REGULATING AND CONTROLLING DRUGS:

MINISTRY OF HEALTH SUBMISSION TO THE LAW COMMISSION

April 2010

Introduction

The Ministry of Health is the Government’s principal advisor on health and disability policy. Among the Ministry’s core functions are the provision of policy advice to the Minister; administration of legislation and regulations on behalf of the Crown; meeting legislative requirements; and servicing ministerial advisory committees.

The Ministry of Health takes a leadership role in relation to the National Drug Policy 2007 – 2012 which is a ‘whole of government’ approach to minimising the harm from drugs including tobacco, alcohol, illegal and other drugs. The responsibility for the provision of drug and alcohol treatment services is vested in the 21 district health boards throughout New Zealand. The Ministry does however directly fund public health services in relation to alcohol and other drugs. The Ministry of Health is responsible for the administration of the Misuse of Drugs Act 1975 (the Act) and as such is responsible for the provision of advisory and secretariat services for the Expert Advisory Committee on Drugs and provides advice to Government on the scheduling of drugs under the Act. The Ministry also administers the Alcoholism and Drug Addiction Act 1966. Ministry officials also take a leadership role in New Zealand’s international commitments in relation to drugs including leadership of the annual delegation to the Commission on Narcotic Drugs.

The Ministry commends the Law Commission on its issues paper “Regulating and Controlling Drugs”. The Ministry believes that this document is a comprehensive and well argued assessment of the main issues facing the development of drug policy in this country and believes that there is much in it that will provide a useful basis for the development of future regulatory policy on drugs in New Zealand.

This submission provides comment from the Ministry’s perspective as principal advisor to Government on the health related aspects of drug policy and as administrator of much of the current Misuse of Drugs legislation. Policy, regulatory and legal teams in the Ministry have collaborated on this submission. The Ministry has provided comment only where it believes it has a useful contribution to make and therefore a number of questions, such as those related to criminal justice issues have not been addressed.

1 The Ministry of Justice administers Part Two of the Act.
National Drug Policy

As pointed out in the issues paper, the Act is not well aligned with the more recent National Drug Policy. The first National Drug Policy was issued in 1998 and introduced the concept of harm minimisation supported by three pillars of supply control, demand reduction, and problem limitation. The principles of harm minimisation were carried through into the second National Drug Policy 2007-2012.

It would be fair to say that the concepts of harm minimisation are often not well understood within the community. The policy is consistent with a public health approach to addressing the harm from drug use which firstly asserts that the most effective way to minimise harm from drugs is not to use them. The objective of abstinence is therefore a key part of the harm minimisation approach. However, harm minimisation also recognises that drug use is a reality and the evidence shows that throughout history, while there have been policy initiatives that have contributed to a reduction in drug use, there is no example of such use having been completely eliminated. The harm minimisation policy therefore acknowledges that some amount of drug use is likely to occur and where harms from this use can be reduced there is a responsibility to take the appropriate action. This part of harm minimisation is often referred to as "harm reduction" and is sometimes criticised by those who believe that people addicted to drugs have the solution in their own hands and are undeserving of services which are not aimed at stopping use.
Chapter 8 – Proposed Approach to Drug Regulation

**Question 1 - Do you agree that the model for regulating drugs other than convention drugs should generally be regulation with restrictions, rather than prohibition, but with prohibition available as a last resort where regulation will not be effective?**

The approach proposed in the issues paper has much in common with the current restricted substances regime. The Ministry of Health considers that the concept behind the restricted substances regime introduced by way of the Misuse of Drugs Amendment Act 2005 and strengthened by the promulgation of the Misuse of Drugs (Restricted Substances) Regulations 2008 has potential for minimising the harm from drugs which are not recognised internationally as needing to be prohibited. The issues paper acknowledges the possibility (paragraph 8.18) that if the supply and use of some psychoactive substances is legal it might lead to an increase in the prevalence of use. However, the Ministry acknowledges the potential that a regulated approach may reduce the availability of such substances if the controls in place (for example minimum purchase age controls, quality control requirements, childproof packaging, restrictions on place of sale, and warning notices) actually make access more difficult than an unregulated system where there are no controls, as was the case with ‘party pills’ containing BZP prior to that substance’s scheduling as a restricted substance.

**Question 2 - Do you agree that a psychoactive substance falling within the ambit of the proposed regime should require an approval from the regulatory body before it can be manufactured or imported?**

Yes, this should be the objective. However, further consideration needs to be given to the initial capture of new and emerging drugs. The Ministry agrees with the Law Commission’s opinion that a psychoactive substance that is not a food, a medicine, or a controlled drug must be a hazardous substance. However, the Hazardous Substances and New Organisms Act has, in practice, been ineffective in controlling psychoactive substances. For example, although it is now accepted that the substance DMAA is a hazardous substance, the HSNO has not prevented this substance from being sold in its pure chemical form within New Zealand, which has resulted in hospitalisations. Nor did the substance BZP ever come to attention as a hazardous substance prior to its scheduling as a restricted substance. Moreover, it is often the case that those who wish to profit from the sale of such substances market them as innocuous products such as “herbal incense” or “CD cleaners”, to circumvent legislation by specifying that the product is not for human consumption - even though users are left in no doubt about the real purpose of the substance. The actual method for ensuring that all sales of regulated substances are proactively identified before they come to market also needs to be given further thought.

**Q3 - Do you agree that all new psychoactive substances that are manufactured or imported for recreational use should be covered by the proposed new regulatory regime?**
Yes, but provision needs to be made to get beneath claims that such substances are not marketed for human consumption.

**Question 4 - Do you agree that the following should be standard minimum requirements:**

*(a) restrictions on the sale or supply of recreational psychoactive substances to persons under 18. (If so, should the age be changed in the event of a change to the purchase age for alcohol?)*

The Ministry submits that all controls on restricted substances under the Misuse of Drugs Amendment Act 2005 and the Misuse of Drugs (Restricted Substances) Regulations 2008 should be maintained as standard minimum requirements on new psychoactive substances.

Specifically, the Ministry agrees that there should be a minimum age for these substances that is aligned with the minimum purchase age for alcohol. If the purchase age for alcohol was raised the Ministry would support a raised purchase age for other recreational psychoactive substances.

*(b) advertising restrictions along the lines of the restrictions on advertising tobacco products under the Smoke-free Environments Act*

There should be strong controls over advertising as provided for currently in the restricted substances regime. The Ministry would also support further controls prohibiting all advertising of these substances, such as the controls on tobacco under the Smoke-free Environments Act. Specifically, the regime should restrict the advertising and display of products and any sponsorship activity.

*(c) a prohibition on the promotion of these substances similar to that currently applying to restricted substances*

Yes, all of the restrictions in the restricted substances regime should be maintained.

*(d) a prohibition on the sale of the substances at: places where alcohol is sold; petrol stations; non-fixed premises such as vehicles, tents, and mobile streetcars; places where children gather; pharmacies.*

Yes, these products should be sold by dedicated outlets which would be required to demonstrate host-responsibility awareness similar to that expected of licenced premises in respect of the sale of alcohol.

