****

**Submission to the Health Select Committee on the Substance Addiction (Compulsory Assessment and Treatment) Bill**

***26 April 2016***

**Contact Person:**

Janet Anderson-Bidois

Chief Legal Adviser

Janetab@hrc.co.nz

**NEW ZEALAND HUMAN RIGHTS COMMISSION SUBMISSION TO THE HEALTH SELECT COMMITTEE ON THE SUBSTANCE ADDICTION (COMPULSORY ASSESSMENT AND TREATMENT) BILL**

**Introduction**

1. The Human Rights Commission (‘the Commission’) supports the broad intent of the Substance Addiction (Compulsory Assessment and Treatment) Bill (‘the Bill’).
2. However, the proposed legislation has significant human rights implications. The Commission has concerns about some aspects of the Bill and the practical implementation of certain provisions. These concerns, and recommendations to address them, are set out below. They can be summarised as follows:
   1. ***The legislation should explicitly recognise the right of the patient to give or withhold consent to treatment (including individual aspects of treatment) to the greatest extent possible – the compulsory regime should not absolutely remove the ability of the patient to remain involved in treatment choices to the extent appropriate to his or her circumstances.***
   2. ***The capacity test in clause 9 is potentially very wide ranging, may be difficult to apply in practice and does not recognise that individuals who might otherwise lack ‘capacity’ as defined might in fact reach the threshold if provided with appropriate support.***
   3. ***The legislation should specifically reflect the requirement to respect human dignity and other fundamental human rights when statutory functions and powers are exercised.***
   4. ***The Commission recommends that the Bill is amended to ensure that all its clauses are fully consistent with the UN Convention on the Rights of the Child special protection requirements in relation to all persons aged under 18 years of age. This would also ensure that the Bill is consistent with proposed changes to the upper age of the Children, Young Persons and their Families Act 1989 that have arisen from the recent review of care and protection services.***
   5. ***The absence of a definition of “appropriate facility” in clause 25(1)(b) introduces the possibility that patients could be detained in police cells or other environments that are not conducive to treatment or humane detention for a period of up to 7 days while awaiting admission to a ‘treatment centre’.***
   6. ***There are no time frames for the ‘urgent review’ process outlined in clause 34.***
   7. ***The basis for providing an extended compulsory treatment period for those patients with a brain injury is unclear.***
   8. ***The ability to secretly check incoming and outgoing mail and electronic communications is particularly intrusive and does not appear to be reasonable.***
   9. ***The ability to access a second clinical opinion (clause 56) or a lawyer (clause 57) are illusory safeguards unless there is clear provision for associated payment and/or practical arrangements that support the ability of the patient to access these services.***
   10. ***The efficient and appropriate implementation of this legislation depends entirely on the provision of adequate ‘treatment centres’ with sufficient staffing and funding to make a clinical difference to those patients detained for compulsory treatment.***
3. These points are discussed further below.

**Human rights implications**

1. As noted in the introduction, the Bill has implications for New Zealand’s human rights obligations under both domestic and international human rights law.
2. In its review of the Bill’s consistency with the New Zealand Bill of Rights Act 1990 (“NZBORA”), the Ministry of Justice has identified that the Bill has implications for the following rights and freedoms:
   1. The right to refuse medical treatment (s 11 NZBORA)
   2. The right to freedom of expression (s 14 NZBORA)
   3. The right to liberty of the person (s 22 NZBORA)
3. The Ministry of Justice concluded that the Bill limits the above rights in a manner that is proportionate and justified for the purpose of s 5 NZBORA. The Commission does not propose to provide a further analysis of the NZBORA implications but notes that the MOJ has identified a potential risk that in some circumstances a patient may be detained for longer than may be necessary.[[1]](#footnote-1) While the MOJ has concluded that this risk is not sufficient to amount to arbitrary detention, the Commission recommends that the Committee place some additional focus on this aspect of the Bill.
4. The Bill also has implications for New Zealand’s international human rights obligations. This includes the corresponding rights to freedom of expression and liberty/security of the person under Articles 7, 9, 10 and 19 of the International Covenant on Civil and Political Rights (“ICCPR”). The UN Human Rights Committee has held that, in ensuring compliance with the right to liberty of the person:

*“States parties should revise outdated laws and practices in the field of mental health in order to avoid arbitrary detention. The Committee emphasizes the harm inherent in any deprivation of liberty and also the particular harms that may result in situations of involuntary hospitalization. States parties should make available adequate community based or alternative social-care services for persons with psychosocial disabilities, in order to provide less restrictive alternatives to confinement”[[2]](#footnote-2)*

