ADDICTION AND THE LAW: A CASE-STUDY OF THE ALCOHOLISM AND DRUG ADDICTION ACT

A thesis submitted in fulfilment of the requirements for the Degree of Master of Laws in the University of Canterbury by M B Webb

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Abstract

The thesis presents a case study of New Zealand’s Alcoholism and Drug Addiction Act 1966 - a civil commitment law used to detain alcoholics and drug addicts for up to two years in state-certified residential treatment facilities.

The thesis positions itself as a call for legislative reform. The central argument is that the Act is an anachronistic and potentially draconian piece of social legislation which has no place on the modern-day New Zealand statute book.

In the first part of the thesis, Chapter 1 introduces the research, outlines the structure and methodology of the thesis, and locates the study within a wider tradition of scholarship on the management of people with alcohol problems. Chapter 2 summarises the analytical framework that is used to evaluate the Act, attaching particular importance to both the philosophical traditions and the practical strategies of harm minimisation and therapeutic jurisprudence. Chapter 3 gives a positivist reading of the legislation: outlining the evolution of the Act, essaying its major provisions, and noting the efforts that have been made to refine or reform the statute since it was passed in the mid-1960s. Chapter 4 draws on the limited amount of data available to describe how the Act is currently operating 'on the ground'.

In the second part of the thesis, the Alcoholism and Drug Addiction Act is put into a comparative context by describing examples of similar-type statutes that exist in two other jurisdictions. Chapter 5 focuses on the New South Wales Inebriates Act 1912; Chapter 6 focuses on the Swedish Act on Care of Addicts in Certain Cases 1989.

The final part of the thesis builds a case for reform of the Alcoholism and Drug Addiction Act. Chapter 7 identifies various practical and clinical problems with the Act, which mean that the statute does not work in instrumental terms. It is submitted that the Act cannot be said to make better provision for the care and treatment of alcoholics. Chapter 8 highlights several legal and philosophical difficulties with the Act, which mean that the legislation does not work in value terms. It is submitted that the Act is offensive to the right to refuse treatment and fundamentally conflicts with the principles of individual autonomy and informed consent. Chapter 9 proposes three options for reforming the Act, expressing a preference for the outright repeal of the statute. Finally, Chapter 10 draws conclusions from the preceding discussion, and speculates on the likelihood that the recommended reforms will be implemented.

Key words: compulsory treatment, alcoholism, harm minimisation, therapeutic jurisprudence, legal policy analysis.
1 Introduction

The human desire to consume intoxicating beverages is a long-standing one, dating back to pre-literate times.\(^1\) Despite the spread of alcohol in most other parts of the world, pre-European New Zealand was one of the few places that alcohol-containing drinks were not developed.\(^2\) Within a fairly short time of European settlement, though, alcohol had assumed a significant role, leading some to describe this period of the nation's history as “baptised in alcohol”,\(^3\) while others invoked a national conceit to refer to New Zealand as “Grog’s Own Country”.\(^4\)

Much has changed in attitudes to and practices involving alcohol these days, yet alcohol still plays a significant part in contemporary New Zealand society, and (heavy) drinking is still firmly embedded in New Zealand culture. Even though most people manage to consume alcohol without harming themselves or others, alcohol misuse nonetheless results in considerable health, social and economic costs, which are borne by individuals, families and the wider community.\(^5\) The most significant of these harms include: alcohol-related deaths and physical health problems, alcohol-related mental health problems, injury and death on the roads, drownings, violence, fetal abnormalities, and workplace injuries, absenteeism and impaired work performance. On an annual basis, the social costs of alcohol misuse in New Zealand have been estimated at between $1.5 billion and $2.4 billion.\(^6\)

As well as causing an estimated 3.1 percent of all male deaths and 1.4 percent of female deaths in New Zealand, alcohol-related health problems result in significant levels of distress and disability.\(^7\) Alcohol is a causative factor in a number of mental health conditions, ranging from short-term episodes of alcohol-induced psychosis to far more long-term alcohol-related dementia. Indeed, alcohol abuse and alcohol dependence constitute diagnosable mental disorders in their own right,\(^8\) and it is not uncommon to find these disorders within the general population.

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\(^1\) See, for example, D Musto, Alcohol control in historical perspective, in M Plant et al. (eds.), Alcohol: Minimising the harm, pp 10-25 (New York: Free Association Books, 1997).


\(^3\) J McNeish, Tavern in the Town (Wellington: Reed, 1984).


\(^6\) N J Devlin et al., The social costs of alcohol abuse in New Zealand. Economics Discussion Paper. (Dunedin: Economics Department, University of Otago), p 16. This estimate, expressed in 1991 dollar terms, includes direct costs such as hospital expenses, accident compensation payments, police and justice system costs; and indirect costs like lost production resulting from premature death and sickness, lost working efficiency and excess unemployment. (Of the total amounts, direct costs were estimated to be between $345 million and $592 million each year; while indirect costs were estimated to be between $1.1 billion and $1.8 billion.) Other authors have estimated the social costs of alcohol misuse in New Zealand to be even higher. See, for example, B Easton, The social costs of tobacco use and alcohol misuse. Public Health Monograph No. 2. (Wellington: Department of Public Health, Wellington School of Medicine, 1997), p 24.

\(^7\) Inter-Agency Committee on Drugs, National Alcohol Strategy, 2000-2003 (op. cit.), p 11.

New Zealand studies have found that between five and nine percent of men and one to two percent of women ‘take an alcoholic drink first thing in the morning’, and ‘have hands shake after drinking’.9 Another study found that 32 percent of men and six percent of women will meet clinical criteria for alcohol abuse or dependence over their lifetime.10 Expressed as a proportion of the total population, this latter study found that almost one-in-every-five people (19 percent) will fit clinical criteria for alcohol abuse or alcohol dependence at some stage in their lives.

In recognition of the health, social and economic costs of harmful alcohol use, the Government released a national policy statement on alcohol in mid-1996, as part of its overall National Drug Policy.11 The Policy recognised that, on the one hand, when used in moderation and in non-hazardous situations, alcohol can provide personal and social benefits; but on the other hand, when it is misused, or is used in risky situations, alcohol can also cause great damage to individual drinkers, their families and to the wider community. The policy approach to alcohol was thus not to try and prevent its use altogether, but rather to minimise the harm associated with alcohol.

One of the future directions listed in the National Drug Policy, to be acted on during the life-span of the policy, was a “review of the provisions for compulsory assessment and treatment of people with alcohol use disorders”.12 These provisions, contained in the Alcoholism and Drug Addiction Act 1966 [ADA Act], are the focus of this study.

1.1 The Alcoholism and Drug Addiction Act

The ADA Act provides for the compulsory detention and treatment of “alcoholics” and “drug addicts” at institutions which are specially certified for this purpose. There are currently 13 such institutions throughout New Zealand: nine publicly-run hospitals, three Salvation Army Bridge Programmes (based in Auckland, Wellington and Christchurch), and the Nova Lodge (a special work-based programme located in the outskirts of Christchurch). The ADA Act is used to commit around 200 people a year for residential care and rehabilitation, typically chronic ‘revolving door’ alcoholics.

Detention under the ADA Act can be either voluntary (applied for by the person seeking treatment) or involuntary (applied for by the person’s relatives, a police officer, or “any other reputable person”). Committal orders are made by District Court Judges and can last for two years, albeit most people are seldom detained for more than four months, and are often eligible for leave after six to eight weeks of treatment (based on satisfactory progress). Recently, a number of practical and legal problems with the ADA Act have become apparent. In December 1996, for example, a Palmerston North District Court Judge directed that a copy of his decision be forwarded to the Director-General of Health, so that she would become aware of the “untenable situation” where no certified institution was prepared to take a particular person for treatment under the ADA Act. The Judge concluded that: “the whole purpose of the continuation of the Act is being frustrated in this regard, and it is quite unworkable”.13

11 Ministry of Health, National Drug Policy (Wellington: Ministry of Health, 1998). A national policy on alcohol and other drugs was one of five strategic directions listed by the government in its earlier mental health strategy, Looking Forward: Strategic Directions for the Mental Health Services (Wellington: Ministry of Health, 1994).
12 Ibid, p 11.
13 Police v Barnes (Unreported, Palmerston North DC, 13 December 1996, CRN 6054012657, per Ross DCJ).
In response to these concerns, and mindful of the National Drug Policy’s target that there be a review of the compulsory assessment and treatment regime for people with alcohol use disorders, the Ministry of Health issued a discussion paper on the ADA Act in March 1999. The 41 submissions received on the paper were analysed in October 1999, with the departmental report on the submissions concluding that “a full review of the ADA Act is needed” - something the Health Ministry was said to support “in principle”, but only after more inter-agency work.

This thesis self-consciously positions itself as a call for such legislative reform. The central argument will be that the ADA Act is an anachronistic and potentially draconian piece of social legislation that has no place on the modern-day New Zealand statute book.

1.2 Structure of the thesis

The thesis is organised as follows.

Chapter 2 summarises the analytical framework which is used to inform the critique of the ADA Act that follows. The chapter first seeks to describe the Act’s target population of problem drinkers, and addresses the threshold question of whether alcoholism is a disease. It then introduces the notion of “harm minimisation”, which is the philosophical underpinning of the New Zealand government’s National Drug Policy and National Alcohol Strategy, and is a useful metric by which to assess the ADA Act. Chapter 2 also highlights a new way of conceiving of legal tools like ADA Act committal orders – the school of thought known as “therapeutic jurisprudence” – which proceeds from a understanding that the law and legal actors can have therapeutic and/or anti-therapeutic effects.

Having laid out these analytical foundations, Chapter 3 seeks to overlay the legal ‘bricks and mortar’ of the ADA Act, backgrounding the development of the legislation in the 1960s, before giving a black-letter reading of the statute itself.

In Chapter 4, discussion turns to how the ADA Act is currently being used ‘on the ground’. This part of the thesis draws on interviews with those involved in the ADA Act process, plus participant observation in a small number of review hearings under the Act. It also rehearses information provided by the New Zealand Health Information Service and Department for Courts on the number of committal orders made under the Act each year, the length of such orders, as well as some basic demographic information about the type of people against whom the orders were made.

As a way of casting the ADA Act into sharper relief, Chapters 5 and 6 offer a comparison of similar-type statutes in overseas jurisdictions, taking as their two illustrative examples the New South Wales Inebriates Act 1912 and the Swedish Act on Care of Addicts in Certain Cases 1989.

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Chapters 7 and 8 outline various problems with the Act, building a case for reform. Major issues canvassed in these chapters include the lack of certified institutions, the often inconclusive outcomes for people committed under the Act, and the dissonance between the ADA Act and other legislation, notably the Mental Health (Compulsory Assessment and Treatment) Act 1992 and the New Zealand Bill of Rights Act 1990. The core practical and clinical argument will be that the Act does not work in instrumental terms, because it does not "make better provision for the care and treatment of alcoholics". The main legal and ethical arguments will be that, in value terms, the Act is offensive to the right to refuse medical treatment and conflicts with the principles of informed consent and self-determination.

Chapter 9 proposes three ways forward. The first option covered is an extensive reform of the Act as a stand-alone piece of legislation, to bring it more into line with contemporary understandings of patient autonomy and the role that coercion may play in the treatment of alcohol use disorders. This would mean recasting the Act into the narrower province of short-term ambulatory care, amending the definition of "alcoholic", and the need for any such compulsory treatment regime to allow for out-patient, not just in-patient, care. The second option that is discussed is incorporating the power to forcibly treat people with alcohol problems into the Mental Health (Compulsory Assessment and Treatment) Act. The third option canvassed is outright repeal of the Act, with minor amendments to other legislation, such as the Protection of Personal and Property Rights Act 1988, in order to clarify the ability of the state to provide support for the minority of people whose alcohol-related brain damage is so severe that they require institutional care.

The final chapter, Chapter 10, draws conclusions from the preceding analysis and discussion, and speculates on the likelihood of the recommended reform being carried forward by the government.

1.3 Methodology

The thesis adopts a case-study design in order to get better purchase on the Alcoholism and Drug Addiction Act 1966. The careful scrutiny of this piece of legislation using a case-study approach is supplemented by comparative research on similar-type legislation in a number of overseas jurisdictions, notably the New South Wales Inebriates Act 1912 and the Swedish Act on Care of Addicts in Certain Cases 1999. The rationale for this comparative work, however, is to cast the New Zealand ADA Act into sharper relief, rather than to enter into a more ambitious cross-cultural analysis.

As part of this design, a mix of primary and secondary research will be used. Broadly speaking, a five-pronged research strategy informs the thesis. First, in order to gather statistical and other policy-relevant information about the use of the ADA Act, a number of requests were made to relevant agencies, such as the Department for Courts and the Ministry of Health, under the Official Information Act 1982. Secondly, on-line legal databases such as Lexis and Westlaw, and CD-ROM clinical databases like PsychLit and Medline, were searched for relevant judicial decisions, journal articles, and so on; while media clipping services, such as the New Zealand Drug Foundation's Media Watch (www.nzdf.org.nz/media) were monitored via the Internet for relevant 'grey literature'. Thirdly, a review of secondary source material was conducted at the University of Canterbury's libraries, relevant international libraries (for instance, the Simon Fraser University library in Vancouver and the U.S. Library of Congress in Washington DC), as well as various specialist research centres, both in New Zealand (such as the Alcohol Advisory Council's library) and overseas (for example, the London-based libraries of Alcohol Concern and the Institute for the Study of Drug Dependence).

10 Alcoholism and Drug Addiction Act 1966, Long Title.
Fourthly, the thesis is informed by primary legal research: involving paper-based study as well as semi-structured interviews and participant observation. For example, research was conducted both through the National Archives' holdings of departmental papers on the ADA Act and its precursors, as well as various District Law Society libraries' holdings of unreported judgements involving the Act. This was augmented by several key informant interviews with those involved in the ADA Act process, such as managers of the four largest certified institutions under the legislation, as well as participant observation in a small number of review hearings under the ADA Act that were held in Auckland.

Fifthly, as indicated above, comparative research was conducted on similar-type statutes to the ADA Act in some overseas jurisdictions. This involved study trips to Sydney and Melbourne in Australia, and Stockholm in Sweden, in 1998, 1999 and 2000, where a small number of treatment facilities were visited and relevant officials were interviewed.

This multi-pronged research strategy has allowed both quantitative and qualitative insights to be woven into the thesis, thus hopefully maximising the strengths of both methodologies, and going some way towards bridging the perceived dichotomy between the objectivism and subjectivism of these different, yet complementary, approaches to research.

Having said this, there are a number of limitations to using this research framework, and it is appropriate that they be declared at the outset. Perhaps the biggest weakness of the research design is that it did not allow for in-depth fieldwork to be conducted at all the certified institutions under the ADA Act, nor for key informant interviews to be conducted with each of the three District Court Judges who are members of Supervisory Committees under the Act. In the end, trade-offs had to be made between the comprehensiveness of the information gathering stage of the research and the need to be able to make generalisable comments about how the legislation works across the country - rather than drilling down too deeply into what may be idiosyncratic approaches at the local level (although, of course, such idiosyncrasies will be important from an analytical point of view, in terms of the consistency of the Act's application throughout the country, and the levels of certainty associated with the legal process as a result).

Similarly, although it was possible to obtain access to a small number of ADA Act review hearings held in Auckland, these were review hearings, rather than hearings that considered initial applications for committal orders under the Act. This necessarily limits the critical insight that one can bring to bear on this phase of the ADA Act procedure, and thus some of the explanatory power of the analysis that follows. In place of direct participant observation, even from a small data set of hearings, the researcher is left with the black-letter task of interpreting the words of the statute, assessing the explicit/implicit procedural safeguards that are expected to operate in this setting, and in many cases second-guessing how the 'law on the books' is translated into 'law in action'.

Other limitations to the research have been self-imposed. For example, the thesis does not attempt to interrogate the power dynamics that are at play between the disciplines of psychiatry and the law, nor does it engage with the often fractious relationship between alcohol and drug services on one hand and mental health services on the other hand.

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In order to reduce the size of the study to manageable proportions, the definitional decision has also been taken to focus on people with alcohol abuse or dependence problems as targets of the ADA Act, rather than expanding the discussion out to include people with other types of substance abuse or dependence issues. In other words, the thesis centres on the compulsory treatment of "alcoholics" under section 2 of the ADA Act, rather than "drug addicts" as defined in section 3 of the legislation. By narrowing the topic of study in this way to alcohol - a legal substance - it sharpens the issues involved, and allows us not to be distracted by the 'noise' around illicit drugs such as cannabis.

Likewise, the thesis does not consider the related topic of public drunkenness, which was decriminalised in New Zealand in 1982; although there are still cross-overs, in that some 'skid row alcoholics' who were targeted under old inebriate laws are the type of people who have compulsory treatment orders made against them under the ADA Act.  

1.4 Previous research

The thesis itself also takes its place within a wider tradition of scholarship on the management of alcohol-affected persons, both directly (in terms of describing treatment modalities and the outcomes of specific interventions) and indirectly (analysing how the application of certain laws / policies impact on people who experience alcohol problems).

There is a large body of international literature on the management of drinking problems, and a general understanding that treatment of alcohol use disorders can result in significant cost savings. Although the majority of people who fit clinical criteria for alcohol abuse or dependence do not seek help for their drinking problems, controlled evaluations of treatment for those people who do seek help for alcohol problems have demonstrated a so-called 'rule of thirds' - whereby around a third of clients will achieve some sort of abstinence, a third will continue drinking but show improvements, and about a third will continue drinking and either show no measurable improvement or will actually get worse than they were before treatment. As a rule of thumb, longer stays in treatment predict greater reductions in alcohol use, albeit efforts to achieve longer treatment episodes are often hampered by high client drop-out rates.

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These findings have led to intense debate on the question of how routinely access should be provided to expensive forms of residential or hospital-based treatment, even for those with moderate to severe alcohol use disorders.24 Although the ‘rule of thirds’ is cited as a reason for being cautious about the cost of channelling people into in-patient alcohol treatment, there is usually a recognition that some of the most severely alcohol dependent people, or people with chronic alcohol problems who have other complicating factors (such as being homeless or having a co-morbid mental health problem) will often still require in-patient treatment.25 Recent interest has also been excited in the possibility of improving treatment outcomes if individual clients can be matched to particular types of treatment.26 However, for solely alcohol use disorders, evidence for such a “matching hypothesis” has been largely inconclusive.27

Sitting beneath this body of literature on the treatment of alcohol problems are a series of specific studies around compulsory treatment options.28 Most commonly, these studies arise in the context of offenders, examining therapeutic interventions which are offered at various stages of the criminal justice process – such as arrest referral schemes run in police cells,29 court-ordered treatment like drink-driving programmes30 or programmes mandated by specialist Drug Courts,31 and prison- or community-based alcohol and drug programmes that are overseen by correctional services.32

There is also a sub-set of literature on what is loosely termed ‘civil commitment’, although many of these studies focus on drug users, especially people who are opioid dependent, rather than looking at people with alcohol use disorders. Civil commitment programmes have been a regular feature of the North American drug treatment landscape, with examples including state legislation that set up ‘civil addict’ programmes in California and New York, and federal statutes like the Uniform Alcoholism and Intoxication Treatment Act, and Federal Narcotic Addict Rehabilitation Act. Forced treatment of alcohol problems is less-often discussed, reflecting the fact that there are only a few compulsory treatment statutes for alcoholics that work purely within a civil law framework. Much of the writing in this area comes from Australia and Sweden, where laws that are equivalent to New Zealand’s ADA Act still exist and operate today.

Another branch of the literature teases out the effect of coercion by non-legal actors on treatment outcomes, such as pressure applied by family members or significant others for an individual to enter treatment, or requirements by employers that their employees attend counselling or rehabilitation modules. These studies show that personal and social networks can exert very real pressure on individuals to change their alcohol consumption patterns and to seek


help, irrespective of the involvement of legal institutions.\(^{39}\) In other words, the absence of explicit, state-backed pressure for a person to enter a treatment programme does not necessarily mean that the person is there ‘voluntarily’.\(^{39}\)

Finally, in this quick précis of previous international research on the compulsory treatment of people with alcohol use disorders, it is important to observe that there is also a rich vein of literature on the general construction of alcohol as a social problem, and the political salience of alcohol-related issues (including the use of coercive levers to recruit or, more accurately, conscript problem drinkers into treatment) at different points in history.\(^{40}\) These studies, often written from an explicitly sociological or public policy perspective, emphasise the importance of seeing laws about alcohol as undergirded by competing ideologies and paradigms, and firmly rooted in specific socio-political and historical contexts.

Turning now to previous New Zealand research, there is a reasonably small body of work on the effectiveness of alcohol and drug treatment,\(^{41}\) led in recent years by the newly-formed National Centre for Treatment Development (Alcohol, Drugs & Addiction) based at the Christchurch Medical School. Previous researchers have focussed on the legal policy implications of providing shelter to homeless people, including inebriates,\(^{42}\) or the town planning implications of situating alcohol and drug clinics in particular residential zones.\(^{43}\) Others have sought to examine the ‘institutional intoxication of Māori in Aotearoa’,\(^{44}\) and whether current treatment programmes are culturally-appropriate for Māori.\(^{45}\) The appropriateness of responses by treatment programmes has also attracted interest from feminist researchers, who have challenged what they see as the inherent male-as-norm bias in alcohol and drug services.\(^{46}\)

More generally, there have been explorations of how the in-patient treatment experience has worked or not worked for ex-residents,\(^{47}\) although the accounts have not looked at people who have been subject to orders under the ADA Act.

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41 For a general introduction, see J D Sellman et al. (eds.), The Long and the Short of Treatment for Alcohol and Drug Disorders (Christchurch: Department of Psychological Medicine, Christchurch Medical School, 1997).


47 For example, see P O’Flaherty, An exploration of discourses concerning transition to life beyond residential drug and alcohol treatment. Unpublished MSc (Psychology) thesis (Auckland: University of Auckland, 1999).
Unlike more highly-developed evidence bases that exist in overseas countries, the small amount of New Zealand research that analyses the role of coercion in the treatment of alcohol problems comes from the legal academy, with only one or two notable exceptions — such as a small Otago survey of people who had made an application to have a relative committed for treatment under the ADA Act. Admittedly, there is a periodically-updated looseleaf series kept on the legislation as part of Trapski’s Family Law service, but overall, the ADA Act has received little attention from front-line alcohol and drug workers, nor has it excited interest from scholars within the policy sciences.

In terms of wider literature on alcohol as a social problem, some New Zealand work has been done to analyse the effect that interpretations of drinking and intoxication might have in shaping and channelling patterns of alcohol use, and the extent to which minimum drinking norms can be a factor in the production and perpetuation of alcohol-related problems in New Zealand.

In summary, then, the present study is located within a strong international tradition of scholarship on the effective management of alcohol use disorders, and a series of more specialised studies on the role of legal and non-legal coercion in the treatment of alcohol abuse and dependence problems. This overseas research base is reasonably well-developed in relation to diversion from the criminal justice process for people who have drinking problems, but less so vis-à-vis compulsory treatment regimes for alcoholics which operate purely within a civil law framework. This relative paucity of evidence and analyses of civil commitment statutes is magnified in the New Zealand setting, where the ADA Act has received little attention from alcohol and other drug workers, legal scholars or policy commentators.

This thesis is an attempt to remedy this relative lack of scholarly and critical attention. The task is begun in Chapter 2.

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Analytical foundations

Before attempting to unpack the ADA Act, it is useful to identify some of the theoretical and empirical foundations that inform the discussion which follows.

It is first important to issue a few caveats. For the purposes of this thesis, it is not possible to attempt a comprehensive coverage of all the analytical filters that could be used to reflect and refract the ADA Act. The constraints of space and the rhetorical demands of the thesis topic militate against an engagement with some of the wider philosophical or historical debates at play in the area of alcohol policy and coerced treatment initiatives. Hence, the following chapter does not attempt to survey post-Foucauldian institutional histories of the medicalization of alcohol problems or mental health by pioneering scholars such as Thomas Szasz and David Rothman. Neither does the chapter canvas the many careful social histories of relevant alcohol-related issues that are available – for instance, tracing the influence of nineteenth century temperance activism, or problematizing the idea of a homogenous working class drinking culture. Instead, the chapter will proceed as a series of practical and theoretical questions that draw from various disciplines. The pragmatic concern will be to build a coherent argument by taking from each researcher or school of thought that which fits the thesis, without being too concerned about the sanctity of boundaries between different analytic traditions.

2.1 What is “alcoholism”?

A useful point of departure is to define the legal policy problem. Which is to ask: what is the mischief that the ADA Act attempts to mitigate? The short answer is provided by the Long Title of the legislation, which states that the Alcoholism and Drug Addiction Act is “an Act to ... make better provision for the care and treatment of alcoholics”. At face value, therefore, the ADA Act is aimed at people with drinking problems who meet the definition of “alcoholics”. This, in turn, begs the question: what is an alcoholic? While the Act itself offers an answer through a statutory definition of the term [section 2 of the Act refers], the legal meaning of alcoholic is not necessarily the same thing as the clinical definition of “alcoholic” or “alcoholism”. Such medically-informed understandings of these terms bear further scrutiny.

Although the word “alcoholism” was coined over a century ago, agreement on what “alcoholism” means is elusive. “Alcoholism” was popularised in the 1940s and 1950s by writers such as Eric Jellinek, Selden Bacon and their colleagues at the Yale Centre of Alcohol Studies, who set out to construct a sociological study of drinking behaviours.

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1 Set at the interface between medical/treatment systems and legal/coercive systems, this literature is alert to the possibility that in moving from ostensibly punitive to therapeutic responses, punishment can actually just be dressed in the Emperor’s New Clothes of treatment - without the due process and civil liberties protections in the health/welfare context that are insisted upon in the justice/corrections context. See, further, P Conrad and J W Schneider, Deviance and Medicalization: From Badness to Sickness (St Louis: Moseby, 1980).
In these early attempts at nosology, alcoholism was characterised as a subset of personality disorders, homosexuality and neuroses. Through an iterative process, such attempts to aggregate diagnostic criteria for alcoholism led to the development of two internationally recognised definitions for what has come to be known as "alcohol dependence". They are outlined in the World Health Organization’s *ICD-10 Classification of Mental and Behavioural Disorders* (1992) and American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV). The ICD-10 classification of alcohol dependence syndrome, with supporting diagnostic guidelines, states:

**Alcohol Dependence Syndrome**

A cluster of physiological, behavioural, and cognitive phenomena in which the use of alcohol takes on a much higher priority for a given individual than other behaviours that once had greater value. A central descriptive characteristic of the dependence syndrome is the desire (often strong, sometimes overpowering) to take alcohol. There may be evidence that return to alcohol use after a period of abstinence leads to a more rapid reappearance of other features of the syndrome than occurs with non-dependent individuals.

**Diagnostic Guidelines**

A definite diagnosis of dependence should usually be made only if three or more of the following have been experienced or exhibited at some time during the previous year:

(a) a strong desire or sense of compulsion to take alcohol;
(b) difficulties in controlling alcohol-taking behaviour in terms of its onset, termination, or levels of use;
(c) a physiological withdrawal state when alcohol use has ceased or been reduced, as evidenced by: the characteristic withdrawal syndrome for alcohol; or use of alcohol with the intention of relieving or avoiding withdrawal symptoms;
(d) evidence of tolerance, such that increased doses of alcohol are required in order to achieve effects originally produced by lower doses (clear examples of this are found in alcohol-dependent individuals who may take daily doses sufficient to incapacitate or kill non-tolerant users);
(e) progressive neglect of alternative pleasures or interests because of alcohol use, increased amount of time necessary to obtain or take alcohol, or to recover from its effects;
(f) persisting with alcohol use despite clear evidence of overtly harmful consequences, such as harm to the liver through excessive drinking; efforts should be made to determine that the user was actually, or could be expected to be, aware of the nature and extent of the harm.

Narrowing of the personal repertoire of patterns of alcohol use has also been described as a characteristic feature (e.g. a tendency to drink alcoholic drinks in the same way on weekdays and weekends, regardless of social constraints that determine appropriate drinking behaviour).

It is an essential characteristic of the dependence syndrome that either alcohol taking or a desire to take alcohol should be present; the subjective awareness of compulsion to use alcohol is most commonly seen during attempts to stop or control alcohol use.

**Includes:**

- Chronic alcoholism.

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The DSM-IV diagnostic criteria for alcohol dependence, with associated features and differential diagnosis, states:  

**Alcohol Dependence**

**Diagnostic Criteria**

A. Alcohol abuse: A destructive pattern of alcohol use, leading to significant social, occupational, or medical impairment.

B. Must have three (or more) of the following, occurring when the alcohol use was at its worst:

1. Alcohol tolerance: Either need for markedly increased amounts of alcohol to achieve intoxication, or markedly diminished effect with continued use of the same amount of alcohol.

2. Alcohol withdrawal symptoms: Either (a) or (b).
   
   (a) Two (or more) of the following, developing within several hours to a few days of reduction in heavy or prolonged alcohol use:
   
   - sweating or rapid pulse
   - increased hand tremor
   - insomnia
   - nausea or vomiting
   - physical agitation
   - anxiety
   - transient visual, tactile, or auditory hallucinations or illusions
   - grand mal seizures
   
   (b) Alcohol is taken to relieve or avoid withdrawal symptoms.

3. Alcohol was often taken in larger amounts or over a longer period than was intended.

4. Persistent desire or unsuccessful efforts to cut down or control alcohol use.

5. Great deal of time spent in using alcohol, or recovering from hangovers.

6. Important social, occupational, or recreational activities given up or reduced because of alcohol use.

7. Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been worsened by alcohol (e.g., continued drinking despite knowing that an ulcer was made worse by drinking alcohol).

**Associated Features**

- Learning Problem
- Dysarthria/Involuntary Movement
- Depressed Mood
- Somatic/Sexual Dysfunction
- Addiction
- Sexually Deviant Behavior
- Dramatic/Erratic/Antisocial Personality

**Differential Diagnosis**

Non-pathologic alcohol use for recreational or medical purposes; repeated episodes of alcohol intoxication.

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9 World Health Organization, *ICD-10 Classification of Mental and Behavioural Disorders* (Geneva: WHO, 1992); available on the Internet at: http://www.mentalhealth.com/icd/p22-sb01.html [accessed 31/10/00].

These attempts at classification cover four main conceptual domains: (1) psychological dependence – experiences of craving, loss of control, inability to cut down, and so forth; (2) physiological dependence – withdrawal and tolerance; (3) harmful consequences – use of alcohol despite experiencing various harms; and (4) pattern and saliency of use – time spent seeking, using and recovering from the effects of alcohol, using alcohol in lieu of other activities, and so on. The ICD-10 and DSM-IV definitions include all four of these conceptual domains in their six diagnostic criteria, although in somewhat different arrays. Both require that a person is diagnosable on at least two and possibly three of the domains before being classifiable as alcohol dependent.

How, then, does the statutory definition of "alcoholic" in the ADA Act conform with these internationally-accepted clinical definitions of "alcohol dependence"? Section 2 of the Act 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.

As will be described in more detail later,\(^{11}\) it is evident that this statutory definition of "alcoholic" allows for some degree of conceptual confusion over who should be the target of the legislation. Both the ICD-10 and DSM-IV definitions of "alcohol dependence" turn on a person being physiologically dependent on alcohol, and exhibiting at least two or three of the following symptoms: tolerance; withdrawal; inability to cut down; sacrificing work, family or social events to drink; devoting a lot of time to finding and consuming alcohol; or continued drinking despite alcohol-related problems. By contrast, the indices that the ADA Act uses in its definition of "alcoholic" do not appear to demand a state of physiological dependence on alcohol, but simply require that a person experiences physical, economic, work or family difficulties because of his or her drinking. At a conceptual level, therefore, the ADA Act definition of "alcoholic" seems to more accurately describe a person who exhibits "problem drinking"\(^ {12}\) rather than full-blown "alcohol dependence".

2.2 Is alcoholism a disease?

Following on from this understanding of the target population of the ADA Act, a second question to pose is whether alcoholism is a disease. The answer to this threshold question has important implications for laws like the ADA Act, because the metaphor of alcoholism as a disease coheres with the assumed need for compulsory treatment of alcoholism. To borrow from American philosopher Robert Goodin: "The policy implications for a distinction between addictions and bad habits are clear ... Since habits are not necessarily bad, public policies discouraging them are not necessarily desirable. Addictions, in contrast, are necessarily bad. Policies discouraging them are therefore always desirable."\(^{13}\) According to this view, alcohol can be seen as a dangerous pathogen that has the potential to afflict the unwary, for whom quarantine in a treatment facility offers perhaps the best hope of a cure. If, on the other hand, alcohol is not considered to be disease-producing in this sense, justification for forced treatment will be harder to find. There may also be second-order consequences for the dynamics of the doctor-patient relationship, depending on whether a person who consistently misuses alcohol is seen as the victim of an illness, or is seen as healthy-but-bad.\(^{14}\)

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\(^{11}\) Supra, Chapter 3, section 3.2.1.

\(^{12}\) "Problem drinking is repetitive use of beverage alcohol causing physical, psychological or social harm to the drinker or to others": D Cahalan, Problem drinkers: A national survey (San Francisco: Jossey-Bass, 1970), p ii.


\(^{14}\) This point is developed by P Davies, Motivation, Responsibility and Sickness in the Psychiatric Treatment of Alcoholism (1979) British Journal of Psychiatry, vol 134: 449-458.
2.2.1 History of the disease concept of alcoholism

Many scholars trace the development of the idea that alcoholism is a progressive disease to 1784 and the work of an American physician, Dr Benjamin Rush. Other ‘men of science’ were soon to follow Rush’s lead. In his Essay, Medical, Philosophical, and Chemical, on Drunkenness (1788), Dr Thomas Trotter outlined his view that: “in medical language, I consider drunkenness, strictly speaking, to be a disease; produced by a remote cause, and giving birth to actions and movements in the living body, that disorder the functions of health”. A century later, medical commentators acknowledged that the preceding years had seen this view become established as a ‘new’ orthodoxy.

Our present jurisprudence, so far as it relates to inebriates, was framed at a time when the physical aspect of inebriety and the diseased condition of a large proportion of inebriates were not even suspected, except by a very few far-seeing philosophic medical observers. In those days, pains, penalties, rebuke and contempt were hurled at drunkards of all degrees and varieties indiscriminately. They were regarded as vicious and depraved sinners.

Now we know better. Let legal luminaries understand that in many instances inebriety has a pathological origin.

By the late nineteenth century, alcoholism had in fact come to be regarded as one of several ‘diseases of the will’ that was coloured by class and gender. Many of the people diagnosed as habitual drunkards / inebriates / alcoholics belonged to social groups believed to have small amounts of self-control and willpower – the so-called ‘vicious poor’. These influences soon merged with what anthropologists have described as “the venerable Protestant drama of sin and salvation”. From its earliest origins, the temperance movement began proselytising for the disease concept of alcoholism. Temperance preachers emphasised the damaging properties of alcohol and sought to achieve a ban of the dangerous substance. It was argued that alcohol destroyed a drinker’s abilities of self-control and self-discipline, and that it would weaken the higher and moral portions of the brain. The only cure for this disease was abstinence.

In short, the disease model characterises alcoholism as a chronic, involuntary, irreversible illness that will inevitably get worse without treatment, and has only one cure – giving up alcohol altogether. The disease model posits that

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18 In his recent analysis, Marc Valverde identifies three gendered classes in the construct of ‘diseases of the will’: the upper-class gentleman, who at worst was suffering from excess virility, the weak-willed ladies, not true alcoholics, but the gullible victims of advertising or poor medical practices; and the degenerate proletarians, whose liquor problems are the result of class-related mental characteristics. M Valverde, ‘Slavery from within’: The invention of alcoholism and the question of free-will (1997) Social History, vol 22(3): 251-268. For a New Zealand perspective on the influence of class and gender on the construction of drunkenness, see C S Hogg, The Languages of Intoxication: Gendered representations of drunkenness in Victorian England, 1870-1900. Unpublished MA(History) Thesis. (Auckland: University of Auckland, 1999).
20 It is interesting that most nineteenth and early twentieth century writers within this tradition advocated that this return to purity was most likely to be achieved in the isolation of the countryside. “The basic idea was to create a new, less stressful environment for the drunkard, free of the enervating energy and corrupting passion that had weakened him …. Drunken asylums then must be situated in the quiet of the countryside, away from the hated, festering city. There, with sympathetic nursing, understanding, rest, and the imposition of regular routine, he or she might be led to recovery”, G Bretherton, Irish inebriate reformatories, 1899-1920: A small experiment in coercion (1986) Contemporary Drug Problems, Fall: 473-502, at 487.
alcoholism is generally outside an individual’s control. To this extent, the disease theory of alcoholism is a sub-set of the broader ‘medical model’, which categorises (socially-unsettling) behaviour as the product of a disease. Features of both models are that they are paternalistic and mechanistic, as American social scientist Jeffrey Schaler explains:\textsuperscript{22}

In the disease or medical model, addicts are considered to have physiological differences from normal people, differences based in a genetic source or created through the chemical effects of drugs. Instead of focussing on the interaction between the self and the environment, advocates of the disease model view the interaction between physiology and the chemicals in drugs as both the disease and the executor of behavior and experience. In this sense the model is mechanistic. The person is viewed as a machine, a highly complex machine, but a machine nevertheless. This disease of addiction is considered to be incurable. People in treatment can only reach a state of perpetual recovery. Treatment of symptoms involves admitting that one is ill by breaking through denial of the disease and turning over one’s life to a ‘higher power’ in a spiritual sense and psychological support to achieve sobriety. Addicts are not bad but sick people. Intervention is required because the machine is broken.

A corollary of the disease or medical model of alcoholism is a view that alcoholics are “unable to think rationally”, and should therefore not be held accountable for their actions, because they are merely the “outpourings of a sick brain”.\textsuperscript{23} The denial of moral agency assumed by this pathological model of alcoholism was a feature of thinking about alcohol at the time that the ADA Act was passed, and certainly, the disease concept of alcoholism held sway within the academy. According to the Director of the Rutgers Centre of Alcohol Studies, for example, writing in 1958, the word “drinking” could not even properly be applied to the intake of alcohol by an addict: “He is no more a drinker than a kleptomaniac is a customer or a pyromaniac is a campfire girl. Alcoholics may consume alcohol. They do not drink”.\textsuperscript{24}

This perception of alcohol use by people with what later came to be called “alcohol dependence syndrome”, gave a compulsive quality to the alcoholic’s behaviour, and helped to elide the differences between people with psychiatric illnesses and people with alcohol use problems. Indeed, so mainstream did the disease model of addiction become in the mid twentieth century that the American Medical Association formally declared alcoholism to be a disease in 1956, and the American Psychological Association and the World Health Organization were both to follow suit by 1967.

In American jurisprudence during this period, the Supreme Court also held that addiction was an illness, and to criminalise an illness was to inflict cruel and unusual punishment in violation of the Eight Amendment to the U.S. Constitution.\textsuperscript{25} By the early 1980s, American legal scholars were able to confidently assert that “the disease theory has won its main polemical battle, and most authorities now reject the notion that alcohol abuse reflects moral failure, believing instead that problem drinkers cannot overcome their dependence on alcohol without outside support”.\textsuperscript{26}

\subsection{2.2.2 Biological or genetic bases of alcoholism}

Central to these pathologising theories is a biological imperative to alcoholism that causes an alcoholic to lose control.

\textsuperscript{25} See the leading case of Robinson v California 370 U.S. 660 (1962).
To bolster their claims, disease model advocates cite research studies which seem to suggest that there may be a genetic predisposition towards alcoholism. For instance, some studies have found that identical twins are more likely to share a drinking problem than fraternal twins, and adopted children whose birth parents were alcoholics are four times likelier than children who are adopted from non-alcoholic homes to become dependent on alcohol themselves.27

Moreover, a recent study by Kenneth Blum and co-researchers published in the *Journal of the American Medical Association* suggested that the dopamine D₂ receptor gene confers susceptibility to at least one form of alcoholism.28 However, studies such as this have failed to control for the influence of a range of personal and environmental factors that may help to answer two fundamental questions that Blum and others avoid: why do people who are genetically predisposed to alcoholism not become alcoholics? and why do people who are not genetically predisposed to alcoholism become alcoholics? Clear answers to these two questions are needed before one can have confidence in the existence of the biological or genetic mechanisms that are theoretically associated with the disease of alcoholism. The need for such answers is further underlined by the fact that attempts to replicate the experimental findings of Blum and associates have found higher levels of D₂ receptor gene in control populations than ‘alcoholic’ populations.29

A recent attempt to take account of such personal and environmental factors is the biopsychosocial model of alcoholism. Interpreting discourses around alcoholism as struggles between hegemonic medical and scientific models, the biopsychosocial model acknowledges that alcoholism “is a multicausal disease, has a physiological component, may be genetic, but occurs within an individual embedded in a family system that is located in a particular social class, historical time, and socioeconomic actualities”.30 Although it signals a move towards understanding alcoholism as multi-dimensional and lying along a behavioural continuum, which is suggestive of a spectrum of problems rather than a discontinuous group of categories, the biopsychosocial model still adheres to the organising metaphor of alcoholism as a “disease”. As such, it comes equally loaded with pre-determined judgements about the optimal way to respond to alcohol problems. These embedded judgements can be, and are, used to justify coerced treatment of alcoholics.31

### 2.2.3 Challenges to the disease model of alcoholism

Although it continues to be vigorously contested,32 and while few now dispute that alcoholism can have a biological or genetic component,33 the threshold question of whether alcoholism is a “disease” has, in recent times, been resoundingly answered in the negative by researchers such as Nick Heather and Ian Roberston,34 who have shown that alcohol misuse is a behaviour influenced by psychological, cultural and environmental forces - not just physiology.

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27 One of the earliest studies to suggest such a correlation was D W Goodwin et al., Alcohol problems in adoptees raised apart from biological parents (1973) *Archives of General Psychiatry*, vol 26: 238-243.


American psychologist Staton Peele has been another leading critic of the disease concept of alcoholism, which he sees as perpetuating an infantilizing myth that people cannot be expected to control their use of alcohol. As Peele explains:  

Neither laboratory nor epidemiological experimentation provides support for the idea that alcoholics lose control of their drinking whenever they consume alcohol. That is, drinking alcohol does not inevitably, or even typically, lead to excessive drinking by the alcoholic. Moreover, experiments with alcoholics demonstrate that they drink to achieve a specific state of intoxication or blood alcohol level; that they are often self-conscious about this state, what it does for them, and why they desire it; and that even when they become intoxicated, they respond to important dimensions of their environments which cause them to drink less or more. In other words, although alcoholics often regret the effects of their drinking, they do regulate their drinking in line with a variety of goals to which they attach more or less value.

Peele points to numerous historical, anthropological and socio-psychological studies of difficult cultures which note how malleable peoples’ drinking habits are, thus denying any supposedly innate addictive qualities of alcohol and pointing to associations between cultural and ethnic variables and the incidence of alcohol-related problems. He urges us to see addictive behaviour as no different from all other human feeling and action in being subject to a range of non-biological factors: cultural, social, situational, ritualistic, developmental, personality and cognitive.

A small selection of these studies challenging the disease model's loss-of-control myth may be quickly surveyed. Two early British studies were especially significant in challenging the assumption that alcohol per se has power over alcoholics. In the first, a long-term follow-up of patients at London's Maudsley Hospital, alcoholics who exhibited a pattern of normal drinking behaviour at follow-up were found to have no physiological differences from those alcoholics who were still drinking at excessive levels. The second study replicated this central finding. Contrary to the predictions of the disease model of alcoholism, it found that alcoholics who were unaware that they were drinking alcohol did not develop an uncontrollable craving to drink more alcohol.

Later researchers have also been able to show through rigorous experimental designs that alcohol use does not trigger ‘binges’ amongst people with drinking problems. For example, in what has become a classic study, Alan Marlatt and colleagues at the University of Washington in Seattle randomly assigned two types of beverages to a group of 64 alcoholics and a paired control group of social drinkers. Some of the subjects were given an alcohol-

containing beverage, but were told that it contained none; while the remainder of the subjects were given an alcohol-free beverage, but were told that it did contain alcohol. The study found that, amongst both the alcoholics' group and the social drinkers' group: "the consumption rates were higher in those conditions in which subjects were led to believe that they would consume alcohol, regardless of the actual beverage administered".\(^\text{40}\)

These results have been widely interpreted as showing that psychological expectancies are a more powerful influence on drinking behaviour than any physiological reaction to alcohol that may be experienced by the drinker.

Perhaps the most basic objection to the behaviourist assumptions that lie behind the disease model of alcoholism are their failure to convincingly explain why, after experiencing negative consequences from drinking alcohol, anyone would want to go back and repeat that unpleasant experience again and again. Here, it is significant that laboratory studies have found that it is very difficult to get rats to drink alcohol. In a series of studies by American scientist Jeremy Falk,\(^\text{41}\) the research team was only able to induce such drinking through the imposition of intermittent feeding schedules that the rodents find highly uncomfortable. In this condition, the rats drink heavily but also indulge in excessive and self-destructive behaviour of many kinds. All such behaviour – including drinking – was found to depend on the continuation of this feeding schedule and disappeared as soon as normal feeding opportunities were restored. Thus, for rats that had been alcohol-dependent, the scientists found that "a history of ethanol overindulgence was not a sufficient condition for the maintenance of overdrinking".\(^\text{42}\)

On the basis of this animal research, alcohol dependence seems to be strongly state-dependent, rather than a persistent characteristic of the organism. Rather than being contradicted by human behaviour, this trend may be even more pronounced for humans. As even one of the champions of the disease model has observed: "The foundation is set for the progression of the alcohol dependence syndrome by virtue of its biologically intensifying itself. One would think that, once caught up in the process, the individual could not be extricated. However, and for reasons poorly understood, the reality is otherwise. Many, perhaps most, do free themselves".\(^\text{43}\)

2.3 What does this imply for responses to alcoholism?

As the quotation above suggests, although some people would like to cling to the notion that alcoholism is a disease which, as its name suggests, requires medical assistance to cure, most people who can be classified as "alcoholics" simply do not conform to such a pathologising model. The disconnect is perhaps best captured by another staunch defender of the disease model of alcoholism, American psychologist George Vaillant, who has lamented that people with alcohol abuse or dependence problems are a little like the rabbit in Lewis Carroll's *Alice in Wonderland*: "Alcoholics appear from nowhere, bewilder us for a while and then mysteriously disappear".\(^\text{44}\)

Moreover, not all alcoholics come out of their rabbit holes; or at least, not to the attention of health professionals.

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like alcohol and other drug counsellors. It is important to note that, in New Zealand as overseas, the majority of people who either misuse alcohol or are alcohol dependent do not seek formal help for their drinking problems.

Of those alcoholics who do come to official attention, what are the implications of finding that alcoholism is not a disease for the way in which the state frames its responses to alcoholics? Specifically, what does the knowledge we have about alcoholism being a socially-learnt behaviour, influenced by a range of possible non-biological (psychological, cultural, environmental) as well biological forces (physiological, genetic), say about the wisdom of compulsory treatment?

2.3.1 What sort of treatment is currently being offered?

Alcohol abuse and dependence problems are addressed by a range of treatment modalities in New Zealand, including hospital-based services, detoxification units, residential and out-patient facilities, pharmacotherapy, telephone-based counselling, and self-help groups such as Alcoholics Anonymous (AA). Many residential treatment centres offer variations of abstinence-based 12-step programmes that were originally developed by the Hazelden Foundation and other Minnesota clinics in the 1950s, which combine psychological and peer counselling with AA attendance.

The most recent estimates of the size of the alcohol treatment sector in New Zealand suggest that there are over 150 treatment services for people with alcohol-related problems. This includes publicly-funded and private services, as well as specific by-Māori-for-Māori treatment facilities and a small number of dedicated services for Pacific people. It has been commented that there has been a trend away from the use of in-patient facilities in favour of out-patient or community-based treatment services, as part of a broader movement towards deinstitutionalisation in mental health.

As far as New Zealand's residential alcohol and drug treatment services are concerned, the majority operate within an abstinence-based 12-step model that is premised on the immersion of a patient within a therapeutic milieu for varying lengths of time, from a few weeks to several months. Some of the more well-known examples of these services are the various Salvation Army Bridge programmes and Odyssey House facilities, and the Hanmer Institute at Queen Mary Hospital. These in-patient facilities have a broadly similar 12-step regimen and matching alcoholism treatment philosophy, which are generally consistent with the disease model of addiction.

45 This may be because of 'barriers to entry' that make helping agencies inaccessible or otherwise unattractive. See, for example, B Tuchfeld, Spontaneous remission in alcoholics — Empirical and theoretical implications (1981) Journal of Studies on Alcohol, vol 42: 626-641; and M Brady, Giving away the grog: An ethnography of Aboriginal drinkers who quit without help (1993) Drug and Alcohol Review, vol 12: 401-411.
47 While AA is seen as the grandparent of all 12-step programmes, the two approaches are not synonymous: AA is a self-help group aimed at sobriety and spiritual renewal; 12-step alcohol treatment programmes adopt some of AA’s tenets but also include a wide array of secular treatment approaches, from psychotherapy to acupuncture. See, further, C Bule: Alcoholics Anonymous: Cure or Cult? (Tuscon: See Sharp Press, 1998); and S Peele et al., Resisting 12-Step Coercion: How to fight forced participation in AA, NA, or 12-Step Treatment (Tuscon: See Sharp Press, 2000), esp pp 82-106.
48 Alcohol Advisory Council of New Zealand, Alcohol Fact Pack. 1997 (Wellington: Alcohol Advisory Council, 1998). For the most up-to-date overview, see Health Funding Authority, National Alcohol and Other Drug Services Funding Strategy: Discussion Document (Wellington: Health Funding Authority, 2000), esp pp 5-9.
Typically, in-patient treatment is only used for people whose drinking problems are at the severe end of the scale [see diagram below]. Forced in-patient treatment would normally only be considered for the most severe cases.

ALCOHOL-RELATED PROBLEMS AND ASSOCIATED RESPONSES

Source: Institute of Medicine, Broadening the Base of Treatment for Alcohol Problems (Washington DC: National Academy Press, 1990), p 212

2.3.2 Is the treatment that is offered effective?

As alluded to earlier,^51 evidence about the effectiveness of any sort of treatment for alcoholism is equivocal at best. As British alcohol researcher Jim Orford conceded in 1978, "if we are honest with ourselves, we have to admit we are impotent to prevent alcoholism occurring, and we have recorded little success in treating it". More recently, the authors of a comprehensive review of the effectiveness of alcohol treatment concluded: "The question of whether treatment is more effective than no treatment at all must be answered in the negative; if by 'effective' is meant permanent improvement in drinking behaviour". The finding that most alcoholism treatment approaches have little lasting effect is now a commonplace in the professional literature on alcohol and drug treatment policy, with particular pessimism reserved for residential treatment which features abstinence-based 12-step modules.^54

In fact, although a range of treatment services are available to help people moderate their drinking, there is a growing body of international literature which suggests that many people reduce their harmful drinking practices

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^51 Supra, Chapter 1, notes 17-22, and accompanying text.
without any 'treatment'.\textsuperscript{55} This phenomenon has been given several names, including spontaneous remission, maturing out and natural recovery.

Not only do many people who drink at abuse or dependence levels quit without treatment, survey evidence suggests that untreated alcoholics are more likely to be able to reduce or control their drinking than those who have received formal treatment. The National Longitudinal Alcohol Epidemiological Survey, which surveyed over 40,000 Americans about their drinking, is instructive in this regard. Of the approximately 4,500 respondents in the Survey who qualified for DSM-IV alcohol dependence at some point in their lives, only 28 percent of those who had undergone treatment reported that they were currently drinking at below abuse or dependence levels, versus 58 percent of those who were not treated. Furthermore, 33 percent of the treated subjects reported that they were currently drinking at abuse or dependent levels, versus only 26 percent of the untreated subjects.\textsuperscript{56}

These results counsel against viewing treatment as a necessary or even sufficient intervention for alcoholics to better manage their drinking. This has grave implications for the legitimacy of compulsory treatment programmes, as it suggests that forcing alcoholics into treatment may not only fail to succeed in terms of helping them to achieve sobriety, but may in fact retard their chances of learning to manage their drinking problems on their own. Indeed, an influential model of the process of giving up harmful alcohol use patterns helps to explain why this may be so. This transtheoretical model – referred to as 'the stages of change' – was developed by two American psychologists, Jim Prochaska and Carlo DiClemente.\textsuperscript{57} It predicts that change in alcohol use involves four stages:

(a) Pre-contemplation: the individual is not aware of any problems associated with his or her drinking, and has no desire to change;

(b) Contemplation: the individual develops some awareness of alcohol-related problems, and begins to weigh up the pros and cons of reducing or moderating his or her drinking;

(c) Action: the individual makes practical efforts to reduce or moderate his or her drinking behaviour;

(d) Maintenance: the individual is involved in an on-going process of holding the gains he or she has made.

If maintenance is unsuccessful, and the drinker experiences a relapse, then the stages of change model foresees that he or she will return to the pre-contemplation stage; initiating a cycle familiar as the ‘revolving door’ alcoholic [see diagram overleaf].


\textsuperscript{56} The full results of the National Longitudinal Alcohol Epidemiological Survey are reported by D A Dawson, Correlates of past-year status among treated and untreated persons with former alcohol dependence: United States, 1992 (1996) \textit{Alcoholism: Clinical and Experimental Research}, vol 20: 771-779.

THE STAGES OF CHANGE MODEL

Exit – long-term reduction in drinking  Enter - problem drinking

Relapse
Maintenance
Pre-contemplation
Action
Contemplation
Determination to cut down


The stages of change model has been widely accepted as providing a useful way of conceptualising the process that alcoholics go through in managing their drinking down below clinically-defined levels of abuse or dependence. It is well-supported by research evidence, and offers a powerful analytical tool for understanding which types of interventions may have an impact for particular alcoholics who are at different stages in their readiness to change. For example, telling pre-contemplators how to become abstinent may have limited or no impact, because they are not at a stage where such information will have any traction for them, whereas they may be more receptive to interventions that aim to keep them safer while they continue to drink (for example, advice on diet and first aid).

2.3.3 Is compulsory treatment more or less likely to be effective?

An understanding of the stages of change model indicates that compulsory treatment of alcoholics may be a poor tool to use for those who are still pre-contemplators, and may even be of limited benefit for contemplators. Although a Court forcing an alcoholic to enter treatment is one way of making an alcoholic recognise problems associated with his or her drinking, the external prompt for that recognition could mean that the alcoholic defines the problem as one that other people have with his or her drinking, instead of one that the drinker 'owns' internally.

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The research literature would suggest that internally-generated recognition of problems associated with drinking – such as personally humiliating events, negative role models, physical ill health, financial or relationship problems – are more likely to prompt an alcoholic to reappraise the costs/benefits of continued heavy alcohol consumption, and decide that ‘enough is enough’.\(^5^9\) The stages of change model would predict that motivational enhancement therapy or similar types of intervention are most likely to have a beneficial effect for bringing pre-contemplators and contemplators to the point where they can start a process of acting to make positive changes in their lives. Forcing such people prematurely into an intensive residential programme that features, say, cognitive behavioural therapy, would in contrast be predicted to be largely a waste of time, and may in fact build resistance to change which is ultimately unhelpful in facilitating the alcoholic’s progression through the action and maintenance stages. Indeed, there is solid support for these predictions in the large-scale Project MATCH study,\(^6^0\) as well as evaluations of smaller-scale pairing of interventions to people with alcohol problems who were at different stages of change.\(^6^1\)

Conversely, if an alcoholic who is already at the action stage of the change cycle is forced into formal treatment, the stages of change model would predict that he or she may derive some added benefit from the intervention. This is because, as mentioned previously,\(^6^2\) it is generally the case that longer stays in treatment predict greater reductions in alcohol use; and alcoholics who are already looking to make practical efforts to reduce or moderate their drinking may welcome the additional ‘push’ that they receive by being put into a residential treatment facility. The existence of a Court order compelling attendance in treatment may also function as a valuable ‘backstop’ if their will to continue with treatment falters, and they are at risk of ‘dropping out’ and relapsing into alcohol misuse.

Having said this, the evidence base on the effectiveness of alcohol treatment interventions would suggest that even such already-motivated alcoholics should be allowed to choose the type of treatment programme they enter. Numerous studies have found that commitment to therapy and ultimately successfully outcomes are encouraged if patients are provided with options, and are empowered to make decisions about the treatment that they receive – for example, whether to pursue an overall goal of abstinence, or whether to aim to better control their drinking.\(^6^3\)

In other words, patient choice can be clinically and therapeutically useful in its own right in alcoholism treatment, and interventions which serve to deny patients' choice can actually impede the change process. It follows that state-compelled treatment could end up doing more harm than good. This is especially true if, as the evidence suggests, when alcoholics are ready to change the way that they drink, they can do so for themselves without professional help. Indeed, using simple cost-benefit notions, some economists have sought to explain how, by

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\(^{60}\) See supra, Chapter 1, note 22.  
\(^{61}\) For a recent Australian example, see N Heather et al., Effects of brief counselling among male heavy drinkers identified on general hospital wards (1996) Drug and Alcohol Review, vol 15: 29-38.  
\(^{62}\) Supra, Chapter 1, note 18.  
lowering the costs of addiction but not directly influencing the benefits of addiction, any treatment can actually make the chances of an addict returning to drinking more likely than if they had not undergone treatment in the first place.\(^{64}\)

### 2.4 Why can we deal with alcoholism in purely policy terms?

At this juncture, it is important to be clear about the reasons why this assessment can be made in purely policy terms, without necessarily referring to the (possible) social utility or moral infrastructure of involuntary alcoholism treatment.\(^{65}\)

One of the theoretical hooks on which this study may be hung is the theme of alcoholics existing outside the "normal" – that is, not participating in the same sorts of moral or ethical conversations as right-thinking members of society. The emerging field of alcohol and literature studies has thrown up many examples of how, in Jane Lilienfeld’s words, "alcoholics ... function as derided Others onto whom are projected that which is deemed culturally unacceptable".\(^{66}\)

The labelling school within the sociology of deviance, epitomised by Harold Becker’s classic work, Outsiders (1963), provides some of the most powerful ways of seeing the social construction of chronic alcohol abusers as ‘other’, which incorporates justifications for punishing such peoples’ deviation and bringing them back within the established order.\(^{67}\)

Building on the functionalist intuition that, in certain ways, a society needs its deviants,\(^{68}\) scholars like Nils Christie have shown how chronic alcohol and other drug users can make “suitable enemies” for societies to declare war upon, especially those whose substance use spills over into public view (for example, vagrant ‘skid row’ alcoholics who congregate together in parks or thoroughfares; or drunken hooligans who are seen to plague some sporting fixtures).\(^{69}\)

Following this neo-functional line of thinking, punishment of alcoholics’ moral deviation from the accepted order (even when dressed in therapeutic clothing) can have important norm-reaffirming benefits. This argument works within a logic whereby, “if insistence on certain standards of behaviour is seen as a kind of moral cement which consolidates society and gives it identity, then enforcement is required to preserve that identity and to prevent harm”.\(^{70}\)

Self-evidently, though, this mode of argument is beset by a series of difficulties, not the least of which is the Protean task of pinning down exactly what moral infrastructure supports a law like the ADA Act. But demonstrating the existence of a ‘public morality’ on alcohol or quantifying the ‘moral harm’ of alcohol abuse or dependence need not delay us here.\(^{71}\) We may also side-step criticisms of assumed ethical consensus in society advanced by scholars taking a so-called postmodern turn,\(^{72}\) who cite the fracturing of moral authority during the period of “late modernity”\(^{73}\) or “reflexive modernisation”.\(^{74}\)

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\(^{65}\) It may be objected that the coverage of moral and social (dis)values of compulsory alcoholism treatment which follow are shallow and question-begging. Discussion of the moral and social subtext of forced treatment is deferred to later in the thesis (supra, Chapters 8 and 10), and then only comparatively briefly, as this thesis sets out to be an exercise in legal policy analysis – not a work of political or legal philosophy. For a more nuanced examination of the moral relevance of freedom and other values in the context of alcohol and other drug dependence, refer to G Oddie, Addiction and the Value of Freedom (1993) Bioethics, vol 7: 374-401.


The basis upon which these difficulties can be avoided is that, unlike the case with *malum in se* such as homicide, legislation aimed at helping people with alcohol use disorders to achieve sobriety, or to moderate their alcohol consumption to within generally-accepted levels, operates in the realm of *malum prohibitum*. This is because (heavy) drinking is still firmly embedded in New Zealand culture, and excessive or habitual use of alcohol does not attract the moral outrage or social opprobrium that other types of behaviour can.

As evidence of this proposition, it is worthwhile reflecting briefly on the levels of community concern about alcohol use in New Zealand that emerge from the 1990 and 1998 national drug surveys, and the 1995 national alcohol survey, conducted by Auckland University’s Alcohol and Public Health Research Unit. These surveys reveal that alcohol is the most commonly used recreational drug in New Zealand, with some 90 percent of men and 85 percent of women having tried alcohol, and only slightly lower proportions having consumed alcohol during the past year. Overall, the survey data indicate that there is a fairly accepting attitude to the risk of alcohol-related harm, with a significant proportion of respondents indicating that they encountered problems with their own drinking, or the drinking of others, yet continued to use alcohol. Comparisons between the 1995 and 1998 surveys suggest, in fact, that there was an increase in the proportion of the sample who reported getting drunk. Finally, in terms of levels of community concern about alcohol relative to other drugs, using a standardised problem scale, these surveys demonstrate that alcohol ranks approximately third, being of roughly the same concern as solvent abuse and illegal drugs other than cannabis.

These survey results tend to indicate that even excessive alcohol use is not greeted with particular moral or social anxiety by the overwhelming majority of New Zealanders, underlining the point that it is not seen as a *malum in se*. (This is consistent with the fact that the offence of public drunkenness was removed from the criminal code in 1982.)

2.5 What analytical approaches give us the most traction on the issues involved?

Building on these empirical and theoretical foundations, it remains to identify which analytical approaches offer the most traction on the ADA Act. Here, two approaches recommend themselves. In many ways, the most powerful explanatory technique for understanding the compulsory treatment of alcoholics is to invoke the metric of harm minimisation that undergirds both New Zealand’s *National Drug Policy* and *National Alcohol Strategy*.

2.5.1 Harm minimisation

The modest success or outright failure of various drug control strategies employed over the past century challenged many policymakers and practitioners to think about drugs, including alcohol, in a new kind of way. One of the products of that rethinking has been the philosophy of harm minimisation that emerged in the 1990s.

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Rather than conceiving of drugs in narrow supply and demand terms, the harm minimisation approach changed the focus to the harm associated with particular types and modes of drug use. The primary goal of this approach was to achieve a net reduction in drug-related harm rather than trying to get users to become drug free overnight.

One of the first to try and systematise the intuitions behind harm minimisation was English sociologist Ralph Newcombe, who proposed two axes of drug-related harm: the type of harm (health, social or economic) and the level at which the harm is experienced (individual, community or society).\textsuperscript{77} Canadian addictions researcher Patricia Erickson and colleagues have subsequently offered one of the best accounts of the paradigm.\textsuperscript{78} They identify the touchstones of harm minimisation as: giving an active and conscious role to the individual drug user; recognising the importance of interaction among physical, psychological, social and cultural factors in shaping prevention and intervention outcomes; and making no assumptions about the moral or legal nature of drug use.\textsuperscript{79}

At the level of policy, harm minimisation provides a framework for asking practical questions and designing strategies to address different patterns of drug-related harm. Typically, these strategies are seen to fall into three main categories: supply control (measures which seek to control the availability of a drug, such as regulation and enforcement), demand reduction (measures which encourage reduced and responsible drug use, such as information and education campaigns) and problem limitation (measures which are aimed at problems stemming from drug use, such as the provision of treatment services).\textsuperscript{80} Harm minimisation is also said to contain an embedded preference for middle-range, down-to-earth policy measures rather than sweeping, macro-level policy measures that are rigidly and uniformly applied to all types and levels of drug-related harm. An advantage of this is that, although often at odds with the dominant policy of legal sanctions, "the middle range and pragmatic nature of harm reduction measures makes it possible for certain harm reduction strategies to be tolerated, accepted or even incorporated by legal authorities, without completely dismantling the counter-productive punitive policy".\textsuperscript{81}

Although the philosophy of harm minimisation is continuing to evolve,\textsuperscript{82} there is now wide agreement on its core components, and it has been officially adopted as the framework for the national drug policies of a number of Western countries, including Canada, Australia and New Zealand. By seeking to avoid the moral, legal and medical reductionist biases of other approaches to drug use, the guiding principle of harm minimisation has contributed to a more flexible approach to tackling drug-related harm, and has encouraged innovative design at both the policy and programme level.

\textsuperscript{77} See supra, Chapter 1, note 51, and accompanying text.
\textsuperscript{79} P G Erickson et al., Harm Reduction: A New Direction for Drug Policies and Programs (Toronto: University of Toronto Press, 1996).
\textsuperscript{80} Ibid, p 23.
\textsuperscript{81} Supply control, demand reduction and problem limitation strategies are often called the 'three pillars' of harm minimisation: see, for example, Drugs and Crime Prevention Committee, Harm-Minimisation: Principles and Policy Frameworks. DCPC Occasional Paper No. 1 (Melbourne: Parliament of Victoria, 1999), p 14.
2.5.2 Alcohol harm minimisation

The signature harm minimisation policies are often seen to occur in illicit drug contexts: for example, methadone maintenance treatment for people with opioid dependence, and needle-syringe exchange schemes for injecting drug users. Increasingly, though, harm minimisation approaches are being applied to alcohol-related problems.\(^{83}\)

Until recently, what might be styled alcohol harm minimisation efforts tended to focus on supply control issues such as state monopolies on the alcohol trade, the number and location of off-premise sales outlets, licensing regulations, drinking age restrictions, laws against selling to intoxicated persons, criminal penalties for driving while intoxicated, and so on – as well as demand reduction issues that were directed at the availability of alcohol – such as advertising and sponsorship restrictions and alcohol taxation policy. This focus on alcohol availability was based on the well-established relationship between alcohol control measures, levels of alcohol consumption, and indicators of alcohol-related health and social problems.\(^{84}\) The broad message was: 'less drinking is better'.

As harm minimisation intuitions have developed, this emphasis on total alcohol consumption has given way to a more attenuated message: 'not all drinking is harmful, but some drinking patterns are more harmful than others'. Canadian public health specialist, Professor Eric Single, points out that this more sophisticated message complements rather than contradicts the message that drinking less alcohol is better, as some harm minimisation approaches (for example, promoting low-alcohol beverages) actually seek to lower overall alcohol consumption:\(^{85}\)

[Harm minimisation] differs from prior alcohol prevention approaches in that it focuses on decreasing the risk and severity of adverse consequences arising from alcohol consumption without necessarily decreasing the level of consumption. It is essentially a practical rather than an idealized approach: the standard of success is not some ideal drinking level or situation (abstention or low-risk levels), but whether or not the chances that adverse consequences have been reduced by the introduction of the prevention measure.

The defining feature of harm minimisation approaches to alcohol, therefore, is an attempt to reduce the harmful consequences of alcohol consumption even (and especially) in situations where people will be continuing to drink. That drinking will take place is accepted as a fact, implying neither approval nor disapproval. The drinker is not seen as abnormal in any way, and he or she is positioned as morally and legally responsible for his or her actions. In this way, harm minimisation approaches to alcohol are value neutral regarding the long-term goals of intervention; which may or may not include sobriety, but may simply involve limiting a person’s episodes of acute alcohol poisoning.

Within this logic, the application of harm minimisation principles can produce what, at first blush, seem to be counter-intuitive policy responses. A good example of such an alcohol harm minimisation measure is provided by the introduction of special early opening hours for an Alberta Liquor Control Board outlet in downtown Edmonton.

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83 For a comprehensive introduction, see M Plant et al. (eds.), Alcohol: Minimising the Harms (New York: Free Association Books, 1997).


The objective of the early opening hours was to reduce the use of potentially lethal non-beverage alcohol by a small population of 'skid-row' alcoholics. The measure was not intended to reduce the alcoholics' consumption; indeed, it was fully expected to increase their intake of beverage alcohol. Instead, the measure was directed exclusively at reducing adverse consequences from their drinking things like shoe polish and methylated spirits.86

Once the presumption has been broken down that ‘any alcohol use by an alcoholic is bad’, policymakers who adopt a harm minimisation approach are also open to the possibility that controlled drinking programmes may be offered as a treatment option for alcoholics.87 Borrowing a phrase from German alcohol researcher Jürgen Rehm, to deny this possibility would be equivalent to insisting upon draining the ocean to prevent shark attacks.88

By focussing on ways of minimising the problems associated with drinking, rather than seeking to reduce alcohol consumption per se, harm minimisation strategies will be more likely to target heavy drinking occasions among all drinkers, rather than people who are considered heavy drinkers in aggregate terms (the prototypical 'alcoholic'). There is growing empirical support for this focus. Analyses of national survey data in Australia,89 Canada90 and the United States91 all indicate that it may be more efficient to focus on heavy drinking occasions rather than the individual's level of alcohol intake. In these analyses, it was consistently found that the number of heavy drinking occasions is a stronger predictor of alcohol-related harm than the overall level of consumption. This is not to say, of course, that programmes which are specifically targeted at heavy drinkers should not be supported. They can and do result in reductions in alcohol problems. However, the philosophy of harm minimisation would suggest that programmes focusing on reducing overall levels of alcohol consumption should not be adopted to the exclusion of approaches which focus on heavy drinking occasions.