*(e) a prohibition on the manufacture, importation and sale of these substances by any person: under the age of 18 years; or who has been convicted within the previous five years of a dealing offence under the Misuse of Drugs Act or an offence under the Crimes Act punishable by seven years imprisonment; or who has been convicted of an offence under the regime applying to these substances and has been prohibited by the court from undertaking any of these activities.*
Yes, this is supported.

(f) a requirement that these substances be stored in child-proof and tamper-proof containers

Yes, this is a provision in the current restricted substances regulations which should be maintained.

(g) a requirement that the labels should contain the contact details of the National Poisons Centre.

Yes, this is a provision in the current restricted substances regulations which should be maintained.

**Question 5 - Are there other matters that should become minimum standard requirements?**

There should be stricter regulations concerning how such substances may be displayed in retail premises – and preferably no display whatsoever.

There should be a requirement for products to display health warnings. This is particularly important to avoid any concern that by not banning the substances, the Government is somehow sanctioning their use.

The Ministry notes that these provisions are currently provided for under the restricted substances regime.

**Question 6 - Do you agree that the regulating body should have power to impose additional conditions on an approval for a new recreational or a psychoactive substance? If so, should the conditions cover: additional place of sale restrictions; labelling restrictions and requirements; packaging restrictions and requirements; health warning requirements; signage requirements; quantity, dosage, form and serving requirements; storage and display restrictions; record-keeping requirements; any other requirements considered necessary or desirable to minimise harm that might occur as a result of use of these products.**

As indicated above, display restrictions and health warnings should be mandatory. All other additional conditions suggested are supported.

**Question 7 - Should the regulatory body have the power to issue manufacturing codes of practice?**

Yes.

**Question 8 - Do you agree that there should be a power of recall? If so, in whom should that power vest?**
Yes, there should be a power of recall which should be exercised by the Director-General of Health.

**Question 9 - Should penalty levels for offences be set at levels currently provided for in HSNO or should they be set at similar levels to penalties in regimes regulating drugs like alcohol and tobacco?**

The Ministry has no comment on penalty levels at this stage.

**Question 10 - Do you agree that new recreational psychoactive substances should be regulated by a separate regime designed specifically for new recreational psychoactive substances rather than HSNO?**

The Ministry of Health believes there is scope to investigate the control of such substances under both the Hazardous Substances and New Organisms and Misuse of Drugs frameworks. The Ministry submits that the role of HSNO in this context should be to regulate the hazardous properties of bulk quantities of such substances, such as flammability or environmental toxicity. However, the sale of such substances for a psychoactive effect should be regulated by drug specific legislation that is administered by the Ministry of Health.

This would avoid the need to determine how the substances that fall within each regime are defined or to specifically exclude substances from HSNO. As identified in response to question one above, there is a need to have a robust system which ensures that all substances are ‘registered’ in some way and HSNO may be a mechanism for achieving that. There are also environmental concerns about some substances for which specific HSNO controls may be appropriate. However, controls in respect of the sale of products intended to produce a ‘legal high’ are better controlled by drug specific legislation.

Other common products, such as glues, aerosols, and other volatile substances which can also be used to produce a psychoactive effect are also problematic in terms of regulatory controls. It is considered that HSNO is the appropriate legislative mechanism to deal with their commercial use, but that any further controls which may be required to deal with recreational use would be better under a separate system.

If joint control of psychoactive substances is not an option the Ministry would opt for a separate regime. The advantages for HSNO control set out in paragraph 8.86 are less evident when put under scrutiny. While there are mechanisms for approving imports and manufacture of hazardous substances, these have not been designed for psychoactive substances and special controls are needed. Even if there was only a limited number of psychoactive substances needing approval it would still be necessary to develop a different approach and a careful definition of what constituted psychoactive substances under either scenario. Further, it would be unlikely that the same agency (ERMANZ) responsible for advising on hazardous substances would take on the additional work required for psychoactive substances.

The Ministry does not necessarily agree that the agency responsible for regulating psychoactive substances should also have responsibility for enforcement. Under the
current regime for controlled drugs these roles are separated and the system works without difficulty. However, the Ministry of Health does have a small enforcement capacity for other legislation and it would be possible, with appropriate resourcing, to take on such an additional role.

**Question 11 - Under the proposed separate regime, do you agree that the Minister of Health rather than the Director-General should issue approvals?**

The Ministry agrees that this should be a statutory function of the Minister, however it points out that in practice such powers are often delegated to the Director-General.

**Question 12 - Is any formal mechanism required to ensure effective coordination between the various regulatory bodies responsible for foods, medicines, hazardous substances and new psychoactive substances?**

The Ministry considers that it will be important for all of the regulatory bodies responsible for foods, medicines, hazardous substances and new psychoactive substances to ensure that there is co-ordination among them. However, it should be pointed out that there are already coordination mechanisms among the Government agencies which can be adapted for this purpose. It is not considered that such a co-ordination mechanism would be required to be a statutory obligation.
Chapter 9 – The Drug Classification System

The Ministry shares some of the criticisms made by the Law Commission about the current system for classifying drugs according to their level of harm. In particular, the Ministry agrees that a number of the substances scheduled are historical classifications and have not been assessed according to evidence of their potential to cause harm. If a harms-based classification system was to be retained, the Ministry would agree with the proposal to assess all the substances or classes of substances to ensure more evidence-based scheduling within the classification system.

Question 13 – Do you favour:
(a) no classes and a single maximum penalty for all drugs;
(b) a two-tier classification system;
(c) retention of the current three-tier system based on an improved assessment of risk and regular reviews;
(d) a more nuanced classification system (four-tier plus) based on a scientifically based drug harm matrix;
(e) some other approach?

The Ministry’s preferred option is to retain the current three-tier system and ensure that the substances currently scheduled are assessed to ensure their classification better reflects their potential to cause harm.

The Ministry considers there to be value in defining the harmfulness of drugs for the purposes of determining enforcement powers which limits certain powers, such as internal searches, to those drugs considered most harmful. However, the Ministry would question the value of using legislation to educate people about the relative harms of drugs and considers education to be a more appropriate vehicle. There is no evidence that the classification of a drug under the Act has any influence on the pattern of use or that decisions on drug use are based on how a drug is classified.

The Ministry would welcome discussion about the relationship between the classification system and any legislation for compulsory treatment for severe substance dependence. One mechanism for determining the substances which would qualify for compulsory treatment might be aligning it to drugs controlled under one or more of the Act’s schedules (in addition to alcohol).

Question 14 – Do you agree that there should be separate criteria for the decision to regulate a drug and the decision to classify a drug in order to determine penalty? Are drug harms an appropriate categoriser of the latter decision under the headings physical harms, dependence potential and social harms? Is prevalence a relevant factor in determining drug harm? Are any other factors relevant?

The Ministry of Health considers it important that the criteria used in determining the harm from drugs be as transparent as possible. In establishing the role and functions of the expert committee it will be important to make it very clear what
considerations need to be taken into account in order to determine the harm from a particular substance and the relative weighting that should be put on an individual criterion. Even the scientific experts have their own personal views about drugs and it is important that, as far as possible, the recommendations of the committee are based on the scientific evidence and are not coloured by personal beliefs.

