
(c) The person's compulsory treatment order expires;
(d) The person is released from compulsory status by an order of a Judge or a responsible clinician;
(e) The person becomes subject to an order under s 24, 25 (1)(a), or (b), or s34 of the Criminal Procedure (Mentally Impaired Persons) Act 2003;
(f) The person becomes subject to an inpatient order under Part 2 of the MH(CAT) ACT 1992 or becomes a special patient as defined in s2(1) of that Act;
(g) The person is sentenced by a court to be detained in prison.

B. Expiry and Extension of a Compulsory Treatment Order

By virtue of s 32(3), a person's compulsory treatment order (CTO) expires on the close of the 56th day (eight weeks) after the date on which the patient's compulsory treatment certificate was signed, although a CTO may be extended for a further 56 days under s 47 of the Act. However, the extension power only applies in cases where the patient is suspected of suffering from alcohol or drug related brain injury.[12] A CTO may only be extended if the patient continues to meet the criteria for compulsory treatment and there are reasonable grounds to believe the patient suffers from a brain injury (s 47). There is no general power of extension. Unlike the situation under the ID(CCR) Act, there is no power to indefinitely extend a compulsory treatment order.

C. Rights of Patients

The rights of patients under the Act are defined in subpart 5 of Part 2. The statement of rights applicable to all patients is comprehensive and comparable to statements of patients' rights under the MH(CAT) Act and the ID(CCR)Act. However, rights unique to patients under this legislation include the right to nominate someone to protect the patient's interests (s 49), the obligation for the principal caregiver, welfare guardian and nominated person to be informed of events affecting patients (s 51), the right to be dealt with in accordance with the objective and principles of compulsory treatment (s 52), and additional rights of children and young persons (ss 65 and 66). A right of complaint of a breach of rights similar to that in s 75 MH(CAT) Act is also given (s 67).

It should also be noted that the rights defined in the SA(CAT)Act exist in parallel with the broad statements of rights of persons with mental disabilities which are equally applicable to persons with substance addictions. Of particular relevance are the human rights treaties to which New Zealand is a party and which are relevant to mental health and disability law, in particular the International Covenant on Civil and Political Rights 1966 (ICCPR), the International Covenant on Economic Social and Cultural Rights 1966 (ICESCR) and the Convention on the Rights of Persons with Disabilities 2006 (CRPD).[13]It is enough to observe in this context that the observance of the human

[12] The qualification that the brain injury be alcohol or drug-related to warrant an extension is not expressed in the statute, but was the evident intention of the Law Commission's recommendations. See Report at [24].
[13] International Covenant on Civil and Political Rights 999 UNTS 171 (opened for signature 16 December 1966, entered into force 23 March 1976); International Covenant on Economic, Social and Cultural Rights 993 UNTS 3 (opened for signature 16 December 1966, entered into force January 3 1976); United Nations Convention on the Rights of Persons with Disabilities 2515 UNTS 3 (opened for signature

rights of persons with disability is not a matter of state discretion. It is a matter of obligation. Human rights are not simply a matter between citizens and their government, but are a matter of international law enforceable against the state on behalf of persons living within or under the control of the state.[14] "Governments do not possess the power to grant or deny human rights and freedoms. Persons possess rights simply because of their humanity."[15]

Of particular importance as this new legislation 'beds in' will be the extent to which practice under the Act gives expression to the human rights of those persons with physical, mental and intellectual disabilities who come within the Act's jurisdiction, but who are also protected by the rights enshrined in the CRPD, in particular the guarantees of equality and non-discrimination.[16] As Kris Gledhill has observed, a question that will arise as the principle of non-discrimination is worked out in practice is whether the obligation of the state is essentially a negative one of "not to interfere" or requiring ostensibly neutral regulation, or whether it requires positive steps to be taken to ensure an equal outcome.[17] These and other human rights issues are likely to be tested as the new legislative regime comes into effect.