2.5.3 Alcohol harm minimisation and compulsory treatment

If alcoholism should be viewed as a social construction rather than a disease entity,92 and if we are to value any reduction in the harm associated with people’s alcohol use, rather than fixing on the need to deliver them into abstinence,93 what implications (if any) does this have for the way we view compulsory treatment of alcoholism?

86 This example is given by Professor Single in The concept of harm reduction and its application to alcohol (ibid), p 8.
91 L Midanik et al., Risk functions for alcohol-related problems in a 1988 U.S. national sample (Berkeley: Alcohol Research Group, California Pacific Medical Center Research Institute, 1994).
93 It is noteworthy, in fact, that outcome evaluations of alcoholism treatment programmes – even those operating abstinence-based 12-step programmes – almost always find that a significant proportion of 'treated' alcoholics return to moderate drinking. In one of the most sophisticated studies, conducted by the Rand Centre, alcoholics were followed-up four years after treatment. It found that close to 40 percent of the treated alcoholics who were free of drinking problems at the four-year level were still drinking, including a substantial minority who had been among the most alcohol-dependent on their admission. J M Polich et al., The course of alcoholism: Four years after treatment (New York: Wiley, 1981). For commentary, refer to R J Hodgson, The course of alcoholism: Four years after treatment (1980) British Journal of Addiction, vol 75: 343-360.
Without prej udging the more textured analysis which follows, a harm minimisation reading of a statute like the ADA Act might first point out that, simply by removing them from the physical opportunity to drink alcohol in harmful ways, forcing alcoholics into treatment is a way of reducing the alcohol-related harm that they experience. As such, compulsory treatment is likely to be viewed favourable within an alcohol harm minimisation framework.

Beyond these short-term harm minimisation gains, if coerced treatment were to contribute to alcoholics making lasting changes in their drinking practices, then such an intervention would also tend to be interpreted positively. Cameron Wild, a Canadian health promotion specialist, has characterised this view as a variation on the familiar 'tough love argument', wherein alcoholics are generally seen as poorly motivated to change their harmful drinking practices, and strong socio-legal sanctions are needed to convince them to change their alcohol intake patterns. Wild sees that compulsory treatment may facilitate alcoholics' recognition that they have a serious problem, thus promoting interest and motivation for behaviour change, and ultimately, a reduction of individual and social harm.

Despite these reasons to be optimistic about the harm minimisation credentials of compulsory treatment, Wild himself cautions that: "there are reasons to question the deceptively easy conclusion that compulsory treatment programs and harm-reduction strategies are conceptually compatible and mutually supportive strategies". For example, Wild notes that there are fundamental attitudinal barriers to the successful marriage of forced treatment and harm minimisation. He cites another study which surveyed 700 front-line Ontario alcohol and other drug counsellors about their agreement with statements such as: "Anybody with an alcohol or drug problem should be forced by law to enter treatment programs". The study found that only 10 percent of treatment service providers agreed with the statement, and that those who were more likely to hold positive attitudes about coerced treatment were less likely to entertain any treatment goals other than total abstinence for their alcohol-dependent clients. These results suggest that: (a) front-line treatment workers may bring ideological brakes to the effectiveness of compulsory treatment; and (b), front-line workers who are sympathetic to the use of coercion may be antithetical to the use of broader harm minimisation strategies, such as teaching controlled drinking skills to alcoholics.

When viewed in this light, the filter of harm minimisation may actually lead to a more ambivalent assessment of compulsory treatment than one might otherwise expect. A wider appreciation of harm minimisation as a philosophy may also offer insights on the way in which a compulsory treatment statute is applied 'on the ground'. For example, as well as questioning an exclusive focus on abstinence as the overall goal of treatment, harm minimisation thinking may call into question the procedures that are adopted for patients who bring alcohol into a residential treatment facility, or those who drink while they are absent on a period of leave from the institution. Any blanket rule that such patients are to be 'breached' off the programme would likely be seen as working

94 See infra, Chapters 7 and 8.
96 T C Wild, Compulsory Substance-User Treatment and Harm Reduction: A Critical Analysis (op. cit.), p 86.
against the interests of harm minimisation – which would recommend retaining patients in treatment, and using such incidents as opportunities to try and build resistance to future relapses and/or teach controlled drinking skills.

2.5.4 Therapeutic Jurisprudence

The second powerful way of looking at the ADA Act is to draw on the school of thought known as “therapeutic jurisprudence” – an approach that traces its lineage back to North American writing on mental health law in the mid to late 1970s, but which only coalesced as an identifiable strand in medico-legal scholarship during the early 1990s. Although it has been slow to be used in an Australasian context, the value of therapeutic jurisprudence as an analytical or heuristic device is increasingly being recognised, particularly in terms of its ability to interrogate the relationship between legal arrangements and therapeutic outcomes.

Broadly speaking, therapeutic jurisprudence concentrates on the way in which the law and legal processes work to promote or inhibit the psychological and/or physical well-being of the people who come into contact with them. It is a perspective that regards the law (rules of law, legal procedures, and the roles of legal actors) as a social force in itself that can produce therapeutic or anti-therapeutic consequences. By looking at the legal world in this way, therapeutic jurisprudence generates a rich set of empirical and normative questions about often taken-for-granted laws. It does not suggest that therapeutic concerns are more important than other consequences or factors; but it does suggest that the law’s role as a potential (anti)therapeutic agent should be recognised and systematically studied.

It is also important to recognise that therapeutic jurisprudence thinking can be applied at a micro, meso or macro level; typically, focussing on the therapeutic or anti-therapeutic effects of a law, legal process or legal actors for individuals, their families, their immediate communities, and society as a whole. Therapeutic jurisprudence is entirely open to the possibility that a particular law, legal rule, or interaction with judges or lawyers, may be therapeutic for some participants and anti-therapeutic for others. Where such experiences do clash, therapeutic jurisprudence does not suggest that the experiences of the individual should take precedence over the experiences of the individual’s family or community, or vice versa. It simply throws light on the conflict (or convergence) of competing (or complementary) interests, without answering any normative questions which may arise. Equally, while therapeutic jurisprudence calls on policymakers to be sensitive to the therapeutic consequences of legal arrangements, it does not go so far as to suggest that therapeutic considerations should trump other considerations – such as due process protections or


privileging the least restrictive alternative from a range of possible responses.\textsuperscript{104} That said, like the harm minimisation paradigm, the therapeutic jurisprudence approach seeks to be policy-relevant, and in mining laws and legal processes for their therapeutic value, it often produces nuggets with law reform potential. This part of the therapeutic jurisprudence project is explained by one of the movement's co-founders, American law professor, Bruce Winick:\textsuperscript{105}

A sensitive policy analysis of the law should seek to measure and weigh all of the various costs and benefits of legal rules. One important but previously neglected aspect of this policy calculus is the therapeutic impact of law. Therapeutic jurisprudence accordingly calls for a systematic study of law's therapeutic or antitherapeutic effects. These are not the only effects worth studying, but they should not be ignored. Therapeutic jurisprudence thus is largely a form of consequentialism .... Once it is understood that rules of substantive law, legal procedures, and the roles of various actors in the legal system such as judges and lawyers have either positive or negative effects on the health and mental health of the people they affect, the need to assess these therapeutic consequences should not be neglected. Accomplishing positive therapeutic consequences or eliminating or minimizing antitherapeutic consequences thus emerges as an important objective in any sensible law reform effort.

2.5.5 Examples of therapeutic jurisprudence analyses

It is easy to see how these sorts of intuitions might inform the analysis of legal policy issues. To take one example, the interrogation of a suspect in police custody can be problematic where the suspect is dependent upon opioid drugs, as the effects of recently-taken drugs or drug withdrawal symptoms can compromise the reliability of the suspect's statements. This problem has already been noted in the medico-legal literature,\textsuperscript{106} and has implications for issues such as fitness to interview, interrogative suggestibility and retracted confessions. When viewed through the lens of therapeutic jurisprudence, these issues can be considered in a way that zeroes in on the therapeutic / anti-therapeutic effects of different management responses to opioid-dependent suspects in police custody; out of which falls practical strategies that can minimise the potential for therapeutic harm, and can maximise the potential for therapeutic benefit.

Another example of the potential application of a therapeutic jurisprudence filter to applied legal policy analysis is the effect that serving on juries can have on jurors, especially in cases that involve graphic evidence of brutalising crimes. One recent American study, for instance, compared stress-levels of capital murder jurors in Texas who were tasked with making sentencing decisions (where the death penalty was sought) with jurors who had no sentencing discretion (where automatic life sentences were sought).\textsuperscript{107} Blending psychological insights with empirical social-science research techniques, studies like these yield policy-rich findings for decision-makers who administer the procedures around jury trials in such capital murder cases - such as ensuring the availability of post-case counselling for jurors.\textsuperscript{108}

\textsuperscript{104} R F Schopp, Therapeutic Jurisprudence and the conflicts among values in mental health law (1993) \textit{Behavioural Sciences and the Law}, vol 11: 31-45. This point was recently expanded upon by B J Winick, \textit{Therapeutic Jurisprudence – Past, Present and Future}. Unpublished paper presented to 20\textsuperscript{th} Annual Congress of the Australian and New Zealand Association of Psychiatry, Psychology and Law (Auckland, 4 August 2000).


\textsuperscript{107} R M Cusack, \textit{Stress and stress symptoms in capital murder jurors: Is jury duty hazardous to jurors' mental health?} Unpublished PhD thesis (San Antonio: St Mary's University, 1999).
Perhaps the clearest example of the application of notions of therapeutic jurisprudence to legal processes is the rapid proliferation of specialist jurisdiction Drug Courts, which have been established to deal with offenders whose alcohol and other drug problems are seen to be criminogenic.\textsuperscript{100} Although most of the published attempts to locate Drug Courts as an outworking of therapeutic jurisprudence appear to misunderstand this new approach (grasping instead at the rubric of therapeutic jurisprudence without a developed understanding of its antecedents or its implications),\textsuperscript{110} it is probably still correct to say that most Drug Courts consciously employ techniques that are consistent with a concern for the therapeutic outcome of legal interventions.

### 2.5.6 Therapeutic jurisprudence and compulsory treatment

Given this thumbnail sketch of the therapeutic jurisprudence way of analysing particular legal arrangements, what general observations would therapeutic jurisprudence suggest about the compulsory treatment of alcoholics? Again, without prejudging the more detailed analysis that follows,\textsuperscript{111} therapeutic jurisprudence would firstly seem to suggest that certain psychological principles that bear upon compliance with generic health care programmes could be applied in a legal context to facilitate the forced treatment of alcoholics. As summarised by the other co-founder of the therapeutic jurisprudence movement, American law and psychology professor, David Wexler:\textsuperscript{112}

> The psychological principles suggest that when one signs a behavioral contract, one is more likely to comply than if one does not make such an agreement. Also, one who makes a ‘public’ commitment to comply – a commitment to persons above and beyond the medical provider – is more likely to comply than one who does not make such a commitment. Further, if family members are involved and aware of a patient’s agreement, the patient is more likely to comply with the conditions than if family members are uninvolved in the process.

A problem that therapeutic jurisprudence anticipates with civil commitment regimes is that they will not always sit comfortably with these psychological principles. Although there is likely to be a fairly close fit with provisions for ‘voluntary’ applications for civil commitment orders, if a person is committed for treatment against their will, it is hard to see where any therapeutically-preferred behavioural contracting between the state and the citizen occurs.

The psychological principles would seem to apply more comfortably if the civil commitment procedure allows for the Court to exercise discretion over whether the treatment was provided in an in-patient or out-patient setting, and if the subjects of applications are given the opportunity to make submissions on their preference to receive treatment services as either a residential or a day programme patient. A therapeutic jurisprudence reading of a compulsory treatment regime may therefore recommend that the committal hearing is split into two phases – a


\textsuperscript{101} See the references cited supra, Chapter 1, note 26.

\textsuperscript{110} Most analyses by legal practitioners demonstrate a shallow understanding of therapeutic jurisprudence and are infected by the disease concept of addiction. For one of the most recent examples, see P F Hora et al., Therapeutic Jurisprudence and the Drug Treatment Court Movement: Revolutionizing the Criminal Justice System's response to Drug Abuse and Crime in America (loc. cit.) [eg. “As opposed to using the traditional criminal justice paradigm, in which drug abuse is understood as a wilful choice made by an offender capable of choosing between right and wrong, Drug Treatment Courts shift the paradigm in order to treat drug abuse as a biopsychosocial disease”: ibid, at 463-464]. Cf. F E Zimring, Drug Treatment as a Criminal Sanction (1993) University of Colorado Law Review, vol 64: 809-817.

\textsuperscript{111} See infra, Chapters 7 and 8.

hitting first on whether an involuntary treatment order should be made, and a subsequent 'sentencing' phase where the soon-to-be-patient had the right to make representations on what form that treatment should take. Using this model, it is more likely that the therapeutic benefits of behavioural contracting, public commitment and the involvement of significant others could be brought into play. Once it becomes clear to an alcoholic that a compulsory treatment order is going to be made, it seems easier to imagine that he or she will want to express a preference for either in-patient or out-patient care, and will be incented to agree to a treatment plan that is consistent with that mode of care (behavioural contracting); will call upon any family members present at the hearing to support that choice (involvement of significant others); and will want to try and convince the Court of his or her ability to succeed in such a setting (public commitment). Such a two-stage committal hearing for compulsory treatment cases, if adopted, would also fit better with recent insights offered by behavioural scientists, who emphasise the importance of ensuring that patients have a "voice" in legal and administrative proceedings.

Going beyond the process used in the particular civil commitment scheme, a therapeutic jurisprudence reading would go on to examine the direct and indirect outcomes of the implementation of that scheme for the participants as well as non-participants. An immediate area of attention would be the efficacy of the treatment programmes for those forced to go through them. A key question here would be whether treatment does more good than harm – looked at both in terms of a period of ambulatory care for people who might literally have been drinking themselves to death, but also the longer-term effects of treatment on the patient's health and social functioning. A related area of inquiry would be whether ordering the alcoholic into treatment leads to therapeutic or anti-therapeutic consequences for the alcoholic's family or friends, and what the therapeutic or anti-therapeutic effects of the compulsory treatment order are (if any) for the alcoholic's local community and, indeed, society as a whole.

A therapeutic jurisprudence analysis would also go further and ask whether any positive outcomes from such compelled treatment were compromised or cancelled-out by negative effects on the patient's psychological state. Perhaps drawing from research by influential social and experimental psychologists, such as Edward Deci's work on amotivational subsystems and Martin Seligman's work on learned helplessness, the therapeutically-aware analyst may detect that, by having choices made for them, alcoholics who are ordered into treatment against their will may experience feelings of self-blame, guilt, incompetence and lowered self-esteem. Because they are labelled as incompetent, or because of "self-handicapping", alcoholics may develop or exacerbate...

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113 This scenario of a person facing compulsory treatment wanting to exercise a choice over what that treatment is (rather than being 'defeasist' and resentful, because other people are making decisions that over-rule his or her own wishes), is probably preconditioned on the Court emphasising that it has an open mind about the treatment setting chosen, and the person understanding that placement in a residential facility can be avoided. See D B Wexler, Therapeutic Jurisprudence and the Criminal Courts (1993) William and Mary Law Review, vol 35: 279-299. For an earlier discussion of these ideas, see S Ensminger and C Liguori, The Therapeutic Significance of the Civil Commitment Hearing: An Unexplored Potential (1979) Journal of Psychiatry and Law, vol 6: 5-18.


depressive disorders that feed a generalised sense of apathy and resignation about their ability to manage their drinking.\textsuperscript{118} If so, the overall effect for some alcoholics who are forced into treatment may be what has been coined "law-related psychological dysfunction".\textsuperscript{119}

A therapeutic jurisprudence reading of a compulsory treatment statute would also be alive to the possibility that such a law may lead to psychological dysfunction by discouraging people from voluntarily seeking the treatment they need, or by encouraging some people who do voluntarily enter treatment to terminate treatment prematurely. It has been argued that, the more coercive a civil commitment regime is, the more it may dissuade some people from seeking help with their problems, for fear that once they come to the attention of treatment services, they too will be compulsorily committed.\textsuperscript{120} Compulsory treatment laws that mandate only in-patient treatment orders may, according to this argument, have the perverse effect of frightening some potential candidates away from making any contact with alcohol and other drug treatment services. Extending this argument still further, it is also possible that voluntary clients who take part in treatment options that are attended by poorly motivated and/or disruptive involuntary patients may become unsettled and disengage from treatment earlier than they otherwise would have.

Yet another possibility suggested by therapeutic jurisprudence is that a compulsory treatment statute which allows for 'voluntary' committals (where proposed patients can seek to have themselves committed under the Act) may introduce a moral hazard in an environment where there are otherwise long waiting lists to enter certain types of treatment programmes. The suggestion here would be that, where waiting lists to enter into 'desirable' treatment programmes exist (possibly residential programmes in idyllic rural areas), some alcoholics may seek to 'jump the queue' by filing an application to be compulsorily treated, which presumably would require them to be enrolled in treatment straight away under the terms of the Court-imposed compulsory treatment order. Although this scenario may seem far-fetched, were there evidence found of such 'moral hazard applications' being lodged, a student of therapeutic jurisprudence would ask whether the deferment of entry into treatment for those still on the waiting list has additional anti-therapeutic consequences.

Finally, a therapeutic jurisprudence analysis of a compulsory alcoholism treatment regime may offer up a series of observations about the way that various actors in the legal process can be (more) effective in managing cases in therapeutically beneficial ways. In relation to Drug Courts, for example, there is already an appreciation of how Judges, in particular, can use their position as authority figures to encourage people with substance use disorders to engage with treatment - praising them if they make progress, and chastising them if they regress.\textsuperscript{121} There will also be opportunities for lawyers who represent people defending compulsory treatment applications to perform their roles in ways that minimise the alleged alcoholic's feelings of anxiety, distress and possible betrayal;

\textsuperscript{118} See, further, B D Sales and L R Kahle, Law and attitudes towards the mentally ill (1980) \textit{International Journal of Law and Psychiatry}, vol 3: 391-412, at 392 [*Apart from the potential stigma of not being able to make one's own decisions, there are also the potential problems of diminished self-esteem caused by the outcome of the adjudication and the actual disuse of decision-making powers, which may lead to degeneration of existing capabilities and behaviours*].


\textsuperscript{121} One of the best examples is to be found in a recent article by sitting Drug Court Judges: see P F Hora et al., Therapeutic Jurisprudence and the Drug Treatment Court Movement: Revolutionizing the Criminal Justice System's response to Drug Abuse and Crime in America (loc. cit.).
as there will be ways that lawyers acting for those who are seeking the compulsory treatment of a family member to advise their clients on how to manage the committal process in a way that minimises such potentially damaging anti-therapeutic effects.  

2.6 Summary

This chapter has sought to lay some analytical foundations to inform the discussion of the ADA Act which follows. The approach it adopted was to pose a series of inter-related questions.

First, in answer to the question ‘what is alcoholism?’, the definition of “alcoholic” in section 2 of the ADA Act was contrasted with the two leading international clinical classifications of “alcohol dependence”. Both the ICD-10 and DSM-IV definitions were seen to turn on a person being physiologically dependent on alcohol, and exhibiting at least two or three of the following symptoms: tolerance; withdrawal; inability to cut down; sacrificing work, family or social events to drink; devoting a lot of time to finding and consuming alcohol; or continued drinking despite alcohol-related problems. By comparison, the ADA Act criteria for “alcoholic” were interpreted as setting a lower threshold, that seem to more accurately describe problem drinking than full-blown alcohol abuse or dependence.

In answer to the second question, ‘is alcoholism a disease?’, it was found that most people who can be classified as “alcoholics” simply do not conform to such a pathologising model. Instead, it was advanced that alcoholism is better seen as a socially-learnt behaviour, influenced by a range of possible non-biological (psychological, cultural, environmental) as well biological forces (physiological, genetic). The implications of this finding were teased out in the third question that was put: ‘what does this imply for responses to alcoholism?’ After recalling that most alcoholism treatment approaches are seen to have little lasting effect, it was noted that most alcoholics do not seek treatment for their drinking problems and yet most of these untreated alcoholics stop abusing alcohol. These results were seen to counsel against viewing treatment as a necessary or even sufficient intervention for alcoholics to better manage their drinking. In turn, this was seen to have serious implications for the legitimacy of compulsory treatment, as it suggested that forcing alcoholics into treatment may not only fail to succeed in helping them achieve sobriety, but it may retard their chances of learning to manage their drinking on their own. Extra support for this view was found in the transtheoretical stages of change model, which suggests that forced treatment may be a poor tool to use for alcoholics who are not yet prepared to address their alcohol use problems.

This led on to the fourth question that was posed: ‘why can we deal with alcoholism in purely policy terms?’ The answer given was that even excessive alcohol use does not seem to be greeted with particular moral outrage or social anxiety by the overwhelming majority of New Zealanders, suggesting that such behaviour is not seen as a malum in se, but operates instead in the realm of malum prohibitum. As such, it was argued that we need not worry unduly about identifying the possible social utility or moral infrastructure of compelled alcoholism treatment.

Following on from this, the final question raised was: ‘what analytical approaches give us the most traction on the issues involved?’ Two approaches were said to recommend themselves: the metric of harm minimisation and the emerging school of social inquiry known as therapeutic jurisprudence.

The defining feature of harm minimisation approaches to alcohol was described as being an attempt to reduce the harmful consequences of alcohol consumption even in situations where people still continue to drink. It was noted that alcohol harm minimisation strategies are value neutral regarding the long-term aim of intervention; it may be complete abstinence, but it may equally involve limiting a person’s episodes of acute alcohol poisoning. Within a harm minimisation framework, it was suggested that compulsory treatment of alcoholics is likely to yield short-term harm minimisation gains. It was further noted that if forced treatment were to contribute to alcoholics making lasting changes in their drinking practices, then such an intervention would also be viewed positively. Against this, however, it was pointed out that front-line treatment workers may bring attitudinal barriers to the effectiveness of compulsory treatment; and that service providers who are sympathetic to the use of coercion may be antithetical to the use of broader harm minimisation strategies, such as teaching controlled drinking skills. It was speculated, therefore, that overlaying the filter of harm minimisation may actually lead to an ambivalent assessment of compulsory treatment, especially when consideration is given to how it is being applied in practice.

For its part, therapeutic jurisprudence was seen to focus on the way in which the law and legal processes work to promote or inhibit the psychological and physical well-being of the people who come into contact with them. When applied to the case of compulsory treatment, therapeutic jurisprudence was predicted to generate a rich set of empirical and normative questions about the law’s role as a possible therapeutic and/or anti-therapeutic agent. It was stated that a therapeutic jurisprudence reading of the ADA Act would be alive to the possibility that such a law may lead to psychological dysfunction, and may introduce a moral hazard in a resource-limited environment. However, it was also noted that a therapeutic jurisprudence reading of the legislation could help to assess where the therapeutic benefits of behavioural contracting, public commitment and the involvement of significant others might be brought into play in the ADA Act hearing process, and could offer up a series of observations about how various actors in the legal process might be (more) effective in managing cases in therapeutically beneficial ways.

Armed with this understanding of harm minimisation and therapeutic jurisprudence, and the way in which the compulsory treatment of alcoholism may be reconciled with them both philosophically and practically, it remains to undertake the substantive task of running something of a harm minimisation and therapeutic jurisprudence ruler over the ADA Act. This task is begun in Chapter 7, following a more fully developed introduction to the Act, an examination of how it is working 'on the ground', and a look at two examples of similar-type statutes overseas.
3 Alcoholism and Drug Addiction Act

In this chapter, the ADA Act will be put under the microscope. The analysis will proceed in three stages. First, the chapter surveys the legislative history of the Act. Secondly, it will outline the major provisions of the Act. Finally, brief comments will be made about efforts to refine and/or reform the Act that have been made since it was passed in 1966.

3.1 Legislative History

The origins of the ADA Act date back to the late nineteenth century and the anxieties expressed at that time about habitual drunkenness in New Zealand society.¹ In a Report on Lunatic Asylums of the Colony for 1895, for example, the Minister of Education was told that "a home for inebriates, and a special institution for idiots and imbeciles, are urgently needed".² In 1894, 26 percent of admissions to lunatic asylums were for alcoholism or drug dependence (n = 576 out of 2168); in 1995, 30 percent of admissions to lunatic asylums were for alcoholism or drug dependence (n = 681 out of 2214).³ In 1907, Frank Hay, the colony's Inspector-General of Mental Hospitals, expressed concern about the increasing number of admissions for inebriates, noting that psychiatric admissions for alcoholism or a drug habit had nearly doubled since 1890 (n = 381), and constituted the cause of 21.7 percent of all male and 4.7 percent of all female admissions to mental hospitals.⁴

3.1.1 The Reformatory Institutions Act 1909

Three statutes followed in the wake of concerns about inebriation in New Zealand society: the Habitual Drunks Act 1906, the Inebriates Institutions Act 1908, and the Reformatory Institutions Act 1909. Of these early twentieth century pieces of social legislation, the 1909 Act was the most far-reaching and widely used. Sixty years later, the Alcoholism and Drug Addiction Act consolidated the law in this whole area, and formally replaced the Reformatory Institutions Act.

According to its Long Title, the Reformatory Institutions Act was designed "to make provision for the establishment and control of reformatory institutions for the reception of habitual inebriates and of fallen women"⁵ [see Appendix 1].

¹ For a broader look at alcohol misuse in historical perspective, see D J Hanson, Historical overview of alcohol abuse, in R T Ammerman et al., Prevention and Societal Impact of Drug and Alcohol Abuse, pp 31-45 (Mahwah: Lawrence Erlbaum Associates, 1999). For a careful study of the history of Australian responses to alcoholism, which have several parallels with New Zealand, see M J Lewis, Alcoholism in Australia, the 1880s to the 1980s: From medical science to political science (1988) Drug and Alcohol Review, vol 7: 391-401.
³ Ibid, p 1.
⁵ Note, "fallen women" were designed to be detained in reformatory homes, which were dealt with in a separate part of the legislation from that dealing with inebriates homes: sections 11 and 12 of the Reformatory Institutions Act refer. It is interesting to note that, during the nineteenth century, "fallen women" were often used as symbols of moral degeneracy and an allegory for the horrors of urban slums. See, further, on this point, A Mayne, The Imagined Slum (Leicester: Alderman, 1993), p 192; and L E Barron, Over the Influence: A feminist poststructuralist account of women's encounter with resistance to alcohol and oppressive dominant knowledge. Unpublished MA(English) Thesis. (Auckland: University of Auckland, 1991), pp 9-10.
The main features of the 1909 Act, and the rationale for its development, are captured in the introductory remarks by the Minister of Education during the Reformatory Institution Bill's second reading in the lower chamber of Parliament.\(^6\)

At present, we have in New Zealand, at Pakatoa Island, an institution where habitual drunkards are sent for treatment. Under the law as it at present stands, the individual concerned must have been convicted by a Magistrate three times for drunkenness within nine months before he can be sent to this island for treatment. The alteration proposed in the Bill is that he can be sent there without previous conviction if the Magistrate is satisfied that he is wasting his substance or otherwise hurting himself. The Bill also provides for an application being made by a relative of the inebriate — say, wife or husband, as the case may be — provided that the application is supported by statutory declarations of two medical men. It is also provided that a Judge of the Supreme Court, on the conviction of any person in that Court for a crime committed under the influence of liquor, or as the result of drunkenness may, in such circumstances, decide to send the prisoner to Pakatoa Island for treatment .... I think it will be found on examination to be a measure that goes in the right direction to secure reformatory treatment of those who are unable to take care of themselves owing to their indulgence in drink.

As explained by the Minister, the Reformatory Institutions Bill therefore heralded a significant extension of the state's reach into the lives of citizens; for the first time divorcing state-compelled treatment from the commission of an offence, by opening up the possibility that relatives could petition the Courts to force a family member into in-patient treatment. This blurring of the criminal and civil spheres could reasonably have been expected to attract close attention by parliamentarians, yet the Bill was passed with a minimum of debate. Originally an initiative of the Legislative Council, the Reformatory Institutions Bill was given its first reading in the House of Representatives on 8 December 1909, received its second reading on 21 December (with just four Members of Parliament [MPs] rising to speak to the draft legislation), it was read a third time without objection on 23 December, and it received Royal Assent the following day.\(^7\)

From a practical point of view, the Reformatory Institutions Act anticipated the establishment of state inebriates homes to receive and treat people committed under the legislation. The Act made it clear that these state inebriates homes were to be new facilities, as section 5 stated that institutions under the Lunatics Act 1908 were not to be Institutions for the purposes of the Reformatory Institutions Act. The intention was to ensure that inebriates were not detained in psychiatric hospitals, but instead that purpose-built facilities would be developed to support privately-run inebriates homes that had already been established (notably on Pakatoa Island) by charitable bodies such as the Salvation Army.

Ultimately, however, the Reformatory Institutions Act was judged to be largely ineffectual, because no state inebriates homes were actually ever established, and only two privately-run inebriates homes were certified to receive "inmates".\(^8\)

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\(^7\) See *New Zealand Parliamentary Debates*, vol 148: 8 December 1909, p 744 (First reading); 21 December, pp 1389-1390 (Second reading); 23 December, pp 1495-1496 (Third reading). The Bill was referred to the lower chamber for consideration after passing its Third reading in the Legislative Council on 8 December: refer to *New Zealand Parliamentary Debates*, vol 148: 8 December 1909, pp 739-741.

\(^8\) K R Evans, *Legal coercion and the treatment of alcoholism*. Paper presented to a symposium on the ADA Act, March 1983 (Wellington: Alcoholic Liquor Advisory Council, 1983), p 1. Nevertheless, this level of uptake was somewhat better than for the Inebriates Institutions Act 1908, which the General Assembly passed at around the same time as the Reformatory Institutions Act. The committal procedures under section 7 of the Inebriates Institutions Act — which largely overlapped with section 9 of the Reformatory Institutions Act — were never invoked during its first 10 years on the statute books, because no institutions were certified to receive patients under that Act. See C B Jordan, Letter to G Cruickshank [Stipendiary Magistrate], 22 August 1921 [held on File J.1931/913, National Archives, File series 71863, Box 794].
The operation of the two inebriates homes that were established by the Salvation Army to receive inmates under the Act – Pakatoa Island and Rotoroa Island, both in the Hauraki Gulf - also gave rise to some misgivings. For example, decisions about the day-to-day running of the institutions often required Ministerial direction under the 1909 statute.\(^9\) Borrowing heavily from analogous 1901 United Kingdom regulations,\(^10\) the Minister of Justice promulgated general regulations for the “good government” of inebriates homes,\(^11\) as well as specific regulations which prescribed features of inmate life. An example of this latter class of regulations is the Reformatory Institutions Act Order 1913, which specified the work tasks that inmates could be compelled to perform by the superintendent of an inebriates home, unless the inmates were medically excused from doing work:\(^12\)

**For Male Inmates**

- Gardening
- Farm-work
- Carpentry or other suitable trades or occupations
- Services in connection with the maintenance, &c., of the Home, and repairs,
  additions, and maintenance of buildings
- Navyling and general labour

**For Female Inmates**

- Laundry work
- Needlework
- Domestic services for the maintenance, &c., of the Home, and such other work as may be considered suitable.

When read together, these general and specific regulations encircled inmates in a tightly-controlled environment, one dictating when they woke or slept, when and what they ate, and what they could and could not do. Inmates’ rights were heavily circumscribed and any complaints they aired were quickly rejected without real examination.\(^13\) Consistent with the penal nature of these facilities, they also acted as certified institutions for the purposes of the Habitual Drunkards Act 1906,\(^14\) and the Reformatory Institutions Act itself contained provisions for the committal of offenders where alcohol was a factor in their offending, in addition to or in lieu of any period of imprisonment.\(^15\)

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\(^9\) In some cases, this reached ridiculous extremes. For instance, archival records show that the Secretary of Justice was called upon to authorise the purchase of a second-hand tractor and drilling of water bores at the Salvation Army’s facility on Rotoroa Island. See J L Robson, Letter to Salvation Army, 29 July 1960; Letter to Salvation Army, 26 January 1961 [both held on File J.18/35/5, National Archives, File series 74340, Box 949].

\(^10\) General Regulations for the Management and Discipline of State Inebriate Reformatories (London: His Majesty’s Stationery Office, 1901) [copy held on File J.18/35/1, National Archives, File series 74340, Box 949].

\(^11\) Reformatory Institutions Act Order 1912, printed in *New Zealand Gazette*, 10 October 1912.

\(^12\) For the background papers associated with the development of this Order in Council, see File J.18/35/1, National Archives, File series 74340, Box 949.

\(^13\) For example, in a complaint about the Superintendent of Rotoroa Island opening an inmate’s mail, the Under-Secretary of Justice wrote to the Postmaster-General: “It is not necessary to take any notice of communications from Braithwaite [the inmate], who is simply an agitator”. C B Jordan, Letter to Postmaster-General, 24 September 1912 [held on File J.1931/913, National Archives, File series 71863, Box 794].

\(^14\) See, for example, certification of Pakatoa Island for this purpose: *New Zealand Gazette*, 5 December 1907.

\(^15\) Sections 8 and 10 of the Reformatory Institutions Act 1909 refer. For examples of where inmates committed under these provisions were transferred back to prison after breaching the regulations of the reformatory institutions, see the transfer orders for Joseph McCarthy, dated 15 December 1947, and William Leslie Davis, dated 1 May 1953, contained in File J.18/35/2, National Archives, File series 74340, Box 949. See also the dicta in *Verschaffelt v Blackburn* (Unreported, Auckland SC, 11 July 1941, per Fair J), p 4: “[P]ersons committed in this way are committed in their own interests, and in the hope that they may cure themselves of their habits. The order is not intended wholly as punishment”.
Despite the apparently militaristic approach to operating inebriates homes, not everything at these institutions was managed with military precision, and deficiencies in their treatment regimes led to a sense of disappointment about the success of the Reformatory Institutions Act, and the wisdom of persisting with this legislative model. Indeed, such were the concerns raised about the Salvation Army's Rotoroa Island facility, in particular, that the Department of Justice initiated a special inquiry into the suitability of the institution as a place for the detention and treatment of inebriates. The inquiry team's report, written after visiting the Island in July 1951, concluded:  

Superficially, the institution appears to be satisfactory, for the grounds are well kept and the site is suitable ... [But] on closer inspection it becomes apparent that the buildings are in a disgraceful condition; not only are they structurally inadequate, but they are also grossly neglected. It was particularly noticed that the sick-bay accommodation was inadequate, dirty, and unsanitary; that the buildings needed painting throughout; that the guttering was defective; that the wallpaper was flaking off the walls; that the lighting system was poor and even dangerous; that the kitchen needed to be entirely re-equipped; that there were no baths; and that there were insufficient recreation rooms or storerooms. In general, the members of the Committee were appalled by the shoddiness of the equipment and the dirtiness of the buildings.

In a separate file note by one of the inquiry team members, the Secretary of Justice, S T Barnett, recorded:  

The most depressing aspect of the whole matter is that there is virtually no work going on calculated to help an alcoholic, apart from:
(a) the physical segregation from the opportunity; and
(b) the religious work done by the Salvation Army.

Personally, I should say that both these so-called aids are more calculated to be irritants.

Few lasting improvements occurred as a result of the special departmental inquiry. Thus, a Magistrate who visited Rotoroa Island in 1954 reported to his superiors that "there seems an unusual amount of discontent on the Island just now". The Salvation Army blamed "an undue influence of difficult and experienced criminals in the inmate body", but the visiting Magistrate thought that the discontent was more likely to have stemmed from "ineptitude on the part of the management". Dissatisfaction with how the Reformatory Institutions Act model was being applied on Rotoroa Island also percolated up to the Chief Secretary of the Salvation Army, Colonel Bramwell Cook, who wrote to the Secretary of Justice in 1956 of his own concerns about the "inadequate and perfunctory" nature of monthly medical examinations performed by the Island's visiting doctor. "Only trivial matters are attended to hurriedly," Colonel Cook conceded, "and no attention whatsoever is paid to the psychiatric needs of inmates".

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16 J H Luxford et al., Report of the Committee inquiring into the suitability of the institution at Rotoroa Island as a place for the detention and reformation of habitual inebriates (Wellington: Department of Justice, 1951), p 1 [held on File J.18/35/5, National Archives, File series 74340, Box 949].
17 S T Barnett, Impressions of Rotoroa Inebriates' Home. Internal file note, p 1 [held on File J.18/35/5, National Archives, File series 74340, Box 949]. This lack of emphasis on anything resembling 'treatment' was a criticism levelled at similar types of institutions elsewhere in the world at this same time. For example, Irish inebriate reformatories were widely held in contempt: "They did not treat, let alone cure, alcoholism or abate to any significant extent any of the serious social problems it produced; nor, it has been argued, did these institutions, as actually administered, even attempt these goals". G Bretherton, Irish inebriate reformatories, 1899-1920: A small experiment in coercion (1986) Contemporary Drug Problems, Fall: 473-502, at 495.
18 L G H Sinclair, quoted in S T Barnett, Briefing to Minister of Justice, 29 July 1954 [held on File J.18/35/5, National Archives, File series 74340, Box 949].
19 Ibid.
20 A B Cook, Letter to Secretary of Justice, 8 May 1956, p 1 [held on File J.18/35/5, National Archives, File series 74340, Box 949].
3.1.2 Immediate background to the ADA Act

Concern about the state's response to alcoholics led the Minister of Justice to convene a conference on alcoholism in 1956, attended by a Senior Stipendiary Magistrate and representatives of the National Society on Alcoholism, Justice Department, Police and health officials. The main recommendation of the conference was that the Reformatory Institutions Act be reviewed, and that "a de facto relationship between members of the medical profession and Magistrates" be developed to better address the treatment needs of people with chronic alcohol problems.21

This momentum to strengthen laws for dealing with 'habitual drunkards' was building elsewhere around the world at much the same time. In particular, it seems no coincidence that leading thinkers on alcohol-related problems in the United Kingdom, such as Professor Griffith Edwards, were beginning to focus on the plight of what had come to be called 'skid row alcoholics', and were pressing for greater involvement by central and local government in helping 'down-and-out drinkers'.22 For their parts, some state agencies were pushing for action to address the public nuisance aspects associated with drinking by the homeless, complaining of the 'honey pot effect' of existing shelters run by charitable bodies where 'undesirables' congregated.23 Scholars have noted that recourse to coercive state powers in this context should be seen as lying in the grey area between punishment and treatment, which had characterised official responses to habitual drunkards since the nineteenth century, and resulted in an institutional structure that simultaneously offered moral, legal, medical and social approaches to pulling people off the 'skid row' treadmill.24 The state's role, however, was seen as central. As Professor Edwards was to write to a specially-convened parliamentary working party on the issue: "I am totally convinced that there is a need for Government action – the Welfare State must accept its responsibility ... [because] the task is too complex and requires too many professional skills for voluntary organisations [to deal with on their own]".25

There was also increasing public concern in the late 1950s and early 1960s about alcoholism, and the wasteful cycle of (re-)arresting street drinkers for public drunkenness.26 Estimates from Auckland and Wellington studies published in a 1958 issue of the New Zealand Medical Journal reported that over 100 alcoholics slept 'rough' in the summer months;27 while a 1962 textbook by a Stipendiary Magistrate and the Medical Superintendent of a psychiatric hospital noted;28

23 Hence, in 1967, for example, the London Boroughs of Southwark and Tower Hamlets petitioned the Secretary of State for Home Affairs and the Minister of Health "with a view to centres being established under the Inebriates Acts 1879-1900 so as to compel the detention of methylated spirits drinkers in appropriate cases as a positive action towards the cure of these unfortunate people". Quoted in B Thom, Dealing with Drink – Alcohol and Social Policy: From Treatment to Management (London: Free Association Books, 1999), p 88. 
26 Writing in the New Zealand Universities Law Review, for example, David Williams opined that: "The current practice of dealing with chronic public inebriates by imposing frequently repeated prison terms or fines is not only totally ineffective but also morally indefensible". D A R Williams, Drunkenness and the Criminal Law in New Zealand (1967) New Zealand Universities Law Review, vol 2: 297-325, at 321.
In most large cities every night the local police arrest the more disorderly drunks in the streets; next morning they are fined a nominal amount, or sent to prison for a week or a month, and then released to appear in Court again the next time. The chronic drunks who have scored over a century of such convictions haunt the back alleys of every city.

Other observers were to comment that, "[a]s the disease construct of alcoholism had taken hold in New Zealand, the public generally became more accepting of alcoholism as an illness, and it was not surprising that the need for a revision of the 1909 legislation was ultimately recognised".29

Although some progress was made in the following years, real impetus for amending the 1909 legislation came from a 1964 conference that was held to consider new draft legislation to replace the Reformatory Institutions Act. The major recommendation of this assembly was that responsibility for services for alcoholics be transferred from the Justice Department to the Health Department. This represented a desire to move from a punitive approach (provided for in a penal statute) to a therapeutic approach (provided for in a health statute). The element of compulsion was nonetheless a feature of both approaches. As such, health authorities, which disliked any use of coercion in a treatment setting, did not support the new draft legislation that was designed to achieve this shift.30

3.1.3 Debate and enactment of the ADA Act

Despite this opposition from health authorities, the Minister of Health introduced the new draft legislation to the House on 24 June 1966, and the Alcoholics Bill (as it was known) was read a first and second time pro forma before being referred to the Statute Revisions Committee for further consideration.31 Although the Prime Minister of the day, Rt Hon Keith Holyoake, was at some pains to emphasise that the Bill was "completely uncontroversial",32 the Government's motion to refer the draft legislation to the legally-oriented Statutes Revision Committee, rather than the health-oriented Social Services Committee, struck several members as anomalous, given the apparent aim of the Bill to recast responses to alcoholism in a therapeutic framework instead of in a punitive framework.33 Opposition Members of Parliament (MPs) called on the Government to "adopt a realistic and humanitarian outlook on what is a social problem, a health and human problem",34 by referring the Alcoholics Bill to the Social Services Committee. However, this proposal was ultimately defeated and the Bill was referred to the already-overloaded Statutes Revision Committee, which proceeded to hear submissions on the draft legislation in July–August 1966.

Although the Statutes Revision Committee itself did not issue a report about its hearings on the Alcoholics Bill, subsequent statements in the House when the Bill was reported back indicate that it encountered some criticism.

32 K Holyoake, New Zealand Parliamentary Debates, vol 346: 24 June 1966, pp 788-789 (“very small and completely uncontroversial Bill”; “there is nothing contentious in this Bill at this stage”; “there is nothing contentious in it”, “I say again that there is nothing contentious in the Bill”).
33 Commenting on the motion to refer the Bill to the Statutes Revision Committee in preference to the Social Services Committee, the Prime Minister reasoned that this was “because the detention of people is mostly a legal question, and not a health question”: ibid, p 783.
“One criticism voiced before the Statutes Revision Committee”, observed the Minister of Health, Hon Don McKay, “was that not enough thought had been given to the legislation, and that there had not been enough discussion with the experts, particularly the psychiatrists”. 34 Other MPs who had sat on the Statutes Revision Committee informed the House that: “Many of those who appeared before the committee had doubts about the degree of success which could be achieved by compulsory treatment, and, indeed, it is likely that the success ratio for compulsorily treated patients will be lower than for voluntary patients”. 35 Another MP noted that psychiatrists who gave evidence to the committee “all realised that compulsion was not a very happy start to treatment, but that it would sometimes be necessary”. 36

The Bill reported back by the select committee in September 1966 contained several changes to the version that was first introduced to the House. Perhaps the most significant change was that formal rights of appeal were written into the draft legislation, so that people against whom compulsory treatment orders were made could seek to have the decision overturned by a superior tribunal. The other significant change relating to the liberty of the individual was to reduce the period of time a person could be detained in a Police station for the purposes of assessing whether he or she was an “alcoholic” or “drug addict”. Initially, the Bill had provided that such interim detention could be continued for up to 10 days, however the Bill reported back to the House cut the permissible period of detention to 48 hours. Several other minor changes were suggested by the Statutes Revision Committee, including a recommendation that the clauses dealing with “drug addicts” be brought forward in the order of the draft legislation, and that the Bill itself be renamed the Alcoholism and Drug Addiction Bill to acknowledge the growing problem of drug addiction. After fairly lengthy debate, these amendments were read into the Bill and it passed uneventfully through its remaining stages, receiving Royal Assent on 20 October 1966.

One of the most striking features of the parliamentary debates on the Alcoholics Bill and its later incarnation is the near unanimity with which MPs couched their support for the legislation in terms provided by the disease model of alcoholism. The following selection of quotes lifted from the parliamentary debates serves to illustrate this point: 37

Here we have a problem which used to be regarded as a crime, but which more and more is being recognised as a sickness.

This is a first step in the recognition and treatment of the disease of alcoholism.

Alcoholism is a progressive disease of compulsive addiction that needs treatment rather than punishment.

There has been some criticism from outside that this measure will restrict the liberty of the individual. I wonder what are the liberties of a man who can be shown to be on a clear medically-defined path to insanity and death, a path through which he is hurting many others and often his own family. The Bill .... is designed to protect the sick person.

36 C Moyle, ibid, p 2813.
Alcoholism is something like cancer: if caught early, recovery is possible .... For almost every disease you need a doctor as well as the will power to pull yourself out.

Once the public come to look upon the alcoholic as a sick person and not as a moral weakling or an outcast, then I believe there is hope that we can overcome and deal adequately with the problem of alcoholism.

An alcoholic is a sick person .... [but] it will not be long before the victims of this illness are cured. They will regain their human dignity and they will again become useful citizens.

It took us many years to discover that this is a disease or illness. This country has over a century of history, but right up until very recently the alcoholic has been treated virtually as a criminal, so there is a vast change in this legislation .... [and it is] a positive step forward, because it will change the whole attitude of people to the alcoholic.

What is the use of talking about the liberty of a man whose whole life has become dominated by that turning away from every problem and having refuge in drink? He has no liberty. He is a complete slave to his fears and the remedy he has sought for them .... [The alcoholic has no freedom that he can use. To that extent he is a sick man. He has not the free will of the ordinary person.

Despite this assumed justificatory strength of the disease model of alcoholism, during the interval between being passed and coming into effect, the ADA Act continued to attract much critical comment.\textsuperscript{30} Superintendents of some hospitals that were certified under the Act expressed fears that they would not have the facilities or the staff to cope with the expected influx of alcoholics.\textsuperscript{40} Responding to these concerns, the Health Department sought plans from each of the certified institutions on how they would carry out their new functions under the legislation, and produced an instructional booklet for the institutions which outlined the requirements of the Act. The Alcoholism and Drug Addiction (Forms) Regulations 1968 were subsequently notified in the New Zealand Gazette on 7 November 1968, and the statute itself was gazetted to come into force on 1 January 1969 [see Appendix 2].\textsuperscript{41}

3.1.4 Major differences between the 1909 and 1966 Acts

There were some significant changes to the committal regime under the Reformatory Institutions Act that were bought about by the ADA Act [compare Appendices 1 and 2]. First, the population group targeted under the ADA Act was significantly widened from that which had applied under the Reformatory Institutions Act, section 2 of which defined "habitual inebriate" as:

\textsuperscript{30} See, further, the documentary evidence held on File 131-158-2, National Archives, File series 74340, Box 949.

\textsuperscript{40} During parliamentary debates on the Alcoholics Bill, only one MP, Andrew King (Waitemata), articulated any reservations about the need for additional services to meet the treatment needs of the target population of the legislation. Refer to New Zealand Parliamentary Debates, vol 348: 23 September 1966, pp 2821-2824 ["On reading the Bill, one cannot escape the conclusion that it places much more emphasis on detention than on treatment, and on compulsion rather than seeking a voluntary solution to the problem .... Detention can be a drastic solution when medical opinion suggests that only about 20 percent of alcoholics are likely to be permanently cured .... It seems to me that our resources, especially in the mental health field, are inadequate to cope with this illness, let alone tackle the other problems mentioned in the Bill .... A major upgrading in the staffing position of mental and general hospitals, and greater expenditure on them, must be an essential part of this Bill. If we are to compel people to be treated, then treatment facilities must be made available. Besides which, I do not believe we can solve the problem by a general hospitalisation of alcoholics. I believe much more good can be done through social workers and outpatient treatment, as well as day treatment in general hospitals, and I hope that emphasis will be on this, rather than on detention for up to two years for alcoholics"].

\textsuperscript{41} Alcoholism and Drug Addiction Act Commencement Order 1968 (SR 1968/210), attached under Appendix 3.
a person who habitually takes or uses in excess alcoholic liquor or any intoxicating, stimulating, narcotic, or sedative drug or drugs, and while under the influence thereof, or in consequence of the effects thereof, is habitually or at times dangerous to himself or others, or is a cause of harm, suffering, or serious annoyance to his family or others, or incapable of managing his affairs, or is likely to suffer serious injury to his health.

The 1909 definition incorporated notions of dangerousness and insisted upon a proximate relationship between the substance use and the evidence of the mischief. As will be discussed shortly, there are no matching requirements in the 1966 Act, which has preferred far more streamlined definitions of "alcoholic" and "drug addict".

The second major liberalisation in the 1966 Act was the extension of the locus standi provisions for making an application for involuntary commitment. The 1909 legislation had limited this power of application to the relatives of the intended inmate [section 9(1) of the Reformatory Institutions Act referred], while the 1966 legislation allows for "a member of the Police or any other reputable person" to make an equivalent application for committal [section 9(1) of the ADA Act refers].

While these two changes allow the ADA Act to cast its net wider than the Reformatory Institutions Act, other differences between the two statutes have the effect of strengthening the procedural protections which apply to proposed patients under the Act. Notable here are the removal of the ability of the Court to dispense with the requirement that applications for involuntary committals be supported by two medical practitioners [section 9(4) of the Reformatory Institutions Act referred], and the introduction of new rules around who can sign supporting medical certificates in the 1966 Act [see section 32 of the ADA Act], designed to prevent conflicts of interest and other possible abuses of process. The 1966 legislation also clarifies the appeal rights of patients [section 23 of the ADA Act refers], and removes the earlier statute's requirement that both voluntary and involuntary committal orders were to be for a minimum of six months [sections 7(2) and 9(3) of the Reformatory Institutions Act referred].

The reach of the ADA Act was also narrowed by the removal of some streams of criminal justice referrals which had been a feature of the 1909 Act. Most notably, the 1966 Act does not contain an equivalent to section 8 of the Reformatory Institutions Act, which had stated:

If, on the trial and summary conviction before a Magistrate of any person for any of the offences mentioned in the Second Schedule to this Act, it appears to the Magistrate (whether by the admission of the defendant, or by the evidence at the trial, or by any other testimony specially called in that behalf at any time before sentence has been passed) that the defendant is a habitual inebriate, the Magistrate may, if he thinks fit, as part of the conviction, and either in addition to or in lieu of any term of imprisonment or any other punishment to which the defendant is liable, order that the defendant shall be detained in a certified Inebriates Home for any period not being less than one year or more than two years.

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42 Section 9(5) of the Reformatory Institutions Act defined "relative" as meaning: "husband, wife, father, grandfather, stepfather, mother, grandmother, stepmother, brother, or sister of the whole or half blood, son, grandson, daughter, granddaughter, stepson or stepdaughter". (This definition of relative is identical in scope to the definition of "relative" given in section 9(8) of the Alcoholism and Drug Addiction Act.)

43 There had been some complaints that the power to seek compulsory treatment of alcoholics rested solely with the relatives of the problem drinker, begging the question: "perhaps the solution would be to bestow a limited power on the Police Department, the Crown Prosecutor, or some other official to initiate a civil commitment proceeding under section 9 of the Reformatory Institutions Act?" Refer, here, to D A R Williams, Drunkenness and the Criminal Law in New Zealand (1967) New Zealand Universities Law Review, vol 2: 297-325, at 325.
The Second Schedule of the Reformatory Institutions Act went on to state that the section 8 applied to various offences against the Licensing Act 1908 and Police Offences Act 1908; the crime of attempting to commit suicide; and the offence of drunkenness, or any offence of which drunkenness formed a necessary element.

The only other changes of note between the 1909 Act and the 1966 Act relate to the nomenclature used to describe the subject of committal orders ("inmates" under the Reformatory Institutions Act became "patients" under the ADA Act) and removal of miscellaneous provisions that underlined the incompetent or quasi-criminal status of people committed under the 1909 Act. For instance, the power for the Public Trustee to be appointed as administrator or curator of an inmate's estate [section 37 of the Reformatory Institutions Act referred] was removed in the 1966 legislation, as was the ability for the costs associated with transporting and housing inmates to be clawed back from the inmates themselves [sections 15 and 38 of the Reformatory Institutions Act referred].

3.1.5 Amendments to the ADA Act since 1966

Before concentrating on the ADA Act as it exists today, it is also worth reviewing several comparatively minor amendments that have been made to the Act since it came into force in 1969. In the main, these amendments have been of a technical rather than a substantive nature.

In 1970, a further sub-section was added to section 7 of the Act, allowing payments to be made to members of Supervisory Committees [new section 7(12) refers]. The word "designated" was also deleted from section 9(5).

In 1975, an addition was made regarding the revocation of leave of absence, and a provision was inserted allowing the payment of fees to medical practitioners who perform examinations and provide medical certificates under the Act. These amendments primarily had the effect of adding sub-sections (5) and (6) to section 20, and inserting a new section 38A.

In 1981, a new section 37A was inserted in the principal Act, providing for the Minister of Health to declare premises as temporary shelters or detoxification centres that people may be taken to by the Police if they are found intoxicated in a public place. This section was amended in 1987 by the addition of a further sub-section, which allows such an intoxicated person to be temporarily taken to and detained at a police station, if it is not immediately practicable for the officer to determine where the person should be taken [section 37A(2) refers].

Apart from these three relatively minor amendment Acts, the ADA Act has also been consequentially amended by the Health Reforms (Transitional Provisions) Act 1993 and the Department of Justice (Restructuring) Act 1995. These statutes introduced a series of more up-to-date references: for instance, replacing references to the Mental Health Act 1969 with references to the MH (CAT) Act 1992, and replacing reference to the Minister of Justice with

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44 For commentary on the section 15 (transportation costs) cost-recovery provision, in particular, see M Findlay, New Zealand Parliamentary Debates, vol 148, 23 December 1909, p 1469.

45 Cabinet papers obtained under the Official Information Act 1982 reveal that this new Police power was sought in response to the Queen Street riots in Auckland during December 1984. See G W R Palmer and A Hercules,
reference to the Minister of the Crown responsible for the Department of Corrections. More substantively, the Coroners Act 1988 consequentially introduced a new section 22A into the ADA Act, which states that managers of certified institutions must notify a member of the Police as soon as they learn that a patient detained under section 9 of the Act has died.  

Since it came into force, in fact, the only significant change to the way that the ADA Act operates has not resulted from an amendment of the principal Act at all. Rather, it derives from the 1985 repeal of section 48A of the Criminal Justice Act 1954. The material parts of that section had read:

48A. Power of Court to order detention and treatment of alcoholic or drug addict on conviction – (1)
If, on the conviction before any Court of any person for any offence of which drunkenness or the taking of drugs forms a necessary element, or for any offence which is shown to have been committed under the influence of alcohol or drugs or of which drunkenness or the taking of drugs is shown to be a contributing cause, it appears to the Court or Judge that the offender is an alcoholic within the meaning of the Alcoholism and Drug Addiction Act 1966 or is a person to whom section 3 of that Act applies, the Court or Judge may, if it or he thinks fit, make an order requiring the offender to be detained for treatment for alcoholism or, as the case may be, for drug addiction in an institution within the meaning of that Act.

(5) The Alcoholism and Drug Addiction Act 1966 shall apply to every offender in respect of whom an order is made under this section as if it were an order made under section 9 of that Act.

Similar in many respects to the powers contained in the Habitual Drunkards Act 1906, section 48A was used fairly irregularly by Courts in the 1970s and early 1980s, until it was repealed in 1985. Reflecting the general neglect of the ADA Act, however, otiose references to section 48A have never been removed from the legislation.

3.2 Mechanics of the Act

In essence, the ADA Act provides for alcoholics and drug addicts to be compulsorily detained for assessment, detoxification and treatment at institutions that have been specially certified for this purpose.

Memorandum to Cabinet Social Equity Committee on Law Relating to Riot [SE (85) 49], 4 July 1985

(Wellington: Office of the Minister of Justice, 1985).

Curiously, this duty has not been extended to cover patients detained under section 8 of the ADA Act.

The Criminal Justice Act 1954 was repealed and replaced by the Criminal Justice Act 1985. There is no equivalent to section 48A in the newer criminal justice legislation. Note, section 48A had been inserted into the 1954 Act by section 6 of the Criminal Justice Amendment Act 1966.

Section 3(1) of the Habitual Drunkards Act provided: "Where on the conviction of any person for drunkenness he becomes an habitual drunkard within the meaning of this Act, the convicting Magistrate, in addiction to or in lieu of any penalty to which such person is liable, may be order commit him to any institution willing to receive him and make provision for his proper care and detention". And "habitual drunkard" was defined in section 2 of the Act to mean: "a person who has been three times convicted for drunkenness within the nine months immediately preceding any conviction for drunkenness".


This section of the Chapter does not attempt to duplicate the annotated legislation service that already exists, merely to provide a commentary on what are seen as the key aspects of the ADA Act. For further reference, consult W J Brookbans, Alcoholism and Drug Addiction, Trapski's Family Law, Volume III, Chapter CA. (Wellington: Brookers, 1993).
3.2.1 Scope of the legislation

Section 2 of the Act 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.

Section 3 of the Act defines a "drug addict" as:

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.

These are widely drawn definitions of "alcoholic" and "drug addict". For example, pack-a-day cigarette smokers theoretically could be covered by the Act, given the status of nicotine as a stimulating drug which can have serious health effects. The ADA Act has already been extended to include harmful and addictive substances like industrial solvents, and it seems likely that people who pose risks to themselves or others by drinking kava could equally be brought within the definition of "alcoholics" or "drug addicts" for the purposes of the legislation.

Beyond the large number of substances to which they can apply, it is important to emphasise two other aspects of these definitions. First, the definitions are directed at "persistent and excessive indulgence", not one-off or widely-spaced episodes of "binge"ing; or regular intake of moderate levels of a substance. As one commentator has put it, "[t]he requirement for 'persistent and excessive indulgence' suggests a state of habitual disability caused by alcoholic consumption as opposed to an incident of alcoholic over-indulgence after which a person is free to pursue normal activities unconstrained by the effects of alcohol." Secondly, the definitions contain a disjunctive test that the "persistent and excessive indulgence" must satisfy. That is, because of the nature of the substance use, persons must: (a) be causing, or be likely to cause, serious injury to their health; (b) constitute a source of harm, suffering or serious annoyance to others; or (c), be incapable of properly managing themselves or their affairs. Irrespective of DSM-IV or ICD-10 criteria, therefore, where a person does not meet at least one of these thresholds, he or she cannot be considered an "alcoholic" or "drug addict" for the purposes of the statute.

If it is thought that a person is either an "alcoholic" or "drug addict", the commitment procedures in the Act can be initiated in one of three ways: (a) 'voluntary' application [section 8]; (b) involuntary application [section 9]; or (c), transfer of a prison inmate for the treatment of alcoholism by the Minister of Corrections [section 21]. Focusing on the remainder of the discussion on "alcoholics", it is appropriate to briefly consider each of these committal routes in turn.

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51 See, for instance, In the matter of J P S [1984] DCR 32 [a case involving a glue sniffer]; cited with approval in Ministry of Transport v Balsley (Unreported, Wanganui DC, CRN 608300382, 7 August 1986, per Unwin DCJ).

52 In Police v Leameitolonga Tupou (Unreported, Wellington DC, 16 November 2000, per Carruthers DCJ), Judge Carruthers held that kava falls within the definition of a "drug" for the purposes of the Land Transport Act 1998.


54 W J Brookbanks, Alcoholism and Drug Addiction (op. cit.), para AD2.02.05.

55 Supra, Chapter 2, notes 9 and 10 and accompanying text.
3.2.2 ‘Voluntary’ applications

Under section 8 of the Act, any person may apply to a District Court Judge to be compulsorily detained for treatment at an institution certified under the Act. The Judge must be satisfied, either by the applicant’s own admission or by some other evidence, that he or she is an “alcoholic” and fully understands the nature and effect of the application. The Judge must also be satisfied that the named institution is willing to accept the applicant as a patient under the Act before making an order for committal under section 8.

While the Judge is empowered to call for evidence about the clinical indications of the applicant’s substance use disorder(s), there is no requirement under section 8 that the Judge must receive such supporting evidence before making a committal order. This may be contrasted with the situation for applications under section 9 of the Act, where a Judge is prevented from making an order unless two medical practitioners have tendered either oral or written evidence to the effect that the alleged alcoholic is an alcoholic within the meaning of the Act, and that the making of the order is expedient in his or her own interests or in that of his or her relatives [section 9(6) of the Act].

While the statute contains a general requirement that all such hearings “shall be heard and determined in private” [section 35(1)], District Court Judges are empowered to give effect to this legislative intent by holding hearings in Chambers, or wherever it is most practical to conduct the hearing – including even the alleged alcoholic’s home.55

Although the application to be committed to an ADA Act institution may be ‘voluntary’, once a Judge has made a committal order under section 8, the order “shall state that the applicant undertakes to remain in the institution, for treatment for alcoholism, until he is released or discharged under this Act” [section 8(2)]. Patients who are detained for treatment following such a ‘voluntary’ application are not free to come and go from institutions as they please, and cannot terminate their course of treatment if they experience a ‘change of heart’. Hence, ADA Act offences relating to breaches of leave conditions [section 17], escaping from a certified institution [section 25] and so on, draw no distinction between patients who have come under the Act through ‘voluntary’ or involuntary paths. ‘Voluntary’ patients are conflated with involuntary and prison-transferred patients once a committal order is made.

3.2.3 Involuntary applications

The second major way in which the commitment procedures in the Act can be initiated is via an application made by a relative of the alleged alcoholic, a police officer, or “any other reputable person”. Relative is defined in section 9(8) of the Act to include a spouse, parent, grandparent, step-parent, sibling, half-sibling, child, step-child, or grandchild of the alleged alcoholic. As defined, the term “relative” therefore does not extend to either same sex or de facto partners, albeit that Courts have recognised the creeping anachronism that such a construction implies. In Re Sorensen,56 Anderson J appeared to accept that “relative” may include the de facto husband of the alleged alcoholic in that case. It is submitted, however, that the correct view was expressed in S v Tahana-Reese & Anor,57 where Hansen J stated obiter that: “[a]lthough, in this day and age a definition which excludes de facto partner lacks realism, that is the law.”

55 T R Gillies, Submission to the 1999 ADA Act review, 20 April 1999, p 2. (Judge Gillies notes in his submission that he would consent to holding such hearings at the alleged alcoholic’s house only as a matter of last resort.)
56 Unreported, HC Auckland, AP 176/89, 16 October 1989, per Anderson J.
In any event, a purposive interpretation can be given to the catch-all category of "any other reputable person" if there is doubt about the ability of a same sex or de facto partner to lodge an application under section 9. This was the approach taken by Judge Somerville in Snell v Hall, where His Honour wrestled with whether an application under section 9 by a step-daughter of the alleged alcoholic should be allowed to proceed, when the marriage which created the step-parent / step-child relationship had since dissolved. In holding that the application on its face was valid, Somerville DCJ reasoned that the step-parent / step-child relationship is an emotional one rather than a legal one:59

In the present case, there is a clear emotional relationship very similar to that of parent and child. It is the closeness of that relationship which entitles a step-child to bring an application under the Act, rather than the legal relationship between the parents of that child and the person against whom the order is sought. I therefore find that the applicant in this case had the legal right to make the application. Even if that is not the case, then she is still able to make application as a "reputable person" and her application is not made invalid by her having specified the wrong category.

Although there is little direct authority on point, this common-sense approach seems likely to harden into judicial convention, with the Courts accepting section 9 applications so long as they are not seen to be trivial or vexatious. As Chisholm J observed in the High Court reference of the Snell v Hall case:60

[The] proposition that a reputable person must have some special standing in the community does not appeal. The dictionary definition of "reputable" is "of good repute, respectable" and I cannot see any reason why that definition should not be applied. The requirement in section 9(1) that if the application is not made by a relative or by a member of the police it must be made by "any other reputable person" is to avoid frivolous applications.

Assuming that the applicant can demonstrate locus standi - and that, if the application is made by a police officer or "any other reputable person", it explains why it is not made by a relative [section 9(2)]61 - a District Court Judge may issue a "summons to the alleged alcoholic to show cause why an order should not be made requiring him to be detained for the treatment of alcoholism in an institution" [section 9(1)]. This effectively reverses the normal burden of proof, requiring the subject of the application to demonstrate why he or she should not be considered an "alcoholic". If the Judge believes that the alleged alcoholic will not comply with the terms of the summons or will not otherwise consent to examination by certifying doctors, then he or she can issue a warrant for the person's arrest [section 9(4)], and may order that that the person submit to a compulsory medical examination [section 9(5)]. The examination is designed to elicit whether the subject of the application is an "alcoholic" as defined by the Act, and whether "the making of an order is expedient in [the subject's] own interests or in that of his relatives" [section 9(6)].

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58 Unreported, Christchurch DC, AD 13/99, 20 May 1999, per Somerville DCJ.
59 Ibid, at 5.
60 Hall v Snell (1999) 5 HRNZ 103, at 106.
61 The need to satisfy the requirements of section 9(2) of the Act has been held to be a mandatory provision of the legislation which cannot be overridden by either section 34 of the ADA Act or section 204 of the Summary Proceedings Act 1981 (orders shall not be considered to be invalid because of mere errors or defects of form), irrespective of whether the subject of the application poses a danger to himself or others, and even where he has a “desperate need for treatment”. S v Tahana-Raese & Anor [2000] NZAR 481, at 486-87 ["It seems to me that in a case where the liberty of the subject is in issue and the legislature has gone to some trouble to specify the steps which need to be taken before an order can be made, it would be wrong to treat them as mere matters of form or technicalities and non-compliance as no more than an irregularity": ibid, per Hansen J].
Once the Court has determined that the application is *prima facie* valid, that the subject of the application is an "alcoholic", and that the making of an order is expedient, the Court can issue a committal order under section 9(7) of the Act if: (a) the alcoholic is present in person; (b) the Judge is satisfied as to the truth of the application; (c) two medical practitioners have either given evidence or provided appropriate certificates that support making such an order; and (d), the institution named in the application is willing to receive the alcoholic into the institution for treatment.

There are several aspects of the hearing process for section 9 applications which benefit from further illumination. First, the requirement that the alcoholic be present in person does not mean that the person has to take an active or even conscious role at the hearing. Although several judgements in ADA Act cases contain *dicta* to the effect that section 9 hearings should not be conducted in a *pro forma* manner, and that it is desirable if the subject of the application is represented by counsel, the very context within which a number of "crisis applications" under the ADA Act are made means that hearings are sometimes held at hospital bedside or in police holding cells, and the subject of the application is either totally unconscious or too intoxicated to take any meaningful part in proceedings. Even so, the alleged alcoholic's incapacity does not preclude a Judge making a committal order under the legislation.

There is also no mandatory requirement that the two medical practitioners who certify that a person is an "alcoholic" within the meaning of the Act have personally examined him or her prior to making that assessment. Although there is lower-Court authority to the contrary, in the leading case of *S v Tahana-Reese & Anor*, Hansen J held an examination of the alleged alcoholic is not a prerequisite to making an order under section 9. While Justice Hansen acknowledged that, at a practical level, "it is unlikely, if not inconceivable, that medical practitioners would give evidence or certify as to the matters referred to in section 9(6) of the Act if they had not carried out some form of examination", it is significant that section 31 of the Act contains an explicit provision that: "[e]very medical certificate given for the purposes of this Act shall be evidence of the facts therein stated as known to or observed by the certifying medical practitioner" (emphasis added). It is submitted that section 31 fully anticipates that a certificate might be given by a physician who had not personally seen the alleged alcoholic, but that the doctor was certifying that the person was an alcoholic based upon their (hearsay) knowledge of them.

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62 For example, in adjourning the hearing of an application under section 9 where neither the applicant nor the certifying medical practitioners were present for (cross) examination, Brenner DCJ opined: "The hearing, in my view, is not to be a *pro forma* hearing. It is to be a substantive hearing". *In re Mrs M* [1993] DCR 673, at 674.