The assessment of the harms from drugs is likely to involve the consideration of a core set of criteria regardless of the ultimate scheduling of the substance as a regulated drug or a classified drug. These should be considered prior to the decision about where the substance is most appropriately placed. However, once a preliminary assessment has been made there will be specific criteria required for controlled drugs – such as the harms from prohibition, and for regulated drugs – such as impact of ongoing use or conflicts with control under other legislation.

The Ministry does not consider that prevalence as such is a relevant matter for determining the harm from a drug – however, if a substance is not currently used in this country it could be a factor in determining the priority that Government places on any proposed scheduling.

**Question 15 - Do you agree that there is a need for an expert committee to advise on drug regulation and classification (if a classification system is retained)? Should the committee be independent? Should it have consumer representation? What expertise is required? What is the committee’s optimal size?**

One of the principles of the National Drug Policy is that decisions will be ‘evidence informed’. This is not the same as ‘evidence-based decision-making’ in the sense that the responsibility for decisions on drug policy must be made by Government. While it is critical that the Government has before it the best available evidence supporting a particular policy initiative it is ultimately the Government’s responsibility to accept or reject such advice.

The National Drug Policy states that: "interventions will reflect practices that are informed by rigorous research, critical evaluation, professional expertise, and the needs and preferences of the community (emphasis added)." Government has a constitutional responsibility to weigh the evidence against the needs and preferences of the community in order to determine the most appropriate policy responses.

It is considered that there are a number of different sources of advice that Government needs in order to establish its policy position. First of all there is the question of the evidence of harm. In regard to the classification of substances, this will require an unbiased assessment of the harm likely to be caused by a particular substance and will be most effectively provided by an independent body of experts made up of representatives from professional groupings such as those proposed by the Law Commission. There is no particular need for this committee to contain consumer representation or Government agency representation provided their views are available to the Government in some other way.

Consumers, providers of drug treatment services, and the community may need a separate mechanism to provide advice on the impact that substances are having.
within the community and to individuals and the effect that a change in status of those substances may have. The Expert Advisory Committee on Drugs has had a member to represent the views of consumers of drug treatment services, but in practice it has been difficult for this member to be effective in the role without any support in canvassing the broad range of views and experience that would be needed to adequately represent the field.

Government agencies have a prime responsibility to provide advice to Ministers about public policy issues and they are in the best position to advise the Government on the practicability of any proposal on changes in policy. It is essential that such advice concerning drug policy and the scheduling of controlled drugs is available to the Government when it makes decisions on these matters. However, representation on the expert committee is not necessarily the best way to ensure this advice is available. A valid reason for such representation would be if they have a special contribution to make in relation to the harm of a particular substance. There are other mechanisms, such as the Inter-Agency Committee on Drugs, for Government agencies to provide advice on such matters as implications for health services, implications for the criminal justice sector, resource implications for enforcement agencies, implications for social development, and a range of other associated public policy issues.

Finally, the political acceptability of any Government policy is a matter for elected representatives to determine and to consider along with other advice.

The Ministry of Health therefore supports the suggestion that there is a need for an expert committee to advise on drug regulation and classification and agrees that the expertise on such a committee would need to include the disciplines suggested in paragraph 9.88. However, the advice from this committee needs to be supplemented by separate advice from Government agencies collectively and individually. Consumer viewpoints could be more effectively made if there was some other mechanism to ensure community perspectives are taken into account.

The Ministry of Health does not have a view on the optimal size of such a committee. However, in addition to determining the size of the committee it would be useful to establish quorum rules and make some provision for how the viewpoint of representatives who are not able to attend a particular meeting may be taken into account.

**Question 17** – Do you agree that drug classifications should be made by primary legislation rather than by Order in Council? If so, should there be a requirement for the Minister to table an expert report on drug harms when legislation is introduced?

**Question 18** – If the Order in Council process is retained, should it be available for reducing classifications as well as increasing them?

The Order in Council process provides the flexibility to move quickly and for this reason is the preferred approach for drug classification. Drug classification by way of primary legislation may take up to 18 months, and this time delay would be prohibitive where a new and harmful drug is identified in the market. The Ministry
agrees with the Law Commission in relation to the importance of the role of the Expert Advisory Committee on Drugs in advising the Minister in relation to the harmfulness of the drug being classified before promoting the Order in Council. If the Order in Council process was also available for reducing a classification, the requirement of the Minister to seek expert advice should also apply.
Chapter 10 – Dealing

Presumption of Supply

The Law Commission discusses presumption of supply at paragraphs 10.55-10.101 of the issues paper.

Given the decision in R v Hansen, where a majority of the Supreme Court held that the presumption in section 6(6) of the Misuse of Drugs Act 1975 is inconsistent with section 25(c) of the New Zealand Bill of Rights Act 1990 (“NZBORA”) and is not a justified limitation under section 5 of NZBORA, the Law Commission has considered four options in the issues paper.

**Question 30 - Do you agree that the offence of possession for supply should be repealed and replaced with two possession offences: simple possession and aggravated possession (the latter involving a quantity that is indicative of supply)?**

**Question 31 - If not, which of the following options do you favour:**

(a) remove the presumption;
(b) establish an evidential presumption;
(c) retain the presumption at its current levels; or
(d) retain the presumption, but set at levels that are more likely to be found justified under [NZBORA].

The Ministry supports the replacement of possession for supply offences with penalties for possession based on quantity on the grounds that it removes the NZBORA concerns whilst concentrating on the quantity of drugs possessed regardless of intended use. The Ministry has not established a firm view on whether possession offences should be categorised by quantity or whether to allow penalties to be determined at sentencing.

Option (d) would appear to acknowledge the important overriding NZBORA concerns, and balance these with the practicalities of prosecution. However, in practice option (d) may be difficult, and as the Law Commission notes it is far from certain that the Supreme Court would consider option (d) to be consistent with NZBORA.

The Police and Customs Service, as enforcement agencies are best placed to comment on the practicalities of these options.
Question 41 - Should there continue to be a criminal offence for drug use?

The Ministry considers an offence of drug “use” to be unnecessary and notes that there is no requirement in the international drug conventions to establish criminal offences for the use of convention drugs. The offence of “use” is rarely charged and currently anyone caught using drugs can already be charged with a possession offence.

Question 43 - What circumstances, other than those identified in paragraph 1.10, could be considered an “aggravated” form of use?

The Ministry supports the retention of an offence for “aggravated” use. This could include circumstances such as the use of needles and syringes to administer drugs in a public place and for the use of drugs in the presence of minors, however the extent of these circumstances would require further policy work.

Utensils offences

Question 44 – Should the possession of utensils for the purpose of using drugs remain a criminal offence?

The Ministry is in favour of minimising the visibility of drug paraphernalia and to this end supports controls over the importation, display and supply of utensils. However, the Ministry is concerned that section 13 of the Act regarding possession of utensils might negatively impact upon the successful implementation of the needle exchange programme.

The Ministry supports the continuation of the needle exchange programme which has been associated with very low rates of HIV amongst injecting drug users and falling rates of Hepatitis C infection. An evaluation of the New Zealand needle exchange programme in 2008 reported that, according to returns on investment calculations, 1,454 cases of Hepatitis C, 1,031 cases of HIV and 20 deaths have been avoided as a result of the needle exchange.

