



# COMPULSORY TREATMENT FOR SUBSTANCE DEPENDENCE

A REVIEW OF THE ALCOHOLISM AND  
DRUG ADDICTION ACT 1966







# COMPULSORY TREATMENT FOR SUBSTANCE DEPENDENCE

A REVIEW OF THE ALCOHOLISM AND  
DRUG ADDICTION ACT 1966

The Law Commission is an independent, publicly funded, central advisory body established by statute to undertake the systematic review, reform and development of the law of New Zealand. Its purpose is to help achieve law that is just, principled, and accessible, and that reflects the heritage and aspirations of the peoples of New Zealand.

**The Commissioners are:**

Right Honourable Sir Geoffrey Palmer SC – *President*

Dr Warren Young – *Deputy President*

Emeritus Professor John Burrows QC

George Tanner QC

Val Sim

The General Manager of the Law Commission is Brigid Corcoran

The office of the Law Commission is at Level 19, HP Tower, 171 Featherston Street, Wellington

Postal address: PO Box 2590, Wellington 6140, New Zealand

Document Exchange Number: sp 23534

Telephone: (04) 473-3453, Facsimile: (04) 471-0959

Email: [com@lawcom.govt.nz](mailto:com@lawcom.govt.nz)

Internet: [www.lawcom.govt.nz](http://www.lawcom.govt.nz)

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The Hon Simon Power  
Minister Responsible for the Law Commission  
Parliament Buildings  
WELLINGTON

20 September 2010

Dear Minister,

NZLC R118 – COMPULSORY TREATMENT FOR SUBSTANCE DEPENDENCE:  
A REVIEW OF THE ALCOHOLISM AND DRUG ADDICTION ACT 1966

I am pleased to submit to you Law Commission Report 118, *Compulsory Treatment for Substance Dependence: A Review of the Alcoholism and Drug Addiction Act 1966*, which we submit under section 16 of the Law Commission Act 1985.

Yours sincerely



Warren Young  
Deputy President

## FOREWORD

In 2007 the Associate Minister of Health invited the Law Commission to review the Misuse of Drugs Act 1975. A number of significant problems, particularly over the adequacy of the legislative framework to deal with new psychoactive substances, were identified alongside long-standing concerns over the Misuse of Drugs Act's fitness for its purpose. The Law Commission's review of the Misuse of Drugs Act is comprehensive and wide-ranging. The objective is to propose a contemporary legislative framework for regulating drugs that supports the effectiveness of drug policy.

In the course of our review, we reached the view that the effective operation of a new legislative framework for drugs would also require an overhaul of the Alcoholism and Drug Addiction Act 1966. The Government's Methamphetamine Action Plan requires a review of the Act and a report back to Cabinet by November 2010. We therefore agreed with the Ministry of Health that we would include this Act within our project.

While work on the Commission's review of the Misuse of Drugs Act is now well advanced, it involves a broad range of issues. A full report on all aspects of that review is consequently still some months away. We have therefore prioritised our review of the Alcoholism and Drug Addiction Act so that we can present our recommendations within the timeframe set by the Government's Methamphetamine Action Plan.

While the views expressed and the recommendations made are those of the Law Commission, the proposals were developed with input and assistance from the Ministry of Health. The Commission expresses its gratitude to the Ministry for its assistance with this work.

The Commissioners responsible for this report are Val Sim and Warren Young, and the senior legal and policy adviser is Jo Dinsdale.



*Warren Young*  
Deputy President





# Compulsory Treatment for Substance Dependence: A Review of the Alcoholism and Drug Addiction Act 1966

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# Summary

**INTRODUCTION** 1 One of the most persistent themes that emerged from the feedback the Law Commission received on its issues papers, *Controlling and Regulating Drugs* and *Alcohol in Our Lives*, was the need to give greater emphasis to treatment both in response to offending and more generally as a response to the harm caused by alcohol and drug dependence. We strongly support the need for a more effective structure and a coherent framework for delivering alcohol and drug treatment.

2 One component of any coherent framework for delivering alcohol and drug treatment is the use of compulsion to require people to undertake treatment. Outside of the criminal justice system, the only provision for compulsory treatment specifically for dependence can be found in the Alcoholism and Drug Addiction Act 1966. That Act is now outdated, and there are difficulties in reconciling the broad powers of detention with the rights and protections in the New Zealand Bill of Rights Act 1990. Over the years some provisions of the Act have also fallen into disuse and the overall framework of the Act has not kept pace with subsequent changes in allied legislation such as the Mental Health (Compulsory Assessment and Treatment) Act 1992. Reform of the Act is long overdue.

**ALCOHOLISM AND DRUG ADDICTION ACT 1966** 3 The Alcoholism and Drug Addiction Act 1966 provides for the compulsory detention of alcoholics and drug addicts in certified institutions so that they may undergo assessment, detoxification and treatment. In chapter 2, we outline the key provisions of the Act and identify some of those that, if a compulsory regime is retained, ought to be discarded or amended.

4 There are a number of significant problems with the Act. The main ones are:

- although two medical certificates are required before a person can be committed, there is no requirement that either be issued by a specialist alcohol and drug practitioner following a personal assessment;
- the committal process begins with an application to the District Court; families find it difficult to make applications; and there can be delays and problems satisfying the regulatory requirements for applications;
- the statutory period of detention is two years, which far exceeds what is normally necessary to undertake any programme of treatment;
- the Act makes inadequate provision for review of the detention decision;
- there are generally insufficient safeguards to protect the rights of people held under the Act; and
- only a few treatment facilities are certified to accept people under the regime and consequently there is little flexibility in the type of treatment programme available.

## WHEN IS COMPULSORY TREATMENT JUSTIFIED?

- 5 Whether the law should continue to authorise the compulsory treatment of alcoholics and drug addicts is the most fundamental issue raised by this review. The right to refuse medical treatment and justifiable limits to it are considered in chapter 3.

### The right to refuse medical treatment

- 6 It is a fundamental common law principle that medical treatment cannot be imposed upon a competent adult without that person's consent (or some other legal justification). Implicit in the requirement for informed consent is the right to refuse medical treatment irrespective of the outcome. Even where death will be an inevitable or immediate consequence of refusing to accept treatment, the right has been said to prevail. This longstanding right is now protected by section 11 of the Bill of Rights Act.

### Justifiable limits

- 7 The right to refuse medical treatment is not an absolute right. Under section 5 of the Bill of Rights Act it is subject to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society. Determining whether limits are reasonable requires an assessment of whether they are proportionate to the object they are intended to achieve. Limits are proportionate when: (a) the objective achieved is of sufficient importance to warrant the limitation; (b) a rational connection exists between the limiting measure and its objective; (c) the limits go no further than is necessary; and (d) the overall effects are beneficial.
- 8 The threshold for justifying compulsory treatment is high. Few statutory regimes authorise compulsory treatment.

### Public interest objective

- 9 We do not think a case can be made for long-term compulsory treatment such as can occur under the existing regime. It is debatable whether reducing substance dependence is in itself a sufficiently important objective to justify intervention. There is in any event limited evidence on the effectiveness of coerced treatment of people who are non-offenders. However, in the case of people who are severely dependent on alcohol or drugs there is an important public interest that is served by intervening to protect them where they have as a result of severe substance dependence, a substantially impaired capacity to care for themselves or make treatment decisions and are therefore at risk of serious harm. In our view protecting such people from immediate harm by restoring their capacity to make treatment decisions is a sufficiently important objective to justify intervention.

### Rational connection

- 10 There is a clear and rational connection between interventions such as detoxification and steps taken to stabilise a person's medical condition and the objective of protecting a person from serious harm by restoring his or her capacity to make ongoing decisions over substance use. There is also evidence, mainly anecdotal, that short-term treatment of this kind is effective in achieving that objective.

### *Minimum intervention and net benefit*

- 11 Proportionality requires that the limits imposed on a person's right to refuse treatment go no further than is necessary. The benefits of those limits must outweigh the harm that impinging on rights will cause. For most drug and alcohol dependent people the acute risks of harm tend to be short-lived. Only a relatively short period of detention to restore capacity, during which detoxification and supporting treatment can be undertaken in appropriate facilities, can therefore be justified. Once capacity has been restored, and there has been an opportunity to engender motivation, we think that people must be free to determine for themselves whether to undertake ongoing treatment on a voluntary basis.

### *Conclusion*

- 12 In conclusion, our assessment is that compulsory treatment for alcohol and drug dependence is only justified in the following circumstances:
- a person's dependence has seriously impaired his or her capacity to make choices about ongoing substance use and personal welfare; and
  - care and treatment is necessary to protect the person from significant harm; and
  - no other less restrictive means are reasonably available for dealing with the person; and
  - the person is likely to benefit from treatment; and
  - the person has refused treatment.

### **OTHER JURISDICTIONS**

- 13 Four Australian states (New South Wales, Victoria, Tasmania and Northern Territory) make provision for the civil committal of people with alcohol and drug dependence.
- 14 Under the New South Wales, Victorian, and Northern Territory regimes, a people can only be compulsorily treated where they are at risk of serious harm and less restrictive means are not available. Two other common features are the requirements for substance dependence to be severe, and for treatment to be beneficial for the person. The objectives of treatment differ slightly, although stabilising health and enhancing capacity to make future decisions about substance use and personal welfare are common to the regimes. In Victoria, however, the degree of harm a person must be exposed to before the regime is available is higher; immediate treatment must be necessary to save the person's life or prevent serious damage to their health and treatment is limited to withdrawal management.
- 15 The new regimes in New South Wales and Victoria authorise compulsion only where people are incapable of making, or have lost the capacity to make, decisions about their substance use. In New South Wales the person must also have refused treatment.

## A NEW COMPULSORY TREATMENT REGIME

16 The United Kingdom does not have a specific scheme for the civil committal of people with alcohol and drug dependence. However, the courts are able to intervene under the Mental Capacity Act 2005 (UK) where treatment is necessary to protect an incapacitated person from serious harm and assist him or her to regain capacity.

17 The Commission recommends a new limited regime for compulsory treatment for alcohol and drug dependence. The main features of the proposed regime, summarised here, are discussed fully in chapter 5.

### Objective of regime is to restore capacity

18 The overall objective of the regime should be to provide treatment in order to restore a person's capacity to make his or her own decisions about his or her future treatment for substance dependence. This objective should be stated in legislation so it is clear that the use of compulsion will not ordinarily extend through a full programme of alcohol and drug treatment. Once treatment has successfully stabilised a person's health to address the risk of harm and restore sufficient capacity to allow the person to make decisions about further treatment for substance dependence, ongoing treatment needs to be undertaken on a voluntary basis.

### Criteria for compulsory treatment

19 A person should only be detained and treated under the proposed new regime when all of the following criteria are satisfied:

- (a) the person has a severe substance dependence;
- (b) detention and treatment is necessary to protect the person from significant harm to himself or herself; and
- (c) the person is likely to benefit from treatment but has refused treatment; and
- (d) no other appropriate and less restrictive means are reasonably available for dealing with the person.

20 The term "severe substance dependence" is defined to mean that a person has:

- (i) a tolerance to a substance; and
- (ii) shows withdrawal symptoms when he or she reduces the level or stops using the substance; and
- (iii) has a substantially impaired capacity to make decisions about substance use and treatment for dependence primarily as a result of his or her dependence.

21 Severe substance dependence is not a diagnostic term but is a legal construct. The requirement is that a person has a diagnosable dependence of such a magnitude or nature that it substantially impairs his or her capacity to make decisions about his or her substance use and in particular decisions about accepting or rejecting treatment for substance dependence.

## Maximum time limits on compulsion

- 22 After consultation with the treatment sector we recommend that the initial maximum period of detention should be six weeks. This is a maximum, so where a shorter period is adequate to restore a person's capacity to engage voluntarily with treatment, the principle of least restrictive intervention means the person must not be detained beyond that point.
- 23 Consultation identified a distinct group of people who will initially come under the regime but have cognitive damage as a result of chronic alcohol or drug use. They will respond more slowly to treatment and take longer to improve. Some will have permanent cognitive damage and will, after they have recovered to the extent they can, be unlikely to benefit from further alcohol and drug treatment. Provision is needed for extensions in such cases to allow for a slower recovery, or (where a person has permanent cognitive damage) for arrangements to be made for ongoing care and protection, probably under the Protection of Personal and Property Rights Act 1988.
- 24 We propose that the Family Court should have the power to extend the period of compulsion for a further three months, but only where a person appears to be suffering from alcohol- or drug-related brain injury and additional time is needed to complete assessment and treatment or to plan the person's discharge from the regime.

## Treatment facilities

- 25 A range of existing treatment facilities should be authorised to accept people under the regime. These include withdrawal management facilities (including hospital wards for medically assisted detoxification) as well as specialist residential facilities including those certified under the current Act. If a person requires medically supported withdrawal in a hospital setting he or she will need to transfer to a specialist drug and alcohol programme elsewhere once that is complete.
- 26 A difficult issue to resolve was whether treatment under the regime could also be provided on an outpatient basis. One of the fundamental principles underpinning the regime is that the least restrictive effective treatment option should always be preferred. On that basis, it follows that if a person who meets the statutory criteria for compulsion can be treated adequately within the community, he or she should be. Feedback on consultation was quite mixed on the appropriateness of community-based treatment.
- 27 We are not persuaded that people detained under the regime can be appropriately accommodated and treated without being required to reside in a specified facility. It is difficult to conceive of circumstances where a person would both meet the criteria for compulsion and also be capable of undertaking effective treatment as an outpatient in the community. If people are so severely impaired by substance dependence that they do not have the capacity to make informed treatment choices for themselves, they are extremely unlikely to be amenable to community-based treatment. If they are well enough to remain at home and attend a day programme, they ought not to come within the regime.



- 28 We are concerned also that the inclusion of community-based treatment, other than as after-care when people are discharged from the regime, has the potential to extend the catchment for the regime beyond that which can be justified under the Bill of Rights Act.

### Voluntary patients

- 29 Another difficult issue has been determining whether there is a place within a civil committal regime of this kind for self referrals where people place themselves under the regime. Under the Alcoholism and Drug Addiction Act people are able to make a voluntary application seeking an order requiring their own detention for treatment. This is something of an enigma and we have found no parallels elsewhere on the statute book.
- 30 Although there is some support across the treatment sector for allowing people to “volunteer” for compulsory treatment, we are not persuaded that this is appropriate. The last resort nature of the regime would be fundamentally altered if people, who have the capacity to undertake voluntary treatment, are able, because they are at risk of relapsing, to choose to come within it.
- 31 We also do not think it is possible to justify a regime that depends on a person’s consent, but then does not allow that consent later to be withdrawn. It is a contradiction in terms to recognise consent for the purposes of opting in but not for later opting out. If people are able to later withdraw consent and opt out then participation in treatment is voluntary.

### Assessment and treatment process

- 32 Under the model we propose the initial committal decision would be made by a specialist clinician and reviewed (and when appropriate overruled) by the Family Court. This is preferable to requiring people to make an application directly to the Court because it is a more appropriate process for dealing with a medical issue where a quick response is needed. A court-based process also perpetuates unhelpful stereotypes that people suffering from severe substance dependence are bad rather than unwell.
- 33 The stages of the proposed process are:
- Applications** – anyone over the age of 18, who believes that a person meets the criteria for compulsory treatment, may make an application to an official called the Director of Area Alcohol and Drug Services who must arrange for the person to be assessed.
  - Assessments** – an authorised specialist assesses the person against the criteria for compulsion and, where the person meets the statutory criteria, authorises the detention and treatment of the person.
  - Treatment** – the person is committed to a treatment facility and detained and treated under the care of a responsible clinician.
  - Court review** – the responsible clinician applies to a Family Court judge for a review of the decision to detain and treat the person under the Act within seven days of the person being committed and the judge undertakes the review within a further seven days.



**Extension of period of compulsion** – the responsible clinician may need to apply to the court for an extension (up to a further three months) beyond the maximum six weeks compulsory period if the person appears to be suffering from alcohol- or drug-related brain injury.

**Discharge planning and after-care** – the responsible clinician undertakes a discharge assessment and develops an after-care plan to cover the type of continuing care that will be provided to the person on a voluntary basis at the expiry of the period of compulsion.

## Safeguards

- 34 A number of important patient safeguards are proposed for the regime. These overlay the committal process from the assessment stage onwards. The main safeguards are:
- A general duty should be imposed on the responsible clinician to discharge a person if it becomes apparent he or she no longer meets the criteria.
  - The regime should provide, as an alternative to habeas corpus, a more accessible right of review under which any person who is being held and treated can seek an urgent review of his or her detention by a Family Court judge.
  - A person should be able to seek a further review by a judge if circumstances change.
  - Provision should be made for a person going through the committal process to nominate a carer to receive information and advice and provide him or her with support through the process.
  - Anyone who is a patient under the regime should have the same patient rights as a patient under the Mental Health (Compulsory Assessment and Treatment) Act.
  - The complaint process for remedying breaches of patient rights contained in the Mental Health (Compulsory Assessment and Treatment) Act should also be available for anyone committed under the proposed regime.
  - District inspectors should be appointed under the regime and given the same functions as they exercise under the Mental Health (Compulsory Assessment and Treatment) Act including general oversight to the operation of the regime.

# Summary of recommendations

## CHAPTER 5

- R1 The Alcoholism and Drug Addiction Act 1966 should be repealed and replaced by a new regime for the compulsory treatment of severe substance dependence.
- R2 The objectives of the proposed regime for compulsory treatment of people with severe substance dependence should be:
- to protect them from harm and restore their capacity to make their own decisions about their future substance use;
  - to stabilise their health through medical treatment (including supported withdrawal);
  - to facilitate a comprehensive assessment of their dependence;
  - to facilitate the planning of ongoing voluntary treatment and aftercare; and
  - to give them an opportunity to engage in voluntary treatment.
- R3 Provisions establishing the regime should be interpreted, and the functions under the regime performed, consistently with the following principles:
- detention and compulsory treatment should only be considered when less restrictive options will not enable treatment to be effectively given;
  - the least restrictive intervention that will enable treatment to be effectively given should always be used where a person is being detained and treated;
  - all interferences with the rights and dignity of a person detained and compulsorily treated should be kept to the minimum necessary; and
  - the interests of the detained person should be paramount in all decision-making about him or her.
- R4 A person should only be detained and treated when all of the following criteria are satisfied:
- (a) the person has a severe substance dependence; and
  - (b) detention and treatment is necessary to protect the person from significant harm to himself or herself; and
  - (c) the person is likely to benefit from treatment for his or her substance dependence but has refused treatment; and
  - (d) no other appropriate and less restrictive means are reasonably available for dealing with the person.

R5 The term “severe substance dependence” should be defined to mean that a person:

- (i) has a tolerance to a substance; and
- (ii) shows withdrawal symptoms when he or she reduces the level or stops using the substance; and
- (iii) has a substantially impaired capacity to make decisions about substance use and treatment for dependence primarily as a result of his or her dependence.

R6 The maximum period of detention and treatment should be six weeks unless an extension is granted.

R7 The Family Court should have the power to extend the period of compulsion for up to a further three months where a person appears to be suffering from alcohol- or drug-related brain injury and additional time is needed to complete assessment and treatment, or to plan the person’s discharge from the regime.

R8 The function of approving facilities for use under the regime should be undertaken by the Director-General of Health under the Health and Disability Services (Safety) Act 2001.

R9 The key stages and features of the assessment and treatment process should be:

**Application:**

- Anyone over the age of 18 who believes that a person meets the criteria for compulsory treatment should be able to make an application to have the person assessed under the regime.
- The application should be made to an official appointed by the Director-General of Health (called the Director of Area Alcohol and Drug Services).
- The application should be supported by a preliminary medical certificate issued by a medical practitioner.
- The certificate should confirm that the medical practitioner has examined the person, has reasonable grounds to believe that the person is likely to meet the criteria, and that the person should be assessed by a specialist for compulsory treatment.
- When a preliminary medical certificate could not be issued because the person refused to cooperate, the medical practitioner would need to confirm that he or she has been unable to examine the person and issue the certificate. The practitioner should also provide any available information on the person’s condition.

**Assessment:**

- When an application is received, the Director of Area Alcohol and Drug Services should arrange for the person to be examined and assessed against the criteria for compulsion by a specialist.
- When an application does not include a medical certificate (because the person refuses the preliminary medical examination) the Director of Area

Alcohol and Drug Services should make his or her own enquiries into the person's circumstances and determine whether there is sufficient evidence to indicate that the person is likely to meet the threshold criteria. If so, the Director should arrange for the person to be assessed against the criteria by a specialist. This specialist should have expertise in alcohol and drug dependence and treatment.

- The assessment to determine whether a person meets the threshold should always include a personal examination.
- If the person meets the criteria the authorised specialist should issue a certificate of dependence authorising the detention and treatment of the person. The certificate would authorise treatment of the person for up to a maximum of six weeks.
- Before issuing a certificate of dependence the authorised specialist would need to consult with staff at relevant treatment facilities to ensure that a suitable place is made available for the person.
- A preliminary treatment plan should be prepared for the person.
- If a certificate is not issued (because the person does not meet the criteria) then the Director of Area Alcohol and Drug Services should ensure the person is given advice about voluntary treatment services.

**Treatment:**

- When a certificate of dependence has been issued the person should be committed to an approved treatment facility and detained and treated there.
- A responsible clinician should be appointed for each person to oversee their treatment.

**Review by the Court:**

- The responsible clinician should be required to apply to the Family Court for a review of the decision to compulsorily treat the person as soon as is practical but no later than seven days after the certificate of dependence was issued.
- The review should be undertaken by a Family Court judge and should occur within seven days of the application being made.
- If the judge is satisfied on the balance of probabilities the person meets the criteria and further treatment under the regime is appropriate, the judge should approve the treatment plan and make a treatment order.

**Extension of period of compulsion:**

- The responsible clinician should apply to the Court for an extension of the treatment order, if it is needed, where the person appears to be suffering from alcohol- or drug-related brain injury.

**Discharge planning and after-care**

- The responsible clinician should be required to undertake a discharge assessment and develop an after-care plan to cover the type of continuing care that will be provided to the person on a voluntary basis at the expiry of the period of compulsion.

- R10 There should be a general duty imposed on the responsible clinician to discharge a person being treated under the regime if it becomes apparent that the person no longer meets the criteria for detention and treatment.
- R11 Persons who are being held and treated under a certificate of dependence should have the right, at any time after the certificate is issued, to seek an urgent review of their detention by a Family Court judge on the grounds that they do not meet the criteria and the certificate should not have been issued.
- R12 After a treatment order is made by the Court, the person subject to the order should be entitled to make an application for a subsequent review when their circumstances later change. To avoid continual review the judge should have a discretion to decide whether to hear the application.
- R13 Persons detained and compulsorily treated under the proposed new regime should have the same patient rights as patients under the Mental Health (Compulsory Assessment and Treatment) Act 1992 while under compulsory treatment.
- R14 The complaint process for remedying breaches of patient rights contained in the Mental Health (Compulsory Assessment and Treatment) Act 1992 should also be available to persons detained and treated under the proposed new regime.
- R15 District inspectors should be appointed and given the same functions as they exercise under the Mental Health (Compulsory Assessment and Treatment) Act 1992 to provide more general oversight to the operation of the regime.
- R16 Provision should be made for a nominated carer to receive information and advice and provide support to a person going through the committal process.
- R17 It should be an offence, punishable by a fine up to a maximum of \$5,000, to supply alcohol to a person the offender knows is under the regime.
- R18 The regime should authorise the apprehension and return of any person during the currency of a treatment order but it should not be an offence for a person to abscond. There should also be a power to apply for a warrant to enter premises for the purposes of removing the person and returning him or her to the treatment facility.
- R19 The Director-General of Health should have the function of appointing suitably qualified practitioners to undertake assessments and issue certificates of dependence under the regime.
- R20 The Director-General should, after consultation with the sector and relevant professional bodies, determine the appropriate specialist training and qualifications necessary for clinicians to undertake the functions of “authorised specialist” and “responsible clinician” under the regime.

- R21 Where a person refuses or fails to attend their assessment examination the Director of Area Alcohol and Drug Services should, if satisfied the person is likely to meet the threshold criteria and an examination and assessment is urgently needed, be authorised to make arrangement to have the person taken to the assessment examination. Police assistance should be available on the same terms as it is under the Mental Health (Compulsory Assessment and Treatment) Act 1992, and a power to obtain a warrant to enter premises should be available.
- R22 Provision should be made for authorised leave to allow a person subject to the regime to leave the treatment facility at which they are required to reside. Leave should be granted by the responsible clinician for a specified period on appropriate conditions.

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CHAPTER 6

- R23 The proposed regime should be implemented via a stand-alone Act.
- R24 All Section 8 and 9 orders still in place under the Alcoholism and Drug Addiction Act 1966 should be treated as though they are treatment orders made under the new regime. Arrangements should be made for a review of each such order and the circumstances of each person transferred into the new regime.
- R25 The Director-General of Health should be required to report annually on the regime. The annual report should cover the: (a) number detained and treated under the regime; (b) the length of detention and treatment; (c) the number of extensions granted; and (d) the number of people who go into voluntary residential treatment or outpatient treatment when discharged.