63 See, for example, *Re Skelchey* (Unreported, HC Auckland, AP 192, 20 March 1992, per Williams J): "It is imperative, in relation to these matters, that the proposed detainee understand the nature of the application and have an opportunity to make representations against the making of an order or the likely form of an order" [at p 3, per Williams J]. See, also, *Re Sorenson* (Unreported, HC Auckland, AP 176/89, 16 October 1989, per Anderson J) ["I think it would be desirable as a general proposition for persons facing the possibility of up to two years detention under the Alcoholism and Drug Addiction Act 1966 to be represented by counsel before orders are made": at p 10]; and the discussion *infra*, Chapter 8, section 8.1.3.

64 This was the scenario, for example, in *S v Tahana-Reese & Anor* [2000] NZAR 481.

65 As, for instance, in *Savage v Savage* (Unreported, HC Hamilton, M 48/84, 19 March 1984, per Tompkins J).

66 This is not seen to contradict the right codified in section 35(2) of the Act that: "every person who is the subject of any such application shall be entitled to be heard and to give and call evidence and may be represented by a solicitor or counsel".

67 Pollock v DK [1994] DCR 218 ["In the case of Dr Fay, however, he has never seen the subject person until this afternoon when he met with her in the Court and it is apparent that his certificate is based exclusively, according to the evidence, on what he read in the file or from a computer ... he is only a purveyor of hearsay .... It is a certificate formed simply on the basis of certain written material in a hospital file not maintained by [Dr Fay] and without any consultation with the patient, discussion with the patient, or examination of the patient. In my view, such a certificate cannot be safely relied upon by the Court": at p 220, per MacAloon DCJ].

The logical force of this interpretation is strengthened by the inclusion of the power in section 30 of the Act for a Judge to receive "any evidence that he thinks fit, whether or not the same would be admissible in a Court of law", and the fact that physicians who have not personally examined the alleged alcoholic are not specified in the list of people who are statute-barred from signing a medical certificate under the Act [section 32 refers].

In another related point, there is also nothing in section 9 that requires the medical practitioners who certify that a person is an "alcoholic" to attend the hearing of the application. Subsection 9(6) expressly provides for the option of medical certificates to be signed rather than oral evidence presented at a formal Court hearing. Mindful of section 31, there is also good authority for the proposition that District Court Judges are entitled to rely upon such certificates without necessarily having to 'lift the clinical veil', and go behind them to look at issues of bona fide.\(^9\)

Once the four procedural hurdles contained in section 9 have been passed – to recapitulate: (a) the alcoholic is present; (b) the Judge is satisfied as to the truth of the application; (c) two medical practitioners have either given evidence or provided appropriate certificates that support the making of such an order; and (d), a current ADA Act institution is willing to receive the alcoholic for treatment – a District Court Judge has the power to make an order "if he thinks fit" [section 9(7)]. In other words, the power to make an involuntary committal order is discretionary. One of the most useful glosses on the exercise of this discretionary power has been given by Justice Anderson:\(^0\)

There are two broad considerations that need to be reconciled as far as possible in proceedings under the Alcoholism and Drug Addiction Act. The first is the natural concern of the community and the relatives of persons afflicted with alcoholism to ensure that appropriate medical treatment is available for persons who are quite often incapable of making informed decisions, let alone of taking constructive steps in their own interests. The second broad consideration is the necessity to ensure that the liberty of the citizen is not assailed without a reasonable opportunity fairly to put matters to the tribunal charged with the responsibility of exercising powers under section 9; which matters might result in either the declining of orders for detention or the terms of detention orders in relation to treatment of a less draconian nature than might otherwise be seemingly necessary .... A further constraint in respect of which the statute is silent but which adumbrates an exercise of statutory powers of discretion is that body of public law which requires the discretion to be exercised on the basis of relevant information, exclusion of irrelevant matters, a weighing of rights of the subject of the application and of the community, and in a general sense the application of fairness.

Before turning to the third route via which the commitment procedures in the Act can be initiated, it is appropriate to highlight one final aspect of the procedure under sections 8 and 9. This relates to interim detention of patients prior to their reception at an ADA Act institution. Section 13 of the Act provides that a District Court Judge may, when making a committal order under the legislation, "give such directions as he thinks fit in respect of the custody of that person, and may direct that he be kept in any police station, psychiatric hospital ... or other place of confinement" for up to 10 days, of which the period of confinement in a police station is not to exceed 48 hours. This power allows Judges to direct that alcoholics be given medically-supervised detoxification at a non ADA Act institution (for example, the Auckland Regional Alcohol and Drug Services' Detoxification Unit), which may be set as a precondition before the ADA Act institution agrees to receive them for in-patient treatment.

\(^9\) A recent example is Maffey v Maffey (Unreported, HC Christchurch, AP 13/99, 16 December 1999, per Chisholm J), especially at pp 3-4 ["I cannot accept that the Judge was obliged to go behind the certificate"].

\(^0\) Re Sorensen (Unreported, HC Auckland, AP 176/89, 16 October 1989, per Anderson J), at pp 5, 8-9.
Transfer of prison inmates

The third pathway for compulsory treatment under the Act is section 21 of the legislation, which allows a window of opportunity for prison inmates to be transferred to ADA Act institutions for treatment of alcoholism. Section 21 states:

21. Transfer of prisoner to institution – (1) The Minister of the Crown who is responsible for the Department of Corrections, with the concurrence of the Minister of Health, may at any time, by order under his hand, transfer to an institution under this Act, for treatment for alcoholism, any person detained in a penal institution under a sentence of imprisonment or corrective training or preventive detention.

(4) A person detained in an institution under this section shall not be discharged or permitted to be absent from the institution under this Act except with the consent of the Minister of the Crown who is responsible for the Department of Corrections and subject to such terms and conditions as that Minister, with the concurrence of the Minister of Health, may impose.

While in the ADA Act institution, the prisoner’s sentence continues to run [section 21(3)], and if his or her prison sentence expires during their treatment, then he or she will be discharged from the institution [section 21(5)(b)]. The maximum period of detention for such a transferee is the same as for any other ADA Act patient [section 21(5)(a)]. It is also notable that the transfer scheme is not designed specifically with prisoners in mind who are approaching the end of their sentences, as a means of rehabilitative transitioning back into the general community, but rather is available to all prison inmates.\textsuperscript{71} Thus, where prisoners are granted a mid-sentence transfer, and they have time still to serve at the end of their course of treatment at the ADA Act institution, the Act requires that the prisoners be sent back to serve out their remaining time in gaol [section 21(5)(c)].

Interestingly, there is no guidance given in section 21 as to what criteria Ministers would use to make decisions on whether or not to invoke the transfer proceedings. This may be contrasted with the equivalent provision in the MH (CAT) Act, section 45 of which allows for the inter-institution transfer of inmates with mental health problems, and is predicated on clinical indications that the move would be in the inmate’s best interests. Section 21 anticipates that the decision will be made by Ministers, without any legal requirement to consider whether the transfer is clinically indicated.

Section 21 of the ADA Act is also at variance with section 45 of the MH (CAT) Act in that a section 21 transferee is still regarded as a prisoner, not a patient; whereas a section 45 transferee has his or her legal status changed from a prisoner to a patient. Put another way, a section 45 transferee is deemed to be under a compulsory treatment order, while a section 21 transferee is not. This difference becomes important because, for example, a section 21 transferee may be formally charged with escaping from, or failing to return to, the ADA Act institution, yet there are no equivalent offences for mental health patients who have been transferred pursuant to section 45.

\textsuperscript{71} The practical reality may be very different, of course. Mental Health Foundation researcher John Dawson notes that Wolfe Home at Carrington Hospital used to admit prisoners from Paremoremo maximum security prison who were near the end of their sentences; however, they found malingering a problem, and once the prisoners had completed their course of treatment, it would generally be inappropriate to return them to prison. Dawson adds that Wolfe Home will now only accept prisoners as voluntary in-patients on the day their prison sentence is completed. J Dawson, The Alcoholism and Drug Addiction Act 1966. Unpublished draft discussion paper (Auckland: Mental Health Foundation, 1983), p 6.
Arguably, nowhere are the differences between the ADA Act and MH (CAT) Act regimes seen more clearly than in the roles which the statutes allow the Minister of Health to perform. In blunt terms, the Minister has nominal oversight of the mental health legislation, with decisions over custodial and clinical issues clearly reserved for responsible clinicians. In contrast, the Health Minister has a potentially much more active role under the ADA Act. As well as possessing the authority to recommend the certification or de-certification of institutions [section 5] and appoint Supervisory Committees for certain institutions [section 7], the Minister has the power to give directions as to the custody of any person pending a committal order under the ADA Act [section 13]. The Health Minister also has the ability to personally order an ADA Act patient's discharge, transfer, or release on leave [section 17]. Although, as a matter of praxis, these Ministerial powers are seldom invoked, the legislation still foresees that they might be, and Courts periodically invite appellants to direct their requests for certain orders to the Minister.  

3.2.5 Procedures for appeal, review, leave and discharge

Section 10 of the ADA Act provides that the maximum period of detention under the legislation is two years. There is no minimum period of detention specified.

Under section 32 of the Act, the appeal provisions of the Summary Proceedings Act 1957 are extended to people who have ADA Act committal orders made against them. Appeals must be lodged within three weeks of the date that the committal order was made; although Courts have usually been lenient in accepting out-of-time appeals from ADA Act patients, who can find it hard to access legal representation and may be otherwise disempowered.

The rules around patient discharge, transfer or release on leave are set out in sections 17 to 20 of the ADA Act. In short, the power to discharge patients from under Act, to transfer patients between certified institutions, or to agree to patients' release on leave, are reposed in the Minister of Health, the person in charge of hospital-based institutions or any designated Supervisory Committees that exist at non-hospital-based institutions [section 17(1)].

The appointment of such Supervisory Committees is a discretionary power for the Minister. There have been instances in the past where non-hospital-based institutions (whose management do not enjoy the same inherent rights regarding patient discharges, transfers or leave as do the superintendents of hospital-based institutions) have not had Supervisory Committees. Where they do exist, Supervisory Committees consist of a District Court Judge who acts as Chair, the superintendent of the institution, a medical practitioner who attends the institution.

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72 An example is Quirke v Quirke (Unreported, HC Palmerston North, M 127/85, 12 December 1985, per Williamson J), at pp 4-5 ["While the simpler and more convenient course for the appellant may be to obtain an order for this Court setting aside the detention order because circumstances have changed, I do not think there is jurisdiction in this case to make such an order .... I have no doubt that the solicitors for the appellant could request the Minister to make an order under section 17, and that if the Minister were then satisfied that it was an appropriate step to take, an order for discharge could be made"].

73 See, for example, Re Skelchey (Unreported, HC Auckland, AP 1/92, 20 March 1992, per Williams J), a case where the appellant wrote to the Court appealing her committal six days after the three week time limit expired: ["In view of her detention and the difficulties associated with communicating with her counsel it is appropriate that leave be granted to her to appeal out of time. This is particularly so bearing in mind we are here in an area involving liberty of the subject": at pp 1-2, per Williams J]. Furthermore, as Justice Williamson noted in Quirke v Quirke (Unreported, HC Palmerston North, M 127/85, 12 December 1985, per Williamson J), the incorporation of the Summary Proceedings Act appeal regime brings with it the power for the Court to extend any time limit prescribed for the filing of any notice [section 123 of the Summary Proceedings Act 1957 refers].

74 For example, Totara Lodge in Masterton: E A Whiteside, Letter to Chief District Court Judge, 24 August 1989 [Held on file 131-158-2, National Archives, File series 71863, box 794].
and one other person [section 7(2) refers]. Supervisory Committee members are appointed for three-year terms and make decisions by majority vote. Committees determine their own procedure [section 7(11)], subject to the over-riding requirement that all hearings under the Act “shall be heard and determined in private” [section 35(1)].

The term “discharge” is not defined in the ADA Act, but an order for discharge has been held to have the effect of revoking the original committal order.75 Under section 18 of the Act, patients have the right to apply for discharge to an institution’s superintendent or Supervisory Committee once they have spent six months there. If the request is turned down, a patient may appeal the decision by filing an application in writing to a Judge of the High Court. The inquiry powers in section 18 include the ability of the Judge to order that the patient be brought before him or her for examination [section 18(2)] and generally resemble the jurisdiction to investigate a writ of habeas corpus.76 To this extent, although section 18 does not allow a Judge to institute an inquiry into the lawfulness of a patient’s detention on his or her own motion – unlike the analogous position under section 84 of the MH (CAT) Act – and the section 18 appeal right only crystallises after a patient has spent six months under the original committal order, an ADA Act patient would presumably still retain the common law right to seek habeas corpus, or to have the validity of his or her detention determined under section 23(1)(c) of the New Zealand Bill of Rights Act 1990.77

In relation to transfers, they cannot be conducted without the consent of the receiving institution [section 17(1)(b)], and do not affect the patient’s status for the purposes of the Act. Hence, patients are still deemed to be in the lawful custody of the transferring institution until they are received in the new host institution [section 17(2)], and could be charged with escaping from lawful custody if they abscond while they are in transit [see section 25(1)(b)]. Likewise, an inter-institution transfer does not affect the duration of the original committal order under the statute.

On the question of leave, section 17 of the Act confers a broad discretion on the Minister, Supervisory Committee or person in charge of a hospital-based institution to release a patient on leave for any period up until the expiry of the original committal order. Any conditions attached to the leave (such as attendance at outpatient alcohol and other drug treatment services, or participation in AA meetings) must be specified in the order granting leave [section 17(1)(c)]. A patient on leave may apply at any time to have any such conditions either varied or revoked [section 19]. Conversely, leave may be revoked where a patient on leave is convicted of an offence involving drunkenness, or has otherwise failed to comply with the conditions attached to his or her leave order [section 20]. Although most institutions will opt to discharge patients who breach their conditions of leave, rather than revoke their leave and recall them for further in-patient treatment, such cases occasionally do come before the Courts.78

3.2.6 Dealing with people found intoxicated in public places

Section 37A of the ADA Act gives a police officer the power to take home a person found intoxicated in a public place; or, if that is not reasonably practicable, to take him or her to a temporary shelter or detoxification centre; or, if neither option is available, to a police station, where the intoxicated person may be detained for up to 12 hours.

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75 Refer to Quirke v Quirke (Unreported, HC Palmerston North, M 127/85, 12 December 1985, per Williamson J).
76 In re M (A mental patient) (Unreported, HC Wellington, M 716/85, 21 April 1986, per Greg J).
77 Section 18(6) of the ADA Act states: “Nothing in this section shall prevent the exercise of any available remedy or proceeding by or on behalf of any person who is or is alleged to be unlawfully detained”. This, then, appears to preserve the ability to challenge the validity of detention orders under the ADA Act even within the first six months of a patient’s period of committal.
78 For example, S v S [1988] DCR 560.
This replaces much more sweeping Police powers vis-à-vis public drunkenness that were formerly contained in sections 41, 42 and 44 of the Police Offences Act 1927.\(^{79}\)

In *Fleming v Police*,\(^{80}\) the High Court held that the powers of detention under section 37A are aimed at ensuring the safety of intoxicated people with the least possible encroachment on their civil liberties. The legislation contains a clearly expressed hierarchy of options for dealing with people who become incapacitated through substance misuse, from a least restrictive (transport to the person’s own home) to a most restrictive alternative (detention in a police station), with a built-in preference for the least restrictive alternative. In practical terms, this has been taken to mean that intoxicated people should only ever be held in Police ‘drunk tanks’ as a last resort.\(^{81}\)

### 3.2.7 Offences and miscellaneous provisions

For the sake of completeness, it is appropriate to end this quick overview of the mechanics of the ADA Act with brief mention of the offence provisions contained in the legislation and one or two other miscellaneous provisions.

Offences under the ADA Act are specified in sections 24 to 29 of the Act. The offences are: willfully detaining or procuring the detainment of a person in an institution for a period longer than is authorised by law [section 24]; escaping or attempting to escape from an institution or lawful custody as a patient, or assisting a patient to escape or attempt to escape [section 25]; willfully engaging in “any violent, unruary, insubordinate, destructive, indecent, offensive, or insulting conduct” [section 26]; supplying “any intoxicating liquor or any stimulating, narcotic, or sedative drug” to a patient, whether they are detained in an institution or absent on leave [section 27]; trespassing on the grounds of an institution [section 28]; and ill-treating or willfully neglecting a patient [section 29].

All of these offences are liable to summary conviction, and carry no right to elect trial by jury [section 37]. Pursuant to section 36 of the Act, where a person is convicted of an offence under the ADA Act, the offender is generally liable to imprisonment for up to three months, or a fine of up to $200, or both. The only exception in this regard is the offence of unlawfully detaining, or arranging for the unlawful detention of, a person in an institution [section 24], which carries a maximum penalty of up to one years’ imprisonment, or a fine of up to $1000, or both.

In terms of other miscellaneous provisions, the ADA Act empowers the Police to arrest any person who is ordered to be detained under the legislation, without the need for a warrant [section 14]. The Police and “any officer or servant employed in or about the institution” are also empowered to effect warrantless arrests of any patient who is absent from a certified institution without lawful justification [section 16].

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79 Commenting on the redefinition of the Police role in relation to public drunkenness, the Minister of Justice, Hon Jim McLay, observed in the House of Representatives, on 16 June 1981, that the former offence provisions can be described, “at best, only as a clumsy method of achieving a measure of social hygiene”: *New Zealand Parliamentary Debates*, vol 437, p 429. For an in-depth analysis of Police powers of detention, see [N Trendle], *Laws of New Zealand, Police*, para 55 (Wellington: Butterworths, 1998).


81 See, further, *Conroy v Police* (1990) 5 CRNZ 600, *Reile v Police* (1992) 9 CRNZ 87. As noted earlier, in order to reduce this study to manageable proportions, the definitional decision has been made not to tease out the related topic of the state’s response to public drunkenness. See *supra*, Chapter 1, note 19 and accompanying text. Section 37A of the ADA Act is, however, referred to subsequently in relation to the use of “intoxication” as the threshold for coercive intervention, and the preference for the least restrictive alternative, as points of contrast to the general ADA Act regime. See *supra*, Chapter 8, section 8.1.5.
Such officers are also given qualified immunity. Section 38 protects from civil or criminal liability any person who purports to act under the authority of the Act, unless he or she has acted in bad faith or without reasonable care.  

3.3 Momentum for reform of the Act

Before concluding this Chapter, an understanding of the efforts to reform the ADA Act may help to place the legislation in a proper historical context.

By 1980, when the ADA Act had only been operative for a little over 10 years, there was already concern about its effectiveness. The National Consultative Committee on Alcohol wrote to the Minister of Justice in July 1980 advising him that criticisms of the legislation were being ventilated in the sector, and that the Act was "generally regarded as a laudable effort but with various technical flaws seriously diminishing its effectiveness". The Committee advised the Minister that it had therefore formed a special ADA Act review committee "to examine the Act, and to make recommendations as to any adjustments needed to bring it more in line with current needs".

The ADA Act review committee’s suggested amendments to the Act were endorsed by the national peak body on alcohol, the Alcoholic Liquor Advisory Council, and were forwarded to the Department of Health in mid-1981. The Department circulated the suggested amendments to Hospital Boards, treatment agencies and relevant professional associations for comment. The submissions received from these bodies indicated that opinion was divided between those who thought that the Act "is an inadequate piece of legislation, the [suggested] amendments [are] unacceptable, and the Act should be repealed", and those who believed that "the amendments will give greater flexibility to the Courts and treatment centres", and that the legislation was thus worth retaining.

The Minister of Health wrote to the National Consultative Committee on Alcohol in late-1982 stating that a formal review of the legislation was underway, and the review committee’s suggestions would be taken into account. No further action was taken until 1983, when the Alcoholic Liquor Advisory Council convened a symposium on the Act, with presentations by representatives from various government departments and treatment agencies. The major outcome of the symposium was the formation of a Departmental Task Force on Alcohol-Related Issues which was given responsibility for driving a review of the ADA Act forward. Concurrently, a legal researcher for a Mental Health Foundation Task Force on Mental Health Legislation circulated a draft discussion paper on the Act, in the hope it could be used as a starting point for the review work by the Task Force on Alcohol-Related Issues.

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82 It is noteworthy that the former Health and Disability Commissioner, Robyn Stent, has expressed concern that section 38 could be applied in a way that excludes providers from liability for a breach of the Code of Health and Disability Consumers Rights. See R K Stent, Submission by Health and Disability Commissioner to the 1999 ADA Act review, 4 May 1999, p.4.
84 L Thornton, Letter to Minister of Justice, 9 July 1980, p 1 [Held on file 3/11, Alcohol Advisory Council archives].
86 A G Malcolm, Letter to National Consultative Committee on Alcohol Dependency, 3 November 1982, p 1 [Held on file 131-158-2, National Archives, File series 71863, box 794].
A small working party drawn from the Departmental Task Force on Alcohol-Related Issues met from 1983 to 1985 to consider the Act. The minutes of the working party’s meetings suggest that no final decisions were reached, although a series of suggested amendments to the legislation were developed. One of the only concrete things to emerge from the working party’s deliberations were a set of agreed principles to guide revisions to the Act.

**Principle 1**: Compulsory detention under the Alcoholism and Drug Addiction Act should apply only when no alternative and reasonable remedy for assisting the alcohol or drug dependent person is available or accepted.

**Principle 2**: The definition of an alcoholic or drug addict for the purposes of the legislation should be narrowed so that the requirement for compulsory treatment for such alcoholics or drug addicts would apply in only limited circumstances.

**Principle 3**: Provisions designed to protect the rights of the committed patient under the Alcoholism and Drug Addiction Act should be developed in conjunction with, and be comparable to, those in the proposed Mental Health Bill.

These principles express a desire to locate the Task Force’s work within the philosophy of ‘the least restrictive alternative’, and to avoid inconsistency with mental health legislation that was being developed at the same time.

Departmental records indicate that a vehicle to progress the Task Force’s work in the mid-1980s was never found and the momentum for reform which had built up in the preceding years was allowed to dissipate. In fact, there appears to have been no energy directed towards reviewing the Act for the latter part of the 1980s or early 1990s. During the development of the Mental Health (Compulsory Assessment and Treatment) Act 1992, however, some thought was given to updating the ADA Act procedures and incorporating them as a separate section in the Mental Health Act. On balance, however, it was decided to keep the ADA procedures separate. Indeed, section 4 of the MH (CAT) Act specifically excludes people from being subject to compulsory assessment and treatment under that Act solely on the basis of a substance use disorder.

In September 1993, a contractor was retained by the Ministry of Health to assist the Mental Health Services section prepare for a full-scale review of the ADA Act. Although the contractor prepared a draft discussion paper for circulation, it was never sent out for consultation, and momentum for a review of the Act was lost once more.

Further work on the ADA Act at officials’ level appears to have been suspended during 1994-96 while the iterative process of developing a national policy statement on alcohol took place, as part of the government’s overall National Drug Policy. One of the future directions listed in the National Drug Policy, to be given effect by 2001, is a “review of the provisions for compulsory assessment and treatment of people with alcohol use disorders”.

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89 The minutes of these meetings are held on file 131-158-5-1, National Archives, File series 74344, box 794. The working party’s suggested amendments are discussed further infra, Chapter 9, section 9.1.
Mindful of this target, the Ministry of Health issued a discussion paper on the ADA Act in March 1999. Forty-one submissions were received on the Ministry's discussion paper, primarily from the treatment field, public sector bodies and judicial/legal practitioners. An October 1999 analysis of the submissions by the Ministry concluded that "a full review of the ADA Act is needed", and foreshadowed that further inter-agency work would be needed. However, no such work was included on the Ministry's 1999/2000 work programme, nor have any further steps been taken to carry forward the necessary inter-agency work during the first half of 2000/01.

3.4 Summary

Drawing these threads together, this chapter has sought to position the ADA Act in more of a historical context, as well as providing a 'black letter' reading of the major provisions of the legislation as it exists today. Firstly, the origins of the Act were traced back to the late nineteenth century, and the anxieties expressed about habitual drunkenness among certain classes in New Zealand society. Superseding the Reformatory Institutions Act 1909 (which for the first time had divorced state-compelled treatment of alcoholism from the commission of an offence), the ADA Act was seen to be a response to the wasteful cycle of arresting alcoholics for public drunkenness, and part of a broader acceptance of the need to see alcoholism as a disease to be treated not a crime to be punished. This convergence of public and official concern about how to respond to alcoholics, and the ascendancy of the disease concept of alcoholism, meant that parliamentary debate about the legislation was relatively uncontroversial.

The legislation passed in 1966 was described as having a number of major differences from its 1909 precursor. Two notable changes were seen to allow the ADA Act to cast its net wider than the Reformatory Institutions Act: first, the population group targeted was significantly widened from the 1909 definition of "habitual inebriate", which had incorporated notions of dangerousness and insisted on a proximate relationship between the substance use and the evidence of harm; second, the 1966 Act extended the power to apply for involuntary committals to police officers and "any other reputable person". Against this, however, some streams of criminal justice referrals under the 1909 Act were removed in the 1966 legislation, and other modernising changes to the 1909 statute had the effect of strengthening the procedural protections which apply to proposed patients under the ADA Act. This discussion of the legislation was completed by examining amendments to the Act since it was passed in 1966. With the exception of the repeal of section 48A of the Criminal Justice Act 1954, these amendments were judged to have been of a technical rather than a substantive nature.

The chapter next looked at the mechanics of the Act. In short, the legislation was seen to provide for alcoholics and drug addicts to be compulsorily detained for assessment, detoxification and treatment at certified institutions. If it is thought that a person is either an "alcoholic" or "drug addict", the commitment procedures in the Act were described as being able to be initiated in one of three ways: (a) 'voluntary' application [section 8]; (b) involuntary application [section 9]; or (c), transfer of a prison inmate for treatment by the Minister of Corrections [section 21]. The discussion then rehearsed the major procedural steps involved in the use of each of these committal routes.

96 C Windsor [Acting Portfolio Manager, Mental Health, Ministry of Health], Email to M B Webb, 16/5/2000 10:09.
The rules around patient appeals, discharges, transfers or releases on leave were then outlined. Briefly, the power to discharge patients from the Act, to transfer patients between certified institutions, or to agree to patients' release on leave, were seen to be reposed in the Minister of Health, the person in charge of hospital-based institutions or any designated Supervisory Committees that exist at non-hospital-based institutions [section 17(1)]. Key aspects of this procedural matrix were noted as being that: committal orders are for a maximum of two years [section 10]; patients have a right to appeal against a committal order within three weeks of the order being made [section 32]; and patients may apply to be discharged from the Act after six months at the institution [section 18]. It was also noted that section 17 of the Act confers a broad discretion on the Minister, Supervisory Committee or person in charge of a hospital-based institution to release a patient on leave, with or without conditions attached.

This overview of the mechanics of the ADA Act was concluded with a brief summary of the offence provisions contained in the legislation (which generally carry with them a maximum fine of three months imprisonment or a $200 fine or both), and several other miscellaneous provisions – such as the power to make warrantless arrests of ADA Act patients who are found away from certified institutions without lawful justification [sections 14 and 16].

Finally, the chapter reflected upon the attempts to reform the ADA Act that have been made since it was passed. These efforts were traced back to the early 1980s, when the Act had been in force for little more than a decade, with several false starts at reviewing the legislation over the succeeding 20 years. Repealing this pattern of failed attempts to generate momentum for reform, current efforts to review the Act were also assessed as having stalled.

Having laid out the history as well as the legal 'bricks and mortar' of the ADA Act, it is now necessary to turn attention to how the statute is actually being used in modern-day New Zealand. This task is tackled in the chapter that follows.
How does the Act work in practice?

In this chapter, discussion turns to how the ADA Act is currently being used ‘on the ground’. The chapter draws on interviews with those involved in the ADA Act process, as well as participant observation in a small number of review hearings under the Act. It also rehearses the limited amount of empirical data on the number of committal orders made under the Act, the length of such orders, and basic demographic information about the type of people against whom the orders are made. Discussion is also provided on how useful the ADA Act is found to be by those who come into contact with the legislation. In doing so, this chapter seeks to build a bridge between ‘law on the books’ and ‘law in action’.

4.1 The application and committal process

To gain a flavour of how applications under the ADA Act are processed, some vignettes which have been relayed by key players in the process are instructive. The first vignette comes from a Whangarei-based District Court Judge, who reflects on his experience of sitting in the Dunedin District Court over a period of approximately eight years:¹

It is my experience that most alcohol and drug addiction applications were by the Police, often at the request of family members where the patient was so intoxicated that they were clearly causing harm to themselves or others in non-specific and non-criminal ways. Most applications that were made did not involve the serving of a summons on the potential patient to appear, because in most cases evidence was led that the patient would not appear and a warrant was issued compelling the attendance of the patient. Most applications were made when the potential patient was in a bout of binge drinking and grossly intoxicated. A patient in such circumstances would be unable to understand or appreciate a summons. The Police would usually arrange for the patient’s own doctor or some other medical practitioner to carry out an examination mostly without the informed consent of the patient. The patient would then be brought to the Police Station and a Judge would visit and interview the patient. In most cases an order was made and the patient was taken to the hospital by the Police. It is my experience that the patient did not remain very long in hospital, usually a week or two during which time they were detoxified, given any medical treatment that their clinical condition required, placed back on their feet and released on leave.

This account is consistent with the recollections of a recently retired Judge who sat at Otahuhu District Court, and who for many years was the Chairman of the Auckland Bridge Programme’s Supervisory Committee:²

If a warrant to arrest is issued, it is customary for the Registrar to arrange with two medical practitioners for them to be available to examine an alleged alcoholic, when arrested – preferably one of the medical practitioners should be the medical practitioner who normally attends the alcoholic, as he would have some personal knowledge of the medical background of the alleged alcoholic. After examination by the medical practitioners, the

medical certificates are made available to the Judge. If both medical practitioners consider the person they have examined is an alcoholic, the alleged alcoholic is brought before a Judge who then informs the alcoholic of the contents of the medical reports and conclusions reached, namely that the alleged alcoholic is an ‘alcoholic’ in terms of the Act, and that the detention and treatment as such is expedient in his own interests or in the interests of his relatives. If the alcoholic accepts the evidence as contained in the two certificates, the Judge can then consider making an order. However, if the alleged alcoholic disputes the two medical certificates and the conclusion he is an alcoholic, and wishes to defend the application, it is then adjourned by the Judge to an early fixture date for hearing. For my part, I usually try to have these matters heard within a week if possible.

Court Registrars who are involved in processing applications under the ADA Act report that, for section 8 applications, where the applicant presents with the necessary confirmation that a certified institution will accept him or her for treatment under the Act (which is usually conditional upon the applicant undergoing a comprehensive assessment at a recognised alcohol and other drug referral agency), a District Court Judge will typically be found to hear the application within the hour. The hearing itself, conducted in the Judge’s chambers, is likely to take one or two minutes at most, with the Judge focussing on making sure that the applicant understands the effect of his or her application.3

There appear to be two other main channels through which section 8 applications proceed. First, the practice of some certified institutions is to encourage those seeking inpatient care to formally commit themselves under the Act, thereby strengthening their incentives to complete the course of treatment. As explained by the Chief Executive Officer of Nova Lodge, Brian Dilger (the major proponent of this approach), the thinking is that, by volunteering to be committed under the Act, an alcoholic will be able to “raise the bar” against prematurely terminating treatment, thus “adding the prospect of a Judge over one shoulder to help them listen to their own conscience on the other shoulder, which can be really useful when the going gets tough, and some people just want to be able to give up and go home”.4

The second major channel for section 8 applications are the Courts themselves, which sometimes invite offenders to ‘volunteer’ under the ADA Act for detention in a therapeutic setting, rather than being sentenced to a term in prison. The way such ‘volunteers’ are inducted is explained by retired District Court Judge Trevor Gillies:5

When I have an offender before me and it is clear from the criminal history sheet or the Probation Officer’s report, or the alcohol assessment that I have obtained, that the offender is clearly an alcoholic, then I point this out to him and suggest that he take in-patient treatment under the Alcoholism and Drug Addiction Act. I usually use a form of persuasion pointing out to him that he is liable for imprisonment on this charge, and that I will imprison him. If it is an excess blood-alcohol charge I usually mention two months or ten weeks in prison, or if it is on some other charge where the period of imprisonment provided is longer, then I usually select some other suitable period. However, I give him the opportunity of making a voluntary application under section 8 and stand him down for him to consider it. If the man is unrepresented, I always grant him legal aid so that counsel can discuss the matter with him. I have found almost invariably they accept my invitation and make a voluntary application. I then see them in chambers and make sure they understand the provisions of the Act and tell them what it is about, and then make the order. I then return to Court and tell them that I am not prepared to sentence them today, but I will

3 N Tanner [Deputy Registrar, Family Court, Christchurch Registry], Interview, 14 November 2000. The discussion about the process of ADA Act applications that immediately follows in the text is drawn from this interview, as well as interviews conducted on 14 November 2000 with Major Ian Hutson [Director, Salvation Army Bridge Programme, Christchurch] and Brian Dilger [Chief Executive Officer, Nova Lodge, Templeton].
4 B Dilger, Interview, 14 November 2000.
await the report from the institution following treatment, and then remand them on bail for some two or three months, depending on the circumstances. I then tell them that if the report I get is a good report and it shows that they have made good use of their time and learned about their alcohol problem, and come to accept that they are alcoholics, then I will take that into account when I finally come to sentence them. If on the other hand the report I get is a poor one I tell them they know what they can expect — meaning imprisonment. I use basically the same words to each one so I can make reference to what I have said to them when they next reappear for sentence.

In excess blood-alcohol cases, if the report is a good one I usually place the offender on probation with a condition that he attend counselling for alcohol dependence or alternatively, that he attend meetings of Alcoholics Anonymous at least once a week, or that he attend such treatment for alcohol dependence as directed by the Probation Officer. I usually then only impose the minimum period of disqualification unless it is an extremely bad case — the offender already has been without a licence for the period he has been in treatment at the institution. Each case depends on its own facts. However, it is important to give the man credit for any progress that he has made and I have usually found that he will respond. If on the other hand the report is poor then I adhere to my original words to him, that I will sentence him to imprisonment, and I impose either the same period that I originally indicated, or give him some credit, if merited, by reducing the term. I have found that over the past few years I have only had to impose imprisonment on about three or four offenders who have not responded to the treatment.

From a procedural point of view, all three of these contexts for invoking section 8 of the ADA Act result in relatively speedy hearings. By contrast, in cases involving contested applications under section 9 of the Act, it is necessary to ball the subject of the application to appear at a subsequent hearing. As a consequence, these cases often cannot be scheduled until two or three weeks’ time — with the ADA Act application taking its place in the queue like any other defended hearing that requires a fixture date. A Deputy Registrar will normally sit in on the hearing, which will take place in a closed Courtroom and will typically be attended by the applicant(s), the subject of the application and supporters for either ‘side’. Normally, the medical practitioners who have signed the supporting certificates do not attend hearings in person, although practices apparently vary on this point throughout the country.6 Similarly, the subject of the application will be represented only rarely by legal counsel, despite the fact that “[p]eople in this position are often isolated; lacking reliable personal support networks”.7 On the other hand, it is quite common for a representative from the potential receiving institution to sit in on the hearing, to be able to answer any questions that might be put to them by the Judge. Such defended hearings are reported to typically last between one and two hours.

With regard to the Judge’s exercise of discretion in the hearing itself — recalling that the Judge is empowered to make an order under section 9(7) of the Act “if he thinks fit” — those experienced with the conduct of such hearings point out that most Judges reserve their decisions for half-an-hour before issuing their rulings, but that committal orders are made in over 80 percent of cases. Few Judges seem prepared to challenge doctors’ assessments (even though they may have only been derived from a 10 minute interview with the alleged alcoholic) and to substitute their judgement of the person (gained from a one to two hour Court hearing). While there is anecdotal evidence that proportionately more applications are refused in some parts of the country,8 this impression cannot be verified by the available data.

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5 T R Gillies, Submission to the 1999 ADA Act review, 20 April 1999, pp 4-5.
6 Former Judge Gillies, for instance, who sat in the Otahuhu Registry, recalls that when he dealt with ADA Act cases under section 9, he had the two medical practitioners who signed the supporting certificates attend the hearing, and that they were “subject to cross examination by the alleged alcoholic or his solicitor or counsel”: T R Gillies, Submission to the 1999 ADA Act review (op. cit.), p 3.
7 N Jamieson, Submission by Rodger Wright Centre to the 1999 ADA Act review, 4 April 1999, p 2.
8 I MacEwan [Manager, Treatment Development, Alcohol Advisory Council], Interview, 20 October 2000.
That being said, figures for the past two years drawn from the Department for Courts database do provide some insight into the extent to which Judges override the wishes of applicants, and decline to make compulsory detention and treatment orders under the ADA Act. Data captured for the 21 major Family Courts throughout New Zealand (which comprise approximately 80 percent of the national volume of Family Court work\(^9\)) for 1998-99 and 1999-2000 are expressed in Table 1.

<table>
<thead>
<tr>
<th>Court</th>
<th>1998-99*</th>
<th>1999-2000*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Section 8</td>
<td>Section 9</td>
</tr>
<tr>
<td></td>
<td>Applications</td>
<td>Orders</td>
</tr>
<tr>
<td>Auckland</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Christchurch</td>
<td>20</td>
<td>22</td>
</tr>
<tr>
<td>Hamilton</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Hastings</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Otahuhu</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Rotorua</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Wellington</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>TOTAL</td>
<td>25</td>
<td>40</td>
</tr>
</tbody>
</table>

* Financial years taken for statistical periods (30 June – 1 July).

As would be expected with such 'voluntary' applications under section 8 of the Act, the figures above indicate that virtually all section 8 applications result in committal orders being made. The above figures tend to confirm that the majority of section 9 applications also lead to committal orders being made, although Courts appear to be much more willing to decline such involuntary applications. For example, in 1998-99, of the 40 section 9 applications received by these Courts in the Family Court division, committal orders were made in 28 of the cases (70 percent); while in 1999-2000, of the 26 applications received under section 9, committal orders were made in 17 of the cases (65 percent).

For both section 8 and section 9 applications, it is uncommon for institutions to refuse to accept people for treatment, although there are instances where this has occurred.\(^{10}\) According to one senior clinician: "When this happens it usually relates to a well-known alcoholic who has caused major problems in the past with little evidence of benefit from treatment. Other refusals pertain to those on certain drugs of dependence which require protracted withdrawal management, or some persons with co-existing major psychiatric co-morbidity.\(^{11}\) Such cases will not normally come to the attention of a Judge, however, because Court Registry staff act as gatekeepers for ADA Act applications, and will normally insist on confirmation from a certified institution that it is prepared to accept a patient under the Act, before they allow the relevant papers to be put before a Judge. In the rare cases where no institution will agree to take a particular person under the Act, an application to commit the person will thus usually stop at the Registry office.

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\(^9\) R Munro [Planning and Information Manager, Department for Courts], Email to M B Webb, 11/10/2000 16:19.

\(^{10}\) One of the only examples to come to judicial notice is Police v Barnes (Unreported, Palmerston North DC, 13 December 1996, CRN 6054012657, per Ross DCJ). Applying section 9(7) of the ADA Act, Judges have held that a committal order under the Act cannot be made where there is no treatment place available for the alcoholic: see B v DR [1994] NZFLR 898, at 900, per von Dadelszen DCJ.
If the alleged alcoholic has been arrested for the purposes of completing a medical examination under section 9(5) of the Act, he or she will be released from police custody, and thus back to the community on his or her own cognisance.

Finally, it should be noted that there have been no attempts to use the committal procedure under section 21 of the Act - which allows for the transfer of prison inmates to ADA Act institutions - during the last five years. Indeed, departmental records indicate only isolated cases of this provision ever having been used in the past.\textsuperscript{12} This has been linked to the fact that, in the rare instances where inmates have been transferred to community alcohol and drug services, they were seen to be disruptive and did not mix well with the other patients.\textsuperscript{13} Some ADA Act institutions have also been reluctant to accept prison referrals because of their lack of lockable facilities.\textsuperscript{14}

4.2 The patients

Currently, the ADA Act is used to make around 200 committal orders a year for inpatient assessment, detoxification and treatment of people with substance use disorders - almost all of whom are held to be "alcoholics" under the Act.\textsuperscript{15} This is significantly less than the number of orders made each year when the legislation was first passed. During its initial decade of operation, the annual number of ADA Act committal orders peaked at over 400, as Table 2 shows.\textsuperscript{16}

\begin{table}[h]
\centering
\begin{tabular}{|c|c|c|c|}
\hline
Year & Section 8 & Section 9 & Total \\
\hline
1970 & 164 & 124 & 288 \\
1971 & 230 & 130 & 360 \\
1972 & 200 & 196 & 396 \\
1973 & 252 & 172 & 424 \\
1974 & 200 & 233 & 433 \\
1975 & 185 & 212 & 397 \\
1976 & 160 & 160 & 320 \\
1977 & 178 & 136 & 314 \\
1978 & 200 & 132 & 332 \\
1979 & 249 & 151 & 400 \\
\hline
\end{tabular}
\caption{Committal orders made by the District Court under the ADA Act, 1970–79}
\end{table}

\textsuperscript{11} G M Robinson, Submission by Capital Coast Health to the 1999 ADA Act review, 23 April 1999, p 1.

\textsuperscript{12} One of the rare examples is the transfer of Mr S, a 28 year old inmate of Manawatu Prison (convicted of reckless driving causing injury and driving while disqualified), who was transferred to the Totara Trust in Masterton for a 13-week residential programme for alcoholism. See B James, Memorandum for the Minister of Health, No 1645, 5 February 1987 [Held on file 131-158-2, National Archives, File series 61280, Box 442].

\textsuperscript{13} See, for example, M Delaney, Submission by Awhina House to the 1999 ADA Act review, 23 April 1999, p 1 ["It made it difficult for the patients already in house, especially women who felt anxious or insecure at night. Some prisoners presented a poor attitude and were discharged ..."].


\textsuperscript{15} There is no delineation in Court records whether a committal order is made because a person is an "alcoholic" or a "drug addict", but there is near unanimity amongst staff of ADA Act institutions that alcohol is the primary substance of abuse for around 95 percent of the people committed under the legislation. B Coffey [Director, Auckland Bridge Programme], Interview, 3 August 2000; D Limmer, [Director, Wellington Bridge Programme], Interview, 25 October 2000; I Hutson, Interview, 14 November 2000; P Jamieson [Deputy Director, Christchurch Bridge Programme], Interview, 13 September 2000; and B Dilger, Interview, 14 November 2000.

\textsuperscript{16} Adapted from M L Routledge, \textit{Committals to Hospitals and Institutions under the Alcoholism and Drug Addiction Act, 1969-1982}. Internal file note, Department of Health [Held on file 131-158-2, National Archives, File series 61280, Box 442].
Table 3, developed with figures provided by the Department for Courts, outlines the number of ADA Act committal orders made by the District Court from 1990-96. They are the most up-to-date national figures available at this time.\(^\text{17}\)

<table>
<thead>
<tr>
<th>Year</th>
<th>Section 8</th>
<th>Section 9</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>93</td>
<td>153</td>
<td>246</td>
</tr>
<tr>
<td>1991</td>
<td>99</td>
<td>178</td>
<td>277</td>
</tr>
<tr>
<td>1992</td>
<td>109</td>
<td>154</td>
<td>263</td>
</tr>
<tr>
<td>1993</td>
<td>64</td>
<td>139</td>
<td>203</td>
</tr>
<tr>
<td>1994</td>
<td>72</td>
<td>149</td>
<td>221</td>
</tr>
<tr>
<td>1995</td>
<td>64</td>
<td>130</td>
<td>194</td>
</tr>
<tr>
<td>1996*</td>
<td>62</td>
<td>114</td>
<td>176</td>
</tr>
</tbody>
</table>

* Figures only collected by the Department for Courts until 1 November 1996 (that is, 10 months).

The Ministry of Health conducted its own census of certified institutions in early 1997, and found that 199 people had been received for treatment under the Act during 1996. Of these, 115 people (60 percent) were involuntary committals under section 9 and 74 people (40 percent) were ‘voluntary’ committals under section 8. This 3:2 ratio of involuntary to ‘voluntary’ committals represents a narrowing of the gap that has ordinarily existed between section 8 and 9 orders, which has often been closer to 2:1 during the 1990s. Interestingly, the biggest proportionate fall in the number of committal orders comes from section 8 applications, which in the 1970s consistently contributed between 150 and 200 orders annually, but now typically only contributes between 50 and 100 orders each year.

To put these numbers in better context, it is also important to realise that people committed under the ADA Act contribute only a very small percentage of the total number of New Zealanders who access treatment services for alcohol and other drug disorders. As an indicative comparison, in 1990 there were 246 people committed under the ADA Act; in the same year, roughly 10,000 people received alcohol and other drug treatment; 8475 new clients were recorded in alcohol and other drug outpatient services,\(^\text{18}\) and a further 1520 people were admitted as inpatients.\(^\text{19}\)

People under compulsory treatment legislation therefore constituted only 2.5 percent of the total treatment population.

4.2.1 Readmission rates

There is no robust information about the number of people who are committed under the ADA Act more than once.\(^\text{20}\)

\(^{17}\) The Department of Courts has stopped routinely collected data on ADA Act committal proceedings, and requests to the Ministry of Justice to initiate a new data series for ADA Act hearings have gone unanswered. The Ministry of Health and the Alcohol Advisory Council of New Zealand are unable to provide updated data, and data captured by the Salvation Army for their own files does not give a nationally representative picture. It thus appears that this 1990-96 data, supplemented by the Family Court data cited earlier (supra, note 9), will have to suffice until the Ministry’s planned Mental Health Information System comes on stream in mid 2001-02.


\(^{20}\) By contrast, there is relatively solid information about the extent to which inmates under the Reformatory Institutions Act 1909 were readmissions under that legislation. For example, a Salvation Army census of the Rotoroa Island treatment population in August 1955 found that inmates under the Act had already been committed an average of 3½ times. See [Unattributed], *Analysis of Alcoholics Committed to Roto Roa Island: Internal file note* [Held on File 131-158-2, National Archives, File series 74340, Box 949].
Anecdotally, however, staff at ADA Act institutions report that it is not uncommon for people to be committed under the legislation three or more times during a decade, with some chronic relapsing alcoholics being seen again and again by services over a 20 or 30+ year drinking ‘career’.21

While it is difficult to gain real purchase on readmission rates for patients under the legislation, it is possible to get some traction on the extent to which people coming into treatment under the ADA Act have already sought treatment. In 1990, the percentage of committed patients in first time admissions to ADA Act services was 8.9 percent of males and 4.2 percent of females.22 In other words, over 90 percent of males and over 95 percent of females committed for treatment under the Act in 1990 were people who had previously accessed alcohol and other drug treatment services. These statistics give support to the view that people who are subject to committal orders under the ADA Act have already had multiple experiences of (ultimately) unsuccessful treatment; reinforcing the impression that the ADA Act is used to compulsorily detain and treat mainly chronic, ‘revolving door’ alcoholics.

4.2.2 Demographic features

In terms of the demographic characteristics of people committed under the Act, the refrain must be repeated that there is no robust data available. Because of the impression that ADA Act patients have higher chronicity than the wider alcohol and drug treatment population, and possibly other differences (such as a higher proportion of co-existing disorders), it would be unsafe to extrapolate from general studies of patients in residential alcohol and drug services.23

Of the small amount of research that is available, some of the early ‘snapshot’ studies on ADA Act treatment populations found that men accounted for 92 percent of total admissions versus 8 percent for women, and that men had a younger mean age (43.8 years) than women (48.7 years).24 Later studies drawing on data from longer time periods found that males made up 85 percent of ADA Act admissions, whereas women contributed 15 percent of the total; with a mean age of 46 years for both groups, ranging from 14 years as the youngest to 78 years as the oldest.25

Beyond these early studies, valuable insight has been provided by a New Zealand Health Information Service (NZHIS) analysis of mental health inpatient data from 1992 to 1994 [Tables 4 to 6 refer].26 Although the data which have been analysed seem to be incomplete,27 they nonetheless offer some basic information about the gender and age of ADA Act patients.

27 For example, when compared to the Department for Courts data for the same three year period, the NZHIS data appears to under-report the total number of committal orders made under the ADA Act. The Salvation Army has been especially critical of what it describes as “the gross inadequacy of reporting and analysis systems that have been used” in relation to the ADA Act, citing its own admission data for 1992-1994 which shows that 94 men and 32 women were committed to Bridge Programmes in 1992 (vs. 57 and 14 nationally as reported by the NZHIS), 66 men and 16 women were committed in 1993 (vs. 49 and 9 reported by NZHIS), and 71 men and 33 women were committed in 1994 (vs. 54 and 24 reported by NZHIS). See, further, W D
Table 4: Number of ADA Act committal orders by gender, 1992-94

<table>
<thead>
<tr>
<th>Year</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>1992</td>
<td>57</td>
<td>14</td>
</tr>
<tr>
<td>1993</td>
<td>49</td>
<td>9</td>
</tr>
<tr>
<td>1994</td>
<td>54</td>
<td>24</td>
</tr>
</tbody>
</table>

Table 5: Number of ADA Act committal orders by age, 1992-94

<table>
<thead>
<tr>
<th>Year</th>
<th>Mean age</th>
<th>Minimum age</th>
<th>Maximum age</th>
</tr>
</thead>
<tbody>
<tr>
<td>1992</td>
<td>37</td>
<td>17</td>
<td>70</td>
</tr>
<tr>
<td>1993</td>
<td>40</td>
<td>19</td>
<td>63</td>
</tr>
<tr>
<td>1994</td>
<td>39</td>
<td>19</td>
<td>71</td>
</tr>
</tbody>
</table>

Table 6: Number of ADA Act committal orders by age group, 1992-94

<table>
<thead>
<tr>
<th>Year</th>
<th>15-24</th>
<th>25-34</th>
<th>35-44</th>
<th>45-54</th>
<th>55+</th>
</tr>
</thead>
<tbody>
<tr>
<td>1992</td>
<td>17</td>
<td>19</td>
<td>13</td>
<td>14</td>
<td>8</td>
</tr>
<tr>
<td>1993</td>
<td>11</td>
<td>11</td>
<td>14</td>
<td>12</td>
<td>10</td>
</tr>
<tr>
<td>1994</td>
<td>18</td>
<td>18</td>
<td>16</td>
<td>10</td>
<td>16</td>
</tr>
<tr>
<td>TOTAL (n)</td>
<td>46</td>
<td>48</td>
<td>43</td>
<td>36</td>
<td>34</td>
</tr>
<tr>
<td>TOTAL (%)</td>
<td>22</td>
<td>23</td>
<td>21</td>
<td>17</td>
<td>16</td>
</tr>
</tbody>
</table>

Quality data on the ethnicity of patients committed under the ADA Act is not available. It is also not possible to analyse the geographical distribution of ADA Act patients from the patchy information available. That being said, there is evidence that some ADA Act patients are transferred out-of-region for treatment, particularly to Nova Lodge, located just outside of Christchurch, and to the Salvation Army’s Bridge Programme on Rotoroa Island.\(^\text{28}\)

\(^{28}\) Arnold, Submission by Salvation Army to the 1999 ADA Act review, 3 May 1999, p 4. The need for more rigorous record-keeping systems has also been noted by those from the research and treatment development communities: see S Adamson, Submission by National Centre for Treatment Development (Alcohol, Drugs & Addiction) to the 1999 ADA Act review, 21 April 1999. Although it is difficult to instantiate, such out-of-region transfers seem to have become far less common under a health system with Regional Health Authorities and regional offices of a national Health Funding Authority. In 1988, for example, of the 430 admissions to the Salvation Army’s Bridge Programme in Auckland, 348 came from metropolitan Auckland (81 percent), 32 came from Waikato (7 percent), and 50 came from other parts of the country (12 percent). J W McLeod, Rotoroa Island: Meeting, 12 May 1989. Internal file note,
4.3 The institutions

There are currently 13 institutions certified to accept people committed under the ADA Act. They include nine hospitals,29 three Salvation Army Bridge Programmes (Auckland, Wellington and Christchurch) and Nova Lodge.

In the Ministry of Health's 1997 census of certified institutions, 173 of the 189 people committed under the legislation (92 percent) were received by the three Salvation Army Bridge Programmes and Nova Lodge. This illustrates where the vast majority of ADA Act patients are sent for treatment.

As these statistics indicate, the overwhelming share of committals under the ADA Act are to non-hospital-based institutions. There are inevitable differences between the type of "care and treatment" for alcoholics that will be available at hospital-based versus non-hospital-based institutions, simply because of scale and specialisation. The current hospital-based institutions certified under the ADA Act operate mostly as wards within general public hospitals, rather than psychiatric hospitals (like Oakley, Carrington and Cherry Farm) as once was the case.30 This means that they are most suitable for providing short-term inpatient detoxification, rather than longer-term residential treatment. This is precisely the role that Healthlink South's Kennedy Villa at Sunnyside Hospital now performs for other Christchurch-based ADA Act institutions, even though it is a certified institution in its own right.

4.3.1 What sort of treatment is offered?

Once an ADA Act patient has been clinically assessed and possibly detoxified, he or she will then be transported (normally by police officers) to the institution named in the committal order as the place of detention for treatment. What will they find when they get there? Here, too, the answer varies between institutions, although there are obvious commonalities in the types of services that are offered by the three Salvation Army Bridge Programmes.

As explained by the Director of the Christchurch Bridge Programme, Captain Ian Hutson, new entrants under the Act will go through a standard induction procedure when they first arrive at the Collins Street address in Addington, overseen by the Bridge's intake Co-ordinator.31 The patient will be offered a copy of the ADA Act and talked through some of the major procedural issues. After undergoing a medical assessment, an individualised treatment plan will be developed in consultation with the patient, and a case manager will be appointed. The patient will then be introduced into the core intensive residential programme that is run by the Salvation Army. On a weekly basis, the patient's treatment schedule is likely to follow a timetable like the one reproduced overleaf:

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29 The full list of hospitals certified under the Act is: Carrington Hospital, Auckland; Kingsseat Hospital, Papakura; Cook Hospital, Gisborne; Tokanui Hospital, Te Awamutu; Porirua Hospital, Porirua; Sunnyside Hospital, Christchurch; Seaview Hospital, Hokitika; Dunedin Public Hospital, Dunedin; Southland Hospital, Invercargill. Refer to the Alcoholism and Drug Addiction Act Institution Order 1969 (SR 1969/1); Alcoholism and Drug Addiction Act Institution Order 1975 (SR 1975/33); Alcoholism and Drug Addiction Act Institution Order 1986 (SR 1986/122); and the Alcoholism and Drug Addiction Act Institution Order 1988 (SR 1988/301).

30 For a useful description of the treatment that used to be offered to ADA Act patients at Cherry Farm hospital, see M Anderson, Treatment in an Alcoholism and Drug Addiction Unit (loc. cit.).

31 I Hutson, Interview, 14 November 2000.
<table>
<thead>
<tr>
<th>MONDAY</th>
<th>TUESDAY</th>
<th>WEDNESDAY</th>
<th>THURSDAY</th>
<th>FRIDAY</th>
<th>SATURDAY</th>
<th>SUNDAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.30am</td>
<td>Rise</td>
<td>Rise</td>
<td>Rise</td>
<td>Rise</td>
<td>Rise</td>
<td>Rise</td>
</tr>
<tr>
<td>6.50am</td>
<td>Shower</td>
<td>Shower</td>
<td>Shower</td>
<td>Shower</td>
<td>Shower</td>
<td>Shower</td>
</tr>
<tr>
<td>7.00am</td>
<td>Breakfast</td>
<td>Breakfast</td>
<td>Breakfast</td>
<td>Breakfast</td>
<td>Breakfast</td>
<td>Breakfast</td>
</tr>
<tr>
<td>7.30am</td>
<td>Work Sections</td>
<td>Work Sections</td>
<td>Work Sections</td>
<td>Work Sections</td>
<td>Work Sections</td>
<td>Work Sections</td>
</tr>
<tr>
<td>8.05am</td>
<td>Walk</td>
<td>Walk</td>
<td>Walk</td>
<td>Walk</td>
<td>Walk</td>
<td>Reading</td>
</tr>
<tr>
<td>8.45am</td>
<td>Reading</td>
<td>Reading</td>
<td>Reading</td>
<td>Reading</td>
<td>Reading</td>
<td>Reading</td>
</tr>
<tr>
<td>9.00am</td>
<td>Admissions (Doctor)</td>
<td>Reflection / Warm up</td>
<td>Addiction &amp; Recovery</td>
<td>Stress Management (Doctor)</td>
<td>Steps</td>
<td>Work Duties 8.30am 9.45am</td>
</tr>
<tr>
<td>10.00am</td>
<td>Morning/Tea</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.15am</td>
<td>Therapy Stage II</td>
<td>Gender Groups</td>
<td>Written work</td>
<td>Stage I</td>
<td>Stage II Therapy Groups</td>
<td>Life Stories &amp; Activities</td>
</tr>
<tr>
<td>11.15am</td>
<td>Lunch Banking etc.</td>
<td>Lunch Banking etc.</td>
<td>Lunch Banking etc.</td>
<td>Lunch Banking etc.</td>
<td>Lunch Banking etc.</td>
<td>Lunch Banking etc.</td>
</tr>
<tr>
<td>1.30pm</td>
<td>House meeting</td>
<td>Written work /Step work Assignments work</td>
<td>Written work /Step work Assignments work</td>
<td>Written work /Step work Assignments work</td>
<td>Bridge Group 1pm</td>
<td>Authorised Leave From 11.30am</td>
</tr>
<tr>
<td>2.00</td>
<td>Family Dynamics</td>
<td>A &amp; D / Health</td>
<td>Self Awareness / Grief Learning</td>
<td>Spiritual Awareness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.45pm</td>
<td>Afternoon Tea</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.00pm</td>
<td>Preparing a Meal</td>
<td></td>
<td>Life Skills II</td>
<td>Recreation</td>
<td>Work Duties</td>
<td></td>
</tr>
<tr>
<td>4.30pm</td>
<td>Visiting Hours</td>
<td>6pm - 7.30pm</td>
<td>Visiting Hours</td>
<td>Visiting Hours</td>
<td>Visiting Hours</td>
<td>Visiting Hours</td>
</tr>
<tr>
<td>5.30pm</td>
<td>Tea</td>
<td></td>
<td>Tea</td>
<td>Tea</td>
<td>Auth/Leave Tea</td>
<td>Tea</td>
</tr>
<tr>
<td>7.30pm</td>
<td>AA at Bridge</td>
<td></td>
<td>Allen at Bridge</td>
<td>NA Meeting at Te Awhina</td>
<td>Recovery Fellowship Voluntary</td>
<td></td>
</tr>
<tr>
<td>11.00pm</td>
<td>Lights Out</td>
<td></td>
<td>Lights Out</td>
<td>Lights Out</td>
<td>Lights Out</td>
<td>Lights Out</td>
</tr>
</tbody>
</table>

C:/My Documents/TIME.DOC

**NOTE LUNCHE TIMES** Once a week you will be asked to be available at 1pm (Tues or Wed) or 2pm (Fri) for a counselling session. This time is part of your programme. This reduces the amount of actual class / group time missed for counselling.

Banking etc means you may leave the premises for banking or other outside things you need to do unless we are concerned about your safety and
As the timetable on the preceding page indicates, a typical day for ADA Act patients at the Christchurch Bridge Programme starts at 6:30am when they are woken, and finishes at 11:00pm when the order comes for lights out. The core hours, however, are 8:45am to 4:30pm Monday to Friday, with two weekly evening support groups and optional meetings of self-help groups like AA and Narcotics Anonymous (NA). The core hours for the intensive residential programme are the same as for the outpatient day programme that runs concurrently at the Bridge, with both residential and day clients taking part in combined group work modules.

The basic treatment course at the Bridge for the intensive residential programme is six to eight weeks’ long, varying according to individual treatment plans. For often more chronic ADA Act patients, this means they will usually stay longer than eight weeks, with an average length of treatment between nine and 12 weeks. Working within a 12-step tradition, treatment modules that may form part of a patient's individual treatment plan include:

- Alcohol and drug education
- Addiction and recovery
- Self awareness
- Assertiveness
- Spiritual Awareness
- Relapse Awareness
- 12 Step Prevention
- AA / NA
- Life Skills
- Grief Groups
- Gender Groups
- Therapy Groups
- Recreation
- Individual counselling
- Family and support person’s counselling
- Problem gambling programme.

As evident from the above list, family members are encouraged to participate in the treatment process by attending both counselling and support groups. For female ADA Act patients, the participation of family members in the treatment process includes the ability to have children stay overnight. This is made possible because of the segregation of male and female accommodation at the Christchurch Bridge Programme, with women housed in a separate wing of the Collins Street building, that has its own lounge, showers, toilets and laundry facilities.

Another feature of the Bridge Programme is the availability of Antabuse for those patients who may require pharmacological support to remain abstinent and achieve on-going sobriety. Bridge Programme staff comment that Antabuse can be a useful adjunct to the psychosocial counselling, group therapy and education undertaken by ADA Act patients, especially during weekends when they may be allowed to spend time away from the service, so long as they return in the evening. Such unsupervised time away from the protected, off-street environment of the Bridge Programme, can often carry with it the temptation to seek alcohol and binge-drink before returning.

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34 See, further, Salvation Army, Serenity Haven – Women’s Rehabilitation Programme. Leaflet (Christchurch: Salvation Army, 1999).
36 I Hutson, Interview, 14 November 2000. Captain Hutson relates that it is not unusual for an ADA Act patient who is given permission to go into town during the weekend to come back that evening smelling of alcohol. In such situations, the patient is given an official warning and may, in serious cases, be recommended for discharge from the Act.
As stated earlier, there are commonalities in the types of services offered by the three Salvation Army Bridge Programmes, and this commentary on the Christchurch operation sufficiently describes how each of them runs. In order to develop a fully-rounded picture of what the main ADA Act institutions look like, though, it is necessary to quickly introduce the Nova Lodge model, which operates a specialised 12-step programme in rural hinterland.

Briefly, the Nova Lodge offers primarily work-based rehabilitation, with directed reading and individual and group therapy packed around it. The work is mainly horticultural and agricultural. Typical tasks include: gardening in several large hothouses, where commercial flowers and vegetables such as capsicums are grown; work with the station's large mob of sheep; as well as tree felling and wood splitting. The psychotherapeutic work that is most readily recognised as 'treatment' is overseen by an on-site psychologist, supported by several alcohol and drug support workers (some of whom are former ADA Act patients who have 'graduated' from the Lodge's programme).

The average duration of stay at Nova Lodge is typically longer than at the Salvation Army Bridge Programmes, with most ADA Act patients remaining for five to six months, but many staying considerably longer – up to the full two years mandated by the legislation. In fact, Nova Lodge offers the opportunity for its ADA Act patients to stay on after the completion of their committal orders, running as 'a rest home option for those not ready to go back to the outside world'. Such boarders pay a minimal accommodation charge (usually taken from income support or sickness beneficiary payments) and continue to undertake work on the farmland on which the Lodge is located, paying for any medical or pharmaceutical needs on a cost recovery basis. The Chief Executive Officer of the Lodge notes that there are four such boarders at the moment, all of whom have alcohol-related brain damage and are reluctant to re-enter mainstream life, preferring instead the 'rural peace and quiet' of the Templeton institution.

In atmosphere, a visitor to Nova Lodge will detect an almost sleepy feeling that harkens back to the bucolic ideal of olden day sanatoriums. The Lodge is set well back from the road on a large farm, in a very quiet area that also has a home for intellectually disabled people and two public prisons tucked out of harm's way (and public view). While only a 15 minute drive from Christchurch, it nevertheless feels somewhat 'cut off from the outside world'. Although ADA Act patients are granted leave from the Lodge, the logistics of travelling to-and-from Christchurch mean that some patients decline the opportunity of taking weekend leave.

For further reference, a copy of Nova Lodge's weekly programme is attached on the page immediately following.

4.3.2 Length of detention and treatment

Section 17 of the ADA Act allows for the discharge, transfer or release of a patient on leave at any time. In exceptional cases, discharges have been authorised as little as six minutes after patients have arrived at ADA Act institutions; because the patient has been violent on his or her initial transfer to an institution, has threatened the safety of staff and/or patients, or because the patient has made it plain that he or she will not comply with any course of treatment.

37 B Dilger, Interview, 14 November 2000.
NOVA TRUST BOARD WEEKLY PROGRAMME

The program set out below is for your benefit. All groups are compulsory. Failure to attend could result in leave not being granted.

<table>
<thead>
<tr>
<th>Monday</th>
<th>8.00am</th>
<th>8.10am-12pm</th>
<th>1pm-3pm</th>
<th>3.15pm-4pm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reading</td>
<td>Reading</td>
<td>Work Therapy</td>
<td>Work Therapy</td>
<td>Big Group</td>
</tr>
<tr>
<td>Work Therapy</td>
<td>Therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tuesday</th>
<th>8.00am</th>
<th>8.10am-12pm</th>
<th>1pm-3pm</th>
<th>3.15pm-4pm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reading</td>
<td>Reading</td>
<td>Work Therapy</td>
<td>Work Therapy</td>
<td>Small Group</td>
</tr>
<tr>
<td>Work Therapy</td>
<td>Therapy</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Wednesday</th>
<th>8.00am</th>
<th>8.10am-12pm</th>
<th>1pm-3pm</th>
<th>3.15pm-4pm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reading</td>
<td>Reading</td>
<td>Work Therapy</td>
<td>Work Therapy</td>
<td>Video</td>
</tr>
<tr>
<td>Work Therapy</td>
<td>Therapy</td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Thursday</th>
<th>8.00am</th>
<th>8.10am-12pm</th>
<th>1pm-3pm</th>
<th>3.15pm-4pm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reading</td>
<td>Reading</td>
<td>Work Therapy</td>
<td>Work Therapy</td>
<td>Small Group</td>
</tr>
<tr>
<td>Work Therapy</td>
<td>Therapy</td>
<td></td>
<td></td>
<td>4.05 allowances canteen open</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Friday</th>
<th>8.00am</th>
<th>8.10am-12pm</th>
<th>1pm-3pm</th>
<th>3.15pm-4pm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reading</td>
<td>Reading</td>
<td>Work Therapy</td>
<td>Open AA Meeting</td>
<td>Leave Meeting</td>
</tr>
<tr>
<td>Work Therapy</td>
<td>Therapy</td>
<td></td>
<td>1pm-2pm</td>
<td>2.45pm</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2pm client feedback</td>
<td></td>
</tr>
</tbody>
</table>

Day leave is on Saturday (only for first leave) from 8.00am until the last bus no 25 which currently arrives at 9.00 pm.

Weekend leave is from directly after the Leave Meeting on Friday afternoon until 5.00pm Sunday, unless prior arrangements have been made.

Your Group Leader is ________________

Your Case Worker is ________________
At the other end of the spectrum, section 10(1) of the Act limits the period of detention under the legislation to no more than two years, and there have been several cases where patients subject to ADA Act committal orders have spent the full two years in an institution—sometimes without receiving anything approximating ‘treatment’. Overall, however, few ADA Act patients remain in certified institutions for the maximum period permitted under the legislation.

Although now out-of-date, the most comprehensive evidence on the length of stay for patients under ADA Act committal orders remains an analysis of 1980-81 data by the Department of Health's Statistical Research Unit, which is reproduced in Table 7:

<table>
<thead>
<tr>
<th>Length of stay</th>
<th>1980</th>
<th>1981</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Section 8</td>
<td>Section 9</td>
</tr>
<tr>
<td></td>
<td>(expressed as percentages of total = 100)</td>
<td>(expressed as percentages of total = 100)</td>
</tr>
<tr>
<td>&lt; 1 month</td>
<td>24</td>
<td>39</td>
</tr>
<tr>
<td>1-3 months</td>
<td>27</td>
<td>33</td>
</tr>
<tr>
<td>3-6 months</td>
<td>34</td>
<td>19</td>
</tr>
<tr>
<td>6-9 months</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>9-12 months</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>12-15 months</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>15-18 months</td>
<td>1*</td>
<td></td>
</tr>
<tr>
<td>&gt; 18 months</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

* Rounding disciplines mean that this result is not reflected as a combined percentage score.

These figures reveal that, in both 1980 and 1981, more than half of all ADA Act patients were discharged within three months of their entry into treatment, and the vast majority of the patients were discharged within six months. Less than five percent of patients who were discharged in both years had been in treatment for longer than a year.

Some interesting differences between section 8 and section 9 patients are apparent from these figures. Patients committed involuntarily under section 9 seem to be discharged earlier than those who initiated their own committal under section 8 of the Act. (Given the forced context in which they entered treatment, it seems likely that a number of these relatively early terminations will be the result of patients' failure to engage in treatment, and consequent disruption of the wider patient population. These results may therefore add support to those who argue that motivation to participate in treatment is an important predictor of successful treatment completion, and thereby overall treatment outcome.)