Under section 13(1)(a) of the Act the possession of any utensil (with exception of a needle or syringe) used for the purpose of an offence against the Act is prohibited. The Ministry is concerned that this criminalises those in possession of injecting equipment, other than a needle or syringe, provided by the needle exchange programme in order to make injecting safer. Examples of this include wheel filters and butterflies which reduce blood clots and vein damage.

Currently, section 13(1)(aa) of the Act describes offences relating to the carriage of needles and syringes. It is an offence to acquire or possess needles which have not been supplied by a person authorised by the Act, namely a medical practitioner, pharmacist or authorised needle exchange outlet. This means that someone who is given a clean needle by their partner or a friend is in breach of the Act. The Ministry
would support provisions to ensure that someone is not criminalised for receiving a clean needle or passing on a clean needle to another person.

The Ministry notes that offences in relation to used needles are in the Health (Needles and Syringes) Regulations 1998 under section 37 of the Act. The Ministry considers that these offences should be in the primary legislation.

New approaches to personal use offences

**Question 45 - Do you agree that a new enforcement approach should be taken to personal use offences?**

The Ministry would be supportive of an approach which provides a systematic and proportionate response to the harms associated with the use of drugs and which aligns best with the principles of the National Drug Policy. In particular, the Ministry would support an approach which allows the provision of information to users and assists them to access brief interventions and treatment. Any new approach should seek to mitigate the potential harms associated with prohibition and reduce the inequitable enforcement of current drug laws on users. The Ministry notes the Law Commission's research which shows that while most drug users do not come to police attention, those most likely to be arrested for cannabis-related offences are male and Maori. The Ministry also considers the likely impact of a drug conviction on the future employment, accommodation and travel prospects of a young person to be disproportionate to the offence, particularly if no opportunity is taken to provide the person with information, help and possible treatment.

**Question 46 - If so, which of options 1–3 do you prefer and why?**

The Ministry does not have a preferred option but considers there to be some potentially constructive concepts in all three of the approaches. The option with greatest alignment to a health-centric approach would be option 1 as this appears to provide the best means for identifying and applying the most effective approach to the needs of a user. A cautioning scheme is an early opportunity to provide information on the legal and health consequences of drug use and to identify any treatment requirements, before a user becomes involved in the criminal justice system. This option would also provide a back-up mechanism for a users to 'progress' to a mandatory brief intervention and possible prosecution in the event of a third apprehension or non-acknowledgement of a caution. The Ministry supports the inclusion of all drugs in such a scheme as most drug users use a range of substances. A number of other jurisdictions have included all drugs in their cautioning schemes.

An infringement offence regime for less harmful drugs (option 2) would provide a low-key response more in proportion to the harm caused by a personal use offence and would keep most drug users out of the criminal justice system. However, this approach would allow little scope for the circumstances of the individual user to be considered, including any treatment needs. In this regard the Ministry does not consider this approach would be appropriate for addressing the use of more harmful drugs, such as those in Schedule 1 (Class A) of the Act.
It is also likely that those who do not, or cannot, pay an infringement fine may still obtain a conviction for non-payment as has been experienced in some Australian jurisdictions, where the burden has fallen disproportionately on those in lower socio-economic groups and on young people. This may be alleviated by the attendance by the user at an education session in lieu of a fine, however this alternative is likely to be the only opportunity to address the health consequences of use.

The ‘menu of options’ (option 3) appears to have value by providing a range of possible responses to the individual user, from the issuing of a caution or infringement notice, to referral to drug treatment, or to prosecution. However, this option would make the majority of decision-making on individual cases subject to police discretion, may be complex to administer and more difficult for the public to understand than the other two options.

**Question 47 - Would you change any of the key components of the preferred options?**

The Ministry’s main concern is to ensure the availability of resources and capacity of services to cope with those in need. There are likely resource implications for the alcohol and other drug (AoD) treatment sector if options 1 or 2 is implemented. The adoption of a cautioning scheme will also require development of education resources and a treatment strategy to ensure all those cautioned receive the appropriate follow up. The Ministry considers it necessary that information should routinely be provided to people who are being cautioned by the police, about the harms of drugs and how to access AoD treatment, irrespective of whether it is the first, second or third caution.

The Ministry considers that the application of any new approach to personal use offences is not appropriate to people suspected of driving with excess blood alcohol or drug impairment and who pose risks to themselves and others through their actions.

**Question 50 - Should “aggravated” use, if it remains a criminal offence, be excluded from any new approach taken to personal use offences?**

As outlined in the Ministry’s response to question 43, the Ministry considers “aggravated” use offences should be retained.

**Question 53 - Do you agree that the manufacture, production, and import or export of drugs for personal use should not be included in any regime that is applied to other personal use offences?**

The Ministry considers that offences for the manufacture, import and export of drugs should be maintained as they are obligations under the international drug conventions.

**Question 54 - Do you agree that the approach that is taken to personal use offences committed by adults should not be extended to personal use**
The answer to this question depends on what approach was adopted. The existing youth justice system already provides more appropriate specific responses to youth drug use than an infringement offence regime would. Young people would lose current opportunities for diversion into treatment and risk accumulation of unpaid fines.

However, if a cautioning scheme was adopted, the inclusion of young people in it would seem sensible: it would provide the same advantages of identifying the individual needs of young people as for adults but would be provided for by legislative framework rather than left to police discretion.

**Question 55 - Should any new approach taken to personal use offences be reviewed after a specified period?**

The Ministry would support a future review in the event of a new approach being implemented. Most Australian jurisdictions have undertaken reviews of their infringement offence or cautioning schemes and have made changes where appropriate. The Inter-Agency Committee on Drugs may be the appropriate body to oversee a review, however any new approach would probably need a minimum of five years in operation to determine its effectiveness, unless evidence suggests it clearly needs earlier review.

**Question 56 - Which of options 1–3 [to be applied in the court system] do you prefer and why?**

The Ministry favours retention of a combination of the options discussed, particularly if a cautioning regime is adopted. If so, it would bring consistency to extend the scope of the Police Adult Diversion Scheme (option 1) beyond its current focus on Class C drugs to also include Class A and B drugs. However, the Ministry notes the point that there may be little to be gained in requiring an individual who has exhausted their caution options (including attendance at a brief intervention session in order to consider entering treatment voluntarily) to then be required to participate in drug assessment or treatment as part of diversion conditions. The additional threat of prosecution may only give a minority of offenders sufficient motivation to attend treatment.

The Ministry considers that less severe penalties for possession offences through the extension of the current statutory presumption against imprisonment (including Class A and B drugs) to be best aligned to a health focus. This would also ensure consistency in the event that a presumption against imprisonment for ‘social supply’ is also adopted.

The Ministry strongly supports greater use of court-based diversion into assessment and treatment (option 3) where problematic alcohol and other drug use and dependence are identified. Evaluations of court-based programmes in Australia show they can reduce drug use by participants and have positive impacts on participants’ general health and well-being. The Ministry believes that outcomes for drug offenders treated in this way are likely to be more favourable than if they are
imprisoned, where there is a much reduced likelihood of their being able to access treatment services.
Import and supply of pipes and utensils

The Ministry considers controls over the importation and supply of pipes and utensils to be important in minimising the visibility of drug paraphernalia.