# Chapter 1

## Introduction

### DRUG HARM

- 1.1 Alcohol and drug use causes substantial harm and imposes significant costs on individuals, their families and the community. This is the case whether the drug is a legal drug like alcohol or an illegal drug like methamphetamine.
- 1.2 All psychoactive substances alter mood, perception, cognition and behaviour.<sup>1</sup> In doing so, they alter the body's functioning to create two different types of effects and possible harms:<sup>2</sup>
  - Toxicity (i.e. intoxication) – the (usually) immediate effect of a drug when the blood-level concentration rises rapidly; and
  - Dependence – the delayed effect of a drug that produces a range of longer-term harms.
- 1.3 Dependence can be mild or severe and its causes are complex. Typically, dependence occurs after frequent use as the body and brain become habituated to exposure to the drug, leading to metabolic and cellular adaptations. The user experiences increasing tolerance as the body and brain accommodate the drug's effects. As a result, when drug use stops, the user will experience a range of withdrawal symptoms that will generally be the opposite of the sought-after effects associated with the drug's use. The risk of dependence varies significantly from drug to drug and from individual to individual. The user's genetic makeup, the method of use and the frequency and duration of use contribute.
- 1.4 Those using drugs may also experience a range of other less direct harms. These include the harms that arise from undertaking activities while intoxicated (for example, driving or operating machinery) or activities in order to obtain money for drugs (for example, theft, burglary or prostitution). The diversion of financial resources into funding drug use also causes harm.<sup>3</sup>

1 Greg Whelan "The Pharmacological Dimension of Psychoactive Drugs" in M Hamilton, T King, and A Ritter (eds) *Drugs in Australia – Preventing Harm* (2<sup>nd</sup> ed, Oxford University Press, Melbourne, 2004) at [17].

2 Greg Whelan, above n 1.

3 Margaret Hamilton "Addressing Drug Problems: The Case for Harm Minimisation" in M Hamilton, T King, and A Ritter (eds) *Drugs in Australia – Preventing Harm* (2<sup>nd</sup> ed, Oxford University Press, Melbourne, 2004) at [131].

1.5 Drug use also harms others, sometimes more than the user.<sup>4</sup> Family members and intimates may be harmed by risky or violent behaviour attributable to drug use, as well as emotional distress and financial hardship. Employers can be affected by absenteeism and lost productivity. Other people in the community are affected by activities such as driving under the influence of alcohol or drugs. Intoxicated people cause damage to property and disorder. Drug use may also lead users to commit crime, due either to the immediate result of drug intoxication, the longer-term effect of drug use on the brain, or the need to finance a drug habit.<sup>5</sup> Society more generally must meet the cost to the health system of responding to drug-related injuries and health conditions, and also of providing rehabilitative and treatment services.

## DRUG POLICY AND TREATMENT

- 1.6 The overall aim of the *National Drug Policy* is to reduce the health, social, and economic harms linked to drug use.<sup>6</sup> The Policy requires a broad and integrated approach to minimising the harm caused by drug use under the three pillars of:
- supply control – measures that control or limit the availability of drugs;
  - demand reduction – measures that seek to limit the use of drugs by individuals, including abstinence; and
  - problem limitation – measures (including drug treatment) that reduce the harm that arises from existing drug use.
- 1.7 Specialist treatment services provided to treat alcohol and drug dependence form an important component of both demand reduction and problem limitation strategies. They are characterised as a problem limitation strategy under New Zealand’s drug policy. However, since these services are designed to assist people in stopping or reducing their drug use, they are in the international context sometimes considered a demand reduction measure.<sup>7</sup>
- 1.8 Defined broadly, “treatment” means the application of any intervention that aims to have a beneficial impact upon the behaviour and welfare of a drug user. Treatment encompasses interventions that operate at the medical, psycho-social and spiritual level and includes interventions that focus on different objectives, such as safer drug use, stabilisation of behaviour, and abstinence.<sup>8</sup>

4 Some commentators argue that most drug-related harms are borne by someone other than the user – see Robert J MacCoun and Peter Reuter *Drug War Heresies: Learning from Other Vices, Times and Places* (Cambridge University Press, 2001) at [106].

5 The link between drug use and crime is contested. See Alex Stevens, Mike Trace and Dave Bewley-Taylor *Reducing Drug-Related Crime: An Overview of the Global Evidence* (R 5, Beckley Foundation Drug Policy Programme, Beckley (UK), 2005).

6 Ministerial Committee on Drug Policy *National Drug Policy 2007–2012* (Ministry of Health, Wellington, 2007) 4. In 1998, New Zealand formally launched the *National Drug Policy 1998–2003*. The policy was updated following consultation and re-launched in 2007 as the *National Drug Policy 2007–2012*.

7 For example, the United Nations use the term “demand reduction” to include all policies (including treatment) that aim to prevent the use of drugs and reduce the adverse consequences of drug abuse. See The Declaration on the Guiding Principles of Drug Demand Reduction: UNGA Resolution 20/3 (8 September 1998) A/RES/S-20/3.

8 Alex Stevens, Christopher Hallam and Mike Trace *Treatment for Dependent Drug Use: A Guide for Policymakers* (R 10, The Beckley Foundation Drug Policy Programme, Beckley (UK), 2006) at [2].

- 1.9 The addiction treatment sector in New Zealand covers a broad spectrum of treatment types and services. The wide range of programmes and services that are available reflects the importance of matching the intervention to the person's needs. Where dependence is severe, people require specialist addiction treatment. This normally consists of withdrawal management (often called detoxification) and specialist community-based or intensive residential treatment involving pharmacotherapies, counselling and psycho-social therapies. Post-treatment care may also be required.
- 1.10 Alcohol and drug treatment are combined in many countries, including New Zealand, largely because many participants in treatment programmes are poly-drug users and a separation would therefore be counterproductive and artificial. Specialist alcohol and drug services are provided by approximately 150 specialist teams spread across the 21 District Health Boards and 16 large non-government organisations. It is estimated that approximately 22,500 people or 0.5 % of the population receive some assistance from specialist alcohol and drug treatment services annually.<sup>9</sup>
- 1.11 There is a large body of evidence that demonstrates that many people with drug dependence benefit from some form of drug treatment. Many studies show that specialist alcohol and drug treatment is effective at reducing substance use and improving health and well-being.<sup>10</sup> There is also clear evidence that treatment can be cost-effective.<sup>11</sup> Most reviews consistently find that addiction treatment yields net economic benefits to society.<sup>12</sup> The National Committee for Addiction Treatment has cited studies that estimate that for every \$1 spent on addiction treatment there is a \$4 to \$7 reduction in the cost associated with drug-related crimes and that for some non-residential programmes total savings can exceed costs by a ratio of 12:1.<sup>13</sup> Similarly, reports prepared by both the Beckley Foundation and the United Nations Office on Drugs and Crime reviewing the research evidence on drug treatment have concluded that there is evidence that drug treatment can be cost-effective.<sup>14</sup>

9 Between May 2007 and April 2008, 22,696 people accessed specialist alcohol and drug treatment services; see National Committee for Addiction Treatment (NCAT) *Investing in Addiction Treatment – A Resource for Funders, Planners, Purchasers and Policy Makers* (NCAT, Christchurch, 2008) at [2].

10 For example, see A Swan and S Alberti *The Alcoholics and Drug-dependent Persons Act (ADDPA) 1968: A Review* (Turning Point Alcohol and Drug Centre, 2004, Melbourne). See also the discussion summarising the evidence available for various forms of treatment in our earlier issues paper; New Zealand Law Commission *Controlling and Regulating Drugs* (NZLC IP 16, Wellington, 2010) at [paras 15.4–15.43].

11 T Babor and others *Alcohol: No Ordinary Commodity* (Oxford University Press, New York, 2003); A Ritter and N Lintzeris “Specialist Interventions in Treating Clients with Alcohol and Drug Problems” in M Hamilton, T King and A Ritter (eds) *Drugs in Australia – Preventing Harm* (2nd ed, Oxford University Press, Melbourne, 2004) at [225].

12 National Committee for Addiction Treatment (NCAT), above n 9, at [2].

13 These figures, cited by the NCAT, seem to be based on information from NIDA National Institute on Drug Abuse on evaluations in the United States rather than in New Zealand. See National Committee for Addiction Treatment (NCAT), above n 9.

14 See Alex Stevens, Christopher Hallam and Mike Trace, above n 8 and United Nations Office on Drugs and Crime *Contemporary Drug Abuse Treatment: A Review of the Evidence Base* (United Nations, New York, 2002).

COHERENT  
FRAMEWORK  
FOR  
TREATMENT

- 1.12 One of the most persistent themes that emerged from the feedback the Law Commission received on its issues papers, *Controlling and Regulating Drugs*<sup>15</sup> and *Alcohol in Our Lives*,<sup>16</sup> was the need to give greater emphasis to treatment both in response to offending and more generally as a response to the harm caused by alcohol and drug dependence. People working in treatment services and professionals dealing with people with dependence consistently expressed significant concern that access to treatment is currently inadequate.
- 1.13 Some of the key messages we received, particularly from those in the treatment sector, were:
- an overall addiction treatment strategy is needed;
  - services are fragmented – there is a lack of an effective structure for delivering treatment in both the criminal justice sector and more generally for the rest of the population;
  - greater emphasis should be placed in the criminal justice sector on the use of treatment;
  - specialist services for specific population groups, including Māori, Pacific people, and Asian people in some regions are needed;
  - specialist services are also needed for youth;
  - there should be a better geographical spread of services; and
  - overall the level of services available is inadequate to meet current demand.
- 1.14 We strongly support the need for a more effective structure and a coherent framework for delivering alcohol and drug treatment and will be addressing the issue in more detail in our forthcoming report on the Misuse of Drugs Act 1975.

COMPULSORY  
TREATMENT

- 1.15 One component of any coherent framework for delivering alcohol and drug treatment is the use of compulsion to require people to undertake treatment. Compulsion is currently utilised within the criminal justice sector. For example, offenders may be coerced into accepting treatment for substance dependence as part of their sentence. The completion of a drug treatment programme in a prison drug treatment unit may also sometimes be a necessary prerequisite for a prisoner seeking parole.
- 1.16 Outside the criminal justice system, the only provision for compulsory treatment specifically for dependence is in the Alcoholism and Drug Addiction Act 1966. That Act is the focus of this Report.
- 1.17 The Act is now quite out-of-date, and there are difficulties in reconciling its broad powers of detention with the rights and protections in the New Zealand Bill of Rights Act 1990. Over the years some provisions of the Act have also fallen into disuse and the overall framework of the Act has not kept pace with subsequent changes in allied legislation such as the Mental Health (Compulsory Assessment and Treatment) Act 1992. Reform of the Act is long overdue.

15 New Zealand Law Commission, above n 10.

16 New Zealand Law Commission *Alcohol in Our Lives: An Issues Paper on the Reform of New Zealand's Liquor Laws* (NZLC IP15, Wellington, 2009).

1.18 Our review of the Act is divided into four parts. In chapter 2, we outline the key provisions of the Act and identify some of those that, if a compulsory regime is retained, ought to be discarded or amended. In chapter 3, we consider whether the law should authorise compulsory treatment for alcohol and drug dependence. In chapter 4, we examine the approach taken on the issue in overseas jurisdictions. Chapters 5 and 6 contain our proposals for a new compulsory treatment regime for dependence.

# Chapter 2

## Alcoholism and Drug Addiction Act

**INTRODUCTION** 2.1 The Alcoholism and Drug Addiction Act 1966 came into force on 1 January 1969, repealing and replacing the Reformatory Institutions Act 1909.<sup>17</sup> It provides for the compulsory detention of alcoholics and drug addicts in certified institutions so that they may undergo assessment, detoxification and treatment. Although it retained a compulsory element, it represented a shift away from the punitive approach provided for in the earlier penal statute to a more therapeutic approach to alcohol and drug treatment.<sup>18</sup>

**COVERAGE OF ACT** 2.2 The term “alcoholic” replaced the earlier term “habitual inebriate” contained in the 1909 Act. Section 2 defines an alcoholic as:

any person whose persistent and excessive indulgence in alcoholic liquor is causing or is likely to cause serious injury to his health or is a source of harm, suffering, or serious annoyance to others or renders him incapable of properly managing himself or his affairs.

2.3 Section 3 also provides that the Act shall apply, in the same way it applies to an alcoholic, to:

any person whose addiction to intoxicating, stimulating, narcotic, or sedative drugs is causing or is likely to cause serious injury to his health or is a source of harm, suffering, or serious annoyance to others or renders him incapable of properly managing himself or his affairs.

2.4 Like the definition of alcoholic, the description of a drug addict appears quite widely drawn. Each has two limbs that need to be satisfied before a person falls within the coverage of the Act. Firstly, a person must either persistently and excessively indulge in alcohol or be addicted to drugs. Secondly, that excessive

<sup>17</sup> The 1909 Act was designed to “make provision for the establishment and control of reformatory institutions for the reception of habitual inebriates and fallen women.” Under that Act reformatory homes were established for “fallen women” and separate inebriate homes were established for “habitual inebriates”. The definition of ‘habitual inebriate’ included any person who habitually took or used drugs as well as alcohol. See Reformatory Institutions Act 1908, ss 2, 11 and 12.

<sup>18</sup> For a discussion on the 1909 Act, problems with the 1909 Act, and the resulting debate that led to the new Act, see M B Webb “Addiction and the Law: A Case-Study of the Alcoholism and Drug Addiction Act” (MA Thesis, University of Canterbury, 2001) at [38–47].





indulgence in alcohol or addiction to drugs must: (i) be causing, or be likely to cause, serious injury to his or her health; or (ii) be a source of harm or suffering or serious annoyance to others; or (iii) render the person incapable of properly managing himself or herself or his or her affairs.

2.5 The definitions determine the coverage of the Act and lead to some inconsistency in the approach to alcoholism and drug addiction respectively. In particular, it seems that a person must have an actual addiction to drugs to qualify as a drug addict, whereas the definition of alcoholic requires only persistent and excessive indulgence in alcohol. This means that a higher threshold applies before drug use comes within the coverage of the Act.

## CERTIFIED TREATMENT FACILITIES

2.6 Only an institution that has been certified by Order in Council may receive patients under the Act.<sup>19</sup> Orders certifying institutions are made by the Governor-General on the recommendation of the Minister of Health. An order certifying an institution can also only be revoked by the Governor-General. The Act authorises the Minister to appoint a supervising committee for any certified institution. A supervising committee must be chaired by a District Court judge. The other members are the superintendent of the institution, a medical practitioner attending at the institution, and one other person. Certain functions under the Act, which are otherwise exercised by the superintendent of the institution, may also be exercised by a supervising committee where one has been appointed.

### Current facilities and the nature of programmes

2.7 There are currently 13 institutions certified to accept people committed under the Act – nine public hospitals and four non-government facilities. Three of the latter are Salvation Army Bridge Programmes located in Auckland, Wellington and Christchurch and the fourth is Nova Lodge in Christchurch. The majority of patients committed under the Act go into the Salvation Army Bridge Programmes and Nova Lodge. These facilities run abstinence-based treatment programmes which combine educational work, counselling and variations on 12 step programmes.<sup>20</sup> Each of the four non-government certified institutions currently have supervising committees appointed by the Minister of Health.

<sup>19</sup> See Alcoholism and Drug Addiction Act 1966, s 5.

<sup>20</sup> Michael Webb “Dying for a Drink” [2003] NZLJ 121 at [122].

COMMITTAL  
UNDER THE  
ACT

- 2.8 There are three different routes by which a person can be committed under the Act for treatment.

### Section 8 – Voluntary applications for detention

- 2.9 Under section 8, people may make a voluntary written application to a District Court judge for an order requiring their own detention for treatment in a certified institution. The application must identify the institution and the applicant must undertake to remain in the institution for treatment until released or discharged under the Act. The judge may order detention if satisfied, either by the admission of the applicant or by any other evidence, that the applicant is an alcoholic or drug addict and understands the nature and effect of the application. Before making an order, the judge must also be satisfied that the institution named in the application is willing to accept the person for treatment.
- 2.10 It is the application that is voluntary and not the following detention.<sup>21</sup> Once a person is subject to an order for detention he or she is compulsorily detained and must remain in the institution until the order expires or he or she is discharged. The courts have consequently considered it particularly important to ensure that applications are genuinely voluntary and have not been made, for example, in response to strong family pressures or to avoid imprisonment.<sup>22</sup>
- 2.11 Voluntary applications are something of an enigma in the Act. There were 63 granted in 2008. It is odd to have a committal process that is initiated by a person's consent to treatment, yet later prevents that person from withdrawing that consent, if he or she wishes, at a later stage. The issue is considered further in chapter 5. (See paragraphs 5.42 to 5.46)

### Section 9 – Court-ordered detention on application of relative or other person

- 2.12 Under section 9 of the Act, a relative of an alleged drug addict or alcoholic, a police officer or “any other reputable person” may apply for an order requiring the alleged addict or alcoholic to be detained for treatment. If an application is made by a police officer or by another person who is not a relative, the application must contain a statement of the reasons why it is made by that person instead of a relative. The term “any other reputable person” used in the section has been held to cover any person who is of good repute and respectable.<sup>23</sup> The definition of relative was amended from 26 April 2005 to cover civil union and de facto partners.<sup>24</sup>

21 Sylvia Bell and Warren Brookbanks (eds) *Brookers Incapacity* (Online, Brookers, Wellington, 2003) at [AD8.04] (accessed 15 January 2010).

22 For example, in the case *Lynette Anne Jury v North Shore District Court and the Attorney General* Simon France J quashed a voluntary committal order and ordered the immediate release of a woman when it became apparent on appeal that she had agreed to a section 8 order after being presented with a choice between remaining in custody for resisting a constable or accepting committal to an addiction facility; see *Lynette Anne Jury v North Shore District Court and the Attorney General* HC Auckland CRI-2005-404-200, 10 June 2005.

23 Chrisholm J rejected the proposition that a reputable person needed to have some special standing in the community: see *Hall v Snell* (1999) 5 HRNZ 103 (HC).

24 Before the amendment the definition of relative was not thought to include same sex or de facto partners: see *S v Tahana-Reese & Anor* [2000] NZAR 481 (HC) at [486].

- 2.13 Where an application is made under section 9 a District Court judge may issue a summons requiring the alleged alcoholic or drug addict, who is the subject of the application, to show “cause” why an order should not be made for his or her detention for treatment in an institution.<sup>25</sup> The judge may also issue a warrant for the arrest of the person who is the subject of an application and may order the person to submit to a compulsory medical examination, but only if the judge believes that he or she will not comply with the terms of the summons or not consent to an examination by two medical practitioners for the purposes of the Act.<sup>26</sup> The medical examination is intended to determine whether the person is an alcoholic or addict as defined in the Act and also whether it would be expedient in the person’s own interests or the interests of his or her relatives for an order to be made. The judge may not issue an order detaining a person for treatment under the section unless two medical practitioners have either given evidence or certified that they believe this to be the case.<sup>27</sup>
- 2.14 Before making an order, a judge must also be satisfied that there is an institution willing to accept the person for treatment. The person must also appear before the judge before an order may be made.<sup>28</sup> This requirement sometimes results in the hearing of applications at hospital bedsides or in police holding cells.<sup>29</sup> Where an order is made, the person who is the subject of the order may be arrested by the police and taken into custody for detention in accordance with the order.<sup>30</sup>
- 2.15 The District Court’s power to make an order under section 9 is discretionary. An order will not necessarily be appropriate just because an application meets the criteria discussed in paragraph 2.13. In a recent case<sup>31</sup> Principal Family Court Judge Boshier held that the threshold for intervention is high. The Court must have regard to the individual’s right to be free from arbitrary detention contained in section 22 of the Bill of Rights Act. Thus, although section 9 authorises an order for detention to be made where treatment would be “expedient” in the person’s own interest or those of his or her relatives, the Judge said a gloss needs to be read into the wording of section 9 to apply a threshold for intervention similar to that used in the Mental Health (Compulsory Assessment and Treatment) Act 1992. On this approach, the court can only deprive people of their liberty if satisfied that their addiction is such that they pose a serious danger to themselves or to others or they are demonstrably unable to care for themselves. Mere inconvenience should not be enough.
- 2.16 Only 14 applications for section 9 orders were made in 2008, of which 11 were granted. This suggests that the application process, which requires applications to be made by specific people directly to the court, may be a barrier to the use of the Act. We recommend quite a different approach under the new regime we propose in chapter 5. (See paragraphs 5.47 to 5.61)

25 See Alcoholism and Drug Addiction Act 1966, s 9(1).

26 See Alcoholism and Drug Addiction Act 1966, s 9(4).

27 See Alcoholism and Drug Addiction Act 1966, s 9(6).

28 See Alcoholism and Drug Addiction Act 1966, s 9(7).

29 M B Webb, above n 18, at [52].

30 Section 14 of the Act provides a power of arrest. Any member of the Police may arrest any person ordered to be detained under the Act and take him or her into custody for detention in accordance with the order.

31 *JH v PCH FC* New Plymouth FAM-2008-043-82, 15 July 2008 at [para 22].

- 2.17 Another problem with the current process concerns the power to make interim arrangements for a person who is the subject of an application. Under section 13 of the Act, a District Court judge is able to issue directions for arrangements pending a person's reception into a certified institution, but only after an order that the person be detained under the Act has first been made. Thus, where there is a need for immediate intervention to facilitate short-term confinement in a hospital for the purposes of beginning a medically supervised detoxification process, directions to facilitate this can only be issued after the judge has first made a detention order. Sometimes final orders have been made while a patient has been intoxicated or unconscious.<sup>32</sup>

### Transfers of prisoners

- 2.18 The third way in which a person might be compulsorily detained for treatment is under section 21, which empowers the Minister of Corrections to order the transfer of any prisoner detained in a prison into a certified institution for the purposes of treatment for alcoholism or drug addiction. The term of a prison sentence continues to run while a prisoner is held in a certified institution.
- 2.19 The procedure for transfer is analogous to the procedure for transfer of an inmate for treatment under section 45 of the Mental Health (Compulsory Assessment and Treatment) Act. However, whereas the procedure in the Mental Health (Compulsory Assessment and Treatment) Act is initiated by the general manager of the penal institution, and the decision is a clinical one made by two medical practitioners, a decision to transfer under the Alcoholism and Drug Addiction Act is taken at a ministerial level.
- 2.20 The Act does not contain any criteria to guide the Minister when considering whether to transfer a prisoner. It has been suggested that involuntary transfers should meet the criteria under section 9 and voluntary transfers should meet the criteria under section 8.<sup>33</sup>
- 2.21 The provision is no longer used because alcohol and drug treatment units are now established within prisons. It is also inappropriate to involve the Minister in transfer decisions in individual cases. We think the provision should simply be repealed.

### Statutory period of detention

- 2.22 Any person subject to the Act may be detained for two years. In practice most people are discharged within the first six months. We consider length of detention in paragraphs 2.42 and 2.43. There is no power in the Act to extend an order beyond two years and it is an offence to deliberately detain or procure the detention of a person for a period exceeding this maximum.

32 For example, in *Savage v Savage* HC Hamilton M48/84, 19 March 1984, Tompkins J considered an appeal from Mrs Savage who had been unconscious at the time the order for her detention was made by the District Court. The District Court judge had seen but had not been able to consult Mrs Savage because she was unconscious. On the basis of the medical evidence an order was made and she was admitted to hospital so that she could be treated until fit enough to go to the relevant certified institution. Tompkins J considered that this had been entirely appropriate given the evidence and the opportunity the Judge had to observe the condition of Mrs Savage.

33 Bell and Brookbanks, above n 21, at [AD21.02] (accessed 15 January 2010).

## Number of committals

- 2.23 The annual number of committal orders made under the Act has fallen over recent decades – from over 400 a year in the 1970s to under 200 a year in the 1990s,<sup>34</sup> and then to approximately 75 a year between 2004 and 2008.<sup>35</sup>
- 2.24 The ratio of section 9 to section 8 orders has also changed over that time. During the 1990s there was typically a 2:1 or 3:2 ratio of section 9 to section 8 orders.<sup>36</sup> In 2008, 85 % of the 77 orders were made under section 8 and only 15 % under section 9.<sup>37</sup>
- 2.25 In proportion to the general population, Māori and women are under-represented in applications made under the Act.
- 2.26 Medical evidence is currently not always required before detention for treatment is ordered under the Act. Even where it is required, it is doubtful whether the level of medical evidence that is required is adequate to justify compulsory detention and treatment, potentially for two years.

## Section 8 applications

- 2.27 Currently there is no legislative requirement for any medical evidence to be submitted when a judge is considering a voluntary application under section 8. The judge may call for or hear medical evidence on the applicant's drug or alcohol use, but is not obliged to do so. Detention may be ordered where the applicant admits to being an alcoholic or drug addict and the judge is satisfied that the applicant understands the nature and effect of the application. In our view, even where the committal process is self-initiated, appropriate medical evidence should be required to determine whether the person meets the criteria for detention and treatment.

## Section 9 applications

- 2.28 An order can only be made under section 9 of the Act after two medical practitioners have either given oral evidence or issued a certificate confirming that the person named in the application is an alcoholic or addict and it is expedient in the person's own interests or the interests of his or her relatives for an order to be made. There are two significant problems with the requirements applying here. Firstly, any medical practitioner can currently issue a certificate or give evidence under the Act. Secondly, the provision does not require that both medical practitioners personally examine the person prior to making their assessment. The High Court in *S v Tahana-Reese & Anor* held that an examination of the alleged alcoholic by both medical practitioners is not a prerequisite to

34 Michael Webb, above n 20, at [122].

35 Ministry of Health *Office of the Director of Mental Health Annual Report 2008* (Ministry of Health, Wellington, 2009) at [35].