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39 This was reported to be a quite common occurrence at Oakley psychiatric hospital in Auckland, before it was decertified as an institution in its own right pursuant to the Alcoholism and Drug Addiction Act Institution Order 1988 (SR 1988/301). See, further, J Dawson, The Alcoholism and Drug Addiction Act 1966. Unpublished draft discussion paper (Auckland: Mental Health Foundation, 1983), p 10.

40 Adapted from M L Routledge, Period of Detention. Internal file note, Department of Health [Held on File 131-158-2, National Archives, File series 74340, Box 949].

41 See Supra, Chapter 1, note 23, and the various studies cited therein.
Of the more recent data that are available, the NZHIS mental health inpatient statistics from 1992 to 1994 discussed earlier offer an idea of the range in length of treatment duration for ADA Act patients [Table 8 refers].

Table 8: Length of treatment duration under ADA Act committal orders, 1992-94

<table>
<thead>
<tr>
<th>Year</th>
<th>Mean stay (days)</th>
<th>Minimum stay (days)</th>
<th>Maximum stay (days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1992</td>
<td>56</td>
<td>2</td>
<td>731</td>
</tr>
<tr>
<td>1993</td>
<td>81</td>
<td>0</td>
<td>311</td>
</tr>
<tr>
<td>1994</td>
<td>104</td>
<td>0</td>
<td>731</td>
</tr>
</tbody>
</table>

More recently still, information provided by the Health Funding Authority indicates that the average length of stay for ADA Act patients during 1997 and 1998 was 183 days (six months) at Nova Lodge, and 150 days (five months) at the Salvation Army Bridge Programmes in Wellington and Christchurch.42 The typical length of treatment under the Act in Auckland-based institutions is said to be between 12 and 16 weeks (three or four months).43

Overall, it appears that people committed under the ADA Act are seldom detained for more than six months. That said, the Chairmen of some Supervisory Committees have expressed a preference for releasing ADA Act patients on leave under section 17(1)(c) of the Act, rather than discharging them under section 17(1)(a), because the patient may then be recalled to the institution if he or she breaches any conditions attached to the leave, rather than having to reapply to the Court for a new committal order.44 This tendency to release on leave with conditions attached (usually relating to aftercare, like attendance at outpatient clinics or self-help groups like AA) can increase the effective length of treatment under the Act to closer to the statutory maximum of two years, and has been described by one Director of a Salvation Army Bridge Programme as their “carrot and stick technique”.45

To this end, while the words of the statute plainly anticipate that patients under the Act will be securely detained, and absconding without leave will be treated as a punishable offence, the reality of the situation is that, except for Rotoroa Island in the Hauraki Gulf,46 people committed under the ADA Act cannot be compelled to stay in treatment, and they are not ‘fenced in’ with high perimeter walls around the treatment facilities, nor are they ‘locked up’ in their rooms each night.47 There have been very few cases where ADA Act patients have been prosecuted for escaping from institutions without leave, and the Police are reported to attach a low priority to picking up any ADA Act patients who do escape.48

42 K Cosgriff [Alcohol and Drug Co-ordinator, Health Funding Authority], Fax to Ministry of Health, 2 March 1999.
43 C Hayes, Submission by Auckland Alcohol and Drug Treatment Services Detoxification Unit to the 1999 ADA Act review, 23 April 1999, p 4.
44 For example, former Judge Gillies states: “I do not favour discharging people from the Act but merely releasing them on leave. My reason is it is more cost efficient: if they relapse, they can be returned to treatment after an Order revoking his or her leave has been made by the Court, if a person has been discharged, a new application will have to be made”. T R Gillies, Submission to the 1999 ADA Act review (op. cit.), p 3. An example of where a patient released on leave was recalled back to the certified institution for further inpatient treatment is reported in S v [1986] DCR 569.
46 Rotoroa Island is accessible only by boat or helicopter from the mainland. The inescapable, ‘Alcatraz Island’ aspect of Rotoroa has recommended it to some observers as a model to copy in other parts of the country, with likely sites for similar treatment facilities being seen as Somes Island in Wellington Harbour and Quail Island in Lyttelton Harbour. See, further, J Marks, Submission to the 1999 ADA Act review, 23 April 1999, p 6.
47 See D J Limmer, Submission by the Wellington Salvation Army Bridge Programme to the 1999 ADA Act review, 6 April 1999, p 2.
48 “Dealing with escapees under the Act is a fairly low priority in terms of general police work”: D B Kerr, Letter to Alcohol Advisory Council, 9 August 1983, p 2 [copy on file at the Alcohol Advisory Council, file series 12/28].
4.3.3 Supervisory committees

An important part of the ADA Act machinery is the system of Supervisory Committees. According to a Ministry of Health survey in July 1998, the current members of Supervisory Committees under the ADA Act are as follows:

**Auckland Bridge Programme**
- Judge Ron Gilbert (Chairman)
- Auxillary Captain Bruce Coffey (Superintendent)
- Dr Maurice Wood (Medical Officer)
- Dr Lesley Hellaby (Community representative)

**Wellington Bridge Programme**
- Judge Ian Borrin (Chairman)
- Major Alistair Harring (Superintendent)
- Dr Pat Hill (Medical Officer)
- Beryl Graham (Community representative)

**Christchurch Bridge Programme**
- Judge John Strettell (Chairman)
- Captain lan Hutson (Superintendent)
- Dr John Smalley (Medical Officer)

**Nova Lodge**
- Judge John Strettell (Chairman)
- Brian Dilger (Superintendent)
- Dr Paul Wilkinson (Medical Officer)

The way in which Supervisory Committees operate vary significantly throughout the country, evidently due to the commitments of the District Court Judge who acts as Chairman of the Committee [section 7(4) of the Act refers]. In Auckland, for example, where the Chairman is a semi-retired Judge with a very light fixture load, Committee meetings are regularly held at the Salvation Army’s Ewenington Avenue and Rotoroa Island facilities, and any patients committed under the Act are able to talk to members of the Committee on the days they are on-site, either formally or informally. Indeed, patients are encouraged to take the opportunity to meet with the Committee to discuss their progress towards achieving the goals of their treatment plan, and they are also able to talk to the Judge and community representative in private about any problems they are experiencing with (in) the institution.\(^50\)

In contrast with the accessibility of the Auckland Bridge Programme’s Supervisory Committee, the situation in Christchurch for both the Nova Lodge and Christchurch Bridge Programme is much less satisfactory. The Chairman of both Supervisory Committees is the busy Executive Judge of the Christchurch Family Court, with a heavy fixture and administrative load. As a result, his ability to attend regular Committee meetings is severely compromised, leading to lengthy delays between meetings. As at November 2000, for example, there had been only one Supervisory Committee meeting for the Bridge Programme in the preceding three months.\(^51\) As a way of managing their way around the constraints that Judge Strettel is under, staff at the Christchurch-based ADA Act institutions have resorted to faxing the Judge copies of relevant discharge and leave forms, occasionally having brief teleconferences about a case where he has particular questions, but otherwise waiting for a faxed copy of the signed order to be sent back.\(^52\) The Superintendents of both Nova Lodge and the Bridge Programme describe this situation as "less than ideal", and note that Judge Strettel has for some time been seeking another Judge to take over his responsibilities in Christchurch under the ADA Act, although to date without any success.\(^53\)

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\(^{50}\) R J Gilbert, Interview, 3 August 2000; L Hellaby, Interview, 3 August 2000; B Coffey, Interview, 3 August 2000.

\(^{51}\) I Hutson, Interview, 14 November 2000.

\(^{52}\) N Tanner, Interview, 14 November 2000.

\(^{53}\) B Dilger, Interview, 14 November 2000; I Hutson, Interview, 14 November 2000. During these interviews, both Mr Dilger and Captain Hutson were careful to emphasise that this is not a personal criticism of Judge Strettel; and they are both grateful for the effort that he devotes to his ADA Act work, given his professional constraints.
In terms of the conduct of Supervisory Committee hearings that do take place, the author was permitted to observe a small number of ADA Act hearings held by the Auckland Bridge Programme’s Supervisory Committee at one of its regular monthly meetings on Rotoraia Island. Each of the six hearings observed were to consider applications by patients for leave under section 17(1)(c) of the legislation. The hearings took place in the Superintendent’s office, with the Chairman sitting behind the Superintendent’s desk in the fashion of a Judge, and with other members of the Committee sitting on seats arranged in a half semi-circle fanning out from one edge of the desk, with a chair for patients set in the middle of the space which completed the line of the semi-circle.

Before each patient entered the hearing room, Committee members reviewed a patient file note that had been prepared by his or her case manager, and the attending Medical Officer was asked whether he had anything to add before the patient was invited in. The hearings themselves were conducted in a reasonably informal way, with the Chairman and community representative usually opening proceedings by asking how things were going, and affixing to the patient: “You’re looking well”; or commenting: “The report we’ve got before us today is a lot better than the one we had the last time we met, so things must be turning around for you. Is that how you feel?”. Such remarks seem designed to put the patient at ease and show encouragement from the Committee members.

In the second phase of the hearings that were observed, the Chairman invited the patients to describe, in their own words, how they thought their treatment was going, and whether they thought that they were ‘on track’ to make positive changes in their lives. Again, this line of questioning seemed designed to build self-esteem in the patient, and to allow for positive reinforcement from the Committee members, especially by the Chairman. Typically, the Chairman then focussed in on the immediate application, and asked a series of questions about the arrangements that the patient had made for transitioning back to life in ‘the real world’. Particular attention was paid to whether others living at the planned domicile were drinkers, and whether the patient had plans to visit outpatient services near where he or she planned to live, and join local chapters of AA or other self-help groups. The emphasis here was on maximising the support networks in place to help the patient remain abstinent, thus minimising the risk of relapse. Finally, patients were asked if they had anything else they wanted to say before the Committee members made their decision about whether or not to approve their application for leave. This opportunity was taken by all of the patients observed. It was noted that the majority of these ‘closing arguments’ were directed personally towards the Judge, in a manner that seemed to acknowledge his authority in the forum.

After these final submissions, the patient was asked to wait outside the hearing room while the Committee took a few moments to deliberate. The decision-making process of the Committee followed a set pattern during the deliberations that were observed. The Chairman began by offering his “gut reaction” to the application, and highlighting what he thought were the most salient aspects. He then deferred to the Medical Officer and asked what he thought, before seeking input from the community representative, and lastly asking whether the senior Salvation Army officer had a different view from what, by then, was a consensus decision in all of the cases seen. As a rule of thumb, if the patient’s progress in the Bridge Programme was deemed to have been sufficiently positive, if they had demonstrated self-insight about their drinking problem and the need to continue to work hard at controlling it, and if there was a suitable after-care plan in place, Committee members would approve the leave.

54 Mindful of section 35(1) of the ADA Act, which states that “every application to a ... District Court Judge under this Act shall be heard and determined in private”, the Chairman of the Supervisory Committee, Judge Young, sought consent from each of the ADA Act patients before the author was allowed to sit in on the hearings. The observation took place on 3 August 2000.
Leave (often with conditions) was approved for all but one of the patients observed during the cycle of hearings. In the other case, the Committee felt that the person required a further period of inpatient treatment before they would “take a risk” with approving leave. However, recognising the patient’s wish to leave the Island and return to the mainland, the Committee agreed to transfer him to the residential programme at the Salvation Army’s Ewenington Avenue facility in Mt Eden, and to reconsider whether leave could be granted in another month’s time.

The patients were asked back into the hearing room for the decision of the Committee to be conveyed to them. In each of the cases, including the one where leave was refused, the patients expressed satisfaction with the outcome, and they sincerely thanked the Committee members. The Chairman and the community representative then typically wished the patient “Good luck” or “We really hope it works out for you”; although it was noted that the Medical Officer and Superintendent often seemed aloof or distant during this encouragement phase. Patients often responded by looking to the Chairman and community representative and promising: “I won’t let you down”.

The striking impression that the author took from this admittedly small sample of ADA Act hearings was the extent to which patients looked for, and received, affirmation from the two ‘outsiders’ on the Committee (the Chairman and the community representative) about their progress. This resonates with some of the writings within the therapeutic jurisprudence tradition about the ability of such legal fora/agents to encourage therapeutic outcomes – a point that will be returned to later in this thesis. Even acknowledging the limitations of participant observation, when they were spoken to afterwards, both the ADA Act patients and the Chairman and community representative on the Committee reported that the Supervisory Committee system is one of the most constructive and personally fulfilling aspects of the ADA Act regime.

4.3.4 The ADA Act client loading in certified institutions

Before moving from a description of the way in which institutions certified under the ADA Act operate, it is worth observing that the proportion that ADA Act patients make up of an institution’s total client load varies considerably from institution to institution. Hospital-based institutions are unlikely to have more than one or two ADA Act patients on a ward at any one time, meaning their proportion of ADA Act patients to general patients is very low. By contrast, an institution like the Nova Lodge – which has a policy of encouraging clients to commit themselves under section 8 of the ADA Act, if they are not already under the legislation – has a much higher proportion of residents who are subject to ADA Act committal orders, sometimes in the order of 60 or 70 percent of their total inpatient population. In between these extremes lie the Salvation Army’s Bridge Programmes, which will typically have several ADA Act patients being treated in their facilities at any time, which in the past has seen ADA Act patients comprise anything up to 40 percent of the total number of clients at places like Rotoroa Island.

More recently, however, as the total number of committals under the Act has fallen, so too has the proportion of ADA Act patients to other patients in both Salvation Army Bridge Programmes and other residential facilities.

55 Infra, Chapter 7.
57 B Dilger, Interview, 14 November 2000.
According to the Manager of the Auckland Regional Alcohol and Drug Services Detoxification Unit, Colin Hayes, whose facility is used for medically-supervised detoxification of ADA Act patients before they are transferred on, Auckland-based institutions restrict the number of ADA Act patients to 10 percent of the total client load, mainly because of the difficulties which these patients can sometimes cause for other clients in the treatment population.

An interesting insight into some of the downsides to having problematic ADA Act clients in a residential treatment setting has been given by a former alcohol and drug counsellor at Auckland’s Bridge Programme:

[Treatment centres can be traumatising and foreign .... In the Bridge there were no locks on doors, women were insecure, and at times the things that took place would curl your hair! I would say that about 50% (and maybe more) of my committed clients [under the ADA Act] were, for lack of another description, middle class, non-offenders, who drank too much at home. The environment was totally shocking for them. These people felt vulnerable, anxious, fearful etc. and the focus of treatment was often about these issues.

4.4 Perspectives on the usefulness of the Act

This quotation begs the question: how useful is the ADA Act found to be by those who come into contact with it?

There is no clear consensus on how easy clinicians find it to invoke the provisions of the ADA Act, with opinion divided between those who "find it very useful" and those who "find the present Act very difficult to work with."

Some New Zealand doctors have been strident in their calls for the ADA Act to be repealed, arguing that "the Alcoholism and Drug Addiction Act is unnecessary, obnoxious in principle and logically unjustifiable", while others counter that the Act can literally save the lives of the people who are committed under its provisions. Wrote the one-time Medical Superintendent of Queen Mary Hospital in Hanmer Springs, for example, "[t]hose of us who are privileged to take detailed histories from alcoholics know that the Alcoholism and Drug Addiction Act can be life-saving; can relieve families of intolerable burdens for a period; and can interrupt the addictive cycle sufficiently for the addict’s brain to clear."

"When a committal is a necessary intervention to save a life, help families regroup and make decisions, and help the individual stabilise in terms of liver function, nutrition, etc., I can see value in the process."

Others note the life-saving quality of some committals under the ADA Act, but also recognise the 'revolving door' nature of such crisis-interventions for particularly chronic substance misusers. One District Court Judge writes:

59 C Hayes, Submission by Auckland Alcohol and Drug Treatment Services Detoxification Unit to the 1999 ADA Act review, 23 April 1999, p 6.
65 R J M Crawford, Alcohol and drugs [Letter to the Editor] (1981) New Zealand Medical Journal, vol 94: 237-238. Refer, also, to G M Robinson, Submission to the 1999 ADA Act review (op. cit.), p 1 ["in some cases the committal has been a life-saving intervention"]; and P Brocherie, Submission by Canterbury Health to the 1999 ADA Act review, 22 March 1999, p 1 ["non-consensual inpatient treatment has in my experience saved lives."] This echoes similar sentiments expressed by clinicians who have had recourse to equivalent legislation in other jurisdictions, such as the New South Wales Inebriate Act: for example, L R H Drew, Compulsory treatment of alcoholism (1990) Drug and Alcohol Review, vol 10: 423.
66 M Delaney, Submission to the 1999 ADA Act review (op. cit.), p 1.
67 T H Everitt, Submission to the 1999 ADA Act review (op. cit.), p 4.
It is my impression that the treatment received was rather like the ambulance at the bottom of the cliff and had no long lasting effect. Frequently applications were made to recall persons that the Court had earlier committed under the Act within a very short time of committal. The impression is one of hopelessness, a patch-up state which is accepted by the hospitals involved that little can be done to change an alcoholic or drug addict in the short term. It is part of a vicious cycle and an expensive one at that.

As with clinicians, there seems to be no clear consensus amongst Judges and lawyers on how they find dealing with the ADA Act, although there is often common ground on the potentially oppressive nature of the legislation. The views of Bill Atkin are typical of many that have been voiced from within the legal community: "the Act is an outdated and draconian measure .... [in relation to which] the time for a radical shake-up has surely arrived". Such concerns are often informed by dealings with the legislation that seem to have deviated from the words or spirit of the Act. To quote an example furnished by a South Auckland District Inspector under the MH (CAT) Act:

[The most recent ADA Act case I dealt with] was about three months ago. This was a person who was elderly and difficult for whom the Act was used to place her in a Rest Home (run by the Salvation Army) against her will – an abuse of the legislation in my opinion. She received no treatment other than being forced to dry out. She was an old lady who suffered from depression, but was happy as long as she had six or seven glasses of wine during the day from about 10am. Her first Rest Home proprietor bought her wine. A social worker made the application and had her removed from that Home, and placed in a Salvation Army run Home which was ‘dry’. The lady is still there. She did not have the energy to appeal the decision.

Those from within the legal community who are most likely to have a positive orientation towards the ADA Act are the Judges who act as Chairmen of Supervisory Committees. Unlike Judges who may be called upon to make one-off orders under the Act, and are unable to follow the progress of people that they commit for compulsory "care and treatment!", District Court Judges who act as Chairmen of Supervisory Committees are able to monitor people who they themselves commit under the Act, and take a much more ‘hands on’ role in their rehabilitation. As Professor Bruce Winick, one of the founders of the therapeutic jurisprudence approach has expressed it, "the Judge is not in the usual role of calling balls and strikes, but rather takes an active role in the treatment process". Intuitions drawn from therapeutic jurisprudence scholarship would suggest that such members of the judiciary are more likely to feel that their interventions have been meaningful and worthwhile, and will be more likely to believe that laws such as the ADA Act help people make positive changes for their own lives and those of their families.

Although such Judges will see readmissions under the Act, too, they will also be witness to the ‘recovery’ of chronic alcoholics who, through a period of detoxification and abstinence, proper nutrition, clothing and shelter, will be transformed from a person who seems near death, to someone with restored physical and social functions.

Such experiences lie behind a comment by Judge Gilbert, current Chairman of the Auckland Bridge Programme’s Supervisory Committee, that his work on the Committee is "the most important and fulfilling work I have done".

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69 PJ Recordon, Submission to the 1999 ADA Act review, 26 April 1999, p 5.
71 See Supra, Chapter 2, section 2.5.6.
72 R J Gilbert, Interview, 3 August 2000.
Others who are likely to respond positively to the ADA Act are relatives who have made successful applications to have family members committed for treatment. Staff at ADA Act institutions often retell stories about the gratefulness of relatives when a family member is given life-saving respite from alcohol under the legislation.\(^{73}\) As well as a wealth of anecdotal reports, there has also been one reported study of the views of relatives involved in ADA Act committals. The Otago Medical School study sent a 16 item questionnaire to all relatives who had made applications in the Otago area between May 1983 and December 1987 for a family member to be committed under section 9 of the ADA Act.\(^{74}\) The study found that the applicants were deeply involved in the decision to seek the ADA Act committal order, although they would have preferred not to be so involved. It also found that applicants were initially uncertain about what to expect from the ADA Act process; but that, after seeing the results of the compulsory care, they felt it was helpful to a certain degree; and were pleased they had gone through with it. However, the applicants considered that their family members' hospitalisation was too short, there were insufficient readmissions for relapses, and that more control of the family member's finances was needed. The study's authors concluded: "[T]he relatives, who have had the experience of seeing the effect over time of compulsory treatment, have a diversity of views but generally favour retaining legislation allowing for this".\(^{75}\)

Before leaving this topic, it is important to reflect on the views of the people who are the subject of committal orders under the Act. It will be recalled that the ADA Act provides the right to appeal against committal orders within three weeks of the date that they are signed [section 23 refers], but that there are no other formal complaints mechanisms built into the statute. When viewed against the fact that committal orders under the ADA Act portend up to two years detention, and that no Court fees are payable in respect of any application under the Act [section 35(2) refers], there are surprisingly few reported cases where people subject to section 9 orders have exercised their rights to appeal.\(^{76}\) At one level, this may signal a sense of resignation at the fact that the Court has made a committal order, or it may reflect the disempowered nature of most people who are subject to such orders, and the tendency for them not to be represented by counsel at their hearings. In any event, it would be seem unwise to take this low level of appeals as any sort of proxy for the fact that most people committed under the Act do not feel strongly enough to lodge an appeal.

Significantly, since the ADA Act has been enacted, the Code of Health and Disability Services Consumers' Rights has been developed and the Office of the Health and Disability Commissioner has been set up.\(^{77}\) On its face, this would seem to offer a second, arguably more accessible, avenue for people committed under the ADA Act to register their dissatisfaction with their experiences of receiving compulsory treatment under the legislation. Again, though, somewhat surprisingly, the Ministry of Health reports that there has been only one case where a person committed for treatment under the ADA Act has formally complained about the treatment that he or she received.\(^{78}\)

\(^{73}\) For example, B Coffey, Interview, 3 August 2000; P Jamieson, Interview, 13 September 2000.
\(^{74}\) B J Spittle and B E Longmore, Alcoholism Commital: The Relatives' Perspective (loc. cit.).
\(^{75}\) ibid, p 58.
\(^{76}\) Examples include: Savage v Savage (Unreported, HC Hamilton, M 48/84, 19 March 1984, per Tompkins J); Quirk v Quirk (Unreported, HC Palmerston North, M 127/85, 12 December 1985, per Williamson J); Re Sorensen (Unreported, HC Auckland, AP 176/89, 16 October 1989, per Anderson J); Re Skelchey (Unreported, HC Auckland, AP 1/92, 20 March 1992, per Williams J); White v Family Court (Unreported, HC Auckland, AP 14/98, 3 March 1998, per Giles J); Hall v Snell (1999) 5 HRNZ 103; Price v Waitakere District Court (Unreported, HC Auckland, AP 151/99, 8 October 1999, per Chambers J); Maffey v Maffey (Unreported, HC Christchurch, AP 13/99, 15 December 1999, per Chisholm J); S v Tahana-Reese & Anor [2000] NZAR 481.
It is perhaps also a little dangerous to read too much into the fact that there have been so few complaints about ADA Act "care and treatment" that have been brought to the attention of the Health and Disability Commissioner. Reasons could include that people committed under the Act accept they have a substance abuse problem and need help, and that the period of compulsory detention and treatment is finite. The much rarer use of medication, seclusion and restraint may also be relevant factors. The ability to discuss concerns with Supervisory Committee members in person may also act as a prophylactic against complaints to a ‘faceless’ Commissioner in Wellington. However, given that each of the certified institutions under the Act have clearly-displayed posters which publicise the Code of Health and Disability Consumers' Rights — which includes the right to refuse treatment services — the fact that only one ADA Act "consumer" has made a complaint in the more than five years that the Office of the Health and Disability Commissioner has been in existence, is very puzzling and cannot be easily explained away.

Some intriguing insights into the feelings of ADA Act patients themselves were afforded during site visits to the certified institutions, as part of the primary research for this thesis. For example, conversations with a small number of ADA Act patients on Rotoroa Island would suggest that, certainly in conversations with researchers, people who are subject to ADA Act committal orders may not see that they are 'coerced' in the same way that outsiders looking in might see it. The Otago Medical School study mentioned earlier also found that applicants for section 9 committal orders considered the initial attitude of their family members to be resentful, but that this lessened over time as the family member came to accept that the applicant had acted in his or her best interests.79

Without formally surveying a representative sample of ADA Act patients, using a rigorous survey instrument and obtaining relevant ethical approval(s), it is impossible to make any meaningful generalisations about how those subject to ADA Act committal orders experience the process. It is also impossible and even counter-productive to speculate on whether ADA Act patients experience a progression from feelings of resentment to indifference to acceptance to gratitude — or any other emotional range. Like so much in this chapter, it is ultimately only possible to point to some suggestive evidence and to highlight the need for more (or even some) research to be conducted.

4.5 Summary

In summary, this chapter has attempted to tease out the limited evidence base on the ADA Act so as to develop a clearer sense of how the Act is being used 'on the ground'. It was found that Courts have developed streamlined procedures for dealing with ADA Act applications, which in the case of 'voluntary' section 8 applications can result in orders being made after hearings of only one or two minutes. This tendency to fast-track aspects of the ADA Act process was also seen to extend to the medical assessment of alleged alcoholics, with Judges reporting that they typically issue warrants of arrest (rather than summons to appear) to compel people to be assessed by medical practitioners. Moreover, in involuntary section 9 applications that proceed to a hearing, even where the alleged alcoholic decides to contest the application, it is unusual for such hearings to last more than a few hours. In part, this reflected that most people subject to such applications are not represented by legal counsel at their hearings, as well as the fact that the two medical practitioners who certify that a person is an "alcoholic" within the meaning of the statute do not usually appear at the hearing, so are not available for direct- or cross-examination.

79 B J Spittle and B E Longmore, Alcoholism Committal: The Relatives' Perspective (op. cit.).
Court data indicated that virtually all 'voluntary' section 8 applications lead to committal orders being made, and that orders are made in over 80 percent of involuntary section 9 applications too. It was also noted that, during the last five years, there has been no use of section 21 of the Act to transfer prison inmates to ADA Act facilities.

In terms of the people detained under the legislation, Court records indicated that the annual number of committal orders have more than halved from over 400 a year in the 1970s to under 200 a year in the 1990s. Within this figure of 200 committal orders, there is typically a 2:1 or 3:2 ratio of involuntary to 'voluntary' committals, and it appears that alcohol is the primary substance of abuse for around 95 percent of people committed under the Act. While there is no robust information about the number of people who are committed more than once under the legislation, there is evidence to suggest that over 90 percent of males and over 95 percent of females committed for treatment under the Act are people who have previously accessed alcohol and other drug treatment services; reinforcing the impression that the ADA Act is used to detain and treat mainly chronic, 'revolving door' alcoholics. Demographically, some of the studies that were reviewed showed that ADA Act patients are predominantly male, with an average age in the mid 40s, although ranging between 14 years as the youngest to over 70 as the oldest. No quality data was found to be available on the ethnicity or any other demographic variables of ADA Act patients.

With regard to the institutions where ADA Act patients are sent for treatment, it was noted that there are currently 13 institutions certified to accept people committed under the ADA Act, but that over 90 percent of all patients are received by non-hospital-based institutions (namely, three Salvation Army Bridge Programmes and Nova Lodge), where ADA Act patients can make up anywhere between 10 and 40 percent of the total inpatient population. Each of these facilities was described as running types of 12-step programmes, which combine educational work, individual and group counselling, and attendance at AA. While there were seen to be commonalities in the types of services offered by the Auckland, Wellington and Christchurch Bridge Programmes, Nova Lodge was found to operate slightly differently, using a work-based model with directed readings and psychotherapy packed around it.

The most credible figures to hand showed that over half of all ADA Act patients were discharged within three months of their entry into treatment, and the vast majority were discharged within six months. Less than five percent of patients who were discharged had been in treatment for longer than a year. Interestingly, it was seen that patients committed involuntarily appear to be discharged earlier than those who initiated their own committal. Overall, it appeared that people committed under the ADA Act are seldom detained for more than six months. Having said this, the observed tendency for Supervisory Committees to release ADA Act patients on leave with conditions attached (usually relating to aftercare, like attendance at outpatient clinics or self-help groups like AA) was seen to increase the effective length of treatment under the Act to closer towards the upper limit of two years.

The way in which Supervisory Committees operate was described as varying significantly throughout the country, depending upon the commitments of the District Court Judge who acts as the Chairman of each Committee. The impression received from observing a small sample of Supervisory Committee hearings was that patients looked for, and received, affirmation from the two 'outsiders' on the Committee. There was also a high degree of satisfaction expressed with the Supervisory Committee system by the ADA Act patients and Committee members.
Finally, the chapter canvassed a range of perspectives on the usefulness of the ADA Act, finding a wide diversity of views amongst clinicians, those from the legal community, relatives who had made applications for a family member to be committed under the Act, and people against whom ADA Act orders had ultimately been made. Of the latter group, it was pointed out that there are very few reported cases where people subject to section 9 orders have exercised their rights to appeal or have filed complaints with the Health and Disability Commissioner.
International analogies: Australia

In some countries, "legal coercion has become a widely accepted and prominent element in the treatment of persons with alcohol-related problems", despite the fact that the treatment community traditionally regard the coerced patient as unmotivated, uninterested and a poor candidate for treatment. Yet, even within larger countries, not all jurisdictions have equivalent civil commitment regimes to the ADA Act. In the United States, for example, whereas all 50 states have legislation that mandates the involuntary treatment of people with mental illness, only two-thirds (32 states) have statutory instruments that allow for involuntary civil commitment of people with alcohol use disorders. Other jurisdictions will allow for criminal justice referrals but not civil referrals. The United Kingdom, for example, has no power to compulsorily detain and treat people with substance use disorders, unless they have committed offences.

As a way of casting the ADA Act into sharper relief, this part of the thesis will review two of the analogous statutory regimes which do exist overseas. From New Zealand's near neighbour Australia, where there are several statutes roughly similar to the ADA Act, attention will be focussed on the New South Wales Inebriates Act; and from the other side of the world, the Swedish Act on Care of Addicts in Certain Cases will be put under the microscope. These jurisdictions have been chosen because they offer an interesting comparison between a country (Australia) which shares New Zealand's harm minimisation approach to drug policy, and a country (Sweden) that is widely seen to have one of the most repressive drug policies, often characterised by a 'zero tolerance' approach to substances misusers.

In this chapter, the discussion will be informed by comparative research that was conducted during short study tours to Sydney and Melbourne in 1998/99 and again in 2000. The study tours involved visits to a small number of treatment facilities, as well as a series of formal and informal meetings with relevant health and justice officials. The research was complemented by university-based study of Australian scholarship on alcohol issues, and study at specialist research centres such as the Australian Drug Foundation library.

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2. P A Galon and R A Liebelt, Involuntary Treatment of Substance Abuse Disorders (1997) New Directions for Mental Health Services, vol 75: 35-45. The authors note, however, that in states where such laws are absent, it may still be possible for alcoholics to be involuntarily treated under mental health civil commitment statutes. Refer, further, to E Beis, State involuntary commitment statutes (1993) Maryland Law Review, vol 7: 358-369.
4. See, for example, the Alcoholics and Drug Dependent Persons Act 1968 (Vic) and the Alcohol and Drug Dependency Act 1968 (Tas). Note, the Northern Territory and Queensland do not have civil commitment statutes for people who are alcohol-affected. For helpful commentary on section 13 of the Victorian Alcoholics and Drug Dependent Persons Act, refer to L Skene, Chemicals and the Law – Retribution or Rehabilitation (1986) Drug and Alcohol Review, vol 5: 169-174, at 172-173.
5.1 The New South Wales Inebriates Act

Of the Australian state jurisdictions, New South Wales arguably provides the most interesting case-study of any of the trans-Tasman equivalents to the ADA Act. The state has devoted more resources than any other to combat substance-related harm, and it has taken the most far-reaching efforts to co-ordinate its response by setting up a special Drug and Alcohol Directorate within the New South Wales Health Department (complete with its own empowering legislation and ‘war chest’ of funds for the direct purchasing of alcohol and other drug-related services).\(^6\)

New South Wales has also led the way in Australia in piloting Drug Courts, which allow judges to play a much more active role in the rehabilitation of offenders who present with alcohol and other drug problems.\(^7\) At the same time, however, New South Wales’s compulsory treatment statute has had to weather criticism almost since its inception, and has fallen so far into disuse that it has been described as “a virtual dead letter”.\(^8\) In fact, the Inebriates Act 1912 was slated for full repeal in the early 1990s by cognate legislation that revised the state’s mental health laws (only surviving when the amending Act was itself repealed\(^9\)), in a proposal that excited virtually no professional comment. This curious ambivalence colours any understanding of the state’s approach to the compulsory treatment of alcoholism.

5.1.1 Background to the Inebriates Act

Legislation in New South Wales to deal with the care, control and treatment of people with alcohol problems first came into force in 1900.\(^10\) Several amendments nine years later led to the consolidated Inebriates Act 1912. This coincided with moves in other Australian jurisdictions to recognise alcoholism as a disease to be cured, not a crime to be punished.\(^11\) The Attorney-General of the day, B R Wise, explained that one of the original justifications for the legislation (like the ADA Act) was to “save habitual drunkards from the well-known cycle of arrest, release and rearrest”; and to “protect the helpless victims of intemperance against themselves and return them to productive life”.\(^12\) However, the Inspector-General of the Insane at the time noted that the immediate catalyst for the legislation was the families of alcoholics, who had been pressurising the state government to put in place appropriate treatment facilities.\(^13\)

Despite the shift from criminalisation to rehabilitation implicit in the movement from the 1900 to the 1912 Inebriates Act, the locale for treatment did not change. Under both, the prison system was used, along with various private and charitable facilities. Prior to 1929, in fact, the only state-sponsored facility for inebriates was the Shaftesbury Institute, set up by the Comptroller of Prisons.\(^14\) Although psychiatric hospitals were considered a possible treatment site, they were generally seen as unsuitable places for the care, control and treatment of people with chronic alcohol problems.

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9. The Inebriates Act was to be repealed by Schedule 1 of the Miscellaneous Acts (Mental Health) Repeal and Amendment Act 1983, albeit the latter piece of legislation was repealed before Schedule 1 could take effect.


14. See, further, M J Lewis, Managing madness: Psychiatry and society in Australia, 1788-1980 (op. cit.). The account which follows in the text borrows heavily from Lewis’s careful historical reconstruction of these events.
Increasing numbers of ‘public drunks’ were brought to the attention of the Police in the late 1920s, placing pressure on the New South Wales government to create separate institutions for inebriates that would not have the stigma of a correctional environment. The then Under-Secretary of the Department of Health recommended that the government take the necessary steps to establish such centres under the Inebriates Act; and, as a stop-gap measure, licensed several psychiatric hospitals throughout the state as institutions for inebriates, so that urgent cases needing attention could be dealt with straight away. The need for this transitional arrangement was made more compelling by the government’s decision to close the Shaftesbury Institute in 1929, ostensibly because it wanted to sub-divide the site, but more likely because it was universally condemned as a failure. Thus, as Mike MacAvoy and Bruce Flaherty have argued: “the choice of psychiatric hospitals as a site to detain inebriates for compulsory alcoholism treatment ... [was] not based on the claim that such institutions offer superior treatment or other rational grounds but merely by default”.15

5.1.2 The mechanics of the Act

In terms of its major provisions, the New South Wales Inebriates Act has many parallels with New Zealand’s ADA Act, although equally there are some important points where the respective statutory models diverge from one another.16

The Inebriates Act permits the Court (whether it be the Supreme Court, a District Court Judge or a Magistrate) to make certain orders in relation to inebriates. An “inebriate” is defined by section 2 of the Act to mean: “[a] person who habitually uses intoxicating liquor or intoxicating or narcotic drugs to excess”. (Unlike the ADA Act, however, section 2 of the Inebriates Act explains that “narcotic drug” does not include “tobacco, cigars, or cigarettes”.) The references in the Inebriates Act formula to “habitually uses ... to excess” resonates with the ADA Act’s reference to “persistent and excessive indulgence”.17 Significantly, though, the New South Wales test for whether someone is an “inebriate” is not conditional upon the use of alcohol “causing or [being] 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”, as the New Zealand definition of “alcoholic” requires. This opens up the New South Wales measure to application in cases where a person’s habitual and excessive use of alcohol is not obviously imperilling either the drinker or others.

Like the ADA Act, the Inebriates Act provides for both ‘voluntary’ and involuntary routes into treatment. Under section 3 of the Inebriates Act, a committal order may be sought by an inebriate or a person authorised by that inebriate while sober; a first degree relative or a business partner of the inebriate; or a police officer of the rank of sergeant or above, at the request of either an attending medical practitioner, a relative of the inebriate, or a Justice of the Peace.

There are two interesting points of contrast with the equivalent locus standi provisions in the ADA Act.18 First, whereas section 9(8) of the New Zealand statute leaves unclear whether a person living in a de facto relationship with an alcoholic is a “spouse” for the purposes of the committal process, section 2 of the Inebriates Act specifically defines “spouse” to mean either an inebriate’s husband/Wife or the other party to a de facto relationship. Secondly, the Inebriates Act anticipates that those involved in a clinical capacity with an inebriate can only advocate for that person’s

16 All quotations from the Inebriates Act 1912 will be indicated in the text according to the corresponding section number in the legislation.
17 The ADA Act’s definitions of “alcoholic” and “drug addict” are described supra, Chapter 3, section 3.2.1.
compulsory treatment through a sympathetic police officer, rather than being able to directly make such an application on their own motion (as allowed for by section 9(1) of the ADA Act, with its catch-all reference to "any other reputable person"). As an extension of this, the only clinicians who seem able to make such a request are those who are "a duly qualified medical practitioner in professional attendance on the inebriate" – limiting the class of potential requesters to specialist physicians and general practitioners who have an inebriate as one of their patients – rather than, say, an alcohol and drug counsellor, social worker or some other type of key support worker who does not have medical qualifications. This seems an unduly restrictive aspect of the Inebriates Act definition, and one that is increasingly out-of-step with the multi-disciplinary team approach used in modern alcohol and drug treatment settings.

Where an application is made under the Inebriates Act, the Court must personally examine the alleged inebriate and view a supporting certificate from a qualified medical practitioner, which attests to the fact that the subject of the application is an "inebriate" within the meaning of the Act. Interestingly, this medical certificate must be accompanied by "corroborative evidence by some other person or persons" [section 9(1)(a) of the Inebriates Act refers], and "shall specify therein the facts upon which he has formed his opinion ... and shall distinguish in such certificate facts observed by himself from facts communicated to him by others, and no order shall be made upon any certificate which purports to be founded only upon facts communicated by others" [section 9(2) of the Inebriates Act refers]. In one sense, this allows for greater transparency and more safeguards to be built into the Inebriates Act committal process than the ADA Act model, which does not require hearsay to be distinguished from first-hand evidence. Yet, it has an arguably weaker corroborative mechanism, in that the ADA Act requires two doctors to sign-off on an application for compulsory treatment, versus only one in the New South Wales model (supported by "some other person or persons"). The Inebriates Act also does not require that the physician certify that the committal of the inebriate will be "expedient in his own interests or of that of his relatives", as section 9(6) of the ADA Act demands.

Like the ADA Act, the Inebriates Act provides for a compulsory detention power to allow clinical evaluations to be conducted on suspected alcoholics. People can be remanded for up to seven days for medical examination, and those who escape from remand may be arrested and returned [sections 9(1A) and 9(1B) of the Inebriates Act refer]. Similarly, the Court is given a broad discretion to determine whether the subject of an application is an "inebriate". Section 9 of the Inebriates Act refers to "proof to the satisfaction of the Court", which mirrors the ADA Act's reference to a District Court Judge making a committal order under that Act "if he thinks fit" [section 9(7) of the ADA Act refers].

Procedurally, all people who are subject to applications under the Inebriates Act have the right to be heard by the Court, and the Court has a countervailing power to direct that any such person be brought before it "in open Court or in private" [section 3(3) of the Inebriates Act refers]. This possibility of Inebriates Act applications being heard in open Court with a public gallery – something the New Zealand statute does not permit [section 35(1) of the ADA Act refers]

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18 A full copy of the ADA Act is attached for reference purposes infra, Appendix 2.
19 An exception is where an attending physician requests a police officer to make the application on his or her behalf. In such cases, section 8 of the Inebriates Act states that: "A medical practitioner who is an applicant under this Act shall not sign a certificate in respect of an inebriate under or for the purposes of this Act". This effectively means that a second medical practitioner must be involved in the committal process under the Act. However, a similar prophylactic exists in the ADA Act, wherein section 32(1)(a) of the Act states that a medical certificate given for the purposes of a section 9 application shall not be signed by the applicant for the order, meaning that if the alcoholic's GP lodged the application as "any other reputable person", then two other independent medical practitioners would need to furnish supporting medical certificates, resulting in three doctors being involved in the committal process. (Compare, also, the prohibition against the medical officer of the institution in which the alcoholic would be received, if the application was granted: section 32(1)(b) refers.)
- is expressly made subject to the right of a person defending the application to elect that their Court hearing be held in private [section 6 of the Inebriates Act refers].

Where, after such a substantive hearing, the Court is satisfied that a person is an "inebriate", and it is minded to make an order under the Act, it has a much wider range of potential orders at its disposal than its New Zealand counterpart. Briefly, the New South Wales Court may order that the inebriate:

- enter into a recognisance, with or without sureties, to abstain from alcohol for a set period of 12 months or more
- be placed under the care and control of a named person, at a specified address, for up to 28 days
- be placed under the care and charge of an attendant(s) or guardian for up to 12 months
- be committed to a licensed institution or a state institution for up to 12 months.

Orders made under the Inebriates Act can be extended for up to an additional 12 months on the order of the Supreme Court or a District Court Judge – although, interestingly, not on the order of a Magistrate [section 9(4)].

No rights of appeal lie against decisions made by the Supreme Court, except with leave by the Supreme Court [section 20A]. The question of appeal rights from Inebriates Act decisions made by District Court Judges or Magistrates is left open, presumably to be interpreted according to normal rules of procedure in New South Wales.

Like the position under section 17 of the ADA Act, the Inebriates Act allows for committed patients to be released on licence [section 14], and for original orders to be varied or rescinded before they have expired [section 20]. There are no timelines given in the legislation before which Courts will not hear applications to vary or rescind Inebriates Act orders, thus they are presumed to be 'remedies' available from the commencement of such orders.

Where an inebriate breaches any conditions of their recognisance, or some other proscribed events occur (for example, he or she is charged with deriving their livelihood by dishonest means, and a Justice of the Peace is satisfied of the truth of the charge), the inebriate may be ordered by a Justice of the Peace to be detained in a state institution designated by the Comptroller of Prisons for the remainder of the term of their recognisance [section 12]. These provisions around recognisances find no equivalent in New Zealand’s ADA Act, nor does the New Zealand legislation foresee that Justices of the Peace would be able to make orders that could deprive people with alcohol problems of their liberty.20 Indeed, under section 11 of the Inebriates Act, there is a whole stream of potential committals under the Act for inebriates who are convicted of offences for which drunkenness is an ingredient; or offences which involve "assaulting women, cruelty to children, attempted suicide or wilful damage to property, and it appears that drunkenness was a contributing cause of such offence" [section 11(1)(6)]. (New Zealand’s one-time equivalent to this, section 48A of the Criminal Justice Act 1954, was repealed in 1985.21)

To the extent that some of these potential committal streams strike a modern-day reader as antiquated, this reflects in part the 50 year gap between the drafting of the Inebriates Act and Alcoholism and Drug Addiction Act.

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20 For that matter, there is no provision for the ADA Act procedures to be invoked by Community Magistrates – the new model of lower-level judges that has recently been piloted in various Court Registries in New Zealand. For a useful discussion of this model, see M Powles, The New Zealand Community Magistrates Scheme: Whose community and what involvement? (2000) New Zealand Universities Law Review, vol 19(1): 29-57.

21 See supra, Chapter 3, note 47 and accompanying text.
Indeed, so fossilised is some of the language used in the Inebriates Act that it still contains references to the Lunacy Act 1898 (sections 9(2), 19(1) and 19(2)) and the Vagrancy Act 1902 (section 12(d)). The older vintage of the Inebriates Act leads not only to archaisms, but also makes certain powers seem a little draconian. Some of the most remarkable provisions contained in the Inebriates Act are the power of the Supreme Court, District Court Judge or Magistrate to make cost-recovery orders against an inebriate’s property to fund his or her “care, charge and maintenance” [section 18]; the power for an authorised Department of Health officer to “inspect any inebriate” in a state institution, and “the power to enter at all reasonable times any such place for the fulfilment of this duty” [section 24]; and penalties for “any person who publishes a report of any proceedings under this Act, except by permission of the Judge” [section 26] - irrespective of whether the hearings themselves are held in open Court.

Finally, it is worth noting that there is no equivalent oversight mechanism to the ADA Act Supervisory Committees in the Inebriates Act. The New South Wales legislation does provide for the establishment of a “Supervising Board” for inebriates, made up of two officers from the Department of Health, but their role is limited to recommending inter-institution patient transfers, and the ability, “at the request of the Minister, [to] inquire into the administration of any institution, examine the inebriates detained therein, and report to the Minister as to any matter arising from such inquiry or examination” [section 29(2)]. Moreover, departmental records indicate that no such “Supervising Board” has ever been established in New South Wales to help administer the Inebriates Act.22 This underscores the fact that decisions on clinical management of Inebriates Act patients are not devolved to the level of the institution under the New South Wales legislation; rather, decisions on patient discharges, trial leave and so on, must be made by the Supreme Court, District Court Judge or Magistrate that made the original order.

5.1.3 What do Inebriates Act institutions actually look like?

The Inebriates Act does not prescribe what the treatment programme must look like for “inebriates” committed under the Act; and as mentioned earlier, at least during the 1930s, psychiatric hospitals were licensed as institutions to receive people under the Act, rather than separate treatment facilities for alcoholics being certified for this purpose.23 It is therefore difficult to visualise what the places are like that people committed under the Inebriates Act get sent to, and what happens to them when they get there. Before turning to the current use of the legislation, then, it is helpful if attention is directed briefly towards what Inebriates Act institutions actually look like.

The first observation to make is that 70 years on from the ‘stop-gap measure’ of licensing psychiatric hospitals to receive Inebriates Act clients, there are still no dedicated alcohol and drug treatment facilities anywhere in New South Wales that have been certified as “state institutions” under the Act. Currently, there are only seven psychiatric hospitals which are licensed to receive Inebriates Act clients: Rozelle Hospital, James Fletcher Hospital, Bloomfield Hospital, Cumberland Hospital, Kenmore Hospital, Gladesville/Macquarie Hospital and Morisset Hospital.24 In addition, not all of the seven hospitals actually receive people under Inebriates Act orders.

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22 P McCarthy [Manager, Alcohol and Illicit Drugs Policy Unit, New South Wales Health Department], Personal communication, 24 August 2000.
23 See supra, note 14.
Hence, in 1995, for example, when an inebriate was ordered to be placed in Gladesville/Macquarie Hospital under section 3(1) of the Inebriates Act, an application to the Administrative Law Division of the New South Wales Supreme Court revealed that there were no longer adequate facilities for the care of inebriates at that institution, and the inebriate was ordered to be released.25

As in New Zealand, modern Australian psychiatric hospitals are typically structured as open campuses. There are few locked wards, with those that do exist being primarily used to contain acutely disturbed patients, usually only for brief periods until they settle. There are also usually a small number of more secure beds, primarily used for forensic patients (that is, from the criminal justice system) and the small number of civil patients who have serious behavioural problems. These highly-charged environments are unlikely to be suited to the detention, let alone the treatment, of inebriates. In such settings, inebriates may be viewed as requiring less intensive case management than other patients on the same wards, especially if the mental health workers staffing the wards feel less confident in dealing with alcohol use disorders than dealing with non-substance-related mental illnesses. As the Area Director of Mental Health Services for New South Wales, Professor Marie Bashir, has commented: “The reality of the situation is that when the relatively small number of inebriate admissions are spread across the psychiatric hospitals, they must be absorbed into open ward programmes. In these areas, the inebriates rarely receive specialised [alcohol] treatment services”.26

5.2 Use of the Inebriates Act

The paucity of information on the Inebriates Act is a significant hurdle to developing a robust sense of how the Act is being used ‘on the ground’.27 A 1991 Health Department survey of admissions under the Inebriates Act offers one of the few empirical snapshots of the use of the legislation. The survey’s major findings were that:28

- Males are over-represented in admissions under the Act
- Aboriginals are over-represented, but were thought to be under-identified in the data collected
- 90 percent of admissions are unemployed people who are in receipt of social security benefits.

Some commentators have drawn on anecdotal reports to suggest that the Inebriates Act is used in selective ways that disadvantage the socio-economically powerless. For instance, MacAvoy and Flaherty assert that:29

["Those who are most likely to be admitted under the Inebriates Act are not the boardroom managers of large public companies and institutions, nor even the married, employed alcoholic who ‘habitually uses intoxicating liquor to excess’. Rather it is the vagrant, homeless, unemployed chronic alcoholic who will be caught up in the Act .... The more affluent, middle class ‘inebriates’ have access to private psychiatric clinics to treat their ‘neurotic depression’ or one of the many euphemistic terms used to cover the real nature of their problems.

25 Eller v Medical Superintendent of Gladesville/Macquarie Hospital (Unreported, NSW Supreme Court, ALD 30075/96, 5 July 1996, per Dunford J).
26 Quoted in M Lodge, Notes of meeting on the inebriates Act, 8 September 1994, p 3.
27 See M G MacAvoy and B Flaherty, Compulsory treatment of alcoholism: The case against (op. cit.), at 268 ["This lack of information reflects the overall poverty of material dealing with the Inebriates Act”].
28 NSW Health Department, Survey of Admissions Data under the Inebriates Act 1912. Unpublished report (Sydney: Mental Health Branch, NSW Health Department, 1992), p 1.
29 M G MacAvoy and B Flaherty, Compulsory treatment of alcoholism: The case against (op. cit.), at 269.
Professor James Rankin, former Acting Director of the New South Wales Drug and Alcohol Directorate, has gone further by questioning whether the Inebriates Act is "only a means of removing society's misfits and rejects from public view".30

Whatever the truth of these charges, there is some evidence that many of the people who are subject to orders under the Inebriates Act have complicating factors in their lives, such as homelessness or co-occurring mental health problems. Based on a data set from a sample of admissions to Morisset Hospital, for example, it was found that about half of the individuals admitted under the Inebriates Act exhibit behavioural problems, around one quarter of those admitted exhibit evidence of dual diagnosis mental health disorders, and about one third of those admitted have a "self-care deficit".31 Other frontline clinicians have reported that every one of the individuals they have had contact with through the use of the Act are brain damaged to some extent, and that detention at a psychiatric hospital is a blunt instrument to try and meet such peoples' clinical needs.32

In terms of the total number of admissions each year, it does not appear that the use of the Act is increasing. A 1987 telephone survey of the major psychiatric hospitals in New South Wales revealed that less than 100 Inebriates Act admissions had been received in the previous year.33 Subsequent surveys found that there were 95 admissions under the Act made to psychiatric hospitals in 1989/90 and 105 admissions in 1990/91.34 Since the early 1990s, two of the previously-licensed Inebriates Act hospitals have also closed, without the remaining seven hospitals experiencing any apparent increase in demand for treatment places under the Act.

Regrettably, there is no data available on the differences, if any, between 'voluntary' and involuntary orders under the Act, nor is there data available on the primary substance of misuse that leads to orders being made.

5.3 Outcomes of detention and treatment under the Inebriates Act

The effectiveness of treatment provided under the Inebriates Act is difficult to assess, precisely because the 'treatment' that is offered to Inebriates Act clients often consists of little more than supported accommodation. According to a New South Wales Health Department official who visited each of the licensed institutions in 1994:35

One sure thing that can be said about the effect of the [Inebriates] Act is that those individuals placed under Inebriate Orders are guaranteed medical attention, food and shelter .... [but] there can be no guarantee that treatment for substance dependence will be provided, or that assessment for alcohol-related brain damage will be made. These interventions are not always within the range of skills possessed by staff in psychiatric hospitals .... It seems to be the case that the offer of appropriate treatment is dependent on the professional speciality of the medical and nursing staff.

30 J G Rankin, Definitive treatment of alcoholism. Paper delivered to the Summer School of Alcohol Studies (Melbourne: University of Melbourne, 1989).
31 A P White, Letter to the NSW Drug and Alcohol Directorate, 5 October 1994.
32 M Lodge, Minutes of meeting of the Review Committee on the Inebriates Act, 8 June 1994.
33 M G MacAvoy and B Flaherty, Compulsory treatment of alcoholism: The case against (op. cit.), at 267.
34 M Lodge, Inebriates Act 1912 (op. cit.), p 11.
Furthermore, a commonly-heard complaint from clinicians at psychiatric hospitals is that Inebriates Act patients are difficult to manage. In a report to the Hunter Area Health Service, for example, the Unit Director of Hunter Hospital's Psychiatric Addiction Services describes how "truculent, uncooperative and restless inebriates have an extremely disruptive effect on the therapeutic milieu of the ward."

There are numerous reports from clinicians about individuals requesting and being granted Inebriates Act orders, merely for the security that psychiatric hospitals offer in terms of food and shelter. Individuals realise that once such an order is made, the hospital has a legal obligation to keep them until the order expires or is rescinded — something which only the Courts, rather than the Hospital Superintendent, has the power to do. Wilfully disruptive inebriates can ignore ward rules or directives, and can refuse to take part in treatment (assuming it is offered). Despite evidence of this practice occurring, hospital staff must keep the mischievous individual safely in hospital. The hospital also does not have the discretion enjoyed by New Zealand ADA Act institutions to refuse to accept particular clients again in the future, even if they have a history of causing problems for staff and/or other patients.

While some doctors who have dealt with the Inebriates Act over a number of years report 'success stories', where the use of the legislation has literally been a life-saving intervention, overall there is little evidence to suggest that Inebriates Act clients generally experience lasting improvements from their coerced detention and treatment. On the contrary, although there are yet to be any rigorously-designed outcome evaluation studies of orders made under Inebriates Act, the weight of opinion seems to favour the fairly pessimistic findings of a 1957 review that:

The present practice of committing largely unselected inebriates to mental hospitals would appear to have little to recommend it. Many inebriates do not respond to treatment in hospital and do not (in the majority of cases) actually receive treatment. On discharge, it is found, therefore, that they quickly relapse.

5.4 Dissatisfaction with the Inebriates Act

Over the last 30 years, the New South Wales Health Department has argued for reform of the Inebriates Act, and there have been several reviews of the legislation aimed at marshalling across-agency support for its repeal. Health officials are not the only ones who have been unhappy with the Inebriates Act, however - conscious as they are that the legislation has historically been used as much for social welfare purposes as to improve health outcomes, yet continues to drain from increasingly-scarce Vote:Health funding. In recent times, justice sector agencies such as the Attorney-General's Department have taken the lead. This follows judicial misgivings

35 M Lodge, Notes of meeting on the Inebriates Act, 8 September 1994, p 2.
37 M Lodge, Inebriates Act 1912 (op. cit.), p 11.
40 For a chronology of this succession of reviews, working parties and inter-departmental committee reports, refer to M Lodge, Inebriates Act 1912 (op. cit.), pp 22-23.
41 B Flaherty, Email communication to the Director of the NSW Drug and Alcohol Directorate, 10/8/99 5:18pm. See, also, M Stafford, Review of the Inebriates Act 1912. Unpublished draft discussion paper. (Sydney: NSW Attorney-General's Department, 1999).
about the Act that have been consistently expressed through the Chief Magistrate’s office, and strongly-worded submissions from the New South Wales Law Reform Commission, the New South Wales Law Society and the New South Wales Legal Aid Commission that the Inebriates Act should be repealed.

At the most fundamental level, dissatisfaction with the Act has centred on the very notion of forcibly detaining and treating people for substance-related problems. Orders made under the Act are plenary in nature; that is to say, the effect of an order appears to be that an inebriate loses all or most of his or her rights to make life decisions. This is perceived to place the Inebriates Act in conflict with the approach of the Mental Health, Disability Services and Guardianship Acts in New South Wales, which are all animated by the ‘least restrictive alternative’ principle.

Underlying such philosophical difficulties are a series of more specific concerns about the mechanics of the Act. For instance, respondents to a 1992 survey of New South Wales Magistrates highlighted several issues that were seen to require attention, such as: extending the protections of the Mental Health Act to cover inebriates, particularly the rights of appeal and review; the need for a system of readily-available legal representation for those subject to applications under the Act; clarification of the criteria for committal under the Act; and a reduction in the maximum length of compulsory treatment orders, possibly to six months. Magistrates also felt that judicial officers should not be forced into making “artificial” medical judgements about people with alcohol and other drug-related problems, and many were critical of the lack of treatment facilities in remote areas of New South Wales, that leads to the Inebriates Act being used to provide care (or containment) that would otherwise not be available.

This latter issue is particularly salient for people in New South Wales who live in rural and remote communities. Given that there are effectively only five psychiatric hospitals throughout the entire state where “inebriates” may be sent for treatment, it is often the case that individuals placed under Inebriates Orders are located many hours travel from family, friends and local support networks. To illustrate this problem, during 1993, of the 15 inebriates admitted to Bloomfield Hospital in Orange, northern New South Wales, only one of the people was from Orange — with the remainder coming from as far away as Wilcannia, Coonabarabran, Condobolin, Parkes and Darlington (in inner-city Sydney, many hundreds of kilometres away). Another issue that arises from having to relocate some inebriates large distances to attend a particular licensed institution is the logistics of transporting the person to-and-from hospital. Where responsibility lies for arranging such transport is not clear under the Inebriates Act, meaning that many people under Inebriates Orders are transported in police cars, other government vehicles and even the private vehicles of concerned workers and family members. The issue is not just one of cost-shifting, but potentially one of medical safety and legal liability. Often travelling over large distances with individuals who may be experiencing acute withdrawal symptoms, untrained drivers (such as police officers) are not in a position to be able to assess the medical needs of such individuals or render assistance, thereby opening themselves up to the legal risks associated with a possible death in custody.


47 ibid, pp 19-20.
Beyond the lack of facilities where inebriates can be sent for treatment – a lack which is intensified by the vast geography of New South Wales – there are profound concerns about the appropriateness of even the limited number institutions which are available. In general, the decision to confine the care of people who have alcohol problems with general psychiatric populations does not seem to have yielded positive results, either for inebriates or for the staff of the psychiatric hospitals and their mental health patients. The Health Department official who visited each of the licensed institutions in 1994 offers the following assessment:48

All of the currently gazetted public hospitals cite the problem of security. Many "inebriates" abscond from the hospitals for various lengths of time. Some do not return, others return intoxicated and cause major disruption to the other patients who, on the whole, are voluntary and motivated to undergo treatment. It is not uncommon for these intoxicated individuals to physically harm and intimidate staff and other patients.49

Where Inebriates Act patients do ‘act out’ in ways that are counter-productive to the management of their own disorder(s) and/or those of their fellow patients, decisions on whether to discharge the inebriate can only be made by the Court that made the original committal order. The primary issue here is the inflexibility of Inebriates Act orders and, in turn, the lack of devolution of decision-making power about Inebriates Act clients to clinical staff.

The inflexibility of Inebriates Act orders raises major issues for clinicians, not only in relation to disciplinary action but also in relation to the management of detoxification. Some inebriates will need detoxification when they first arrive at a licensed institution. In most cases, detoxification will not be problematic. In other cases, however, the withdrawal episode is likely to be an acute medical emergency. Psychiatric hospitals are not equipped to act as acute care units, and individuals in need of such care should be moved to an appropriate facility for medically-supervised detoxification. The current inflexibility of Inebriates Act orders militates against this option, though, because variations to orders must go before the same Court, Judge or Magistrate that made the original order [section 20], with judicial timeframes that are likely to be inconsistent with emergency health imperatives. As a consequence, many clinicians have requested that, prior to any order being made under the Act, the Courts confer with clinical staff at the hospital that is forecast to receive the inebriate.50 This would allow the order to be sensitised to meet the needs of the individual; and, if appropriate, provide for the inebriate’s medically-supervised detoxification at a hospital, prior to transfer to his or her eventual destination at a licensed psychiatric hospital.51

Although there is no statutory requirement for the manager or Superintendent of the receiving institution to agree to accept a person under the Act, there is nothing in the legislation which (mandates or) prevents a Master, Judge or Magistrate from seeking appropriate clinical input before making committal orders under the Act, and including directions about initial detoxification at a hospital in their original orders. In fact, the power to make such directions is specifically provided for in the Act [sections 20(1)(a), (2)(a) and (3)(a) of the Inebriates Act refer]. Arguably, the fact that calls have been made for the Courts to take a more proactive role in addressing the clinical needs of Inebriates Act patients underlines the failure of the judiciary to work ‘sympathetically’ with the legislation.

48 M Lodge, Notes of meeting on the Inebriates Act, 8 September 1994, p 3.
49 As required by New Zealand’s ADA Act: section 9(7) of the Act refers. See supra, Chapter 3, section 3.2.3.
5.5 Summary

Such failures to work 'sympathetically' with the Inebriates Act expresses what appears to be a widespread dissatisfaction that the legislation is not working as intended, but also a lack of will to do anything about this fact. The legislation has numerous provisions for the “care and control” of inebriates other than detention in licensed psychiatric hospitals, yet it appears that these provisions are never, or rarely, used. The provisions for recognisance, seven day custody for more careful medical examination of suspected inebriates, the appointment of a guardian(s), and provisions relating to the treatment of inebriates convicted of certain offences, all seem to have been disregarded. There is no evidence that the planned "Supervising Board" for inebriates was ever set up [section 29], nor evidence of a system for the review or inspection of institutions for inebriates [section 24]. Most significantly of all, perhaps, section 9 of the Act anticipates the establishment of special "state institutions" for the care and control of inebriates, yet no such institutions have ever been set up, tending to undermine the entire legislative intent of the Inebriates Act.

Other failures to engage with the legislation have seen certain provisions in the Act become anachronistic over time. For example, the very broadly-framed definition of "inebriate" fails to distinguish between people who may be temporarily intoxicated, and those who, because of the nature and extent of their substance misuse, pose a danger to themselves or others. The Act does not require the Court to be satisfied that the "inebriate" is unable to manage his or her affairs, or to consider whether or not the person is dangerous to himself/herself or to others. Moreover, once a person has been involuntarily committed under the Act, there is no proper review mechanism to enable the progress of the patient to be monitored, or to protect his or her rights while he or she is being detained.

Disengagement from the Inebriates Act is a little easier to understand when one considers the overall lack of evidence for the efficacy of orders made under the Act. Taking another view, some see the poor outcomes of "care and control" under the Act as a case of the legislation being set up to fail, whereby state authorities do not allow it to perform more than a respite care or stabilization function for people experiencing trouble with alcohol. 52 Again, though, whatever the truth of such charges, the key point is that the Inebriates Act seems to be ineffective. More than that, there are some worrying indications that the Act is used in selective ways that disadvantage particular population groups - namely vagrants, the homeless, unemployed and Aboriginal Australians - and that it has the potential to be applied as a means of 'street sweeping' to "remov[e] misfits and rejects from public view". 53

In conclusion, the Inebriates Act has fallen into disrepair since it was consolidated in the early twentieth century. As one critic has lamented: "the fact that the legislation has never been significantly amended, updated or even repealed, and has not been accompanied by any development and funding of proper hospital addiction services, is a sad reflection on government and on the community". 54 Such laments have also been heard in relation to the ADA Act. 55 Before turning to consider such criticisms, it is instructive to examine another example of a civil commitment law from an overseas jurisdiction, this time Sweden, where there has been strong official backing of the statute. Sweden's Act on Care of Addicts in Certain Cases is the topic of examination in the following chapter.

52 For example, J Leanne, Letter to the Editor (op. cit.).
54 G A Edwards, Mental illness and civil legislation in New South Wales (op. cit.), p 169. See infra, Chapters 7 and 8.
In contrast to Australia, which shares New Zealand’s harm minimisation approach to drug policy, Sweden is often characterised as having one of the most repressive of all national drug policies, where supply control measures are preferred to demand reduction initiatives. Certainly, while there are important differences between the three countries, there are several important similarities. As anthropologist Harry Levine reminds us, Sweden is one of nine so-called “temperance cultures” that includes New Zealand and Australia - predominantly Protestant countries which historically drank a large proportion of their total alcohol intake as distilled liquor (in the main, vodka, gin, whiskey and rum).\(^1\) Moreover, despite differences in the accent that is placed on demand reduction initiatives relative to supply control measures in the respective countries, there are similarities to the extent that the provision of compulsory treatment is one of the problem limitation strategies that exist in each of their national policies on reducing substance-related harm.

In this chapter, the Swedish Act on Care of Addicts in Certain Cases 1989 (typically referred to by the shorthand “LVM”) will be assessed in much the same way as the New South Wales Inebriates Act was in the previous chapter. Again, the focus will be on casting the ADA Act into sharper relief, and drawing lessons from the overseas experience which have relevance to the continued operation of a compulsory treatment law for alcohol disorders in New Zealand.

Also as in the previous chapter, the discussion will be informed by comparative research done during a short study tour - this time to Stockholm during 1999 – which involved a visit to an LVM treatment centre, and interviews with health, social welfare and justice officials. This phase of the research exercise was complemented by conversations with the author of a recent in-depth study of the Swedish drug control system, Tim Boekhout van Solinge, based at the University of Amsterdam’s Centre for Drug Research; as well as several informal conversations with members of the Swedish delegation at meetings of the United Nations Commission on Narcotic Drugs in Vienna, during 1998 to 2000.

6.1 Alcohol in Sweden

In order to contextualise Sweden’s compulsory treatment statute, it is important to provide a brief description of the place of alcohol in Swedish society, and responses to alcohol-related problems that have been developed by the state.

Sweden is said to belong to ‘the vodka belt’ - the zone stretching from Europe to North America that includes Canada, Russia, and the countries of Scandinavia, where there is a strong tradition of drinking distilled spirits, like schnapps.\(^2\)

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\(^2\) One of the main reasons these countries traditionally used stronger liquors is because wine could not be produced and beverages like beer could not be stored or were difficult to distribute. See, further, L Lenke, The significance of distilled beverages: Reflections on the formation of drinking cultures and anti-drug movements (Unpublished paper presented to the Kettil Brunn Society, Stiguna, Sweden, June 1991), p 5.
It is popularly thought that Swedes drink a lot of alcohol. Yet, compared to many countries — including New Zealand — total consumption of pure alcohol per capita is not that high. An important feature of alcohol consumption in Sweden, though, is that alcohol is widely used as a means of intoxication rather than as merely a table drink. Swedes are said to have typical Nordic intoxication-oriented drinking habits. In other words, when it comes to drinking the aim is to get drunk. Indeed, the expression "drinking" in the Swedish language already expresses that a state of drunkenness will probably be reached. This is sometimes said to indicate that Swedes are not able to use alcohol in a controlled way.

Explanations for this pattern of drinking-to-become-intoxicated have included naturalistic, climatic and social factors, as well as suggestions that drinking offers an excuse for what would otherwise be seen as un-Swedish irresponsibility. According to Åke Daun:

One of the social and psychological functions of drinking in Swedish culture is to lessen the individual's fear of making a fool of him - or her - self - for example, the anxiety people feel about saying the wrong thing. Instead, under the influence, it is permitted to be 'too' aggressive, 'too' sentimental, 'too' loud or gay. The individual then never - or seldom - is accountable for breaking the norms .... What matters to the drinker is less the psychological effects of alcohol than the 'cultural ticket' to a freer and more irresponsible pattern of social interaction.

Although in recent years there seems to have been a movement away from this intoxication-oriented drinking pattern, towards a more 'European' drinking style (which is also increasingly characteristic of countries such as New Zealand), there is still a marked contrast between the Swedish drinker's uncontrolled approach to alcohol and the very tight state-controlled system which is used to make alcohol available in Sweden. Since the nineteenth century, the aim of Swedish alcohol policy has been to reduce the total level of alcohol consumption, in order to minimise the social and personal harm that results from alcohol misuse. The primary levers used to achieve this have been a state monopoly on alcohol distribution, coupled with state control of the price at which alcohol is sold.

The 'Bratt System' was introduced in 1917, consisting of a government monopoly on the sale of alcohol, and a ration book entitling people to buy alcohol up to a certain quota. This control system led to an increase in alcohol prices, especially of the harder liquors. Rules were strict: the minimum age to get a ration book was 25, and before it was issued an examination was carried out to establish whether the applicant was abusing alcohol and whether his financial position was satisfactory. The authorities could reduce the ration or withdraw the ration book if a person was not purchasing in conformity with the rules. Generally, the husband as head of family was the ration book holder, having the right to buy up to four litres of spirits a month. Married women had no ration books, whilst single women received a smaller ration. Alcohol supply was also restricted in restaurants, especially for women and young people.

