

# **Review of the Alcoholism and Drug Addiction Act 1966**

**A discussion paper for consultation**

March 1999

*Policy Branch  
Ministry of Health*

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# REVIEW OF THE ALCOHOLISM AND DRUG ADDICTION ACT 1966

## 1 INTRODUCTION

The purpose of this discussion paper is to ask for submissions which will help the Ministry of Health determine a direction for the review of the Alcoholism and Drug Addiction Act 1966 (the ADA Act).

This review of the ADA Act is one of the directions in the Government's *National Drug Policy*<sup>1</sup> which was released in July 1998.

The ADA Act provides for the compulsory detention and treatment of alcoholics and drug addicts at certified institutions, and is administered by the Ministry of Health.

This Act is now over 30 years old and there are questions about how effective it is in achieving its goal which is "to make better provision for the care and treatment of alcoholics and drug addicts"<sup>2</sup>. Over recent years, the Ministry has become aware of a number of practical and legal problems with the ADA Act. These include:

- the inability to match treatment type to client need
- a lack of certified institutions
- institutions being unable or unwilling to accept clients
- inconsistency with the New Zealand Bill of Rights Act 1990 and the compulsory assessment and treatment regime under the Mental Health (Compulsory Assessment and Treatment Act) 1992.

There are also questions about whether the views of society have changed and whether alcoholism and drug addiction are significant enough conditions that society needs to intervene to remove people's liberty in order to enforce assessment, detoxification and treatment. This is especially relevant in view of the fact that international research shows that the medium- to long-term outcomes of compulsory treatment are generally poor and often inconclusive.

This document provides a background to the ADA Act and poses questions about how it may be amended if it is retained. It also asks whether there is a need at all for legislation to compulsorily treat people who are addicted to alcohol or other drugs, and if not what powers should society have to manage people who do not have the ability or are unwilling to give informed consent to treatment.

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<sup>1</sup> Ministry of Health. 1998. *National Drug Policy: A National Drug Policy for New Zealand 1998 2003*. Wellington: Ministry of Health.

<sup>2</sup> Alcoholism and Drug Addiction Act 1966, long title.



## **2 BACKGROUND INFORMATION**

### **2.1 *Legislative history***

The ADA Act 1966 superseded the Reformatory Institutions Act 1909, which was designed “to make provision for the establishment and control of reformatory institutions for the reception of habitual inebriates and of fallen women”.

The impetus for amending the 1909 legislation came from a 1964 conference which recommended that responsibility for services for alcoholics be transferred from the Justice Department to the Health Department. This represented a move away from a punitive approach to the compulsory treatment of alcoholics (provided for in a penal statute) to a therapeutic approach to the compulsory treatment of alcoholics (provided for in a health statute).

By 1983, when the ADA Act had been in place for nearly 20 years, there was already concern about its effectiveness. A working party met from 1983 to 1985 to consider the ADA Act. The minutes of the working party’s meetings suggest that no resolution was reached.

During the development of the Mental Health (Compulsory Assessment and Treatment) Act 1992, 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 Act procedures separate. Indeed, section 4 of the Mental Health Act specifically excludes people from being subject to compulsory assessment and treatment under that Act solely on the basis of a substance use disorder.

As a consequence of their historical development, the compulsory treatment of people with mental health problems, and those with drug and alcohol problems is different. The review of the ADA Act will allow for some of the lessons learnt in mental health treatment to be applied to drug and alcohol problems and for new thinking to be incorporated into the legislative process.

### **2.2 *Overview of the ADA Act procedures for compulsory treatment***

In essence, the ADA Act provides for alcoholics and drug addicts to be compulsorily detained to be assessed, detoxified and treated at institutions specially certified to receive them.

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 very widely drawn definitions. It is theoretically possible, for example, that pack-a-day cigarette smokers could be covered by the Act's compulsory treatment regime. The Act has also been extended to harmful and addictive substances such as industrial solvents.<sup>3</sup>

#### Question 1

How relevant are these definitions now? Should they be changed, and if so, how?