**Question 61 - Is an offence prohibiting the supply and import of utensils still required?**

**Question 62 - If an offence is required:**

(a) **Do you agree that it should be in primary legislation, rather than be established via regulation-making power?**

(b) **Should the offence be broadened to cover utensils for using other drugs [as well as cannabis and methamphetamine]?**

The Ministry supports retaining the offence prohibiting the importation and supply of utensils in order to minimise the visibility of drug paraphernalia and to reduce availability. It is desirable that the notice provisions under section 22(1A) of the Act be retained to allow the flexibility to quickly respond to unanticipated and urgent safety issues, including allowing fast response to broaden the offence where necessary to minimise harm in relation to emerging drugs and drug taking methods.
Chapter 13 – Exemptions to Prohibition

**Question 114** - Do you agree that the main components of the licensing scheme should be in the Act?

**Question 115** - Do you agree that the Director-General of Health should continue to be the licensing authority?

**Question 116** - Do you agree that the Minister of Health should not be involved in individual licensing decisions?

The Ministry agrees in principle with matters of substantive policy being included in primary legislation in order to comply with the Legislation Advisory Committee Guidelines, provided, as discussed at paragraph 13.10, that the primary legislation contains appropriate regulation-making powers so that the regulations can provide for more detailed aspects and implementation details of the licensing scheme. Further, the Ministry agrees that the licensing regime and powers should sit solely with the Director-General of Health.

Currently Ministerial approval for individual medicines licences has been delegated to the Manager of Medsafe and therefore the Minister of Health is not involved in the making of these decisions. As this situation appears to be working effectively the Ministry considers that the requirement for the Minister to be involved in individual licensing decisions is not necessary.

**Question 117** – Do some health professionals need exemptions that permit them to manufacture and produce controlled drugs?

The current definition of “manufacture” would indicate that no health professionals need exemptions to manufacture and produce controlled drugs. However, “Licences to Deal” should continue to enable manufacturing, if specified in the licence conditions.

The current situation regarding the authority for midwives to prescribe controlled drugs, other than pethidine, needs to be clarified.

**Question 118** – Should District Health Boards and other certified hospitals be authorised to hold general supplies of controlled drugs for the purposes of treating patients as practicality dictates?

Yes, the Ministry agrees that this authorisation should be given.

**Question 119** – Should any other institutions also be authorised to hold general supplies of controlled drugs for the purposes of treating their patients?

It may be necessary for hospices and prisons to be given such an authorisation. However, such authorisations would need to be accompanied by strict criteria.
**Question 120 – Are all of the current interventions in section 8 still needed? Are any other inventions needed?**

The Ministry suggests that diagnostic testing kits could be exempted under section 8 (3).

Currently a Licence to Import Controlled Drugs is issued for all imports of diagnostic testing kits by Beckman Coulter NZ Ltd and Siemans Healthcare Diagnostics. Siemans have a range of 44 varieties and Beckman Coulter has 30 varieties. The use of these kits appears to be increasing with approximately 100 testing kits being licensed in 2009.

The quantity of controlled drug in these kits is measured in micrograms and nanograms. The licensing requirements which often require Ministerial approval are considered excessive for such minute quantities of controlled drug. A corresponding export licence is not issued by either Australia or the USA, which indicates that neither of these jurisdictions sees these products as a concern.

**Question 121 – Are all of the exemptions currently in regulations still needed or are some obsolete? Are any new exemptions needed?**

The Ministry considers that all of the current exemptions are still required but there are no new exemptions required.

**Question 122 – Do you agree that the exemptions should in principle be in the Act and that more limited regulation making powers that authorise exemptions only for a limited time to deal with emergencies would be appropriate?**

The Ministry agrees with this proposition.

**Relationship with the Medicines Act**

**Question 123 - Do you agree that the exemptions that apply to controlled drugs should all be in one Act (with appropriate cross references)?**

The Ministry considers that the relationship between the Act and the Medicines Act is confusing and there is a lack of transparency around requirements for controlled drugs that are also medicines. The Ministry also considers that the current framework results in two separate regimes: one that governs prescribing drugs for dependence; and the other for prescribing the same drugs as medicines. The result is that people who are addicted to certain medicines receive different treatment if they are being treated for dependence as opposed to receiving treatment for what is considered a “legitimate” medical condition. The reality is that many people in pain become addicted to opioids as a consequence of their medical treatment and many people who are being treated for opioid dependence experience ongoing and poorly managed pain.
The Ministry prefers that all requirements, restrictions and prohibitions relating to controlled drugs that are also medicines be in the Medicines Act. The Medicines Act is currently under review with the view to future amendment which would allow for these changes to be made.

Drug Dependency

**Question 124 – Do you agree that section 20 should be repealed or should a more confined version of section 20 be retained under which medical officers of health can publish (in a limited way) information about people suspected of being drug seekers?**

The Ministry considers that Restriction Notices and Privileged Statements can serve a useful purpose and are still in current use. Practitioners are able to cite such restrictions as reasons for refusal to prescribe. The Ministry, acting on behalf of Medical Officers of Health, undertakes rigorous investigations to ensure that the effects have been absolutely corroborated before any such notice is issued.

However, should section 20 be repealed the Ministry considers that the Privacy Act 1991 and the Health Information Privacy Code 1994 would be the most appropriate means of dealing with these matters.

**Question 125 – If it is retained, do you agree that it should only apply to drug seeking behaviour and that the person who is the subject of the statement should have an opportunity to challenge any statement?**

Should section 20 remain, the Ministry supports the Law Commission’s proposed approach as follows:

- Disclosure being limited to members of those classes who might be reasonably considered to have a direct interest in the information
- Information about a person’s likelihood to become dependent on a controlled drug is health information and should be dealt with in accordance with the health information regime (as set out in the Privacy Act 1991 and the Health Information Privacy Code 1994)
- That any test should be focussed on drug seeking behaviours and not suspected dependence\(^2\)
- That people should be notified and have the opportunity to challenge any statement.

The Ministry notes the need for more detail to underpin the means by which people can challenge such statements and the mechanisms for conflict resolution.

These provisions present an opportunity for named people to be referred for a comprehensive alcohol and drug assessment. The Ministry acknowledges that many people classified as “drug seekers” will already be known to addiction treatment services and some will be resistant to help. However, this should not on its own deter a response that seeks to ameliorate their problems.

\(^2\) The Ministry acknowledges the fine line in distinguishing between “drug seeking” and “dependence.”
The Ministry wishes to emphasise that people who are opioid dependent have a serious health condition often accompanied by other co-existing mental health and physical health conditions. Drug seeking behaviour is very often motivated by a need to obtain a drug that will prevent themselves, or perhaps friends or family members from experiencing a prolonged and severely uncomfortable withdrawal. People who are in this situation need to be supported, treated with respect and compassion, and provided with treatment where possible.