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3 National Institute of Public Health, *Swedish Alcohol Policy — Background and present situation* (Stockholm: NIPH, 1995), pp 14, 37. Even when unregistered alcohol consumption is factored into the equation, annual Swedish alcohol consumption during the 1990s has been estimated to be around 8 litres per capita, placing it slightly below the level of actual annual alcohol consumption per capita in New Zealand (which hit a low point of 8.3 litres during 1987, and in recent years has started to rise again): see Statistics New Zealand, *Alcohol available for consumption: December 1999 quarter* (Wellington: Statistics New Zealand, 2000), p 1.


7 The discussion which follows relies heavily on the excellent summary provided by T Nilson, *Alcohol in Sweden — A Country Profile*, in T Kortteinen (ed.), *State Monopolies and Alcohol Prevention*, pp 311-354 (Helsinki: Social Research Institute of Alcohol Studies, 1989).
The ration book system encountered growing criticism, particularly in the post-war period, and was abolished in 1955. Yet despite the demise of rationing, several aspects of the restrictive alcohol policy remain in force today. The government retains a virtual monopoly on distribution, with the state-owned alcohol outlets (systembolaget) controlling all alcohol sales except lighter-strength beer - containing less than 3.5 percent alcohol by volume - which can be bought in supermarkets. There are currently only 395 systembolaget in the whole of the country, which only open until 6.00pm on weekdays. Hence, after 6.00pm or during weekends, although alcohol can still be bought in bars, restaurants and clubs, it is not possible to buy stronger beer, wine or spirits in a takeaway form.

While Sweden was forced to give up its state monopoly on alcohol wholesaling, distillation, imports and exports in 1995 as part of its negotiations to enter the European Union, the systembolaget monopoly on alcohol retailing has been retained. The restrictive nature of Swedish government policy on alcohol continues, therefore, with an emphasis even now on external control by the state rather than self-control being exercised by individual drinkers. In fact, a recent experiment with self-service sales of alcohol in systembolaget was dropped in favour of the current supervised, over-the-counter, transactions, when it was found to have led to an increase in purchases of alcohol.

6.2 The Act on Care of Addicts in Certain Cases

While the public face of Swedish alcohol policy is one dominated by supply control, there is nevertheless an extensive infrastructure of treatment services available for any Swedes who develop alcohol- and other drug-related problems. The explicit goal of such services is rehabilitation, not punishment. Having said this, one of the most striking features of the treatment services provided and their utilisation is the extent to which forced treatment is used. This reflects a mixture of paternalism and a confidence that treatment 'works'. As the Swedish National Institute of Public Health publication, Drug Policy – The Swedish Experience (1995), states: "a drug-free society is a vision expressing optimism and a positive view of humanity; the onslaught of drugs can be restrained, and drug abusers can be rehabilitated."

6.2.1 Background to the LVM

There has been legal provision for compulsory treatment of alcoholics in Sweden since the early 1900s. Scholars trace the development of such laws back to an influential thesis by Dr Magnus Huss, Alcoholismus Chronicus (1849), where Huss outlined his view that alcoholism is a disease, and advocated for treatment asylums for alcoholics. At that time, drunkards were incarcerated in forced labour camps under general laws against vagrancy. By the 1890s, the first private asylums for alcoholics in Sweden were established in Stockholm; although expensive patient fees made it impossible for poorer people with alcohol problems to access help at such facilities. There were several proposals from municipalities to arrange state-financed care, since drunkards imposed a heavy burden on the resources of local cities.

In 1913, the Act on Alcoholics was adopted. Its key paragraph stated:

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8 Information Department, Systembolaget and the European Union (Stockholm: Information Department, 1996).
13 Quoted in A Gerdner, Compulsory Treatment for Alcohol Use Disorders: Clinical and Methodological Studies of Treatment Outcome (Malmö: Lund University, 1998), p 17. The discussion which follows on the historical background to the LVM draws heavily from the comprehensive treatment of this topic provided by Dr Gerdner.
If a person is addicted to drunkenness, and if therefore he is found to be a danger to the personal safety of another person or to himself, or if he subjects his wife and children, whom he is obliged to provide for, to destitution or obvious mismanagement, or if he becomes a charge on the public, or on his family, then it may be decided that he shall be placed in a public institution for the care of alcoholics, in accordance with this Act.

Alcoholics who were committed under the 1913 Act were detained in institutions for 12 months - a ‘sentence’ that could be extended if a relapse occurred within six months of discharge.

The criteria in the Act on Alcoholics remained largely unchanged in revised laws of 1931 and 1954. In 1931, the words “disorderly way of life” and “not able to care for oneself” were included in the statutory definition of “alcoholic”, although the primary emphasis of the legislation was still cast as safety of the community. Preventive measures and social control of alcoholics in municipalities were more extensive in 1931 than before, and incarceration of the abuser was no longer the only response seen to be available. In 1954, a hierarchy of interventions (advice, supervision, and so on) was introduced, and it had to be shown that they were of no use, before decisions on compulsory commitment could be taken. The duration of compulsory institutional care in most cases was one year, and two years where there was an additional ‘sentence’ within five years of the last forced treatment order. The compulsorily committed alcoholic could be allowed to leave the institution earlier on supervised parole, and the law also allowed for the possibility of voluntary admission, including "Homerian coercion"14 similar to applications under section 8 of New Zealand’s ADA Act.

In the 1950s, the thinking behind the Act on Alcoholics began to be challenged, coinciding with the introduction of Antabuse and the development of more out-patient clinics and advisory services. Compulsory treatment was criticised in the 1970s for being a “class law”, mostly directed against the underprivileged, and the emerging class of therapeutic communities charged state-backed institutions with keeping patients passive and retarding their opportunities for personal growth.15 While not entirely discredited, therefore, coercive treatment under the Act on Alcoholics – with its primary orientation towards sanctions rather than rehabilitation – did not enjoy widespread support during this period.

6.2.2 The 1982 and 1989 LVMs

Against this backdrop, a new Social Welfare Act came into force in 1982, with the touchstones of care, respect and support. At the same time, compulsory care in certain cases was provided for in two items of special social legislation: the Act on Care of Addicts in Certain Cases (LVM), dealing with adult abusers; and the Act on Care of the Young (LVU), dealing with care of 13 to 21 year olds with anti-social behaviour problems, including substance-related issues.

The LVM differed from the Act on Alcoholics in several important respects. First, the LVM included the abuse of drugs other than alcohol as a basis for compulsory commitment. Second, compulsory treatment had to be motivated above all to meet the needs of the individual.16 References to class-based criteria for commitment were removed, as were

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14 The term, coined by Ton Tännö, refers to a time-limited protective coercion that the individual signs up to themselves, usually through a formal ‘contract’. The phrase borrows from Homer’s Odyssey, where the hero, curious to hear the famed Sirens, ordered his men to tie him to the mast of his ship, before navigating through the dangerous waters. See, further, T Tännö, Tvång i Vården (Stockholm: Bokförlaget Thales, 1994).


references to danger to the community; although danger to “close persons” (family) remained. Significantly, LVM also incorporated a series of procedural safeguards for the person subject to the committal process, with decisions being made at a judicial hearing, in which individuals had the right to legal counsel, as well as appeal rights to a higher court.

In 1989, a revised LVM came into force. Whereas the first LVM was viewed as essentially an acute intervention law, the 1989 Act had more ambitions about initiating treatment. Thus, the duration of an LVM order, which had been limited to two months (with a possible extension of two months), was extended to six months. Abuse of solvents and a new criterion of risk of “seriously damaging one’s future” were included as grounds for commitment. The law was also changed to oblige municipal Boards of Social Welfare to act in cases meeting the criteria for compulsory commitment, thereby effectively devolving responsibility to initiate treatment of severely alcohol- and other drug-affected individuals.

This model was further refined in 1994. Although it is still at the local, municipal level of the socialdistrikt where the decision is made whether or not to apply for compulsory treatment of a particular individual, if a committal order is made by the County Court, the decision on where that person shall receive treatment has been centralised under the National Board of Institutional Care (Statens Institutionssstyrelse) [SIS]. One reason for this policy shift was that many LVM institutions had been criticised for poor care and lack of adequate treatment. Another reason was to ensure that people who displayed acting-out behaviour and personality disorders got admitted, as social workers had complained that these patients were often denied admission in certain institutions under the pretext that they had no empty beds. To ensure that all eligible cases would be admitted and to create a basis for treatment differentiation, decisions on admission were thus centralised to the SIS. Some institutions were directed to specialise in the care of alcoholics and drug addicts with psychiatric co-morbidity, others were assigned to care for most violent addicts, and still others were assigned to care for those in need of special attention due to their age, organic brain damage or somatic problems. The development of gender-specific units was also encouraged, so that women and men could be treated separately.

6.2.3 Major provisions of the current Act

The current LVM states in its opening paragraph that the general goals of the Social Welfare Act should be applied in compulsory commitment cases – in other words, that “treatment should be based on respect for the individual’s right to self-determination and for his integrity”, and that treatment “so far as possible shall be planned and carried out in co-operation with the individual”.18

The second paragraph states: “treatment may be provided independently of the consent of the individual”. This means that compulsory commitment may be ordered even where there is consent by the person concerned, if there is reason to believe that he or she does not have a genuine desire and/or the capacity to voluntarily complete treatment.

The Act goes on to record that the goal of compulsory care is: “to motivate the abuser, so that he can be assumed to be able to co-operate in continuous treatment on a voluntary basis and to accept help to overcome his abuse” (§ 3).

17 A useful gloss on this policy shift is given by A. Gardner, Compulsory Treatment for Alcohol Use Disorders: Clinical and Methodological Studies of Treatment Outcome (op. cit.), pp 22-24.
18 All quotations from the 1989 Act (as amended) are taken from the translation provided by National Institute of Public Health, Swedish Alcohol Policy – Background and present situation (op. cit), and will be indicated in the text according to the corresponding paragraph number in the legislation.
This goal is discussed in *General Advice on the LVM* (1994), promulgated by the National Board of Social Welfare.19

This implies both a long-term goal - namely, freedom from abuse - and a short-term goal - namely, motivation to enter voluntary treatment. In the preamble to the Act, it was stated that another important aim is to stop a destructive process. It underlines that care according to LVM shall be seen as the beginning of a treatment that can lead to freedom from abuse and an improved lifestyle in other respects. The planning of treatment shall therefore include appropriate services in connection with the coercive care. Treatment goals should be flexible and adapted to the motivation of the individual and his ability to profit from treatment.

The fourth paragraph of the Act outlines the criteria for detention under the legislation. Paragraph four states that:

Compulsory treatment shall be decided on if someone, due to ongoing abuse of alcohol, drugs or volatile solvents, is in need of care to overcome his abuse and the need for care cannot be provided according to the Social Welfare Act or otherwise [that is, voluntarily] if, due to his abuse, he:

- Seriously endangers his physical and psychological health; or
- Is at obvious risk of ruining his life; or
- Risks serious danger to himself or to persons close to him.

These aggravating features of a person's substance use, which are thresholds that must be met before compulsory treatment will be ordered, are referred to as the health criterion, social criterion and the violence criterion, respectively.

Authorities which come into contact with substance abusers on a regular basis are under a statutory duty to report any individuals who may require treatment under the Act to the relevant municipal Board of Social Welfare (§ 6). The Board investigates the need and applies for compulsory commitment to the administrative County Court (§§ 7 to 11). The person concerned has the right to be present at the Court hearing and to receive legal assistance (§§ 39 and 42). When a committal order is made, the person who is subject to the order has the right to appeal to a higher court (§ 44).

Preliminary, "immediate decisions" may be taken by Police or the municipal Board of Social Welfare, if the delay in seeking a Court order would result in serious risk of deterioration of the person's health, acute danger to him or herself or persons close to him or her. The social criterion is, however, not applicable here (where a person is seen as being "at obvious risk of ruining his life"). Such immediate decisions must be put to the County Court at once, which decides within four days whether the decision will stand until there is an opportunity to proceed with the ordinary proceedings (§ 17).20 These provisions allow the LVM to be used in crisis situations, where immediate ambulatory care is needed.

The management of each LVM institution must keep municipal Boards of Social Welfare informed about the progress of treatment (§ 26). Interestingly, unlike the in-patient only requirement of New Zealand's ADA Act, LVM patients may be treated outside an LVM institution, so long as a plan for such treatment is negotiated between the patient, the local Board of Social Welfare and the LVM institution (§§ 27 to 28). If such out-patient treatment is not commenced within three months, the management of the LVM institution must report the reason why to the board of the institution (§ 29).

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20 During this period, the person is typically transferred to the nearest hospital or LVM institution for stabilization.
In terms of the length of orders, LVM committals end when the treatment goal is reached or after six months of treatment, whichever comes first. Time spent in non-treatment settings that is not approved by the LVM institution - such as time when absconding - is not included in the calculation of treatment time under the 1989 Act (§§ 20 and 21).

In the same way that the ADA Act provides for initial detoxification before transfer to a residential treatment facility, treatment under the LVM is provided for at specified institutions (§ 22) but may, if needed, begin in a hospital (§ 24). Some LVM institutions, adapted to patients in need of "special attention" (§ 23), have locked wards and may inspect mail and personal belongings (§§ 34 to 35). External body searches may be performed to ensure that neither drugs or drug-taking paraphernalia enter the institution (§ 32). The Police are also empowered to assist Boards of Social Welfare and institutions by taking people under LVM orders into custody or transferring them when necessary (§ 45).

6.2.4 What do LVM institutions actually look like?

The LVM does not prescribe what the compulsory treatment programme must look like for alcoholics committed under the Act. This lack of specificity has been criticised by some as a major short-coming of the legislation. For example, most Swedish social workers are said to broadly agree with the law, but are concerned about what they see as the lack of treatment content in many LVM institutions. In order to gain a flavour of the sort of treatment that may be offered to LVM patients, some brief descriptions of a number of LVM institutions are given below.

- Ekebylund is a LVM centre aimed mainly at female alcoholics, although its client group sometimes includes people who have combined alcohol and other drug problems. The treatment approach employed at Ekebylund blends individualised interventions and milieu therapy with education. Each patient has a contact person among the staff, group sessions twice a week, plus one gender-specific group. There are also study circles, physical training, stress management, and leisure activities organised by a peer group association.

- Rålambshov is a locked LVM unit for female drug addicts. After a morning group meeting for patients and staff, every patient has to do cleaning. Once a week they are offered the option of doing art work with an artist who visits the unit, and they are also offered primary-level education on a voluntary basis. Otherwise, there might be a visit by a social worker, a supervised visit to the dentist or a supervised walk outside. According to a recent evaluation, however, most of the patients' time is spent smoking and watching television, and the overall programme is described as monotonous, both in terms of treatment interventions and other structured activities.

- The Frösö treatment centre specialises in caring for addicts with behavioural and/or psychiatric problems, and offers what may be characterised as a highly individualised programme. Effort is made to plan for each client's future "social restitution", covering issues such as accommodation, employment or day-to-day activities, financial

21 Although not provided for specifically in the Act itself, a policy circular sent by SIS to LVM institutions has also mandated the use of urine testing and breath analysers, providing that such testing is not done "coercively". See National Board of Institutional Care, Internal General Advice for the Activities at LVM Institutions (Stockholm: NBIC, 1997), p 1.
22 V Petterson, Fyra år med LVM - En uppföljning fyra kommuner (1989) Socialjästaprojektet, vol 12: 46-52. Translation of the findings of this study and the immediately following ones were provided by Dr Elisabeth Rymning, Associate Professor of Public Law, University of Uppsala; for which the author is deeply indebted.
management and legal advice. All clients have contact persons among the staff. Since many are functionally illiterate, they are also offered primary-level education three times a week. A variety of work opportunities are also made available, such as forestry, textiles, carpentry and gardening. There are also chances to exercise in an on-site gymnasium, and occasional excursions to the surrounding countryside for fishing, skiing or nature walks.25

- Runnagården offers both voluntary and coercive care to alcoholics and other people with drug dependence problems, combining both locked wards (either as detoxification units or "motivation wards") and unlocked units. The daily schedule includes lectures about substance dependence, meetings with social workers as well as alcohol and drug counsellors, and clients are also able to attend Alcoholics Anonymous meetings in the evening. The overall programme is relatively intensive, with little unstructured time available for extra-curricula activities.26

- The Karlsvik Rehabilitation Centre is divided into one locked ward and four open villas, separated on the basis of gender, age and degree of social stability. Care at Karlsvik is based on key support workers – who are either social workers, "social pedagogues", or alcohol and drug counsellors. The general programme includes daily morning meetings, weekly individual counselling, lectures, groups sessions on relaxation / stress management techniques, and fortnightly "counselling concerning existential matters and quality of life". Clients on open wards also help the Centre's staff with cleaning, washing, cooking and gardening chores as part of their daily regimen. Specific programmes can include one-on-one sessions with psychiatric nurses, physicians and psychologists, and clients can also elect to take modules on coping skills / relapse prevention techniques (including acupuncture) and attend off-site AA meetings; as well as being able to participate in a range of activities during their free time, such as physical training, ceramics and textiles workshops.27

Even from these brief descriptions, one can conclude that LVM institutions come in many different shapes and sizes, and vary in terms of the education, social planning, counselling services and leisure activities that they offer to clients. Not all programmes conform to what may be thought of as "treatment", with some institutions appearing to provide little more than respite care or secure accommodation.28

6.3 Use of the LVM

Swedish researcher Arne Gerdner provides one of the most comprehensive pictures of the use of the LVM. Analysing data on LVM decisions from 1982 to 1995, Gerdner reports that although orders under the Act have decreased from a high of 1500 in 1991, the total number of compulsory treatment orders still average between 700 and 900 each year.29

According to the SIS, there are 25 LVM institutions spread throughout Sweden, most clustered in major urban areas.30

27 B Sallmén, Compulsory treatment of alcoholics: Psychiatric comorbidity, psychological characteristics, coercive expectations and outcomes (Lund: Lund University, 1999), pp 78-82.
28 The same could equally be said for at least one of the institutions certified to take patients under the ADA Act: refer supra, Chapter 4, section 4.3.1.
29 A Gerdner, Compulsory Treatment for Alcohol Use Disorders: Clinical and Methodological Studies of Treatment Outcome (op. cit.), p 23.
Not all LVM orders are made against the wishes of the person treated. Some research suggests that LVM orders in spite of consent are made in roughly a quarter of all LVM cases. In half of these cases, the patients were judged to be insincere in their consent, while the other half were judged incapable of completing treatment without coercion, because of their record of dropping-out from previous episodes of treatment. Against this, however, the LVM is typically used in the context of "immediate decisions" by Police or municipal Boards of Social Welfare, to minimise the risk of imminent harm. In 1995, for example, 886 such "immediate decisions" were taken, of which 80 percent were later confirmed in the regular County Court proceedings. In 82 percent of the cases, the local Board of Social Welfare took the emergency action, while Police intervened in the remaining cases where "immediate decisions" were taken.

With regard to the criteria which are typically invoked to order compulsory detention under the Act (§ 4), the same 1995 study found that most of the applications for compulsory treatment (98 percent) referred to the health criterion ("seriously endangers his physical and psychological health"), 50 percent of cases referred to the violence criterion (28 percent referred to "danger to himself", while 22 percent referred to "danger to persons close to him"), and 41 percent referred to the social criterion ("obvious risk of ruining his life"). Self-evidently, more than one criterion was used in most committal orders made under the Act, although almost all came under the rubric of a health protection measure.

In terms of the substance of abuse which warranted compulsory treatment, alcohol was the most commonly reported drug of abuse for those against whom LVM orders were made (76 percent), 47 percent abused illicit drugs and three percent abused solvents. In 23 percent of the cases, combinations of all three substances were said to be abused.

Most demographic studies of the LVM population agree that patients under the Act have much more severe problems concerning their social situation, mental health and abuse than voluntary clients do. For example, reporting on LVM cases from four municipalities between 1982 and 1985, one researcher found that only 20 percent had steady work, only 30 percent had more than primary education, only about half of the patients had grown up together with both biological parents, and only 27 percent were living with a partner at the time they had been committed for treatment.

An earlier study reported on compulsory treatment under the LVM which was administered by the City of Stockholm. There were 450 discharges from compulsory commitment in 1986. Only 14 percent of patients had more than primary school education (nine years) and 12 percent had not completed even this phase of their education. On average, women LVM patients were found to have had less education than their male counterparts did. Only 15 percent of patients had steady work, and those were mostly male alcoholics; women patients were found to be much less likely to have had work. About 50 percent of those under the Act had their own residence, while another 10 to 12 percent lived at other abodes. Approximately one third of patients were homeless, and about 70 percent lived alone. Only 17 percent lived with a spouse and another 12 percent lived with another relative or a friend.

33 Ibid, p 7.
35 V Pettersson, Fyra år med LVM – En uppföljning fyra kommuner (loc. cit.).
Some studies of LVM patients have sought to compare compulsorily committed patients at particular treatment facilities with those who are receiving care at the same facilities on a voluntary basis. For instance, Eckhart Berglund and Gunnar Ågren studied 23 compulsorily treated women and 94 voluntarily treated women at the Ekebylund treatment centre.\textsuperscript{37} They found that the compulsorily treated patients were more often homeless (26 percent versus 7 percent) and without regular work (82 percent versus 54 percent) than were the voluntarily treated sample of patients.

Similar differences were discovered by Arne Gerde and colleagues in patient cohorts at the Runnagården treatment centre.\textsuperscript{38} When compared with the 89 voluntarily admitted patients, the 32 compulsorily committed patients more often lacked above primary school education (50 percent versus 33 percent), lacked regular work (75 percent versus 46 percent), and were less likely to live with a partner or spouse (87 percent versus 71 percent). Coerced patients were found to be significantly more chronic substance users, with a longer mean duration of use (16.2 years versus 14.6 years) and a younger mean age of first use (21.5 years versus 27.5 years). LVM patients were also seen to use other drugs more often in addition to alcohol (61 percent versus 38 percent); and, interestingly, compulsory patients were more likely to fit clinical criteria for chronic alcohol abuse than voluntary patients (69 percent versus 64 percent).

Recent national screening studies in Sweden have tended to confirm this picture of the demographic characteristics of LVM patients. In a 1997 audit of 1144 clients treated at LVM units,\textsuperscript{39} nearly half (48 percent) lacked their own home or residence, and 17 percent were homeless. More than two thirds (68 percent) lived alone, and only 20 percent lived with their spouses, parents or other relatives. Only one-in-ten had regular employment. The two most common methods of financial support for clients were social security benefits (30 percent) and disability pensions (28 percent).

Likewise, a 1996 survey of 1047 LVM unit clients at intake and discharge\textsuperscript{40} found that virtually all of them (98 percent) had had previous contact with authorities in relation to their substance abuse, and more than half had previously been compulsorily committed under the LVM or the LVU - the equivalent compulsory treatment statute for 13-21 year olds. Over two-thirds had been convicted of criminal offences (68 percent). Worryingly, 70 percent of female LVM clients and 40 percent of the male LVM clients had been abused - either physically, sexually or emotionally - during their substance abuse careers. Around half of the LVM clients had lasting physical deficits or disorders affecting their lives.

6.4 Outcomes of detention and treatment under the LVM

In contrast to most other countries, which are poorly served with rigorous outcome evaluations of coercive treatment, Sweden’s LVM has been relatively widely studied and reported upon. Indeed, it would be fair to say that the Swedish research base is the richest source of evidence on the efficacy of compulsory treatment services that exists anywhere. In order to round out the comparative picture of the LVM regime, then, as well as to inform later discussion about the clinical usefulness of compulsory treatment of alcohol problems under the ADA Act, it is appropriate to devote some time to unpacking the evaluative material that is available on the LVM.

\textsuperscript{40} M Berg and I Jansson, LVM-klienter vid och Utskrivning 1996 (Stockholm: Statens Institutionstyreelse, 1997).
One of the earliest attempts to systematically evaluate the effectiveness of treatment mandated under the LVM was a study by Anders Bergmark and Lars Oscarsson. Citing various studies, the researchers concluded that compulsory treatment cannot lay claim to being a life-changing intervention, nor in most cases a long-term life-saving intervention. Three of the studies that were essayed by Bergmark and Oscarsson serve to illustrate the basis for these conclusions.

In a 1987 study, after a one-year follow-up, only four percent of LVM clients were abstinent, and their social situation had deteriorated. This finding was confirmed by a Stockholm study of 57 LVM clients during 1988/89. Only seven percent of the sample were abstinent at the six and 12 month follow-ups. Moreover, the follow-ups revealed that only 25 percent had their own housing, only two percent were able to support themselves financially without state assistance, and 42 percent had been forced to undergo another round of compulsory treatment in the intervening time. Echoing these themes, a 1992 study of 102 LVM clients found that six months after discharge only nine percent of the sample were abstinent, and 13 percent had been subject to compulsory treatment again. The socioeconomic situation of the sample had hardly improved, and some seven percent of the LVM clients had died by the six-month follow-up.

More recently, Arne Gerdner has reviewed the 17 published follow-up studies of patients treated at LVM institutions up until 1997. They include 2465 people with alcohol or drug disorders, of which 1554 were coerced under the LVM. A summary of these studies is presented in the table overleaf.

Because of the different research designs of these studies, including their sample populations, measures of validity, criteria for assessing client improvement, and success in following-up the chosen treatment cases, it is difficult to synthesise their results in any meaningful way. However, as Gerdner argues, some conclusions can be advanced with a reasonable degree of confidence. Overall, people who were treated in a coercive setting did not seem to do any better than those treated in a voluntary context. Seven studies compared compulsorily committed to voluntary patients who were treated at the same institutions. Four of these studies found no differences in client outcomes, one found a non-significant correlation (p < 0.1) between total abstinence and clients' feeling of being treated voluntarily, while two studies found that coerced patients had a worse outcome (but without controlling for intervening variables).

Gerdner's review emphasises that some apparent differences between compulsory and voluntary treatment outcomes disappear when multi-variate analysis techniques are used. For example, in a reinterpretation of one of his own earlier studies, Gerdner examined 10 months post-completion data for a group of 121 alcohol abusers (89 voluntary clients and 32 compulsory clients), finding that the 'volunteers' showed greater improvement than coerced individuals, but that most of the 'improvements' were related to their living with a spouse and participation in self-help groups. When Gerdner followed-up the sample eight-and-a-half years after their initial discharge from treatment, he found that almost a quarter of them had died (24 percent) - 8.7 times the expected mortality rate. Abstinence was the only statistically significant predictor of outcome: ex-patients who were abstinent at follow-up had lower mortality rates; whether they had been LVM or non-LVM patients was not correlated to survival.

42 A Gerdner, Compulsory Treatment for Alcohol Use Disorders: Clinical and Methodological Studies of Treatment Outcome (op. cit.), pp 38-41.
43 A Gerdner et al., Prediction of outcome in coerced and voluntarily treated alcoholics (loc. cit.).
Table 1: Follow-up studies on LVM treatment conducted up to October 1997

[from A Gardner, Compulsory Treatment for Alcohol Use Disorders: Clinical and Methodological Studies of Treatment Outcome (op. cit.), pp 38-41.]

<table>
<thead>
<tr>
<th>Reference</th>
<th>Sample</th>
<th>Follow-up method</th>
<th>Criteria on improvement</th>
<th>Lost to follow-up</th>
<th>Percent improved</th>
<th>Mortality</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arnhof (1983)</td>
<td>28 coerced drug addicts (18 women, 10 men) treated at Runnagården in 1982; 15 heroin, 12 amphetamine and 1 cocaine as drug of choice.</td>
<td>Interview with referring social worker. Follow-up time: 11 months mean.</td>
<td>1 abstainer, 4 less abuse, 2 in prolonged voluntary treatment = 7 improved.</td>
<td>0%</td>
<td>25% including 4% totally abstinent.</td>
<td>3.9 % dead per year.</td>
<td>These were the first drug addicts under compulsory commitment in Sweden.</td>
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<tr>
<td>Rosvall (1984)</td>
<td>34 coerced drug addicts (19 women, 15 men) treated at Runnagården in 1983. Types of drug not presented.</td>
<td>Mail questionnaire to the referring social workers Follow-up time: 6 months mean.</td>
<td>2 totally abstained, 2 almost abstained and 7 less abuse since discharge.</td>
<td>8.8%</td>
<td>32% of the original sample, including 6% totally abstinent.</td>
<td>11.8 % dead per year.</td>
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<tr>
<td>Gardner (1986)</td>
<td>90 patients (53 men and 37 women; 36% LVM) who completed an intensive 5 week AA-oriented programme at the Runnagården in 1984: Mainly alcohol.</td>
<td>Mail questionnaires to patients and to referring social worker. 78 responses. Additional clinical data for 9 patients. Follow-up time: 7 months mean.</td>
<td>Less abuse since discharge according to conservative rating of both patient and social worker.</td>
<td>3.3%.</td>
<td>59% improved including 11% totally abstinent.</td>
<td>3.8% dead per year.</td>
<td>No differences between men and women, or voluntary and coerced patients. But coerced women had worse outcomes.</td>
</tr>
<tr>
<td>Berglund &amp; Agren (1987)</td>
<td>157 patients (40 men and 117 women; 15% LVM) treated at Ekebylund 1984-1985: Mainly alcohol 79% or alcohol plus unspecified drugs 21%.</td>
<td>33% of patients were interviewed. Additional interview were made with social workers. Follow-up time: 86% of interviews took place 6-7 months after discharge.</td>
<td>Not using during one month prior to follow-up</td>
<td>7.6%</td>
<td>27% of the original sample (36% of women and 11% of men).</td>
<td>No death during follow-up.</td>
<td>Comparison between voluntary and coerced women: 37% vs. 30% improved. No significant difference.</td>
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<tr>
<td>Reference</td>
<td>Sample</td>
<td>Follow-up method</td>
<td>Criteria on improvement</td>
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<td>Gerdner et al. (1988)&lt;sup&gt;10&lt;/sup&gt;</td>
<td>121 patients (87 men and 34 women; 25% LVM) who completed an intensive 5 week AA-oriented programme at the Runnagården in 1985: 8% abused illicit drugs, 31% benzodiazepines and 99% alcohol.</td>
<td>Mail questionnaires to patients and to referring social worker. 116 responses. Additional clinical data for 3 patients. Follow-up time: 10 months mean</td>
<td>Less abuse since discharge according to conservative rating of both patient and social worker.</td>
<td>1.7%.</td>
<td>55% improved including 13% totally abstinent.</td>
<td>No death during follow-up.</td>
<td>No difference in outcome between men and women or between alcohol and drug addicts. Voluntary had better outcome than coerced (p&lt;0.05).</td>
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<tr>
<td>Fugelstad (1989)&lt;sup&gt;10&lt;/sup&gt;</td>
<td>152 coerced drug addicts (70 women, 82 men) treated at Serafen 1986-1988: 91 opiates, 37 amphetamine and 24 other as drug of choice.</td>
<td>Registers of social welfare, out-patient drug treatment, hospitals and death register. Follow-up time: 0.5-2.5 years.</td>
<td>Not abusing at follow-up, with no reference to abstinent time. Incl. methadone maintenance and in drug-free in-patient treatment.</td>
<td>&quot;Some&quot; (?) are missing</td>
<td>7% of the original sample.</td>
<td>12% dead per year.</td>
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<td>Franér &amp; Ågren (1990)&lt;sup&gt;19&lt;/sup&gt;</td>
<td>All 196 patients (34 women and 162 men; 87% LVM) treated at Frösö treatment centre June 1987 - Dec. 1988: 89% abused alcohol, 12% heroin, 7% hashish and 19% amphetamine.</td>
<td>Interview with 93 referring social workers &amp; 73 patients. In 30 cases information from &quot;others&quot;, incl. mortality registers. Follow-up time: six month mean.</td>
<td>Less abuse than before treatment</td>
<td>11%</td>
<td>26% improved of the original sample, including 7% totally abstinent since discharge</td>
<td>8% dead per year.</td>
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<td>Gieritz (1991)&lt;sup&gt;104&lt;/sup&gt;</td>
<td>207 cases reported for LVM treatment in 1989 in Malmö County. 57% were not sentenced. 31% women. 75% were alcoholics, 10% abusers of illicit drugs and 14% of both, 1% solvents.</td>
<td>Questionnaires to the social workers, handling the cases. Follow-up conducted &quot;in 1990&quot;. (7).</td>
<td>Social worker rated the measures as &quot;sufficient and effective&quot;.</td>
<td>37% (27% coerced and 43% not coerced)</td>
<td>19% of cases in the original sample had &quot;sufficient and effective&quot; measures</td>
<td>Not presented.</td>
<td>22% of coerced &quot;had sufficient and effective measures&quot; vs. 17% of those not coerced.</td>
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<td>Fernstedt (1992a)&lt;sup&gt;111&lt;/sup&gt; (1992b)&lt;sup&gt;112&lt;/sup&gt;</td>
<td>108 coerced drug addicts treated Nov. 1989- June 1991 at Håkanstorp (48), Rålamshof (30) and Salberga (30) treatment centres. 40% women.</td>
<td>Questionnaire to social workers. Follow-up time: 6 months.</td>
<td>Less abuse at the time of follow-up. No reference to observation time.</td>
<td>19%</td>
<td>25% improved, including 8% abstainers out of the original sample.</td>
<td>14% dead per year.</td>
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<td>Reference</td>
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<td>Bjurner (1992)</td>
<td>98 female coerced patients treated at Rålambsbo 1987-1990: 52 heroin, 51 amphetamine, 12 alcohol and 2 other as drug of choice.</td>
<td>Interview with referring social worker or other contact person. Follow-up time: Approx. mean = 21 months, range 1-40.</td>
<td>Not using at the time of follow-up, regardless of abstinent time.</td>
<td>20%</td>
<td>20% of the original sample.</td>
<td>4.1% dead per year.</td>
<td>One during abscondence but &quot;no other death occurred near the time of discharge&quot;.</td>
</tr>
<tr>
<td>Bergmark (1994a)</td>
<td>62 persons (55% coerced, 15% women) treated at least 30 days at Älgård in July-Dec. 1991 and accepted to be interviewed: 93% alcohol, 25% illicit drugs and 21% licit drugs.</td>
<td>Questionnaire to social worker. Follow-up time: 6 months</td>
<td>No continual use and improved in terms of substance use according to social worker</td>
<td>8%</td>
<td>21% improved, including 12% abstaining from all substance abuse since discharge</td>
<td>3.2% dead per year</td>
<td>Improvement was positively correlated to female gender (p&lt;0.01) and client appreciation of previous institutional care (0.05)</td>
</tr>
<tr>
<td>Bergmark (1994b)</td>
<td>125 substance abusers from 4 municipalities previously treated according to LVM in 1982-1985.</td>
<td>Central registers F-u. times: on LVM sentence: 3-6 years and on mortality: 5-8 years.</td>
<td>Survival and lack of new compulsory commitment.</td>
<td>0%</td>
<td>32% &quot;improved&quot;, i.e., survived and were not sentenced for another LVM-treatment.</td>
<td>SMR=7 Annual death not presented.</td>
<td>Higher mortality among women, drug addicts and persons of foreign origin.</td>
</tr>
<tr>
<td>Giertz (1994a)</td>
<td>188 persons reported for LVM treatment during 12 months 1991-1992 in Malmö County. 52% were not sentenced. 43% women. Type of drugs not given.</td>
<td>Questionnaires to the referring social worker. Follow-up time: 6 months since discharge or after decision not to be sentenced.</td>
<td>Abstinent from alcohol at least 3 months after treatment or after decision not to be sentenced.</td>
<td>29% of coerced and 31% of those not sentenced.</td>
<td>20% improved in the original sample (LVM: 11% vs. 28% of those not sentenced p&lt;0.01)</td>
<td>13% dead per year of coerced and 6% of others.</td>
<td>78% of those not sentenced started voluntary treatment and 50% completed it.</td>
</tr>
<tr>
<td>Nilsson &amp; Tops (1994)</td>
<td>57 coerced addicts (67% women) treated at &quot;Malmö detoxification unit&quot;. Amphetamines 30%, opiates 25%, hashish 9%, alcohol 7%, licit drugs 5%, solvents 2%, poly-drug 23%.</td>
<td>Non-systematic: personal contact with patients and different professionals. Follow-up after 2 months to 5 yrs. Approx. median 2.5 yrs.</td>
<td>Drug-free at follow up, including at voluntary drug-free residential treatment.</td>
<td>12%</td>
<td>12% (7 persons) including 2% (1 person) abstinent living outside of residential treatment.</td>
<td>2.5% per year</td>
<td>Most of those improved were amphetamine addicts, none was opiate addict.</td>
</tr>
<tr>
<td>Reference</td>
<td>Sample</td>
<td>Follow-up method</td>
<td>Criteria on improvement</td>
<td>Lost to follow-up</td>
<td>Percent improved</td>
<td>Mortality</td>
<td>Comments</td>
</tr>
<tr>
<td>------------------------</td>
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</tr>
<tr>
<td>Gerdner et al</td>
<td>All 603 patients (76% male, 42% LVM) treated at Runnagården 1988-1990: 97% abused alcohol, 29% benzodiazepines, 32% illicit drugs as hashish or amphetamines and 10% abused solvents. There were 4 different lines of treatment: intensive programme, adapted programme, referral to voluntary setting and only detox. and motivation.</td>
<td>Mail questionnaires to patients, to referring social worker and to significant other. Follow-up time: 24 months mean.</td>
<td>Less abuse since discharge according to conservative rating of all three questionnaires.</td>
<td>21%</td>
<td>40% improved of the original sample, including 9% totally abstinent.</td>
<td>3.5 percent dead per year.</td>
<td>Same outcome in men and women, in alcohol and drug addicts. Voluntary had better outcome than coerced (p=0.001), but there were no differences within the different lines of treatment.</td>
</tr>
<tr>
<td>Salminen &amp; Berglund</td>
<td>A sample of 104 patients who volunteered to participate in the study (73 men, 31 women, 56% LVM), treated at Karlsvik Nov. 1990 - Dec. 1992: Current dependency rates (DSMIIIIR): 99% alcohol, THC 39%, benzodiazepines 28%, amphetamines 11%, opiates 3%, other 2%.</td>
<td>Personal interview, validated by social workers and additional clinical data. Follow-up time: 12 months since discharge, median.</td>
<td>Less than 60 days of drinking alcohol during 12 months since discharge</td>
<td>11%</td>
<td>30% improved, including 3% totally abstinent of the follow-up sample.</td>
<td>21% dead per year.</td>
<td>Neither improvement nor mortality were related to coercion. Coerced patients were slightly more willing to participate (p&lt;0.08).</td>
</tr>
<tr>
<td>Möller et al.</td>
<td>All 135 patients (23 women, 112 men; 39% LVM) treated at Rällsögården 1991-1992: 99% abused alcohol, 22% benzodiazepines, 9% solvents and 27% illicit drugs, specified as hashish 20%, amphetamine 21%, heroin 3% and other 3%.</td>
<td>Mail questionnaire to patient and to referring social worker Some questionnaire response concerning 84% of 75 mailed. Additional clinical data for 38 patients. Follow-up time: 24 months.</td>
<td>Less abuse since discharge according to conservative rating of both patient and social worker.</td>
<td>16%</td>
<td>29% improved of the total original sample, including 7% totally abstinent since discharge.</td>
<td>6.3% dead per year.</td>
<td>No differences in outcome between voluntary and coerced, or between men and women. Drug addicts were more often improved (p&lt;0.02).</td>
</tr>
</tbody>
</table>
In the most recent study of its kind, Björn Sallmén and Mats Berglund followed-up 104 clients at the Karlsvik Rehabilitation Centre (73 men and 21 women, of whom 56 were compulsorily committed and 48 voluntarily admitted) 18 months after discharge from treatment. Using a sophisticated research design, the follow-up included re-tests and interviews with the clients, interviews with their assigned social counsellor, and an analysis of medical records. Follow-up data was available for 92 of the original 104 clients: 50 former LVM patients and 42 former voluntary clients.

Sallmén and Berglund found that 24 percent of the subjects were dead 18 months after recruitment to the research programme. Mortality was 12.7 times the expected rate, standardised to gender and age, and was not related to severity of abuse or treatment modality (coercion versus voluntariness). Neither did changes in alcohol consumption the year after discharge differ between compulsorily committed and voluntarily admitted subjects. Despite the high levels of psychiatric comorbidity in the sample, psychiatric disorders were also found to be unrelated to both drinking outcome and mortality. The main outcome determinant in the follow-up study was seen to be level of social stability. Among subjects without stable housing conditions or a partner, mortality was 41 percent and the mean number of drinking days was 110 per year. Among subjects with housing and structured daytime activities and/or a partner, none were dead at the 18 month follow-up, and the mean number of drinking days was estimated at less than 60. Only four percent of the sample had achieved complete abstinence, and only five percent had managed to cut their annual number of drinking days to less than 21.

When these studies are considered together, it is difficult to state any firm conclusions beyond Gardner's finding that people who are forced into treatment do not seem to do any better than those who enter into treatment voluntarily. Apparent differences between compulsory and voluntary treatment outcomes - such as higher mortality for LVM patients - seem to disappear in multi-variate analyses, where confounding factors such as the patient's social stability are controlled for. Interestingly, the severity of patients' alcohol abuse and presence of co-morbid psychiatric disorders do not seem to be related to post-treatment drinking patterns or health outcomes. Ex-patients' abstinence from alcohol and access to social stabilizers - such as housing, structured daytime activities and/or a partner - were seen to be the only protective factors which predict improved outcome, irrespective of whether patients have been through LVM or non-LVM treatment. It is tempting to suggest that such results say more about whether any treatment 'works' than it does about the respective advantages and disadvantages of compulsory and voluntary treatment, in-patient and out-patient treatment, and so on; especially when the counterfactual of 'no treatment' might have produced equal or even superior outcomes.

6.5 Changes to the way that the LVM is being used

Before concluding this overview of the Swedish experience of coerced treatment of alcohol use disorders, it is important to reflect upon what appear to be some changes in the way that the LVM has been used in recent years. These trends are instructive for the light they shed on the perceived usefulness of Sweden's compulsory treatment law in an environment where there is strong official backing of the legislation and support for resourcing its implementation.

46 See supra, Chapter 2, section 2.3.2, especially note 55 and accompanying text.
The first observation to make is that, for the past decade, problems have arisen because of the large number of patient transfers from one LVM facility to another. For example, in their study of LVM treatment in the Stockholm area, Peter Franér and Gunner Ågren reported that about 30 percent of all discharges from compulsory treatment were, in fact, transfers to other compulsory treatment centres; and fewer than one in four of these transfers were for disciplinary reasons. Since LVM orders explicitly aim at motivating patients to engage in further voluntary treatment, where patients fail to make progress towards this goal (what Prochaska and DiClemente would see as moving along the stages of change), this will often encourage treatment workers to transfer a patient to another LVM centre which offers a different type of care that the patient may find more motivating. Put another way, if a patient is not seen to be making sufficient progress, the LVM itself anticipates the already natural tendency to try and ‘shift the problem’ by transferring the patient. Yet all these transfers may be counterproductive in the sense that many alcoholics with personality disorders have problems in building therapeutic relationships with staff at treatment centres; problems that are likely to be aggravated if they are shifted around between key workers during a series of inter-institution transfers.

A second observation extends from the fact that many LVM institutions lack a recognised “treatment” programme, offering instead mere respite care or secure accommodation. Questionnaires completed by those referring patients to LVM facilities, as well as staff working within such units, often reveal that half of all the respondents call for changes in the way that LVM centres are run, with one third stating that this is a “major need”. In answers to open questions, most respondents propose more treatment-oriented content and less emphasis on providing custodial care, coupled with a desire for more motivational work and better co-operation with social services, especially in providing after-care.

These criticisms have been confirmed in a recent study by Arne Gerdner, which surveyed social workers who had been associated with a random sample of the discharged patients from all LVM institutions. Gerdner found that the social workers were generally satisfied with the acute care of LVM patients in order to arrest on-going abuse, and they approved of work by institutions to keep patients sober during treatment and their efforts to promote physical recovery. However, they were less satisfied with the fulfilment of other patient needs, such as motivation to seek further treatment for substance abuse, and assistance with relationship problems. According to the social workers surveyed, comprehensive assessment and treatment planning were often lacking at LVM institutions. They were particularly concerned about the lack of treatment for some patients’ concurrent emotional or psychiatric problems. In short, the social workers who were referring patients under the Act felt that LVM institutions were reasonably successful in achieving the short-term goals of committal under the legislation (stabilising the person and preventing life-threatening substance abuse), but were rather less successful at achieving its medium- to long-term goals (“to motivate the abuser, so that he ... co-operate[s] in continuous treatment on a voluntary basis ... to overcome his abuse” [LVM § 3]).

A final comment would be that, although no precise figures are available, the number of people placed under LVM orders appears to be falling. Interestingly, this may have less to do with any philosophical retreat from the principles or praxis of compulsory treatment than it does with crude cost-benefit economics. Citing what has happened in the municipalities of Stockholm and Botkyrka, for example, Tim Boekhout van Solinge has pointed to the fact that, in an

47. P Franér and G Ågren, LVM 1986 – Tvångsvård administrerat av Stockholms stad (op. cit.).
48. See supra, Chapter 2, note 57 and accompanying text.
49. For example, A Giertz, Anmäld enligt LVM. Del 2. Missbrukare som vårdats enligt LVM (Malmö: Sociala enherten, Länsstyrelsen i Malmöhus län, 1994).
environment of shrinking budgets, fewer people are being forced into treatment; and if they are, the period of treatment has been shortened; both of which means that there are less referrals to LVM institutions for expensive compulsory care of up to six months duration. Boekhout van Solinge gives the case of the municipality of Bottkyrka, which in 1993 spent two million kronor on compulsory treatment (equivalent to ≈$0.5 million New Zealand dollars). Confronted with these high costs, and the questionable effectiveness of compulsory treatment, local politicians decided to use the legal machinery of the LVM only in rare cases, preferring instead to fund places in much cheaper out-patient treatment programmes which people opt into voluntarily.

6.6 Summary

This chapter has offered a second case-comparison of a civil commitment law for people who have alcohol problems. Sweden's Act on Care of Addicts in Certain Cases was foregrounded with a brief discussion of the place of alcohol in Swedish society. Since the nineteenth century, it was noted that the aim of Swedish alcohol policy has been to reduce the total level of alcohol intake, so as to minimise the social and personal harm that results from alcohol misuse. To this end, there was seen to be a marked contrast between the typical Swedish drinker's uncontrolled approach to alcohol and the very tight state-controlled system which is used to make alcohol available in Sweden. Even today, the Swedish government retains a virtual monopoly on the distribution of alcohol, through state-owned systembolaget.

This emphasis on external control of alcohol by the state rather than self-control being exercised by individual drinkers has been carried over into the provision of treatment services for alcoholics. It was reported that there has been legal provision for compulsory treatment of alcoholics in Sweden since the early 1900s. The current compulsory treatment statute for adults (LVM) came into force in 1989, and was refined in 1994. The purpose of intervention under the LVM was characterised as not being about coercing an individual though a complete rehabilitation programme, but rather, through short-term, crisis intervention, to overcome a life-threatening situation and motivate the individual to make his or her own decision to seek on-going care. In the words of one observer, "LVM is not as much a real treatment, but merely used as a means to get someone into (voluntary) treatment".

It was outlined how the decision to apply for compulsory treatment of a particular individual is made at the local level of the socialdistrikt, either by Police or municipal Boards of Social Welfare. LVM orders are made by County Courts, where individuals have a right to legal counsel, and appeal rights to a higher court. Such orders can last for up to six months, with treatment normally provided on an in-patient basis, although there is provision for out-patient care to be negotiated by patients, the local Board of Social Welfare and the LVM institution which initially receives them for care. It was further noted that the decision on where the committed person receives treatment has been centralised under the National Board of Institutional Care (SIS). Some LVM institutions specialise in the care of alcoholics with psychiatric co-morbidity, others in the care of more violent addicts, and others in the care of special needs patients. There are also a number of gender-specific LVM units that allow for male and female patients to be treated separately.

50 A Gerdner, The quality of LVM treatment according to the judgment of social services (Stockholm: NBIC, 1997).
51 T Boekhout van Solinge, The Swedish Drug Control System: An in-depth review and analysis (op. cit.), p 126.
After rehearsing the major provisions of the LVM, the chapter provided several vignettes of current LVM institutions. The point was made that the LVM does not prescribe what the compulsory treatment programme must look like under the Act, and that LVM institutions consequently vary in terms of the education, social planning, counselling services and leisure activities they offer to clients. Moreover, not all programmes were said offer what may be thought of as ‘treatment’ services, with some institutions appearing to provide little more than respite care or secure accommodation.

Turning to the use of the Act, it was noted that there are presently 25 LVM institutions spread throughout Sweden. While the annual number of LVM orders was reported to have decreased from a high of 1500 during the early 1990s, it was highlighted that the total number of compulsory treatment orders still averages between 700 and 900 each year. Although it was acknowledged that not all LVM orders are made against the wishes of the people who are subject to them, the legislation is most often used in the context of “immediate decisions” by municipal Boards of Social Welfare or Police, ostensibly as an emergency/ambulatory health protection measure to prevent further alcohol-related harm. In around 80 percent of these sorts of cases, the “immediate decisions” are later confirmed in formal Court hearings.

A depressing demographic picture was sketched of the people who are made subject to such LVM committal orders, with most studies agreeing that patients under the Act have far more severe problems concerning their social situation, mental health and abuse than do voluntary clients. Recent national screening studies of clients at LVM units were shown to have found that: nearly half lacked their own home or residence, more than two thirds lived alone, and only one-in-every-five clients lived with their spouses, parents or other relatives; only one-in-ten had regular employment; and the two most common means of financial support for clients were social security benefits and disability pensions.

Like the patient population under the ADA Act, it was further noted that alcohol is the primary substance of abuse for the vast majority of people committed under the LVM; that virtually all of them (98 percent) had had previous contact with state agencies in relation to their substance abuse, and that over half had been compulsorily committed before. This reinforced the impression that the LVM, too, is used to detain and treat mainly chronic, ‘revolving door’ alcoholics.

In terms of the outcomes achieved under Sweden’s compulsory treatment law, it was commented that, even though the research base on the LVM is the best source of evidence on the efficacy of forced treatment that exists anywhere, it is difficult to synthesise the research in a meaningful way. In particular, it was noted that apparent differences between compulsory and voluntary treatment outcomes – such as higher mortality for LVM patients – seem to disappear using multi-variate analysis techniques. Interestingly, the severity of patients’ alcohol abuse and presence of co-morbid psychiatric disorders do not seem to be related to post-treatment drinking patterns or health outcomes. Ex-patients’ abstinence from alcohol and access to social stabilizers were seen to be the only protective factors which predict improved outcome, irrespective of whether patients have been through LVM or non-LVM treatment. When these outcome studies are considered together, it is difficult to state any firm conclusions beyond the general finding that people who are forced into treatment do not seem to do any better than those who enter into treatment voluntarily.

It was noted finally that the fortunes of forced treatment in Sweden appear to be waning. In particular, the number of people placed under LVM orders seems to be falling. This trend was seen to reflect both the high costs of care under six-month LVM orders, as well as concerns over the medium- to long-term effectiveness of care in many LVM facilities.
Practical and clinical issues

To this point in the thesis, the discussion has focussed on trying to locate the ADA Act within various contexts. In Chapter 2, the legislation was analytically located within larger debates, such as whether alcoholism is a disease, before it was placed in a particular socio-cultural and moral milieu that affects the way that alcohol-related problems are framed in New Zealand. The Act was also positioned vis-à-vis the philosophical traditions and practical strategies of harm minimisation and therapeutic jurisprudence. In the fashion of legal positivism, attention turned in Chapter 3 to the legislation itself: how it evolved, what its major provisions are, and what efforts have been made to refine the Act since it was passed. This positivist reading of the Act was animated in Chapter 4 by an examination of how the law operates in practice, drawing on the limited amount of quantitative and qualitative data that is available on the Act. In the next part of the thesis, Chapters 5 and 6, the legislation was put into a comparative context by describing examples of similar-type statutes in two overseas settings. Through each of these contextualising steps, ways of seeing and better understanding the Act were suggested.

The following two chapters begin the substantive task of using these ways of seeing and understanding to evaluate the ADA Act. The discussion will proceed in two phases. First, the Act will be judged in instrumental terms, to see whether it does indeed "make better provision for the care and treatment of alcoholics". Secondly, this assessment will be widened to look at whether the Act works in value terms, to see whether the legislation itself, and the way it is being implemented, are consistent with New Zealand's prevailing legal and ethical norms.

7.1 Practical issues

At a purely practical level, there appear to be several impediments to realising the ADA Act's stated aim of making better provision for the care and treatment of alcoholics. The most significant of these barriers are discussed below.

7.1.1 Infrequent use of the Act

At the outset, it must be acknowledged that the ADA Act committal procedures are infrequently used in New Zealand, and that the number of committal orders made under the Act are on the decline. The annual number of ADA Act committal orders have more than halved from over 400 a year in the 1970s to under 200 a year in the 1990s. Moreover, in the last five years there have been no attempts to use the section 21 committal procedure - which allows for the transfer of prison inmates to ADA Act institutions - and section 21 was only ever used infrequently before then.

Interestingly, this drop in the annual number of ADA Act committal orders and the failure to use criminal justice sector referral streams echoes the declining fortunes of Sweden's LVM and, in particular, New South Wales' Inebriates Act.

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1 Alcoholism and Drug Addiction Act 1966, Long Title.
2 See supra, Chapter 4, section 4.2; especially Tables 2 and 3.
3 See supra, Chapter 6, section 6.3; and supra, Chapter 5, section 5.2, respectively.
There are likely to be demand and supply side explanations for the ADA Act's falling popularity. On the demand side, although no direct evidence is available, it seems likely that there is a fairly low level of public awareness about the existence of the ADA Act. Added to this, many potential applicants may discount the possibility of having a loved one compulsorily committed under the Act as too extreme, or as likely to cause an irreparable schism between the applicant and the subject of the application. Whatever the reason, when one considers that one-in-every-five New Zealanders will fit clinical criteria for alcohol abuse or dependence at some stage in their lives, and the consequent large pool of people who might potentially be committed under the ADA Act, the fact that so few applications are made under the legislation each year suggests that there is little public demand for such interventions by the Courts.

On the supply side of the equation, the low level of uptake of the ADA Act procedures may also relate to the difficulty that could be experienced in finding an institution that is first able, and secondly willing, to treat a potential patient. For one thing, there has been a drop in the number of institutions certified to take patients for mandated treatment. In 1988, there were 19 facilities certified to receive ADA Act patients; currently, there are just 13 approved institutions. Furthermore, these institutions are spread unevenly throughout the country, with treatment places clustered in Auckland, Wellington and Christchurch, but with gaps in coverage existing in other significant population centres, such as Hamilton and Dunedin. The prospect of needing to arrange an out-of-region placement is likely to discourage some potential applicants under the Act, who may wish to involve family members or significant others in the course of treatment. Such an out-of-region placement may not even be possible under the contracting arrangements between the health funder in the applicant’s region and the proposed treatment provider, which might have already filled its allocation of funded ADA Act treatment places during a particular financial period. This scenario is already said to be occurring at some ADA Act institutions, which have multiple contracts with regionally-based health funders.

Yet another (demand and supply side) constraint could be the lack of current ADA Act treatment facilities which are specifically designed to cater for Māori and Pacific peoples. There is a residual question mark over whether the use of compulsion through a court-mediated process like the ADA Act will be culturally-appropriate for Māori, but the lack of any by-Māori-for-Māori services which are certified to accept ADA Act patients, or for that matter services which operate according to a Māori kaupapa, may be barriers to greater levels of uptake of ADA Act procedures by Māori. Similar reservations may be expressed about how comfortable the ‘fit’ is for Pacific peoples, and whether the use of the ADA Act to force problem drinkers from the Pacific community into mainstream services is culturally-appropriate.

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4 See supra, Chapter 1, notes 8 and 9 and accompanying text.
5 For a discussion of the relatively low threshold that must be met before the ADA Act committal process can be invoked (e.g. a person's “persistent and excessive indulgence in alcoholic liquor” is causing or is likely to cause “serious annoyance to others”; and the making of an order is “expedient”), see supra, Chapter 3, section 3.2.
6 [Unattributed], Institutions certified under the Alcoholism and Drug Addiction Act 1968 as at 14-10-88. Internal file note, Department of Health [Held on File 131-158-2-1, National Archives, File series 79253, box 794]
7 These gaps are even more curious when one considers that the Salvation Army – the provider of the lion’s share of ADA Act treatment places – runs equivalent Bridge Programmes in both Hamilton and Dunedin, and would presumably experience no difficulty in having these facilities certified as ‘institutions’ under the ADA Act. B Dílger, interview, 14 November 2000.
9 For a general discussion of some of the issues for Māori in mainstream alcohol and drug treatment settings, see T Huriwai et al., Treatment for Maori with Alcohol and Drug Problems, in J D Sellman et al. (eds.), The Long and the Short of Treatment for Alcohol and Drug Disorders, pp 32-37 (Chirstchurch: Christchurch Medical School, 1997); and J D Sellman et al., Cultural Linkage: Treating Maori with Alcohol and Drug Problems in Dedicated Maori Treatment Programs (1997) Substance Use & Misuse, vol 32(4): 415-424.
10 The ineffectiveness of mainstream services in addressing the contexts of Pacific drinkers has been essayed in several studies, for example: K K Aiolupotea, Message in a Bottle: Developing effective alcohol interventions strategies for Samoan drinkers. Unpublished MA (Education) thesis. (Auckland: University of Auckland, 1994).
The lack of certified institutions under the ADA Act has also been criticised by some exasperated members of the judiciary. As noted earlier, a Palmerston North District Court Judge recently directed that a copy of his decision be forwarded to the Director-General of Health, so that she became aware of the "untenable situation" where no certified institution was prepared to take a particular person for treatment under the ADA Act. The Judge concluded that: "the whole purpose of the continuation of the Act is being frustrated in this regard, and it is quite unworkable". Where those involved in the committal process experience difficulty in getting proposed patients into treatment, it follows that they can be expected to become disillusioned with the statute, and less-inclined to push for placements under the Act.

7.1.2 Cost constraints

A second set of impediments to realising the ADA Act's aim of making better provision for the care and treatment of alcoholics derive from inadequate or unclear funding arrangements. For example, the question of who pays to transport patients to and from institutions continues to vex those involved in the day-to-day operation of the Act. Clinicians such as Dr Geoff Robinson decry that "issues of onus/payment for transport or escorts appear unclear to those involved (Police/Health/A&D agencies), and a good deal of time is wasted in orchestrating such matters". These are long-standing issues that defy solution until wider Health/Justice sectoral boundary disputes are resolved.

The inability to clearly resolve the question of 'who pays?' has also been identified as a major reason why no temporary shelters or detoxification centres have ever been set up under section 37A of the ADA Act. Immediately following the decriminalisation of public drunkenness, voluntary agencies such as the Salvation Army urged Ministers and officials to consider the establishment of temporary shelters and detoxification centres, especially in major cities like Auckland and Wellington. These calls fell on deaf ears, however, as bureaucrats argued about whose responsibility it was to act as lead agency on the issue, and whether such sobering-up facilities should be funded by Vote:Social Welfare, Vote:Health or Vote:Police. One of the results of these squabbles over departmental baselines is that Police holding cells continue to act as de facto sobering-up facilities. This failure to engage the potential of section 37A of the ADA Act to set up a network of temporary shelters and detoxification centres for intoxicated people finds a ready parallel in the failure to implement various empowering provisions in New South Wales' Inebriates Act.

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12 Supra, Chapter 1, note 12 and accompanying text.
13 Police v Barnes (Unreported, Palmerston North DC, 13 December 1996, CRN 6054012657, per Ross DCJ).
14 G M Robinson, Submission by Capital Coast Health to the 1999 ADA Act review, 23 April 1999, p 2. Speaking at a special symposium on the ADA Act in the early 1980s, a Senior Police Legal Adviser complained: "An order was obtained from the Timaru District Court Judge committing an alcoholic to Totara Trust in Masterton. The problem was then dumped in the laps of the Timaru Police who had to spend $285 from public money to escort that person to Masterton". D B Kerr, Comments on the Alcoholism and Drug Addiction Act 1966. Paper presented to a symposium on the ADA Act, March 1983 (Wellington: New Zealand Police, 1983), p 2. The Chief Executive Officer of the Nova Lodge has also recounted many examples of where a car from his service has had to meet Police escorts or family members half-way to the Templeton facility (eg. in Arthur's Pass for transfers from the West Coast, or in Ashburton for transfers from Timaru) to address the fact that no agency is funded to perform such relocations. B Dilger, Interview, 14 November 2000.
15 It is interesting to note that the forerunner to the ADA Act, the Reformatory Institutions Act, included a specific clause (section 15) which provided for the payment out of public revenues of the expenses relating to conveyance of persons under that Act; or for the recovery of such costs directly from the parties, where they had the ability to pay for them. For commentary, see M Findlay, New Zealand Parliamentary Debates, vol 148, 23 December 1909, p 1468.
16 A raft of correspondence on this issue between the Salvation Army, other voluntary agencies, government departments and Ministers - including detailed costings for such temporary shelters and detoxification centres - is held on File 131-158-2, National Archives, File series 74340, Box 949.
17 These are summarised Supra, Chapter 5, section 5.5.
Cost is also seen to be a factor in the difficulty in getting community representatives to sit on ADA Act Supervisory Committees. One of the biggest sticking points in the operation of Supervisory Committees is the payment of fees for the "one other person" who section 7(2) of the ADA Act states "shall" form part of a Supervisory Committee. This issue most recently came to light when Dr Lesley Hellaby was appointed as the "one other person" to sit on the Supervisory Committee of the Auckland Bridge Programme, with repeated letters being sent to the Ministry of Health and successive Ministers of Health seeking the payment of Dr Hellaby, as provided for by section 7(12) of the Act.\textsuperscript{18}

In her final reply to the enquiries by the Auckland Bridge Programme, the Minister of Health, Hon Annette King, noted that the Chairman's role on the Supervisory Committee is funded by the Department for Courts, while the Medical Officer's role is covered by the funding associated with the total service contract negotiated between the certified institution and the Health Funding Authority (HFA). The Minister chose not to address the possibility of a specific Parliamentary appropriation for such work, with the position of the "one other person" on Supervisory Committees to be handled by each institution in its annual contract negotiations with the HFA. The Minister concluded:\textsuperscript{19}

> The funding provided in the total service contract is expected to cover the costs of the Supervising [sic] Committee, including the remuneration of its members to the degree that the Committee deems appropriate. I am advised that no separate contract exists with the Health Funding Authority for payment for this remuneration and that no other source of funding is available. If you continue to have concerns about adequate funding for the Bridge Programme, including funding for the Supervising [sic] Committee, I suggest you contact the Health Funding Authority directly to discuss additional funding.

7.1.3 The work of Supervisory Committees

The payment of fees to members of Supervisory Committees has been a ‘running sore’ in the ADA Act’s history, leading to particular difficulties in recruiting and retaining community representatives to provide input to their work. Indeed, there have even been instances in the past where non-hospital-based institutions (whose managers do not enjoy the same inherent rights regarding patient discharge, transfers or leave as superintendents of hospital-based institutions\textsuperscript{20}) have not bothered to set up Supervisory Committees, despite the legislative presumption that such oversight bodies are required.\textsuperscript{21} In many ways, such problems with Supervisory Committees are emblematic of the wider resourcing issues that, at a practical level, can hamper the day-to-day effectiveness of the legislation.

One feature of the current operation of Supervisory Committees deserves separate comment under this heading. As mentioned earlier,\textsuperscript{22} the way in which Supervisory Committees operate varies significantly throughout the country, evidently due to the commitments of the District Court Judge who acts as Chairman of the Committee. In contrast with the accessibility of the Auckland Bridge Programme’s Supervisory Committee, where the Chairman is a semi-retired Judge with a very light fixture load, the situation in both Wellington and Christchurch is less satisfactory. In Wellington, the Chairman of the Bridge Programme’s Supervisory Committee, Judge Borin, has for some time been Acting Police Complaints Authority, as well as a busy District Court Judge in his own right.

\textsuperscript{18} R J Gilbert, Letter to Director of Mental Health, 10 March 1999; A Herring, Letter to Director of Mental Health, 10 March 1999; A Herring, Letter to Director of Mental Health, 22 April 1999; A Herring, Letter to Associate Minister of Health, 29 July 1999; A Herring, Letter to Associate Minister of Health, 20 October 1999.
\textsuperscript{19} A King, Letter to the Director of the Auckland Bridge Programme, 31 January 2000.
\textsuperscript{20} Section 17 of the Act refers.
\textsuperscript{21} An example is the Totara Lodge in Masterton, which was decertified as an institution under the ADA Act by the Alcoholism and Drug Addiction Institution Order 1996 (SR 1996/291).
The situation in Christchurch is even more pressurised: the Chairman of the Nova Lodge and Bridge Programme’s Supervisory Committees is the Executive Judge of the Christchurch Family Court, with a very heavy fixture and administrative load. Consequently, the Judge’s ability to attend Committee meetings is severely compromised, leading to lengthy delays between meetings. It was noted earlier that, as a way of managing their way around the constraints that Judge Strettel is under, staff at the Christchurch-based ADA Act Institutions have resorted to faxing the Judge copies of relevant discharge and leave forms, occasionally having brief teleconferences about a case where he has specific queries, but otherwise waiting for a faxed copy of the signed order to be sent back – a situation that the Superintendents of the Nova Lodge and the Bridge Programme describe as “less than ideal”.23

One response to the problems evident with the Supervisory Committee model in Wellington and Christchurch might be to replicate the Auckland approach of appointing a semi-retired Judge as the Committees’ Chairman. Unburdened by a heavy workload, such Judges would presumably have more time to devote to Supervisory Committee work, and may bring additional gravitas and authority to the role because of their more senior years. In turn, these characteristics could enhance the Judges’ ability to achieve therapeutically-preferred outcomes, if they use their position as authority figures on the Committee to praise ADA Act patients for their progress, and to chastise and re-encourage those ADA Act patients who are not doing so well in achieving their treatment goals.24

Conversely, having older Judges acting as Committee Chairmen may be a ‘double-edged sword’, as elder members of the judiciary are sometimes the most locked-in to old orthodoxies, like conceiving of alcoholism as a disease. These tendencies are evident in the submissions made on the Act by two Judges who have had long involvement in the ADA Act process. The former Chairman of the Auckland Bridge Programme’s Supervisory Committee, for example, has written that he sees “no inconsistency with modern civil liberties statutes of detention of people under the Act”, because “it must surely be evident that those persons who are committed require constraints on their liberty and need to be confined”.25 Yet the weight of research evidence, and indeed theoretical approaches like the stages of change model, indicate that there is no self-evident “need” for alcoholics to be “confined” or to “require constraints on their liberty”; rather, that such coercion may be counter-productive.26

7.1.4 The fiction of secure confinement

Even were it self-evident that alcoholics “need to be confined”, as discussed earlier in the context of how the Act is working in practice,27 with the limited exception of Rotoroa Island, people committed under the Act are not compelled to stay in treatment. While the words of the statute plainly anticipate that ADA Act patients will be securely detained, and absconding without leave will be treated as a punishable offence, the reality is that patients are not fenced in with perimeter walls around the facilities, nor are they locked up in their rooms at night. Patients may be allowed to spend time away from institutions, especially during weekends, and it is reportedly not unusual for patients who are permitted to go on weekend leave to come back from the leave smelling of alcohol.28

22 Supra, Chapter 4, section 4.3.3.
23 Supra, Chapter 4, note 53.
24 The possibility that legal actors can be (more) effective in managing cases in therapeutically beneficial ways is discussed supra, Chapter 2, note 121 and accompanying text.
26 See supra, Chapter 2, especially sections 2.2 and 2.3.
27 Supra, Chapter 4, section 4.3.2.
28 See, further, the discussion supra, Chapter 2, note 36 and accompanying text.
Furthermore, there have been very few cases where patients have been prosecuted for escaping from institutions without leave, and the Police are reported to attach a low priority to picking up ADA Act patients who do escape.\textsuperscript{29}

At a practical level, then, although some alcoholics may “require constraints on their liberty”, committing such people to ADA Act institutions by no means guarantees that they will be securely detained. Indeed, the ADA Act itself contains two ‘safety valves’ which mean that not all alcoholics who “need” to will actually be “confined”. First, both section 8 and section 9 of the Act require that the Court is satisfied that a certified institution is willing to accept the proposed patient for treatment, before the Judge can issue a committal order. Although it is rare for institutions to refuse to accept a person under the Act, there are cases where this has occurred – typically, involving well-known alcoholics who have caused problems in the past and have benefitted little from treatment.\textsuperscript{30}

Secondly, because section 17 of the Act allows for a patient to be discharged at any time, in exceptional cases discharges have been authorised as little as six minutes after some patients have arrived at ADA Act institutions.\textsuperscript{31} Many other ADA Act patients are discharged prematurely because of violent conduct, threats to the safety of staff and patients, or because the patients have made it plain that they will not comply with their course of treatment.\textsuperscript{32}

In summary, because of these types of legislative ‘safety valves’, alcoholics who might be seen as most in “need” of “constraints on their liberty” may in fact be refused entry to an ADA Act treatment programme in the first place; or, if they are accepted into treatment, may quickly be breached off the Act and returned back into the community.