The ADA Act procedures for compulsory treatment can be initiated in three ways:

- a voluntary application for committal (section 8)
- an involuntary application for committal (section 9)
- transfer of a prison inmate for treatment by the Minister of Corrections (section 21).

### **2.3 Voluntary application**

Firstly, under section 8 of the Act, any person may apply to a district court judge to be compulsorily detained for treatment at a specific certified institution. The judge must be satisfied, by the applicant's admission or by other evidence, that he or she is an alcoholic or drug addict and fully understands the nature and effect of the application.

It has been suggested that few applicants under section 8 are genuinely volunteers, in the sense that such applications are usually made in response to strong family pressure or as a result of the applicant being faced with a choice between seeking treatment and being sent to prison.

The Mental Health (Compulsory Assessment and Treatment) Act 1992, which is more recent legislation than the ADA Act but affects a similar client group, contains no provisions about voluntary patients. The assumption is that people who are willing to attend treatment voluntarily do not need legislation to enforce this.

#### Question 2

Should people still be able to volunteer to be committed through a legal process?

### **2.4 Involuntary application**

Secondly, a district court judge may make an order for the detention and treatment of an involuntary patient under section 9 of the Act. Such applications may be made by a relative of the involuntary patient, a police officer, or "any other reputable person". In

<sup>3</sup> See for instance, *In the matter of JPS* [1984] 2 DCR 32, a case involving a glue sniffer.

the first instance, the judge will make an order which effectively acts as a subpoena, summoning the “alleged alcoholic [or drug addict] to show cause why an order should not be made requiring him to be detained for treatment”. The judge may also issue a warrant for the arrest of the alleged alcoholic or drug addict, if this is shown to be necessary to compel his or her attendance to be dealt with in accordance with the Act.

Section 9(5) of the Act also requires two medical practitioners to assess a person prior to committal for treatment. If the person refuses to have a medical examination as required by the Act, the judge may issue a warrant for his or her arrest and at the same time order that the alleged alcoholic or drug addict undergo medical examination by two medical practitioners.

On hearing the application, the judge cannot make a committal order unless two medical practitioners give either oral or written evidence that they believe the involuntary patient to be an alcoholic or drug addict within the meaning of the Act, “and the making of an order for his detention and treatment as such is expedient in his own interest or in that of his relatives” (section 9(6) of the Act). Note that the term “relative” refers to direct relations and does not include de facto or same-sex partners.

If, on the evidence, the judge is satisfied the application is appropriate, and that the institution is willing to accept the person for treatment, the judge may order that he or she be detained for treatment (see section 9(7) of the Act).

## **2.5 *Transfer of a prison inmate***

The third pathway for compulsory treatment under the ADA Act is a little-used provision which allows for prison inmates to be transferred to a certified institution. Section 21 of the Act states:

The [Minister 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.

The Ministry is not aware that this provision has been used in recent years to transfer a prison inmate to a certified institution for treatment under the ADA Act. Section 21 is also somewhat anomalous in that the provision in the old Criminal Justice Act 1954 upon which it was based, section 48A, was repealed without replacement by the new Criminal Justice Act 1985.

### **Question 3**

The provision of discharge of inmates from prison to a certified institution for compulsory treatment is very rarely used. Is it appropriate for this to continue to be part of compulsory treatment legislation?

## **2.6 *Provision for dealing with people found intoxicated in public places***

Section 37 of the ADA Act gives a police officer the power to take home a person found drunk or otherwise intoxicated; 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 he or she may be detained for up to 12 hours).

In *Fleming v Police* (1988) 3 CRNZ 184, the High Court held that the powers of detention under section 37 of the ADA Act are directed to ensuring the safety of a drunk person with the least possible encroachment on the person's civil liberties. The Court observed that detention at a police station should always be a last resort.

#### **Question 4**

Is this an appropriate role for the police? Are there other ways in which people who are intoxicated in a public place could be managed?