**Question 126 – Do you agree that medical officers of health should continue to have the power to issue notices imposing restrictions on the supply of controlled drugs to restricted persons?**

**Question 127 – If so do you agree that the test in section 49 of the Medicines Act, which sets a lower threshold, would be a better test to use?**

**Question 128 – Do you agree that the offence of supplying or prescribing a controlled drug to a person in contravention of a restricted person notice should be repealed?**

The Ministry agrees that it is helpful for prescribers to be able to refer to the authority and statutory powers of the Medical Officer of Health in any refusal to prescribe controlled drugs to a registered drug seeker. This may help preserve the therapeutic relationship between the prescriber and client. Ideally, a prescriber would be able to engage in a robust discussion about the reason for the refusal; however, many prescribers find it very difficult to address addiction issues in consultations. Increased opportunities for training and education are one response to this but culture change takes time.

The Ministry prefers the lower threshold test in section 49 of the Medicines Act to the test in section 25 of the Misuse of Drugs Act. The reason for this is because the test is easier to apply and, arguably, less subjective (section 25 asks the Medical Officer of Health to be satisfied that the person is a ‘drug seeker’ and that the person has been obtaining drugs over a ‘prolonged’ period).

If the offence of supplying or prescribing controlled drugs to a person in contravention of a restricted person notice is repealed it would not be possible to enforce a restriction notice.

**Question 129 – Do you agree that section 23 should be repealed?**

The Ministry agrees that section 23 should be repealed and any appropriate disciplinary action be taken in accordance with the Health Practitioners Competence Assurance Act 2003.

**Question 130 – Overall, do you think that the legislative controls that are in place are adequate? If not, what further legislative controls do you think are necessary?**
The ability for the Ministry of Health to electronically monitor Class C controlled drugs, in particular benzodiazepines, in addition to the Class B drugs currently monitored, would make the “tests” applied before the release of a Privileged Statement or imposition of a Restriction Notice more rigorous and improve the efficiency of the Medical Officer of Health’s work.

**Question 131 – Do the legislative controls that are in place provide adequate support for professional education and guidance and appropriate monitoring systems? If not, what changes do you think are necessary?**

**Question 132 - Is section 24 too restrictive? If so, what changes are needed?**

The Ministry believes that the current framework is inadequate and needs to be redeveloped to address the causes of dependency. The question as to whether section 24 is too restrictive is not the right question. There is a need to ensure that a framework is developed for protecting the public from the risks of prescribing drugs for dependency but which also addresses the harms arising from medicines prescribed for therapeutic purposes.

The Ministry believes that opioid dependence is a long term health condition similar to diabetes and asthma which can be appropriately and effectively managed in primary care. However, at the present time, the primary health care sector lacks both the capacity and capability to provide this treatment. This contributes to “bottlenecks” in specialist opioid substitution treatment services that prevent people accessing treatment or the most appropriate form of treatment based on their level of need.

A number of factors sit behind the lack of capacity and capability to prescribe for dependence including the need for training and education as discussed in the issues paper. A further contributing factor is section 24 that, in effect, requires GPs to “opt in” to providing opioid substitution treatment. There are no such restrictions on prescribing opioids for pain and the consequences of this are discussed above.

A degree of specialist knowledge and experience is required for medical practitioners to prescribe for dependence. If the net is widened to enable more people to prescribe for dependence, prescribers must be provided with training, supportive frameworks, and ongoing professional development. Such measures reduce the risks of working in isolation and increase the likelihood of positive outcomes for people receiving treatment for dependence. This raises resourcing issues as well as the development of a suitable framework.

The current legislative framework does not require specialist knowledge as a criterion to determine suitability to prescribe for opioid dependence. However, in practice, prescribers are not gazetted or authorised to prescribe for dependence unless they have appropriate expertise and capability. There are no formal or agreed criteria for assessing expertise and capability.

The Ministry believes there needs to be a system for approving GPs and other primary health care practitioners to prescribe for dependence based on completion of an existing training module and evidence of periodic refreshers and ongoing peer review.
The Ministry considers that GPs and other primary health care practitioners should:

- Be able to prescribe for dependence so long as they can demonstrate competence
- In complex cases, share care with specialist alcohol and drug treatment services
- Be monitored when prescribing drugs that can lead to dependency beyond an agreed cut-off date.\(^3\)

This approach would help to:

- Reduce the contribution by GPs and other primary health care practitioners to opioid dependence through ill-informed prescribing practices
- Ensure that people who are opioid dependent receive appropriate treatment including the ability to transfer between GPs more easily
- Increase the knowledge base of GPs and other primary health care practitioners in the management of addiction issues.

The Law Commission may consider that this approach does not require a regulatory framework.

The Ministry notes that the Australasian Chapter of Addiction Medicine has submitted an application to the Medical Council of New Zealand for recognition as a Vocational Branch in New Zealand. Currently, there are thirty two NZ fellows. The Addiction Medicine Chapter provides a collegiate home for addiction medicine specialists and promotes the following in the field of addiction medicine:

- study and advancing knowledge
- high levels of skill, expertise and ethical standards
- raise and maintain the educational standards of medical graduates wishing to enter this field
- to act as an authoritative body re consultation and educational or public interest
- foster collaboration with clinicians and others to advance knowledge
- guide continuing professional development for qualified practitioners.

Also, the Institute of Environmental Science and Research (ESR) over the next year is undertaking a research project that will look at the supportive infrastructure (including financial incentives) required to increase the capacity and capability of primary health care to deliver opioid substitution treatment. This project includes a review of the authorising and gazetting framework set out in section 24. While the findings and recommendations are not due until after the Law Commission review of the Act has been concluded, it is likely that it will contribute to the implementation of any new legislation which may result from the review.

**Question 133 – Do you agree that a provision allowing the Minister of Health to impose restrictions on exemptions to deal with unanticipated and urgent safety issues should be retained?**

\(^3\) At the NAOTP meeting in March 2010 reference was made to a NSW model where GPs prescribing opioids for pain are monitored after a cut-off date of 2 weeks. This model needs further investigation.
The Ministry agrees this provision should be retained.

**Question 134 – Should the Minister of Health’s approval be required before certain controlled drugs can be supplied or used?**

Consideration could be given to transferring this power to the Director-General of Health.

**Medicinal Cannabis**

The Ministry of Health acknowledges that the evidence, whilst not overwhelming, supports the medical use of cannabis for the treatment of certain serious conditions when other treatment options have been trialled and failed.

**Question 135 – Do you agree that the law should authorise the medicinal use of cannabis by people suffering from chronic or debilitating illness?**

The Ministry notes that there is already provision in the Act for the possession and use of controlled drugs, including cannabis, upon application to the Ministry of Health for a licence. A person or company can also apply to the Ministry to cultivate a prohibited plant, including cannabis, under section 9 of the Act. The Ministry has never received an application for the cultivation or possession of cannabis for the treatment of medical conditions. Currently there is no framework for licensing cannabis cultivation in New Zealand.

Whilst these provisions exist under the Act, the Ministry does not support the use of unprocessed leaf cannabis for the treatment of serious medical conditions. There are potential harms from smoking cannabis and, although these harms can be mitigated through the use of vaporisers or alternative routes of administration, there are no controls over the titration, potency or quality of unprocessed cannabis. There is also the risk of contaminants in unprocessed cannabis, such as mould, which could be harmful for people with compromised immune systems. In addition, there is the potential for the diversion of cannabis cultivated for medical purposes to an illegal market.