\subsection*{7.2 Clinical issues}

In addition to these practical issues, there are clinical issues that can prevent the stated goal of the ADA Act being realised. These clinical issues are both procedural and substantive, and go to the heart of whether the Act is defensible in instrumental terms, as “mak[ing] better provision for the care and treatment of alcoholics”.

\subsection*{7.2.1 Courts making clinical decisions}

Under the rubric of procedural issues, one of the most potent criticisms that can be levelled at the ADA Act is that it does not insist on comprehensive clinical assessments for people who are subject to forced detention and treatment. The HFA has been particularly critical of this aspect of the ADA Act regime. The HFA notes that the ADA Act contains no requirement for a proper assessment to be made by a specialist alcohol and other drug clinician, or even a medical practitioner with experience in diagnosing and managing alcohol and other drug disorders; nor does the Act require independent clinical input as to the suitability of a potential patient’s placement at a given ADA Act treatment facility.\textsuperscript{33}

\textsuperscript{29} See supra, Chapter 4, note 48.
\textsuperscript{30} Examples are cited supra, Chapter 4, notes 10 and 11 and accompanying text.
\textsuperscript{31} See supra, Chapter 4, note 38.
\textsuperscript{32} The right of ADA Act patients to refuse to participant in ‘treatment’ such as group counselling, psychotherapy, and so forth, is dealt with more extensively infra, Chapter 8, section 8.1.2.
\textsuperscript{33} As a former District Court Judge who was heavily involved in ADA Act committals has recalled, “Judges have no way of knowing about the suitability of a particular treatment facility other than what they are told [and] unfortunately what a Judge is told about a facility is not always correct”. T R Gilles, Submission to the 1996 ADA Act review, 20 April 1999, p 5.
These gaps are seen as major weaknesses. According to Dr Murray Patton, the Clinical Adviser for the HFA's Mental Health Operating Group:34

The Court should be basing its decision upon advice provided to it, following careful assessment of the person's needs, and of the potential services that can meet the needs of the person. People involved in the field should provide this advice. The Court can then be regarded as providing support to a clinical decision and authority for a clinical process, rather than determining itself the clinical process.

The need for such comprehensive assessments and expert clinical input are likely to be even more pronounced when people who may be considered for compulsory treatment under the ADA Act are transient in their attachments to particular services or localities.

As things stand, there is no requirement that the two doctors who certify that a person is an "alcoholic" under the Act actually examined the person; indeed, the Act fully anticipates that a medical certificate might be based on hearsay knowledge, and there is statute and case-law authority for the proposition that Judges are entitled to rely upon such certificates, without "lifting the clinical veil" to satisfy themselves that the certificates are well-founded.35 Moreover, it is unusual for the doctors who have signed the certificates to attend the committal hearing in person, meaning that they are not available for direct or cross-examination by the alleged alcoholic, his or her legal counsel (in the unlikely event that the alleged alcoholic will be legally represented), or the Court itself.36 Yet few Judges seem prepared to challenge the assessments contained in such certificates, even though they may have only been based on hearsay, or a fairly perfunctory interview with the alleged alcoholic.37

To this extent, the informational base for the Court's clinical decision-making in ADA Act hearings contrasts sharply with the information before the Court to make decisions under the analogous provisions of the MH (CAT) Act. Form H.156 - the form used to provide medical certificates in applications under section 9 of the ADA Act - requires that the certifying physician sets out reasons in full for the belief that the person is an alcoholic within the meaning of the Act.38 Unlike Forms H.20 and H.23 which are used to furnish equivalent medical certificates under the MH (CAT) Act, there is no requirement in Form H.156 for the certifying physician to state that he or she has personally examined the alleged alcoholic; the facts observed on which the medical opinions are based; facts observed on other occasions; facts communicated by others; or the nature of any treatment that has already been used with the alleged alcoholic.

There is such a poverty of good clinical information before the Courts in most hearings under section 9 of the ADA Act that there must be real concerns over the ability of District Court Judges to exercise well-informed clinical judgements whether or not to commit a person for compulsory treatment. This view is shared by legal researcher John Dawson, who has written on behalf of the Mental Health Foundation that:39

34 M D Patton, Submission by Health Funding Authority to the 1999 ADA Act review, 28 April 1999, p 8.
35 Supra, Chapter 3, notes 68 and 69 and accompanying text.
36 Supra, Chapter 4, notes 6 and 7 and accompanying text.
37 Supra, Chapter 4, note 8.
38 A copy of Form H.156 is attached infra, Appendix 4.
We have grave doubts as to the effectiveness of this certification process. If no family general practitioner is available the examining doctors may have no prior knowledge of the person they examine and it may be impossible for a realistic assessment to be made. The doctor has, perhaps, an hour in which to examine the person. There is no opportunity to adequately observe the person's behaviour and the doctor is obliged to believe the person's statements as to their drinking in the absence of other evidence. One Auckland police surgeon who has signed certificates for a number of years described the process as follows: following the issue of a warrant, the person concerned is picked up by the Police at around six in the morning. By the time he makes the examination it may be two or three in the afternoon, by which time the person will be relatively sober, making assessment very difficult or impossible. A certain amount can be detected with blood and liver enzyme tests, the results of which can be obtained in an hour. This places the examination on a 'vaguely scientific' basis.

At stake here is the fundamental issue of whether it can be right that a person is deprived of their liberty for up to two years based on a 'vaguely scientific' assessment that they have an alcohol problem. Judges appear to attach significant weight to ADA Act medical certificates, even when they have not been based on a comprehensive assessment made by specialist clinicians, or doctors who have experience in diagnosing and managing alcohol and other drug disorders. Others have been particularly critical of this aspect of the ADA Act regime. To borrow Professor Winick's metaphor once again, if Judges are to take an active role in the treatment process, rather than just "calling balls and strikes", it would seem to be incumbent upon them to know as much as they can about the players.

7.2.2 Denial of patient choice

A second procedural concern about the ADA Act is that it serves to deny patient choice in the help-seeking and treatment process. This can be seen as a particular problem vis-à-vis involuntary applications under section 9 of the legislation.

As mentioned earlier, patient choice in the alcoholism treatment process can be clinically and therapeutically useful in its own right, and interventions which deny patients' choice can actually impede the change process. Although a Court forcing an alcoholic to enter treatment is one way of making the person recognise problems associated with his or her drinking, the external prompt for this recognition could mean that the alcoholic defines the problem as one that other people have with his or her drinking, instead of one that the drinker 'owns' internally. The research literature was seen to suggest that internally-generated recognition of problems associated with drinking is more likely to prompt an alcoholic to reevaluate the costs/benefits of continued heavy alcohol use. The stages of change model also predicted that prematurely forcing pre-contemplators and contemplators into an intensive residential programme would be largely a waste of time, and may in fact build resistance to change which is ultimately unhelpful in facilitating the alcoholic's progression through the action and maintenance stages. There was seen to be solid support for these predictions in the Project MATCH studies, as well as evaluations of smaller-scale pairing of interventions to people with alcohol problems who were at different stages of change.

41 Supra, Chapter 2, section 2.3.3.
43 See the studies cited supra, Chapter 1, note 27; and supra, Chapter 2, note 61, respectively.
The research literature was also seen to suggest that already-motivated alcoholics should be allowed to choose the type of treatment programme that they enter. Numerous studies were shown to have found that commitment to therapy and ultimately successfully outcomes are encouraged if patients are provided with options, and are empowered to make decisions about their treatment – for example, whether to pursue an ultimate goal of abstinence, or whether to aim to better control their drinking. Yet, it was noted that over 90 percent of all ADA Act patients are committed for treatment to either Nova Lodge or one of the Salvation Army Bridge Programmes, which run variations of disease model 12-step programmes that have abstinence as their overall treatment goal.

Problems relating to the denial of patient choice in the ADA Act regime are further illuminated through the lens of therapeutic jurisprudence. As foreshadowed in earlier discussion, a therapeutic jurisprudence reading of the ADA Act anticipates that several clinically-important psychological processes will not be engaged where a person is involuntarily committed for residential treatment under section 9 of the statute. As Professor Wexler explains:

> [When one signs a behavioral contract, one is more likely to comply than if one does not make such an agreement. Also, one who makes a ‘public’ commitment to comply – a commitment to persons above and beyond the medical provider – is more likely to comply than one who does not make such a commitment. Further, if family members are involved and aware of a patient’s agreement, the patient is more likely to comply with the conditions than if family members are uninvolved in the process.

In the involuntary context of section 9 hearings, the power imbalance between the subject of the application and the applicant, medical practitioners and Judge means that there is no ‘bargaining’ towards a behavioural contract. Neither will there be any public commitment to comply with the compulsory detention and treatment order; rather, there is likely to be open resistance to any order. And the oppositional nature of the application process, where the subject of the application and the applicant are on different sides, will typically mean that a wedge is driven between the family members who are involved in the process; not bringing them together in a therapeutic alliance. In this sense, patients who are conscripted into treatment under section 9 of the ADA Act are likely to derive none of the therapeutic benefits of behavioural contracting, public commitment or the involvement of significant others - thus undermining the stated intention of the Act to make better provision for the care and treatment of alcoholics.

Putting to one side for the moment the ethical concerns that are raised by forcing a person to receive treatment, there would seem to ways in which involuntary patients could still derive some of the therapeutic benefits of behavioural contracting, public commitment and the involvement of significant others – even where their ‘choices’ are made in a forced context. In particular, these psychological processes would seem to apply more comfortably if the section 9 procedure allowed for the Court to exercise discretion over whether the treatment is provided in an out-patient or in-patient setting, and if subjects of ADA Act applications are given the opportunity to make submissions on their preference to receive treatment services as either a residential or a day programme patient.

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44 Supra, Chapter 2, note 63.
45 Supra, Chapter 4, section 4.3.1.
46 Supra, Chapter 2, section 2.5.6.
48 These are discussed infra, Chapter 8, section 8.2.
If ADA Act applications under section 9 were split into two phases in this way — a hearing first on whether an involuntary treatment order should be made, and a subsequent ‘sentencing’ phase where the soon-to-be-patient can make representations on what form that treatment should take — it is much more likely that the therapeutic benefits of behavioural contracting, public commitment, and the involvement of significant others could be invoked. Once it becomes clear to an alcoholic that a compulsory treatment order is going to be made, it seems easier to imagine that he or she will want to express a preference for either in-patient or out-patient care, will be incentivised to agree to a treatment plan that is consistent with that mode of care (behavioural contracting), will call upon any family members present at the hearing to support that choice (involvement of significant others), and will want to try and convince the Court of his or her ability to succeed in such a setting (public commitment). Such a two-stage committal hearing for section 9 cases, if adopted, would also seem to fit better with recent insights offered by behavioural scientists, who emphasise the importance of ensuring that patients have a “voice” in legal and administrative proceedings.

In summary, the research literature suggests that the psychology of choice is important, even ‘choices’ that are made in coerced contexts. As the legal process is currently configured, the ADA Act is characterised by implicit and explicit denial of patient involvement in decision-making; a feature that is predicted to lead to anti-therapeutic effects and poorer clinical outcomes. By contrast, if the subjects of ADA Act applications are given more voice and validation during the committal phase, there is reason to believe that they may not experience the use of compulsion as necessarily coercive, and that their overall experiences of treatment may be more productive.

7.2.3 Is treatment under the ADA Act effective?

These observations beg the question of whether treatment for alcohol use disorders under the ADA Act is effective. Before attempting to answer this substantive question, a caveat given earlier in this thesis must be reiterated. The paucity of empirical data on treatment under the ADA Act, combined with the almost total lack of any former or current patients’ perspectives on the Act, inevitably mean that it is difficult to make any reliable generalisations about the therapeutic value of the legislation. Certainly, there is some evidence which suggests that over 90 percent of people committed under the Act have already had multiple unsuccessful treatment episodes, and anecdotal reports that it is not uncommon for people to be committed under the Act three or more times over a ten year period. This reinforces the impression that the ADA Act is sometimes used to provide little more than respite care for chronically-damaged ‘revolving door’ alcoholics. Equally, though, clinicians who have worked at ADA Act institutions report that committal under the Act has in some cases been a life-saving intervention.

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49 See, further, the studies cited supra, Chapter 2, note 113. For a useful exploration of the clinical value of the involvement of significant others, see M D Stanton, The Role of Family and Significant Others in the Engagement and Retention of Drug-Dependent Individuals, in L S Onken et al. (eds.), Beyond the Therapeutic Alliance: Keeping the drug-dependent individual in treatment, pp 157-180. NIDA Research Monograph No 165 (Rockville: US Department of Health and Human Services / National Institutes of Health, 1997).
50 Supra, Chapter 2, note 114.
51 This point that referral source does not exhibit any precise correspondence with client perceptions of coercion is made strongly by T C Wild et al., Perceived coercion among clients entering substance abuse treatment: Structural and psychological determinants (1998) Addictive Behaviors, vol 23(1): 81-95.
52 Supra, Chapter 4, section 4.4.
53 Supra, Chapter 4, notes 21 and 22, and accompanying text.
54 Supra, Chapter 4, notes 65 and 66, and accompanying text.
In fact, there is only one extant study on the effectiveness of treatment at an ADA Act institution.\textsuperscript{55} However, because it was conducted in the 1970s at a hospital-based institution which has since been de-certified under the Act, the study offers few clues about the clinical efficacy of the ADA Act in the twenty-first century. For the record, though, using a one year sample of patients who were followed up 12 months after discharge, the study found that 42 per cent of patients had been re-hospitalised for alcoholism, while only 11 per cent had adopted an abstinent life-style. The study’s author – who was the clinical psychologist at the institution – concluded: "The present practice of encouraging residential treatment cannot be justified .... [and] we can no longer afford, in human or financial terms, to continue to finance costly treatments for alcoholism".\textsuperscript{56} In a finding that resonates with both the philosophy of harm minimisation and the therapeutic jurisprudence school of thought, she went on to observe that: "Abstinence should not be the only specified treatment goal. Patients consistently fail to achieve it. Staff need encouragement to conceptualise treatment as attempts to approach a number of individually formulated goals and to evaluate treatment efforts on these lines".\textsuperscript{57}

In the absence of well-controlled contemporary outcome evaluation studies on the ADA Act, reliance must be placed on studies of analogous in-patient alcohol treatment programmes, especially those in which legal coercion is a feature.

7.2.4 In-patient versus out-patient treatment

There are many factors that could be expected to have an influence on whether coerced treatment under the ADA Act is clinically useful. For example, such factors could include idiosyncratic patient variables; whether the application for committal was ‘voluntary’ (section 8) or involuntary (section 9); the type and quality of the treatment provided; the length of stay in treatment; the patient’s social situation at discharge; and whether after-care services were mandated.

One of the inherent features of ADA Act treatment – the in-patient setting – may also influence the Act’s effectiveness. In this respect, the question of whether residential treatment (such as that offered under the ADA Act) is superior or inferior to non-residential treatment (such as day programmes offered by community-based alcohol and drug services) is vigorously contested.\textsuperscript{58}

On the one hand, several studies have found that more in-patients than out-patients are successful in completing detoxification,\textsuperscript{59} and more in-patients successfully complete treatment than those who attend hospital day clinics.\textsuperscript{60} These studies tend to suggest that the amount and intensity of treatment may be important influences on whether the treatment ‘works’, although other variables such as the availability of follow-up care will also be important. To this extent, the treatment setting (whether it is a residential programme, or whether patients are free to come and go) may impact on the amount of treatment that a person with an alcohol problem receives, as well as its perceived intensity.

\textsuperscript{56} Ibid, p 236.
\textsuperscript{59} For example, M Hayashida et al., Comparative effectiveness and costs of inpatient and outpatient detoxification of patients with mild-to-moderate alcohol withdraw syndrome (1989) New England Journal of Medicine, vol 320: 358-365.
\textsuperscript{60} A recent example is J MackKay et al., Effect of random versus non-random assignment in a comparison of inpatient and day hospital rehabilitation for male alcoholics (1995) Journal of Consulting and Clinical Psychology, vol 63: 70-78.
In this sense, treatment setting can be seen as mediating the experience and, in turn, the final outcome of treatment.\(^{51}\)

On the other hand, various commentators point out that individual variables can be just as important. For instance, a recent review of 14 studies comparing the outcome of in-patient and out-patient treatment for alcohol use disorders found that five favoured in-patient treatment, another two favoured intense out-patient (day hospital) treatment, while the remaining seven studies found either no significant difference between the modalities or favoured non-intensive out-patient treatment.\(^{62}\) The review's authors concluded that treatment setting may have some effect on outcome, but that the critical factors were related to the patients themselves.\(^{63}\) Three main sets of patient variables were seen to be significant:\(^{64}\)

Most important, whereas patients with only substance use disorders may be treated as effectively in community residential and outpatient as in inpatient settings, patients with psychiatric disorders may do better with initial inpatient treatment. Similarly, compared with more socially stable patients, an initial episode of inpatient treatment may be more effective for patients who have fewer resources, such as residentially unstable and homeless patients, and patients who have more severe problems in areas other than substance use. Finally, compared with patients who have relatively benign life contexts, a respite of inpatient treatment may be especially helpful for patients whose family members and friends drink heavily and whose community contexts promote heavy drinking.

On balance, therefore, it seems that patients with higher inherent support needs or other complicating life factors, such as psychiatric co-morbidity, homelessness or coming from a high-risk social environment, may benefit more from an initial period of stabilization in a residential treatment setting. However, for patients whose alcohol use disorders are not complicated by such issues, there is a weaker foundation for in-patient care. For such patients, there is persuasive evidence that out-patient treatment is as effective as residential treatment for alcohol use disorders.\(^{65}\)

Regrettably, there is little New Zealand research on the effectiveness of in-patient versus out-patient treatment. One of the few rigorously-designed studies to be published came from doctoral work by Philippa Howden-Chapman in the early 1990s.\(^{66}\) In order to evaluate the efficacy of a range of New Zealand alcoholism treatment programmes available at that time, she randomly assigned 113 male and female alcoholics after in-patient detoxification to one of three modalities that provided decreasing levels of treatment intensity: a six week in-patient programme, a six week out-patient programme, and a single confrontational interview where patients were referred to non-hospital services. Howden-Chapman found that on measures of abstinence, or consistent reduction in drinking and improvement in psychosocial functioning, there were no significant differences in outcome between the three modalities.


\(^{62}\) J Finney et al., The effectiveness of inpatient and outpatient treatment for alcohol abuse: The need to focus on mediators and moderators of setting effects (1996) *Addiction*, vol 91: 1773-1796.

\(^{63}\) Refer, also, to the typology proposed by Jim Orford, who identifies six factors that may account for variation in treatment outcome: individual cognitive factors; treatment delivery factors; non-specific treatment ingredients; therapist and treatment alliance factors; severity of other psychological problems; and social support for non-problem drinking. J Orford, What works in the treatment of alcohol problems: Making sense of recent research findings, in Alcohol and Drug Foundation of Queensland, *Proceedings of the 1997 Winter School in the Sun*, published on the internet at: http://www.adfq.org/orford2.html [accessed on 19/05/00].


Furthermore, when followed-up at 18 months after their initial treatment, those who stayed in treatment did not show significantly more long-term improvement than those who either refused treatment or dropped out of treatment early. These results were not found to be affected by the provision of aftercare to patients after they had been discharged.67

Of course, it is also important to remember that what benefits and life-changes may be made possible in a sheltered treatment setting will not always be durable in the harsher environment to which a patient returns after their treatment. Several studies have demonstrated that factors such as a lack of vocational skills or training are "prognostically unfavourable" for the on-going sobriety of patients who have been compulsorily treated for alcohol use disorders.68 Unfortunately, treatment programmes which focus narrowly on teaching patients mastery over alcohol, but fail to address wider issues in their lives (such as feelings of low self-esteem from being unemployed), seem unlikely to guarantee lasting abstinence – if indeed this is viewed as the long-term objective of the patient entering into treatment.

7.2.5 12-step residential treatment

Narrowing in on the type of in-patient treatment which is offered to over 90 percent of all ADA Act patients - variations of traditional 12-step programmes run by the Salvation Army Bridge Programmes and the Nova Lodge69 - a large number of authoritative international studies now cast doubt on the therapeutic value of such treatment.

In a comprehensive review of the effectiveness of treatment programmes, New Mexico psychologists Reid Hester and William Miller concluded that, even for people with severe drinking problems, behavioural treatments (such as brief interventions, contracts governing drinkers' conduct, and coping-skills training) worked significantly better than approaches typically used in 12-step modules (group psychotherapy, educational lectures, confrontational counselling, and referral to AA) [see Table 1]. The researchers found that the gap between those treatments shown to be effective (behavioural) and those that are more widely used (12-step) "could hardly be larger if one intentionally constructed treatment programs from those approaches with the least evidence of efficacy", and were particularly critical of 12-step aftercare plans that were premised on attendance at AA, which they found "wholly lacks experimental support for its efficacy".70 A recent meta-analysis of 21 controlled outcome studies found that attending conventional AA meetings was worse than no treatment or alternative treatment, and in fact "coercion [to attend such AA meetings] apparently yields significantly worse results than treatment alternatives".71

69 See supra, Chapter 2, section 2.3.1; and supra, Chapter 4, section 4.3.1.
71 In Table 1 (overleaf), the higher or lower the score, the higher or lower the indicated degree of effectiveness.
Table 1: Most and least effective approaches to the treatment of alcoholism

<table>
<thead>
<tr>
<th>Highest rated</th>
<th>Lowest rated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief interventions</td>
<td>+239 Relaxation training -109</td>
</tr>
<tr>
<td>Social skills training</td>
<td>+128 Confrontational counselling -125</td>
</tr>
<tr>
<td>Motivational enhancement</td>
<td>+87 Psychotherapy -127</td>
</tr>
<tr>
<td>Community reinforcement</td>
<td>+80 General alcohol counselling -214</td>
</tr>
<tr>
<td>Behavioural contracting</td>
<td>+73 Alcoholism education programmes -239</td>
</tr>
</tbody>
</table>


Hester and Miller’s meta-analysis, together with the more recent results of the Project MATCH studies, indicates that treatment for alcohol use disorders need not be complex or expensive in order to yield positive outcomes for patients. The evaluation literature on alcohol treatment suggests that brief interventions aimed at changing alcohol-related cognitions and behaviour (such as motivational enhancement therapy) are more effective in most circumstances than longer and more intensive treatment. Positive results from brief interventions in primary care settings have also been shown in a large, multi-country World Health Organization study. Indeed, according to a 1993 review of brief interventions for alcohol problems, such approaches “are usually significantly more effective than no intervention ... show similar impact to that of more extensive interventions ... [and] can enhance the effectiveness of subsequent treatment”. Pharmacological interventions like Naltrexone and Acamprosate are also showing considerable promise.

Studies such as these raise serious concerns about the relative effectiveness of the 12-step residential milieu treatment which is provided in New Zealand’s main ADA Act institutions. Although they will doubtless provide some short-term harm minimisation gains (simply by removing drinkers from the physical opportunity to drink alcohol in harmful ways), forcing alcoholics into 12-step treatment programmes based around the outdated disease model of addiction would appear to be one of the least effective ways of helping alcoholics deal long-term with their problematic use of alcohol.

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72 See supra, Chapter 1, note 22.
73 N Heather, Interpreting the evidence on brief interventions for excessive drinkers: The need for caution (1995) Alcohol and Alcoholism, vol 3: 287-296; D C Drummond, Alcohol interventions: Do the best things come in small packages? (1997) Addiction, vol 92: 639-645. Typically, though, these studies involve early stage, minimally-dependent drinkers who were identified through screening programmes - rather than in ambulatory, public order or criminal justice contexts - and thus usually exclude more complex, problematic patients. It is not clear to what extent these positive results can be extrapolated to the wider potential treatment population.
These misgivings about the treatment approach used in the main ADA Act institutions echoes the concerns that were evident in relation to Sweden's main compulsory treatment facilities. As described earlier, in many cases where LVM institutions offer 12-step programmes, they are criticised for ultimately providing patients with little more than secure accommodation. While LVM institutions were seen to be fairly successful at achieving the short-term goals of involuntary commitment (stabilising the person and preventing life-threatening substance abuse), they were rather less successful at achieving the long-term goal of compulsory treatment ("to motivate the abuser, so that he ... co-operate[s] in continuous treatment on a voluntary basis ... to overcome his abuse" [LVM § 3]).

7.2.6 Does compulsion have therapeutic value?

The Swedish experience is also instructive when drawing conclusions about the overall value of using compulsion in a therapeutic setting. Even though the research base on the LVM is the best source of evidence we have on the efficacy of forced treatment, it is impossible to draw any firm conclusions from it. The most that can be said with any confidence is that, ceteris paribus, people who are compelled into treatment do not seem to do any better or worse than those who enter into treatment voluntarily.

Elsewhere, one of the most methodologically-sound studies of the impact of legal coercion on treatment outcome was designed by Gallant and colleagues. In their study, 84 'revolving-door' alcoholics were randomly assigned to one of four treatment options: compulsory group therapy for six months; compulsory group therapy and Antabuse; compulsory Antabuse; and voluntary treatments. Only seven patients (8.3 percent) were successfully retained in treatment and achieved improvements in their drinking behaviour. No differences were apparent between the groups.

The finding that there are no significant differences in treatment outcomes between coerced and 'voluntary' patients is widely reported within the evaluation literature, and has been taken to indicate that there is no clear-cut relationship between the compulsory nature of treatment and eventual treatment outcome. Others go on to make the argument that because treatment can never work unless people receive it, and coerced patients do not seem to do any worse than 'voluntary' patients, forcing alcoholics into treatment at least gives them a chance to overcome their alcoholism.

77 Supra, Chapter 6, section 8.5, especially notes 49 and 50 and accompanying text.
78 Supra, Chapter 6, section 6.4.
82 For example, L S Onken, Treatment for Drug Addiction: It won't work if they don't receive it, in L S Onken et al. (eds.), Beyond the Therapeutic Alliance: Keeping the drug-dependent individual in treatment (op. cit.), pp 1-3.
The argument that forcing alcoholics into treatment at least gives them a chance is strengthened by the empirical finding that the existence of a Court order is usually associated with lower rates of drop-out from treatment. However, this finding has doubtful relevance to the New Zealand environment, because ADA Act patients committed involuntarily under section 9 of the Act seem to be discharged earlier than those who initiated their own committal under section 8 of the legislation. Given that this higher attrition rate will be the result, at least to some extent, of patients’ lack of motivation to engage in treatment, this feature of the ADA Act may add support to those who argue that motivation to participate in treatment is an important predictor of overall treatment outcome. Indeed, the stages of change model would seem to suggest a reason for such rates of premature attrition and eventual treatment failure.

Moreover, as discussed earlier, researchers have demonstrated that front-line treatment workers may bring ideological brakes to the effectiveness of compulsory treatment; and that those workers who are sympathetic to the use of coercion may be antithetical to the use of broader harm minimisation strategies, such as teaching controlled drinking skills to alcoholics. This is despite the fact that several well-controlled studies have found that abstinence from alcohol is not a pre-requisite for an alcoholic to achieve an overall improvement in life situation.

When viewed in this light, forcing alcoholics into abstinence-oriented treatment at 12-step ADA Act institutions may end up doing little to help facilitate the lasting improvement of such alcoholics’ health and social functioning. Put another way, forcing alcoholics into treatment may not only fail to succeed in helping them achieve sobriety, but may actually build resistance to treatment and retard their chances of learning to self-manage their drinking. In therapeutic jurisprudence language, the harm minimisation gains of ambulatory care may be cancelled-out by negative psychological effects for alcoholics who are ordered into treatment against their will. In particular, alcoholics may experience feelings of self-blame, guilt and lowered self-esteem if they (again) fail to become abstinent, which in turn may lead to or exacerbate depressive disorders that feed a generalized sense of apathy and resignation about their ability to control their drinking. In either case, the collective effect for some alcoholics who are forced into treatment may be what has been coined ‘law-related psychological dysfunction’.

In clinical terms, therefore, compelling an alcoholic into residential treatment could well do more harm than good, even (and in some ways, especially) considering the nature of the people who are being captured by the ADA Act.

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64 See Supra, Chapter 4, section 4.3.2.
65 See Supra, Chapter 1, note 23, and the various studies cited therein.
66 Supra, Chapter 2, section 2.3.2; and, further, see J O Prochaska et al., In search of how people change: Applications to addictive behaviors (1992) American Psychologist, vol 47: 1102-1114; and C C DiClemente and C W Scott, Stages of Change: Interactions with Treatment Compliance and Involvement, in L S Onken et al. (eds.), Beyond the Therapeutic Alliance: Keeping the Drug-Dependent Individual in Treatment (op. cit.), pp 131-156.
67 Supra, Chapter 2, section 2.5.3.
68 For example, F Duckert, What kind of changes can be expected in drinking patterns after treatment? (2000) Nordic Alcohol and Drug Studies, vol 17: 68-77; especially at 76.
69 This perverse result may be even more likely for patients who get care at hospital-based ADA Act services, which are less-well-equipped to engage in the behavioural treatment approaches which have been shown to be the most effective. See, for example, F O’Loughlin and M Webb, Controlled assessment of alcoholics admitted involuntarily to a general psychiatric hospital (1996) Irish Journal of Psychological Medicine, vol 13(4): 140-143, esp at 143 ["short-term certification is not an effective means of treating alcohol dependence"].
70 See Supra, Chapter 2, notes 115-118 and accompanying text.
The Manager of the Auckland Regional Alcohol and Drug Services Detoxification Unit describes this as a paradox:  

"The most dependent, damaged and socially disadvantaged individuals are those by any severity criteria which are most likely to be committed for compulsory treatment. However, we now know that these individuals are generally the least likely to respond to treatment. Lifelong habitual drinking, the dynamics of dependency, more severe cognitive damage and extensive co-existing health problems, combine to make for a very limited prospect for change. On the other hand, those that are equally dependent, but much earlier in the process of addiction with limited cognitive impairment, and moderate co-existing health problems, are far more likely to respond well to treatment. However, these people ... are not likely to be considered for compulsory treatment. This may well result in certified agencies becoming overwhelmed with people who are highly resistant to treatment."

7.2.7 The cost-effectiveness of ADA Act treatment

Before ending this discussion of some of the practical and clinical issues raised by the ADA Act, it is important to consider the economic implications of the conclusion that 12-step treatment of alcoholism in residential facilities may be of questionable clinical value.

In a recent World Bank and World Health Organization project on the global burden of disease, it was argued that, because no country can afford to fund health and disability support services for all its citizens, such services should be rationed according to the relative burden of each condition and the cost-effectiveness of treating it. Looking at alcohol-related harm, the project’s expert panel found that alcohol is the leading cause of male disability and tenth largest cause of female disability in countries with established market economies, like New Zealand. Clearly, alcohol misuse contributes significantly to the overall burden of disease, with high costs being incurred from non-intervention, thus tipping the scales in favour of funding interventions such as alcohol treatment services. However, an awareness of the high cost-profile of a condition like alcoholism is not a sufficient basis upon which to make rational decisions about the allocative efficiency of a particular intervention, such as residential treatment for alcoholism. Rather, it is well-established that an intervention should only be considered appropriate if its expected benefits exceeds the sum of its expected costs/risks. As health economist Ronald Kessler explains:

Need is not the issue here, but rationality in calculating the costs of intervention relative to the costs of nonintervention. If we want to help rationalize social policy decisions about the allocation of scarce intervention resources ... we need to obtain data that can be used to make these calculations of cost ratios. A critical problem here is that we lack even the most basic understanding of the costs .... [n]or do we have a thorough understanding of the extent to which clinical or preventive interventions are capable of addressing the costs. As a result, the magnitude of the cost-benefit ratio of intervening versus not intervening is unclear.

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92 C Hayes, Submission by Auckland Alcohol and Drug Treatment Services Detoxification Unit to the 1999 ADA Act review, 23 April 1999, p 6.
It is much easier to make an exact calculation of the direct treatment costs of intervention than the often hidden indirect costs of nonintervention. When the former are low, it is sometimes not necessary to have a complete understanding of the latter. For example, the decisions to add fluoride to the drinking water or iodine to table salt were not based on detailed analyses of the societal costs of tooth decay or cretinism, but rather on a general appreciation of the low costs of these interventions in relation to their presumed positive effects on public health. The situation becomes more complex, though, when the costs of intervention are substantial, in which case social policy decisions require clear reckoning of costs versus benefits.

Using Kessler's example, how are we to judge the state's decision to mandate the treatment of alcoholics in residential facilities under the ADA Act? At a simplistic level, the costs of not intervening for the Act's target population of alcoholics could be viewed as relatively high, given that almost one-in-every-five New Zealanders will fit clinical criteria for alcohol abuse or dependence at some stage in their lives (most of whom can safely be assumed to theoretically come within the ADA Act's definitional net by causing "serious annoyance to others"), and the social costs of alcohol misuse in New Zealand are estimated at between $1.5 to $2.4 billion each year (a proportion of which will be attributable to those who, again theoretically, come within the ambit of the ADA Act).

Yet, if we reject 'one size fits all' thinking, and if we accept that some patients get treated inappropriately, then we simply do not know the proportion of people who may fit clinical criteria for alcohol use disorders who are likely to benefit from treatment in ADA Act institutions. Neither are we able to determine how many people who have already been forced into treatment might have been more appropriately treated using non-ADA Act services. In fact, all we are able to say with confidence is that the costs of intervening with the ADA Act are high compared with other alcohol treatment modalities — in particular, brief interventions and out-patient day programmes — and there is, at best, limited empirical evidence for the assumed benefits of such 12-step residential milieu treatment.

A careful cost-benefit analysis might very well conclude that, although alcohol use disorders can be a costly condition, the direct and indirect costs of forcing alcoholics into treatment at current ADA Act institutions outweigh the uncertain direct and indirect benefits of such treatment. Indeed, the analyst might go further and say that any effort to resuscitate the ADA Act would do more harm than good, as greater demand for placements under the

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98 N J Devlin et al., The social costs of alcohol abuse in New Zealand. Economics Discussion Paper. (Dunedin: Economics Department, University of Otago), p 16; and refer infra, Chapter 1, note 5, and accompanying text.
99 This can happen in at least two ways. First, patient can receive the wrong type of treatment. For example, one recent study found that nearly one-third of patients with depressive disorders were treated inappropriately using tranquillizers: see K B Wells et al., Use of minor tranquillizers and antidepressant medications by depressed outpatients: Results from the medical outcomes study (1994) American Journal of Psychiatry, vol 151: 694-700. Just as importantly, however, as referred to earlier [infra, Chapter 2, section 23.2.2], forcing someone to receive any type of treatment can, in some circumstances, end up doing more harm than good.
100 Some broad estimates are contained in Health Funding Authority, National Alcohol and Other Drug Services Funding Strategy: Discussion Document (Wellington: Health Funding Authority, 2000), esp pp 5-9. The unit cost of a 'typical' placement under the ADA Act versus other treatment approaches is subject to wide variation in official costings. Furthermore, those tentative costings from Vote:Health that have been developed do not take account of associated costs from Vote:Courts and Vote:Police, and thus under-estimate cost multiplier effects of using Police to arrest/escort ADA Act patients, the role of District Court staff in ADA Act hearings, and the costs of District Court Judges acting as Chairmen of Supervisory Committees for ADA Act institutions.
ADA Act may siphon off resources from community alcohol and other drug treatment services that are already under-funded.\textsuperscript{101} Mindful of the low threshold that must be satisfied before a committal order under the ADA Act can be justified, if the procedures under the Act were streamlined to encourage people to use it more often, then it would significantly expand the pool of candidates for compulsory treatment for alcohol problems, which could in turn skew the distribution of resources within the alcohol and other drug and mental health sectors. Any such 'net-widening' would be viewed as sub-optimal given the equivocal cost-benefit ratio of ADA Act treatment.\textsuperscript{102}

Instead of recommending additional spending on ADA Act treatment places, a fiscal analysis would be far more likely to favour greater investment in brief interventions or mutual-help approaches, which are better supported by evidence of net savings in social and health costs associated with heavy drinking, as well as yielding improved quality of life.\textsuperscript{103}

7.3 Summary

This chapter has outlined some of the practical and clinical problems with the Alcoholism and Drug Addiction Act.

First, at a purely practical level, there were seen to be several impediments to realising the ADA Act’s stated aim of making better provision for the care and treatment of alcoholics. Some of the most significant of these barriers were the low level of uptake of the ADA Act committal procedures, the lack of institutions certified to take ADA Act patients, and various cost pressures which frustrate out-of-region transfers and the recruitment of community representatives on Supervisory Committees. It was noted that, in many ways, such problems with Supervisory Committees are emblematic of the wider resourcing issues that, at a practical level, can hamper the Act’s day-to-day effectiveness.

One aspect of the work of Supervisory Committees was highlighted for separate comment. It was observed that the work commitments of the current Chairman of the Wellington- and Christchurch-based Committees are compromising the Supervisory Committee model, and leading to lengthy delays between Committee meetings (or in some cases, the ability to even hold face-to-face meetings). This situation was described as being suboptimal; although the most readily apparent solution – appointing a semi-retired Judge as Chairman, as done in Auckland – was seen to have a ‘double edged’ quality to it, as elder members of the judiciary are sometimes the most likely to be locked-in to older ways of conceiving of alcoholism as a disease.

Also under the heading of practical issues, it was noted committing people to ADA Act institutions can only invoke a legal fiction that they will be securely detained. Indeed, the ADA Act was seen to contain two ‘safety valves’ which mean that alcoholics who might be most in "need" of treatment may in fact be refused entry to an ADA Act

\textsuperscript{101} See Health Funding Authority, National Drug Policy work programme – Treatment services gap definition. Unpublished paper for the Ministerial Committee on Drug Policy (Hamilton: Health Funding Authority, 1999).

\textsuperscript{102} The potential for net-widening has been seen in other contexts, such as psychiatric admissions. For example, researchers found that after statutes were relaxed in Washington state, involuntary commitments for in-patient mental health treatment increased by 91 percent the year after the amending legislation was passed. See M Durham, Implications of need-for-treatment laws. A study of Washington state’s involuntary treatment Act (1985) Hospital and Community Psychiatry, vol 36: 975-977.

institution in the first place; or, if they are accepted into treatment, may quickly be breached off the Act and sent back to the community. While arguably necessary to ensure the smooth functioning of ADA Act facilities, such ‘safety valves’ inevitably erode the Act’s claim to making better provision for the care and treatment of alcoholics.

In addition to these practical issues, the chapter highlighted several clinical issues that can prevent the stated goal of the ADA Act being realised. These clinical issues were seen to go to the heart of whether the Act is defensible in instrumental terms. The Act was first criticised on the basis that it does not insist on comprehensive clinical assessments for people who are deprived of their liberty. It was submitted that there is such a poverty of good clinical information before the Courts in most ADA Act hearings that there must be real concerns over the ability of Judges to exercise well-founded clinical judgements whether or not to commit people for compulsory treatment.

The ADA Act regime was further criticised on procedural grounds for the way that it serves to deny patient choice, both in the hearing process and disallowing alcoholics to choose the type of treatment programme that they enter. This was argued to be a particular problem because of the therapeutic value of allowing patients to have a ‘voice’ in legal proceedings; and the fact that patient choice in the treatment process can be clinically and therapeutically useful in its own right, and that interventions which deny patients’ choice can actually impede the change process.

On the substantive question of whether treatment under the ADA Act is effective, while it was acknowledged that legal coercion does not appear to vitiate the potential efficacy of treatment per se, a large number of authoritative international studies were shown to cast doubt on the therapeutic value of the 12-step residential treatment which is offered to over 90 percent of ADA Act patients. It was noted that, although it will provide some short-term harm minimisation gains (simply by removing drinkers from the physical opportunity to drink alcohol in harmful ways), forcing alcoholics into 12-step treatment programmes would appear to be one of the least effective ways of helping such people deal with their drinking problems in the long-term. Moreover, it was argued that the harm minimisation gains of ambulatory care may be cancelled-out by negative psychological effects for alcoholics who are put into treatment against their will. In this sense, forced treatment could end up doing more harm than good.

Finally, the chapter pointed out that, in pure cost-benefit terms, the direct and indirect costs of forcing alcoholics into treatment at ADA Act facilities appear to outweigh the uncertain direct and indirect benefits of such treatment.
Legal and philosophical issues

The preceding chapter sought to judge the ADA Act in instrumental terms, to see whether it does, as it claims, make better provision for the care and treatment of alcoholics. In this chapter, attention turns to whether the Act works in value terms, to see whether the legislation itself, and the way it is being implemented, are consistent with New Zealand's prevailing legal and ethical norms. To this end, the discussion below will not directly canvass the debate about the constitutionality of forced alcoholism treatment that has been raised in the American literature, which in recent years has centred around whether Court-ordered referral to 12-step and AA programmes amounts to a breach of the First Amendment to the United States Constitution.\(^1\) Rather, the discussion will be organised around important statements of New Zealand's legal culture, such as the New Zealand Bill of Rights Act 1990 [the NZBORA].

8.1 Legal issues

When seen from an explicitly legal perspective, there appear to be numerous difficulties associated with the ADA Act. The most significant of these difficulties are discussed below.

8.1.1 Process problems

Starting at a proaeic level, some legal problems with the ADA Act derive from the slow pace of bureaucratic servicing for certified institutions. Departmental files on the Act are peppered with examples of plaintive and often repeated requests from certified institutions for administrative servicing from officials. There are many cases where serious delays were encountered in updating the physical addresses of particular certified institutions under the ADA Act, thereby imperilling the legality of committal orders made to those locations. In September 1988, for instance, the Social Services Secretary for the Salvation Army wrote to the Director-General of Health, noting that the property being used by its Auckland Bridge Programme had not been updated, despite many requests: "We would not like to be challenged in Court about the legality of holding a committed patient in an unregistered institution", he concluded.\(^2\) This was not an idle fear. In cases such as Police v Garrick,\(^3\) the prosecution of an ADA patient for escaping from custody foundered because the Salvation Army's new Wellington Bridge Programme site had not been certified by Order in Council at the time when the original committal order was made against the patient.

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2 M Taylor, Letter to Director-General of Health, 26 September 1988 [Held on file 169-13-39, National Archives, File series 71863, box 794]. Such delays were not uncommon. An earlier letter by Lt Colonel Taylor to the Director-General, dated 12 March 1986, seeking clarification of the legal status of various properties under the ADA Act, was not replied to until 30 September 1986. See B James, Letter to Salvation Army Social Services Secretary, 30 September 1986 [Held on file 131-158-2, National Archives, File series 71863, box 794].

3 Unreported, Wellington DC, 13 December 1985, CRN 6054012657, per Ross DCJ.
In the same vein, the lack of attention by officials to issues of legal process under the ADA Act mean that there is a very real possibly that some ADA Act Supervisory Committee members are acting *ultra vires*. According to departmental papers released under the Official Information Act, the last Ministry of Health audit of ADA Act Supervisory Committee membership was conducted on 1 July 1998. Given the three year statutory limit for appointments to Supervisory Committees under the ADA Act [section 7(3) of the Act refers], and the fact that a number of the members listed in the Ministry of Health audit were already part-way through their appointed terms, it seems inevitable that a number of current members of ADA Act Supervisory Committees through New Zealand are acting *ultra vires*. Unlike other legislation which has a savings clause to prevent such problems arising, the ADA Act does not provide for any ‘roll-over’ of membership on Supervisory Committees until such time as the member either resigns in writing, or is formally reappointed / replaced on the Committee by the Minister of Health.

Another area of legal process where the inattention of officials causes potential and actual problems is the failure of the Ministry of Health’s Director of Mental Health to maintain and/or monitor an up-to-date list of ADA Act patients. Section 33 of the ADA Act states that, when a committal order or revocation of leave order is made, “a minute under the hand of the District Court Judge or of the Registrar or Deputy Registrar of the District Court or of the High Court, as the case may require, shall be sent forthwith ... to the Director of the Division of Mental Health in the Department of Health”. Although occasional committal orders are received by the Director of Mental Health in compliance with section 33, these are typically orders made in the smaller Court Registries. The much larger Court Registries, which make the vast majority of ADA Act committal orders, such as the Family Court division of the Christchurch District Court, never forward copies of ADA Act orders through to the Ministry of Health. The Director of Mental Health’s failure to insist upon compliance with the procedural requirement of section 33 means that she is unable to gain any first-hand intelligence about how the legislation is being used, and is also unable to verify the committal figures which are generated by the New Zealand Health Information Service and the Department for Courts – even though their ‘official’ data on ADA Act committals has been seen to be unreliable.

It is submitted that this example, albeit small, is symptomatic of the more general neglect of the Act by officialdom, which leaves the working of the Act relatively opaque, and in turn, stifles well-informed debate about its operation.

There is also a lack of transparency about the criteria to be used to certify treatment facilities under the ADA Act. The only explanation in departmental files of the criteria which are used by officials to assess the suitability of an institution for certification under the Act states:

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5 An example is section 4(5) of the Alcohol Advisory Council Act 1976, which provides that “Every member of the Council, unless he sooner vacates his office, shall continue in office until his successor comes into office”.
6 N Tanner, Interview, 14 November 2000.
7 See supra, Chapter 4, note 27, and accompanying text.
8 Another example is the failure to make consequential amendments to the ADA Act to take account of the repeal of other legislation. Significantly, no modernising references are made to the MH (CAT) Act in the ADA Act, but rather references are left to the now-repealed Mental Health Act 1969. In some instances this is not problematic (eg. reference to section 23 of the 1969 Act in section 35 of the ADA Act), but elsewhere there may be certain legal difficulties which result from this inattention by officials and parliamentary draftspersons (eg. reference to section 124 of the 1969 Act in section 38 of the ADA Act).
9 The Minister of Health has equivalent roles in certifying other facilities for the treatment of dependency issues – notably under section 24 of the Misuse of Drugs Act 1975 (methadone clinics) and section 30A of the Transport Act 1962 (drink driver assessment centres). It is notable that none of these certification procedures are guided by criteria which are spelt out in the empowering legislation.
Before forwarding a recommendation to the Minister, the department would seek detailed background information from an institution, on the proposed number of beds, staffing levels and an outline of therapeutic or rehabilitative programmes. Comments on the appropriateness or otherwise of the proposed treatment programmes would also be sought from the local hospital board. The department would also seek information from the institution on the names and qualification of the superintendent of the institution and the medical practitioner attending the institution.

Nowhere are these criteria made explicit or transparent, however, and it must be doubted whether current Ministry officials are aware of the existence of this rough check list, which was developed by their predecessors in the 1980s. Thus, while some current agencies certified under the ADA Act, such as the Nova Lodge, have accreditation from the New Zealand Alcohol and Drug Accreditation Board, and other facilities may have achieved ISO 9002 accreditation, the driver to achieve such standards has typically been to win additional treatment places from public health funders, which insist upon the existence of proper audit procedures, and so forth.\textsuperscript{11} Nowhere are there any legislative requirements for, or therefore guarantees of, the clinical suitability of a treatment facility if it goes through the ADA Act certification process. This omission from the Act contrasts with the recent move to introduce greater transparency about the factors considered relevant to the exercise of such Ministerial decisions.\textsuperscript{12} It also underlines the poor informational base upon which Judges are effectively making clinical decisions. As a former Judge who was heavily involved in ADA Act cases has recalled, "Judges have no way of knowing about the suitability of a particular treatment facility other than what they are told [and] unfortunately what a Judge is told about a facility is not always correct".\textsuperscript{13}

8.1.2 Right to refuse treatment

A far more fundamental legal objection to the Act is its provision for detaining and treating alcoholics against their will. It is well established at common law that a competent adult has the right to refuse medical treatment,\textsuperscript{14} and provision of treatment without a patient’s consent will, all other things being equal, amount to a criminal battery.\textsuperscript{15} As Lord Donaldson MR observed in \textit{Re T (Adult: Refusal of Medical Treatment)}:\textsuperscript{16} "[I]t matters not whether the reasons for the refusal were rational or irrational, unknown or even non-existent. This is so notwithstanding the very strong public interest in preserving the life and health of all citizens".\textsuperscript{17} This right to refuse even life-saving treatment was given one of its most eloquent expressions by Cardozo J in \textit{Schloendorff v Society of New York Hospital}:\textsuperscript{18} "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body". New Zealand’s leading case on medical negligence echoes this reasoning,\textsuperscript{19} as does section 11 of the NZBORA, which provides that

\begin{itemize}
  \item \textsuperscript{11} B Dilger, Interview, 14 November 2000.
  \item \textsuperscript{12} Seen most recently in the specification of criteria that inform scheduling decisions for controlled drugs: refer to the Misuse of Drugs Amendment Act 2000, section 3 (which introduced a new section 3A to the principal Act).
  \item \textsuperscript{13} T R Gilles, Submission to the 1999 ADA Act review, 20 April 1999, p 5.
  \item \textsuperscript{14} \textit{Beatty v Cullingham} [1986] BMJ 1546; \textit{R v Johnston} (1903) 9 ALR 11, etc.
  \item \textsuperscript{15} \textit{Reibl v Hughes} [1980] 2 SCR 880, at 890-891; \textit{In re F (Mental Patient: Sterilisation)} [1990] 2 AC 1, at 71. See, generally, P D G Skegg, Medical Procedures and the Crime of Battery [1974] Criminal Law Review 699-711. In \textit{Mailett v Shulman} (1990) 67 DLR (4th) 321, a doctor who gave a blood transfusion to an unconscious Jehovah’s Witness who carried a card prohibiting such an action, was found guilty of battery and ordered to pay the patient C$20,000 in damages.
  \item \textsuperscript{16} (1992) 3 WLR 782, at 799. See, also, \textit{Re MB (Medical Treatment)} [1997] FLR 426.
  \item \textsuperscript{17} Even where the risks of refusing treatment are foreseen, it is not material that the decision to refuse treatment is irrational: \textit{Sidaway v Board of Governors of the BRHN Hospital} [1985] AC 871. An example is the American case of \textit{Lane v Candura} 376 NE 2d 1232 (1978), where the Massachusetts Court of Appeals found that a competent patient could refuse to submit to a leg amputation even where it was not the "rational" thing to do.
  \item \textsuperscript{18} 105 NE 92, at 93 (1914).
  \item \textsuperscript{19} \textit{Smith v Auckland Hospital Board} [1965] NZLR 191, at 219, per Gresson J ("An individual patient must ... also retain the right to decline operative investigation or treatment, however unreasonable or foolish this may appear in the eyes of his medical advisers"). See, generally, R Paterson, \textit{The Right of Patients to Refuse Treatment}, \textit{New Zealand Doctor}, 19 August 1991, p 33.
\end{itemize}
“Everyone has the right to refuse to undergo any medical treatment”.

The Code of Health and Disability Services Consumers’ Rights [Code], set out in a schedule to the Health and Disability Commissioner (Code of Health and Disability Services Consumers’ Rights) Regulations 1996, also has a bearing on the present discussion.\(^{20}\) The Code places particular emphasis on the need for patients to give informed consent, to the extent that his or her competence allows.\(^ {21}\) Most saliently, Right 7 of the Code provides as follows:

7. (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.

(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 the 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 ....

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

It cannot be assumed that, just because a person has an alcohol use disorder, he or she is incapable of giving informed consent to services, or that his or her right to refuse services [Right 7(7) of the Code refers] is automatically over-ridden. Right 7(2) of the Code contains a presumption of competence, and Right 7(3) states that, even where a consumer has diminished competence – for example, alcohol-related brain damage manifesting as Wernicke-Korsakoff Syndrome\(^ {22}\) - the consumer retains the right to make informed choices and to give informed consent to the extent appropriate to his or her level of competence.\(^ {23}\) Commenting on the potential application of the Code to ADA Act patients, the former Health and Disability Commissioner has ventured that:\(^ {24}\)

The rights in the Code must be read together to enable the most appropriate services to be provided. Subject to the limitations specified in the Code, providers must take all reasonable actions in the circumstances to meet those rights. Obviously, application of some of the rights may be curtailed to a degree where a consumer is subject to compulsory detention and treatment, for example the right to be free from coercion (Right 2) and the right to dignity and independence (Right 3). However, providers must still take steps to ensure these rights are observed as much as possible in the circumstances .... [Similarly,] an exception to a consumer’s right to give informed consent (Right 7) should only apply to those aspects of the consumer’s treatment specified in the detention order. The consumer would therefore retain the right to consent to treatment or care not so specified, to the extent appropriate to his or her level of competence.

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\(^{21}\) Note, however, Right 7(1) of the Code provides an exception where “any enactment” provides otherwise, and clause 5 of the Code also stipulates that “nothing in this Code requires a provider to act in breach of any duty or obligation imposed by any enactment or prevents a provider doing an act authorised by any enactment”.

\(^{22}\) For a useful overview of this condition, see A S Truswell, Australian experience with Wernicke-Korsakoff syndrome (2000) *Addiction*, vol 95(6): 829-832.

\(^{23}\) If the Health and Disability Commissioner finds there has been a breach of the Code, he or she may report his or her opinion that there has been a breach together with his recommendations, to the relevant provider, professional body or employer. The Commissioner may also refer the matter to the Director of Proceedings. The Director of Proceedings has an independent discretion as to whether or not legal proceedings should be issued against the party in breach. The Director of Proceedings can choose to pursue civil proceedings before the Complaints Review Tribunal. If the matter is proved, the Complaints Review Tribunal can grant a declaration to that effect, issue a restraining order or award damages.

Of course, like most rights, the right to refuse medical treatment is not an absolute right, and there are a number of exceptions to the general proposition that treatment without consent is likely to amount to criminal battery. The limited class of cases in which care can be provided without a patient's consent have been summarised as those where: a general rule of public policy justifies over-ruling a competent refusal of consent; the patient is clearly incompetent to make decisions about their own health and well-being; the care amounts merely to the provision of the vices and virtues of everyday life (unexceptional procedures, such as changing a dressing); or finally, a statutory exception mandates involuntary treatment. While this list is not exhaustive, it illustrates the narrow range of circumstances in which it is foreseen that a person's wish not to receive treatment can be 'trumped' by either a health or disability service provider.

From this quick overview of the law in this area, two questions arise in relation to committal orders under the ADA Act. First, does the type of psycho-social counselling that is commonly used in ADA Act institutions count as "treatment"? Second, if so, does the ADA Act provide one of the limited statutory exceptions that mandates involuntary treatment?

In relation to the first question, "treatment" is not defined in either the ADA Act or the MH (CAT) Act. Reviewing other health-related legislation, however, section 2 of the Accident Insurance Act 1988 states that: "Treatment" includes physical rehabilitation [and] cognitive rehabilitation", which captures both senses of the care which most ADA Act institutions provide. Section 2 of the Health and Disability Commissioner Act 1994 defines "health care institution" to include institutions certified under the ADA Act, and goes on to give a wide definition of "health care procedure" as: "any health treatment, health examination, health teaching, or health research administered to or carried out on or in respect of any person by any health care provider; and includes any provision of health services to any person by any health care provider". Similarly, section 2 of the Health and Disability Services Act 1993 defines "personal health services" as meaning "health services provided to an individual for the purpose of improving or protecting the health of that individual, whether or not they are also provided for another purpose". From these and other definitions in analogous legislation, and mindful of the overarching scheme of the Acts Interpretation Act 1999, it may be reasoned that counselling, 12-step programmes, and other common ADA Act interventions will qualify as "treatment".

Turning to the second question - whether the ADA Act provides a statutory exception to the ordinary right of a competent adult to refuse treatment - several cases are apposite. Some District Court Judges have accepted that the Act provides just such a legislative mandate to compel unwilling alcoholics to receive treatment. Thus, in S v S, Judge Paterson revoked the leave of an alcoholic under the Act and returned him to complete his term of treatment at the local Salvation Army Bridge Programme. In his reasons for decision, Paterson DCJ remarked that:

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26 For a useful discussion of the scope of the right to refuse treatment under New Zealand’s mental health law, refer to B Miles, *Consent to treatment under the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Unpublished LLB(Hons) dissertation (Auckland: University of Auckland, 1997); and see the leading case of Re S [1992] 1 NZLR 363.
27 *See, supra*, Chapter 4, section 4.3.1.
28 For example, section 56 of the Criminal Justice Act 1985 provides that: "the fact that an offender has consented to the imposition upon him or her of a sentence of a community programme shall not in itself be taken for the purposes of any other enactment or rule of law to mean that the offender has consented to any specific medical or other treatment or surgical procedure that may be considered desirable in the course of the programme that the offender is to undergo or is undergoing". For commentary on this provision, see the useful discussion in *R v Melchoir* (Unreported, HC Napier, S/18-93, 10 December 1993, per McGechan J).
[T]his Act is of a remedial nature and perhaps the attainment of its object should be paramount. That necessarily points to an interference with personal liberty to the extent that is necessary to achieve the object of the Act .... In terms of the intention of the Act as I read it as a whole, and for the well-being of the patient, I consider it an urgent matter that S be returned immediately to the institution from which he has been granted leave, with the intention that he shall be detained for the full extent of the detention period .... [T]his is not only a legal application under section 20 of the Alcoholism and Drug Addiction Act but it is a cry for help by the S family, Mrs S and her children and her husband, and it would be a tragedy if every endeavour was not made to get S back to a state of health with regard to alcoholism where the family could function happily as a unit again, despite the undoubted scars that will be left. I make the orders accordingly.

The Judge in this case ordered that the alcoholic, S, be returned to the Bridge Programme for further treatment, despite finding that S, a barrister, was "a very intelligent person", who was deeply opposed to further treatment - as evidenced by the fact that he had successfully filed a writ for habeas corpus and been released on bail between his detention for breaking conditions of his leave (three episodes of sherry drinking) and his hearing date. Clearly, this was not a disempowered 'skid row' alcoholic, but a self-aware and highly competent individual whose strongly-held opposition to (further) detention for treatment of alcoholism was nonetheless over-ruled by the Court.

Other District Court Judges have taken a different approach, as exemplified by the reasoning of Bremner DCJ in In re Mrs M.\textsuperscript{31} Exploring the application of the NZBORA to the ADA Act, and starting from the position that the ADA Act is "somewhat Draconian" in modern-day New Zealand,\textsuperscript{32} Judge Bremner commented obiter that the Act does not confer a power of preventive detention, but rather the only legal basis of detention is "for treatment of alcoholism" [sections 8(4) and 9(1) of the ADA Act refers]. It follows that, where an ADA Act patient is competent to refuse treatment and does so, the lawful object of the detention powers under the Act is frustrated, and to continue to detain the patient under the legislation would be to act ultra vires. Legal commentators Sylvia Bell and Warren Brookbanks offer the following gloss:\textsuperscript{33}

\begin{quote}
[T]he Act does not confer a direct statutory power on health officials to compulsorily treat people detained under it; the compulsion only applies to detention for the purposes of treatment, not to the treatment itself .... [T]he focus on treatment is determinative of the powers of detention. Continued detention of a patient when there is no further therapeutic justification would presumably constitute unlawful detention under the Bill of Rights.
\end{quote}

It is submitted that Judge Bremner's interpretation of the reach of the NZBORA represents a correct statement of the law as it relates to compulsory detention under the ADA Act. This interpretation does not rely upon the right to refuse medical treatment under section 11 of the NZBORA, given that the Bill of Rights Act is not supreme law [section 4 of the NZBORA refers], and there is High Court authority for the proposition that the provisions of the ADA Act are not an "unreasonable invasion of the rights and freedoms" set out in the Bill of Rights Act [section 5 of the NZBORA refers].\textsuperscript{34}

\textsuperscript{31} [1993] DCR 673.
\textsuperscript{32} Ibid, at 674.
\textsuperscript{33} S A Bell and W J Brookbanks, Mental Health Law in New Zealand (Wellington: Brooker's Ltd, 1998), p 252.
\textsuperscript{34} S v Tahana-Reese & Anor [2000] NZAR 481, at 485, per Hansen J.
Where a competent ADA Act patient refuses to submit to "treatment for alcoholism", it would seem entirely proper that he or she could challenge their on-going detention under section 23(1)(c) of the NZBORA and/or the common law right to seek habeas corpus. In practice, as was discussed earlier,35 such legal challenges do not arise, because ADA Act institutions typically discharge patients who refuse to participate in treatment. Nevertheless, the fact that the ADA Act does not confer a direct power to compulsorily treat people detained under it represents a fundamental flaw. It means that, in the face of opposition by patients, the Act's compulsory detention powers can be rendered nugatory, thus undermining the stated aim of the legislation ("to make better provision for the care and treatment of alcoholics...").

8.1.3 Lack of procedural protections

Another basis upon which the ADA Act regime may be critiqued is that it offers few procedural protections. This critique has several limbs. First, people who are subject to applications under the Act are only rarely represented by counsel. This is despite the fact that "[p]eople in this position are often isolated; lacking reliable personal support networks"36 - a point which has received judicial notice in several cases.37 Whatever the reasons for so few alleged alcoholics being represented by counsel, one of the consequences is that a proportion of these people (many of whom are already disempowered38) will fail to mount a proper 'defence', and may end up being deprived of their liberty where legally-represented people will not.

A comparison may be drawn here with the pool of lawyers specially trained in mental health law who are available to act as advocates for people who are facing compulsory treatment orders under the MH (CAT) Act. No equivalent pool of lawyers is available for people facing applications under the ADA Act. Similarly, there is no inspectorate system of patient reviews under the ADA Act, such as exists under the MH (CAT) Act. As one barrister has observed: "There are no checks and balances [in the ADA Act] that one would expect in an Act which can result in compulsory detention".39 This feature of the ADA Act regime has led the former Health and Disability Commissioner, Robin Stent, to speculate that a specialist advocacy role, similar to that for District Inspectors of Mental Health, could be developed for the purpose of overseeing the progress of ADA Act patients.40

Other shortcomings in the procedural protections afforded to ADA Act patients relate to rights of appeal. The ADA Act provides the right to appeal against committal orders within three weeks of the date that they are signed [section 23 of the ADA Act refers]. Under section 18 of the Act, a person who is ordered by the Court to be detained and treated at a certified institution must attend that institution for a minimum of six months before he or she can apply for a discharge. The existence of various appeal mechanisms for people subject to compulsory

35 Supra, Chapter 4, note 48, and accompanying text; supra, Chapter 7, notes 31 and 32, and accompanying text.
36 N Jamieson, Submission by Rodger Wright Centre to the 1999 ADA Act review, 4 April 1999, p 2.
37 See, for instance, Re Skelcher (Unreported, HC Auckland, AP 1/92, 20 March 1992, per Williams J): "It is imperative, in relation to these matters, that the proposed detainee understand the nature of the application and have an opportunity to make representations against the making or an order or the likely form of an order" [at p 3, per Williams J]. See, also, Re Sorenson (Unreported, HC Auckland, AP 179/89, 16 October 1989, per Anderson J) ["I think it would be desirable as a general proposition for persons facing the possibility of up to two years detention under the Alcoholism and Drug Addiction Act 1966 to be represented by counsel before orders are made": at p 10].
38 An example is the subject of the application in Re Sorenson (loc. cit.). In that case, Anderson J found that the woman "may not have fully understood what was involved nor been really able to speak adequately for herself in opposition to the application" [ibid, at p 8].
40 R K Stent, Submission by Health and Disability Commissioner to the 1999 ADA Act review, 4 May 1999, p 3.
treatment orders under the MH (CAT) Act begs the question why similar mechanisms are not also available for ADA Act patients. Certainly, it is difficult to see any compelling rationale for the six month 'stand down period' before an ADA Act patient can apply for a discharge, and there are few overseas precedents which support such a disqualification. More commonly, civil commitment laws make no time-based limitations on appeal rights. Thus, for example, section 29 of Tasmania's Alcohol and Drug Dependency Act 1968 provides that a committed patient can make an application for discharge at any time to a central Alcohol and Drug Dependency Tribunal.

Further irregularities in the appeal provisions of the ADA Act are built into section 18 of the Act. Section 18 contains a provision that requires a patient who seeks discharge from the Act to first apply to the Minister of Health, Supervisory Committee, or superintendent of the institution in which he or she is detained. Only then, if the application for discharge is refused, may the patient "apply to a Judge of the High Court in writing for an order directing that he be discharged from detention under this Act". Subsection 18(2) provides that the Judge "may order that the patient be brought before him for examination". As David Williams QC, later to become a High Court Judge himself, has noted: "It is difficult to understand why a Judge of the High Court should be selected to adjudicate upon such an application. It would seem that the appropriate officer in all respects to consider such an application would be the District Court Judge who first made the order of detention".\(^{41}\) It is also difficult to see how a High Court Judge would over-rule a clinical decision not to discharge a patient made by a Supervisory Committee or the superintendent of the institution. Moreover, it is troubling that the hearing of any such application does not require the patient to be brought before the Court, but rather leaves the decision whether or not to examine the patient to the discretion of the High Court Judge.

8.1.4 Contradictions and conceptual confusion in the Act

Legal misgivings can also be expressed about the ADA Act because of apparent contradictions and conceptual confusion within the legislation. Arguably the most far-reaching of these concern the definition of "alcoholic".\(^{42}\) To recapitulate, section 2 of the Act 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.

By way of contrast, section 3 of the Act defines a "drug addict" as:

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.

It is open to question why full-blown "addiction" is required to ground a compulsory detention and treatment order for "drug addicts", yet the ADA Act procedures can be initiated for "alcoholics" based on mere "persistent and


excessive indulgence. This lower threshold which applies to people with alcohol use problems has been heavily criticised by other scholars. As it stands, the definition of “alcoholic” is a legal one rather than a clinical one, and draws no meaningful distinction between people who would satisfy a DSM-IV or ICD-10 classification of alcohol abuse or dependence and those who are mere regular heavy drinkers. This has led some commentators to opine that addiction and loss of control should have been included in the definition of “alcoholic”, so as to ensure that only the true alcoholic and not the excessive imbibers is captured by the ADA Act. To quote Williams again: “As it stands the legislation tends to equate mental illness with mere socially deviant behaviour.”

Interestingly, the threshold for coercive intervention used in section 37A of the ADA Act is one of “intoxication” – defined as a state in which a person “is under the influence of intoxicating liquor, drug, or other substance to such an extent as to be incapable of properly looking after himself” (section 37A(7)) – rather than the Act’s more general concern with “persistent and excessive indulgence”, that seems directed at a state of dependence. This lower threshold for the use of state power over alcohol-affected people makes the section 37A powers conceptually distinct from the other provisions in the ADA Act. The embedded preference to use the least restrictive alternative in caring for people who are severely alcohol-affected (transport to the person’s own home) is also at odds with the built-in preference for the most restrictive alternative for section 8 and 9 committal orders (detainment in a residential treatment facility for up to two years).

8.1.5 Unprincipled inconsistency with other legislation

The ADA Act is not only internally inconsistent in places, it is inconsistent with other health- and welfare-related legislation in several respects. The modern preference for the ‘least restrictive alternative’, a notion which came out of the movement towards deinstitutionalization and mainstreaming of people who require treatment for mental illness, can again be usefully applied here. In the same way that there is seen to be a default preference for community-based treatment orders for those people subject to compulsory treatment under the MH (CAT) Act, it could be argued that the default position for ADA Act patients should be outpatient treatment. It is notable that the privileging of the least restrictive intervention also occurs at common law, and finds statutory expression in analogous New Zealand legislation, such as the Protection of Personal and Property Rights Act 1988 (PPPR Act).

A similar disjunction occurs when one explores the ADA Act’s provision for ‘voluntary’ or self-referred committals. The MH (CAT) Act contains no equivalent provisions about ‘voluntary’ patients, for the simple reason that people who are willing to attend treatment voluntarily will presumably not need a legislative channel to give effect to their desire to seek help. This reasoning was behind the dropping of provision for informal patients under the old Mental Health Act 1969 when the MH (CAT) Act was passed in 1992, and illustrates the extent to which the ADA Act has fallen out of step with contemporary understandings of the appropriateness of coercion in clinical settings.