V. Procedure for CTO Application Hearing

Subpart 6 of Part 2 defines the procedure for the hearing of an application. Jurisdiction rests with the Family Court and the procedural steps are very similar to those applicable to the hearing of a CTO application under the MH(CAT) Act. Certain persons are entitled to appear and be heard (s 71) and relevant documentation served on the patient by the responsible clinician who applies for a review of the patient's compulsory status (s 72). A District Inspector has standing to appear on the patient's behalf and be heard on the application, if the patient so desires, and must communicate orally with the patient for this purpose (s 74). As with the review procedure in s18 of the MH(CAT) Act, a Judge acting pursuant to the SA(CAT) Act must interview the patient before an application for review of the compulsory status of a patient is heard (s 75). The patient is entitled to be present at the hearing, unless excused or excluded, and is entitled to legal representation. The person may call witnesses and cross-examine witnesses called by another party, and must be given an opportunity to address the court if capable of doing so (s 77(3)).

13 December 2006, entered into force 3 May 2008) (CRPD). For a very thorough recent account of the relevance of these human rights treaties in the context of mental health law see Kris Gledhill, "Examining New Zealand Mental Health Law from a Human Rights Perspective" (paper presented to New Zealand Law Society "Focus on Mental Health in the Courts" Continuing Legal Education Intensive, September 2017) 1.

[14] Lawrence Gostin and others *Principles of Mental Health Law and Policy* (Oxford University Press, Oxford, 2010) at 105.

[15] At 105.

[16] Articles 5 and 12.

[17] Gledhill, above n 13, at 5.

At the hearing the Court is not bound by the rules of evidence (s 80), and may call any witnesses whose evidence may be of assistance to the Court (s 82). The Court can also dispense with a formal hearing if satisfied no one wishes to be heard on the application (s 83). Competent interpreters must be provided where the person's preferred language is a language other than English, or where the patient is unable, because of disability, to understand spoken language (s 84).

There is a right of appeal to the High Court in any case where the Family Court has refused to make an order or has dismissed an application (s 85).

A. Office Holders

Subpart 7 of the Act deals with issues of administration and public assistance and defines the roles of particular office holders, including the Director of Addiction Services (s 86), Directors of Area Addiction Services in specified areas (s 88), District Inspectors and Authorised Officers (ss 90 and 91). The powers of office holders to delegate functions, duties and powers are also spelled out here (ss 87 and 89). The subpart also defines the process for designating approved providers and their reporting duties in relation to their functions under the Act (s 93).

The rules governing the assignment of responsible clinicians and the designation of approved specialists are laid out in ss 94-96.

B. District Inspectors

Subpart 8 deals with the role of District Inspectors with regard to the visitation of treatment centres. The authority to appoint District Inspectors for this purpose is given in s 90. The Minister of Health may appoint any number of lawyers to the District Inspector role in respect of the locations specified by the Minister in the instrument of appointment. The powers given to District Inspectors are almost identical to those given to district inspectors under the MH(CAT) Act. However, it is unclear whether a person appointed as a District Inspector under this Act can also hold the same role under mental health legislation. The answer may lie by analogy with the situation pertaining to the IDCCR Act, under which the Director-General of Health has the power to designate district inspectors for the purposes of the Act.[18] Under s 144(3) of the IDCCR Act the Director-General may only designate as District Inspectors "persons who are District Inspectors or Deputy District Inspectors appointed under the Mental Health (Compulsory Assessment & Treatment) Act 1992". What of the position under the SA(CAT) Act? Do District Inspectors already have to hold that role under the mental health legislation? Such an approach would at least be consistent with that taken under the ID(CCR) Act. Equally, however, in the absence of a statutory limitation identical to s 144(3) of the ID(CCR) Act, it might be argued that a purpose of the legislative scheme is to give the Minister of Health, as the designating authority, the power to appoint District Inspectors de novo for the distinctive purposes of the SA(CAT) Act, whether or not they have or currently hold the role under the mental health legislation.

[18] See Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, s 144 (1).

It is of interest that neither the Act itself nor the explanatory materials preceding the passage of the legislation through Parliament addresses this question.

C. Enforcement

Subpart 9 deals with powers of enforcement under the Act. The power to seek police assistance is modelled on the same power given in s 41 MH(CAT) Act and authorises detention by a constable for the shorter of six hours or the time taken to conduct a specialist assessment (s 105(3)). The subpart also provides for the apprehension of patients who are absent without leave from a treatment centre (s 106). The jurisdictions for a Judge or Registrar to issue a warrant is defined (s 107) together with the parameters for the use of force. Under s 109 a person authorised to use force may use such force as "is reasonably necessary" in an emergency and in circumstances where a person is obliged to accept treatment or to comply with a lawful direction (s 109(3)).