### **2.7 Role of the Minister under the ADA Act**

The Minister of Health can have an active role in administering the ADA Act. As well as possessing the authority to recommend the certification of institutions (section 5) and appoint supervisory committees for certain institutions (section 7), the Minister may give directions on the custody of any person pending a committal order (section 13). The Minister of Health also has the power to order a patient's discharge, transfer, or release on leave (section 17). In the past, however, little use has been made of these powers, and on only two occasions during the last four years has the Minister had to play a role under the Act (involving re-certification of institutions).

## **3 CURRENT USE OF THE ADA ACT**

### **3.1 Description of client group**

The ADA Act is used to commit around 200 people each year for inpatient assessment, detoxification and treatment, mainly chronic alcoholics. Table 1, 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.

As a comparison of the size of the group, in 1990, 8475 new clients were recorded in alcohol or drug outpatient services<sup>4</sup> and approximately 1520 people were admitted as inpatients<sup>5</sup> at a time when there were only 246 persons committed under the ADA Act.

There are currently 14 institutions certified to accept people committed for treatment under the ADA Act. They include ten hospitals, three Salvation Army Bridge Programmes (Auckland, Wellington, and Christchurch) and the Nova Trust Lodge (Christchurch) which offers a special work-based programme.

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<sup>4</sup> Hughes OR. 1992. *New Zealand Alcohol/Drug Outpatient Statistics 1990*. Wellington: Alcohol Advisory Council of New Zealand.

<sup>5</sup> Department of Health Statistical Services. 1992. *Mental Health Data 1990*. Wellington: Department of Health.

In some cases, people committed under the Act have been referred to other treatment settings, even though they are not certified institutions under the Act. It is unclear how widespread this practice is of referring on patients to non-certified institutions.

**Table 1: Committal orders made by the District Court under the ADA Act from 1990–96**

Year	voluntary (sec 8)	involuntary (sec 9)	Total
1990	93	153	246
1991	99	178	277
1992	109	154	263
1993	64	139	203
1994	72	149	221
1995	64	130	194
1996*	62	114	176

\* Figures only collected by the Department for Courts until 1 November 1996 (ie. 11 months)

The Ministry conducted a census of certified institutions in early 1997 and found that 189 people had been received for treatment under the Act during 1996, with 74 people (40 percent) being voluntary committals and 115 people (60 percent) being involuntary committals. One hundred and seventy-three of the 189 people committed under the Act (92 percent) were received for treatment by the three Salvation Army Bridge Programmes and the Nova Trust Lodge. This illustrates where the vast majority of ADA Act patients are detained for treatment.

In terms of the demographic characteristics of people who are committed under the Act, some insight is provided by a New Zealand Health Information Service (NZHIS) analysis of mental health inpatient data conducted between 1992 and 1994. Although this data appears to be incomplete (for example, when compared to the Department for Courts data, it under-reports the total number of committal orders made under the ADA Act), it nonetheless offers some basic information about the gender and age of such patients.

**Table 2: Number of ADA Act committal orders by gender, 1992–94**

Year	Male	Female
1992	57	14
1993	49	9
1994	54	24

**Table 3: Number of ADA Act committal orders by age, 1992–94**

Year	Mean age	Minimum age	Maximum age
1992	37	17	70

1993	40	19	63
1994	39	19	71

**Table 4: Number of ADA Act committal orders by age group, 1992–94**

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

Robust data on the ethnicity of patients committed under the ADA Act is not available. It is also impossible to analyse the geographical distribution of ADA Act patients from the available information. Only patchy data are available. Another complication in looking at the available data for signs of any patterns is that a small number of ADA Act patients are transferred out of region for treatment, particularly to the Nova Trust Lodge which is located just outside Christchurch.

### **3.2 Length of treatment**

The ADA Act allows an institution to discharge, transfer or release a person on leave at any time. However, the person only has the right to apply for discharge after being detained for six months, and can be detained for a maximum of two years.

The NZHIS mental health inpatient data from 1992 to 1994 also provide a rough indicator of the average length of treatment for ADA Act patients.