36 Michael Webb, above n 20, at [122].

37 Ministry of Health, above n 35, at [35].



making an order under section 9. Hansen J did note that at a practical level it would be quite unlikely that medical practitioners would give evidence or provide a certificate if they had not undertaken some form of examination.<sup>38</sup>

- 2.29 We think that the type of medical assessment needed before a person should be subject to compulsion under the Act requires specialist expertise. It should be undertaken by a practitioner who has expertise in alcohol and drug dependence and treatment. It should always require a personal examination. In any event, it is arguable that an order made in the absence of such appropriate evidence could be challenged as constituting an arbitrary detention under section 22 of the New Zealand Bill of Rights Act 1990.

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#### LEGAL REPRESENTATION

- 2.30 Section 35(2) of the Act expressly provides that every person who is the subject of an application under the Act is entitled to be heard, to give and call evidence, and to be represented by counsel.
- 2.31 The right to legal representation at a committal hearing under the Act is now supported by section 23(1)(b) of the Bill of Rights Act, which confers on everyone who is arrested or detained under any enactment, “the right to consult and instruct a lawyer without delay and to be informed of that right”. Consistent with this principle a person who is the subject of an application should always be offered access to a lawyer before any order is made.<sup>39</sup>

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#### APPEALS

- 2.32 Section 23 provides that the appeal provisions of the Summary Proceedings Act 1957 apply to orders under sections 8 and 9 of the Act. Orders for the return or removal of a patient to a certified institution made by a District Court judge can also be appealed to the High Court. An appeal must be lodged within three weeks of the order. However, because of the difficulties a person held under an order may experience accessing legal representation and because a person’s liberty is involved, the courts are generous in granting extensions of time.<sup>40</sup> The Act does not specify any particular grounds upon which an appeal can be brought. It has been suggested that the courts are in practice willing to contemplate broad grounds of appeal on the basis that the jeopardy faced by the person held under an order is analogous to that of a person charged with a criminal offence carrying up to two years imprisonment.<sup>41</sup>

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38 See *S v Tahana-Reese*, above n 24, at [486].

39 In *re Mrs M* [1993] DCR 673 at [674].

40 *Re Skelchy* HC Auckland AP1/92, 20 March 1992.

41 Bell and Brookbanks, above n 21, at [AD23.01] (accessed 15 January 2010).



- 2.33 Section 17 gives the Minister, a supervising committee appointed for the institution (if there is one), or the person in charge of the certified institution, the power to discharge, transfer, or release on leave any patient detained under the Act.<sup>42</sup>

### Requests for discharge

- 2.34 After six months in an institution a patient who is being detained under an order made under section 8 or 9 may request a discharge.<sup>43</sup> A request for discharge must be made to either the Minister, the supervising committee for the institution, or the person in charge of the institution. Once an order for discharge has been made, the order under which the person has been detained is deemed to have been revoked.
- 2.35 If the request is refused, the person may apply to a High Court judge for an order directing that he or she be discharged under the Act. On such application the High Court judge may order that the patient be brought before the Court for examination. The judge must determine following the examination and on such medical and other evidence as the judge requires whether it is still expedient either in the interests of the patient or in the interests of others that the patient continues to be detained for treatment.
- 2.36 At any time a person held under the Act also has the right to challenge that detention by an application for a writ of habeas corpus under the Habeas Corpus Act 2001. This is the only mechanism for review available to a patient during the first six months.
- 2.37 We think that these provisions provide inadequate access to a review at least during the first six months. The Act itself should provide patients with the ability to seek a discharge at any stage during their detention, both from the person in charge of the institution responsible for their treatment and, if that is refused, from a court. We consider this in more detail in paragraphs 5.64 and 5.65 in chapter 5.

### Transfer or release on leave

- 2.38 A supervising committee, the person in charge of the institution, or the Minister, can also transfer a patient to another certified institution. To do this they first need the agreement of the receiving institution. A patient who is transferred cannot be detained by the receiving institution for a period longer than the remaining time on the original detention order.
- 2.39 A leave of absence can be granted by the Minister, a supervising committee, or the person in charge of the certified institution for any period up to the expiry date of the original order. The Act imposes no statutory criteria for determining whether to grant leave. In practice it seems that special conditions, such as attending outpatient clinics or Alcoholics Anonymous meetings, are sometimes imposed by supervising committees. Those who are on leave can be discharged

<sup>42</sup> It should be noted that a transferred prisoner cannot be discharged or released on leave without the consent of the Minister of Corrections. The Minister may, with the concurrence of the Minister of Health, also impose terms and conditions on any such discharge or leave of absence.

<sup>43</sup> A transferred prisoner is not able to formally apply for a discharge in this way.

during the period of leave. If they breach the terms of the leave, an application can be made to the District Court for an order revoking their leave and requiring their return to the institution or another institution to be detained under the original order.<sup>44</sup>

- 2.40 Where patients are released on leave, rather than discharged, they technically remain within the ambit of the Act because the order under which they were detained is still in force.<sup>45</sup>

### The right not to be arbitrarily detained

- 2.41 Once a person has completed or no longer requires treatment for alcoholism or addiction, there is no lawful basis for his or her continued detention under the Act. The Act does not confer a power of preventive detention and the only legal basis for detention is for treatment for alcoholism or drug addiction.<sup>46</sup> If no further treatment is needed, the justification for detention accordingly no longer exists. Some commentators argue that once treatment ceases to be effective, or is persistently rejected, the mandate for detention is withdrawn and the patient should also be discharged.<sup>47</sup> Where competent patients refuse to submit to treatment, there would seem to be no legal basis to continue to detain them. Detention that continues when there is no therapeutic basis for it may constitute unlawful detention and breach section 22 of the Bill of Rights Act. In practice it seems that any patient who persistently refuses to engage in treatment is normally discharged from the institution holding him or her.

### Length of detention

- 2.42 Although all orders authorise detention for two years, almost all patients are discharged or otherwise released on leave well before two years.<sup>48</sup> Most inpatient residential treatment programmes offered within certified institutions are completed within three to six months. The inpatient programme for those detained at Nova Lodge runs for six months, although some patients are discharged before completing it. Thus, over half of all the people committed for treatment are discharged or released on leave within three months, and the vast majority are discharged or released on leave within six months.<sup>49</sup>
- 2.43 It is evident that the period of two years authorised by the Act far exceeds what is normally necessary for an inpatient programme. If detention for compulsory treatment is retained, the maximum length of detention should, as a matter of principle, be no longer than is necessary to treat the person so that he or she no longer meets the criteria for detention.

44 See Alcoholism and Drug Addiction Act 1966, s 20.

45 Although, as we have already noted, where a person is released on leave (except for a specific period) a court order is required to revoke such leave.

46 See Alcoholism and Drug Addiction Act 1966, ss 8(4) and 9(7).

47 This is, for example, the argument put forward by S A Bell and W J Brookbanks *Mental Health Law in New Zealand* (2<sup>nd</sup> ed, Brookers, Wellington, 2005) at [339] and Michael Webb, above n 20, at [123].

48 Bell and Brookbanks, above n 21, at [AD10.04] (accessed 15 January 2010).

49 Michael Webb, above n 20, at [122].

## Other points

- 2.44 A number of other points arise under the current discharge process:
- Patients currently have no direct access to an independent tribunal or court.
  - The Minister of Health has the authority to determine an application for discharge. (The question of whether the powers the Minister currently has under the Act are appropriate is discussed in paragraphs 2.46 to 2.48.)
  - Applications for discharge can be determined without the patient being examined.
  - An independent clinical assessment is not required at any stage, although the court can ask for an independent clinical report and an assessment would be required to complete this.
- 2.45 More generally the Alcoholism and Drug Addiction Act offers few of the types of procedural protections that have been incorporated into more recent mental health legislation to safeguard the rights and interests of vulnerable people. In the course of the 1999 review of the Alcoholism and Drug Addiction Act, the Health and Disability Commissioner and others suggested that a new advocacy and oversight role similar to that of district inspectors under the Mental Health (Compulsory Assessment and Treatment) Act would be desirable for patients detained under the Alcoholism and Drug Addiction Act. Under the Drug and Alcohol Treatment Act 2007 (NSW), which is being piloted in parts of Sydney, official visitors are appointed with functions similar to those of district inspectors. These functions include, for example, acting as an advocate for patients within the alcohol or drug dependence treatment system and inspecting treatment centres and reporting on matters of significant concern as they relate to patient safety.<sup>50</sup> We discuss other aspects of the New South Wales Act in paragraphs 4.2 to 4.14 in chapter 4.
- 
- 2.46 The Minister of Health has, at least on the face of the legislation, a much more active role under the Act than under other analogous legislation. The Minister has, for example, the power to discharge, to transfer or to grant or cancel leaves of absence.
- 2.47 Historically, these types of ministerial powers have seldom been exercised and over recent decades they have not been used at all. We understand that only the Minister's power to re-certify institutions and the power to appoint new members to supervising committees are now periodically exercised.<sup>51</sup> We think that the other ministerial powers reflect an earlier era. It is inappropriate for a Minister to be involved in this type of decision-making in individual cases. These provisions should be repealed.
- 2.48 The process of certifying institutions and programmes by Order in Council also seems to be out-of-step with the approach now taken to certifying other types of health care providers. We propose a new certification process in paragraphs 5.34 to 5.36 in chapter 5.

## ROLE OF THE MINISTER OF HEALTH

50 See Drug and Alcohol Treatment Act 2007 (NSW), ss 26 and 27 for a full list of functions.

51 Ministry of Health *Review of the Alcoholism and Drug Addiction Act 1966* (Ministry of Health, Wellington, 1999) at [6].

ACCESSING  
TREATMENT

- 2.49 The Act limits access to treatment facilities in two ways. Firstly, it provides only for detention in a certified institution. However, there are few certified facilities, with none outside Auckland, Christchurch and Wellington. In addition, none will take people who are under the age of 20 years. Young people under that age cannot receive inpatient treatment under the Act.
- 2.50 The unavailability or unwillingness of facilities to accept patients and the limited geographical spread of institutions have posed ongoing problems for the courts. In several cases judges have commented that applications have failed only because applicants have been unable to find an institution willing to take the person in need of treatment.<sup>52</sup>
- 2.51 A second, but related issue, is that the Act provides only for residential treatment. Some argue that since inpatient treatment fares no better than outpatient treatment other than for patients with severe dependence,<sup>53</sup> outpatient or community treatment should be an option under the Act. We consider this issue further in paragraphs 5.37 to 5.41 in chapter 5.

## OFFENCES

- 2.52 The Act creates a number of offences. The maximum penalty for all offences (other than that of unlawful detention in an institution) is three months imprisonment and/or a fine of up to \$200.<sup>54</sup> The maximum penalty for unlawful detention is 12 months imprisonment and/or a fine of up to \$1000.

## Ill-treatment and neglect of patients

- 2.53 There are two separate offences in section 29 dealing respectively with the ill-treatment and wilful neglect of any patient in an institution. Section 29 does not appear to apply to a patient who is on leave or otherwise absent from an institution. The section is analogous to section 114 of the Mental Health (Compulsory Assessment and Treatment) Act which contains the offence of intentionally ill-treating or neglecting any mentally disordered person. However, the difference in penalties is significant: two years imprisonment under the Mental Health (Compulsory Assessment and Treatment) Act<sup>55</sup> but only three months imprisonment under the Alcoholism and Drug Addiction Act.<sup>56</sup>
- 2.54 The Law Commission has recently proposed substantial reforms to the law relating to the ill-treatment and neglect of children and vulnerable adults.<sup>57</sup> In particular, we have proposed a redraft of section 195 of the Crimes Act 1961 (formally entitled “cruelty to a child”), addressing ill-treatment and neglect by

52 In *Edmonds v Lucas-Edmonds*, for example, Judge Grace dismissed an application after noting that the absence of a certified institution meant that an order could not be made in respect of a young man of 17. The Judge expressed his deep concern that this was a situation “where no assistance [was] available to a person who clearly need[ed] it.” *Edmonds v Lucas-Edmonds* FC Wellington MFP085/4/03, 23 May 2003. Applications have similarly been dismissed in other cases because there have not been any places available: for example, see *B v DR* [1984] NZFLR 898.

53 There is some evidence that long-term inpatient treatment can be superior for patients with a severe dependence; see Ministry of Health *Review of the Alcoholism and Drug Addiction Act 1966*, above n 51, at [10–11].

54 See Alcoholism and Drug Addiction Act 1966, s 36.

55 Bell and Brookbanks, above n 21, at [AD29.01] (accessed 15 January 2010).

56 See Alcoholism and Drug Addiction Act 1966, s 36.

57 New Zealand Law Commission *Part 8 of the Crimes Act 1961: Crimes Against the Person* (NZLC R111, Wellington, 2009) chapter 5.

those with care or charge of a child or vulnerable adult. At present section 195 only applies to child victims. We consider that vulnerable adults<sup>58</sup> are entitled to the same protection. The Commission has proposed a broader and objective “gross negligence” test as part of that reform. Rather than needing to find deliberate neglect or ill-treatment, as at present, a court would only need to be satisfied that the conduct alleged was a major departure from the standard of care to be expected of a reasonable person.<sup>59</sup>

- 2.55 In view of the Commission’s proposal to broaden the scope of section 195 to cover the ill-treatment or neglect of patients detained in institutions, it is unnecessary to retain specific offences such as those contained in section 29. If the Commission’s proposals for section 195 of the Crimes Act are adopted, section 29 should be repealed.<sup>60</sup>
- 2.56 The Commission has also proposed two other substantial reforms to Part 8 of the Crimes Act that would apply to patients detained in certified institutions under the Alcoholism and Drug Addiction Act. These are:
- a new offence where a staff member of a residence fails to take reasonable steps to protect a vulnerable person in that residence from any known risk of death, serious injury or sexual assault,<sup>61</sup>
  - an extension to the scope of the duty provision in section 151 of the Crimes Act, by introducing an additional requirement to take reasonable steps to protect a vulnerable person from injury.<sup>62</sup>

### Improper conduct

- 2.57 It is an offence under section 26 for a person committed as a patient under the Act to wilfully engage in violent, unruly, insubordinate, destructive, indecent, offensive or insulting conduct. Commentators describe this offence as an historical anachronism and suggest that it is anomalous to threaten people with punishment for insubordinate and unruly behaviour, who, by the nature of their condition, are likely to be so disposed.<sup>63</sup> We could find no case law on the section.
- 2.58 Some of the proscribed conduct is already covered by other general offences. For example, there are already offences in the Crimes Act 1961 and elsewhere that prohibit violence, destruction of property, indecency and offensive conduct. Where conduct is not covered by an existing offence, we do not think that it should be criminalised in this context; only conduct that would be an offence if it occurred outside an institution should be an offence within an institution.

58 For the purposes of the reforms a vulnerable adult is a person unable, by reason of detention, age, sickness, mental impairment, or any other cause, to withdraw himself or herself from the care or charge of another person.

59 New Zealand Law Commission, above n 57, at [52].

60 Section 114 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 could similarly be repealed.

61 New Zealand Law Commission, above n 57, at [55–57].

62 New Zealand Law Commission, above n 57, at [60].

63 Bell and Brookbanks, above n 21, at [AD26.01] (accessed 15 January 2010).



### Trespass

- 2.59 It is an offence under section 28 for any person to deliberately trespass on any land knowing or having reasonable cause to believe that it is part of a certified institution. This offence appears unnecessary as it duplicates the general law of trespass.

### Escaping from an institution

- 2.60 It is an offence under section 25 for a person committed as a patient under the Act to escape or attempt to escape from an institution or from other lawful custody under the Act, or to wilfully refuse or fail to return to an institution at the end of a period of lawful absence.<sup>64</sup> It is also an offence under the section for another person to induce or knowingly assist a person to escape or to knowingly assist a patient to avoid being caught. The police or any employee of the institution may arrest without warrant any patient who is unlawfully absent from an institution and return him or her to the institution.
- 2.61 There is no equivalent offence of escaping from a psychiatric institution under the Mental Health (Compulsory Assessment and Treatment) Act. The rationale is that those suffering from a mental disorder that is serious enough to result in their compulsory detention under that Act have diminished capacity, so it is not appropriate to hold them culpable for escaping. The same argument might be made in respect of a person committed as a patient under the Alcoholism and Drug Addiction Act.
- 2.62 On the other hand, it can be argued that an offence of this kind reinforces the compulsory nature of the detention and gives it more “teeth”. We return to this issue in paragraphs 5.85 to 5.89 in chapter 5.

### Supplying drugs or alcohol to patients

- 2.63 It is an offence under section 27 for any person, other than a medical practitioner or someone acting under his or her authority, to supply any drugs or alcohol to any patient held under the Act. This offence also covers any period when the patient is on a leave of absence or otherwise absent from the institution. We propose changes to this offence in paragraphs 5.82 to 5.84 in chapter 5.

### Unlawful detention in an institution

- 2.64 Finally, under section 24, it is an offence to deliberately detain a person in an institution under the Act for a period longer than is legally authorised or to detain a person “otherwise than in due course of law”. This appears to cover any situation where continued detention is not otherwise lawful, or any failure to discharge a patient from the institution where a court has ordered the patient’s discharge. We consider this offence further in paragraph 5.81 in chapter 5.

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64 See Alcoholism and Drug Addiction Act 1966, s 25.



# Chapter 3

## When is compulsory treatment justified?

- INTRODUCTION 3.1 Whether the law should authorise the compulsory treatment of alcoholics and drug addicts is the most fundamental issue raised by this review.
- 3.2 In this chapter we consider the right to refuse medical treatment and what reasonable limits may be justified and imposed on that right in respect of alcohol and drug treatment.

### THE RIGHT TO REFUSE TREATMENT

- 3.3 It is a fundamental common law principle that medical treatment cannot be imposed upon a competent adult without that person's consent (or some other legal justification).<sup>65</sup> Implicit in the requirement for informed consent is the right to refuse medical treatment irrespective of the outcome. Even where death will be an inevitable or immediate consequence of refusing to accept treatment, the right has been said to prevail. Lord Keith in *Airedale NHS Trust v Bland* summed it up in the following way:<sup>66</sup>

... it is unlawful, so as to constitute both a tort and the crime of battery, to administer medical treatment to an adult, who is conscious and of sound mind, without his consent... Such a person is completely at liberty to decline to undergo medical treatment, even if the result of his doing so will be that he will die.

- 3.4 This longstanding and fundamental right established by the common law is now protected by section 11 of the New Zealand Bill of Rights Act 1990. Section 11 of the Bill of Rights Act provides:

#### **11. Right to refuse to undergo medical treatment**

Everyone has the right to refuse to undergo any medical treatment.

- 3.5 The right protected by section 11 is arguably broader than the right at common law. It is said to protect not only the physical aspects of bodily integrity but also human dignity and autonomy in the making of personal decisions about medical

65 See P D G Skegg and Ron Paterson (eds) *Medical Law in New Zealand* (Brookers, Wellington, 2006) at [154]; A Butler & P Butler *The New Zealand Bill of Rights Act: A commentary* (LexisNexis NZ Ltd, Wellington, 2005) at [11.9.1].

66 *Airedale NHS Trust v Bland* [1993] AC 789 (HL) at [857].

treatment and investigation.<sup>67</sup> It also covers all forms of medical treatment (including many which are not covered by the tort of battery or capable of constituting a criminal assault).

- 3.6 The tort of battery was not abolished in New Zealand by the accident compensation scheme; rather compensatory damages at common law for injuries covered by the scheme are no longer available. Professor Skegg suggests that the tort could still be used, as it has been in English cases, as the basis for obtaining a declaration or an injunction requiring health practitioners to desist from treating a patient.<sup>68</sup>

### Meaning of medical treatment

- 3.7 Medical treatment is a comprehensive term that includes psychological and psycho-social therapy, and arguably any other treatment that is intended to relieve a patient of medical symptoms.<sup>69</sup> To reflect the overall purpose of section 11, the assessment and diagnosis process is medical treatment since “it is a part of the overall mission of treatment, and will often involve invasion of personal interests and bodily integrity, which is the goal of section 11 to protect”.<sup>70</sup>

### The requirement that a person has the capacity to consent

- 3.8 The common law principle protects only the right of the competent adult to consent to or refuse treatment.
- 3.9 At common law there is no all-purpose test as to whether a person is competent or has capacity to give or refuse consent. Even within the context of medical treatment the courts have not adopted and used one test to the exclusion of others.<sup>71</sup> However, in a number of relevant cases, capacity is considered to be most appropriately measured by a person’s ability to understand the nature of the treatment in question and the likely consequences of having or not having the treatment and the ability to make a decision based on that understanding.<sup>72</sup> In *In the matter of FT* Principal Family Court Judge Boshier identified four factors to consider when assessing capacity: (a) the person’s ability to communicate choices; (b) his or her understanding of relevant information; (c) his or her appreciation of the situation and of its consequences; and (d) his or her manipulation of information or ability to follow a logical consequence of thoughts in order to reach a decision.<sup>73</sup>

67 A Butler & P Butler, above n 65, at [11.6.2].

68 See P D G Skegg and Ron Paterson, above n 65, at [154].

69 A Butler & P Butler, above n 65, at [11.8.2].

70 P Rishworth et al *The New Zealand Bill of Rights* (OUP, Melbourne, 2003), at [256].

71 P D G Skegg and Ron Paterson, above n 65, at [174].

72 This is the formulation or test of capacity to refuse treatment set out in *Re MB (Medical Treatment)* [1997] 2 FLR 426, at [437].

73 *In the matter of FT* FC Auckland PPR 68/94, 11 Jan 1995, cited in *Re CMC* [1995] NZFLR 538, at [541] also reported as *Re C* [PPPR] 13 FRNZ 112, at [115].

- 3.10 When considering whether a person has capacity to make a particular decision, the courts have also said that the question is whether the person has at the time of the decision a capacity that is commensurate with the gravity of the decision being made.<sup>74</sup> Lord Donaldson MR in the case *T (Adult: Refusal of Treatment)* said:<sup>75</sup>

It may not be a case of capacity or no capacity. It may be a case of reduced capacity. What matters is whether at that time the patient's capacity was reduced below the level needed in the case of a refusal of that importance, for refusals can vary in importance.

A decision to refuse treatment requires a higher level of competence if the consequences will be serious and irreversible rather than insignificant.<sup>76</sup>

- 3.11 On the face of it, section 11 of the Bill of Rights Act does not limit the right only to those with capacity to consent. In an early case, *Re S*, decided soon after the Bill of Rights Act came into force, Barker J put a gloss on section 11 and read down the term "everyone" to mean "every person who is competent to consent".<sup>77</sup> Essentially the Judge took the view that section 11 was to be given the same scope as the common law principle. If the decision in *Re S* is correct (and section 11 only applies to everyone who has capacity), medical treatment decisions for many of the most vulnerable people in society could be made without any reference to the Bill of Rights Act. We do not think this can be correct and prefer the alternative interpretation that "everyone" means every human being from birth to death regardless of whether they are competent to give or refuse consent.
- 3.12 The Butlers in their commentary on the Bill of Rights Act have taken the same view.<sup>78</sup> They suggest that the correct approach is to first enquire into whether the person has capacity to refuse medical treatment. If the person is not competent to refuse treatment, he or she should not be excluded from section 11 and thereby lose its protection; the inquiry should rather become one as to who may refuse treatment on his or her behalf.<sup>79</sup> In some cases it may be a guardian or the state, while in others it will be a court. This approach enables issues over capacity to be resolved within the framework provided by the Act, thus ensuring that vulnerable people who lack capacity have any consequential limitations on their right to refuse treatment determined by the same high standard that applies to others.

<sup>74</sup> *Re T (Adult: Refusal of Treatment)* [1992] 4 All ER 469 (CA), at [661].

<sup>75</sup> *Re T (Adult: Refusal of Treatment)*, above n 74, at [664].

<sup>76</sup> P D G Skegg and Ron Paterson, above n 65, at [157].

<sup>77</sup> *Re S* [1992] 1 NZLR 363 (HC), at [374].

<sup>78</sup> The Butlers point out that Barker J's approach is not supported by the White Paper draft Bill of Rights; A Butler & P Butler, above n 65, at [11.6.5].

<sup>79</sup> A Butler & P Butler, above n 65, at [11.9.1].

### Right 7 of the Code of Health and Disability Services Consumer Rights

3.13 The Health and Disability Commissioner Act 1994 and the promulgation of the Code of Health and Disability Services Consumer Rights (the Code) now spell out the requirement for informed consent in more detail.<sup>80</sup> Right 7 of the Code outlines the requirements for informed consent and applies to the provision of all health and disability services. Rights 7(1) and (7) state:

(1) Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Code provides otherwise.

(7) Every consumer has the right to refuse services and to withdraw consent to services.

3.14 The “services” referred to are defined in the Code to mean health services and/or disability services including health care procedures. “Choice” is also defined and means a decision to receive, refuse, or withdraw consent to services. The requirement for informed consent introduced by the Code is consequently broader than the requirement at common law. The Code imposes more stringent requirements for informed consent than was previously the case.

3.15 Right 7 of the Code also contains a presumption that consumers have capacity to make choices over health services and give informed consent. Consumers with diminished capacity still retain the right to exercise the degree of choice they are able to exercise. Right 7(2) and (3) state that:

(2) Every consumer must be presumed competent to make an informed choice and give informed consent, unless there are reasonable grounds for believing that the consumer is not competent.