In the case of certain serious conditions for which traditional treatments have not worked, the Ministry considers the use of pharmaceutical preparations of cannabis may be appropriate and makes provision for the prescribing of Sativex®. Sativex® is a THC-based mouth spray manufactured by GW Pharmaceuticals and is currently unapproved as a medicine in New Zealand; an application for approval is pending. Sativex® can be prescribed under section 29 of the Medicines Act 1981 which allows for medical practitioners to supply unapproved medicines under certain conditions.

The Ministry acknowledges that there are problems with the accessibility of Sativex®. The principal barrier for patients is the cost of Sativex® which is not subsidised by PHARMAC and costs around $500 per month. Another potential obstacle is that because of Sativex's® classification as a Class B1 controlled drug the application requires the endorsement of a medical specialist and ministerial approval.
The Ministry requires an application to be made by one of the following specialists: oncologist, neurologist, anaesthetist or palliative care specialist. Other controlled drugs used for therapeutic purposes have similar restrictions including methylphenidate and dexamphetamine which are used for attention deficit disorders. Morphine, which is also a Class B drug, has an exemption which allows general practitioners to prescribe it but the Ministry would not support such wide-spread prescribing for cannabis preparations. The conditions for which the Ministry approves the use of pharmaceutical cannabis products is limited to serious medical conditions including AIDS-related wasting, pain associated with cancer, multiple sclerosis and spasm associated with spinal cord injury. Given the seriousness of the listed conditions, the Ministry considers that a specialist is best placed to determine treatment rather than a general practitioner.

**Question 138 – If a medicinal cannabis scheme is established, should specific conditions for which cannabis can be prescribed be specified by legislation or should medical practitioners determine the circumstances in which it might be used?**

Currently the conditions for which cannabis preparations can be prescribed are listed in Ministry of Health guidelines available on the Ministry website. The Ministry considers that this is more appropriate than listing them in the legislation as it allows them to be more easily updated as evidence about the efficacy of cannabis for different conditions becomes available. The Ministry would not support medical practitioners having the authority to go outside of an approved list of conditions in their prescribing practice. The Ministry considers that the efficacy of medicinal cannabis should be determined by medicines regulators, such as Medsafe. It would be unwise to draw conclusions about efficacy solely on the basis of published studies without appropriate comparisons with controlled medicinal dose forms.
Chapter 15 – Achieving Balance in Drug Policy

Question 145 – Should greater use be made of treatment as a disposition option within the courts for people with alcohol and other drug dependence and abuse problems? If so, how?

Treatment is currently a disposition option for the Courts and it is important that the judicial decision is based on good clinical information and that commensurate resources exist to implement recommended treatment plans. The Ministry supports the development of more efficient ways for people subject to the criminal justice system to be linked into both assessment and treatment.

Question 147 – Do you agree that additional reporting requirements or the establishment of an advisory committee with policy, accountability, and advocacy functions for drugs and alcohol would have insufficient benefit to justify the cost? If not, what benefits would there be?

The Ministry agrees with the Law Commission that this is not required.

Question 148 – Do you agree that the development of a blueprint for drug and alcohol and other addiction service delivery could provide a practical way of significantly increasing the emphasis on treatment?

The Ministry agrees in principle with the development of a comprehensive strategy for drug and alcohol and other addiction service delivery. The Ministry notes that the Mental Health Commission proposes that the future strategy be based on best practice principles and address:

- the level and type of service, how much, what type, and where it is based;
- required resourcing and staffing levels, including workforce issues;
- the design of a service system, including models of care pathways, service delivery systems and co-ordination;
- transition and implementation planning; and
- monitoring and oversight.

The first three points above are currently being addressed by the Ministry of Health through Matua Raki, the alcohol and other drug treatment workforce programme. This activity is called workforce forecasting. A model will be available by the end of June 2010, and will be updated and refined over time.

The Ministry considers that the strategy should also include the following:

- A funding plan that identifies funding streams from Vote: Health and other Votes
- Research, evaluation and outcomes goals
- Responsibility for development and implementation must also include DHBs, ALAC, and other government agencies
- Accountability needs to be personalised to particular positions for example, DHB CEOs
• A reporting framework (for example, the annual reports of the Office of the Director of Mental Health or the Ministry of Health).

The Ministry believes that any agency that leads this work needs to have credibility with the addiction treatment sector, which has developed considerably over the course of the last decade. Any future strategic development needs to take account of a far wider range of stakeholders than has been involved previously. The consumer voice will be particularly important if it is to be a truly representative strategy. Any such strategy needs to respond to new and emerging issues - for example, methamphetamine and the emergence of new ‘party pills’ and ‘legal highs’ as well as responding to alcohol.

The Ministry has reservations about the use of the term “Blueprint” as this terminology reflects the current framework utilised for purchasing addiction treatment (and mental health) services for populations.

**Question 149 – What else might be done to provide greater support for demand reduction and problem limitation measures?**

Demand reduction and problem limitation measures are indispensable pillars of New Zealand’s approach to countering drug related harm and need to have significant emphasis. The National Drug Policy encompasses these pillars and sets the framework for prevention, treatment, enforcement, and harm reduction approaches. However, only some of these are triggered by specific legislative measures. Having said that, if there is a way that a legislative approach can reinforce a determination to provide the necessary resources for the prevention of drug related harm and the treatment and rehabilitation of drug users, the Ministry would support that. Such an approach needs to have the objective of better social integration and a restoration of dignity and hope to those affected. The activities of communities, families and whanau, social, cultural and sporting organisations and the media need to become engaged in the promotion of a society free from drug misuse.

The Ministry believes there needs to be greater recognition and support for the development of recovery oriented systems of care that respond to the chronic, relapsing nature of recovery from substance dependence. Evidence shows that both the paid and volunteer peer support workforce has a vital role to play in helping people achieve and sustain recovery, particularly 12 step fellowships such as Narcotics Anonymous and Alcoholics Anonymous. The Ministry would also like to see formal acknowledgement of the valuable contribution consumers make to addiction treatment services through peer support work.

The Ministry would support the development of a recovery charter setting out the expectations that consumers can reasonably have of addiction treatment service providers and for which service providers can be held to account by the Office of the Health and Disability Commissioner. This is an issue that could be discussed with the Health and Disability Commissioner.
Question 150 - Do you agree that a regime allowing civil committal for the detention and treatment of alcohol and drug dependence should be retained?

The Ministry agrees that a regime allowing civil commitment for detention for initial treatment of severe substance dependence should be retained. The approach should be enhanced to provide a treatment pathway comprising civil commitment for managed withdrawal (detoxification). The pathway would incorporate assessment of treatment needs, a determination of the person’s capacity to consent to treatment and, where capacity exists, providing an opportunity for voluntary engagement in treatment and ensuring the development of a post-discharge treatment plan. Where decision making capacity does not exist, the process should facilitate people accessing the most appropriate ‘care’ pathway that responds to their complex needs (that may involve utilising the Protection of Personal and Property Rights Act 1988 or similar provisions).

Question 151 - If civil committal for the detention and treatment of alcohol and drug dependence is retained, do you agree with the key features and safeguards outlined in paragraph 16.103? Are there any others you would add?

Pending further work on developing a policy framework and options for the retention of legislation enabling civil commitment for severe substance dependence, the Ministry agrees with the key features and safeguards identified in the paragraph referred to above.

