Nurse Practitioners New Zealand
A division of the College of Nurses Aotearoa (NZ) Inc
PO Box 1258
Palmerston North 4440
+64 6 358 6000
admin@nurse.org.nz
www.nurse.org.nz/npnz

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Submission on:

Substance Addiction (Compulsory Assessment and Treatment) Bill

Submission To: Committee Secretariat
Health
Parliament Buildings
Wellington

Prepared on behalf of NPNZ by:

Louise Leonard Nurse Practitioner
NPNZ Executive

Mark Baldwin Nurse Practitioner
NPNZ Secretary

Jeff Symonds Nurse Practitioner
NPNZ Executive

Overview

Nurse Practitioners New Zealand (NPNZ) welcomes the opportunity to comment on the long-awaited review of the Alcoholism and Drug Addiction Act 1966 and the proposed Substance Addiction Compulsory Assessment and Treatment of individuals who have a severe substance addiction and who do not have the capacity to participate in treatment.

We support the review and overhaul of legislation that is currently used, with considerable difficulty. This is due in part to the lack of flexibility in terms of duration that people can be committed to compulsory treatment under the current Act, the limited number of gazetted places available and that the present legislation is seen as a last resort; as a result it is almost impossible to use in a timely fashion, to change the trajectory and progression of a person's substance use disorder.

We also support the delay in implementation of the new Act to allow services to be developed and/or re-aligned, and guidelines and standards to be drawn up. Currently there are major deficits around service availability, alignment of services and the availability of skilled clinicians able to recognise the advantages of compulsory treatment and implement it.

We would like to make some suggestions in relation to the act:

In relation to **Clause 3 section (a)**

We note that in outlining the purpose of the Act where compulsory treatment may protect an individual from harm that there is no definition of harm within the document.

In relation to **Clause 9** "**Capacity to make informed decisions**"

This is problematic; as it stands if the patient can weigh up the information given to them, retain it, weigh that information as part of their decision making process and then communicate it , then they have capacity.

However, if a person is addicted to a substance; intoxicated to a degree that may not be apparent due to their level of neuroadaptation; has limited insight, poor judgement and a lack of motivation to change , then they are likely to weigh up the information and wish to continue using substances – despite the health information they are given. This would then create similar legal problems that we currently face in mental health regarding treatment of physical health conditions.

In relation to **Clause 15** "**Application requirements"** part 2 sub-part (e) where it states that an application must be accompanied by (i) a medical certificate under section 17 or (ii) a memorandum under section 18

NPNZ propose that the skills, significant experience and training of Nurse Practitioners (NP's) be recognised in affording them the right to undertake the specialist assessments and reviews if deemed suitably qualified by the Director of Addiction Services. This would be more in-line with the Health Practitioners (Statutory References to Medical Practitioners) Bill that is currently before Parliament.

Clause 16 would therefore require alteration replacing the term Medical with Health in the title "Assistance in arranging medical examination for application", and then in clause 16 (1); 16(3); 16 (4)(a) and 16(4)(b).

Section 17 "Medical certificate" in clause 1 we note that "A Medical practitioner may –" and **Section 18**

NPNZ believes it is well within the skill set of NP's, particularly NP's who specialise in addictions, to complete the assessment and the term 'medical ' should be replaced by either Nurse Practitioner assessment /certificate or Health Practitioner assessment /certificate (in line with the Health Practitioners (Statutory References to Medical Practitioners) Bill.

Further, NP's are well placed to support Authorised Officers to assess the patient, make the diagnosis of severe substance dependence and recommend the appropriate treatment plan, including compulsory treatment. Specialist Addiction NP's are currently doing this work, albeit not signing off the medical certificate, whilst also supporting Non-Government addiction services to identify those requiring compulsory treatment. To a large extent this is because there is a shortage of medical addiction specialists and currently their work is largely focussed on delivering community – based Opioid Substitution Treatment.

Section 26 (2) (f) states that a copy of the Compulsory Treatment certificate and a written statement of the patient's rights and other entitlements be sent to the people specified in subsection 2. Subsection 2 part (f) states "the medical practitioner who usually attends the patient". NPNZ note that particular phrase is being changed in the Health Practitioners (Statutory References to Medical Practitioners) Bill, *Clause 44* inserts definitions of "health practitioner" and "Primary Health Care Provider" into section 2 of the Mental Health (Compulsory Assessment and Treatment) Act. A Primary Health Care Provider is the Health Practitioner who manages and provides primary and ongoing health care to a patient. This reflects the growing number of Nurse Practitioners in Primary care who autonomously and independently manage a patient's health needs. We also note in Clause 34 the "Right to apply to court for urgent review of patient's status" subsection 2 part (f) and Clause 71 "Persons entitled to appear and be heard", subsection 1 part (h) are similarly affected and would need amending as outlined above.