(3) Where a consumer has diminished competence, that consumer retains the right to make informed choices and give informed consent, to the extent appropriate to his or her level of competence.

The term “competent” is used rather than capacity, but in this context the terms mean the same.<sup>81</sup>

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80 The Code is contained in the Health and Disability Commissioner (Code of Health and Disability Services Consumers’ Rights) Regulations 1996. It is delegated (or subordinate) legislation and therefore has full legal effect (provided its provisions have been authorised by the Health and Disability Commissioners Act 1994).

81 Professor Skegg says that it is apparent that it is the same legal concept that is at issue; see P D G Skegg and Ron Paterson, above n 65, at [172].

- 3.16 The right to refuse to undergo medical treatment protected by section 11 is not an absolute right. Under section 5 of the Bill of Rights Act, the right is subject to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society. Determining whether limits are reasonable and can therefore be justified requires an assessment of whether they are proportionate to the object they are intended to achieve.
- 3.17 In *R v Oakes*,<sup>82</sup> the Canadian Supreme Court set out what has become an accepted methodology for evaluating the proportionality of proposed limitations on fundamental rights. One variation or another on this approach is now utilised in New Zealand.<sup>83</sup> It involves considering whether:<sup>84</sup>
- (a) the objective to be achieved by the limiting measure is of sufficient importance to warrant limiting a fundamental right (i.e. the sufficiency of the conflicting legislative objective); and
  - (b) there is a rational connection between the limiting measure and its objective; and
  - (c) the limitations imposed on the right go no further than is necessary to achieve that objective; and
  - (d) the beneficial effects of the limiting measure outweigh the harm or damage it causes.
- 3.18 This framework is useful for assessing whether limitations proposed in new legislation are consistent with the Bill of Rights Act.<sup>85</sup> However, it should not be applied in an abstract, mechanical or legalistic way. Rather, attention needs to be paid to the context in which the different relevant factors are weighed up. Ultimately judgement needs to be exercised as to whether within the particular context any proposed limitation can be justified.<sup>86</sup>

### Statutory regimes limiting the right to refuse treatment

- 3.19 Before we consider whether the law should continue to authorise the compulsory treatment of alcoholics and drug addicts, it is instructive to consider other situations where the law prescribes limits on the right to refuse medical treatment. Although most of these predate the Bill of Rights Act, they identify the types of intrusions that have been regarded as reasonable in New Zealand in the past. This helps us understand the types of intrusions that might be justified under section 5.
- 3.20 Very few statutory regimes authorise compulsory treatment.

<sup>82</sup> *R v Oakes* [1986] 1 SCR 103 (SC).

<sup>83</sup> One form or another of this test was, for example, applied by all five Supreme Court justices in *R v Hansen*; see *R v Hansen* [2007] 3 NZLR 1 (NZSC) at [para 42] per Elias CJ, [paras 64–81] per Blanchard J, [paras 103 and 120–124] per Tipping J, [paras 203–205] per McGrath J, and [paras 269–272] per Anderson J.

<sup>84</sup> This formulation (although slightly modified here) is taken from an article by Claudia Geiringer and Steven Price; See C Geiringer & S Price “Moving from Self-Justification to Demonstrable Justification – The Bill of Rights and the Broadcasting Standards Authority” in Jeremy Finn and Stephen Todd (eds) *Law, Liberty, Legislation: Essays in Honour of John Burrows QC*, (LexisNexis NZ Limited, Wellington, 2008) 295, at [313].

<sup>85</sup> We note however that this approach has been criticised as complex (particularly when one is trying to determine whether a particular exercise of administrative power is justified or not under section 5); see, for example, A Butler & P Butler, above n 65, at [6.15.3] and C Geiringer & S Price, above n 84, at [313–315].

<sup>86</sup> For a discussion on the importance of context see A Butler & P Butler, above n 65, at [6.11.11] and [6.12.1].



*Public health exceptions*

3.21 The first group of statutory powers that limit the right to refuse treatment are those authorising health officials (acting on behalf of the state) to detain, isolate and, in some circumstances, treat people where it is believed they have an infectious disease. Similar provisions are found in most other jurisdictions. Since infectious disease poses a significant risk to public health it is generally accepted that detention for compulsory treatment in this type of situation may be justified in a free and democratic society.<sup>87</sup>

*Tuberculosis Act 1948 and the Health Act 1956*

3.22 The Tuberculosis Act 1948 provides that a Medical Officer of Health may apply to the District Court for an order that a person be detained. An order may be made where the court is satisfied that the person has infectious tuberculosis and (amongst other things) it is in the person's interest that he or she "be properly attended and treated".<sup>88</sup> Where a judge makes an order, the person may be taken to a facility that has the capacity to both quarantine and appropriately treat him or her. The person subject to the order can then be detained at that place for the period specified by the Judge in the order. This period may not exceed three months. Successive court orders may impose further periods of detention.

3.23 Section 79 of the Health Act 1956 authorises a Medical Officer of Health to order the removal of a person to hospital or some place where he or she can be isolated if the person is "likely to spread infectious disease". The Medical Officer must have reason to believe or suspect that the person is likely to cause the spread of an infectious disease and that without such an order the person cannot be effectively isolated or properly attended. In this case there is no requirement for a court order. Section 88 also requires that people with a venereal disease place themselves under ongoing treatment to ensure it is not communicable.<sup>89</sup> Where they fail to do this, they can be detained and isolated under section 79.

3.24 Neither the provisions in the Tuberculosis Act nor section 79 of the Health Act expressly authorise treatment of the person without his or her consent. Both only expressly authorise detention in quarantine. In a post Bill of Rights Act environment commentators take the view that a person probably cannot be compulsorily treated under either provision. Professor Skegg states that section 79 authorises the detention of a person but should not be taken to authorise the imposition of (non-consensual) treatment on a competent person. Where the person refuses treatment of a nature that would render him or her non-infectious, he or she might have to be detained indefinitely.<sup>90</sup> Similarly, Professor Skegg argues, the Tuberculosis Act authorises detention but treatment cannot be imposed without consent or some other lawful justification.<sup>91</sup>

87 A Butler & P Butler, above n 65, at [11.9.20].

88 Tuberculosis Act 1948, s 16(1).

89 It is an offence for a person not to do this.

90 P D G Skegg and Ron Paterson, above n 65, at [236].

91 Here his view is based partly on the specific wording of a 1950 amendment that specified detention but not treatment. See P D G Skegg and Ron Paterson, above n 65, at [235].



- 3.25 This interpretation is consistent with the principle that limitations go no further than is necessary to achieve the objective. The risk an individual infectious person poses to others would normally be addressed by isolation, so it would not seem necessary to forcibly treat the person. However, the practicality of providing ongoing isolation, particularly where there is some type of outbreak, also needs to be considered. We envisage that there might be circumstances where treatment would be necessary to achieve the objective of protecting the public.
- 3.26 The Act does in fact expressly permit interventions that constitute medical treatment in some circumstances. Where emergency powers are invoked (because of an outbreak of an infectious disease) or where a quarantine is imposed (to prevent such an outbreak), people can be required to submit to examination and testing.<sup>92</sup> In these circumstances testing is needed to determine whether a person has an infectious disease and what, if any, follow-up management is required. Powers of this type are primarily for use during the early stages of an epidemic, when the medical authorities are trying to determine the nature of a disease or keep the disease out of New Zealand.

#### Public Health Bill 2007

- 3.27 There is currently a Public Health Bill before the Parliament.<sup>93</sup> If enacted it will replace both the Health Act and the Tuberculosis Act. It largely re-enacts, but with appropriate statutory safeguards, the current powers to detain, isolate and treat people who may have serious communicable diseases where this is necessary to prevent the spread of those diseases.
- 3.28 Part 4 of the Public Health Bill contains a number of provisions that require individuals to undergo a medical examination and other treatment in some situations where they pose a health risk to others because they have a communicable condition. The Bill authorises Medical Officers of Health to direct any person who they believe, on reasonable grounds, poses a health risk to undertake a number of medical examinations.<sup>94</sup> The District Court may also, as part of a health risk order, require any person to accept treatment for the condition that has made him or her subject to the health risk order.<sup>95</sup> The Court may also make an examination order requiring an individual to undergo specified medical examinations.<sup>96</sup>
- 3.29 Under Part 7 of the Bill, Medical Officers of Health are given powers to act where a public emergency has been declared. Part 7 also deals with maintaining quarantine at New Zealand's border. Officials have powers to manage the risk

92 Where a state of emergency has been declared a Medical Officer of Health can require people to submit themselves for medical testing where such testing is require to prevent the outbreak or spread of any infectious disease; Health Act 1956, s 70. A Medical Officer of Health is authorised to examine a person liable to quarantine and to take a bodily sample from him or her; Health Act 1956, s 97D.

93 Public Health Bill 2007 (177-2).

94 Public Health Bill 2007 (177-2), cl 97(2).

95 Public Health Bill 2007 (177-2), cl 114(1)(f).

96 Public Health Bill 2007 (177-2), cl 117(2).

that people and craft coming into, or leaving, New Zealand may be a source of infection. Under these provisions, Medical Officers of Health may also require individuals to submit to medical examinations.<sup>97</sup>

- 3.30 In the Public Health Bill, the powers of health officials and the courts to order compulsory treatment are subject to the following overarching principles: (1) preference must be given to the least restrictive measure; (2) individuals should be treated with respect; and (3) an individual affected by the exercise of powers should be properly informed about that exercise.<sup>98</sup>

#### Detention for care – section 126 of the Health Act

- 3.31 Section 126 of the Health Act should be separately mentioned here. Under this section a Medical Officer of Health may apply to a District Court for an order for the committal of an “aged, infirm, incurable, or destitute person” who is found to be living in insanitary conditions and “without proper care and attention”. The Court may order the committal of the person to any appropriate hospital or institution available to receive such people. If the person refuses to comply with the order, he or she can be forcibly taken and detained in the hospital. The section does not address the question of treatment, so it is not certain what the position would be if the person refused to accept basic personal and health care. In any event the provision is practically redundant as it has been superseded by the broader provisions in the Protection of Personal and Property Rights Act 1988 under which the Family Court may make personal care orders that cover personal care and also treatment.
- 3.32 A similar type of provision has been carried through into Subpart 5 of Part 4 of the Public Health Bill. Clause 128 of the Bill provides that a District Court may make “a residence order” requiring a person to reside in a specific place and be supervised and cared for as specified in the order. Before making an order, the Court must be satisfied that the person is unable to care for himself or herself and that as a result of a lack of care the health of the person or other people is likely to be adversely affected. In addition, the Court must be satisfied that without an order the person will not receive adequate care.
- 3.33 A residence order requires that the person reside in a specific place and be supervised or cared for there. Orders may be for up to six months and may be extended on more than one occasion if the Court is satisfied that the order is still required.

97 Public Health Bill 2007 (177-2), cl 266(1)(f).

98 Public Health Bill 2007 (177-2), cls 90–93.

## *Protection of Personal and Property Rights Act 1988*

- 3.34 Under the Protection of Personal and Property Rights Act, the Family Court has jurisdiction only in respect of someone who:<sup>99</sup>
- (a) lacks wholly or partly, the capacity to understand the nature, and to foresee the consequences, of decisions in respect of matters relating to his or her personal care and welfare; or
  - (b) has the capacity to understand the nature, and to foresee the consequences, of decisions in respect of matters relating to his or her personal care and welfare, but wholly lacks the capacity to communicate decisions on these matters.

In deciding whether jurisdiction exists, the presumption is in favour of competency.<sup>100</sup> In other words the onus is on the applicant for an order to demonstrate that jurisdiction on one or other of the two possible grounds exists.<sup>101</sup>

- 3.35 If jurisdiction does exist, the Court may make three classes of order:
- a specific order under section 10;
  - a property order under section 11; or
  - an order appointing a welfare guardian under section 12.

Only orders under sections 10 and 12 are relevant for our purposes here.

### *Specific orders under section 10*

- 3.36 Under section 10, the Court may make one of the following specific orders:<sup>102</sup>
- (d) an order that the person shall enter, attend at, or leave an institution specified in the order, not being a psychiatric hospital or a licensed institution under the Mental Health Act 1969;
  - (e) an order that the person be provided with living arrangements of a kind specified in the order;
  - (f) an order that the person be provided with medical advice or treatment of a kind specified in the order;
  - (g) an order that the person be provided with educational, rehabilitative, therapeutic, or other services of a kind specified in the order.
- 3.37 Before making any such order, the Court must consider two issues: (a) whether it has jurisdiction over the person (which involves analysing the person's capacity); and (b) whether an order should be made in the circumstances. Application of the Act turns on the question of capacity, although a finding that

99 Protection of Personal and Property Rights Act 1988, s 6(1). Note also that its jurisdiction under the Act does not extend to those under 20 years of age who have never married; Protection of Personal and Property Rights Act 1988, s 6(2).

100 Protection of Personal and Property Rights Act 1988, s 5.

101 An application can be made to the Family Court by any of the following classes of people: (1) the person themselves; (2) a relative or attorney; (3) a social worker or a medical practitioner; (4) the principal manager of any hospital, rest home, or residential disability care facility providing care to the subject of the application; or (5) a representative of a charity or other group that is engaged in the provision of (not for profit) services for any group of people who might come under the Act. The Court may also grant leave for other people to apply; Protection of Personal and Property Rights Act 1988, s 7.

102 Protection of Personal and Property Rights Act 1988, ss 10(1)(d), (e), (f) and (g). The reference in (d) to the Mental Health Act 1969 should be read as a reference to the replacement Mental Health (Compulsory Assessment and Treatment) Act 1992.

a person does not have capacity does not necessarily mean an order should be made. Section 8 of the Act sets out the primary objectives of the Court when considering an application as being:

- (a) to make the least restrictive intervention possible in the life of the person in respect of whom the application is made, having regard to the degree of that person's incapacity:
  - (b) to enable or encourage that person to exercise and develop such capacity as he or she has to the greatest extent possible.
- 3.38 This sets a high threshold for intervention and the Court will exercise great care before using its power under the Act to intervene and order treatment. Even where the treatment intervention appears necessary to prevent death, the Court must still apply these principles and be satisfied the treatment is the least restrictive available and will ultimately support the person exercising and developing capacity.<sup>103</sup>

#### Appointment of welfare guardians under section 12

- 3.39 The appointment of a welfare guardian under section 12 is very much a last resort. The Court cannot appoint a welfare guardian unless it is satisfied that the person “*wholly* lacks the capacity to make or communicate decisions” in respect of aspects of his or her care or welfare and “the appointment of a welfare guardian is the only satisfactory way to ensure that appropriate decisions are made relating to those particular aspects of the person’s personal care and welfare”.<sup>104</sup>
- 3.40 The order must specify which aspects of the person’s care and welfare the welfare guardian has power to determine.<sup>105</sup> With certain important exceptions the welfare guardian may make and implement personal decisions on behalf of the person.<sup>106</sup> An important exception is that the guardian cannot refuse to consent to any standard medical treatment or procedure intended to save the person’s life or to prevent serious damage to the person’s health.<sup>107</sup> A welfare guardian who wanted to refuse standard treatment would need to apply for a specific order under section 10 because only the Court may make that decision for a person.

#### *Mental Health (Compulsory Assessment and Treatment) Act 1992*

- 3.41 People can be compulsorily assessed and treated under the Mental Health (Compulsory Assessment and Treatment) Act 1992. The Act provides a three stage process for assessment and review which may result finally in the making of a compulsory treatment order. A review is available at each stage to minimise the opportunities for unnecessary compulsion.<sup>108</sup>

103 *Re CMC* [1995] NZFLR 538, at [543] also reported as *Re C* [PPPR] 13 FRNZ 112, at [117].

104 Protection of Personal and Property Rights Act 1988, s 12(2).

105 Protection of Personal and Property Rights Act 1988, s 12(1).

106 Protection of Personal and Property Rights Act 1988, ss 11 and 19(1).

107 They also cannot consent to electro-convulsive treatment, surgical or chemical lobotomy, or to medical experimentation (except where conducted to save the person’s life or preventing serious harm) on behalf of the person; see Protection of Personal and Property Rights Act 1988, ss 11 and 18.

108 P D G Skegg and Ron Paterson, above n 65, at [363].

## The staged assessment and treatment process

- 3.42 The process begins with an application to the Director of Area Mental Health Services for a compulsory assessment. Anyone who believes that a person may be suffering from a mental disorder may make an application. The application must be supported by a doctor's certificate stating that in the doctor's opinion there are reasonable grounds for believing that the person may be suffering from a mental disorder and giving reasons for this. Once a valid application is received, the Director of Area Mental Health Services must ensure that the proposed patient is examined and assessed "forthwith".<sup>109</sup>
- 3.43 The Act provides that the examination must be conducted by a psychiatrist, or failing this, a doctor with specific credentials approved by the Director of Area Mental Health Services for that purpose.<sup>110</sup> Following this preliminary clinical assessment by such a specialist, a person can be detained for a period of five days (**the first period**) for further compulsory assessment and treatment. During the first period the patient and various other people with an interest in the matter, including the applicant, may apply at any time to the Family Court<sup>111</sup> for a review of the decision.<sup>112</sup> The Court has the power to discharge a patient who the judge considers to be no longer mentally disordered.<sup>113</sup>
- 3.44 During the first period the patient is treated as necessary. The degree of intervention authorised during the preliminary stages of the process is the minimum necessary to preserve the person's health and safety. If at any stage the patient is considered fit to be released, he or she must be discharged. If the responsible clinician believes that the person still exhibits a mental disorder and further compulsion is necessary, the clinician is authorised to maintain compulsory assessment and treatment for a further 14 days (**the second period**). A certificate authorising the second period must be completed during the first period and copies sent to certain people specified in the Act. These include the patient, the applicant, the patient's doctor and also a district inspector.
- 3.45 The involvement of a district inspector at this stage adds an important protection. The district inspector is obliged to talk to the patient and decide whether an application should be made to the Court for a review of the patient's condition. If the district inspector is of the view that an application should be made, he or she may encourage and assist the patient or any other recipient of the certificate to make the application for review. The district inspector may also report the matter to the Court, which may review the patient's condition of its own motion.
- 3.46 The responsible clinician must issue a final certificate of assessment during this second period of assessment. If the clinician believes that the person still exhibits a mental disorder and further compulsion is necessary, he or she must apply to the Court for a compulsory treatment order.

109 *Sestan v Director of Area Mental Health Services Waitemata DHB* [2007] 1 NZLR 767 (CA) at [paras 26 and 27].

110 Mental Health (Compulsory Assessment and Treatment) Act 1992, s 9(3).

111 Where a Family Court judge is not available another District Court judge may undertake the review.

112 We should also note that the person can also challenge his or her detention for a preliminary assessment under the New Zealand Bill of Rights Act 1990 or by way of a habeas corpus application.

113 Mental Health (Compulsory Assessment and Treatment) Act 1992, s 16.



## Compulsory treatment orders

- 3.47 At the stage an application is made to the Court for a compulsory treatment order there is a comprehensive clinical assessment available to the Court and a proposed plan for any necessary further compulsory treatment. At each stage, as there is greater interference with the person's autonomy, greater certainty of diagnosis is required and additional safeguards are also applied.
- 3.48 Where an application for a compulsory treatment order is made by the responsible clinician, the patient can be detained for assessment and treatment for a further period of 14 days beyond the expiry of the second period to allow the Court time to hear the application. The Court may extend this period by up to one month if the judge believes it is not practicable to determine the application within the 14 day time frame. An application that is not determined within the additional month must be dismissed and the person must be immediately released.
- 3.49 The Court may make a compulsory treatment order if it considers that the person falls within the definition of mental disorder in the Act. Two types of orders can be made: community treatment orders or in-patient treatment orders. There is a presumption in the Act in favour of community treatment, so that the Court must make a community treatment order unless the patient cannot be adequately treated in the community. The presumption means that the obligation is to impose the minimal level of intervention necessary. Compulsory treatment orders normally expire after six months, but can be reviewed and extended beyond this.<sup>114</sup>

## Definition of mental disorder

- 3.50 The definition of “mental disorder” must be met at all stages of the assessment and treatment process. It is not lawful to detain people beyond the first period unless they are (or are reasonably thought to be) mentally disordered. A “mental disorder” is defined in section 2 of the Act to mean:
- an abnormal state of mind (whether of a continuous or an intermittent nature), characterised by delusions, or by disorders of mood or perception or volition or cognition, of such a degree that it—
- (a) poses a serious danger to the health or safety of that person or of others; or
- (b) seriously diminishes the capacity of that person to take care of himself or herself.
- 3.51 Brookbanks says the threshold “is thus a legal construct, not a clinical diagnosis”.<sup>115</sup> The legal test contains two parts: there must be an abnormal state of mind (whether continuous or intermittent in nature) characterised by delusions, or disorders of mood, perception, volition or cognition; and this state of mind must either: (a) pose a serious danger to the person or others; or (b) seriously diminish the person's capacity to take care of himself or herself.

<sup>114</sup> Applications for extensions are effectively treated as new applications so the review is extensive. After a third extension an indefinite order may be made. Patients retain rights to periodic clinical and judicial reviews; see Mental Health (Compulsory Assessment and Treatment) Act 1992, s 76.

<sup>115</sup> P D G Skegg and Ron Paterson, above n 65, at [364].



- 3.52 The second part of this test essentially involves a risk assessment to determine whether the abnormal state of mind is of sufficient magnitude to justify the compulsory assessment and treatment of the person. Factors that are relevant to determining whether a serious danger is posed include: the nature and magnitude of the harm involved; its imminence or frequency; and any situational circumstances and conditions that influence the likelihood of the harm or its imminence.<sup>116</sup> Regard should be had not just to the possibility of physical harm, but also to the impact of the person's behaviour on the psychological and emotional wellbeing of himself or herself and on others.<sup>117</sup> Mere neglect is not sufficient to demonstrate that the person has diminished capacity to care for himself or herself. Personal care must be compromised to such a degree that it puts the person's health and safety at significant risk.<sup>118</sup>
- 3.53 The risk of serious danger or harm from impaired care should also be balanced against the impact that an intervention of the type proposed will have on the person. Due regard must be had to the individual freedoms contained in the Bill of Rights Act.<sup>119</sup>
- 3.54 It is worth noting here that the definition of mental disorder does not directly require a determination of incapacity to consent to or refuse treatment. While many people will be incapable of giving or refusing consent because their mental disorder is continuous or is of a nature that impairs their capacity, others are likely to have at least fluctuating capacity. In contrast to the common law and to most cases under the Protection of Personal and Property Rights Act,<sup>120</sup> therefore, the Mental Health (Compulsory Assessment and Treatment) Act does limit the right of a competent adult to refuse medical treatment.

#### Limits on compulsory treatment

- 3.55 Limits have been placed on the power to compulsorily treat persons detained under the Act. Patients are of course required to accept any treatment as directed by the responsible clinician while they are undergoing assessment. They are also required to accept any treatment for their mental disorder that the responsible clinician directs during the first month after a compulsory treatment order is made.<sup>121</sup> But they are entitled to refuse any medical (including psychiatric) treatment that has not been prescribed for their mental disorder.

116 These criteria are taken from the discussion of relevant Mental Health Review Tribunal cases in D Webb, M Henaghan, B Atkin et al (eds) *Butterworths Family Law in New Zealand Vol 2* (13<sup>th</sup> ed, LexisNexis, Wellington, 2007) at [376].

117 *R W D* (1994) 12 FRNZ 387, at [403].

118 P D G Skegg and Ron Paterson, above n 65, at [403].

119 *R W D*, above n 117, at [403].

120 The Protection of Personal and Property Rights Act 1988 authorises the treatment of a competent adult if they wholly lack the ability to communicate their decisions.

121 Mental Health (Compulsory Assessment and Treatment) Act 1992, ss 57, 58 and 59.

*Section 36 of the Policing Act 2008*

- 3.56 For completeness we note also the power in section 36 of the Policing Act 2008 to temporarily detain and care for acutely intoxicated people who are a risk to themselves and need medical or other supervision for a short time while they sober up.<sup>122</sup> Under section 36, police have powers to take an intoxicated person found in a public place or trespassing on private property to the person's home, or to a temporary shelter, or if it is not reasonably practicable to provide for the person's care and protection in his or her home or at a temporary shelter, into custody. Police officers may only exercise these powers where they believe that people are incapable of looking after themselves, or are likely to cause physical harm to another person or significant damage to property.
- 3.57 A person can normally only be detained for 12 hours under section 36, although provision is made for detention for a further 12 hours where this is necessary and a health practitioner is satisfied that the person is still intoxicated and incapable of caring for himself or herself. Most of the intoxicated people picked up by police under section 36 only need supervision briefly and sober up within a few hours.
- 3.58 A few need emergency medical intervention. In an emergency or life threatening situation or in any other similar situation where it is not practicable to communicate with a person and obtain consent, the common law principle of necessity allows such action as is reasonable in the circumstances to be taken in the best interests of the person.<sup>123</sup> Under this principle, treatment can be provided by emergency services to manage severely intoxicated people where their safety and that of others is at risk. But treatment should not normally extend beyond that which is necessary to address that situation.<sup>124</sup>

**Summary**

- 3.59 The statutory schemes discussed here demonstrate that the law places a very high value on personal autonomy and self determination. Although the right to refuse medical treatment is not absolute, the threshold for justifying compulsory treatment is high.
- 3.60 The objective to be achieved by the compulsion needs to be of sufficient public interest to justify overriding a person's rights. Public health legislation protects the important public interest of preventing the spread of infectious disease. The risk of harm to other people and to society more generally that is posed by infectious disease is sufficient to justify detaining people in quarantine or requiring them to submit to examination and testing where they are suspected of carrying an infectious disease. Where a health emergency has been declared because there is a risk of an epidemic, health officials have greater powers to detain and also (in specific situations) treat people without consent.