D. Offences

The Act also specifies five specific offences which apply to persons involved in the management of or employment by a service operating a treatment centre. The offences track the identical offences in the MH(CAT) Act.[19] The offences of neglect or ill-treatment of patients, assisting a patient to be absent from a treatment centre without leave, and obstruction of inspection defined in ss 110, 111 and 112, respectively, relate exclusively to the manager of a treatment centre, or a person employed or engaged by the manager or the service operating the treatment centre. The offence of neglect or ill-treatment under s 110 also applies to any person performing any function or exercising any power in relation to a patient under the Act.

The offences defined in ss 112-114, namely, false or misleading certificates and further offences involving false or misleading certificates, may be committed by any person and are not specifically limited to those involved in management or employment within treatment centre. The most serious of these offences, neglect or ill-treatment of patients under s 110, carries a maximum term of imprisonment not exceeding two years.

E. Legal representation

The Act is silent on the issue of the right of subject persons to free legally aided lawyers. However as with both the MH(CAT) Act and the ID(CCR) Act, the Act does provide a right to legal advice (s 57). Since the SA(CAT) Act is remedial legislation proceedings under the Act would qualify as civil proceedings for the purposes of the Legal Services Act 2011. Legal aid may be granted for civil proceedings in the Family Court or the District Court.[20] Eligibility for legal aid will depend on the likely cost of the

[19] See Mental Health (Compulsory Assessment & Treatment) Act 1992, ss 114, 115A, 117, 118 and 119.
[20] Legal Services Act 2011, s 7(1)(a).

proceedings to the applicant and the applicant's ability to fund the proceedings if legal aid is not granted.[21] Other factors, including a lack of reasonable grounds for taking or defending the proceedings and arrears in respect of repayment of a previous grant of legal aid, may also affect eligibility. However, particular rights guaranteed by the CRPD, in particular the right of effective access to justice "in order to facilitate their effective role as direct and indirect participants",[22] would seem to imply a positive duty on the state to ensure that the subject person does not experience unreasonable barriers to effective participation in the proceedings, including financial barriers. However, this is an issue that will need to be conclusively determined by the courts in an appropriate case.

VI. Subordinate Instruments and Miscellaneous Provisions

Part 3 of the Act is concerned with subordinate instruments and miscellaneous provisions. It provides for the Director–General of Health to issue guidelines and standard, and covers such matters as the making of regulation (s 118), matters to be disclosed in annual reports (s 119), the Ministry of Health's obligation to review the Act (s 119A) and provisions governing delegations (s 120).

The Act concludes with Schedules which govern transitional, savings and related provisions, and consequential amendments to other acts and repeals.

VII. Conclusion

As the Law Commission has observed, people suffering from severe substance dependence have quite distinct needs from people suffering from severe mental disorders.[23] Their needs for access to detoxification centres and ongoing access to alcohol and drug treatment programmes dictates the need for a statutory regime specifically targeting this area of social need. While the regime of the Alcoholism and Drug Addiction Act 1966 has served the interests of the community in the management and care of those with severe substance and alcohol addictions for over 50 years, the increased sophistication and complexity of a modern society's interaction with mind–altering substances requires a statutory model better suited to modern needs. It should be able to deliver care swiftly and efficiently while attuned to the rights and entitlements of addicts and substance abusers as persons with disabilities and entitled to the full protection of the law. Yet, as Young and Sim observe, law reform on its own is not enough where insufficient treatment facilities currently exist in New Zealand for both compulsory and voluntary treatment.[24] The lack of adequate resourcing to address treatment needs will inevitably limit the effectiveness of the legislative regime.

Nevertheless, such limitations notwithstanding, the principles and objects specified in the Act should support the fundamental public interest directive, identified by the Law

[21] Legal Services Act 2011, s 10(2).
[22] CRPD, above n 13, art 13.
[23] Law Commission, above n 3, at [6.8].
[24] Young and Sim, above n 1, at 388.

Commission, that people who are severely dependent on alcohol or drugs should be subject to intervention to protect them from the risk of serious harm where, as a result of severe substance dependence, they have substantially impaired capacity to care for themselves and to make treatment decisions.[25]

[25] Law Commission, above n 3, at [9].