The Ministry also considers that:

- Engagement and persuasion skills are essential for staff working in the managed withdrawal and assessment facility in order to encourage people into further treatment options
- Every person subject to involuntary care must, while in care, receive a comprehensive assessment which then forms the basis for a transitional/post-discharge treatment plan
- On the basis of the plan, people are to be actively linked to appropriate services, including primary care and case management and to receive assertive follow-up
- Where decision making capacity cannot be restored, the legislative framework should facilitate civil commitment along a care pathway involving residential care, protection and support in suitable facilities.

Question 152 - If a regime for civil detention and treatment is retained, should there be a new offence of escaping from an institution as discussed in paragraphs 16.58 to 16.60?

The Ministry does not consider it appropriate that absconding from a facility where people are detained for compulsory assessment and treatment for severe substance dependence should be treated as an offence. Such an approach is not conducive to
promoting engagement and fostering therapeutic relationships - both of which are so vital in addiction treatment.

The Ministry believes that the police should be empowered to detain people and deliver them to appropriate facilities where they can be examined in respect of their need for involuntary care, and in the event that they abscond, to return them to the facility where they are being detained. However, as far as possible, the person should be delivered into care through informal means, such as by an addiction worker or other service provider, or family member.

**Question 153 - Do you agree that alcohol and drug treatment facilities operating within a new regime should, as discussed in paragraph 16.53, be certified by the Director-General of Health under the Health and Disability Services (Safety) Act 2001 in the same way as other health care providers?**

Yes, the Ministry agrees with this proposition.

**Question 154 - Do you agree that the threshold for compulsion should be:**

(a) that the person has a severe dependence on alcohol or other drugs; and

(b) detention and treatment is necessary to protect the person from serious harm; and

(c) the person is likely to benefit from treatment for his or her alcohol or drug dependence but has refused treatment; and

(d) no other appropriate and less restrictive means are reasonably available for dealing with the person.

“Dependence” means that a person has:

(i) a tolerance to a substance; and

(ii) shows withdrawal symptoms when he or she reduces the level or stop using the substance; and

(iii) has a substantially impaired capacity to make decisions about his or her substance use and personal welfare due primarily to his or her dependence on the substance.

**Question 155 - If you do not agree with the approach we have set out in Q154, what criteria do you suggest?**

Pending further work on developing a policy framework and options for the retention of legislation enabling civil commitment for severe substance dependence, the Ministry agrees with the definition of the threshold for compulsion and the meaning of dependence.

**Question 156 - Do you agree that people should not be able to be detained on the grounds that they are unable to care for themselves when detention is not necessary to protect them from serious harm?**

The Ministry considers that there should be a high threshold and strong principles that must necessarily accompany involuntary treatment. The Ministry is mindful of
the fact that the available literature on civil commitment for treatment for severe substance dependence does not provide an adequate basis for any safe conclusions about the effectiveness of involuntary treatment for non-offenders.

**Question 157 - Do you agree that a person should not be able to be detained on the grounds that they are perceived to pose a serious danger to others?**

The Ministry agrees that involuntary interventions in the interests of others, such as family members and the community cannot be justified. The Ministry fully acknowledges the distress experienced by family members and communities as a consequence of the actions of people with severe substance misuse problems. Families need support in navigating systems and services that can help them to manage and make good decisions.

The Ministry considers it vital that civil commitment for compulsory treatment is in the primary interests of the person compelled. The Ministry is mindful of the risk of compelling people for treatment as a means of social control or to protect people from discomfort. Civil commitment needs to be tightly targeted towards those who are themselves at risk of serious harm as a consequence of their own substance dependence. The Ministry notes that legislative provision exists to assist family members and communities at risk of harm from people with substance use problems including harassment, domestic violence and child protection legislation.

**Question 158 - Do you think that the legislation should, like the Drug and Alcohol Treatment Act 2007 (NSW), set a maximum period for detention? If so, what should the maximum be?**

**Question 159 - Should provision be made allowing the courts to extend this? If so, for how long and on what grounds?**

The Ministry agrees with setting a maximum period for detention of up to 28 days with the Court being able to extend this to no more than three months in exceptional cases.

**Question 160 – should provision be made for community based treatment orders?**

The Ministry agrees that where compulsory treatment is short term only there is no role for community based treatment orders. The Ministry is also not persuaded that community based treatment orders are appropriate for people with severe alcohol and other drug dependence (excluding those coerced as a consequence of the operation of the criminal justice system) because the success of alcohol and other drug treatment depends to such a large extent on engagement and motivation.

Many people engage in treatment unwillingly under informal pressure from one source or another and motivation is often enhanced during the course of treatment. However, state ordered coercion to comply with outpatient based addiction treatment may, firstly, be ineffective because it limits the ability to build engagement and motivation and, secondly, will be very difficult to enforce in community settings.
It is worth considering the advantages and disadvantages of compulsory outpatient treatment using pharmacotherapies. For example, opioid substitution treatment (assuming suitability criteria are met) could be a valid compulsory outpatient based treatment option. One reason for this is that opioid substitution treatment retains most clients for an extended period and requires ongoing prescribing and monitoring of medication. Equally, naltrexone and acamprosate prescribing (assuming suitability criteria are met) for alcoholism could form part of a compulsory treatment regime in a community setting. This would need to be further explored with leading clinical experts. Both community based treatment options’ potential for compulsory treatment would also need human rights consideration.

**Question 161 - Which of the options outlined in paragraphs 16.116 to 16.121 do you think provides the best legislative vehicle for any civil regime for compulsory drug and alcohol assessment, detoxification and treatment?**

The Ministry notes that the Law Commission supports incorporation of a compulsory treatment regime into the legislative framework for regulating and controlling drugs. Its reasons are as follows:

- It will assist with broadening the existing focus of drugs legislation to align with New Zealand’s drug policy with its emphasis on reducing harms through an appropriate balance of strategies
- The inclusion of measures to deal with alcohol dependence would be one way to acknowledge the risks posed by alcohol even though it remains legally available
- The possibility of including a degree of compulsion or coerced assessment and treatment as an alternative to criminal sanctions for personal use and/or social supply. Consistency and appropriate linkages between the provisions would be easier to manage within one piece of legislation
- All provision for drug and alcohol treatment would be contained in one statute, which would assist in making the law transparent and accessible.

The Ministry is of the view that the policy development work is still at a relatively early stage and it is too soon to be able to make confident decisions about the appropriate legislative vehicle for civil commitment for compulsory alcohol and other drug treatment.

The Ministry has concerns about the Law Commission’s proposal that a compulsory treatment regime be incorporated into the legislative framework for controlling and regulating drugs. The Ministry believes that the health and recovery needs of people who have severe substance dependence disorders should be a main consideration in any options analysis and this is not apparent in the Law Commission’s approach.

The Ministry is concerned about the extent to which incorporation of a regime for civil commitment for alcohol and other drug treatment into the legislative framework for controlling and regulating drugs may deter people from using the legislation because of the association with a statute that creates criminal offences. At this stage, the Ministry supports a legislative response for compulsory treatment for severe substance dependence that sits in or alongside other compulsory treatment and/or care legislation.