122 Section 36 dealing with the care and protection of intoxicated people replaced s 37A of the Alcoholism and Drug Addiction Act 1966 which was repealed from 1 September 2008 and had previously provided police with similar powers.

123 *Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1 (HL), at [73–74].

124 There is some question as to whether the common law justification of necessity would be applied in non-emergency situations in New Zealand given the existence of various legislative provisions for addressing these. See the discussion in P D G Skegg and Ron Paterson, above n 65, at [250].

- 3.61 A different, but similarly important public interest, of protecting vulnerable incapacitated adults from serious harm is protected by the Protection of Personal and Property Rights Act and the Mental Health (Compulsory Assessment and Treatment) Act. Where people are at risk of serious harm because they do not have sufficient capacity to make decisions over their own personal care and medical treatment, intervention that overrides their right to determine these matters for themselves can be justified if it is necessary to protect them from harm and help to restore their capacity.<sup>125</sup>
- 3.62 In many of the legislative schemes there is also a connection between the nature of the intervention and the objective or public interest that it is intended to protect. In addition, as is most evident in more recent legislation, the limitations imposed on a person's rights should go no further than is necessary to achieve that objective.
- 3.63 In the public health area this approach is most readily seen in the Public Health Bill which contains overarching principles requiring officials and the courts to give preference to the least restrictive measure available. Where the public interest objective can be achieved by isolating a person in quarantine, this is preferred to compulsory treatment. The Court, when considering an application under the Protection of Personal and Property Rights Act, is required to make the least restrictive intervention possible in the life of the incapacitated person having regard to the degree of the person's incapacity, and should do this so as to enable the person to exercise and develop his or her capacity to the greatest extent possible.

## SEVERE ALCOHOL AND DRUG DEPENDENCE

- 3.64 In the case of people who are dependent on alcohol and drugs, there is an equally important public interest that is served by intervening to protect them where they have, as a result of their dependence, a significantly diminished capacity to care for themselves and are consequently at risk of serious harm. Some of these people cause harm not only to themselves but also to others such as family members. There would seem to be two groups of people that fall into this category and are not covered by the Mental Health (Compulsory Assessment and Treatment) Act:
- Firstly, people who would otherwise be considered to be suffering from a mental disorder because they have an abnormal state of mind that would meet the test in the Mental Health (Compulsory Assessment and Treatment) Act for compulsory treatment have been expressly excluded from that Act if their mental disorder has resulted solely from substance abuse.<sup>126</sup> In practice some of these people are, prior to a diagnosis of substance abuse, compulsorily treated under the Mental Health (Compulsory Assessment and Treatment) Act because it is not immediately apparent that their disorder is solely attributable to alcohol or drug use. However, once this is diagnosed they cannot be treated under that Act.

<sup>125</sup> In the case of mental health legislation we have noted that the test for intervention is not directly one of incapacity but turns on whether a person suffers from a mental disorder which is an abnormal state of mind of a magnitude that poses a serious risk of harm to either themselves or others.

<sup>126</sup> A specific exclusion in s 4(d) of the Mental Health (Compulsory Assessment and Treatment) Act 1992 prevents that Act being used where a person meets the criteria solely as a result of substance abuse.

- Secondly, other people suffer from substance dependence that does not give rise to a mental disorder but that seriously impairs their capacity to make rational choices about their substance use and their personal welfare. Whether these people have impaired volition (at least in the sense that that term is used as part of the definition of mental disorder under the Mental Health (Compulsory Assessment and Treatment) Act) is a complex question. Most probably do, but not everyone who experiences a disorder of mood, perception, volition or cognition should be diagnosed as having “an abnormal state of mind”, which is a pre-requisite for a diagnosis of mental disorder under that Act.
- 3.65 In our view, protecting both of these groups from harm is a sufficiently important objective to justify intervention. For both groups the use of and dependence on alcohol and drugs has resulted in a seriously diminished capacity to function and preserve their own health and safety. We suggest that intervention may be justified where those who fall into one of these groups are also at risk of causing significant harm to themselves. Beyond protecting these two groups we do not think that there is sufficient public interest to justify coerced treatment. As we have already noted, in an emergency or life threatening situation, the common law principle of necessity allows reasonable care and treatment to be given to an unconscious or otherwise incapacitated person.<sup>127</sup>

#### A rational connection

- 3.66 There should be a rational connection between the intervention and the important objective it serves. In this context that essentially means considering whether compulsory treatment is an effective form of intervention and what it can achieve.
- 3.67 Very little research has been done either in New Zealand or elsewhere on the effectiveness of coerced treatment of people who are not offenders. A systematic review of international research on the effectiveness of compulsory treatment of chronic alcohol or drug addiction in non-offenders was undertaken for the Ministry of Health in 2008.<sup>128</sup> That review found that most of the international research compared the outcome of voluntary and compulsory treatment of offender populations in the criminal justice system. While many of the studies comparing offenders identify positive outcomes from coerced treatment, it is not known whether these findings can be generalised to also cover non-offenders.<sup>129</sup>
- 3.68 Very little research has been carried out on the compulsory treatment of civilian population groups, so there is a little reliable evidence comparing the efficacy of compulsory treatment with voluntary treatment for this group.<sup>130</sup>
- 3.69 Two comprehensive literature reviews undertaken in Australia have similarly found little reliable evidence comparing compulsory with voluntary treatment. In 2004 the Legislative Council’s Standing Committee on Social Issues in New South Wales, in the course of reviewing the Inebriates Act 1912 (NSW),

127 *Re F (Mental Patient: Sterilisation)*, above n 123, at [73–74].

128 Broadstock M, Brinson D, and Weston A *The Effectiveness of Compulsory, Residential Treatment of Chronic Alcohol or Drug Addiction in Non-offenders* (Health Services Assessment Collaboration, 2008).

129 Broadstock M, Brinson D, and Weston A, above n 128, at [39].

130 Broadstock M, Brinson D, and Weston A, above n 128, at [39].

was unable to find significant evidence of the efficacy or otherwise of compulsory treatment of individuals with alcohol or drug dependence.<sup>131</sup> A separate comprehensive literature review undertaken by Turning Point for the Victoria Government,<sup>132</sup> as part of Victoria's review of its Alcoholic and Drug-dependent Persons Act 1968 (Vic), also concluded that there is no available evidence to support or reject compulsory treatment for non-offenders.<sup>133</sup> (These two Australian reviews are discussed in chapter 4.)

- 3.70 It is important not to misunderstand the lack of evidence about the relative effectiveness of compulsory and voluntary treatment. Firstly, it does not imply that treatment is not effective. In fact we know from many studies that treatment is effective at reducing substance use and improving health and well-being. There is a significant body of evidence that demonstrates more generally the effectiveness of alcohol and drug treatment for dependence.<sup>134</sup> A number of studies also show that treatment is a cost effective intervention.<sup>135</sup> Secondly, it also does not mean that compulsory treatment is less effective than voluntary treatment. There is evidence available showing that coerced alcohol and drug treatment for offenders can be as effective as voluntary treatment.<sup>136</sup> What is missing, however, is robust evidence comparing the efficacy of compulsory treatment with voluntary treatment for non-offenders.
- 3.71 While evidence of that nature is unavailable, many experts and many working in the alcohol and drug treatment sector consider that compulsory treatment can be effective in some situations for some people. Most of those we consulted considered that the short-term use of compulsion is effective where there is an imminent risk to a person's health or safety and the person is incapable, because of his or her dependence, of making decisions about his or her drug use and personal welfare. In these circumstances most agree that compulsion can be effective to get people to a position where they can more readily help themselves.<sup>137</sup>
- 3.72 There is, however, no consensus across the sector over the effectiveness of compulsion in other situations. For example, some in the sector believe there is evidence that ongoing compulsion is not effective. The Mental Health

131 Legislative Council Standing Committee on Social Issues *Report on the Inebriates Act 1912* (Legislative Council report 33, Sydney, 2004), at [77].

132 A Swan and S Alberti *The Alcoholics and Drug-dependent Persons Act (ADDPA) 1968: A Review* (Turning Point Alcohol and Drug Centre, 2004, Melbourne).

133 Victorian Government Department of Human Services *Review of the Alcoholics and Drug-dependent Persons Act 1968* (Victorian Government Department of Human Services, Melbourne, 2005), at [10].

134 For example see A Swan and S Alberti, above n 132.

135 For example see National Committee for Addiction Treatment (NCAT) *Investing in Addiction Treatment – A Resource for Funders, Planners, Purchasers and Policy Makers* (NCAT, Christchurch, 2008). See also the discussion summarising the evidence available for various forms of treatment in our earlier issues paper; New Zealand Law Commission *Controlling and Regulating Drugs* (NZLC IP 16, Wellington, 2010), at [paras 15.4–15.43]

136 National Committee for Addiction Treatment (NCAT), above n 135, at [7].

137 For example, Submission of Alcohol Drug Association New Zealand (submission dated April 2010), at [5]; Submission of Odyssey House Trust, Auckland (submission dated 27 April 2010), at [3]; Submission of National Committee for Addiction Treatment (NCAT) (submission dated 23 April 2010), at [4]; and Submission of New Zealand Drug Foundation (submission dated 29 April 2010), at [5]; Submission of Waitemata District Health Board Community Alcohol and Drug Services (submission received 30 April 2010) at [4]; and Submission of National Addiction Centre, University of Otago (submission dated 6 May 2010), at [3].



Commission submitted that forced treatment for drug addiction has been shown to be relatively ineffective for the majority of people and does little to address ongoing environmental issues that are critical in reducing substance dependence in the longer term.<sup>138</sup>

- 3.73 The Standing Committee for the New South Wales review concluded that, in the absence of evidence of efficacy, compulsory treatment could only be justified where intervention was necessary either to save a severely dependent person's life or to protect him or her from serious harm.<sup>139</sup> In other words, compulsory treatment could be justified as a way of protecting a person from serious harm in order to restore capacity, but could not be justified for the purposes of treating substance dependence. Any intervention with the objective of restoring capacity should consequently only be of a short-term nature.
- 3.74 We have reached a similar conclusion. We think that a rational connection can be readily demonstrated between compulsory treatment of a short-term nature aimed at protecting severely dependent persons from serious harm and restoring their capacity. There is a clear and rational connection between interventions such as detoxification and steps to stabilise a person's medical condition and the objective of restoring the person's capacity to make decisions over substance use. However, in the absence of evidence on the effectiveness of ongoing coerced treatment and the objective of reducing substance dependence, a rational connection cannot be readily demonstrated. Even if there was such evidence, it is debatable whether that objective is sufficiently important to justify such a significant limitation of a person's fundamental rights.

### Minimum intervention and a net benefit

- 3.75 Compulsion should not be used in any individual case unless the person is likely to benefit from treatment and has refused it. Proportionality requires also that the limits imposed on a person's right to refuse treatment must go no further than is necessary. The benefits of those limits must also outweigh the harm that impinging on rights will cause. For most drug and alcohol dependent people the acute risks of harm tend to be short-lived. Only a relatively short period of detention to restore capacity, during which detoxification and supporting treatment can be undertaken in appropriate facilities, can therefore be justified.
- 3.76 The literature review undertaken in Victoria found that civil committal is principally beneficial as a short-term lifesaving intervention for individuals who are unaware of the level of self harm they are inflicting. Other identified benefits include providing "time out" for people from their circumstances in a treatment setting and giving people an opportunity to acknowledge an alcohol or drug dependence and understand the available treatment options for the future.<sup>140</sup> This last benefit is sometimes described as an opportunity to engender motivation. The costs include those resulting from depriving people of their liberty and overriding their autonomy.

138 Submission from the Mental Health Commission (submission dated 11 May 2010), at [4].

139 Legislative Council Standing Committee on Social Issues, above n 131, at [6.35].

140 A Swan and S Alberti, above n 132, at [32].



- 3.77 Once a person, normally after completing detoxification, has regained capacity and there has been an opportunity to engender motivation, he or she is in a position to decide whether to voluntarily engage with ongoing treatment. We think that from this point the person must be free to determine for himself or herself whether to engage in ongoing treatment. On a practical level it is also important to remember that most ongoing drug treatment requires active cooperation and participation. Evidence indicates that alcohol and drug treatment is most successful when a person is motivated<sup>141</sup> and there are significant obstacles to treatment when he or she is not. Thus, while a short period of compulsion may provide an opportunity to motivate a person to engage with a treatment programme, the success of that programme will depend on his or her ongoing participation and active engagement.
- 3.78 From the point at which a person has regained sufficient capacity to consent to or refuse ongoing treatment, we think that the harm caused by overriding personal autonomy will far outweigh the uncertain benefits that might be achieved by ongoing compulsion. In conclusion, our assessment is therefore that compulsory treatment for alcohol and drug dependence is only justified in the following circumstances:
- a person's dependence has seriously impaired his or her capacity to make choices about ongoing substance use and personal welfare; and
  - care and treatment is necessary to protect the person from significant harm; and
  - no other less restrictive means are reasonably available for dealing with the person; and
  - the person is likely to benefit from treatment; and
  - the person has refused treatment.

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141 A Swan and S Alberti, above n 132, at [32].

# Chapter 4

## Other jurisdictions

**INTRODUCTION** 4.1 Four Australian states (New South Wales, Victoria, Tasmania and Northern Territory) make provision for the civil committal of people with substance dependence. In this chapter we briefly look at these regimes. We also give an overview of the approach taken to compulsory treatment for substance dependence in other Australian states and in the United Kingdom.

**NEW SOUTH WALES** 4.2 The Drug and Alcohol Treatment Act 2007 (NSW) provides the legal basis for a two year trial of short-term involuntary care and treatment of adults living in areas covered by the Sydney West Area Health Services.<sup>142</sup> The Act and the trial under it result from a detailed and systematic examination of the outdated Inebriates Act 1912 (NSW) by the Standing Committee on Social Issues of the Legislative Council of New South Wales. The Committee recommended the repeal of the Inebriates Act and its replacement with legislation providing for short-term involuntary care for people with substance dependence whose decision-making capacity is compromised so they are at risk of serious harm, for the purpose of protecting their health and safety.<sup>143</sup>

4.3 In response to the Committee's report the Drug and Alcohol Treatment Act was enacted and the trial of a new regime based on the Committee's recommendations was begun in West Sydney. The Inebriates Act remains in place for the rest of New South Wales during the trial, although it is likely to be repealed if that trial is successful.<sup>144</sup>

### Drug and Alcohol Treatment Act 2007 (NSW)

4.4 The Act provides for the involuntary detention of a person who has severe substance dependence. The intention is to provide short-term detoxification and treatment in order to restore a person's capacity to engage voluntarily in longer-term rehabilitation services.

<sup>142</sup> Regulations made under the Act provide that these are "Auburn, Blacktown City, Blue Mountains City, Hawkesbury City, Holroyd City, Lithgow City, Parramatta City (other than the site of the Cumberland Hospital), Penrith City and The Hills Shire". See Regulation 4 of the Drug and Alcohol Treatment Regulations 2009.

<sup>143</sup> Legislative Council Standing Committee on Social Issues *Report on the Inebriates Act 1912* (Legislative Council report 33, Sydney, 2004) Recommendations 1 & 2 at [66] and [105].

<sup>144</sup> New South Wales Government *NSW Government Response to the Report on the Inebriates Act 1912* *Legislative Council Standing Committee on Social Issues*, [www.parliament.nsw.gov.au](http://www.parliament.nsw.gov.au).

- 4.5 The objects of the Act are:<sup>145</sup>
- (a) to provide for the involuntary treatment of persons with a severe substance dependence with the aim of protecting their health and safety, and
  - (b) to facilitate a comprehensive assessment of those persons in relation to their dependency, and
  - (c) to facilitate the stabilisation of those persons through medical treatment, including, for example, medically assisted withdrawal, and
  - (d) to give those persons the opportunity to engage in voluntary treatment and restore their capacity to make decisions about their substance use and personal welfare.
- 4.6 Although the Act authorises the detention of a dependent person for the purposes of involuntary treatment, there are a number of safeguards around the exercise of this power. The objects section requires the Act to be interpreted, and the functions conferred by the Act to be performed, so far as practicable to ensure that:<sup>146</sup>
- involuntary detention and treatment is a consideration of last resort;
  - the interests of a person involuntarily detained and treated under the Act are paramount in all decision-making about him or her under the Act;
  - a person involuntarily detained under the Act will receive the best possible treatment in the least restrictive environment that will enable treatment to be effectively given; and
  - any interference with the rights, dignity and self-respect of a person involuntarily detained under the Act will be kept to the minimum necessary.
- 4.7 An accredited medical practitioner may only issue a “dependency certificate”, stating that the person may be detained for a specified period if, after assessing the person, he or she determines that:<sup>147</sup>
- (a) the person has a severe substance dependence, and
  - (b) care, treatment or control of the person is necessary to protect the person from serious harm, and
  - (c) the person is likely to benefit from treatment for his or her substance dependence but has refused treatment, and
  - (d) no other appropriate and less restrictive means for dealing with the person are reasonably available.
- 4.8 The accredited practitioner may have regard to any serious harm that may occur to:<sup>148</sup>
- (a) children in the care of the person, or
  - (b) dependants of the person.

145 Alcohol and Drug Treatment Act 2007 (NSW), s 3(1).

146 Alcohol and Drug Treatment Act 2007 (NSW), s 3(2).

147 Alcohol and Drug Treatment Act 2007 (NSW), s 9.

148 Alcohol and Drug Treatment Act 2007 (NSW), s 9(4).

- 4.9 “A severe substance dependence” is defined in the Act to mean the person:<sup>149</sup>
- (a) has a tolerance to a substance, and
  - (b) shows withdrawal symptoms when the person stops using, or reduces the level of use of, the substance, and
  - (c) has lost the capacity to make decisions about his or her substance use and personal welfare due primarily to his or her dependence on the substance.
- 4.10 The dependency certificate must be for no more than 28 days and the practitioner must, as soon as practicable after issuing the certificate, bring the person before a magistrate to review the issuing of the certificate.<sup>150</sup> In a review, the magistrate may confirm the issuing of the dependency certificate for the same or a shorter period, or order that the person be discharged.<sup>151</sup>
- 4.11 An accredited medical practitioner can apply to a magistrate to extend the period of a dependency certificate if the practitioner is satisfied that the person is suffering from alcohol- or drug-related brain injury and more time is needed for treatment or to plan the person’s discharge. The extension can be for no more than three months from the date of issue of the dependency certificate.<sup>152</sup> The accredited medical practitioner may decide to release the detained person at any time if he or she is satisfied that continued detention will not achieve the purpose of treatment.<sup>153</sup> If a person consistently refused to engage in treatment while detained, he or she might be released under this provision. The Act requires the discharge of any dependent person if the person no longer meets the criteria for detention and treatment.
- 4.12 The Act provides for information to be promptly given to the dependent person about his or her legal rights and other entitlements<sup>154</sup> and appeal rights.<sup>155</sup>
- 4.13 There is also provision for the involvement of the dependent person’s family. A dependent person may appoint a primary carer.<sup>156</sup> Notice of the detention must be given to the person’s primary carer within 24 hours of the issue of the certificate.<sup>157</sup> The primary carer should also receive notice of certain events: that the person is absent without permission; that the person has been discharged; or that an application has been made to extend the period of the dependency certificate.<sup>158</sup>
- 4.14 The Act is designed to ensure that the person is adequately assessed by an appropriate medical practitioner. A dependency certificate can only be issued by an accredited medical practitioner after he or she has assessed the person.<sup>159</sup> An

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149 Alcohol and Drug Treatment Act 2007 (NSW), s 5.

150 Alcohol and Drug Treatment Act 2007 (NSW), s 14.

151 Alcohol and Drug Treatment Act 2007 (NSW), s 34.

152 Alcohol and Drug Treatment Act 2007 (NSW), s 36.

153 Alcohol and Drug Treatment Act 2007 (NSW), s 25.

154 Alcohol and Drug Treatment Act 2007 (NSW), s 16.

155 Alcohol and Drug Treatment Act 2007 (NSW), s 18.

156 Alcohol and Drug Treatment Act 2007 (NSW), s 13.

157 Alcohol and Drug Treatment Act 2007 (NSW), s 17.

158 Alcohol and Drug Treatment Act 2007 (NSW), s 19.

159 Alcohol and Drug Treatment Act 2007 (NSW), s 9.

accredited medical practitioner is appointed by the Director-General of Health. If the practitioner is unable to access the person to conduct the assessment requested, a magistrate may make an order authorising the practitioner to visit and assess the person.<sup>160</sup> The order gives accredited medical practitioners (and any other person authorised under the Act to assist them) authority to enter premises, if need be by force, to carry out the assessment.

## VICTORIA

- 4.15 The Victorian Government recently reviewed the Alcoholics and Drug-dependent Persons Act 1968 (Vic). The outcome of the review is a new Act, which received assent on 10 August 2010. It is scheduled to come into operation by March 2011.<sup>161</sup>

### Severe Substance Dependence Treatment Act 2010 (Vic)

- 4.16 The Severe Substance Dependence Treatment Act 2010 (Vic) provides for the detention and treatment of persons with severe substance dependence. The objects of the Act are:<sup>162</sup>

- (a) to provide for the detention and treatment of persons with a severe substance dependence where this is necessary as a matter of urgency to save the person's life or prevent serious damage to the person's health; and
- (b) to enhance the capacity of those persons to make decisions about their substance use and personal health, welfare and safety.

- 4.17 Two guiding principles of interpretation are also included in the Act. The objects and all the operative provisions must be interpreted consistently with the principles that:<sup>163</sup>

- detention and treatment under the regime should be considered a last resort; and
- any limitations on the human rights or interference with the dignity and self-respect of a person must be kept to the minimum necessary.

- 4.18 A person may only be detained for treatment if:<sup>164</sup>

- he or she is 18 or older; and
- has a severe substance dependence; and
- immediate treatment is necessary and urgent to save the person's life or to prevent serious damage to the person's health; and
- the treatment can only be provided by admitting the person to a treatment centre; and
- a less restrictive means of providing treatment is not reasonably available.

160 Alcohol and Drug Treatment Act 2007 (NSW), s 10.

161 Severe Substance Dependence Treatment Act 2010 (Vic), s 2(2).

162 Severe Substance Dependence Treatment Act 2010 (Vic), s 3(1).

163 Severe Substance Dependence Treatment Act 2010 (Vic), s 3(2).

164 Severe Substance Dependence Treatment Act 2010 (Vic), s 8.



- 4.19 “A severe substance dependence” is defined to mean:<sup>165</sup>
- (a) the person has a tolerance to a substance; and
  - (b) the person shows withdrawal symptoms when the person stops using, or reduces the level of use of, the substance; and
  - (c) the person is incapable of making decisions about his or her substance use and personal health, welfare and safety due primarily to the person’s dependence on the substance.
- 4.20 The term “treatment” is given quite a restricted meaning within the Act. “Treatment” is anything done in the course of exercising professional skills to provide medically assisted withdrawal from a severe substance dependence or to lessen the ill effects, or the pain and suffering, of the withdrawal.<sup>166</sup> The focus of the Victorian Act is therefore narrower than the New South Wales Act. It only authorises detention of a person suffering from severe substance dependence for medically assisted withdrawal (detoxification). The time limits imposed on detention are consequently shorter. Detention and treatment orders made under the Act can authorise up to 14 days detention.
- 4.21 Another important difference from the New South Wales model is that under the Act the Magistrates’ Court, and not a specialist medical practitioner, determines whether a person should be detained and treated. An application for a detention and treatment order may be made to the Court by any person aged 18 years or over.<sup>167</sup> The application must include a current recommendation for detention and treatment by a prescribed registered medical practitioner who has personally examined the person within 72 hours of making the recommendation.<sup>168</sup> Before making the recommendation the medical practitioner needs to be of the opinion that the person meets the criteria for detention and treatment and must consult the senior clinician of the treatment centre at which it is proposed the person would be detained.<sup>169</sup> The senior clinician or manager of the treatment centre is required to provide the Court with a certificate outlining the facilities and services available at the treatment centre (if any) for the treatment of the person who is the subject of the application.<sup>170</sup>
- 4.22 The Court must hear the application within 72 hours of the application being filed. The person who is the subject of the application has the right to appear and take part in the hearing. The Court may make an order if:<sup>171</sup>
- it is satisfied, on the balance of probabilities, that each of the criteria for detention and treatment applies to the person (the onus of proof is on the applicant);
  - detention and treatment at a treatment centre is necessary, having regard to all relevant matters;

165 Severe Substance Dependence Treatment Act 2010 (Vic), s 5.

166 Severe Substance Dependence Treatment Act 2010 (Vic), s 6.

167 Severe Substance Dependence Treatment Act 2010 (Vic), s 10(1).

168 Severe Substance Dependence Treatment Act 2010 (Vic), s 10(1)(b).

169 Severe Substance Dependence Treatment Act 2010 (Vic), s 12.

170 Severe Substance Dependence Treatment Act 2010 (Vic), s 14.

171 Severe Substance Dependence Treatment Act 2010 (Vic), s 20(2).

- the Court has obtained a certificate from the senior clinician or manager of the treatment centre outlining the facilities and services available at the treatment centre.