43 For example, D A R Williams, A Lawyer’s View of the Alcoholism and Drug Addiction Act 1966 (loc. cit.).
44 Ibid.
46 See, for example, Mitchell v Allen [1969] NZLR 110.
47 Sections 8(a) and 28(a) of the PPPR Act require that the Courts follow a course of action or grant an order that intervenes in the least possible way in the affected person’s life, having regard to their level of incapacity. For useful commentary on the PPPR Act, see B Atkin, The Courts, Family Control and Disability – Aspects of New Zealand’s Protection of Personal Rights and Property Act 1988 (1988) Victoria University of Wellington
As things stand, 'voluntary' ADA Act patients are conflated with involuntary and prison-transferred patients once a committal order is made, and offences relating to breaches of leave conditions [section 17 of the ADA Act refers], escaping from a certified institution [section 25 of the ADA Act refers], and so on, draw no distinction between patients who have come under the Act through 'voluntary' or involuntary paths. This seems a bizarre result and one that is not easily reconciled with the approaches taken in analogous health- and welfare-related statutes. This is particularly so for the offence of escaping from an institution, which has no equivalent in the MH (CAT) Act, and seems counter-intuitive in relation to 'voluntary' patients.

Likewise, there appears to be little justification for the ADA Act's retention of an offence of "improper conduct" [section 26 of the Act refers]. Once again, the offence is anachronistic and has no equivalent in the MH (CAT) Act. As Associate Professor Brookbanks has persuasively argued: "It seems anomalous to threaten people with punishment for insubordinate and unruly behaviour, who, by the nature of their condition, are likely to be so disposed .... It is doubtful that such conduct, occurring in a therapeutic context, should be criminally prescribed."

Yet another example of the ADA Act's inconsistency with other health- and welfare-related legislation is what can be seen as its presumption of incompetence. Under statutes such as the PPPR Act, people are presumed to be competent to manage their own affairs and to be capable of making informed decisions about the way they live their lives [sections 5 and 24 of the PPPR Act refer]. The burden of proof in applications under such legislation falls on those who wish to argue that a particular person is incompetent, and any doubt will be resolved in favour of the individual who is the subject of the application. This contrasts sharply with the position under the ADA Act. As discussed previously, if a person seeking the committal of an alleged alcoholic under section 9 of the Act can demonstrate locus standi, a District Court Judge may issue a "summons to the alleged alcoholic to show cause why an order should not be made requiring him to be detained for the treatment of alcoholism in an institution" [section 9(1) of the ADA Act refers]. This effectively reverses the normal burden of proof, requiring the subject of the application to demonstrate why he or she should not be held to be an "alcoholic" within the meaning of the Act. A corollary is that, for a person to be considered an "alcoholic" under the Act, he or she is presumed incompetent, and in need of coerced treatment.

There seems to be no principled reason why the same protections and privileges that are available to patients under the MH (CAT) Act, PPPR Act and analogous legislation are not also available to patients under the ADA Act. To the extent that these baseline protections and privileges do not apply to the ADA Act's target population, "it slicks out like a sore thumb as a coercive mechanism to deprive a person of their liberty, with few or none of the safeguards and procedures now found in other areas of the law."
In addition to these legal concerns, New Zealand's civil commitment law for people with alcohol problems also raises a number of broader questions - questions as fundamental as whether the state is ever justified in forcibly detaining people for treatment, whatever the reason.

Before examining some of the most significant philosophical and ethical questions that are suggested by the ADA Act, it is worth noting that different analytical filters can cast coerced treatment laws in both a positive and a negative light. From one perspective, for example, laws which induct problematic drinkers into treatment can be seen as ethically justified responses by a society concerned about the welfare of its members. As Canadian sociologist Robin Room explains, "providing effective treatment or other help for these drinkers who find they cannot control their drinking can be regarded as an obligation of a just and humane society". Viewed from another angle, though, laws that mandate the treatment of alcoholics against their will can be seen as the state reaching illegitimately into the lives of its citizens. This position is taken by several libertarians, for example American thinker Thomas Szasz, who reject the law having any place in seeking to regulate individual decisions whether or not to use alcohol or any other drug.

In the area of forced alcoholism treatment, it would seem, what one sees depends very much on where one stands. Rather than risk the sterility of arguing from any one standpoint, it is thus perhaps wise to proceed from what the World Health Organization has accepted as a consensus position on forced treatment - it could only be justified if there are due process protections built around the treatment regime, and the treatment itself is both humane and effective. A useful and agreed starting point for an exploration of these issues is the four major ethical principles that have emerged from the growing literature on bioethics: beneficence; non-malefeasance; respect for autonomy; and justice. With these points of departure in mind, it is instructive to tease out the implicit and explicit justifications for the ADA Act from a philosophical point of view.

8.2.1 Paternalism

One oft-heard rationale for compulsory treatment regimes is that, because of limitations in people's cognitive capacities, some drinkers may not always act in their own best interests, and that in these circumstances, society has a responsibility to protect them from themselves. Another argument commonly advanced to defend compelled treatment is that some people's drinking not only harms themselves, but can also have a detrimental effect on others' welfare (such as an intoxicated parent's abuse of his or her child, or feelings of insecurity among pedestrians who must walk past street drinkers). There are structural similarities to both arguments: in the case of imperfect rationality,
the individual's present freedom and autonomy are restricted in order to protect their future welfare; while in the externally scenario, the freedom and autonomy of the individual are limited so as to protect the welfare of second or third parties. In both situations, it has been argued that it is legitimate for the state to compel treatment as a means of minimising alcohol-related harm.57

In jurisprudential terms, the legitimacy of civil commitment laws is grounded on the state's *parens patriae* power to provide care to individuals who are unable (or unwilling) to care for themselves.58 Although there is divided authority on the point,59 the High Court's inherent jurisdiction over personal matters (as preserved by section 17 of the Judicature Act 1908) has been held to extend to cases where "health or related matters" are at issue.60 On a broad reading, this would seem to encompass cases involving alcohol-related disorders.

Decisions by some Judges who hear ADA Act applications resonate with this logic of paternalism. A good example is provided by the oral judgement in the case of *Price v Waitakere District Court*,61 where Chambers J told the appellant (who appeared in person before the Court):

> I have explained to Mrs Price that in this jurisdiction all the courts want to do is what is best for her. She is not a criminal. She is a person who needs assistance from appropriate authorities. I am satisfied that she now realises that she must voluntarily continue seeking the assistance of those specialist agencies who are prepared to help her. I hope that she will continue to take advantage of the services provided, but I do give her a warning that if there is slippage, she can expect another order to be made under the Act. That is a remark made in her own best interests to remind her that defeating alcoholism is horrendously difficult. It requires great self-control on the part of the person affected and Parliament has determined that at times people need assistance in the fight against alcoholism.

Similar sentiments underlie the approach taken vis-à-vis some PPPR Act applications. For instance, in the 1995 case of *In the matter of M K*,62 Judge Robinson explained her decision to grant a property order under section 10 of the PPPR Act in the following terms:

> The evidence ... satisfies me that although Mr K has some understanding of his needs and some insight into his disability he does not have full command of his faculties, nor does he have an ability to control his impulses. His ability to control his affairs deteriorates when he abuses alcohol, which occurs on those occasions when he is unable to control his impulses. I am also satisfied that when he is unable to control his impulses, his judgement to

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56 Of the many references that could be recommended, these ethical threads are given one of the best venues by B Furrow et al., *Bioethics: Health Care Law and Ethics*. Third edition (St Paul: Free Press, 1997).


59 The range of judicial opinion is illustrated by the fact that, in *Re X (Sterilisation: parental consent)* [1991] NZFLR 49, Hillyer J accepted that the *parens patriae* jurisdiction was still available to the Courts; in *Re BM* [1993] NZFLR 531, Williams J speculated that such a residual jurisdiction may exist; and in *Re H* [1993] NZFLR 225, Judge Inglis QC cast doubt on the existence of the jurisdiction. For other instructive commentary on whether the Court should exercise *parens patriae* jurisdiction, refer to *In the matter of G* [1997] 2 NZLR 201.

60 *Re W*[1994] 3 NZLR 600.

61 Unreported, HC Auckland, A 151/99, 8 October 1999, per Chambers J, at pp 3-4 [emphasis added].
make decisions concerning his finances is impaired, as he dissipates his very limited resources on the purchase of alcohol to satisfy his impulse to consume alcohol .... Consequently, I am satisfied that there is jurisdiction to grant the application for a property order.

Traversing the writings of H.L.A. Hart and other key contributors to the debate about paternalism, the ‘best interests’ approach has a number of defenders within the academy. However, this approach also has its critics: for example, Norwegian social researchers Even Nilssen and Roger Lien conclude that, in the context of coerced treatment of people with substance use problems, "strong paternalism is morally dubious, especially where adults are concerned".63

The paternalistic limits of the law in dealing with ‘personal vice’ has been debated in the context of what has been variously styled as "crimes without victims",64 "self-regarding one-party crimes"65 and "harmless wrongdoing".66 Writing on 'victimless crimes' in relation to alcohol and other drug use finds perhaps its most heroic exponents in scholars like Douglas Husak, who argue that adults have a positive right to use psychoactive substances, and that the state has no legitimate countervailing interest in such recreational drug-taking, even if it is self-harming.67

Some jurists are unconcerned about such objections to the reach of the so-called Therapeutic State. An example of such a pragmatic approach is found in the submission by Judge Everitt to the Ministry of Health’s 1999 review of the ADA Act, where His Honour opined that: "any civilised society must have a place in its legal procedures to intervene where consequences of alcohol dependence or drug addiction have deleterious outcomes for the individual or to society generally".68 Judge Everitt confesses that he does not understand what patients need to be protected from, couching his language in terms which effectively deny chronic alcoholics either free will or social agency;69

There is a tendency to concentrate too much on rights and liberty and this confuses the issues. There should be a re-focussing on need for treatment, hospitalisation, etc. A grossly intoxicated alcoholic who has not eaten for several days, his liver is inflamed and kidneys failing, who has cut their head badly when falling down stairs, does not require his or her rights or liberty to be massaged but needs his or her body and mind to be healed .... Surely, again, we should be focussing on the health needs of the patient not on their rights and liberties. A person cannot be free or at liberty when their body and mind is so diseased by alcohol or drugs that he or she cannot function as an individual human being.

8.2.2 Utilitarianism

The extension of such ‘ends justifies the means’ thinking is a utilitarian reading of compulsory alcohol treatment. Without referencing paternalistic arguments, utilitarian analysts contend that forced treatment is legitimate per se.

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They point to studies which show that deteriorations in mental faculties that are often seen in chronic alcoholics (for example, impaired concentration and memory loss) may to some extent be reversible once heavy alcohol consumption stops. Even though compulsory treatment for severely-dependent alcoholics may not have lasting clinical benefits for the individual, therefore, some authors contend that such programmes can be judged as successful, because they have several knock-on public health and social benefits for the community as a whole.

The utilitarian case in favour of coerced treatment is summarised by American psychiatrist, Sally Satel:

With the aid of coercion, substance abusers can be rescued earlier in their "careers" of abuse, at a time when intervention can produce greater lifetime benefits. With coercion, more substance abusers will enter treatment than would enrol voluntarily, and those who enrol will enjoy an increased likelihood of success .... Indeed, addicts who are legally pressured may outperform voluntary patients, because they are likely to stay in treatment longer and are more likely to graduate. Without formal coercive mechanisms, the treatment system would not attract many of the most dysfunctional addicts, and surely could not retain them.

Other champions of coerced treatment argue that when a person sustains significant temporary brain damage from substance misuse, then this ultimate intrusion is warranted, on the basis that "[s]uch time-limited, often life-saving suspension of autonomy allows for urgent medical attention to suicidal impulses, severe depression, or psychosis". ( Interestingly, though, each of the conditions which are said to justify emergency detention of a substance-affected person are psychiatric disorders in their own right, and would bring the person within existing mental health legislation provisions for compulsory assessment and treatment, with its more sophisticated range of procedural safeguards.)

American ethicist J F Fletcher takes this point to its logical conclusion with his conception of "situational ethics". Fletcher argues that, regardless of what it means for the rights of those involved, one must calculate the gains and losses of various courses of action or inaction, and then select the course which offers the greatest good for society. "Ideally, it is better to do the moral thing freely", Fletcher states, "but sometimes it is more compassionate to force it to be done than to sacrifice the well-being of the many to the egocentric 'rights' of a few." Applied to the situation of chronic alcoholics, Fletcher's ethical filter would foresee the interests of the community around the alcoholic receiving treatment outweighing the individual's right to continue using alcohol in ways that are harmful.

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70 Refer to R S N Liu et al., Association between brain size and abstinence from alcohol (2000) Lancet, vol 355: 1969-1970. While alcohol consumption is widely seen to exist in a dose-response relationship to mental impairment (that is to say, the higher the level of alcohol intake, the greater the resulting mental dysfunction), the length of drinking history is less significant, with some very recent studies suggesting that heavy drinking careers of as little as four years can lead to similar levels of progressive mental deterioration seen in people who have been alcoholics for 25 years. W W Beatty et al., Neuropsychological deficits in sober alcoholics: Influences of chronicity and recent alcohol consumption (2000) Alcoholism: Clinical and Experimental Research, vol 24: 149-154.

71 R G Smart and R E Mann, The impact of programs for high-risk drinkers on population levels of alcohol problems (2000) Addiction, vol 95: 37-52. One of the most widely-quoted statistics is that every dollar spent on treatment generates seven dollars worth of 'downstream' savings, primarily through the health care and criminal justice systems. See, for example, D R Gerstein et al, Evaluating Recovery Services: The California Drug and Alcohol Treatment Assessment (CALDATA) (Sacramento: California Department of Drug and Alcohol Programs, 1994).


74 See P A Galon and R A Liebelt, Involuntary Treatment of Substance Abuse Disorders, in M R Munetz (ed.), Can Mandatory Treatment be Therapeutic? New Directions for Mental Health Services no. 75, pp 35-45 (San Francisco: Jossey-Bass, 1997).

75 J F Fletcher, The Ethics of Genetic Control: Ending Reproductive Roulette (Garden City: Doubleday, 1974).
There is also a body of research which suggests that involuntary, and in fact even 'voluntary', committals to treatment may serve latent functions. At an institutional level, involuntary commitment can function as a way to avoid patients prematurely terminating their treatment, which can be an important consideration depending upon the way that treatment places at the institution are funded. Researchers have also identified the way that such committal orders can function to solve family or community problems. For example, legal researcher John Dawson encourages us to look beyond 'curing' alcoholics to understand the other roles that the ADA Act plays:

Providing treatment to alcoholics in the hope they will achieve prolonged abstinence is, in fact, only one of its many functions. The Act... also provides relief to alcoholics' families and the pressures of coping with them, and preventive detention of brain-damaged alcoholics who are not susceptible to treatment but who may endanger themselves or others if left to wander at large.

Indeed, as American scholar Constance Weisner points out in her overview of the use of coercion in alcohol treatment: "there has been a realization that most people enter treatment because of some family, health or job-related pressure... [in fact] there has been a tendency to question whether self-referral is or has ever been a concept applicable to the process by which individuals seek treatment".

However, as a reason for depriving a person of his or her liberty, it is difficult to detect an ethical justification for using a person instrumentally for the benefit of others. This is a simple application of the Kantian categorical imperative. Applied to the immediate subject of study, whether or not the making of an order under the ADA Act is "expedient" for people other than the patient is, from an ethical point of view, an irrelevant consideration.

8.2.3 Autonomy and rights-based discourse

American political scientist Mary Ann Glendon has sought to show how the language of rights has largely displaced other modes of conducting political discourse. A symptom of this process, she contends, is that opponents on issues of public concern often get forced to conceive of counter-arguments in terms of competing rights, rather than casting their argument in terms of opposing interests. In many ways, the debate over compulsory treatment of alcohol use disorders conforms to this description. The literature on forced treatment of alcoholics is typically infused with the language of rights.

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76 Ibid, p 180.
79 For example, K Mäkelä, What can medicine properly take on?, in M Grant (ed.), Alcohol Treatment in Transition, pp 225-243 (London: Croom Helm, 1980).
81 C M Weisner, Coercion in Alcohol Treatment, in Institute of Medicine, Broadening the Base of Treatment for Alcohol Problems, pp 579-609 (Washington DC: National Academy Press, 1990), at 594.
82 For the interests of others to become relevant, it would be necessary to recall the language used in section 9 of the ADA Act to specify that the making of the order was "necessary" in the interests of other people in a proximate relationship to the patient (eg. section 118 of the Criminal Justice Act 1985).
Invoking this rights-based discourse, the main normative obstacles to coerced treatment of alcoholics are likely to be seen as the individual's right to autonomy and self-determination.

Refined by various medieval scholars and theologians, the idea of the autonomous moral agent found its classic exposition in the metaphysics of Immanuel Kant. In the twentieth century, the notion of autonomy has been especially prominent in the discourse on biomedical ethics. For instance, British academic Max Charlesworth argues that a liberal pluralist society cannot abdicate its central commitment to the value of personal autonomy, a concomitant of which is the need to respect people's decisions that they do not want to have treatment for disorders like alcoholism.\(^{84}\) Indeed, most ethical theories accept that personal autonomy is valuable in analysing the 'morality' of such scenarios.\(^{85}\)

The philosophical bases of such arguments rest with thinkers such as Thomas Hobbes and John Locke, with their ideas of the right to self-determination and the inherent moral quality of being able to act freely without restraint. Wrote Hobbes in 1651: "Of the voluntary acts of every man. The object is some good to himself",\(^{86}\) while Locke recorded in 1690: "Every man has a Property in his own Person. This no Body has any Right to but himself".\(^{87}\)

Applied to the ADA Act, it is important to recall that the issue is not one of coercion simpliciter. Many, if not most, people who access services for alcohol problems have been coerced into treatment, typically through ultimatums by family members.\(^{88}\) The important issue is one of coercion by the state. And, as Dawson has pointed out:\(^{89}\)

> Despite its therapeutic label, compulsory detention for treatment is always likely to be regarded as punitive from the point of view of the person detained. Confinement in a total institution, for whatever reason, entails a massive infringement of fundamental liberties: to go where one wishes, to associate with whomever one wishes, simply to be left alone.

Whereas approaches rooted in paternalism or utilitarianism would involve a balancing exercise, and use of a value judgement if there is conflict between competing interests, the rights-based discourse, "by virtue of its very absolutism ...

\[^{84}\] Refer to M Charlesworth, Bioethics in a Liberal Society (Cambridge: Cambridge University Press, 1993), esp Chapter 3.


\[^{88}\] According to the Manager of the Christchurch Bridge Programme, "No alcoholic comes into treatment without at least one arm behind their back", such as one partner threatening to report their other partner to the Department of Child, Youth and Family for child abuse if they do not seek treatment 'voluntarily'. J Hutson, Interview, 14 November 2000. See, further, D L Polcin and C Weisner, Factors associated with coercion in entering treatment for alcohol problems (1999) Drug and Alcohol Dependence, vol 54: 63-68; and infra, Chapter 1, note 39 and accompanying text.


\[^{90}\] R Bailey-Harris, Patient autonomy – A turn in the tide?, in M Freeman and A D E Lewis (esd.), Law and Medicine, pp 127-140 (Oxford: Oxford University Press, 2000), p 133.
A consequence of using such a deontological, rights-based approach to examine the ADA Act is that it is ethically-preferred to permit a tragic but unintended consequence (alcoholics drinking themselves to death) in order to avoid what some would perceive as relatively trivial wrongs (forcing alcoholics into residential treatment).

8.2.4 Informed consent

Beyond the dissonance between the ADA Act and the privileged rights to autonomy and self-determination, serious ethical questions are raised about the validity of forcing anyone to enter treatment when the effectiveness of that treatment is either unknown or unproven. As Constance Weisner observes, "[i]t is this concern speaks to the lack of outcome research on coerced populations in general, as well as to the lack of outcome measures related more specifically to the different types and levels of coercion". People who enter treatment under pressure should be made fully aware of the (limited) evidence of the efficacy of the treatment regime that it is intended they be put through, and should be made fully aware of their residual legal right to refuse that treatment if they so wish.

This leads into what is arguably the most significant area of ethical concern with the ADA Act - the notion of informed consent - which is animated by the twin principles of providing a person with a proper understanding of the proposed course of treatment, as well as available information on the efficacy of that treatment programme. Putting to one side the inherent difficulties in securing genuine informed consent in any treatment setting, it has long been recognised that people with substance use disorders present a number of unique complications when it comes to obtaining informed consent. In fact, some commentators have characterised informed consent as "missing in action in addiction treatment".

People are routinely mandated into treatment by the courts. The vast majority are not informed about alternative treatments that have had better outcome records in clinical research. Issues of outpatient versus inpatient treatment are similarly decided based on what the program offers ... rather than on proven efficacy .... To say that such interventions violate standard practices of informed consent is, once again, a serious understatement. This is problematic not only from a legal and ethical point of view, but also because, as discussed previously, therapeutic jurisprudence instructs that patient choice in the treatment process can be clinically and therapeutically useful per se, and interventions that deny patients' choice can retard progression through the 'stages of change'.

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91 C M Weisner, Coercion in Alcohol Treatment, in Institute of Medicine (op. cit.), at 601.
92 This is not the place for a comprehensive examination of consent to care and treatment in New Zealand law. Suffice it to acknowledge the standard text: D B Collins, Medical Law in New Zealand (Wellington: Brooker & Friend, 1992). A useful coverage is also given by C Thomas, Informed Consent - A Comparative Study between Australia and New Zealand (Wellington: Massey University College of Business, 2000).
This chapter has outlined some of the legal and philosophical issues with the Alcoholism and Drug Addiction Act.

First, there were seen to be some legal problems relate to the slow pace of bureaucratic servicing for ADA Act institutions. These problems were identified as including the likelihood that some Supervisory Committee members are acting ultra vires, the lack of transparency about the criteria used to certify treatment facilities under the Act, and the Ministry of Health's failure to maintain or monitor an up-to-date list of ADA Act patients. It was noted that, in many ways, such problems are symptomatic of the more general neglect of the statute by officialdom; which leaves the working of the ADA Act relatively opaque, and in turn, stifles well-informed debate about its operation.

Also under the heading of legal issues, it was noted that it is well established at common law that a competent adult has the right to refuse medical treatment, and provision of treatment without a patient's consent will, ceteris paribus, amount to a criminal battery. The chapter rehearsed relevant statute and case-law to demonstrate that, where a competent ADA Act patient refuses to submit to "treatment for alcoholism", he or she could challenge detention under section 23(1)(c) of the NZBORA and/or the common law right to seek habeas corpus. In practice, it was noted that such legal challenges do not arise, because ADA Act institutions typically discharge patients who refuse to participate in treatment. Nevertheless, the fact that the ADA Act does not confer a direct power to compulsorily treat people detained under was argued to represent a fundamental legal flaw. It means that, in the face of opposition by patients, the Act's compulsory detention powers can be rendered nugatory, thus undermining the stated aim of the legislation ("to make better provision for the care and treatment of alcoholics").

A further series of legal problems were presented under the heading of the Act's lack of procedural protections. This critique proceeded on several fronts, notably: people who are subject to applications under the ADA Act are only rarely represented by counsel; there are limitations around the right to appeal against ADA Act committal orders; and there are irregularities evident in these appeal provisions (which mean that the hearing of ADA Act appeal applications do not require the patient to be brought before the Court, and leaves this to judicial discretion).

Further legal misgivings were expressed about the ADA Act because of contradictions and conceptual confusion within the legislation, such as around the definition of "alcoholic". The Act was also described as being inconsistent with analogous health- and welfare-related legislation, in particular the MH (CAT) Act and the PPPR Act. Points of difference were shown to include: the privileging of the least restrictive intervention, provision for 'voluntary' or self-referred committals, offence provisions involving escape from an institution and "improper conduct", and the statutory presumption of competence. It was concluded that there is no principled reason why the same protections and privileges that are available to patients under the MH (CAT) Act, PPPR Act and other analogous legislation should not also be available to patients under the ADA Act.

In addition to these legal issues, the chapter highlighted several philosophical and ethical issues raised by the ADA Act. These issues were seen to go to the heart of whether the compulsory treatment law is defensible in value terms.
The assumed legitimacy of the Act was first discussed in terms of the state’s *parens patriae* power and the logic of paternalism, before canvassing ‘ends justifies the means’ utilitarian analyses of compulsory alcohol treatment. These perspectives were critiqued on the grounds that they effectively deny alcoholics free will or social agency.

Finally, the chapter argued that the ADA Act is offensive to the right to refuse treatment that every competent adult enjoys, and it conflicts with the cherished principles of autonomy and self-determination. It was submitted that that the ADA Act is antithetical to the principle of informed consent, and jumps from an ‘is’ to an ‘ought’ in a way that masks a normative principle: just because we can treat a person for alcoholism, does it mean we should? – especially over the person’s objections to treatment? The chapter concluded that such embedded questions are open to serious challenge.
Options for reform

It will be apparent from the preceding chapters that there is much that is wrong with the ADA Act, and that (in the author's view at least) retention of the status quo is not a viable response to these problems. In presenting this thesis, however, the intention is to go beyond the immediate demands of exposition and critique, or indeed the discussion of theoretical perspectives like therapeutic jurisprudence. Rather, the thesis sets out to make a contribution to the practical task of reforming the ADA Act. Comparative law on coerced treatment of people with alcohol use disorders unearths a wide spectrum of alternative regimes, some of which have already been canvassed in Chapters 5 and 6. In this penultimate chapter, three basic options for reforming ADA Act will be canvassed. In short, those options are:

1. Retain the ADA Act as a stand-alone statute, but with appropriate modernising amendments;

2. Incorporate compulsory treatment powers for substance use disorders into the MH (CAT) Act; or

3. Repeal the ADA Act, and allow the MH (CAT) Act or PPPR Act to be used in the small number of cases where it will be appropriate to provide short-term, ambulatory care for people with substance use disorders.

While it is not intended to offer a comprehensive policy analysis of the three options, a brief commentary on each of these broad directions will be given below.

9.1 Modification of the Act

The first broad option is to retain separate legislation which provides for the compulsory detention and treatment of people with substance use disorders. This has been the favoured option for health officials charged with examining the ADA Act, who have consistently taken the view that "the retention of separate legislation is both sensible and justified". Three main arguments are typically advanced in favour of separate legislation. First, it is said that keeping separate legislation will facilitate continuing official recognition of the role of voluntary agencies in treatment service provision. Second, it is contended that the multi-disciplinary approach required in alcohol and other drug treatment, and the need for a range of treatment services, can be better accommodated in separate legislation. Third, it is argued that incorporation of compulsory treatment powers for substance misuse disorders within, say, the MH (CAT) Act would potentially 'muddy the waters' with the target population of that Act.

Basing their recommendations on these three main arguments, the subcommittee of the Task Force on Alcohol that considered the ADA Act in the early 1980s arrived at the following statements of principle for a revised Act:

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1. The provisions of an amended Act pertaining to the committal and review process and the corresponding patient safeguards, should ... correspond with the ... Mental Health Act.

2. Legislation should refer to "Substances affecting mental function/behaviour and thus causing harm to self/others", instead of defining specific substances, eg, alcohol.

3. All persons over the age of 20 should possess the right to initiate committal proceedings; no reference to specific categories (eg, next of kin) should be made.

4. The definition of a person liable for committal should be tightened considerably. The person's addiction should be required to be seriously injurious to his/her own health or a source of serious psychological/ emotional, etc, harm and suffering to others. The mismanagement of the person's affairs should also be grounds for committal, but this clause should become more stringent. Reference to the alleged addict causing serious annoyance to others should be omitted.

5. It should be stated that committal proceedings would be instituted when "no alternative or reasonable remedy is available or acceptable".

6. Patient safeguards during the committal proceedings should be improved, with reference to the right for patient legal representation, to call evidence, and to cross-examine.

7. Provisions should be incorporated to require the assessment/examination of the alleged substance dependent person after his/her initial appearance before the Court.

8. Such an assessment could occur preceding, or following, a committal; committal should not represent a final decision. Two periods of assessment could also be required by the Court.

9. An assessment following committal should be of up to two weeks duration; if prior to any decision on committal, a shorter period (three days, for instance) should be specified.

10. The assessment should be undertaken by a panel selected by the Court Registrar, and would not necessarily possess a link with the treatment facility. The panel would comprise a medical practitioner; a practitioner or a recognised psychologist; and possibly also a lay person. The latter two categories would be drawn from a list comprising the Director-General [of Health]'s appointees.

11. The legislation should contain provision enabling an individual referred to one facility to be referred to another, if this was the most feasible option.

12. A substance dependent person definitely committed would be regularly reviewed (eg, every three or six months) by a panel (Supervisory Committee). The legislation should also provide for individuals to be transferred to other institutions by way of an administrative decision.

13. The enforcement provisions in the legislation should be strengthened.

9.1.1 Key legislative amendments

While the subcommittee of the Task Force on Alcohol's list is not an exhaustive one, it is certainly true that there are several aspects of the ADA Act regime that could be improved through amendment to the primary legislation.

Given the practical, clinical and legal flaws that are evident in the ADA Act and the way it is being implemented, there would seem to be several key amendments which will need to be made if the Act is to be retained as a defensible piece of stand-alone legislation.

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3 These are described more fully supra, Chapters 7 and 8.
For example, it would seem important that any package of amendments to the ADA Act include a new definition of "alcoholic" which addresses the current confusion between notions of addiction and dependence. Some have suggested replacing the conjunctive with the alternative, so that the tripartite test "or" is changed to "and". Thus, because of the nature of their drinking, people must: (a) be causing, or be likely to cause, serious injury to their health; (b) constitute a source of harm, suffering or serious annoyance to others; and (c), be incapable of properly managing themselves or their affairs. Others have mooted a definition of "alcoholic" that adopts the bifurcated style of the MH (CAT) Act: first specifying the phenomenon that constitutes alcoholism as an aberrant condition, then separately specifying the relevant risk factors. Associate Professor Warren Brookbanks proposes the following definition which adopts this formulae, while doing away with the "dangerously subjective criterion" of reference to serious annoyance to others that exists in the present definition:

"Alcoholism" means an aberrant state of mind characterised by a severe dependency upon alcohol and manifested in a pattern of addictive behaviour of such a degree that the sufferer:

(i) Is likely to cause serious harm to himself or herself or others; or
(ii) Is incapable of caring for himself or herself or of managing his or her own affairs.

In a similar vein, it would also seem important to remove the current privileging of family members in the ADA Act, which places the legislation at odds with the neutral status accorded to relatives in statutes like the PPPR Act. Submissions on this point made during the Ministry of Health's review of the ADA Act in 1999 stressed that, as a matter of practice, de facto and same-sex partners were more than likely to be captured under the "any other reputable person" clause of the current wording of the Act, with one sitting District Court Judge commenting that: "Common sense and legal training dictate that the definitions be interpreted reasonably .... [and the] very process involves sufficient protections to ensure that frivolous and self-interested applications would be dealt with appropriately". However, other submitters sought to have the locus standi provisions clarified, with some even pushing for boarders to have the right to make such applications, on the basis that their safety and possessions may be at risk "due to out of control behaviour by an active substance dependent member of the household".

In the interests of consistency, the MH (CAT) Act refers to the ability of "any person" over the age of 18 years being able to initiate the committal process under that legislation [section 8 of that Act refers], and there seems no reason in principle why the same construction should not also apply to the ADA Act. As other scholars have noted, "[t]he nomination of 'relative' as the only intimate person who may make an application for detention under section 9 presupposes the typical familial arrangements pertaining at the time the Act was passed", and there is no reason to think that, as family constellations change, the power to make an application would not also change.

Whereas removing the special status accorded to family members is aimed at widening the scope of the Act, other possible amendments could look at narrowing the potential reach of the legislation. An example here is the option of removing provision for 'voluntary' committals under section 8 of the ADA Act. It is fair to say, however, that opinion on this point is divided, with some less-than-robust rationales being used on either side of the debate.

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4 For example, C Hayes, Submission by Auckland Alcohol and Drug Treatment Services Detoxification Unit to the 1999 ADA Act review, 23 April 1999, p 1.
6 T H Everitt, Submission to the 1999 ADA Act review, 5 May 1999, pp 1, 4.
8 W J Brookbanks, Submission to the 1999 ADA Act review (op. cit.), p 7.
For example, one District Court Judge has defended the retention of section 8 using the discourse of rights: "Such provisions empower people to apply as of right", His Honour states. "To remove the right to make a voluntary application takes away a person's right. It leaves that person entirely at the discretion of others". (It is difficult to see how such reasoning proceeds, given that such people are still able to seek help for their substance use problems at both public and private treatment services, without reliance on section 8.) Likewise, one psychiatric District Nurse wrote to the Ministry of Health's 1999 review of the ADA Act that: "While it is doubtful that the 'voluntary' part of the Act is viable ... the trick will be not to throw the baby out with the bathwater". Yet abolition of the category of 'voluntary' patients would eliminate some of the most troubling aspects of the legislation, like the offence of escaping from a certified institution [section 25 of the Act refers] being applicable to 'voluntary' patients.

To this end, there is no equivalent to section 25 of the ADA Act in the MH (CAT) Act, and there seems no compelling reason why people detained under the ADA Act should be subject to possible criminal sanctions for an offence which does not apply to people detained under mental health legislation. This anomaly could be removed in any package of amendments to the ADA Act. Having said this, while there appears to be a strong case for deleting the offence of escaping from the legislation, there are sound policy arguments for retaining the offence of inducing or assisting an ADA Act patient to escape [section 25(2) of the Act refers], and supplementing this offence with a prohibition against assisting an ADA Act patient to be absent without leave, which is an offence under the MH (CAT) Act [section 115 of that statute refers], and yet is not included as an offence in the ADA Act. A 'root and branch' review of the ADA Act would allow these sorts of curious anomalies to be identified and fixed.

Some of the most striking inconsistencies between the ADA Act and other health- and welfare-related legislation concern the matrix of due process protections which apply to patients. One potential model for any redrafted ADA Act could be Part VI of the MH (CAT) Act, which gives statutory expression to the right to respect of cultural identity [section 65 refers], the right to treatment [section 66], the right to legal advice [section 70], the right to receive visitors and make telephone calls [section 72], the right to send letters and postal articles [sections 73 and 74], and so forth. The point has already been forcefully made11 that there seems to be no principled reason why the same protections and privileges that are available to patients under the MH (CAT) Act, PPPR Act and analogous legislation are not also available to patients under the ADA Act. This was seen to be particularly the case in relation to appeal rights.12

Another key amendment that would seem to be called for, if the ADA Act was to be kept as a stand-alone statute, is the freeing up of the ability of Judges to commit people for treatment on an outpatient (day programme) basis. The consensus of submissions made to the Ministry of Health during its review of the ADA Act in 1999 was that: "the legislation should be flexible enough to allow treatment to take place in non-institutional settings in appropriate cases".13 This would allow greater consistency to be achieved with mental health legislation, which contains a statutory presumption in favour of community-based treatment [section 29 of the MH (CAT) Act refers], and would resonate with the preference for the least restrictive intervention in legislation such as the PPPR Act.14

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9 T H Everitt, Submission to the 1999 ADA Act review (op. cit.), p 1.
10 S D Crone, Submission to the 1999 ADA Act review, 21 May 1999, p 2 [attached to submission of E Laracy].
11 Supra, Chapter 8, note 52 and accompanying text.
12 Supra, Chapter 8, section 8.1.3.
14 Refer supra, Chapter 8, note 47 and accompanying text.
The maximum length of ADA Act committal orders could also be reviewed as part of any suite of amendments. Many overseas civil commitment laws have a six month time-limit, with provision for a further six month extension: examples include Sweden’s LVM, and Tasmania’s Alcohol and Drug Dependency Act 1968 [section 27 refers]. The length of stay data presented earlier indicate that few ADA Act patients remain in treatment longer than six months, meaning that any reduction of the maximum period of detention from two years to six months, say, would affect only a small number of patients currently receiving treatment under the Act. Indeed, it is questionable whether patients staying longer than six months are receiving supported accommodation, more than “treatment”. A reduction in the maximum length of committal orders would have the benefit of ensuring that people with, for example, alcohol-related brain damage, are identified earlier and directed towards more appropriate services, rather than creating blockages to the limited number of treatment places that are available at ADA Act institutions.

Before leaving this quick overview of the types of amendments that it would be important to assess if the ADA Act was to stay as a stand-alone piece of legislation, one further issue warrants separate consideration and comment. This concerns the possible removal of the ability for ADA Act institutions to refuse to accept particular clients. Although some critics argue that “it defeats the purpose of the legislation if institutions are granted the de facto power to pick and choose who they will or will not receive as patients”, not only is it uncommon for institutions to refuse to accept patients under the ADA Act, there are sound reasons why institutions should retain this power.

Each of the major certified institutions under the ADA Act are voluntary or charitable organisations which, while publicly-funded, are not part of the network of state-run hospital and health services – making them unlike the major institutions that receive patients under MH (CAT) Act compulsory treatment orders. As such, it would seem oppressive if privately-run facilities were required by law to take and treat certain individuals for alcohol problems, especially if the institutions have previously had the person as a patient but had to discharge him or her on behavioural grounds. To require otherwise may, in fact, compromise the care of the extent treatment population at the facility. As the Director of Christchurch’s Salvation Army Bridge Programme contends: “alcohol treatment organisations need to have control over their environment, so as to protect existing client groups”. If Judges had the power to force institutions to take particular clients, it might have a ‘chilling effect’ on any new institutions volunteering to become certified under the Act, and already certified facilities may wish to reconsider their status.

9.1.2 Allied administrative changes

To pick up on this last point, any legislative amendments to a retained ADA Act would need to be accompanied by a series of practical reforms. One immediate priority would be to encourage more residential alcohol and drug treatment services to apply for certification under the ADA Act, thereby alleviating the pressure on places at the existing treatment facilities, and adding to the range of choice for District Court Judges who sit on ADA Act cases.

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15 See the discussion supra, Chapter 6, section 6.2.3.
16 Supra, Chapter 4, section 4.3.2.
17 W J Brookbanks, Submission to the 1999 ADA Act review (op. cit.), p 8. Note, also, the perspective of the Health Funding Authority, which bluntly argues: “Services funded to provide the care and treatment of particular classes of person should not be able to decline to accept those patients”. M D Patton, Submission by Health Funding Authority to the 1999 ADA Act review, 28 April 1999, p 8.
18 See supra, Chapter 4, notes 10 and 11 and accompanying text.
It is notable in this regard that the Salvation Army Bridge Programme has facilities in both Dunedin and Hamilton which would, on their face, seem suitable for certification under the current Act, as they offer substantially similar intensive residential treatment modules (offering both counselling and group work) as their sister programmes in Auckland, Wellington and Christchurch. It is unclear why the Salvation Army has not chosen to seek certification for these other two Bridge Programmes, but it seems clear that the Minister of Health would support any such application from the Salvation Army. There are also a range of other suitable treatment facilities throughout the country which seem, on the face of it, to be good candidates for certification under the ADA Act, including some inpatient treatment centres that have already expressed an interest in receiving ADA Act clients.

Another major but readily achievable administrative change that would need to accompany any decision to retain the ADA Act as a stand-alone statute relates to the level of servicing provided by Ministry of Health officials. As mentioned previously, some of the legal problems with the ADA Act derive from the slow pace of bureaucracy such as delays in updating the physical addresses of certified institutions under the ADA Act, and lack of attention to the membership of ADA Act Supervisory Committees which may mean they are operating ultra vires. These problems can be addressed reasonably simply without the need for legislative change, and would help to streamline the effective operation of the legislation, if the ADA Act is to be sustained as a stand-alone statute.

9.2 Incorporation within the MH (CAT) Act

The second broad option for reforming the ADA Act is to incorporate compulsory treatment powers for people with substance use disorders into the MH (CAT) Act.

A number of submitters to the Ministry of Health review of the ADA Act in 1999 expressed disappointment that the Ministry’s discussion paper did not explain why the ADA Act was not conflated into the MH (CAT) Act when the Mental Health Act was extensively redrafted in the early 1990s. Besides which, as the Mental Health Commission points out: "the fact that compulsory treatment of people with mental health problems and those with alcohol and drug problems has been separate historically is no reason for assuming they should remain so". Given the growing body of evidence which hints that the majority of people who are most severely affected by alcohol also require treatment for co-existing mental health problems, the Chair of the Mental Health Commission, Dr Barbara Disley, has argued for the removal of structural constraints, such as different legislative interventions, that perpetuate the myth that substance use disorders and mental health disorders must be treated separately. Noting that mental health services will need to receive patients under compulsory treatment orders who have concurrent substance use and mental disorders, inclusion of substance abuse commitment criteria within the MH (CAT) Act would thus seem to be one of the least complicated options available for bridging this mythical schism.

20 An overview of the Bridge Programmes offered by the Salvation Army is contained in its submission to the 1999 ADA Act review, dated 3 May 1999, pp 2-3.
21 An example is Ashburn Hall, a private psychiatric centre on the outskirts of Dunedin, which runs a therapeutic community. See J B Adams, Submission by Ashburn Hall to the 1999 ADA Act review, 20 April 1999, p 2.
22 See supra, Chapter 8, section 8.1.1.
24 See, generally, F Todd et al., The Assessment and Management of People with Co-Existing Substance Use and Mental Health Disorders (Christchurch: National Centre for Treatment Development, 1999).
25 B Disley, Submission to the 1999 ADA Act review (loc. cit.).
Certainly, in relation to alcohol abuse and dependence, these conditions are diagnosable mental disorders in their own right under DSM-IV, and it would seem to be a simple matter from a legislative drafting point of view to bring people with substance use disorders under the aegis of the MH (CAT) Act. In short, it would merely require the repeal of section 4(d) of the MH (CAT) Act – which states that the compulsory assessment and treatment procedures contained in the statute shall not be invoked vis-à-vis any person solely because of substance abuse.

Were this legislative change to be made, it would have a ‘cascade effect’ of bringing ADA Act patients within the much more extensive matrix of procedural protections (involving layered review and appeal rights) that are enjoyed by patients who are detained for treatment under the MH (CAT) Act. This would be a significant advance on the current position, and would elide many of the most troubling difficulties associated with the ADA Act regime, such as the ADA Act's power of detention not being linked to a direct statutory power to compel treatment. Some critics have argued that:

> There is no reason in principle why the review jurisdiction of the [Mental Health] Review Tribunals could not be extended to ADA Act detainees with appropriately-qualified persons designated to sit on the Tribunals. This would provide a valuable check against the possible ‘draconian’ effects of the legislation and would ensure that ADA Act detainees are given the same rights of review as other compulsorily detained persons.

Folding the forced assessment and treatment provisions for people with substance use disorders into general mental health legislation would also address many of the other anachronisms and anomalies in the ADA Act, such as the ability of the Minister of Health to exercise custodial and clinical judgements in individual cases, and the fact that managers of non-hospital-based ADA Act institutions do not enjoy the same inherent rights regarding patient discharge, transfers or leave as superintendents of hospital-based institutions.

For the sake of completeness, those sections of the ADA Act which currently give Police the power to detain grossly intoxicated people (section 37A primarily refers) could be migrated across to other legislation, such as the Summary Offences Act 1981. Alternatively, new stand-alone legislation which deals with this narrower issue could be explored, perhaps taking as a model the New South Wales Intoxicated Persons Act 1979, which provides for short-term detention of people affected by alcohol or other drugs to allow them to regain their sobriety.

### 9.3 Repeal of the Act

While they would both offer undoubted improvements on the status quo, the options of continued stand-alone legislation or collapsing the forced treatment power for people with substance use disorders into the MH (CAT) Act both fail to answer the core question of whether there is a need for legislation which mandates the compulsory detention and treatment of people with alcohol and other drug problems.

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26 Refer supra, Chapter 2, section 2.1.
27 See the discussion supra, Chapter 8, note 33, and accompanying text.
29 Refer supra, Chapter 3, note 72 and accompanying text.
30 Section 17 of the Act refers; see, further, the discussion supra, Chapter 7, note 20 and accompanying text.
Even if the answer that one arrives at in relation to this threshold question is 'yes', there are further questions of degree. There may be broad agreement that an emergency detention power should be retained, but how long such ambulatory powers should be exercised might be vigorously contested. As Mike MacAvoy and Bruce Flaherty, former New South Wales' health officials, have persuasively argued:31 "The fact that persons whose drinking is drastically impairing their health initially refuse treatment does not diminish the responsibility to offer care and beneficial treatment. An initial refusal of treatment requires clinicians to remain persistent, even clever in their offers of treatment. However, there comes a point when a clear consistent refusal must be respected". It follows that emergency restraint may be justified in life-threatening situations, but only until the alcoholic has been stabilised.32 And if there are life-threatening situations which are seen to justify temporary restraint, it would seem more appropriate that these emergency detention powers be brought within the MH (CAT) Act for the sake of consistency.

Even more fundamentally, it may be asked whether a legal response is ever justified to an otherwise law-abiding person who has an alcohol problem. This is not just an academic question, as this example taken from the even more highly-charged environment of mental health law illustrates:33

'The Province of Ontario abolished the legal power to treat competent psychiatric patients without their consent in 1986. That is, irrespective of whether the patient is in hospital or in the community, and, if in hospital, whether a voluntary or an involuntary patient. The world did not end. If anything, the suspicion (unprovable, since the absence of data prior to the change makes comparison impossible) is that it has resulted in better communication between patients and doctors, better negotiation of treatment regimes, outcomes acceptable to both, and better rates of continuation of treatment in the long term. If that is correct, the non-discriminatory approach is not merely workable; it provides better health care.

Such experiments in doing away with compulsory treatment regimes force us to face an even more fundamental question: is the state ever justified in locking up some of its non-offending citizens and not others? Attempting to answer these more profound questions would call for a rather different sort of study than has been presented here; and indeed, for the key rhetorical purposes of this thesis, it is not necessary to provide definitive answers to them. The reason is that, as discussed earlier,34 excessive alcohol use does not appear to be treated as a malum in se in New Zealand society, and compulsory treatment of alcoholism can thus be approached on purely policy terms, without recourse to the (possible) social utility or moral infrastructure that may undergird laws like the ADA Act. And, in policy terms, it is submitted that the case for the retention of ADA Act regime - either as a separate Act, or conflated into mental health legislation - is hardly compelling. In addition to legal and philosophical difficulties that forced treatment of alcoholics raises, at a pragmatic level, the direct and indirect costs of coercing alcoholics into treatment at ADA Act facilities seem to outweigh the uncertain direct and indirect benefits of such treatment.35

32 For example, Austria provides for emergency detention of at-risk substance abusers for up to seven days, with the possibility of an additional seven days. Similarly, in Finland, where there is a risk to the health of the alcoholic or drug addict, he or she may be coerced into five days of detoxification. See, further, L Porter et al., The law and treatment of alcohol and drug dependent persons - A comparative study of existing legislation (Geneva: World Health Organization, 1986), p 60.
34 Supra, Chapter 2, section 2.4.
35 Supra, Chapter 7, especially section 7.3.
Given the myriad of problems that beset the ADA Act regime, and the limited evidence of its success in "mak[ing] better provision for the care and treatment of alcoholics", it is submitted that there is a strong argument for the outright repeal of the ADA Act, without introducing any other legislation in its place. Under this proposal, the treatment of chronic substance misusers would be dealt with primarily on the basis of the person's voluntary participation in available treatment services, or through programmes associated with the criminal justice system. Court-ordered intervention for people whose substance use places themselves or others at risk of serious harm would only be an act of last resort by the state, in offering care and protection to a group of vulnerable individuals.

It is submitted that sufficient legislative protection exists in the MH (CAT) Act and the PPPR Act to cover the need for involuntary detention of New Zealanders with substance use disorders. Provided that section 4(d) is repealed, the MH (CAT) Act provisions for mentally disordered individuals can be used to justify the emergency restraint of substance-affected people in life-threatening situations. The PPPR Act provides the legislative basis for acting on behalf of those individuals who are not capable of managing their own affairs because of substance use difficulties. More specifically, section 10(1) of the PPPR Act lists the types of orders which a Court can make in respect of a person under that legislation. These include:

(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 ...
(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.

These powers in the PPPR Act are sufficiently broadly framed to make the specific powers in the ADA Act otiose. If the ADA Act were repealed, and if candidates for involuntary treatment were instead brought under the PPPR Act, this would induct people with substance use disorders into an environment characterised by a clear set of procedural safeguards, animated by a presumption of competence, the principle of the least restrictive alternative, encouragement of self-reliance and normalisation, and a commitment to integrating patients into the community.37 There would be an added benefit of this jurisdiction being exercised exclusively by District Court Judges who hold Family Court warrants, and who are more accustomed to applying the 'best interests test' in their determinations.

In summary, it is submitted that there is everything to gain and little if anything to lose in repealing the ADA Act outright. Repealing the ADA Act and allowing any 'slack' to be taken up in the MH (CAT) Act and the PPPR Act would seem to be an optimal solution to a problem of a draconian, anachronistic and increasingly irrelevant piece of legislation that is of questionable effectiveness, and conflicts with modern approaches to civil liberties and substance misuse treatment.

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36 Interestingly, New South Wales government officials are looking to do the same thing in their jurisdiction with the Inebriates Act 1912 (which was profiled extensively supra, Chapter 5). The New South Wales' Disability Services and Guardianship Act 1987 and the Mental Health Act 1990 are seen to provide adequate protection for persons suffering alcohol-related brain damage and who are unable to manage their own affairs; while the Intoxicated Persons Act 1979 provides for the short-term detention of persons affected by alcohol or drugs, so as to enable them to regain their sobriety. The repeal of the Inebriates Act would mean no statutory mechanism would exist in New South Wales' for providing for the involuntary admission of persons suffering severe alcohol abuse. However, given the shortcomings of the Inebriates Act, the retention of the Act (at least in its current form) is viewed as unacceptable. P McCarthy, Personal communication, 24 August 2000; and see, further, M Lodge, Inebriates Act 1912 (Sydney; NSW Health Department, 1997), esp p 22.

37 For a useful overview, see D Webb et al. (eds.), Family Law in New Zealand, Ninth edition, volume two (Wellington: Butterworths, 1999), pp 1529-1598.
This thesis was born, in part, of an impatience with the slow pace of reform of the Alcoholism and Drug Addiction Act, and a sense of pessimism that the current moves towards reviewing the Act will be any more successful than the other false starts at reform that litter departmental records dating back the last 20 years. The study also flowed from a scepticism about the utility of the ADA Act model, and a sense of disquiet that this 1960s legislation is out of step with modern understandings of civil liberties. However, the research has been wary of the nature of alcohol-related harm, which sees broad scope for “problem inflation” (focussing only on the alcohol connection, or counting all drink-related problems even if they are non-causal) or “problem deflation” (giving higher priority to non-alcohol-related variables). The thesis has attempted to chart a middle course between these positions, presenting the available quantitative and qualitative evidence on the ADA Act in a way that does not over- or under-emphasise the fundamental policy problem.

While every effort has been made to be analytically evenhanded, the central policy problem with the ADA Act remains: the legislation does not seem to be achieving what it sets out to achieve. In blunt terms, the Act fails to live up to its legislative intentions. When looked at through interdisciplinary eyes, which assess the ADA Act regime through legal, clinical and public policy filters, the ADA Act does not “make better provision for the care and treatment of alcoholics”. Ultimately, this must offer at best a weak basis for retaining the legislation in its present form; or, in fact, any form at all.

It is possible to make the argument that, given the small numbers of people placed under committal orders each year, there remains a place for the ADA Act within the wider spectrum of possible therapeutic interventions in New Zealand to address alcohol-related problems; that, in fact, we should be looking to expand the array of possible responses, not reduce them. True, there are some anecdotal reports of where recourse to legislative tools such as the ADA Act have literally been life-saving, and people placed under such Acts have gone on to make full ‘recoveries’ and retake their place as productive members of the community. However, such success stories should not distract us from assessing in a dispassionate way whether the ADA Act, on first principles, is a good piece of law; and whether, overall, its potential and actual therapeutic effects for people outweigh its potential and actual anti-therapeutic effects.

To recapitulate, several aspects of the legislation were found to derogate from contemporary notions of due process protections, only using the least restrictive intervention, and acknowledging the right of competent patients to give informed consent to treatment or to refuse treatment. Moreover, the statute was seen as inherently flawed, to the extent that it does not insist on comprehensive clinical assessments for people who are deprived of their liberty for up to two years. The ADA Act was further criticised for the way that it serves to deny patient choice, both in the hearing process and in disallowing alcoholics to choose the type of treatment programme that they enter.

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This was argued to be a particular problem because of the therapeutic value of allowing patients to have a “voice” in legal proceedings; and the fact that patient choice in the treatment process can be clinically and therapeutically useful in its own right, and that interventions that deny patients’ choice can actually impede the change process.

On the critical question of whether treatment under the ADA Act is effective, it was noted that, although it will provide some short-term harm minimisation gains (simply by removing drinkers from the physical opportunity to drink alcohol in harmful ways), forcing alcoholics into 12-step treatment programmes would appear to be one of the least effective ways of helping such people deal with their drinking problems in the long-term. Moreover, it was argued that the harm minimisation gains of ambulatory care may be cancelled-out by negative psychological effects for alcoholics who are put into treatment against their will. In this sense, forced treatment could end up doing more harm than good.

On balance, the weight of evidence was seen to be against retaining the ADA Act as a stand-alone piece of legislation or conflating its provisions within general mental health legislation. Instead, it was argued that there is everything to gain and little if anything to lose in repealing the ADA Act outright; confident in the residual coverage offered by the Mental Health (Compulsory Assessment and Treatment) Act and the Protection of Personal and Property Rights Act.

10.1 Final thoughts

Instead of offering a simple vertical recitation of the summaries of the preceding chapters, this final chapter of the thesis will attempt to draw some horizontal conclusions from the analysis and discussion that has led to this point, and to signal avenues for future research that are suggested by this examination of the Alcoholism and Drug Addiction Act.

As an initial comment, this study has laboured under the difficulties associated with any grounded social-science-type research rather than more legally-oriented research, such as the ability to run automatism defences in the criminal law due to gross alcohol intoxication. The legal and clinical issues in such contexts are far ‘cleaner’ than they are here. But, by throwing some light on the theory and praxis of the ADA Act, it was hoped that the thesis could expose some value positions masquerading as objectivity in the legislation itself, and the way it is being given effect ‘on the ground’, as well as to undermine some complacent notions that exist around the treatment of alcohol problems in New Zealand. A related project for the study was to underline the need to be alive to the dangers of first, pathologising, and second, effectively criminalising, deviance, in the same way that we have been warned about the medicalisation of deviance.

These ambitions derive from a logically prior question: if we proceed on the basis that there is only limited evidence that supports the use of coerced treatment for alcoholism, how are we to explain the persistence of this response to problematic alcohol use? What types of socio-moral forces may sit above, below and behind laws like the ADA Act?

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2 This is not the place to exhaustively rehearse the leading authorities or large body on commentary on this issue. Suffice it to highlight the Canadian case of R v Daviault [1994] 93 CCC (3d) 21; the Australian cases of R v O’Connor [1980] 146 CLR 64; R v Coleman (1990) 19 NSWLR 467; R v Gigney (Unreported, SA District Court, 21 May 1997); S C Small v Noa Kunimalawi (Unreported, ACT Magistrates Court, 22 October 1997); from England, DPP v Majewski [1977] AC 443; and from New Zealand, R v Kampbell [1976] 2 NZLR 810 (CA). Two of the most recent reviews of the law on this vexed area, drawing from both common law and continental jurisdictions, are Parliament of Victoria Law Reform Committee, Criminal Liability for Self-Induced Intoxication (Melbourne: Victorian Government Printer, 1999); and S M W Rajaratnam et al., Intoxicating and Criminal Behaviour (2000) Psychiatry, Psychology and the Law, vol 7(1): 59-69.

This question takes on added significance in relation to the ADA Act if we consider that the state does not look up pack-a-day smokers and try and cure their addiction, yet their drug of choice is more likely to kill them or lead to other disabilities than alcohol; nor does it 'certify' them if they refuse to have their smoking-related cancer treated. So why do so with alcoholics? The suspicion is that there are powerful yet unseen forces at play which privilege some types of drug use over others, and which also legitimise some sorts of anti-drug interventions over others.

At one level, the ADA Act is self-consciously remedial: it identifies a particular pattern of behaviour as sub-optimal, and establishes a legal process through which those who engage in that pattern of behaviour can be assisted into (what the framers of the legislation believe is) a more functional way of life for both the individual and society. It is not surprising that there should be disagreements about this bounded vision of the ideal, as in a sense the state is attempting to redistribute its preferred alcohol-related norms and behaviours. Legislation such as the ADA Act therefore exists in the contested public-private space animated by what J R Gusfield terms "morality politics" and what K J Meier calls "the politics of sin".

Putting to one side the fact that under-consumption of alcohol in New Zealand society can also be seen as deviant, habitual drunkenness is sometimes depicted as a symbol of moral decay, signalling a selfish focus on individual pleasure at the expense of concern for others. Alcohol here is seen as a social evil which immiserates the vulnerable, destroying their ability to lead morally respectable lives. Whether or not a government and/or a society sees itself as having a responsibility for the moral guardianship of its citizens will thus necessarily impact on the type of policies around alcohol misuse that it chooses to implement.

Those who believe that tolerance of such behaviour erodes the core values upon which society rests feel that a society which fails to punish drug use relinquishes its proper responsibility. Similarly, if insistence on certain standards of behaviour is seen as a kind of moral cement which consolidates society and gives it identity, then enforcement is required to preserve that identity and to prevent harm.

American philosopher Herbert Fingarette has described reliance on this sort of disease concept of addiction as a "cultural self-delusion" which help construct geographies of fear that the sickness of alcoholism may strike down an unsuspecting person at any time. It is undoubtedly the case that the existence of civil commitment laws like the ADA Act can be culturally (re)iterative in itself, and that processing citizens through treatment programmes using such laws can lead to institutionalised conformity and the reinforcement of prevailing modes of domination.

\[4\] In a 1930 decision, Smith J observed of the ADA Act's precursor that: "The Reformatory Institutions Act of 1909 is of its own nature remedial, and it must receive such fair and liberal construction as will best ensure the attainment of its objects according to its true intent and meaning." In re Hazlett [1930] NZLR 777.


Going beyond the existing attempts to tease out the symbolism of drinking and intoxication in New Zealand society, it is perhaps time to corrode some of the "timeless orthodoxies" and interrogate the taken-for-granted assumptions that exist about alcohol in New Zealand. In doing so, it will be important to problematise the place of the law in alcohol policy, recognising that the law not only serves the social order, but also plays a part in determining the shape of that order. As scholars from within the Critical Legal Studies tradition point out, the constitutive character of the law reveals the inseparability of the law to practices of living, and the law's indivisibility from practices of knowing. In some cases, the law accepts that a history of alcohol use can be a mitigating factor, while in others, the law sees the consumption of alcohol as an aggravating factor. Where does it draw the line, and why does it draw it there?

This is not the place for further musing on this topic. Suffice it to say that the contingency and complicity of laws like the ADA Act are fertile ground for further study, and will assist the task of invigorating alcohol social science research.

10.2 Prospects for policy change

It is appropriate, finally, to wonder aloud what the prospects are for the ADA Act being reformed in the manner argued for by this thesis. Although such augury is notoriously imprecise, the omens are more positive than they might appear.

One the one hand, it is fair to say that public, political and even professional consciousness about the ADA Act is extremely low. The directly affected population of ADA Act patients only constitutes around 2.5 percent of the total annual alcohol and other drug treatment population, counselling against any real impetus for policy change. Even if parliamentarians were energised about the issues involved, they may also have a sense of deferred guilt about the recent lowering of the legal drinking age, and for an exhaustion about dealing with alcohol-related policy issues after major reform of the Sale of Liquor Act 1999 during the last few years.

On the other hand, there is also reason for cautious optimism. One of the future directions listed in the government's National Drug Policy, to be actioned by 2003, is a "review of the provisions for compulsory assessment and treatment of people with alcohol use disorders". The government is also preparing to launch its first-ever National Alcohol Strategy, which includes a number of strategies that the already-planned review of the ADA Act could springboard off with greater across-agency support.

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15 For example, R v Dowling [1985] 1 NZLR 182 (alcoholism and mental subnormality).
16 For example, R v Clarke [1982] 1 NZLR 654 (CA) (driving offence where the presence of alcohol was not an ingredient of the offence); and see, further, the discussion by M Casey, The Laws of New Zealand: Sentencing (Wellington: Butterworths, 1999), at para 105.
18 It is not only politicians and officials who might not want to engage with the issue of compulsory treatment of alcoholics. In surveys of the medical profession, alcoholism is reported to be the least favourered of the organic and psychiatric illnesses, which is unlikely to attract qualified people to the alcohol and drug treatment services, nor to serve them well if they do play a role in treating people with alcohol use disorders. One of the earliest studies is E B Macdonald and A R Patel, Attitudes towards Alcoholism (1975) British Medical Journal, vol 2: 430-431.
The current fashion for Drug Courts,21 which has entered Ministerial- and officials-level debates in recent months, may also be viewed as a sign of policymakers looking to the Courts to solve, or salve, what are essentially social problems. This could translate into additional impetus to reform the ADA Act regime for people with substance use disorders: given that, as one critic has put it, "the legislative base is more often than not expressed as a naïve moral statement by government and the wish to be seen to do something constructive".22

The prospect of the suggested reform occurring could also be strengthened by further development of the limited research base on the ADA Act. This is despite the fact that findings of alcohol-related research are often ignored by policymakers, as recent experience in New Zealand,23 Australia,24 the United Kingdom25 and elsewhere26 has shown.

In The Paradoxes of Legal Science, celebrated American jurist Benjamin Cardozo observed that, "our course of advance [in the law] ... is neither a straight line nor a curve. It is a series of dots and dashes. Progress comes per saltum, by successive compromises between extremes".27 To repeal the ADA Act, remove section 4(d) of the MH (CAT) Act, and to utilise the PPPR Act to help manage some people with chronic alcohol problems, would be just such a middle-way between the 'absolutes' of infantilising alcoholics and respecting their autonomy to death. In the submission of the author, it would also be an important and overdue development for this little-known piece of social legislation, which sits at the vigorously contested interface between addiction and the law, the individual and the state.

21 For a primer on Drug Courts, see supra, Chapter 1, note 31 and accompanying text.
22 J Ross, Is there a place for compulsory treatment?, in R Godding (ed.), Proceedings of the 1993 Autumn School of Studies on Alcohol and Drugs, pp 57-55 (Melbourne: Department of Drug and Alcohol Studies, St Vincent's Hospital, 1993), p 64.
Appendices

1. The Reformatory Institutions Act 1909

2. The Alcoholism and Drug Addiction Act 1966

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An Act to make Provision for the Establishment and Control of Reformatory Institutions for the Reception and Detention of Habitual Inebriates and of Fallen Women.

[24th December, 1909.

BE IT ENACTED by the General Assembly of New Zealand in Parliament assembled, and by the authority of the same, as follows:—

1. This Act may be cited as the Reformatory Institutions Act, 1909, and shall come into operation on the first day of January, nineteen hundred and ten.

2. In this Act, unless a contrary intention appears,—

"Habitual inebriate" means a person who habitually takes or uses in excess alcoholic liquor or any intoxicating, stimulating, narcotic, or sedative drug or drugs, and while under the influence thereof, or in consequence of the effects thereof, is habitually or at times dangerous to himself or others, or a cause of harm, suffering, or serious annoyance to his family or others, or incapable of managing himself or his affairs, or likely to suffer serious injury to his health:

"Inmate of an institution" means any person in respect of whom an order is in force under this Act for his detention in an institution, whether he is for the time being in the institution or elsewhere:

"Institution" means a certified Inebriates Home under this Act, or a certified Reformatory Home under this Act:

"Managers" means, with respect to any institution, the person or persons, society, or body corporate having the possession and control of the institution:

"Superintendent" means, with respect to any institution, the chief resident officer of that institution:

"Voluntary inmate of an institution" means a person who has been ordered on his own application, under section seven of this Act, to be detained in that institution as an habitual inebriate.

Certified Institutions under this Act.

3. (1.) The Governor, on the application of any person or society (whether incorporated or not) desirous of establishing or maintaining an Inebriates Home or a Reformatory Home under this Act, may by warrant gazetted, if satisfied as to the fitness of the Home and of the person or society proposing to establish or maintain it, certify it as an Inebriates Home or as a Reformatory Home, as the case may be, under this Act, and thereupon, and at all times thereafter while the warrant is in force, the Home so certified shall be a certified Inebriates Home or a certified Reformatory Home, as the case may be, under this Act accordingly.

(2.) The Governor may at any time, by warrant under his hand, revoke any warrant issued under this Act in respect of an institution, and thereupon the institution shall cease to be an institution
under this Act as from the date mentioned in that behalf in the warrant of revocation.

4. (1.) An institution under the control of a Hospital and Charitable Aid Board under the Hospitals and Charitable Institutions Act, 1908, may, if used or intended to be used for the reception of inebriates, or as a reformatory institution for women or girls, be certified under this Act as an Inebriates Home or a Reformatory Home, as the case may be, and shall thereupon become an institution under this Act as well as under the Hospitals and Charitable Institutions Act, 1908.

(2.) A private hospital in respect of which a license is in force under the Hospitals and Charitable Institutions Act, 1908, may, if used or intended to be used for the reception of inebriates, be certified under this Act as an Inebriates Home, and shall thereupon become subject both to this Act and to the said Hospitals and Charitable Institutions Act accordingly.

(3.) If and so far as in respect of any such institution or private hospital there is any conflict between this Act or any regulations made thereunder and the Hospitals and Charitable Institutions Act, 1909, or any regulations or by-laws made thereunder, the provisions of this Act and of the regulations made thereunder shall prevail.

5. No institution in respect of which a license is in force under the Lunatics Act, 1908, for the reception and detention of lunatics therein shall be certified as an institution under this Act.

6. Every place in which at the commencement of this Act habitual drunkards may be lawfully received and detained by virtue of any warrant issued by the Governor under section thirty-seven of the Police Offences Act, 1908, or section four of the Habitual Drunkards Act, 1906, shall be deemed to be a certified Inebriates Home under this Act; and all the provisions of this Act shall apply thereto and to all persons received and detained therein, whether before or after the commencement of this Act, accordingly, and every such warrant shall be deemed to have been issued under this Act.

Orders for Detention in an Inebriates Home.

7. (1.) Any habitual inebriate desirous of being received into a certified Inebriates Home may make application in person to a Magistrate for an order under this section.

(2.) Every such application shall be in writing in the form numbered (1) in the First Schedule hereto or to the like effect, and shall state the time during which the applicant undertakes to remain in the institution, being not less than six months or more than two years.

(3.) The signature of the applicant shall be attested by the Magistrate to whom the application is made.

(4.) The application shall be heard and determined by the Magistrate in private.

(5.) If the Magistrate is satisfied, whether by the admission of the applicant or by any other evidence, whether legally admissible in a Court of law or not, that the applicant is an habitual inebriate, and that he fully understands the nature and effect of his application, and that the superintendent of the institution named in the applica-
tion is willing to receive the applicant, the Magistrate may (if he thinks fit) make an order, in the form numbered (2) in the First Schedule hereto or to the like effect, for the detention of the applicant in that institution for the period mentioned in the application, or for any lesser period not being less than six months.

(6.) No Court fees shall be payable in respect of any proceedings under this section.

8. If, on the trial and summary conviction before a Magistrate of any person for any of the offences mentioned in the Second Schedule to this Act, it appears to the Magistrate (whether by the admission of the defendant, or by the evidence at the trial, or by any testimony specially called in that behalf at any time before sentence has been passed) that the defendant is a habitual inebriate, the Magistrate may, if he thinks fit, as part of the conviction, and either in addition to or in lieu of any term of imprisonment or other punishment to which the defendant is liable, order that the defendant shall be detained in a certified Inebriates Home for any period not being less than one year or more than two years.

9. (1.) On the complaint on oath of a relative (as herein defined) of any person that such person is an habitual inebriate, a Magistrate may issue his summons to that person to show cause why an order should not be made for his detention in a certified Inebriates Home.

(2.) If by reason of special circumstances the Magistrate thinks fit he may, on such complaint as aforesaid, instead of issuing a summons, or after the issue thereof, issue his warrant for the arrest of the alleged inebriate.

(3.) On the hearing of the complaint, the alleged inebriate being then present before him, the Magistrate may, if he thinks fit, and if he is satisfied of the truth of the complaint, and that the detention of the alleged inebriate is expedient in his own interest or in that of his relatives, make an order, in the form numbered (3) in the First Schedule hereto or to the like effect, for the detention of the alleged inebriate in any certified Inebriates Home for any period not being less than six months or more than two years.

(4.) No order shall be made under this section unless two registered medical practitioners certify, by their testimony given before the Magistrate, or by statutory declaration made in the form numbered (4) in the First Schedule hereto or to the like effect, that they have examined the person against whom the order is sought, and that they believe him to be an habitual inebriate whose detention as such is expedient in his own interest or in that of his relatives:

Provided that if the alleged inebriate refuses to submit himself for medical examination, or obstructs or delays the same, the Magistrate may dispense with the requirements of this subsection and make an order for detention accordingly.

(5.) The term "relative" in this section means husband, wife, father, grandfather, stepfather, mother, grandmother, stepmother, brother, or sister of the whole or half blood, son, grandson, daughter, granddaughter, stepson, or stepdaughter.

(6.) When any person has been detained in an institution under this section, no further order for his detention shall be made under
Reformatory Institutions.