1. Further to this point, the Commission notes the implications that the Bill has regarding the general human right to dignity. The first recital of the Universal Declaration of Human Rights states that the “recognition of inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world”. The same statement is included in the preamble of the International Covenant on Civil and Political Rights (“ICCPR”). The preambles of both the ICCPR and International Covenant of Economic Social and Cultural Rights (“ICESCR”) recognise that the rights contained therein “derive from the inherent dignity of the human being”. Article 3(a) of the Convention on the Rights of Persons with Disabilities (“CRPD”) provides that the principles of the Convention “shall be respect for inherent dignity, individual autonomy including the freedom to make ones’ own choices, and independence…”
2. **The Commission accordingly recommends that clause 12(e) be amended so that there is a clear requirement to exercise powers with proper respect for the inherent dignity of the patient**. This would be consistent with international human rights obligations.
3. The Bill also has implications for the rights of children and young people under the UN Convention on the Rights of the Child (“UNCROC”). The Commission notes that the Bill defines a child or young person as a person aged under 18, in alignment with the requirements of UNCROC. Yet the Bill does not extend the UNCROC-consistent differential protections to 17 year olds under proposed clauses 24 and 33 regarding compulsory treatment certificates and compulsory treatment orders respectively. The Commission recommends that the Bill is amended to ensure full consistency with the UNCROC special protection requirements in relation to all persons aged under 18 years of age. This would also ensure that the Bill is consistent with proposed changes to the upper age in the Children, Young Persons and their Families Act 1989 that have arisen from the recent review of care and protection services.

**Consent to Treatment**

1. The proposed legislation should more explicitly recognise the right of individuals to maintain the ability to make decisions regarding their treatment, to the greatest extent possible. This principle should apply notwithstanding that aspects of their care may be provided without consent if the statutory criteria are met. If an individual reaches the threshold for compulsory treatment for a substance or alcohol addiction this does not necessarily mean that he or she should forfeit their right to make all decisions regarding their care and treatment.
2. It is well established that consent is not a binary concept – even those with significantly impaired capacity can usually retain the ability to have some degree of active involvement in their care and treatment – for example by choosing between two equally reasonable clinical treatment options or expressing a preference about different courses of action.

1. This requirement is explicitly recognised in Right 7(3) of the Code of Health and Disability Services Consumers’ Rights which states that consumers with diminished competence retain the right to make informed choices and give informed consent to the extent appropriate to his or her level of competence. Supporting patient involvement and participation would seem particularly important in the area of substance and alcohol addiction where active engagement in treatment is more likely to support a positive outcome. The efficacy of treatment provided under compulsion may be questionable.

1. The requirement to obtain informed consent before providing treatment to a patient is reflected in section 11 of the New Zealand Bill of Rights Act 1990. Section 57 of The Mental Health (Compulsory Assessment and Treatment) Act 1993 (“MHCAT”) explicitly states that a patient or proposed patient can refuse consent to any form of treatment for mental disorder except as provided for in part 5 or section 110A of the Act. Article 12 (4) of the United Nations Convention on the Rights of Persons with Disabilities requires the implementation of safeguards to ensure that measures relating to the exercise of legal capacity respect the rights of, will and preferences of the person concerned, are proportional and tailored to the person’s circumstances, apply for the shortest time possible and are subject to regular review (amongst other provisions).
2. The Provisions can also be contrasted with section 8 of the Protection of Personal and Property Rights Act 1988 (‘PPPRAct’) which require a court to, among other things, enable and encourage a person to exercise and develop such capacity as he or she has to the greatest extent possible.

1. The Commission’s view is that the current Bill could more explicitly support the requirement to give effect to personal autonomy to the greatest extent possible within the broader mandatory treatment framework. This could be achieved in several ways, including the insertion of an explicit recognition of this requirement in clause 12. Although current clauses 12(a),(b) and (c) touch on the level of coercion, the views of the patient and minimising interference with rights - **inclusion of a statement that specifically requires the recognition of consent / refusal of consent to the greatest extent possible would be more consistent with a rights based approach and would establish clear expectations in this area.**
2. It should be noted that this is not the same as merely having a “right to treatment’ (clause 53) or the right to be informed about treatment (clause 54).