- 4.23 As has been noted, the Court may authorise the detention and treatment of the person for a period of 14 days following admission of the person to the treatment centre.<sup>172</sup> The Act expressly states that a person who is held under a detention and treatment order may be treated without his or her consent.<sup>173</sup>
- 4.24 A person who is subject to a detention and treatment order may at any time apply to the Magistrates' Court to have the order revoked. The Court must revoke an order if it is satisfied that one or more of the criteria for detention and treatment no longer apply.<sup>174</sup> In addition, the Act requires the senior clinician at the treatment centre to discharge a person if the senior clinician forms the opinion that one or more of the criteria for detention and treatment no longer apply.<sup>175</sup>
- 4.25 There are some important safeguards in the Act concerning the rights of individuals detained under an order. First, they may nominate another person to protect their interests.<sup>176</sup> Secondly, they and their nominated person must be given a statement of their rights and entitlements within 24 hours of being admitted.<sup>177</sup> Thirdly, an official called the public advocate must also be notified within 24 hours that they have been admitted.<sup>178</sup> The role of the public advocate is similar to that of a district inspector under the New Zealand Mental Health (Compulsory Assessment and Treatment) Act 1992. The advocate must visit individuals detained as soon as practicable after their detention and then may make representations on their behalf or act for them or provide advice to them on their rights and entitlements under the legislation.<sup>179</sup>

## TASMANIA

- 4.26 Under the Alcohol and Drug Dependency Act 1968 (Tas), a person can be detained in a treatment centre for up to six months. An application for treatment may be made personally by a person suffering, or appearing to be suffering, from alcohol or drug dependency or may be made by the person's relative or by an official called a welfare officer who is appointed under the Act to carry out this function.<sup>180</sup> The application is made to the superintendent of an approved treatment centre. Except in the case of personal applications, an application must be supported by a medical opinion given by a practitioner who has personally examined the person. The medical opinion must confirm: (a) that the person is suffering from alcohol or drug dependency to a degree that warrants his or her detention in a treatment centre for medical treatment; and (b) that it is necessary

172 Severe Substance Dependence Treatment Act 2010 (Vic), s 20(3).

173 Severe Substance Dependence Treatment Act 2010 (Vic), s 28.

174 Severe Substance Dependence Treatment Act 2010 (Vic), s 22.

175 Severe Substance Dependence Treatment Act 2010 (Vic), s 35.

176 Severe Substance Dependence Treatment Act 2010 (Vic), s 24.

177 Severe Substance Dependence Treatment Act 2010 (Vic), s 25.

178 Severe Substance Dependence Treatment Act 2010 (Vic), s 25.

179 Severe Substance Dependence Treatment Act 2010 (Vic), s 27.

180 Alcohol and Drug Dependency Act 1968 (Tas), s 23.

to detain the person for the protection of his or her health and safety or to protect others.<sup>181</sup> Applications for discharge are heard by the Alcohol and Drug Dependency Tribunal.<sup>182</sup>

- 4.27 A review of the 1968 Act is currently being undertaken by the Tasmanian government for similar reasons to those that have led to New Zealand's review. The Tasmanian legislation is now out-of-date and is not in keeping with current practice and service delivery in this area. As a result, the Act is seldom invoked for involuntary treatment. The lack of protection of people's rights and the lack of mandatory oversight and safeguards (including reviews by relevant bodies and tribunals) within the Act have also been identified as a problem contributing to the need for a review. We understand that Tasmania will be seeking to establish a new legislative framework that reflects contemporary models of service provision and human rights values.

#### NORTHERN TERRITORY

- 4.28 Northern Territory has a specific legislative regime allowing compulsory detention and treatment for volatile substance abuse. Under the Volatile Substance Abuse Prevention Act 2005 (NT), a number of agencies and authorised people can apply to the Department of Health for an assessment under the Act where they believe that a child or adult is at risk of severe harm from volatile substance abuse.<sup>183</sup> Abuse of a volatile substance means misuse of the substance by deliberately inhaling it to become intoxicated. Assessments are undertaken by specialist assessors appointed under the Act. An assessor must prepare an assessment report about the person to the Chief Health Officer and the report must indicate whether the person is assessed as being at risk of severe harm.<sup>184</sup>
- 4.29 Depending on the outcome of the assessment, the Chief Health Officer may apply to the local court for a treatment order in respect of the person.<sup>185</sup> The Chief Health Officer may only apply for a treatment order in relation to the assessed person if satisfied that all of the following circumstances apply:<sup>186</sup>
- (a) the person has been assessed as being at risk of severe harm;
  - (b) a treatment programme has been recommended for the person;
  - (c) the person has not participated in a treatment programme since the assessment report was made;
  - (d) a treatment order will be in the best interests of the person; and
  - (e) the person cannot be adequately protected from severe harm in any other way.
- 4.30 Applications for treatment orders are heard and determined in the Magistrates' Court. If the Court is satisfied that the criteria (above) are met it may make a treatment order requiring the person's attendance at a treatment programme for

181 Alcohol and Drug Dependency Act 1968 (Tas), s 24.

182 Victorian Government Department of Human Services *Review of the Alcoholics and Drug-dependent Persons Act 1968* (Victorian Government Department of Human Services, Melbourne, 2005) at [6].

183 Volatile Substance Abuse Prevention Act 2005 (NT), s 33 provides that applications can be made by: police officers or authorised persons; family members of persons at risk; responsible adults for children; doctors, registered nurses, Aboriginal health workers and psychologists, and Northern Territory Families and Children service.

184 Volatile Substance Abuse Prevention Act 2005 (NT), s 34.

185 Volatile Substance Abuse Prevention Act 2005 (NT), s 35.

186 Volatile Substance Abuse Prevention Act 2005 (NT), s 35(2)

up to 16 weeks.<sup>187</sup> This period can be extended by the Court, if necessary, for up to a further 16 weeks.<sup>188</sup> The range of treatment programmes that are available under the Act include residential programmes, treatment for withdrawal, stabilisation and aftercare, other appropriate therapies and health, diversionary and educational interventions. Treatment orders specify the nature and components of the programme the person must attend. They may (but do not necessarily) require the person to reside at a treatment facility. Community-based treatment orders are also available.<sup>189</sup>

- 4.31 Once a court order has been made attendance is compulsory. If a person fails to participate in the court-ordered treatment programme or absconds, a treatment warrant can be obtained to compel the person to attend.<sup>190</sup> An application for a treatment warrant can be made to the Court by the Chief Health Officer or by the police.<sup>191</sup> Once a treatment warrant has been issued by the Court the person may be taken to the treatment facility specified and detained there to complete the programme.<sup>192</sup>

#### REMAINING AUSTRALIAN STATES

- 4.32 The other states within Australia do not make provision for the civil commitment of people with alcohol or drug dependence.<sup>193</sup> The Australian Capital Territory and South Australia do provide for short-term care and protection of intoxicated persons.<sup>194</sup> In Western Australia, apprehension, involuntary assessment and treatment is permitted in certain circumstances under mental health and child welfare legislation.<sup>195</sup>

#### UNITED KINGDOM

- 4.33 The United Kingdom does not have a specific scheme for the civil committal of people with alcohol and drug dependence. However, the Court of Protection<sup>196</sup> is able to exercise its powers in adult protection proceedings under the Mental Capacity Act 2005 (UK) so as to require a dependent person, who meets the test of incapacity in the Act, to reside in a treatment facility and undergo treatment. The Act is only available in those cases where a person lacks capacity (either temporarily or permanently) in relation to decisions over his or her personal welfare “because of an impairment of, or a disturbance in the functioning of, the mind or brain.”<sup>197</sup> A lack of mental capacity can be due to substance abuse.
- 4.34 Where the Court determines that a person lacks capacity to make his or her own decisions about his or her personal welfare, the Court may either: (a) make the decision or decisions on the incapacitated person’s behalf; or (b) appoint a person (a “deputy”) to make those decisions on the person’s behalf.<sup>198</sup> As a matter of

187 Volatile Substance Abuse Prevention Act 2005 (NT), s 41.

188 Volatile Substance Abuse Prevention Act 2005 (NT), s 41.

189 Volatile Substance Abuse Prevention Act 2005 (NT), s 41.

190 Volatile Substance Abuse Prevention Act 2005 (NT), s 41A.

191 A number of other people and agencies are also authorised to make applications for warrants; see Volatile Substance Abuse Prevention Act 2005 (NT), s 41A.

192 Volatile Substance Abuse Prevention Act 2005 (NT), s 41B.

193 Victorian Government Department of Human Services, above n 182 at [6].

194 Legislative Council Standing Committee on Social Issues, above n 143, at [28].

195 Legislative Council Standing Committee on Social Issues, above n 143, at [28].

196 The Court of Protection is a superior court of record created by s 45 of the Mental Capacity Act 2005 (UK).

197 Mental Capacity Act 2005 (UK) s 2.

198 Mental Capacity Act 2005 (UK) ss 16(2)(a) and (b).

principle the Act establishes that a court decision on the person's behalf is preferable to the appointment of a deputy.<sup>199</sup> The powers the Court gives to the deputy should be as limited in scope and duration as is reasonably practicable in the circumstances.<sup>200</sup> Before making any order, the Court must also consider the important principles set out in section 1 of the Act, which essentially require the minimum interference with a person's rights of self determination, and must also consider what is in the person's best interests.<sup>201</sup>

- 4.35 In an appropriate case, where all the necessary criteria are met, the Court has the power to make an order giving or refusing consent to drug and alcohol treatment in a specified place.<sup>202</sup> The principles and other safeguards in the Act that apply mean that in reality the Court can only ever order treatment interventions if they are necessary to protect the incapacitated person from serious harm and assist him or her to regain capacity. Once a person, normally after completing detoxification, has regained capacity, the Court has no jurisdiction to make any further decisions on his or her behalf.
- 4.36 The Mental Capacity Act contains a number of statutory safeguards for protecting the interests of people who lack capacity to make some important decisions. This includes provision for independent mental capacity advocates who can support and represent a person who is the focus of adult protection proceedings under the Act.<sup>203</sup>

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#### SUMMARY

- 4.37 There is a degree of similarity between the different regimes. Under the New South Wales, Victorian, and Northern Territory reforms, people can only be compulsorily treated where they are at risk of serious harm and less restrictive means are not available. Two other common features are the requirements for substance dependence to be severe, and for treatment to be beneficial for the person. The objectives of treatment differ slightly, although stabilising health and enhancing capacity to make future decisions about substance use and personal welfare are common to the regimes. In Victoria, however, the degree of harm a person must be exposed to before the regime is available is higher; immediate treatment must be necessary to save the person's life or prevent serious damage to their health, and treatment is limited to withdrawal management.
- 4.38 The new regimes in New South Wales and Victoria authorise compulsion only where individuals are incapable of making, or have lost the capacity to make, decisions about their substance use. In New South Wales they must also have refused treatment. The threshold for intervening under these regimes is therefore similar to that in the United Kingdom's Mental Capacity Act, where the Court may only order treatment if it is necessary to protect an incapacitated person from serious harm and assist him or her to regain capacity.

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199 Mental Capacity Act 2005 (UK) s 16(4).

200 Mental Capacity Act 2005 (UK) s 16(4).

201 The process for determining a person's best interests is set out in s 4 of the Mental Capacity Act 2005 (UK).

202 Mental Capacity Act 2005 (UK) ss 17(1)(a) and (d).

203 Mental Capacity Act 2005 (UK) s 36.



# Chapter 5

## A new compulsory treatment regime

**INTRODUCTION** 5.1 We concluded in chapter 3 that compulsory treatment for alcohol and drug dependence can be justified under the New Zealand Bill of Rights Act 1990. The key features of a new regime are considered below.

- OBJECTIVES OF THE NEW REGIME**
- 5.2 The objectives of a new regime should be clearly stated in the legislation.
- 5.3 For the reasons canvassed in chapter 3, we believe the objectives of a new regime for compulsory treatment of persons with severe substance dependence should be:
- to protect them from harm and restore their capacity to make their own decisions about their future substance use;
  - to stabilise their health through medical treatment (including supported withdrawal);
  - to facilitate a comprehensive assessment of their dependence;
  - to facilitate the planning of ongoing voluntary treatment and aftercare; and
  - to give them an opportunity to engage in voluntary treatment.
- 5.4 It is important to be clear that the use of compulsion under the proposed new regime will not ordinarily extend through a full programme of drug and alcohol treatment. Once treatment has successfully stabilised a person's health to address the risk of harm and restore sufficient capacity to allow the person to make decisions about future substance use or treatment for dependence, ongoing treatment will need to be undertaken on a voluntary basis.
- 5.5 Most of the submissions made by organisations and people working in the treatment sector supported these confined objectives. The vast majority argued that there is a place for the limited and short-term use of compulsion.<sup>204</sup> They considered that in the short-term compulsion may be effective to get people who are incapable of making rational decisions over their substance use to a position

<sup>204</sup> Fifty-one of the submissions the Law Commission received on its issues paper *Controlling and Regulating Drugs* responded to the questions on the chapter on the Alcoholism and Drug Addiction Act 1966. Of these 47 favoured the retention of a limited regime for compulsory treatment.

where they can more readily help themselves.<sup>205</sup> Many considered that compulsion should only be used in specific cases of severe acute disturbance where there is an immediate or imminent risk to health or safety.<sup>206</sup>

#### PRINCIPLES OF INTERPRETATION

- 5.6 Detention and compulsory treatment of a person under the regime should always be considered an option of last resort. Wherever possible a person should be given the opportunity to engage with treatment on a voluntary basis. Where compulsion is necessary the level of coercion utilised should be the least restrictive possible to enable effective treatment. It is essential that interferences with the rights and dignity of a person are kept to a minimum. The interests of the person under compulsion should remain at the centre of any decision-making in respect of that individual.
- 5.7 We would like to see these principles expressly included as overarching principles of interpretation. That will ensure they are applied to all decision-making under the regime. A similar approach has been taken in the New South Wales and Victorian Acts. The inclusion of interpretive principles has also become a more common feature of New Zealand legislation.
- 5.8 We recommend that provisions establishing the new regime should be interpreted, and the functions under the regime performed, consistently with the following principles:
- detention and compulsory treatment should only be considered when less restrictive options will not enable treatment to be effectively given;
  - the least restrictive intervention that will enable treatment to be effectively given should always be used where a person is being detained and treated;
  - all interferences with the rights and dignity of a person detained and compulsorily treated should be kept to the minimum necessary; and
  - the interests of the detained person should be paramount in all decision-making about him or her.

#### CRITERIA FOR COMPULSORY TREATMENT

- 5.9 In *Controlling and Regulating Drugs*, we proposed that a person should only be detained and treated when the following criteria are satisfied:<sup>207</sup>
- (a) the person has a dependence on alcohol or other drugs; and
  - (b) detention and treatment is necessary to protect the person from significant harm; and
  - (c) the person is likely to benefit from treatment but has refused treatment; and
  - (d) no other appropriate and less restrictive means are reasonably available for dealing with the person.

205 For example, Submission of Alcohol Drug Association New Zealand (submission dated April 2010) at [5]; Submission of Odyssey House Trust, Auckland (submission dated 27 April 2010) at [3]; Submission of National Committee for Addiction Treatment (NCAT) (submission dated 23 April 2010) at [4]; and Submission of New Zealand Drug Foundation (submission dated 29 April 2010) at [5].

206 For example, Submission of Odyssey House Trust, Auckland (submission dated 27 April 2010) at [3]; Submission of National Committee for Addiction Treatment (NCAT) (submission dated 23 April 2010) at [4]; Submission of New Zealand Drug Foundation (submission dated 29 April 2010) at [5]; Submission of Waitemata District Health Board Community Alcohol and Drug Services (submission received 30 April 2010) at [4].

207 New Zealand Law Commission *Controlling and Regulating Drugs* (NZLC IP16, Wellington, 2010) at [381].

Dependence was defined to mean that a person has:

- (i) a tolerance to a substance; and
- (ii) shows withdrawal symptoms when he or she reduces the level or stops using the substance; and
- (iii) has a substantially impaired capacity to make decisions about substance use and personal welfare due primarily to his or her dependence on the substance.

- 5.10 The requirement in criterion (c) that a person has refused treatment, and the requirement in criterion (d), that other appropriate and less restrictive means of treating the person are not reasonably available, capture between them the obligation imposed by the Bill of Rights Act that the degree of interference with the person's rights is the minimum necessary. In addition, the inclusion of the requirement in criterion (c) that the person must be likely to benefit from the treatment provides a further safeguard. The application of the Bill of Rights Act at an individual case level requires this type of assessment.
- 5.11 Submitters generally strongly supported the criteria.<sup>208</sup> However some from within the treatment sector questioned whether the term "dependence" was intended to equate to a clinical diagnosis of "dependence".<sup>209</sup> They drew attention to the meaning of the term in the diagnostic tests of "dependence" in diagnostic manuals like the DSM IV-R or ICD 10. There was concern that it would be confusing to use the same diagnostic term but attribute a different meaning.
- 5.12 As a consequence, we now propose to use the term "severe substance dependence" in the definition rather than "dependence". This will clarify that it is not a diagnostic term but a legal construct. The requirement is that a person has a diagnosable dependence of a magnitude or nature that substantially impairs his or her capacity to make decisions about his or her substance use and, in particular, decisions about accepting or rejecting treatment for substance dependence.
- 5.13 We also propose to change the definition in order to clarify that the impairment of capacity is in respect of decision-making over substance use and treatment for dependence. The test should centre on whether a person adequately understands his or her treatment choices and the likely consequences of having or not having the treatment and his or her capacity to make a decision based on that understanding.

208 For example, Submission of Odyssey House Trust, Auckland (submission dated 27 April 2010) at [3]; Submission of National Committee for Addiction Treatment (NCAT) (submission dated 23 April 2010) at [4]; Submission of New Zealand Drug Foundation (submission dated 29 April 2010) at [5]; Submission of Waitemata District Health Board Community Alcohol and Drug Services (submission received 30 April 2010) at [4].

209 For example, Submission of Waitemata District Health Board Community Alcohol and Drug Services (submission received 30 April 2010) at [7]; Submission of Sheridan Pooley (submission dated 29 April 2010) at [11]; Submission of Waitemata District Health Board (30 April 2010) at [3].

### Risk of harm to others

- 5.14 In *Controlling and Regulating Drugs*, we asked for feedback on whether criterion (b) should include the alternative of “or to protect other people from significant harm”. A few submissions argued for such an extension,<sup>210</sup> but the majority of submitters did not favour it.
- 5.15 Those who argue for expanding the criterion to cover other people do so because of concern that severe substance dependence causes harm not only to the person himself or herself but to others, particularly family members. Family members are sometimes harmed by risky, violent, or neglectful behaviour attributable to drug and alcohol use. They also suffer emotional distress and sometimes financial hardship. Others in the community can also be adversely affected by another’s dependence. In *Alcohol in Our Lives: Curbing the Harm* we outlined the catalogue of harms visited on third parties as a result of others’ excessive consumption.<sup>211</sup>
- 5.16 We do not in any way minimise the harm that can be experienced by the family members of a person who is substance dependent. Nevertheless, we do not support extending the criteria to include the alternative of “protecting others from serious harm”. To do so would move the focus of the test from protecting people who have a substantially impaired capacity to care for themselves and make decisions, to one of protecting others from harm. We are not convinced this can be justified.
- 5.17 It is difficult to conceive of a case in which a person has such severe substance dependence that he or she has a substantially impaired capacity to make treatment decisions for himself or herself, but at the same time is posing a serious risk of harm only to others and not himself or herself. If substantial impairment of capacity remains a criterion, therefore, we think the distinction between harm to others and harm to the person who is substance dependent is more academic than real.
- 5.18 If the protection of others from serious harm were to be included as an alternative and independent criterion, therefore, the requirement that the person have substantially impaired capacity would arguably need to be removed. We think that this would pose two related risks. First, there is a risk it expands the catchment of the regime out to include people who are well enough to care for themselves and make their own treatment decisions, but choose not to. Secondly, if the regime is available to protect others from the risk of harm, then, as some submitters noted, there is a risk that people may be compelled into treatment as a means of social control rather than to restore their health.<sup>212</sup>

210 Submission from New Zealand Law Society (submission dated 17 May 2010) at [34–35]; Submission from the Auckland District Law Society (submission dated 21 May 2010) at [14].

211 New Zealand Law Commission *Alcohol in Our Lives: Curbing the Harm* (NZLC R114, Wellington, 2010) chapter 3.

212 Submission of National Committee for Addiction Treatment (NCAT) (submission dated 23 April 2010) at [4]; Submission of the Ministry of Health (submission dated April 2010) at [31].

- 5.19 We also think that compulsory treatment on the basis of a risk of harm to others, without the existence of substantially impaired capacity, is unlikely to be a justified limitation under section 5 of the Bill of Rights Act. It would, in essence, amount to coerced treatment simply as a preventative measure.

### Recommended criteria

- 5.20 We therefore recommend that a person should only be detained and treated when all of the following criteria are satisfied:
- (a) the person has a severe substance dependence; and
  - (b) detention and treatment is necessary to protect the person from significant harm to himself or herself; and
  - (c) the person is likely to benefit from treatment for his or her substance dependence but has refused treatment; and
  - (d) no other appropriate and less restrictive means are reasonably available for dealing with the person.

The term “severe substance dependence” should be defined to mean that a person has:

- (i) a tolerance to a substance; and
- (ii) shows withdrawal symptoms when he or she reduces the level or stops using the substance; and
- (iii) has a substantially impaired capacity to make decisions about substance use and treatment for dependence primarily as a result of his or her dependence.

### MAXIMUM TIME LIMITS ON COMPULSION

- 5.21 In *Controlling and Regulating Drugs*, we proposed that the maximum period of detention and treatment should be specified in legislation.<sup>213</sup> We suggested that a maximum period of 28 days might be appropriate, with the Court being able to extend this to no more than three months in exceptional cases. These are the time limits used in the New South Wales Act.

### Maximum for initial period

- 5.22 We proposed that 28 days would be sufficient to enable a person to complete a withdrawal from substance use and to provide a brief window to engender motivation to engage with drug and alcohol treatment. A few submitters argued that this was sufficient for compulsory detoxification and assessment and to provide sufficient recovery of functioning for the affected individual to make rational choices as to his or her treatment needs, provided it could be extended in some cases.<sup>214</sup>

<sup>213</sup> New Zealand Law Commission *Controlling and Regulating Drugs*, above n 207, at [382].

<sup>214</sup> Submission of The National Addiction Centre (submission dated 6 May 2010) at [3] argued that a brief period of compulsion of 1-2 weeks with the option to extend it following review was adequate. Submission from the Mental Health Commission (submission dated 11 May 2010) at [5–6] supported the 28 day period with extensions only available in exceptional circumstances.



- 5.23 However, the National Committee for Addiction Treatment (NCAT), the Alcohol Drug Association New Zealand and a significant number of others advised us that 28 days would be inadequate to enable some people to reach the point where they are able to help themselves.<sup>215</sup> Their advice suggests that the initial maximum period of detention should be six weeks.<sup>216</sup>
- 5.24 The appropriate time period was difficult to determine in the face of competing advice. However, we think it is better to provide for a longer period of six weeks provided there are appropriate safeguards and review mechanisms to ensure that a person is not detained beyond the point where he or she no longer meets the criteria. We therefore recommend that the maximum period of detention and treatment should be six weeks unless an extension is granted.

### Extensions in exceptional circumstances

- 5.25 In *Controlling and Regulating Drugs*, we also proposed that the Family Court (rather than the District Court as under the Alcoholism and Drug Addiction Act 1966) should have the power to extend the period of compulsion beyond the initial maximum period up to a maximum of three months in total.
- 5.26 Submitters supported provision being made for extensions.<sup>217</sup> In particular, some noted that this is required for a small group of people with alcohol- or drug-related brain injuries.<sup>218</sup> While this group meets the criteria for the proposed regime, they have long-term or permanent cognitive impairment. They may need detention for longer than six weeks for two reasons.
- 5.27 First, their impairment may mean they respond more slowly than others to treatment and take longer to improve. More time may therefore be needed to assess their degree of impairment and determine whether they have reached the point where they have the capacity to make their own choices.
- 5.28 Secondly, a small number may have such a degree of impairment that they are not responsive to ongoing treatment at all and, after withdrawal management, will need ongoing residential care. Sufficient time is therefore required to make arrangements for their care (most likely under the Protection of Personal and Property Rights Act 1988). Six weeks will sometimes be inadequate for this purpose.

215 Submission of National Committee for Addiction Treatment (NCAT) (submission dated 23 April 2010) at [5]; Submission of Alcohol Drug Association New Zealand (submission dated April 2010) at [6]; Submission of New Zealand Drug Foundation (submission dated 29 April 2010) at [5]; and Submission of Odyssey House Trust, Auckland (submission dated 27 April 2010) at [5].

216 Submission of Alcohol Drug Association New Zealand (submission dated April 2010) at [6]; Submission of National Committee for Addiction Treatment (NCAT) (submission dated 23 April 2010) at [5]; and Submission of New Zealand Drug Foundation (submission dated 29 April 2010) at [5]; Submission of Odyssey House Trust, Auckland (submission dated 27 April 2010) at [5].

