New Zealand Medical Association
Te Hauora mō ngā Iwi Katoa

22 April 2016

Health Committee
Select Committee Services
Parliament Buildings
WELLINGTON 6160

By email: health@parliament.govt.nz

Substance Addiction (Compulsory Assessment and Treatment) Bill

Dear Sir/Madam

The New Zealand Medical Association (NZMA) wishes to provide feedback on the above Bill. The NZMA is New Zealand's largest medical organisation, with more than 5,500 members from all areas of medicine. The NZMA aims to provide leadership of the medical profession, and to promote professional unity and values, and the health of all New Zealanders. Our submission has been informed by feedback from our Advisory Councils and Board.

1. We welcome the above Bill and strongly support its intent and purpose. The Alcoholism and Drug Addiction Act 1966, which the Bill is intended to replace, is cumbersome and reflects an outdated treatment philosophy. It is no longer fit for purpose and needs to be repealed. We agree that the best option for its replacement is the development of standalone legislation rather than amendments to existing legislation.

2. The harms arising from severe substance addiction are substantial and impact on individuals, their families, communities and society as a whole. We agree that compulsory treatment for severe substance addiction is justified under certain circumstances. We consider the principles and threshold criteria included in the Bill to be consistent with a modern, rights-based compulsory assessment and treatment regime for people with severe substance addiction. We believe the maximum period of detention of 56 days is reasonable and welcome the safeguards to protect the rights of patients who are subject to compulsory assessment and treatment, including the specific provisions to protect the rights and needs of children and young persons. We note that the Office of the Children's Commissioner is empowered to monitor the treatment centres under the legislation.

3. We have some reservations at the omission of 'significant harm to others' as a relevant criterion for committal for treatment. We note that the Regulatory Impact Statement (RIS) considers that including this criterion would not be appropriate as 'Existing legislation directed at

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child protection, family violence and other criminal behaviour is available to deal with situations where behaviour arising from substance addiction results in a risk of serious harm to others'. We note that the Law Commission also did not support the inclusion of 'harm to others' because it 'changes the focus of legislation from protecting people from significantly impaired capacity to one of protecting others from harm'. We seek clarification as to what existing legislation would ensure that a person who would stand to benefit from compulsory treatment of their substance abuse, has harmed others and meets all of the criterial for compulsory treatment—aside from harm to themselves—receives treatment. We also contend that the harm caused to others by a person with severe substance addiction is quite likely to be associated with harm to themselves, thus casting some uncertainty as to the validity of the Law Commission's opinion. We note that 'harm to others' is a consideration under the analogous Mental Health (Compulsory Assessment and Treatment) Act 1992.

4. Our main concern with the Bill is the inadequate resourcing to accompany it. This represents a major risk. We consider the estimate that only 200 patients per year are likely to meet the criteria for compulsory assessment and treatment to be overly conservative. Given that the Ministry of Health estimates 60,500 people in New Zealand have an untreated substance dependence disorder, we envisage considerably more than 0.3% of this cohort would meet the Bill's criteria for compulsory assessment and treatment.

5. We note that the predicted operational costs (exclusive of GST) are $350,000 to set up the proposed statutory framework and ongoing administrative costs to the health sector of $775,000 annually. This figure appears to be low and no detail has been provided on how it has been calculated. More importantly, we are very concerned at the lack of funding for the clinical aspects arising from this Bill. The availability of resources will become a rate limiting factor. No funds have been allocated for new services and none for accommodating patients within existing services. Even if the conservative figure of 200 patients is correct, then for a period of 56 days each, this would represent a cost of $5.15 million per annum (based on an average daily cost of $460 for a hospital bed).[1] We ask the Committee to consider where these patients will be treated.

6. Our understanding is that there are currently no funded secure Alcohol or Drug inpatient bed providers in the country. This means that any admission under the new Act is likely to be to a mental health inpatient unit. This would be highly inappropriate. Mental health inpatient units are not designed to provide this kind of treatment. Furthermore, mental health beds are scarce and expensive, costing well over $500 per night, with acute beds commanding a significant premium due to the high staffing ratios required. There is no surplus capacity in current mental health services. If these beds are occupied by patients under the new Act, then people with mental health crises will be disadvantaged by not being able to access these services. If this Bill is to be successful, we believe that it is necessary to ensure dedicated and specific services with appropriately trained clinicians. It is disingenuous to profess that the implications of the Bill will be cost neutral. While we certainly view treatment as an investment, we contend that there needs to be sufficient investment at the front end to ensure that predicted gains in the health, social and justice sectors are realised.

7. We have some reservations at learning that police are named as the agents who will have to find and return patients under committal who abscond from their treatment centres, even though it is not an offence to abscond. The Police could argue that social workers or some other agency should be the ones tasked with finding absconders. It is unclear in the commentary just how police will be able to arrest, or otherwise detain, a person who has committed no offence. Nevertheless, we acknowledge the precedent of this occurring with the analogous Mental Health

[1] http://www.stuff.co.nz/waikato-times/news/7875249/Quicker-turnaround-of-patients-at-Waikato-Hospital

legislation and are not able to identify a realistic alternative. We also hold the view that health professionals do not (and should not) have the power to force someone to return to hospital against their will.

8. We welcome the requirement that addiction services provide families with advice and assistance, irrespective of whether the person comes within the scope of the legislation. As the RIS notes, family-inclusive practices are also an important part of the legislation's implementation, particularly as some people who will be under the legislation will have become estranged from their families over time. We hope that doctors will be able to invoke this section whenever they engage with substance addicted patients and their families. Doctors should also be able to access the requisite services in a timely manner as part of the legislation's implementation.

We hope that our feedback has been helpful. We would like to have the opportunity for an oral hearing before the Committee to support our written submission.

Yours sincerely

Dr Stephen Child
NZMA Chair