**Test for Capacity**

1. The Commission notes that the test for capacity contained in clause 9 contains 4 criteria. These appear to be disjunctive meaning that a person only need satisfy one aspect of the test to meet the clause 7(b) “impaired capacity” limb of the overall criteria for compulsory assessment and treatment. So the person need only be unable to understand relevant information, OR retain the information, OR use or weigh the information as part of a decision making process, OR communicate decisions.
2. The Commission notes that this is an expansive definition. It is in contrast to the jurisdictional threshold in section 6(1)(a) of the PPPR Act which requires that the subject person lack, wholly or partly, the capacity to understand the nature **and** to foresee the consequences of decisions relating to his or her personal care and welfare.
3. In addition to being broad, the test may be difficult to apply in the context of an illness that is likely to manifest itself in a fluctuating manner. For example, a person may meet the statutory criteria when under the influence of a substance but may not meet the criteria when sober. There is no guidance in the legislation as to whether these criteria must be established on an enduring basis. This raises the possibility of potential over-application or misuse of the provisions.
4. Further, the provisions refer to capacity in absolute terms and do not appear to require or anticipate that those who on one test may lack “capacity” as defined might well be able to understand, retain, weigh or use the information in other circumstances. This may include situations where they are provided with appropriate support and the information is tailored to their specific requirements and level of understanding.
5. **The Commission recommends that consideration be given to narrowing the definition of ‘capacity’ and that amendments be made to ensure that options to enhance and support the level of understanding/capacity of an individual are fully explored before the “test” in clause 9 is applied**.

**Appropriate Facility**

1. Clause 25(1)(b) provides that a patient can be detained in an “appropriate facility” until the patient is admitted to a treatment centre under subpart 2. There is no definition of an “appropriate facility”. There is a real possibility that patients may be detained in police cells or other suboptimal environments for extended periods pending admission to a treatment centre. The location and capacity of these yet to be established ‘treatment centres’ will have a significant influence on the length and likelihood of detention in an ‘appropriate facility’. If there is a compelling need to have the ability to detain a patient in an alternative facility pending admission to a ‘treatment centre’ then the Act should specifically state that such a facility is limited to a health and disability service provider’s premises so as to exclude detention in police cells.

**Urgent Review**

1. The Commission notes with concern that there does not appear to be a timeframe or process for dealing with requests for urgent review of a patient’s status under clause 34 of the Bill. This absence is noted in the 27 November 2015 report of Ministry of Justice Chief Legal Counsel to the Attorney General who states:[[3]](#footnote-3)

*The urgency of an application under clause 34 is therefore entirely reliant on the time at which the urgent application is filed, which may not be materially different from the point at which the application for review is filed under clause 29(c). Establishing clearer and more expeditious timeframes for an interview and decision in the case of an urgent review would assist in making the Bill more rights consistent.*

1. The cumulative effect of the proposed provisions is that a person may be detained for up to 14 days before being interviewed by a judge and for either 17 or 27 days before a Court makes a final determination. In this context, the Commission is of the view that the absence of an effective and timely urgent review procedure to underpin the apparent right to apply for an urgent review is significant. Independent review is a critical safeguard to protect against misuse of the powers granted under this proposed legislation.
2. **The Commission strongly recommends that the legislation be amended to ensure that an urgent review application is considered by the Court within 48 hours of being made**.

**Brain Injury**

1. Clauses 45 and 46 of the Bill provide for the extension of a compulsory treatment order where a responsible clinician considers there are reasonable grounds to believe that the patient appears to suffer from a brain injury. A brain injury is very broadly defined as an acquired, enduring neurocognitive impairment.
2. The reason for permitting an extended period of detention for those individuals with a brain injury is not clear in the legislation. This provision appears arbitrary and based solely on the *existence* of a brain injury rather than any assessed need for further compulsory treatment. This additional detention provision does not apply to any other groups of persons.
3. Article 14 of the Convention on the Rights of Persons with Disabilities (‘CRPD’), to which New Zealand is a signatory, states:

***Article 14 - Liberty and security of the person***

*1. States Parties shall ensure that persons with disabilities, on an equal basis with others:*

1. *Enjoy the right to liberty and security of person;*
2. *Are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law,* ***and that the existence of a disability shall in no case justify a deprivation of liberty.***

*2. States Parties shall ensure that if persons with disabilities are deprived of their liberty through any process, they are, on an equal basis with others, entitled to guarantees in accordance with international human rights law and shall be treated in compliance with the objectives and principles of this Convention, including by provision of reasonable accommodation. (*Emphasis added)