217 Submission of Alcohol Drug Association New Zealand (submission dated April 2010) at [6]; Submission of National Committee for Addiction Treatment (NCAT) (submission dated 23 April 2010) at [5]; and Submission of New Zealand Drug Foundation (submission dated 29 April 2010) at [5]; Submission of Odyssey House Trust, Auckland (submission dated 27 April 2010) at [5].

218 The group was identified by a number of the clinicians we consulted and we discussed with them what specific arrangements would need to be made to cater for their longer term assessment, treatment and care needs.

- 5.29 Views were divided on the length of time that would be needed in these cases. However, on the basis that there would be a requirement that any persons detained under the regime be released as soon as they no longer meet the threshold criteria, as well as an ability to seek a review from the Family Court at any stage, we recommend that the maximum period for an extension should be a further three months. Within this maximum, the Court would determine in any particular case the appropriate length of the extension.
- 5.30 We think that the Family Court should undertake this and other judicial functions under the regime because of its related experience under the Mental Health (Compulsory Assessment and Treatment) Act 1992 and the Protection of Personal and Property Rights Act. Moving these review and oversight functions to the Family Court also supports the shift away from treating severe substance dependence as a criminal rather than a health issue.
- 5.31 Under the New South Wales Act, an extension can only be applied for where the person *is* suffering from alcohol- or drug-related brain injury and additional time is needed to carry out treatment and to plan the person's discharge.<sup>219</sup> We think this is unnecessarily restrictive because it excludes complex cases where the nature of a person's cognitive damage will not have been adequately diagnosed. Accordingly, we think it should be sufficient that the person *appears to be* suffering from alcohol- or drug-related brain injury.
- 5.32 Some may argue that the scope of extensions should be drawn more widely and include others who, in exceptional circumstances, require longer than six weeks to be brought to the point where they can make informed choices for themselves over ongoing treatment. We are not convinced that this is required. We have some difficulty in seeing how a court would determine any application for an extension in these circumstances. In our view, it should not be enough for the person to merely have rejected the option of ongoing treatment, but it is not obvious what else the Court would base a judgement on.
- 5.33 We therefore recommend that the Family Court should have the power to extend the period of compulsion for up to a further three months where a person appears to be suffering from alcohol- or drug-related brain injury and additional time is needed to complete assessment and treatment, or to plan the person's discharge from the regime.

## TREATMENT FACILITIES

- 5.34 A range of treatment facilities should be authorised to accept people under the regime. These should include withdrawal management facilities (including hospital wards for medically assisted detoxification) as well as specialist residential facilities including those certified under the current Act. Where a person requires medically supported withdrawal in a hospital setting, it is likely that he or she would need to transfer after that stage is completed to a specialist drug and alcohol programme at a residential facility. Both services would need to be authorised under the regime.
- 5.35 The process of authorising or certifying suitable alcohol and drug treatment facilities to accept people committed under the regime needs to be simplified. It is not necessary to retain the current method of certifying institutions by

<sup>219</sup> Alcohol and Drug Treatment Act 2007 (NSW), s 35.

Order in Council used under the Alcoholism and Drug Addiction Act 1966. Hospitals and other institutions providing other forms of health care are certified by the Director-General of Health after being assessed under the Health and Disability Services (Safety) Act 2001.<sup>220</sup> Under the certification process in that Act, providers need to meet appropriate standards related to the type of care they provide.

- 5.36 The function of approving facilities for use under the proposed new regime should, in our view, be undertaken by the Director-General of Health in the same way as for other health services under the Health and Disability Services (Safety) Act.

### Community-based treatment

- 5.37 A difficult issue to resolve was whether treatment under the proposed regime should always be in-patient or whether treatment could be provided on an outpatient basis in the community. One of the fundamental principles underpinning the regime is that the least restrictive intervention that enables effective treatment should always be preferred. On that basis, it follows that if a person who meets the statutory criteria for compulsion can be treated adequately within the community, he or she should be.
- 5.38 We canvassed this issue during consultation and feedback was mixed. Some submitters proposed community-based treatment as a way of introducing more flexible treatment options. One or two emphasised the difficulties that occur under the current Act because everyone under compulsion is treated within four certified institutions located in Auckland, Wellington, and Christchurch. These submitters expressed concern that the current approach not only restricts the numbers who can be accommodated within the regime, but also unduly limits the options for treatment.<sup>221</sup>
- 5.39 However, while we certainly agree that a broader range of treatment options than those currently available are needed, we are not persuaded that people detained under the regime can be appropriately accommodated and treated without being required to reside in a specified facility. It is difficult to conceive of circumstances where a person would both meet the criteria for compulsion and also be capable of undertaking effective treatment as an outpatient in the community. If people are so severely impaired by substance dependence that they do not have the capacity to make informed treatment choices for themselves, they are extremely unlikely to be amenable to community-based treatment. If they are well enough to remain at home and attend a day programme, they ought not to come within the regime.
- 5.40 We are concerned also that the inclusion of community-based treatment, other than as after-care when people are discharged from the regime, would result in the extension of the regime to cover people whose condition was not sufficiently severe to warrant it. That could not be justified under the Bill of Rights Act.

220 The certification process in the Act also covers “hospital mental health care” provided under the Mental Health (Compulsory Assessment and Treatment) Act 1992.

221 For example, Submission of Waitemata District Health Board Community Alcohol and Drug Services (submission received 30 April 2010) at [9].

## VOLUNTARY PATIENTS

- 5.41 We anticipate that over time a more diverse range of residential treatment providers would be approved by the Director-General under the regime. This would ensure a broader geographical spread and include facilities providing non-medical detoxification.
- 5.42 Another difficult issue has been determining whether there is a place within a civil commitment regime of this kind for self referrals where people voluntarily place themselves under the regime. Under the current regime, a person may make a voluntary application to the Court for an order requiring his or her own detention for treatment in a certified institution. This voluntary application process is something of an enigma. We have found no parallels elsewhere on the statute book and it seems an antiquated approach to treatment.
- 5.43 During consultation with the treatment sector, some made the point that in practice some people appear to benefit from an approach that allows them to “volunteer” for compulsory treatment.<sup>222</sup> People may, for example, want to address their dependence, but believe they will be unable to do so if not under compulsion. They may perceive detention under a treatment order, because it takes the decision out of their hands, as a way of forcing themselves to make changes they recognise as beneficial.
- 5.44 We acknowledge these arguments but are not persuaded that it is appropriate to retain self-initiated applications or to provide for voluntary patients within the regime. If people have the capacity to consent to treatment, they do not meet the threshold criteria for compulsion, even if they have concerns over their ability to maintain a course of treatment on a voluntary basis. The criteria would be altered if people with the capacity to undertake voluntary treatment could, because they were at risk of relapsing, choose to be treated under the regime. Substance dependence is a long-term relapsing condition. Almost everyone who is severely substance dependent is at risk of relapse. The regime would not be the option of last resort.
- 5.45 We also do not think it is possible to justify a regime that depends on a person’s consent, but then does not allow that consent to later be withdrawn. It is a contradiction in terms to recognise consent for the purposes of opting in but not for later opting out. If people are able to later withdraw consent and opt out, participation in treatment is voluntary.
- 5.46 Finally, the regime we are proposing is intended to cater for a small number of people who cannot be effectively treated by less restrictive means. Resources are likely to be limited and it should be necessary for everyone admitted under the regime to be clinically assessed against the same threshold criteria. This would not be the case if people who did not meet the criteria were able to access the regime via an alternative route as voluntary patients.

222 This point was made at several consultation meetings including the one the Commission held with managers and staff from Nova Lodge and the Christchurch Bridge programme in Christchurch on 11 March 2010.

ASSESSMENT  
AND  
TREATMENT  
PROCESS

- 5.47 It is essential that the assessment and treatment process is readily accessible. A repeated criticism of the present Act is that it is very difficult to utilise. The process is begun by application directly to the District Court and is cumbersome and the sector reports that family members and others concerned about a person with severe substance dependence have considerable difficulty making such an application.
- 5.48 The alternative process we recommend for the proposed new regime is a committal process similar to that in the Mental Health (Compulsory Assessment and Treatment) Act. Under this model the initial committal decision is made by a specialist clinician and is reviewed (and when appropriate overruled) by the Family Court. We think that this is far preferable to requiring people to make an application directly to the Court for two reasons. First, the process is for dealing with a medical issue where there is a need to respond promptly. Secondly, a court-based process perpetuates unhelpful stereotypes that people suffering from severe substance dependence are bad rather than unwell.
- 5.49 Each stage of the proposed process is considered below. There is a degree of overlap between some. For example, review by the Court will occur while treatment is being undertaken and discharge planning will also occur while the person is in treatment. We are recommending a number of important patient safeguards that will apply from the assessment stage. These will overlay all the stages of the process. They are outlined and discussed later in paragraphs 5.63 to 5.76.

**Applications**

- 5.50 The key features of the application process should be:
- Anyone over the age of 18 who believes that a person meets the criteria for compulsory treatment should be able to make an application to have the person assessed under the regime.
  - The application should be made to an official appointed by the Director-General of Health (called the Director of Area Alcohol and Drug Services). This role would be equivalent to the role performed by the Director of Area Mental Health Services under the Mental Health (Compulsory Assessment and Treatment) Act.
  - The application should be supported by a preliminary medical certificate issued by a medical practitioner.
  - The certificate should confirm that the medical practitioner has examined the person, has reasonable grounds to believe that the person is likely to meet the criteria, and that the person should be assessed by a specialist for compulsory treatment. This medical examination would provide an opportunity for the person to go into treatment voluntarily and would filter out cases where compulsion was clearly unjustified.
  - When a preliminary medical certificate could not be issued because the person refused to cooperate, the medical practitioner would need to confirm that he or she has been unable to examine the person and issue the certificate. The practitioner should also provide any available information on the person's condition.



## Assessment

- 5.51 The key features of the assessment process should be:
- When an application is received, the Director of Area Alcohol and Drug Services should arrange for the person to be examined and assessed against the criteria for compulsion by a specialist. This specialist should have expertise in alcohol and drug dependence and treatment.
  - When an application does not include a medical certificate (because the person refuses the preliminary medical examination) the Director of Area Alcohol and Drug Services should make his or her own enquiries into the person's circumstances and determine whether there is sufficient evidence to indicate that the person is likely to meet the threshold criteria. If so, the Director should arrange for the person to be assessed against the criteria by a specialist.
  - The assessment to determine whether a person meets the threshold should always include a personal examination.
  - If the person meets the criteria, the authorised specialist should issue a certificate of dependence authorising the detention and treatment of the person.
  - Before issuing a certificate of dependence the authorised specialist would need to consult with staff at relevant treatment facilities to ensure that a suitable place is available for the person.
  - A preliminary treatment plan should be prepared for the person.
  - If a certificate is not issued (because the person does not meet the criteria) then the Director of Area Alcohol and Drug Services should ensure the person is given advice about voluntary treatment services.

## Treatment

- 5.52 When a certificate of dependence has been issued, the person should be committed to a treatment facility and detained and treated there. Responsibility for the person needs to shift at this point to the clinician responsible for the person's treatment at the treatment facility. The responsible clinician should further develop (as necessary) and oversee the treatment plan.
- 5.53 The nature of treatment provided would be determined by the objectives of the regime and the needs of the person. Treatment could include supported withdrawal and medical treatment needed to stabilise the person's health. Other treatments (including psychosocial) would also be delivered to assist the person to determine whether he or she wanted to engage in ongoing voluntary treatment.

## Review by the Court

- 5.54 Where a certificate of dependence has been issued and a person is in treatment, the responsible clinician should be required to apply to the Family Court for a review of the decision to issue the certificate. This responsibility should be on the responsible clinician because he or she has the most up to date information on the person's condition.

- 5.55 The responsible clinician should be required to apply to the Court for the review as soon as is practical but no later than seven days after the certificate has been issued. This review by the Court is an important safeguard. The review should be undertaken by a Family Court judge and should occur within seven days of the application being made. (This would mean a maximum of 14 days detention and treatment before court review.)
- 5.56 After hearing from specialists and from the person or his or her representative, the judge would determine whether the person meets the criteria for compulsory treatment. The responsible clinician would be required to place all available clinical evidence before the Court and to provide details of treatment to date and proposals for further treatment (the treatment plan).
- 5.57 If the judge is satisfied on the balance of probabilities the person meets the criteria and further treatment under the regime is appropriate, the judge would approve the treatment plan and make a treatment order. The six week maximum period would apply so the order would (unless it was discharged earlier or extended by the Court) expire six weeks after the date of the original certificate of dependence had been issued.
- 5.58 If the judge is not satisfied the person meets the criteria, he or she should discharge the person immediately.

#### Extension of period of compulsion

- 5.59 The responsible clinician should apply to the Court for an extension where this is necessary because the person appears to be suffering from alcohol- or drug-related brain injury and additional time is necessary to manage their care. (See above paragraphs 5.25–5.33)

#### Discharge planning and after-care

- 5.60 The proposed regime should place a far greater emphasis on active after-care and ongoing support for the person following discharge than does the current regime. Compulsion should be used only to stabilise a person and restore his or her capacity to make decisions about ongoing treatment. The new regime, like that in New South Wales, must make adequate provision for planning the discharge and post-discharge treatment and support of any person who is held under the regime.<sup>223</sup>
- 5.61 The responsible clinician should be required to undertake a discharge assessment and develop an after-care plan to cover the type of continuing care that will be provided to the person on a voluntary basis at the expiry of the period of compulsion.

<sup>223</sup> See Alcohol and Drug Treatment Act (NSW), s 25.

- 5.62 We recommend that a number of patient safeguards be built into the regime. These will overlay the committal process from the assessment stage onwards.

### Duty on responsible clinician to discharge a person

- 5.63 There should be a general duty imposed on the responsible clinician to discharge a person from the regime at any stage it becomes apparent that the person no longer meets the criteria for detention and treatment.

### Rights of review

- 5.64 People being held under the type of regime we have proposed will have the right to challenge their detention by an application for a writ of habeas corpus under the Habeas Corpus Act 2001. However, habeas corpus applications are made to the High Court, are generally heard in public, and involve a degree of formality. We therefore propose that the regime provide, as an alternative to habeas corpus, a more accessible right of review. We recommend that people being held and treated under a certificate of dependence should have the right, at any time after the certificate has been issued, to seek an urgent review of their detention by a Family Court judge on the grounds that they do not meet the criteria and the certificate should not have been issued. There is a similar right of review under the Mental Health (Compulsory Assessment and Treatment) Act. We do not anticipate that this right would be used very often because of the statutory requirement that all certificates of dependence are reviewed by a judge within 14 days of their being issued.

### Changes in circumstances

- 5.65 We think that after a treatment order is made by the Court, the person subject to the order should also be entitled to make an application for a subsequent review if his or her circumstances change. To avoid the risk of continual review, the judge should have a discretion to decide whether to hear an application. In making the decision whether to hear the application, the judge would consider any evidence indicating whether the person's condition has changed since the previous review. This is broadly the approach taken to subsequent reviews in the Mental Health (Compulsory Assessment and Treatment) Act.<sup>224</sup> Again we would anticipate that this provision would only rarely be used because of the standing obligation on the responsible clinician to discharge a person from compulsion at any stage he or she ceases to meet the threshold criteria.

### Patient rights and a complaints process

- 5.66 There are clear parallels between the position of people committed for treatment under the proposed regime and those treated under the Mental Health (Compulsory Assessment and Treatment) Act. Similar protections and safeguards are needed.

<sup>224</sup> Mental Health (Compulsory Assessment and Treatment) Act 1992, s 16.

- 5.67 Part 6 of the Mental Health (Compulsory Assessment and Treatment) Act contains a number of specific patient rights. Some of these are described as “status” or “contextual” rights because they derive from the person’s particular status as a compulsory patient.<sup>225</sup> These rights and the corresponding duties they impose on facilities and the staff treating patients are additional to the rights all patients have when receiving any health services. They comprise the right to:
- information about his or her rights as a patient;
  - proper respect for cultural identity and personal beliefs;
  - medical treatment and other health care appropriate to his or her condition;
  - an explanation of the expected effects of any treatment, including the expected benefits and any likely side-effects, before that treatment commences;
  - refuse to be video- or audio-taped;
  - seek a second opinion from an independent specialist of his or her choice;
  - request a lawyer to advise the patient on his or her status and rights as a patient or any other matter;
  - the company of others, except where seclusion is expressly authorised by statute;
  - receive visitors and make telephone calls; and
  - receive unopened any mail addressed to him or her and send letters without them being opened.
- 5.68 We recommend that anyone who is being detained and compulsorily treated under the proposed regime should have these rights while he or she is under compulsory treatment.
- 5.69 Breaches or denials of patient rights under the Mental Health (Compulsory Assessment and Treatment) Act are remedied through a statutory complaints procedure. When patients or someone else on their behalf make a complaint, it is investigated by a statutory officer called a district inspector. The district inspector must, if satisfied that the complaint has substance, report the matter to the Director of Area Mental Health Services with recommendations as to how the complaint can be resolved. The Director of Area Mental Health Services is required to take steps to rectify the matter. This first stage is essentially a mediated resolution process. Complainants who are dissatisfied with the outcome of their complaint may refer the case to the Mental Health Review Tribunal for further investigation and a decision.
- 5.70 We recommend that the same complaint process be available under the proposed new regime. To the extent it is possible to do so, the complaints machinery utilised under the Mental Health (Compulsory Assessment and Treatment) Act should be extended to cover people detained and compulsorily treated under the proposed regime.

225 P D G Skegg and Ron Paterson (eds) *Medical Law in New Zealand* (Brookers, Wellington, 2006), at [390].

## District inspectors

- 5.71 District inspectors have specific responsibilities for safeguarding the rights of patients detained under the Mental Health (Compulsory Assessment and Treatment) Act. They are lawyers appointed to monitor the application of the regime to people who are subject to a compulsory treatment order. Their key areas of responsibility include providing information, documentation checking, visitations and inspections, complaint handling and resolution, and conducting inquiries. The role of district inspector has been described as that of a watchdog for patient rights, a kind of mental health care ombudsman.<sup>226</sup> The Drug and Alcohol Treatment Act 2007 (NSW)<sup>227</sup> and the Severe Substance Dependence Treatment Act 2010 (Vic)<sup>228</sup> both respectively make similar provision for “official visitors” and “public advocates”.
- 5.72 We recommend that district inspectors be appointed and given similar functions to those they exercise under the Mental Health (Compulsory Assessment and Treatment) Act.

## Principal carer

- 5.73 From the beginning of the assessment process, a person should have the opportunity to receive support from a friend or member of their family or whanau.
- 5.74 The Mental Health (Compulsory Assessment and Treatment) Act provides an ongoing role for the “principal caregiver” who is “the friend of the patient or the member of the patient’s family group or whanau who is most evidently and directly concerned with the oversight of the patient’s care and welfare”.<sup>229</sup> Throughout the assessment, treatment and review processes under that Act, there is a statutory requirement that caretakers be informed at all relevant stages of the process.
- 5.75 However, there is a need to balance giving recognition to the family with respect for the autonomy and wishes of the individual who may have expressed a clear request that family involvement be limited. The New South Wales Act makes provision for a nominated primary carer to receive information and advice. The responsible clinician must accept the nomination unless he or she believes it would put the dependant person at risk of harm. We prefer this approach as it allows the person being assessed and treated to determine who takes the carer role.
- 5.76 We recommend that provision be made for a nominated carer to receive information and advice and provide support to a person going through the committal process.

226 Sylvia Bell and Warren Brookbanks (eds) *Brookers Family Law — Incapacity* (Online, Brookers, Wellington, 2003) at [MH95.04] (accessed 26 August 2010).

227 See Drug and Alcohol Treatment Act 2007 (NSW), ss 26 and 27 for a full list of functions.

228 Severe Substance Dependence Treatment Act 2010 (Vic), s 27.

229 Mental Health (Compulsory Assessment and Treatment) Act 1992, s 2.



## OFFENCES

5.77 In chapter 2 we discussed offences under the Alcoholism and Drug Addiction Act.

### Ill-treatment and neglect of patients

5.78 We concluded that it was unnecessary to retain the two offences in section 29 of the Act for dealing with the ill-treatment and wilful neglect of patients. The Law Commission has recently proposed substantial reforms to the law relating to the ill-treatment and neglect of children and vulnerable adults.<sup>230</sup> Under these proposals, section 195 and other offences in the Crimes Act 1961 are extended to cover the ill-treatment or neglect of patients detained in institutions. Specific offences, like those in section 29, are therefore unnecessary.

### Improper conduct

5.79 In chapter 2, we also determined that the offence of improper conduct in section 26 of the current Act was unnecessary because all of the proscribed conduct that should be criminalised is already covered by general offences in the Crimes Act. Behaviour that is merely unruly, insubordinate, or insulting should not be criminalised. As a matter of principle, we think that only conduct that would be an offence if it occurred outside an institution should be an offence within an institution.

### Trespass

5.80 Similarly we concluded in chapter 2, that the specific offence of trespass in section 28 is unnecessary as it duplicates the general law of trespass.

### Unlawful detention

5.81 It is an offence under section 24 of the Act to deliberately detain a person in an institution for a period longer than is legally authorised. We are not persuaded that this type of provision is necessary. A criminal offence of this type is not an appropriate way to ensure that the time limits and other requirements imposed on those administering the regime are adhered to. We think that the review and complaint mechanisms we have proposed for the regime will be more effective at ensuring compliance.

### Supplying drugs or alcohol to patients

5.82 It is an offence under section 27 for any person, other than a medical practitioner or someone acting under his or her authority, to supply any drugs or alcohol to a person held under the current Act. The offence requires knowledge that the person is a patient under compulsion. The offence also covers periods when the patient is on a leave of absence or otherwise absent from the institution.

5.83 We propose that this offence be modified and retained. It is unnecessary to cover the supply of drugs because this is already prohibited by sections 6 and 7 of the Misuse of Drugs Act 1975. However, a specific provision is appropriate to cover the supply of alcohol to someone under the regime. The offence should require

<sup>230</sup> New Zealand Law Commission *Part 8 of the Crimes Act 1961: Crimes Against the Person* (NZLC R111, Wellington, 2009) chapter 5.

knowledge that the person is under compulsory treatment and the maximum penalty should be increased so it is consistent with other offending involving a similar level of culpability.

- 5.84 We think that the supply of alcohol to this group of vulnerable adults is broadly on a par with supply of alcohol to a minor. We therefore propose a maximum fine of \$5,000 which is the same penalty the Commission recommended for the social supply of alcohol to a minor.<sup>231</sup>

### Absconding and unauthorised absences

- 5.85 Finally, the regime must address unauthorised absences from treatment facilities. It is currently an offence for a person committed under the Alcoholism and Drug Addiction Act to escape from a certified institution. The police or any employee of the certified institution may arrest the person without warrant and return the person to the institution. There is no equivalent offence of escaping from a psychiatric institution under the Mental Health (Compulsory Assessment and Treatment) Act or under the New South Wales or Victorian Acts.
- 5.86 In *Controlling and Regulating Drugs*, we proposed that the offence of escaping from an institution be abolished. We proposed that the approach should be aligned with the mental health regime which authorises the police (as well as other officials) to apprehend and return a person to a treatment centre. We proposed this because people detained and treated under this type of regime have a substantially impaired capacity and it is not appropriate to hold them culpable for escaping in those circumstances.
- 5.87 Most submissions agreed. The New Zealand Law Society said a punitive approach was counterproductive and a rehabilitative approach more beneficial.<sup>232</sup> Others argued that an offence is not conducive to promoting engagement and fostering the therapeutic relationship vital to addiction treatment.<sup>233</sup> There was also support for aligning the regime with mental health legislation.<sup>234</sup>
- 5.88 A few of those consulted believed an offence is needed. They suggested it reinforced the compulsory nature of the confinement and provided a basis for obtaining police assistance to apprehend and return the person.<sup>235</sup> We think, however, that these points can be addressed without an offence.
- 5.89 We therefore recommend that the regime authorise the apprehension and return of any person but it should not be an offence for a person to abscond. The police should be expressly authorised to apprehend and return a person during the currency of a treatment order, as they are under the Mental Health (Compulsory Assessment and Treatment) Act. There should also be a power to apply for a

231 New Zealand Law Commission *Alcohol in Our Lives: Curbing the Harm* above n 211, at [263–266].

232 Submission from New Zealand Law Society (submission dated 17 May 2010) at [33].

233 Submission of the Ministry of Health (submission dated April 2010) at [29–30].

234 Submission of the Ministry of Health (submission dated April 2010) at [29–30]; Submission of the Drugs Rights Project (submission dated 14 May 2010) at [29].

235 This argument was made in favour of retaining the offence at the consultation meeting the Commission held with managers and staff from Nova Lodge and the Christchurch Bridge programme in Christchurch on 11 March 2010. The second point was also raised in the Submission of the New Zealand Police (submission dated 18 June 2010) at [9].

warrant to enter premises for the purposes of removing the person and returning him or her to the treatment facility. Legal authority to apprehend and return the person is sufficient to reinforce the compulsory nature of the regime.

## ANCILLARY MATTERS

- 5.90 Some other matters also need to be addressed.