With regards to **Section 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;

NPNZ wishes to highlight the current shortage of dedicated beds for medically managed withdrawal, which, if not extended and adequately resourced, would severely limit the use of the new Act. We also would like to highlight that the phrase "medically managed" would imply the exclusion of suitably qualified Nurse Practitioners to take a lead role in delivering these treatment regimens as they are not medical practitioners. We suggest more inclusive terms should be used to replace terms such as 'medical examination', 'medicated' and 'medically managed'.

Regarding section 37, Treatment given or authorised by responsible clinician

(1)

The responsible clinician may, subject to this Act, give, or authorise the giving of, any treatment (including any medication) that the Responsible Clinician thinks fit for the treatment of the patient's severe substance addiction.

(3)

To avoid doubt, this section does not authorise a Responsible Clinician to prescribe any treatment (including any medication) that the Responsible Clinician is not otherwise authorised to prescribe

NPNZ recommends that Addiction Specialist NP's be considered Responsible Clinicians and are able to prescribe or authorise the prescribing of controlled drugs in line with changes proposed to the Misuse of Drugs Act 1975, under the Health Practitioners (Statutory References to Medical Practitioners) Bill.

Regarding section 65, Child or young person entitled to have adult present

Every child or young person who is examined by a Medical Practitioner ,

NPNZ proposes that this be replaced by the term Health Practitioner, in line with changes proposed in the Health Practitioners (Statutory References to Medical Practitioners) Bill, with reference to the Children's Young Persons, and their Families Act.

We note that **Clause 111 "Assisting patient to be absent from treatment centre without leave"** only applies to staff of the treatment facility, it does not cover people who may take detained people out on leave, (as leave can be granted under Clause 39), and fail to bring them back. The Mental Health (Compulsory Assessment and Treatment) Act has section 115A that states:

115A Assisting patient on inpatient order to be absent without leave

(3) Every person commits an offence and is liable to imprisonment for a term not exceeding 3 months or to a fine not exceeding $1,000, if he or she—

- (a) intentionally instigates or assists any patient who is subject to an inpatient order to become, or to attempt to become, absent without leave from the hospital specified in the order or to which the patient has been transferred under Section 127; or
- (b) intentionally assists any patient who is so absent to avoid, or to attempt to avoid, being retaken.

We propose that similar legislation be inserted in clause 111 of the proposed Substance Addiction (Compulsory Assessment and Treatment) Bill.

Finally, NPNZ argues that there are some overarching factors that must be addressed to enable this new Act to succeed and deliver better health outcomes for patients and reduce harm to individuals, families and communities. Most importantly, workforce and service development required to support the new Act must be adequately resourced. The projected estimate of 200 people per annum affected by the new Act, with an additional approximate $775, 000 per annum nationally to address the need, is a gross underestimate of need, which

is not surprising given our current paucity of data collection specific to alcohol and drug treatment. Our current systems do not detect the multitude of clients with severe addiction who either fail to engage or indeed ‘drop out’ of addiction treatment because they are unable to access timely and appropriate treatment due to either lengthy waiting times for treatment or a lack of skilled addiction clinicians able to address the complex needs of this client group.

Further, resources must be made available to prioritise detection and early intervention for young adults, before the dysfunctional trajectory caused by addiction becomes entrenched.

Similarly, adequate resourcing must take into account the co-morbidities that exist alongside addiction (mental health, family violence, crime) and the harm caused to the individual and the community as a result. Under the new Act there is a shorter duration of compulsory treatment followed by a review at 8 weeks and a return to voluntary treatment as soon as possible (i.e. less restrictive treatment that is ‘closer to home’). Therefore, the social environments people are likely to return to post compulsory treatment must be considered and more suitable options made available.

We look forward to watching the progress of this important Bill that has the potential to greatly facilitate addiction treatment to those who most need it.

Yours sincerely

Jane Jeffcoat RN, NP, MN (Hons)
Chair
Nurse Practitioners New Zealand