1. Clauses 45 and 46 of this Bill appear inconsistent with Article 14.1.b of the CRPD in that the additional detention period is based on the mere existence of a brain injury. Although it is conceivable that there may be instances where there could be a legitimate clinical reason for an additional detention period, such a decision should be based on objective functional criteria rather than solely on an arbitrary diagnosis. Each situation should be assessed on a case by case basis with reference to the level of individual functioning without resort to a provision that discriminates on a blanket basis against those with a brain injury. **The Commission recommends that clauses 45 and 46 be removed. If it is considered necessary to allow for further detention in some situations this should be based on objective functional criteria, not solely based on a brain injury diagnosis.**

**Checking and withholding mail and electronic communications**

1. Clauses 61-64 contain provisions relating to the withholding of mail and electronic communications. The Commission’s view is that these provisions are overly intrusive, lack sufficient safeguards and are not justified.
2. These provisions go much further than those contained in the Mental Health (Compulsory Assessment and Treatment) Act 1993 and extend to the ability to remove computers and devices from patients. Although it is possible that there would be situations where it may be clinically desirable to limit access to information and/or communications the current proposed process is concerning for a number of reasons. These include:
   1. Decisions of this magnitude and intrusiveness should be made by the District Inspector or the Court, not by the responsible clinician and the Area Director. A high degree of independence should be required to ensure that the step is genuinely required and not used for purposes of expedience or for punitive reasons.
   2. There should be an explicit requirement to tell the patient in advance that the step might be taken and that their communications might be monitored and/or access to devices restricted. To take such drastic action without prior warning to the patient is extreme – people receiving care and treatment in a health facility, even on a compulsory basis, are unlikely to anticipate that staff treating them would have access to their private communications. The ability of treatment providers to “snoop” would be abhorrent in any circumstances but is particularly concerning when the patient is being treated under duress. The Act provides for retrospective notification only pursuant to clause 64(1), not prior warning.
   3. Clause 63 exempts certain communications from being withheld. These include communications with judges, district inspectors, lawyers and medical specialists. The Bill contains no mechanism for ensuring these exemptions actually occur. In fact, it is difficult to envisage a system whereby this might be achieved given current technology.
3. **The Commission strongly recommends that these clauses be removed, or at a minimum be replaced with provisions that require District Inspector or Court authorisation, prior notification of the power to patients and a practical process for ensuring that exempted communications are actually protected in practice**.

**Second Opinions and Legal Advice**

1. The Bill provides patients with the right to access a second clinical opinion and to receive legal advice. Although these are important safeguards, they are illusory unless they are supported with a practical process, and associated funding, for accessing these professionals. Patients detained under this legislation might well face practical and financial difficulties in obtaining appropriate professional advice. Given the extensive nature of the coercive powers contained in this Bill it is incumbent on the state to ensure that these rights can, in fact, be exercised.
2. It can be assumed that the current mental health roster lawyer system that covers patients receiving compulsory assessment and treatment under the MH(CAT) Act would be extended to cover patients receiving treatment under this legislation. However, the Bill is silent on this point and merely states that the patient has a right to request legal advice (clause 56). **The Commission recommends that the Bill be amended to explicitly ensure that free legal advice is provided to detained patients upon request and urges the Select Committee to seek assurances regarding funding and resource availability to support this process**.
3. Similarly, the right to seek a second opinion from an approved specialist of the patient’s choice is set out in the Bill. However, the Bill is silent on payment arrangements for the second opinion. **The Bill should be amended to ensure that the responsible clinician is required to take reasonable steps to facilitate the obtaining of a second opinion and that the second opinion must be provided at no cost to the patient**.

**Sufficient Funding and Staffing for Treatment Centres**

1. Whether this legislation can achieve its purported purpose will depend on the availability of adequate funding for treatment centres and the engagement of sufficient numbers of appropriately qualified and experienced staff. The challenges in this respect should not be underestimated.

1. <http://www.justice.govt.nz/policy/constitutional-law-and-human-rights/human-rights/bill-of-rights/substance-addiction-compulsory-assessment-and-treatment-bill>, at paragraph 58 [↑](#footnote-ref-1)
2. UN Human Rights Committee, General Comment No 35: Article 9: Liberty and Security of the Person, 16 December 2014, CCPR/C/GC/35, paragraph 19 [↑](#footnote-ref-2)
3. <http://www.justice.govt.nz/policy/constitutional-law-and-human-rights/human-rights/bill-of-rights/substance-addiction-compulsory-assessment-and-treatment-bill> paras 53-58 [↑](#footnote-ref-3)