### Authorised specialists and responsible clinicians

5.91 The new regime will need to authorise suitably qualified alcohol and drug treatment specialists to undertake the role of “authorised specialist” and carry out assessments and issue certificates of dependence. Under the Mental Health (Compulsory Assessment and Treatment) Act, assessment examinations must be conducted by a psychiatrist or another suitably qualified practitioner who has been specifically approved by the Director of Area Mental Health Services for this purpose.<sup>236</sup> Under the New South Wales Act, suitably skilled practitioners are appointed by the Director-General of Health. In *Controlling and Regulating Drugs*, we suggested a similar approach.

5.92 Feedback from consultation on this issue has reinforced the importance of ensuring that the assessment and decision to bring someone under the regime is made by a professional with an appropriate level of skills and expertise. Community Alcohol and Drug Services Waitemata stated that:<sup>237</sup>

Addiction medicine is an area of medicine with its own specialist training and qualification. Stipulating a minimum level of expertise would go some way towards protecting the individual’s rights and would be more in line with the application of legislation like the Mental Health (Compulsory Assessment and Treatment) Act.

5.93 On balance we favour the option of giving the function of appointing suitably skilled practitioners to the Director-General of Health. At a later stage, once the regime is well established, the Director-General may, if he or she considers it appropriate, delegate this function to the Director of Area Alcohol and Drug Services for each area. We therefore recommend accordingly.

5.94 In addition, consideration must be given to the range of professionals who can perform the role of “responsible clinician” within an authorised treatment facility or service. Under the regime all individuals must have, while they are under compulsion, a specific clinician who is responsible for their care.

5.95 The National Addiction Centre has suggested that over time, as the new regime is phased in, it might be appropriate to allow suitable professionals other than doctors, such as clinical psychologists and nurse practitioners, to act as responsible clinicians under the regime.<sup>238</sup>

5.96 We recommend that the Director-General should, after consultation with the sector and relevant professional bodies, determine the appropriate specialist training and qualifications necessary for clinicians to undertake the functions of “authorised specialist” and “responsible clinician” under the regime.

236 Mental Health (Compulsory Assessment and Treatment) Act 1992, s 9(3).

237 Submission of Waitemata District Health Board Community Alcohol and Drug Services (submission received 30 April 2010) at [5].

238 Submission of National Addiction Centre, University of Otago (submission dated 6 May 2010) at [6].

## Assessment when a person is uncooperative

- 5.97 The regime has to make appropriate provision for managing the application and assessment stages of the process in cases where a person is not willing or able to cooperate. Under the Mental Health (Compulsory Assessment and Treatment) Act, arrangements can be made to have a person taken to a place for examination and assessment if the person does not cooperate with the assessment process. This power can only be used if the person needs to have the assessment urgently and all reasonable steps have been made to have this done without the use of force.
- 5.98 In a situation where the person is believed to be in urgent need of medical intervention, the Director of Mental Health Services can have him or her taken, with the assistance of the police if this is necessary, to a specialist examination and assessment. Except in an emergency, a warrant is required before premises can be entered for the purposes of removing the person.<sup>239</sup>
- 5.99 We recommend that similar provision is made under our proposed regime. If a person refuses or fails to attend his or her assessment examination, then the Director of Area Alcohol and Drug Services should, if satisfied the person is likely to meet the threshold criteria and an examination and assessment is urgently needed, be authorised to arrange to have the person taken to the assessment examination. Police assistance should be available on the same terms as it is under the Mental Health (Compulsory Assessment and Treatment) Act, and a power to obtain a warrant to enter premises should be available.

## Leaves of absence

- 5.100 Provision for leaves of absence is needed to enable someone subject to a certificate of dependence or treatment order to leave the treatment facility for a period of time in appropriate circumstances. The New South Wales Act provides for leave to be granted on any grounds the authorised specialist considers appropriate, but stipulates that leave should not be granted unless the practitioner is satisfied that, as far as practicable, adequate measures have been taken to prevent the person from causing harm to himself or herself. We think this type of provision is needed to cover absences that are necessary on compassionate or medical grounds, but it might also be appropriate to grant leave, particularly towards the end of the period of compulsion, to assist with a transition back into the person's home environment.

<sup>239</sup> Mental Health (Compulsory Assessment and Treatment) Act 1992, s 41(7).

## RECOMMENDATIONS

- R1 The Alcoholism and Drug Addiction Act 1966 should be repealed and replaced by a new regime for the compulsory treatment of severe substance dependence.
- R2 The objectives of the proposed regime for compulsory treatment of people with severe substance dependence should be:
- to protect them from harm and restore their capacity to make their own decisions about their future substance use;
  - to stabilise their health through medical treatment (including supported withdrawal);
  - to facilitate a comprehensive assessment of their dependence;
  - to facilitate the planning of ongoing voluntary treatment and aftercare; and
  - to give them an opportunity to engage in voluntary treatment.
- R3 Provisions establishing the regime should be interpreted, and the functions under the regime performed, consistently with the following principles:
- detention and compulsory treatment should only be considered when less restrictive options will not enable treatment to be effectively given;
  - the least restrictive intervention that will enable treatment to be effectively given should always be used where a person is being detained and treated;
  - all interferences with the rights and dignity of a person detained and compulsorily treated should be kept to the minimum necessary; and
  - the interests of the detained person should be paramount in all decision-making about him or her.
- R4 A person should only be detained and treated when all of the following criteria are satisfied:
- (a) the person has a severe substance dependence; and
  - (b) detention and treatment is necessary to protect the person from significant harm to himself or herself; and
  - (c) the person is likely to benefit from treatment for his or her substance dependence but has refused treatment; and
  - (d) no other appropriate and less restrictive means are reasonably available for dealing with the person.
- R5 The term “severe substance dependence” should be defined to mean that a person:
- (i) has a tolerance to a substance; and
  - (ii) shows withdrawal symptoms when he or she reduces the level or stops using the substance; and
  - (iii) has a substantially impaired capacity to make decisions about substance use and treatment for dependence primarily as a result of his or her dependence.



## RECOMMENDATIONS

- R6 The maximum period of detention and treatment should be six weeks unless an extension is granted.
- R7 The Family Court should have the power to extend the period of compulsion for up to a further three months where a person appears to be suffering from alcohol- or drug-related brain injury and additional time is needed to complete assessment and treatment, or to plan the person's discharge from the regime.
- R8 The function of approving facilities for use under the regime should be undertaken by the Director-General of Health under the Health and Disability Services (Safety) Act 2001.
- R9 The key stages and features of the assessment and treatment process should be:

### **Application:**

- Anyone over the age of 18 who believes that a person meets the criteria for compulsory treatment should be able to make an application to have the person assessed under the regime.
- The application should be made to an official appointed by the Director-General of Health (called the Director of Area Alcohol and Drug Services).
- The application should be supported by a preliminary medical certificate issued by a medical practitioner.
- The certificate should confirm that the medical practitioner has examined the person, has reasonable grounds to believe that the person is likely to meet the criteria, and that the person should be assessed by a specialist for compulsory treatment.
- When a preliminary medical certificate could not be issued because the person refused to cooperate, the medical practitioner would need to confirm that he or she has been unable to examine the person and issue the certificate. The practitioner should also provide any available information on the person's condition.

### **Assessment:**

- When an application is received, the Director of Area Alcohol and Drug Services should arrange for the person to be examined and assessed against the criteria for compulsion by a specialist.
- When an application does not include a medical certificate (because the person refuses the preliminary medical examination) the Director of Area Alcohol and Drug Services should make his or her own enquiries into the person's circumstances and determine whether there is sufficient evidence to indicate that the person is likely to meet the threshold criteria. If so, the Director should arrange for the person to be assessed against the criteria by a specialist. This specialist should have expertise in alcohol and drug dependence and treatment.
- The assessment to determine whether a person meets the threshold should always include a personal examination.

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## RECOMMENDATIONS

- If the person meets the criteria the authorised specialist should issue a certificate of dependence authorising the detention and treatment of the person. The certificate would authorise treatment of the person for up to a maximum of six weeks.
- Before issuing a certificate of dependence the authorised specialist would need to consult with staff at relevant treatment facilities to ensure that a suitable place is made available for the person.
- A preliminary treatment plan should be prepared for the person.
- If a certificate is not issued (because the person does not meet the criteria) then the Director of Area Alcohol and Drug Services should ensure the person is given advice about voluntary treatment services.

**Treatment:**

- When a certificate of dependence has been issued the person should be committed to an approved treatment facility and detained and treated there.
- A responsible clinician should be appointed for each person to oversee their treatment.

**Review by the Court:**

- The responsible clinician should be required to apply to the Family Court for a review of the decision to compulsorily treat the person as soon as is practical but no later than seven days after the certificate of dependence was issued.
- The review should be undertaken by a Family Court judge and should occur within seven days of the application being made.
- If the judge is satisfied on the balance of probabilities the person meets the criteria and further treatment under the regime is appropriate, the judge should approve the treatment plan and make a treatment order.

**Extension of period of compulsion:**

- The responsible clinician should apply to the Court for an extension of the treatment order, if it is needed, where the person appears to be suffering from alcohol- or drug-related brain injury.

**Discharge planning and after-care**

- The responsible clinician should be required to undertake a discharge assessment and develop an after-care plan to cover the type of continuing care that will be provided to the person on a voluntary basis at the expiry of the period of compulsion.

## RECOMMENDATIONS

- R10 There should be a general duty imposed on the responsible clinician to discharge a person being treated under the regime if it becomes apparent that the person no longer meets the criteria for detention and treatment.
- R11 Persons who are being held and treated under a certificate of dependence should have the right, at any time after the certificate is issued, to seek an urgent review of their detention by a Family Court judge on the grounds that they do not meet the criteria and the certificate should not have been issued.
- R12 After a treatment order is made by the Court, the person subject to the order should be entitled to make an application for a subsequent review when their circumstances later change. To avoid continual review the judge should have a discretion to decide whether to hear the application.
- R13 Persons detained and compulsorily treated under the proposed new regime should have the same patient rights as patients under the Mental Health (Compulsory Assessment and Treatment) Act 1992 while under compulsory treatment.
- R14 The complaint process for remedying breaches of patient rights contained in the Mental Health (Compulsory Assessment and Treatment) Act 1992 should also be available to persons detained and treated under the proposed new regime.
- R15 District inspectors should be appointed and given the same functions as they exercise under the Mental Health (Compulsory Assessment and Treatment) Act 1992 to provide more general oversight to the operation of the regime.
- R16 Provision should be made for a nominated carer to receive information and advice and provide support to a person going through the committal process.
- R17 It should be an offence, punishable by a fine up to a maximum of \$5,000, to supply alcohol to a person the offender knows is under the regime.
- R18 The regime should authorise the apprehension and return of any person during the currency of a treatment order but it should not be an offence for a person to abscond. There should also be a power to apply for a warrant to enter premises for the purposes of removing the person and returning him or her to the treatment facility.

*continued over*

RECOMMENDATIONS

- R19 The Director-General of Health should have the function of appointing suitably qualified practitioners to undertake assessments and issue certificates of dependence under the regime.
- R20 The Director-General should, after consultation with the sector and relevant professional bodies, determine the appropriate specialist training and qualifications necessary for clinicians to undertake the functions of “authorised specialist” and “responsible clinician” under the regime.
- R21 Where a person refuses or fails to attend their assessment examination the Director of Area Alcohol and Drug Services should, if satisfied the person is likely to meet the threshold criteria and an examination and assessment is urgently needed, be authorised to make arrangement to have the person taken to the assessment examination. Police assistance should be available on the same terms as it is under the Mental Health (Compulsory Assessment and Treatment) Act 1992, and a power to obtain a warrant to enter premises should be available.
- R22 Provision should be made for authorised leave to allow a person subject to the regime to leave the treatment facility at which they are required to reside. Leave should be granted by the responsible clinician for a specified period on appropriate conditions.

# Chapter 6

## Implementation issues

**INTRODUCTION** 6.1 In this chapter we briefly canvass options for advancing legislation. We consider the potential demand for treatment under the regime and identify some key implementation issues that need to be addressed to ensure the new regime can be effectively rolled out.

**LEGISLATION** 6.2 In *Controlling and Regulating Drugs*, we discussed three possible legislative vehicles for the proposed regime:

- a new stand-alone Act;
- inclusion in a new legislative framework developed to replace the Misuse of Drugs Act 1975;
- inclusion in the Mental Health (Compulsory Assessment and Treatment) Act 1992.

6.3 Another option, which we did not put forward at that stage, would be inclusion in the Protection of Personal and Property Rights Act 1988.

6.4 We suggested in *Controlling and Regulating Drugs* that there might be some advantages in incorporating the regime into a new legislative framework for regulating drugs. The current focus of the Misuse of Drugs Act gives an incorrect impression that supply control rather than harm minimisation is the primary objective of drugs policy. If all demand reduction and problem limitation initiatives that required legislation (including provision for compulsory treatment) were contained in the same statute as more conventional supply control measures, it would help to reinforce harm minimisation as the key plank of drug policy.

6.5 We suggested also that there would be a symbolic significance in including alcohol in the drugs regime. The inclusion of measures to deal with alcohol dependence in the proposed new legislative framework for drugs would be one way to acknowledge the status of alcohol as a drug that poses significant risks, even though it remains legally available.



- 6.6 Feedback from submissions on this proposal was limited. Most who commented on the issue saw fewer problems with a new stand-alone Act than with the other options.<sup>240</sup> Some working in the treatment sector felt reticent about including this aspect of alcohol and drug treatment in the proposed legislative framework for drugs because, notwithstanding our proposed focus on harm minimisation, that legislation is still primarily concerned with prohibiting the use of drugs or imposing restrictions on use and establishing offences. Drugs legislation has a long association with the criminal law.
- 6.7 There was some support from submitters for incorporating the regime into the Mental Health (Compulsory Assessment and Treatment) Act.<sup>241</sup> They noted that in practice some people are, prior to a diagnosis of substance abuse, compulsorily treated under the Mental Health (Compulsory Assessment and Treatment) Act, because it is not immediately apparent that their disorder is solely attributable to alcohol or drug use. There may be benefits for people with co-existing mental disorder and substance abuse disorders if substance abuse is brought into the mental health regime.<sup>242</sup> There is considerable overlap between the two regimes. For example, many of the mechanisms within the Mental Health (Compulsory Assessment and Treatment) Act, such as the district inspector regime, would, under our proposals, apply equally to compulsory drug and alcohol assessment and treatment.
- 6.8 However, the majority of submitters did not favour this. They considered that there are important practical barriers relating to the configuration and management of the different services. People suffering from severe substance dependence have quite distinct treatment needs from people suffering from severe mental disorders. They need access to detoxification facilities in the first instance, and then access to ongoing drug and alcohol treatment programmes. Significant changes would need to be made to the way mental health and alcohol and drug services are resourced and configured before this option would be appropriate. The option of bringing civil committal for severe substance dependence and the mental health regime together would require a full review of mental health legislation and services. This would significantly delay implementation of the new regime. We agree with these views, and do not support the use of the Mental Health (Compulsory Assessment and Treatment) Act as a legislative vehicle.

240 For example, Submission of Waitemata District Health Board Community Alcohol and Drug Services (submission received 30 April 2010) at [10]; Submission of Adrian Gray (submission dated 1 May 2010) at [7]; Submission of National Addiction Centre, University of Otago (submission dated 6 May 2010) at [4]; Submission from the Mental Health Commission (submission dated 11 May 2010) at [6–7].

241 For example, the Submission of Waitemata District Health Board Community Alcohol and Drug Services (submission received 30 April 2010) at [10]. While they considered it inappropriate at present, the Mental Health Commission thought there was potential for this at some later stage; Submission from the Mental Health Commission (submission dated 11 May 2010) at [6–7].

242 The Ministry of Health estimates that approximately 30% of patients who present in crisis to mental health services have co-morbid mental illness and substance use disorder or dependence. While this suggests that treatment for substance abuse could fit within the framework of the Mental Health (Compulsory Assessment and Treatment) Act, not all of those with co-morbidity would reach the threshold for compulsory treatment under the Mental Health (Compulsory Assessment and Treatment) Act.

- 6.9 For completeness, we have also considered the Protection of Personal and Property Rights Act. However, substance dependence is a long-term relapsing condition causing intermittent and fluctuating impairment of capacity rather than continual ongoing loss. The guardianship regime in the Protection of Personal and Property Rights Act is appropriate for managing cases where there is ongoing brain impairment caused by long term drug or alcohol use, but it would be too cumbersome for dealing with cases of severe substance dependence where the loss of capacity is of a temporary or fluctuating nature.
- 6.10 We have therefore concluded that the most straightforward option is to enact a new stand-alone Act dealing solely with civil compulsory treatment for drug and alcohol dependence. We recommend accordingly.

#### ESTIMATING THE LEVEL OF DEMAND

- 6.11 It is difficult to accurately estimate the level of demand for treatment under the proposed regime because of a lack of data on the number of people with severe substance dependence who might meet the criteria for compulsion.
- 6.12 Approximately 74 people are detained each year under the current regime. They spend an average of two to three months in residential treatment. We envisage that under the new regime, with greater flexibility in the treatment facilities to which people could be committed, there would be some increase in numbers. We have not been able to estimate the size of the increase, but do not expect it to be substantial.
- 6.13 Any costs arising from that increase may be off set by the fact that the compulsory element of the regime will not normally exceed six weeks. The regime involves a more proactive after-care component, so that some additional resources may be required to deliver this.

#### IMPLEMENTATION

- 6.14 Implementation of the new regime raises a number of issues. This detailed planning work is well beyond the scope of this review, so we only raise a few key issues for consideration.

#### Developing services to deliver the regime

- 6.15 Currently a person spends an average of one week in withdrawal management before he or she transfers to a specialist residential alcohol and drug programme. This would be unlikely to change.
- 6.16 However, the configuration of services providing specialist residential alcohol and drug programmes would require significant change, at least over the longer term, if the proposed regime is to be effective. Nova Lodge and the three Bridge programmes are currently certified to provide residential treatment programmes. These programmes would clearly still be needed. Assuming some increase in demand for treatment under the regime, some additional residential programmes with an appropriate geographical spread would need to be authorised to treat people under the regime. Some of these programmes would need to cater for youth, women and Māori.

### Ongoing voluntary engagement and after-care

- 6.17 The proposed regime places a far greater emphasis on active after-care and ongoing support than the current regime. Compulsion is used to stabilise people and restore their ability to make their own ongoing decisions about treatment. We think it is critical that the new regime, like that in New South Wales, must make provision for planning the discharge and post-discharge treatment and support of any person who is held under the regime.<sup>243</sup>
- 6.18 For the pilot in New South Wales, the Salvation Army has been contracted to provide community-based support and follow-up care for people when they are discharged. In practice social workers employed by the Salvation Army go into the residential treatment facility and begin to work with people in the weeks before they are discharged. The clinical staff at the New South Wales pilot have found that there is a better success rate when people have three to six months of after-care.<sup>244</sup> Research also shows that the length of time in treatment has been found to be one of the most consistent predictors of favourable post-treatment outcomes among drug users.<sup>245</sup>

### Workforce development

- 6.19 A major barrier to increasing treatment provision, irrespective of whether it is compulsory or voluntary, is a shortage of skilled practitioners, both specialist addiction treatment practitioners and non-specialist professionals with the capability to provide lower-level treatment services.<sup>246</sup> There is currently a limited alcohol and drug treatment workforce in New Zealand of approximately 1300. Workforce development for the addiction treatment sector has been identified as an area of need, and is being addressed through existing strategies.<sup>247</sup> There will be a time lag between training new people for this workforce and their availability to contribute to it.

### Functions under the new regime

- 6.20 Against this general background, specific consideration will need to be given to the necessary skills to carry out the new roles and functions under the proposed regime.
- 6.21 We have considered already the functions of “authorised specialists” and “responsible clinicians”. The role of the Director of Area Alcohol and Drug Services is also critical. One option that should be considered is whether the functions of the Director of Area Alcohol and Drug Services and the staff supporting him or her in managing the application process should be combined

243 See Alcohol and Drug Treatment Act (NSW), s 25.

244 Representatives from the Commission met with the clinical team at the Involuntary Treatment Unit at Nepean Hospital (where the pilot is being conducted) on 8 June 2010 to discuss the pilot.

245 Micheal Gossop “Developments in the Treatment of Drug Problems” in Philip Bean and Teresa Nemitz *Drug Treatment: What Works?* (Routledge, United Kingdom, 2004) 65 at [70].

246 National Committee for Addiction Treatment (NCAT) *Investing in Addiction Treatment – A Resource for Funders, Planners, Purchasers and Policy Makers* (NCAT, Christchurch, 2008) at [2].

247 Minister of Health *Te Kōkiri: The Mental Health and Addiction Action Plan 2006–2015* (Ministry of Health, Wellington, 2006).

with the same roles and functions under the Mental Health (Compulsory Assessment and Treatment) Act. The implications of this would need to be carefully explored.

- 6.22 We have already recommended that, to the extent it is possible to do so, the roles and functions of district inspectors and the tribunal mechanism under the Mental Health (Compulsory Assessment and Treatment) Act should be utilised across both regimes.

### Transitional arrangements for patients

- 6.23 One of the most important implementation issues is the transition of people held under the old regime into the new regime. We consider that it would not be appropriate for these people to remain under the old regime because of its very limited rights of review and other patient safeguards.
- 6.24 We recommend that all orders that are still in place under the old Act should be treated as though they are treatment orders made under the new regime at the time when the new regime comes into force. A transitional provision should require that arrangements are made for a review of the circumstances of each person transferred into the new regime. This is to ensure that the person does actually meet the criteria for continued compulsion. If not, his or her ongoing treatment must be undertaken on a voluntary basis.

### Reporting

- 6.25 Finally, we think it is essential that the use of the new compulsory treatment regime be closely monitored and reported on.
- 6.26 We therefore recommend that the Director-General of Health be required to report annually on the regime. The report should cover the number detained and treated under the regime, the length of detention, the number of extensions granted and the number of people who go into voluntary residential treatment or outpatient treatment at the end of the compulsory period.
- 6.27 We suggest also that an evaluative review of the new regime be programmed by the Ministry of Health after five years to assess how well the regime is meeting its stated objectives and to assess the regimes overall effectiveness.

RECOMMENDATIONS

- R23 The proposed regime should be implemented via a stand-alone Act.
- R24 All Section 8 and 9 orders still in place under the Alcoholism and Drug Addiction Act 1966 should be treated as though they are treatment orders made under the new regime. Arrangements should be made for a review of each such order and the circumstances of each person transferred into the new regime.
- R25 The Director-General of Health should be required to report annually on the regime. The annual report should cover the: (a) number detained and treated under the regime; (b) the length of detention and treatment; (c) the number of extensions granted; and (d) the number of people who go into voluntary residential treatment or outpatient treatment when discharged.



# Appendix

## List of submissions

### Submitters who raised treatment issues in written submissions

Adam Wilson	M Bigwood
Adrian Grey	Matt 116
Alcohol Drug Association of New Zealand (ADANZ)	Matt Bear
Andrew Gates	Medical Council of New Zealand
Anonymous 108	Mental Health Commission (MHC)
Auckland District Law Society (ADLS)	Michael Britnell
CADS (Community Alcohol and Drug Services) Auckland	Michael Kudson
Caitlin Wheeler	Ministry of Health
CAYAD (Community Action on Youth and Drugs) Auckland City	NAC Dunedin
CAYAD Clendon/Manurewa	Nandor Tanczos
CAYAD Otautahi	National Addiction Centre (NAC)
CAYAD Te Tai Tokerau Region	National Committee for Addiction Treatment (NCAT)
Child and Youth Mortality Review Committee	National Council of Women of New Zealand (NCWNZ)
Children's Commissioner	Nelson Bays Community Law Centre
Chris Fowlie	New Zealand Drug Foundation (NZDF)
Citizens Commission on Human Rights	New Zealand Law Society (NZLS)
David Currie	New Zealand Nurses Organisation (NZNO)
David Small	New Zealand Police
Dillon Alderson	New Zealand Police Association
Drugs Rights Project	New Zealand Red Cross
Dunedin Community Law Centre	Odyssey House
Family Planning	Sheridan Pooley
Fight Against P and Sensible Sentencing Trust	SHORE (Centre for Social and Health Outcomes Research and Evaluation)
Geoff Noller	Victory Community Health Centre
Health Action Trust	Waitemata District Health Board
Libertarianz	Wendy Allison
Jade Winter	WellTrust
James Williamson	Whitireia Community Law Centre
Josh Van der berg	Young Labour NZ

## Targeted consultation meetings on treatment issues

Arohata Women's Prison Drug Treatment Unit	Moana House Dunedin
Auckland University School of Population Health and School of Pharmacy	National Association Incorporated of Opioid Treatment Providers
CADS Waitemata – Robert Steenhuisen and Sheridan Pooley	National Committee for Addiction Treatment
CAYAD Central	Nelson's Alcohol, Drug and Co-occurring Disorders Service
CAYAD Northern	New Zealand Drug Foundation Consultation Group
CAYAD Southern	New Zealand Drug Foundation Pacific Consultation Group
Doug Sellman and Simon Adamson	Nova Lodge and Christchurch Bridge Programme
Health Action Trust – Community workers at Nelson Hub	Odyssey House
Higher Ground Auckland	Rimutaka Prison Drug Treatment Unit
Matua raki leadership day Christchurch	Tasman District Council
Ministry of Health – Treatment pathway workshop with clinicians	
Ministry of Health – Committal process workshop	

A full list of submitters to *Controlling and Regulating Drugs* (NZLC IP16, 2010) will be published in our final report on the Review of the Misuse of Drugs Act.

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