Section, by the same or any other Magistrate, within a period of months after his discharge from custody under the first order.

(7.) Subject to the provisions of this Act, all the provisions of Justices of the Peace Act, 1906, with respect to complaints and orders shall, so far as applicable, apply to complaints and orders under this section, but no order for the payment of costs shall be made against the defendant.

(8.) No stamp duty shall be chargeable on any statutory declaration required under this section, and no Court fees shall be payable respect of any proceedings under this section.

(9.) Any complaint under this section may be heard and determined by the Magistrate in private.

10. (1.) If on the trial and conviction of any person in the Supreme Court for any offence punishable by imprisonment it appears to the Judge before whom the trial takes place (whether the admission of the defendant, or by the evidence at the trial, or any testimony specially called in that behalf at any time before sentence has been passed) that the offence was committed under the influence of alcohol, or that drunkenness was a contributing cause of the offence, and (in either case) that the defendant is an habitual brawler, the Judge may, if he thinks fit, in addition to or in lieu of a term of imprisonment or other punishment to which the defendant is liable, and as part of the sentence of the Court, order the defendant to be detained in a certified Reformatories Home for any term not less than one year or more than two years.

(2.) This section shall extend and apply to any case in which a person has been committed to the Supreme Court for sentence on plea of "Guilty," in the same manner as if he had been there tried and convicted on indictment.

Orders for Detention in a Reformatory Home.

11. On the trial and summary conviction before a Magistrate any woman or girl who is or appears to be over the age of fourteen years of any offence mentioned in the Third Schedule hereto, the Magistrate may, if he thinks fit,—

(a.) With the consent of the defendant; or

(b.) Without her consent, if he is satisfied (whether by the admission of the defendant, or by the evidence at the trial, or by any testimony specially called in that behalf at any time before sentence is passed) that the defendant is a common prostitute or habitually leads an immoral life,—

12. If any woman or girl who is or appears to be over the age fourteen years is convicted in the Supreme Court of any indict-
able offence mentioned in the Third Schedule hereto, or is committed to the Supreme Court for sentence on a plea of “Guilty” to any such offence, the Judge before whom the defendant is so convicted or brought for sentence may, if he thinks fit,—
(a.) With the consent of the defendant; or
(b.) Without her consent, if he is satisfied (whether by the admission of the defendant, or by the evidence at the trial, or by any testimony specially called in that behalf at any time before sentence has been passed) that the defendant is a common prostitute or habitually leads an immoral life,—

order, as part of the sentence of the Court, and either in addition to or in lieu of any term of imprisonment or other punishment to which the defendant may be liable, that she shall be detained in a certified Reformatory Home for any period not exceeding one year; and in determining in what certified Reformatory Home she is to be so detained the Judge shall take into consideration, together with all other circumstances that seem to him relevant, her age, religion, previous conduct and character, the nature of her offence, and the suitability of the proposed Home for her reformation.

Reception, Transfer, and Discharge.

13. When an order is made under this Act for the detention of any person in an institution without any prior term of imprisonment, the Judge or Magistrate by whom the order is made shall issue a warrant under his hand in the form numbered (5) in the First Schedule hereto or to the like effect, and any constable or any person to whom the warrant is so addressed may thereupon arrest the person so ordered to be detained, and take him to the institution, there to be detained according to the order.

14. When an order is made under this Act for the detention of any person in an institution, and at the same time, or at any time thereafter while he remains an inmate of the institution, he is sentenced to imprisonment for any offence, he shall on the expiry of the period of his sentence, or on his earlier discharge from custody under that sentence, be taken by any constable, or by any officer of the prison in which he has been so imprisoned, to the institution in which he is ordered to be detained, and he shall be there detained in accordance with the order.

15. (1) The expenses incurred by any constable, or by any officer or servant of any institution, or by any officer of a prison, in conveying or returning any person to an institution in which he is ordered to be confined or to which he has been transferred in pursuance of this Act, shall be deemed to be moneys expended in the conveyance to prison of a person sentenced to imprisonment, and shall be payable out of the public revenues accordingly.

(2.) All sums so paid out of the public revenues on account of the conveyance or return of any person to an institution shall constitute a debt due by that person to the Crown, and shall be recoverable by action accordingly in any Court of competent jurisdiction.

(3.) On the hearing of an application or complaint under section seven or section nine of this Act the Magistrate may, if
he thinks fit, make it the condition of the granting of an order of detention that the applicant or complainant shall deposit, with such person as the Magistrate directs, such sum as the Magistrate thinks sufficient for the conveyance to the institution of the person ordered to be detained therein, and the sum so deposited, or such part thereof as may be necessary, shall be expended accordingly, and the residue, if any, shall be repaid to the person by whom the deposit was made.

16. After the making of an order for the detention of any person under this Act, and pending the reception of that person into an institution in pursuance of the order, the Magistrate or Judge by whom the order is made, or the Minister of Justice, may give such directions as he thinks fit touching the custody of that person, and may, except in the case of an applicant under section seven of this Act, direct him to be kept in any prison or other place of confinement, but no person shall be detained in custody under the authority of this section for a longer continuous period than fourteen days.

17. An inmate of an institution may at any time while he is absent from the institution without lawful justification, whether by reason of his escape from lawful custody or by reason of any other circumstance, be arrested without warrant by any constable or by any officer or servant employed in or about the institution, and may thereupon be taken to the institution or otherwise dealt with according to law.

18. (1.) The Minister of Justice may at any time, by order under his hand,—

(a.) Discharge any person detained or ordered to be detained in an institution under this Act:

(b.) Transfer any such person from one institution to any other institution of the like kind (but, in the case of a voluntary inmate, only with his own consent in writing):

(c.) Release on probation, and on such terms and for such reasons as he thinks fit, any person so detained or ordered to be detained:

(d.) Revoke at any time, and notwithstanding the terms thereof, any such order of release on probation, and order the return of the person so released to the same or (save in the case of a voluntary inmate) any other institution of the like kind, for the portion then unexpired of the period of his detention.

(2.) When any person has been transferred from one institution to another under this section, he shall be detained in the institution to which he has been so transferred until the expiry of the period of detention mentioned in the original order of detention, unless he is sooner released or transferred in due course of law.

(3.) Any person ordered to be transferred from one institution to another shall be deemed to remain an inmate of the former of those institutions until he has been received into the latter, and may be taken in custody to the latter institution by any constable or by any officer or servant of either of those institutions.

(4.) When an order of release on probation has been revoked, any constable or any officer or servant of the institution may arrest
the person so released and take him back to the institution, or to any other institution specified in that behalf in the order of revocation, there to remain in confinement until the expiration of the period of his detention.

19. (1.) The period of the detention of any person in an institution under any order made by a Magistrate or Judge shall be computed as from the date of the first reception of that person into an institution in pursuance of that order or in pursuance of any order of transfer made by the Minister of Justice.

(2.) Any period during which a person has been absent from an institution on probation or by virtue of an order made under section twenty of this Act shall be computed as part of the period of his detention.

(3.) No period during which a person has been imprisoned in any prison, or has been absent from the institution after the revocation of an order for release on probation, or after his escape from the institution, shall be computed as part of the period of his detention.

(4.) Save as in this section provided, the period of detention or any person shall be computed continuously as from the date of his actual reception into the institution.

20. (1.) In the case of the illness of any inmate of an institution, he may, with the consent of a Magistrate or of the Minister of Justice, be removed by the managers or superintendent of the institution to any hospital or other institution under the Hospitals and Charitable Institutions Act, 1908.

(2.) Any person so removed shall be deemed to remain in lawful custody under the order by which he was detained in the institution under this Act, and he may at any time be returned to that institution by the managers or superintendent thereof, or by any officer of the hospital or other institution to which he has been so removed.

21. Save by virtue of a contract made in that behalf, the managers or superintendent of an institution shall be under no obligation to receive into the institution any person ordered to be detained therein, or to permit the return to the institution of any person who has been released on probation or has been imprisoned.

22. If an order is made for the detention of any person in an institution, and that person is refused admission to the institution, the Minister of Justice shall thereupon, by order under his hand, either discharge or transfer that person in accordance with the provisions of section eighteen of this Act.

23. (1.) The superintendent of an institution may at any time and for any reason discharge a voluntary inmate of the institution before the expiry of the period for which he was ordered to be detained.

(2.) No inmate of an institution, other than a voluntary inmate, shall after his reception therein be discharged therefrom except on the expiration of the period for which he was ordered to be detained, or in pursuance of an order of discharge or transfer made by the Minister of Justice.

(3.) If any inmate of an institution is, after his reception therein, discharged therefrom otherwise than in due course of law, every officer or servant of the institution who procured, aided, per-
mitted, or took part in the discharge shall be severally guilty of an
offence punishable on summary conviction by a fine not exceeding
twenty pounds.

(4.) For the purposes of this section an inmate of an institution
shall be deemed to be discharged if he is permitted to be absent
therefrom for more than twenty-four hours at any one time otherwise
than in pursuance of the provisions of this Act.

Offences.

24. (1.) Every person commits an offence who wilfully detains
any other person, or wilfully aids, abets, or procures the detention
of any other person, in an institution under this Act otherwise than
in due course of law, or for a longer period than is authorised by
law.

(2.) Every such offence shall be punishable on indictment by
imprisonment with or without hard labour for a period not exceeding
one year, or by a fine not exceeding two hundred pounds.

25. Every inmate of an institution who escapes or attempts
to escape therefrom, or from lawful custody as such inmate, or
who wilfully refuses or neglects to return to the institution
after the expiration or determination of any period of lawful
absence therefrom, shall be guilty of an offence punishable on
summary conviction by imprisonment for a period not exceeding
three months.

26. Every inmate of an institution, and every officer, servant,
or other person employed in or about an institution, who wilfully
commits a breach of any regulation made under this Act in respect
of the breach of which any penalty by way of fine or imprisonment
is prescribed by regulations shall be guilty of an offence punishable
on summary conviction by the penalty so prescribed.

27. If any inmate of an institution is wilfully guilty of any
violent, unruly, insubordinate, destructive, indecent, offensive, or
insulting conduct, he shall be liable, on summary conviction before
a Magistrate, to imprisonment for a period not exceeding three
months.

28. Every person, other than a registered medical practitioner,
who, save in pursuance of the written authority of a registered
medical practitioner, procures or attempts to procure any intoxicating
liquor, or any stimulating, narcotic, or sedative drug for, or sends,
takes, or delivers, or attempts to send, take, or deliver, any such
liquor or drug to any person whom he knows to be an inmate of a
certified Inebriates Home (whether that inmate is detained in the
institution or is absent therefrom on probation or otherwise howso-
ever) commits an offence, and is liable on summary conviction to a
fine not exceeding twenty pounds.

29. Every person commits an offence and is liable on summary
conviction to a fine not exceeding twenty pounds who—

(a.) Ill-treats or (being an officer, servant, or other person
employed in or about an institution) wilfully neglects
any inmate of an institution; or

(b.) Induces or knowingly assists any inmate of an institution
to escape therefrom or from lawful custody.
Procedure.

30. All the provisions of the Justices of the Peace Act, 1908, as to appeals from convictions or orders shall apply, with the necessary modifications, to any order for detention made by a Magistrate under this Act (other than an order made under section seven thereof against any person on his own application) in the same manner as if detention in an institution under this Act was imprisonment within the meaning of the said Justices of the Peace Act.

31. No person charged before a Magistrate with any offence punishable on summary conviction shall be entitled to be tried on indictment by reason merely of the fact that he is liable under this Act to be detained in an institution.

32. When an order is made by a Magistrate or Judge under this Act for the detention of any person in an institution, a minute of the order under the hand of the Magistrate or of the Registrar or Deputy Registrar of the Supreme Court, as the case may be, shall be forthwith sent by him, by post or otherwise,—

(a.) To the Minister of Justice at Wellington;
(b.) To the superintendent of the institution; and
(c.) Where the person so ordered to be detained has at the same time been sentenced to any term of imprisonment, to the Gaoler of the prison in which he is to be so imprisoned.

33. In any proceedings, civil or criminal, a certificate in writing setting out the substance of any order made under this Act, signed by any Magistrate by whom the order has been made, or by any Registrar, clerk, or officer having the custody of the record of the order, shall be sufficient evidence thereof on proof of the signature and official character of the person by whom the certificate is signed.

34. No order, warrant, or other document made or issued in respect of any institution under this Act shall be invalidated by any misnomer or erroneous description of the institution, or of any person ordered to be confined, or by any other error or defect of form.

35. For the purposes of any order to be made under this Act for the detention of any person in an institution, on the trial and conviction of that person for an offence it shall not be necessary that the defendant should be formally charged in the information or indictment or otherwise with being an habitual inebriate, or a common prostitute, or with habitually leading an immoral life, or with any other fact or circumstance necessary to give the Judge or Magistrate jurisdiction under this Act.

36. Justices of the Peace shall not be capable of exercising any of the powers conferred by this Act upon a Magistrate.

Miscellaneous.

37. When an order has been made against any person (whether before or after the commencement of this Act) for his detention in an institution, the Public Trustee may be appointed as the administrator or interim curator of his estate, in accordance with Part III of the Prisons Act, 1908, and all the provisions of sections fifty-five to seventy-five of that Act shall, so long as the order of detention
remains in force, apply to that person accordingly in the same manner in which those provisions apply to persons imprisoned.

38. (1.) The cost of the maintenance of any person in any institution in which he is detained under this Act shall, to the extent and in the cases (if any) prescribed by regulations, constitute a debt owing by that person and accruing due from week to week, and shall be recoverable by action in any Court of competent jurisdiction at the suit in his own name of the superintendent or managers of the institution at the time of action brought:

Provided that the Magistrate or Judge by whom the order is made, or the Minister of Justice, in making an order of transfer, may in and by the order exempt, wholly or partially, the person so ordered to be detained or transferred from the requirements of this section.

(2.) Nothing in this section shall affect any contract made by any person in respect of the maintenance of himself or any other person in an institution under this Act.

(3.) If the Public Trustee is appointed under this Act as the administrator or interim curator of the estate of any inmate of an institution, he shall pay from time to time out of the estate all sums payable by that inmate in respect of his maintenance (whether by virtue of this section or of any contract), so far as such payment can, in the opinion of the Public Trustee, be made without inflicting undue hardship on the family of that inmate.

39. (1.) The Governor may from time to time, by Order in Council gazetted, make regulations—

(a.) Prescribing the conditions on which institutions may be certified under this Act as Inebriates Homes or Reformatory Homes:

(b.) Regulating the establishment, management, maintenance, and inspection of institutions:

(c.) Regulating and prescribing the appointment and duties of officers and servants of institutions:

(d.) Regulating the classification, treatment, control, and discipline of persons detained in institutions:

(e.) Prescribing compulsory employment for persons detained in institutions:

(f.) Prescribing the sums to be paid by inmates of institutions in respect of their maintenance therein, and the cases in which such sums are payable:

(g.) Prescribing penalties by way of fine or imprisonment for the breach of any such regulation, but so that the fine so prescribed shall not exceed twenty pounds or the term of imprisonment exceed one month.

(2.) Regulations so made may apply either to all institutions under this Act, or to institutions of any specified class, or to any individual institution.

40. No action shall lie against any person for anything done in good faith and with reasonable care in pursuance or intended pursuance of this Act, or of any order, warrant, or regulation made or issued, or purporting to be made or issued, under this Act.

41. Sections thirty-four to thirty-nine of the Police Offences Act, 1908 (relating to habitual drunkards), are hereby repealed, but
every order made under section thirty-five of that Act, or under section three of the Habitual Drunkards Act, 1906, and in force at the commencement of this Act, shall remain in force for the residue of the period for which it was made, and shall be subject to the provisions of this Act in the same manner as if made thereunder in respect of a certified Inebriates Home.

SCHEDULES.

FIRST SCHEDULE.

(1) APPLICATION FOR RECEPTION INTO CERTIFIED INEBRIATES HOME.

The Reformatory Institutions Act, 1909.

To C. D., Esq., Stipendiary Magistrate.

I, A. B., [Occupation and address], hereby make application for an order under section 7 of the Reformatory Institutions Act, 1909, for my detention as an habitual inebriate in the certified Inebriates Home situate at [Name of institution]; and I undertake to remain therein for [lesser period as may be specified in the order, or until such time as I am otherwise lawfully discharged in accordance with the provisions of the said Act].

Dated this day of , 19

Signed by the said A. B. this day of , 19 , in the presence of—

C. D.,
Stipendiary Magistrate.

(2) ORDER FOR DETENTION IN CERTIFIED INEBRIATES HOME UPON APPLICATION OF HABITUAL INEBRIATE.

The Reformatory Institutions Act, 1909.

WHEREAS on , the day of , 19 , A. B., [Occupation and address], personally appeared before me, a Stipendiary Magistrate, and made application under the provisions of section 7 of the Reformatory Institutions Act, 1909, for his detention as an habitual inebriate in the certified Inebriates Home situate at [Name of institution]; and known as [Name of institution]; And whereas I am satisfied that the said A. B. is an habitual inebriate within the meaning of the said Act, and that he fully understands the nature and effect of his application; And whereas the superintendent of that certified Inebriates Home is willing to receive the said A. B. as an inmate of that institution:

Now, therefore, I do order that the said A. B. be detained as an habitual inebriate in the certified Inebriates Home situate at [Name of institution], for the period of

Given under my hand, at this day of , 19.

C. D.,
Stipendiary Magistrate.

(3) ORDER FOR DETENTION IN CERTIFIED INEBRIATES HOME UPON COMPLAINT OF RELATIVE.

The Reformatory Institutions Act, 1909.

WHEREAS on , the day of , 19 , E. F., [Occupation and address], being a relative of A. B., [Occupation and address], appeared before me, a Stipendiary Magistrate, and complained on oath that the said A. B. is an habitual
inebriate: And whereas G. H. and I. J., registered medical practitioners, have
certified to me that they have examined the said A. B., and that they believe
him to be an habitual inebriate whose detention as such is expedient [or And
whereas the said A. B. has refused to submit himself for medical examination [or as
the case may be], and I have dispensed with such examination accordingly]: And
whereas I am satisfied that the said A. B. is an habitual inebriate as aforesaid, and
that it is expedient that he should be detained in a certified Inebriates Home:

Now, therefore, I do order that the said A. B. be detained as an habitual
inebriate in the certified Inebriates Home situate at [Name of institution], for the period of

Given under my hand, at [Name of place], this day of [Name of day], 19 [Year].

C. D., Stipendiary Magistrate.

(4.) Declaration of Medical Practitioner as to Habitual Inebriate.

The Reformatory Institutions Act, 1909.

I, G. H., of [Name], in the Dominion of New Zealand, medical practitioner, do
solemnly and sincerely declare,—

(1.) That I am a duly registered medical practitioner.

(2.) That I have examined A. B., [Occupation and address], and believe him to
be an habitual inebriate within the meaning of the Reformatory Institutions Act,
1909, and that his detention as such in a certified Inebriates Home is expedient in
his own interest [or in that of his relatives].

And I make this solemn declaration conscientiously believing the same to be
true, and by virtue of the Justices of the Peace Act, 1906.

Declared at [Name of place], this day of [Name of day], 19 [Year], before me—

G. H.,

Justice of the Peace [or as the case may be].

(5.) Warrant for Arrest of a Person Ordered to be Detained in a
Reformatory Institution.

The Reformatory Institutions Act, 1909.

To M. N., constable, and to all other constables in New Zealand [or (and) to
any other person or persons named or described in the warrant],

Whereas on the day of [Name of day], 19 [Year], an order was made by
me under the Reformatory Institutions Act, 1909, for the detention of A. B., [Occupation
and address], in the certified Inebriates Home [or certified Reformatory Home]
situate at [Name of place], and known as [Name of institution], for the period of

This is to command you to apprehend the said A. B., and to take him
[or her] to the said institution, there to be detained in accordance with the said
order.

Given under my hand, at [Name of place], this day of [Name of day], 19 [Year].

C. D., Stipendiary Magistrate [or Judge of the Supreme Court].

SECOND SCHEDULE.

Offences to which Section 8 of this Act Applies.

1. Drunkenness, or any offence of which drunkenness forms a necessary element.
2. Any offence against Part VI of the Licensing Act, 1908, by any person in respect
of whom a prohibition order is in force.
3. Attempting to commit suicide.
4. Any offence against sections 41, 42, or 49 of the Police Offences Act, 1908.
THIRD SCHEDULE.

OFFENCES TO WHICH SECTION 11 OF THIS ACT APPLIES.

1. An offence against sections 83, 41, 42, or 49 of the Police Offences Act, 1906.
2. Attempting to commit suicide.
3. Drunkenness, or any offence of which drunkenness is a necessary element.
4. An offence against section 194 of the Crimes Act, 1908.
ALCOHOLISM AND DRUG ADDICTION

REPRINTED AS ON 1 JUNE 1985

NOTES: 1. Except where otherwise indicated, all references to money in decimal currency in square brackets were substituted for references to money in the former currency by s. 7 of the Decimal Currency Act 1964.
2. Except where otherwise indicated, all references in square brackets to a psychiatric hospital within the meaning of the Mental Health Act 1969 were substituted for references to a public institution within the meaning of the Mental Health Act 1911 by s. 129 (6) of the Mental Health Act 1969.
3. Except where otherwise indicated, all references to the High Court in square brackets were substituted for references to the Supreme Court by s. 12 of the Judicature Amendment Act 1979; and all references to the District Court and to a District Court Judge in square brackets were substituted for references to the Magistrate’s Court and to a Magistrate or Stipendiary Magistrate by s. 18 (2) of the District Courts Amendment Act 1979.

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THE ALCOHOLISM AND DRUG ADDICTION ACT
1966

1966, No. 97

An Act to consolidate and amend the Reformatory Institutions Act 1909 and its amendments, and to make better provision for the care and treatment of alcoholics and drug addicts
[20 October 1966]

1. Short Title and commencement—(1) This Act may be cited as the Alcoholism and Drug Addiction Act 1966.
(2) This Act shall come into force on a date to be appointed for the commencement thereof by the Governor-General by Order in Council.

This Act came into force on 1 January 1969; see S.R. 1968/210.

2. Interpretation—in this Act, unless the context otherwise requires,—
“Alcoholic” means a 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:
“Committal order” means an order requiring a person to be detained in an institution for treatment for alcoholism (other than an order made under section 8 of this Act):

“Institution” means a certified institution under this Act:

“Managers”, in relation to any institution (other than an institution conducted by the Crown), means the person or body of persons having the possession and control of the institution:

“Minister” means the Minister of Health:

“Patient” means any person in respect of whom an order is in force for his detention in an institution, whether he is for the time being in the institution or elsewhere or is absent on leave under the provisions of this Act:

“Superintendent”, in relation to any institution, means the chief resident officer of the institution:

“Supervising Committee”, in relation to any institution, means a Supervising Committee appointed for the institution under section 7 of this Act.

Cf. 1909, No. 30, ss. 2, 36

3. Drug addicts—This Act shall apply, in the same way as 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.

4. Advisory and technical committees—(1) For the purpose of assisting in the administration of this Act the Minister may from time to time appoint such advisory or technical committees as he thinks fit.

(2) Every such committee shall have such functions in relation to this Act as the Minister may from time to time determine.

(3) There may be paid to the members of any such committee, out of money appropriated by Parliament for the purpose, remuneration by way of fees, salary, or allowances and travelling allowances and expenses in accordance with the Fees and Travelling Allowances Act 1951, and the provisions of that Act shall apply accordingly as if the committee were a statutory Board within the meaning of that Act.

(4) Subject to the provisions of this Act and of any regulations made under this Act, every such committee may regulate its own procedure.
5. Certified institutions—(1) Where any person or body of persons (whether incorporated or not) is desirous of establishing or maintaining an institution under this Act, the Governor-General may by Order in Council, on the recommendation of the Minister made on the application of that person or body, and if satisfied in respect of the fitness of the institution and of that person or body, certify the institution as an institution under this Act:

Provided that no licensed hospital within the meaning of the Hospitals Act 1957 and no licensed institution within the meaning of [the Mental Health Act 1969] shall be so certified.

(2) Without limiting the generality of subsection (1) of this section, it is hereby declared that any hospital (including [a psychiatric hospital within the meaning of the Mental Health Act 1969]) conducted by the Crown may, without application, be certified under that subsection as an institution under this Act.

(3) Any such Order may at any time be revoked by the Governor-General by Order in Council; and thereupon the institution shall cease to be an institution under this Act as from the date specified in that behalf in the last-mentioned Order.

Cf. 1909, No. 33, ss. 3, 4

In the proviso to subs. (1), the Mental Health Act 1969, being the corresponding enactment in force at the date of this reprint, has been substituted for the repealed Mental Health Act 1911.


Nothing in s. 24 (1)-(5) of the Misuse of Drugs Act 1975 (as to the treatment of persons dependent on controlled drugs) is to apply to a patient in an institution under this Act, see s. 24 (6) of the Misuse of Drugs Act 1975.

6. Existing institutions—Every institution which at the commencement of this Act is a certified Inebriates Home under the Reformatory Institutions Act 1909 shall be deemed to be a certified institution under this Act; and all the provisions of this Act shall apply thereto and to all persons received and detained therein, whether before or after the commencement of this Act:

Provided that any person detained in any such institution at the commencement of this Act shall be discharged on the date on which he would have been discharged if this Act had not been passed unless an order is made under this Act for his discharge on an earlier date.

Cf. 1909, No. 30, s. 6
7. Supervising Committees for certain institutions—
(1) For the purposes of this Act, the Minister may if he thinks fit from time to time appoint for any institution under this Act, other than an institution within the meaning of the Hospitals Act 1957, [a psychiatric hospital within the meaning of the Mental Health Act 1969], or any other institution conducted by the Crown, a Supervising Committee, which shall have such functions as are conferred upon it by or under this Act.

(2) Every such Committee shall consist of a [District Court Judge], the superintendent of the institution, a medical practitioner attending the institution, and one other person.

(3) The members of the Committee, other than the superintendent of the institution and the medical practitioner attending the institution, shall be appointed for a term of 3 years, but may from time to time be reappointed, or may at any time be removed from office by the Minister, or may at any time resign their office by writing addressed to the Minister.

(4) The [District Court Judge] shall be the Chairman of the Committee.

(5) The Chairman and the superintendent of the institution shall constitute a quorum at any meeting of the Committee.

(6) The Chairman shall preside at all meetings of the Committee and shall have a deliberative vote, and, in the case of an equality of votes, shall also have a casting vote.

(7) Every question before any meeting of the Committee shall be determined by a majority of the votes of the members present and voting thereon.

(8) In any case where the Chairman of the Committee is prevented by illness or absence or any other cause from acting in his office, any [District Court Judge] may act in his place, and while so acting shall have all the powers and may perform the functions of the Chairman.

(9) In the absence from any meeting of the Committee of the superintendent of the institution, any person authorised in that behalf by the superintendent may attend the meeting in his stead, and while so attending shall be deemed to be the superintendent of the institution.

(10) The fact that any [District Court Judge] is acting for the Chairman or that any person is attending a meeting in the place of the superintendent of the institution shall be conclusive evidence of his authority to do so, and no person shall be concerned to inquire whether the occasion for his so acting or so attending has arisen or ceased.
(11) Subject to the provisions of this Act and of any regulations made under this Act, the Committee may determine its own procedure.

[(12) There may be paid to the members of any Supervising Committee, out of money appropriated by Parliament for the purpose, remuneration by way of fees, salary, or allowances and travelling allowances and expenses in accordance with the Fees and Travelling Allowances Act 1951, and the provisions of that Act shall apply accordingly as if the Committee were a statutory Board within the meaning of that Act.]

Cf. 1918, No. 8, s. 11
Subs. (12) was added by s. 2(1) of the Alcoholism and Drug Addiction Amendment Act 1970, as from 1 January 1969, see s. 2(2) of that Act.

Orders for Detention and Treatment

8. Voluntary applications for detention in institution—
(1) Any person desirous of being received into an institution may make application in person to a [District Court Judge] for an order under this section.

(2) Every such application shall be in writing in the prescribed form, and shall specify the institution into which the applicant desires to be received, and shall state that the applicant undertakes to remain in the institution, for treatment for alcoholism, until he is released or discharged under this Act.

(3) The signature of the applicant shall be attested by the [District Court Judge] to whom the application is made, or by the Registrar or Deputy Registrar of a [District Court].

(4) If the [District Court Judge] is satisfied, whether by the admission of the applicant or by any other evidence, that the applicant is an alcoholic, and that he fully understands the nature and effect of his application, the [District Court Judge] may, if he thinks fit, and if he is satisfied that the managers or the superintendent of the institution, as the case may require, are willing to receive the applicant into the institution, make an order in the prescribed form for the detention of the applicant, for treatment for alcoholism, in the institution named in the application.

Cf. 1909, No. 30, s. 7
As to the prescribed forms mentioned in subs. (2), see S.R. 1968/211.

9. Power of District Court Judge to order detention and treatment on application of relative or other reputable person—(1) On the application in the prescribed form of a relative (as defined in this section) of any person, or on the application in the prescribed form of a member of the Police
or of any other reputable person, that the person to whom the application relates is an alcoholic, any [District Court Judge] may if he thinks fit issue his summons to the alleged alcoholic to show cause why an order should not be made requiring him to be detained for treatment for alcoholism in an institution.

(2) Where the application is made by a member of the Police or by any person who is not a relative of the alleged alcoholic, the application shall contain a statement of the reason why it is made by the applicant instead of by a relative.

(3) All statements contained in the application shall be verified by the statutory declaration of the applicant or of some other person, unless the [District Court Judge] otherwise permits, and, if the [District Court Judge] sees fit, by the evidence on oath of the applicant or some other person at the hearing of the application.

(4) If, on any such application as aforesaid, the [District Court Judge] is satisfied, by evidence on oath, that a warrant is necessary to compel the attendance of the alleged alcoholic or that other circumstances exist that render the issue of a warrant expedient the [District Court Judge] may, whether or not a summons has been issued or served, issue his warrant for the arrest of the alleged alcoholic. Every person arrested pursuant to any such warrant shall be brought before a [District Court Judge], as soon as possible, to be dealt with in accordance with this Act.

(5) If the [District Court Judge] is satisfied that the alleged alcoholic has refused to undergo examination by 2 medical practitioners for the purposes of this Act or has wilfully failed to attend for any medical examination required for the purposes of this Act, he may issue his warrant under subsection (4) of this section for the arrest of the alleged alcoholic and may at the same time order that the alleged alcoholic shall, after his arrest, undergo medical examination by 2 ... medical practitioners.

(6) On the hearing of the application the [District Court Judge] shall not make an order under subsection (7) of this section unless 2 medical practitioners either give evidence to the effect or give certificates in the prescribed form to the effect that they believe the alleged alcoholic to be an alcoholic within the meaning of this Act and that the making of an order for his detention and treatment as such is expedient in his own interest or in that of his relatives.

(7) Subject to subsection (6) of this section, on the hearing of the application, the alleged alcoholic being then present
before him, the District Court Judge may, if he thinks fit, and if he is satisfied of the truth of the application, and that the managers or the superintendent of an institution, as the case may require, are willing to receive the alcoholic into the institution, make an order requiring the alcoholic to be detained for treatment for alcoholism in that institution.

(8) In this section, the term "relative" means a spouse, parent, grandparent, stepfather, stepmother, brother, sister, half-brother, half-sister, son, daughter, grandson, grand-daughter, stepson, or stepdaughter.

In subs. (5) the word "designated" was omitted by s. 3 of the Alcoholism and Drug Addiction Amendment Act 1970.

As to the prescribed form mentioned in subs. (1), see S. R. 1968/211.

10. Period of detention—(1) No person in respect of whom an order for detention is made under the foregoing provisions of this Act or under section 48A of the Criminal Justice Act 1954 shall be detained under that order in any institution or institutions under this Act for more than 2 years altogether after his first reception in an institution pursuant to the order.

(2) Subject to the provisions of this Act, every such person shall be detained until he is discharged pursuant to this Act.

Cf. 1909, No. 30, ss. 7 (2), 8, 9 (3), 10 (1), 23 (2)

11. Mode of computing period of detention—(1) The period of the detention of any person in an institution under any order made pursuant to this Act shall be computed from the date of his first reception into an institution pursuant to the order.

(2) Any period during which a person is lawfully absent on leave from an institution, or is absent pursuant to section 22 of this Act, shall be computed as part of the period of his detention.

(3) No period during which any person is detained in any penal institution, or is absent from an institution under this Act after the revocation of an order releasing him on leave of absence, or after his escape from the institution, shall be computed as part of the period of his detention.

(4) Except as provided in this section, the period of detention of any person shall be computed continuously from the date of his actual reception into the institution.

Cf. 1909, No. 30, s. 19; 1936, No. 58, s. 67
12. Enforcement of order of detention when term of imprisonment imposed—When an order is made under this Act or under section 48A of the Criminal Justice Act 1954 for the detention of any person in an institution, and at the same time, or at any time thereafter while he remains a patient of the institution, he is sentenced to imprisonment or [corrective training] for any offence, he shall on the expiry of the period of his sentence, or on his earlier release from custody under that sentence, be taken by any member of the Police, or by an officer of any penal institution, to the institution under this Act in which he is ordered to be detained, and he shall be detained there in accordance with the order:

Provided that where the sentence was imposed while he was a patient at the institution he shall not be so taken to it if more than 2 years have elapsed since his first reception in an institution pursuant to the order.

Cf. 1909, No. 30, s. 14

The words in square brackets were substituted for the former words by s. 10 (1) of the Criminal Justice Amendment Act (No. 2) 1980.

13. Pending reception into institution, person may be detained—After the making of an order for the detention of any person under this Act, and pending the reception of that person into an institution pursuant to the order, the [District Court Judge] by whom the order is made, or the Minister, may give such directions as he thinks fit in respect of the custody of that person, and may direct that he be kept in any police station, [psychiatric hospital within the meaning of the Mental Health Act 1969], or other place of confinement:

Provided that the total period for which a person may be detained in custody under the authority of this section shall not exceed 10 days and any part of that period during which he is detained in a police station shall not exceed 48 hours.

Cf. 1909, No. 30, s. 16

14. Power of arrest—Any member of the Police may arrest any person ordered to be detained under this Act and take him into custody for detention in accordance with the order and the provisions of this Act.

Cf. 1909, No. 30, s. 13

15. Detention during transit—While any patient is being taken to or from any institution, he may be detained in any
other institution or in a police station, [psychiatric hospital within the meaning of the Mental Health Act 1969], or other place of confinement.

16. **Patient unlawfully absent may be arrested without warrant**—Any patient may at any time while he is absent from the institution without lawful justification, whether by reason of his escape from lawful custody or by reason of any other circumstance, be arrested without warrant by any member of the Police or by any officer or servant employed in or about the institution, and may thereupon be taken to the institution or otherwise dealt with according to law.

Cf. 1909, No. 30, s. 17

17. **Discharge, transfer, or release on leave of patients**—

(1) Subject to the provisions of this Act, the Minister, or the Supervising Committee (if any) of an institution, or the superintendent in the case of an institution under the control of [an area health board or] a Hospital Board or of a [psychiatric hospital within the meaning of the Mental Health Act 1969], may at any time by order in writing—

(a) Discharge any patient:

(b) Transfer any patient who is detained under a committal order from one institution to any other institution under this Act with the consent of the medical superintendent or of the governing body of the receiving institution:

(c) Release any patient on leave of absence for any period not exceeding the balance of the period of 2 years for which he is liable to be detained, upon and subject to such terms and conditions (to be specified in the order) as the Minister or the Supervising Committee or the superintendent thinks fit.

(2) Any patient ordered to be transferred from one institution to another under this section—

(a) May be taken in custody to that other institution by any member of the Police or by any officer or servant of either of the institutions and, while in such custody, shall be deemed to remain a patient of the institution from which he is transferred:

(b) Shall on his reception into the other institution become a patient of that institution and shall be detained there until the expiry of the period for which he is liable to be detained under the original order for
detention, unless he is sooner discharged or released on leave or transferred under this Act.

(3) Any patient who is on leave of absence under paragraph (c) of subsection (1) of this section may at any time during the currency of his period of leave be discharged under paragraph (a) of that subsection.

Cf. 1909, No. 30, ss. 18 (1) (a)–(c), (2), (3), 23 (1)
In subs. (1) the words in the first set of square brackets were inserted by s. 98 of the Area Health Boards Act 1983.

18. Patient may apply for discharge—(1) Any patient may at any time after the expiration of 6 months from his first reception in an institution pursuant to an order made under section 8 or section 9 of this Act or under section 48A of the Criminal Justice Act 1954 request the Minister or the Supervising Committee or superintendent, as the case may require, in writing to discharge him under paragraph (a) of subsection (1) of section 17 of this Act and, if that request is refused, may then apply to a Judge of the [High Court] in writing for an order directing that he be discharged from detention under this Act.

(2) On any such application the Judge may order that the patient be brought before him for examination at a time to be specified in the order.

(3) If on the examination of the applicant, and on such medical or other evidence as the Judge may require, the Judge is satisfied that the continued detention of the applicant is not expedient, either in his own interest or in the interest of others, or that he is unlawfully detained as an alcoholic, the Judge may by order direct that the patient be discharged, either forthwith or at such time as may be specified in the order, or that he be released on leave of absence for a period, not exceeding the balance of the period of 2 years for which he is liable to be detained, and upon and subject to such terms and conditions as the Judge thinks fit.

(4) In deciding whether or not to make an order under this section the Judge may take into consideration the fact that any relative or friend of the patient is able and willing to take care of him.

(5) On the taking effect of an order of discharge under this section, the order for detention under which the patient is then detained shall be deemed to be revoked.

(6) Nothing in this section shall prevent the exercise of any available remedy or proceeding by or on behalf of any person who is or is alleged to be unlawfully detained.
(7) Where an application under this section is refused a further application under this section shall not be entertained unless 6 months have elapsed since the date of the refusal and unless the application has been preceded by a further request for the discharge of the applicant under paragraph (a) of subsection (1) of section 17 of this Act.

19. Variation of conditions of leave of absence—Where a patient is on leave of absence under paragraph (c) of subsection (1) of section 17 of this Act, the Minister, Committee, or superintendent who released the patient on leave of absence may, on the application of the patient, vary or revoke all or any of the terms and conditions on which the patient has been released and where a patient is on leave of absence under subsection (3) of section 18 of this Act, any Judge may, on the application of the patient, make an order varying or revoking all or any of the conditions on which the patient has been released.

20. Revocation of leave of absence—(1) Where any patient who is absent on leave from an institution is convicted in any Court of any offence of which drunkenness forms a necessary element, or of any offence which is shown to have been committed under the influence of alcohol or in which drunkenness is shown to be a contributing cause, the Judge or [District Court Judge], as the case may be, may if he thinks fit revoke the order under which the patient was released on leave of absence and order that he be returned to the institution or removed to any other institution of a like kind, to be detained there in accordance with the original order for detention.

(2) Where any [District Court Judge], on the application of any member of the Police or of any other reputable person, is satisfied that any patient who is absent on leave from an institution has been taking or using in excess alcoholic liquor or any intoxicating, stimulating, narcotic, or sedative drug or drugs, or has contravened or failed to comply with any of the terms or conditions on or subject to which he was released on leave, the [District Court Judge] may if he thinks fit revoke the order under which the patient was released on leave and order that he be returned to the institution or removed to any other institution of a like kind, to be detained there in accordance with the original order for detention.

(3) On any application under subsection (2) of this section the [District Court Judge] may, if he thinks fit, issue his warrant for the arrest of the patient.
(4) Where an order is made under this section the patient may be taken to an institution in the same manner as if the order were an order for detention under this Act.

(5) On any application under subsection (2) of this section the [[ District Court Judge ]] may, in his discretion, adjourn the determination of the application from time to time, for periods not exceeding one month at any one time and not exceeding 2 months in the aggregate, and may from time to time make such order as he thinks fit for the care, control, and detention of the person to whom the application relates pending the determination of the application.

(6) On any adjournment under subsection (5) of this section the [[ District Court Judge ]] may, if he thinks fit, cause the person to whom the application relates to be examined by a medical practitioner during the period of the adjournment, and may indicate the matters on which he requires the opinion of any such medical practitioner, and the medical practitioner examining that person pursuant to this subsection shall, upon the completion of such examination, report in writing to the [[ District Court Judge ]] with regard to the material facts and his opinion thereon.

Cf. 1909, No. 30, s. 18 (1) (d), (4)

Subss. (5) and (6) were added by s. 2 of the Alcoholism and Drug Addiction Amendment Act 1975.

21. Transfer of prisoner to institution—(1) The Minister of Justice, with the concurrence of the Minister of Health, may at any time, by order under his hand, transfer to an institution under this Act, for treatment for alcoholism, any person detained in a penal institution under a sentence of imprisonment or [corrective training] or preventive detention.

(2) The Minister of Justice, with the concurrence of the Minister of Health, may at any time in like manner direct the return of any such person to a penal institution for the purpose of continuing to serve the said sentence or any other sentence applicable to him.

(3) While any person is detained in an institution under this section the term of any sentence he is then liable to serve shall continue to run. If at any time before the expiry of any such sentence he escapes from detention or custody the term of the sentence shall cease to run and shall not begin to run again until he is retaken.

(4) A person detained in an institution under this section shall not be discharged or permitted to be absent from the institution under this Act except with the consent of the
Minister of Justice and on and subject to such terms and conditions as that Minister, with the concurrence of the Minister of Health, may impose.

(5) The following provisions shall apply in respect of every person detained under this section:

(a) The provisions of section 10 of this Act shall apply as if the transfer under this section were an order for detention made under this Act:

(b) If every sentence of detention applicable to that person expires, or he is discharged thereunder, before the expiry of the period of 2 years referred to in the said section 10, he shall be discharged from the institution under this Act:

(c) If on the expiry of the said period of 2 years he is still liable to detention under any such sentence, he shall be returned to such penal institution as the Minister of Justice directs.

Cf. 1918, No. 8, s. 10

In subs. (1) the words in square brackets were substituted for the words "borstal training" by s. 10(2) of the Criminal Justice Amendment Act (No. 2) 1980.

22. Absence of patient for medical or dental treatment, etc.—(1) Subject to the provisions of this Act, in the case of the illness of any patient, he may, with the consent of the Supervising Committee or, if there is no Supervising Committee, [a District Court Judge] or the Minister, be removed by the managers or superintendent of the institution to any hospital or other institution under [the Area Health Boards Act 1983 or] the Hospitals Act 1957.

(2) Subject to the provisions of this Act, the superintendent of an institution, on the recommendation of the medical practitioner attending the institution, may permit any patient to be absent from the institution for the purpose of receiving medical or dental treatment for any specified period, not exceeding 5 days at any one time.

(3) Subject to the provisions of this Act, the superintendent of an institution may, with the consent of the Supervising Committee or, if there is no Supervising Committee, a [District Court Judge] or the Minister, permit any patient to be absent from the institution for any other purpose for any specified period not exceeding 14 days at any one time.

(4) Any person removed or absent under this section shall be deemed to remain subject to the order by which he was detained in the institution under this Act, and may at any time be returned to the institution by the managers or superin-
tendent of the institution, or by any member of the Police at the request of the managers or superintendent, or by any officer of any hospital or other institution to which he has been so removed.

Cf. 1909, No. 30, s. 20; 1936, No. 58, s. 66
In subs. (1) the words in the second set of square brackets were inserted by s. 98 of the Area Health Boards Act 1983.

Appeals

23. Appeals against order of District Court Judge—All the provisions of the Summary Proceedings Act 1957 in respect of appeals from convictions or orders shall apply, with the necessary modifications, to any order for detention and treatment or any order for the return or removal of a patient to an institution on the revocation of an order for leave of absence, made by a [District Court Judge] or a [District Court] under this Act, in the same manner as if the person ordered to be so detained and treated or returned or removed had been sentenced to detention within the meaning of the Summary Proceedings Act 1957:

Provided that an appeal under this section may be made at any time within 3 weeks after the date on which the order for detention and treatment or return or removal was signed by the [District Court Judge].

Cf. 1909, No. 30, s. 30; 1918, No. 8, s. 13; 1957, No. 87, s. 213

Offences

24. Unlawful detention in institution—Every person commits an offence against this Act and is liable to imprisonment for a term not exceeding one year or to a fine not exceeding [[$1,000]], or to both, who wilfully detains any other person, or wilfully procures the detention of any other person, in an institution under this Act otherwise than in due course of law, or for a longer period than is authorised by law.

Cf. 1909, No. 30, s. 24; 1954, No. 50, s. 40 (1)

25. Escaping from institution—(1) Every patient commits an offence against this Act who—
(a) Escapes or attempts to escape from the institution; or
(b) Escapes or attempts to escape from lawful custody as a patient; or
(c) Willfully refuses or fails to return to the institution after the expiration or determination of any period of lawful absence therefrom.

(2) Every person commits an offence against this Act who induces or knowingly assists any patient to escape from an institution or from lawful custody or who knowingly assists any patient who has so escaped to avoid or attempt to avoid being retaken.

Cf. 1909, No. 30, ss. 25, 29 (b)

26. Improper conduct—Every patient commits an offence against this Act who is wilfully guilty of any violent, unruly, insubordinate, destructive, indecent, offensive, or insulting conduct.

Cf. 1909, No. 30, s. 27

27. Supplying liquor or drugs to patients—Every person commits an offence against this Act who, not being a registered medical practitioner or a person acting pursuant to the written authority of a registered medical practitioner, procures or attempts to procure any intoxicating liquor or any stimulating, narcotic, or sedative drug for, or sends, takes, or delivers, or attempts to send, take, or deliver any such liquor or drug to, any person whom he knows to be a patient, whether that patient is detained in the institution or is absent therefrom on leave or otherwise howsoever.

Cf. 1909, No. 30, s. 28

28. Trespass—Every person commits an offence against this Act who wilfully trespasses without lawful excuse on any land knowing or having reasonable cause to believe that it is part of an institution.

Cf. 1918, No. 8, s. 12

29. Ill-treatment of patients—Every person commits an offence against this Act who—
   (a) Ill-treats any patient in an institution; or
   (b) Being an officer, servant, or other person employed in or about an institution, wilfully neglects any patient.

Cf. 1909, No. 30, s. 29 (a)

Evidence

30. Evidence in proceedings—In any proceedings under this Act (other than any prosecution for an offence)—
(a) The Judge or [District Court Judge] may receive any evidence that he thinks fit, whether or not the same would be admissible in a Court of law:
(b) The husband or wife of the applicant or alleged alcoholic shall be a competent but not compellable witness.
Cf. 1909, No. 30, s. 7 (5)

31. Medical certificate evidence of certain facts—Every medical certificate given for the purposes of this Act shall be evidence of the facts therein stated as known to or observed by the certifying medical practitioner, and of the opinion therein stated to have been formed by the certifying medical practitioner as to the condition of the person to whom the certificate relates.

32. Who may not sign medical certificate—(1) A medical certificate given for the purposes of section 9 of this Act shall not be signed by any of the following persons:
(a) The applicant for the order:
(b) The superintendent, or a medical officer of the institution into which (if granted) the order would authorise the alleged alcoholic to be received:
(c) The husband or wife, father or father-in-law, mother or mother-in-law, son or son-in-law, daughter or daughter-in-law, brother or brother-in-law, sister or sister-in-law, or the partner, principal, or assistant of the applicant or of the alleged alcoholic or the guardian or trustee of the alleged alcoholic:
(d) Any person by whom the order is made.
(2) Neither of the persons signing any such medical certificate shall be the father or father-in-law, mother or mother-in-law, son or son-in-law, daughter or daughter-in-law, brother or brother-in-law, sister or sister-in-law, husband or wife, or the partner, principal, or assistant of the other of them.
(3) Every such certificate shall contain a statement that the certifying medical practitioner is not prohibited by this Act from signing the same.
(4) Where application for a committal order in respect of any person is made under this Act by an officer on the staff of any hospital under the Hospitals Act 1957 or by an officer on the staff of any institution conducted by the Crown (not being an institution within the meaning of this Act), a medical practitioner employed in or attached to that hospital or institution shall not, for the purposes of paragraph (c) of subsection (1) of this section, be deemed by reason of his official relationship
to the applicant, to be his partner, principal, or assistant, and in no case shall any medical practitioner employed in or attached to any hospital or institution as aforesaid be deemed by reason of his official relationship to any other such medical practitioner, to be the partner, principal, or assistant of such other medical practitioner.

**Procedure**

33. **Notice of order of detention to be given**—When an order is made under this Act or any other enactment for the detention of any person in an institution, or for his return or removal to an institution on the revocation of an order for leave of absence, a minute under the hand of the [District Court Judge] or of the Registrar or Deputy Registrar of the [District Court] or of the [High Court], as the case may require, shall be sent forthwith—
(a) To the Director of the Division of Mental Health in the Department of Health; and
(b) To the superintendent of the institution.

Cf. 1909, No. 30, s. 32

34. **Immaterial errors not to invalidate orders, etc.**—No order, warrant, or other document made or issued in respect of any institution under this Act shall be invalidated by any misnomer or erroneous description of the institution, or of any person ordered to be detained, or by any other error or defect of form.

Cf. 1909, No. 30, s. 34

35. **Legal proceedings**—(1) Every application made to a Court or a Judge or a [District Court Judge] under this Act shall be heard and determined in private.

(2) Every person who is the subject of any such application shall be entitled to be heard and to give and call evidence and may be represented by a solicitor or counsel.

(3) No Court fees shall be payable in respect of any such application.

(4) The determination of an application under section 9 of this Act may be adjourned in accordance with the provisions of [section 23 of the Mental Health Act 1969] which section shall apply with such modifications as are necessary, but this subsection shall not limit any other power of the Court, Judge, or [District Court Judge] to adjourn the determination of the application.
36. General penalty—Every person who commits an offence against this Act for which no penalty is provided elsewhere than in this section is liable to imprisonment for a term not exceeding 3 months or to a fine not exceeding $200 or to both.

37. Offences to be punishable on summary conviction—Every offence against this Act or against any regulations made under this Act shall be punishable on summary conviction.

Miscellaneous Provisions

[37A. Persons found intoxicated in public place—(1) For the purposes of this section, the Minister may from time to time, by notice in the Gazette, declare any premises to be a temporary shelter or a detoxification centre.

(2) Any constable who finds any person intoxicated in any public place—

(a) May take or cause that person to be taken to his usual place of residence or, if he is temporarily residing elsewhere, to his temporary place of residence; or

(b) If that place cannot reasonably be ascertained or it is not reasonably practicable to take that person to it or if it may not be safe to leave him there, may take that person or cause him to be taken to any temporary shelter or detoxification centre; or

(c) If neither the course authorised by paragraph (a) nor that authorised by paragraph (b) of this subsection is reasonably practicable, detain or cause that person to be detained in a police station for any period not exceeding 12 hours.

(2A) Notwithstanding anything in subsection (2) of this section, where it is not immediately practicable for the constable to determine where to take the person in accordance with that subsection, the constable may take the person to a police station and detain that person there for such time as may be reasonably required to enable enquiries to be made as to the appropriate course to be followed.

(3) If, after being detained under subsection (2)(c) of this section for a period of 12 hours, any person is still, in the opinion of any constable, so intoxicated as to be incapable of properly looking after himself, the constable may take that person or cause him to be taken to a temporary shelter or detoxification centre.

(4) Where any person is being detained under subsection (2)(c) of this section, he shall be entitled to telephone one person of his choice.

(5) Every constable is justified in detaining in accordance with this section, for any period not exceeding 12 hours, any person
whom he believes on reasonable and probable grounds to be intoxicated.

(6) Notwithstanding the foregoing provisions of this section, any constable who finds any person subject to the Armed Forces Discipline Act 1971 intoxicated in any public place may, instead of dealing with him under those provisions, deliver or cause him to be delivered into service custody to be dealt with in accordance with that Act.

(7) For the purposes of this section, a person is intoxicated if he is under the influence of intoxicating liquor, drug, or other substance to such an extent as to be incapable of properly looking after himself.

(8) In subsection (5) of this section “justified” means not guilty of an offence and not liable to any civil proceeding.

This section was inserted by s. 49 (1) of the Summary Offences Act 1981, but as to subs. (6), as from 1 December 1983; see s. 49 (2) of that Act and S.R. 1983/292.

38. Protection from civil or criminal liability of persons acting under authority of this Act—A person who does any act in pursuance or intended pursuance of any of the provisions of this Act shall not be under any civil or criminal liability in respect thereof, whether on the ground of want of jurisdiction, or mistake of law or fact, or any other ground, unless he has acted in bad faith or without reasonable care, and the provisions of section 124 of the Mental Health Act 1969 shall apply accordingly with such modifications as are necessary.

Cf. 1909, No. 30, s. 40

S. 124 of the Mental Health Act 1969, being the corresponding enactment in force at the date of this reprint, has been substituted for subss. (3) to (6A) of s. 6 of the repealed Mental Health Amendment Act 1935.

[38A. Fees payable to medical practitioners—There shall be payable to medical practitioners, out of money appropriated by Parliament for the purpose, in respect of any certificates or reports in writing supplied by them to a District Court Judge for the purposes of this Act, such fees as may be prescribed.]

This section was inserted by s. 3 (1) of the Alcoholism and Drug Addiction Amendment Act 1975.

39. Regulations—(1) The Governor-General may from time to time, by Order in Council, make regulations for all or any of the following purposes:

(a) Prescribing the conditions on which institutions may be certified under this Act:
(b) Regulating the establishment, management, maintenance, and inspection of institutions:

c) Prescribing and regulating the functions and procedure of Supervising Committees appointed for institutions under this Act:

(d) Regulating and prescribing the appointment and duties of officers and servants of institutions:

(e) Regulating the classification, treatment, control, and discipline of patients:

(f) Prescribing and regulating employment for patients:

(g) Prescribing the sums to be paid by patients in respect of their maintenance in institutions, and the cases in which such sums are payable:

(h) Prescribing forms [and fees] for the purposes of this Act:

(i) Prescribing offences against any regulations made under this Act, and prescribing fines not exceeding [§100] in respect of any such offence:

(j) Providing for such matters as are contemplated by or necessary for giving full effect to the provisions of this Act and for the due administration thereof.

(2) Any regulations made under this section may apply either to all institutions under this Act, or to institutions of any specified class, or to any specified institution.

Cf. 1909, No. 30, s. 39

In subs. (1)(b) the words "and fees" were inserted by s. 3 (2) of the Alcoholism and Drug Addiction Amendment Act 1975.

40. Repeals and amendments—(1) The enactments specified in the Schedule to this Act are hereby repealed.

(2) Every reference in any enactment, or in any regulation, order, or warrant, or in any document whatsoever, to a certified inebriates home or an inebriates home shall hereafter, unless the context otherwise requires, be read as a reference to an institution within the meaning of this Act.

SCHEDULE

Section 40 (1)

ENACTMENTS REPEALED


1918, No. 8—The Reformatory Institutions Amendment Act 1918. (1957 Reprint, Vol. 13, p. 225.)

1936, No. 58—The Statutes Amendment Act 1936: Sections 66 to 68. (1957 Reprint, Vol. 13, pp. 216, 226.)
SCHEDULE—continued

1944, No. 25—The Statutes Amendment Act 1944: Section 55. (1957 Reprint, Vol. 13, p. 227.)

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THE ALCOHOLISM AND DRUG ADDICTION ACT
COMMENCEMENT ORDER 1968

ARTHUR PORRITT, Governor-General
ORDER IN COUNCIL

At the Government House at Wellington this 4th day of November 1968

Present:

HIS EXCELLENCY THE GOVERNOR-GENERAL IN COUNCIL

Pursuant to the Alcoholism and Drug Addiction Act 1966, His Excellency the Governor-General, acting by and with the advice and consent of the Executive Council, hereby makes the following order.

ORDER

1. This Order may be cited as the Alcoholism and Drug Addiction Act Commencement Order 1968.


P. J. BROOKS,
Clerk of the Executive Council.

Issued under the authority of the Regulations Act 1936.
Date of notification in Gazette: 7 November 1968.
This order is administered in the Department of Health.
THE ALCOHOLISM AND DRUG ADDICTION (FORMS) REGULATIONS 1968

ARTHUR PORRITT, Governor-General

ORDER IN COUNCIL

At the Government House at Wellington this 4th day of November 1968

Present:

HIS EXCELLENCY THE GOVERNOR-GENERAL IN COUNCIL

Pursuant to the Alcoholism and Drug Addiction Act 1966, His Excellency the Governor-General, acting by and with the advice and consent of the Executive Council, hereby makes the following regulations.

REGULATIONS

1. Title and commencement—(1) These regulations may be cited as the Alcoholism and Drug Addiction (Forms) Regulations 1968.
   (2) These regulations shall come into force on the commencement of the Alcoholism and Drug Addiction Act 1966.

2. Interpretation—In these regulations,—
   "The Act" means the Alcoholism and Drug Addiction Act 1966:
   "Drug addict" means a person to whom the Act applies by virtue of section 3 thereof.

3. Forms—(1) An application under subsections (1) and (2) of section 8 of the Act shall be in form 1 in the Schedule to these regulations.
   (2) An order under subsection (4) of section 8 of the Act shall be in form 2 in the Schedule to these regulations.
   (3) An application under subsection (1) of section 9 of the Act shall be in form 3 in the Schedule to these regulations.
   (4) A summons under subsection (1) of section 9 of the Act may be in form 4 in the Schedule to these regulations.
   (5) A warrant under subsection (4) of section 9 of the Act may be in form 5 in the Schedule to these regulations.
   (6) A certificate under subsection (6) of section 9 of the Act shall be in form 6 in the Schedule to these regulations.
   (7) An order under subsection (7) of section 9 of the Act may be in form 7 in the Schedule to these regulations.
SCHEDULE

Form 1

Voluntary Application for Detention in an Institution

Section 8, Alcoholism and Drug Addiction Act 1966

To a Magistrate at

I, [Name, Occupation, and Address of Applicant] hereby make application for an order under section 8 of the Alcoholism and Drug Addiction Act 1966. I desire to be received into the institution situated at and known as [Name of Institution] and I undertake to remain in that institution for treatment for alcoholism *(or addiction to drugs) until I am released or discharged under that Act.

Dated at this day of 19 .

Signature of Applicant.

Signed by the above-named applicant in the presence of ................

Magistrate or (Deputy) Registrar of Magistrate's Court.

*Strike out words which do not apply.

Form 2

Reg. 3 (2)

Order for Detention Upon Voluntary Application

Section 8, Alcoholism and Drug Addiction Act 1966

Whereas [Name, Occupation, and Address of Applicant] has made application under section 8 of the Alcoholism and Drug Addiction Act 1966 for an order under that section; and has specified the institution situated at and known as [Name of Institution], as the institution into which he desires to be received:

And Whereas the said [Name of Applicant] has appeared before me and I am satisfied that the said [Name of Applicant] is an alcoholic *(or drug addict) and that he fully understands the nature and effect of his application and that the managers *(or superintendent) of that institution *are (is) willing to receive the said [Name of Applicant] into that institution:

Now, therefore, I do order that the said [Name of Applicant] be detained, for treatment for alcoholism *(or addiction to drugs), in the institution situated at and known as [Name of Institution].

Given under my hand at this day of 19 .

..........................
APPLICATION BY RELATIVE OR OTHER REPUTABLE PERSON FOR COMMITTAL ORDER

Section 9, Alcoholism and Drug Addiction Act 1966

To a Magistrate at

I, [Name, Occupation, and Address of Applicant] hereby make application pursuant to section 9 of the Alcoholism and Drug Addiction Act 1966 in respect of [Name, Occupation, and Address of person to whom the Application relates], hereinafter in this application referred to as the said person; on the grounds that the said person is an alcoholic *(or drug addict).

I believe that the said person is an alcoholic *(or drug addict) because [set out full reasons for applicant’s belief]:

I am [Insert degree of relationship, if any or words “not related”] to the said person.

[To be completed only if the applicant is not a relative† of the said person]: This application is made by me instead of by a relative because [state reason]:

Dated at this day of 19 .

Signature of Applicant.

STATUTORY DECLARATION

[To be completed unless Magistrate otherwise permits]

Under section 9 (3) of the Alcoholism and Drug Addiction Act 1966 I, [Insert Name, place of abode, and occupation of Applicant or Other Person making Declaration] solemnly and sincerely declare that the statements contained in the foregoing application under section 9 of the Alcoholism and Drug Addiction Act 1966 are true (add “to the best of my knowledge and belief” if declaration is made by person other than applicant). And I make this solemn declaration conscientiously believing the same to be true and by virtue of the Oaths and Declarations Act 1957.

Declared at this day of 19 .

Signature.

Before me

Justice of the Peace,
Solicitor, or other person authorised to take a statutory declaration.

*Strike out words which do not apply.
†Relative for the purposes of section 9 of the Act means spouse, parent, grandparent, stepfather, stepmother, brother, sister, half-brother, half-sister, son, daughter, grandson, granddaughter, stepson, or stepdaughter.
Section 9, Alcoholism and Drug Addiction Act 1966

To [Full name] of [Address and occupation]

[Full name] of [Address and occupation] has stated that you the said [Full name] are an alcoholic* (or drug addict).

You are summoned to appear on the day of 19 at a.m. (p.m.) before a Magistrate at the Magistrate's Court at to show cause why an order should not be made requiring you to be detained for treatment for alcoholism* (or drug addiction) in an institution.

Dated at this day of 19.

Magistrate
(Deputy) Registrar of Magistrate's Court.

Note—Section 35 (1) of the Alcoholism and Drug Addiction Act 1966 provides that every application under that Act shall be heard and determined in private.

*Delete whichever is inapplicable.

Reg. 3 (5)

WARRANT TO ARREST

Section 9, Alcoholism and Drug Addiction Act 1966

To Every Constable:

In an application dated the day of 19 and made under section 9 of the Alcoholism and Drug Addiction Act 1966 it has been stated that [Full name] of [Address and occupation] is an alcoholic* (or drug addict).

†I am satisfied, by evidence on oath, that a warrant is necessary to compel the attendance of the said [Full name] to show cause why an order should not be made requiring him to be detained for treatment for alcoholism* (or drug addiction) in an institution:

†or I am satisfied, by evidence on oath, that circumstances exist that render the issue of a warrant expedient;

†or I am satisfied that the said [Full name] has refused to undergo examination by two medical practitioners for the purposes of the Alcoholism and Drug Addiction Act 1966;

†or I am satisfied that the said [Full name] has wilfully failed to attend for a medical examination required for the purposes of the Alcoholism and Drug Addiction Act 1966:

AND I DIRECT YOU to arrest the said [Full name] and bring him with all convenient...
†AND I FURTHER DIRECT that the said [Full name] shall, after his arrest, undergo medical examination by and being two medical practitioners.
Dated at this day of 19.

Magistrate.

*Delete whichever is inapplicable.
†Delete if inapplicable.
(Not printed)

Form 6
Reg. 3 (6)

MEDICAL CERTIFICATE

Section 9, Alcoholism and Drug Addiction Act 1966

I, [Name and Address of Medical Practitioner], being a medical practitioner registered in New Zealand, do hereby certify that I believe [Name, Occupation, and Address of Person to whom the certificate relates] is an alcoholic within the meaning of the Alcoholism and Drug Addiction Act 1966 *(or a drug addict within the meaning of the Alcoholism and Drug Addiction (Forms) Regulations 1968) and that the making of an order for his detention and treatment as such is expedient in his own interest *(or in the interest of his relatives).

The following are the reasons for my said belief [set out reasons in full]:

I hereby declare that I am not prohibited by section 32 of the Alcoholism and Drug Addiction Act 1966 from signing this certificate.
Dated at this day of 19.

Signature of Medical Practitioner.

*Strike out words which do not apply.

Form 7
Reg. 3 (7)

COMMITTAL ORDER ON APPLICATION BY RELATIVE OR OTHER REPUTABLE PERSON

Section 9 (7), Alcoholism and Drug Addiction Act 1966

WHEREAS [Name, Occupation, and Address of Applicant] (being a relative of [Name of Person to whom the Application relates]) † has made an application dated the day of 19 pursuant to section 9 of the Alcoholism and Drug Addiction Act 1966 in respect of [Name, Occupation, and Address] on the grounds that the said [Name] is an alcoholic *(or drug addict):

And Whereas [Name and Address of Medical Practitioner] and [Name and Address of Medical Practitioner] have given evidence *(or certificates in the prescribed form) to the effect that they believe the said [Name] to be an alcoholic *(or drug addict) and that his detention and treatment as such is expedient in his own interest *(or in the interest of his relatives):
And whereas the said [Name] has appeared before me and I am satisfied that the said [Name] is an alcoholic *(or drug addict) and that the managers *(or superintendent) of the institution situated at and known as [Name of Institution] are *(is) willing to receive the said [Name] into that institution:

Now, therefore, I do order that the said [Name] be detained for treatment for alcoholism *(or addiction to drugs) in the institution situated at and known as

Given under my hand at this day of 19 .

[Signature]

Magistrate.

*Strike out words which do not apply.
†Delete if inapplicable.

P. J. BROOKS,
Clerk of the Executive Council.

EXPLANATORY NOTE

This note is not part of the regulations, but is intended to indicate their general effect.

These regulations prescribe forms for the purposes of the Alcoholism and Drug Addiction Act 1966.

Issued under the authority of the Regulations Act 1936.
Date of notification in Gazette: 7 November 1968.
These regulations are administered in the Department of Health.
Application of Relative or Other Reputable Person for Committal Order

Section 9, Alcoholism and Drug Addiction Act 1966

To a Magistrate at ____________________________

I. ____________________________  ____________________________
   (Name)                        (Occupation)

   (Address)

hereby make application pursuant to Section 9 of the Alcoholism and Drug Addiction Act 1966 in respect of

_____________________________  ____________________________
   (Name)                        (Occupation)

   (Address)

hereinafter in this application referred to as the said person; on the grounds that the said person is an alcoholic *(or drug addict).

I believe that the said person is an alcoholic *(or drug addict) because (set out full reasons for applicant’s belief).

________________________________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________________________________

I am ____________________________ to the said person (to be completed only if the applicant is not a relative* of the said person): this application is made by me instead of by a relative because (state reason):

________________________________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________________________________

Dated at ____________________________ this _______ day of ____________________________ 19______

______________________________________________
   (Signature of Applicant)

*Strike out words which do not apply.

†Relative for the purposes of Section 9 of the Act means spouse, parent, grandparent, stepfather, stepmother, brother, sister, half brother, half sister, son, daughter, grandson, granddaughter, stepson or stepdaughter.

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STATUTORY DECLARATION

(To be completed unless Magistrate otherwise permits)

I, ____________________________ (Name) ____________________________ (Occupation)

of ____________________________ (Address)

solemnly and sincerely declare that the statements contained in the foregoing application under Section 9 of the Alcoholism and Drug Addiction Act 1966 are true; (add "to the best of my knowledge and belief" if declaration is made by person other than applicant).

And I make this solemn declaration conscientiously believing the same to be true and by virtue of the Oaths and Declarations Act 1957.

Declared at ____________________________

this ______ day of ____________________________ (Signature)

19 ______

Before me ____________________________ Justice of the Peace, solicitor, or other person authorized to take a statutory declaration.

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2,000/13/7 1-4586 V
MEDICAL CERTIFICATE

Section 9, Alcoholism and Drug Addiction Act 1966

I, ________________________________ of ________________________________

______________________________ being a medical practitioner

registered in New Zealand, do hereby certify that I believe ________________________________

(Name) ________________________________ (Occupation)

is an alcoholic within the meaning of the Alcoholism and Drug Addiction Act 1966 *(or a drug addict within the
meaning of the Alcoholism and Drug Addiction (Forms) Regulations 1968) and that the making of an order for his
detention and treatment as such is expedient in his own interest *(or in the interest of his relatives).
The following are the reasons for my said belief (Set out reasons in full).

________________________________________

________________________________________

________________________________________

________________________________________

________________________________________

________________________________________

I hereby declare that I am not prohibited by Section 32 of the Alcoholism and Drug Addiction Act 1966 from signing
this certificate.

Dated at ________________________________ this __________ day of ________________________________ 19

(Signature of medical practitioner)

*Strike out words which do not apply.
EXCERPTS FROM THE ALCOHOLISM AND DRUG ADDICTION ACT 1966

Section 2
Definition: “Alcoholic” means a 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.

Section 9
Sub Sec, (6)
Power of District Court Judge to order detention and treatment on application of relative or other reputable person.

“The District Court Judge shall not make an order unless two medical practitioners give evidence or certificates in the prescribed form that they believe the alleged alcoholic to be an alcoholic within the meaning of this Act.”

“Drug Addict” means 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.

Section 32
Persons prohibited from signing medical certificate.

(a) The applicant
(b) The Superintendent or medical officer of the receiving institution
(c) Close relative, partner, principal or assistant or the guardian or trustee or the alleged alcoholic
(d) Person making the order

NOTE: Subsection (4) of Section 32 prevents the application of the terms “partner, principal or assistant” to doctors employed in Hospital Board or Crown institutions.
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