**Table 5: Length of treatment duration under ADA Act committal orders, 1992–94**

Year	Mean length of stay (days)	Minimum length of stay (days)	Maximum length of stay (days)
1992	56	2	731
1993	81	0	311
1994	104	0	731

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 (6 months) at the Nova Trust Lodge, 150 days (5 months) at the Salvation Army Bridge Programme in Wellington, and 122 days (4 months) at the Salvation Army Bridge Programme in Auckland.

Overall, it appears that people committed under the ADA Act are seldom detained for more than four months, and are often eligible for leave after six to eight weeks of

treatment. Unfortunately, we have no information about the number of people who are committed under the ADA Act more than once. This information would have helped us determine how effective this treatment had been.

### **3.3 Complaints mechanism**

The ADA Act provides the right to appeal against a committal within three weeks after the date that the order is signed. There are no other complaints mechanisms built into this Act.

Since the ADA Act was implemented, the Code of Health and Disability Services Consumer's Rights has been developed and the Office of the Health and Disability Commissioner has been established. The Ministry is aware of only one recent case where a person committed for treatment under the ADA Act has made a complaint about the treatment received. Very few complaints from consumers or their families have been brought to the attention of the Health and Disability Commissioner.

The reasons for this apparent low level of concern by people committed under the ADA Act and their families are unclear. 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 lower use of medication, seclusion and restraint may also be relevant factors. Alternatively, it may be that there has been a low level of publicity at certified institutions about the ability of patients to make complaints about their treatment, or to initiate review and appeal procedures.

Despite the negligible level of direct complaints by consumers and their families, in recent years the Ministry has become aware of a number of practical and legal problems with the ADA Act.

## **4 TREATMENT OUTCOMES**

A literature search of the Psychlit and Medline databases identified little recent information relating to the enforced treatment of people with drug and alcohol problems who have not been part of the justice system, that is sentenced to compulsory treatment or where compulsory treatment is used as diversion or as a condition of parole.

Most of the information on compulsory treatment of drug and alcohol abuse indicates that there are small or no differences in post-treatment outcomes between voluntary and involuntary clients.<sup>6, 7, 8</sup> This finding is used both positively and negatively by

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<sup>6</sup> Anglin MD. 1988. The efficacy of civil commitment in treating narcotic addiction. *National Institute on Drug Abuse Research Monograph Series* 86: 8-34.

<sup>7</sup> Simpson DD and Friend HJ. 1988. Legal status and long-term outcome for addicts in the DARP follow-up project. *National Institute on Drug Abuse Research Monograph Series* 86: 81-95.

<sup>8</sup> Lawenthal E, McLellan AT et al. 1996. Coerced treatment for substance abuse problems detected through workplace urine surveillance: is it effective? *Journal of Substance Abuse*. 8(1): 115-28.

writers on the issue. For example, Maddux (1988) writing on the treatment of opiate abusers identifies that civil commitment:

- cannot overcome deficits in treatment services
- can bring drug users into treatment but cannot assure that they will participate
- restricts personal liberty.<sup>9</sup>

In contrast, Anglin (1988) maintains that:

How an individual is exposed to treatment seems to be irrelevant. What is important is that the narcotics addict must be brought into an environment where intervention can occur over time. (p31)<sup>6</sup>

The World Health Organization Committee on Drug Dependence in its 1998 report writes:

With respect to the role of compulsion in the treatment of persons dependent on alcohol and other drugs, the Committee concluded that the clinical evidence available is not sufficient either to support or to refute the case for various forms of compulsory treatment. It noted that, in spite of considerable experience, compulsory detention alone has not been shown to be beneficial.<sup>10</sup>

#### **4.1 Appropriate length of time in treatment**

Most of the writing on the question of length of time in treatment seems to indicate that the longer the treatment time, the more likely the post-treatment success.<sup>6, 8, 11</sup> In addition, follow-up treatment of clients seems to further enhance treatment outcomes. For example, Hiller et al (1996) in an initial evaluation on post-treatment outcomes of 492 probationers on a six month residential programme, found that those who were in specialised residential aftercare following treatment had better outcomes.<sup>12</sup>

#### **4.2 Matching treatment to client needs**

Under the ADA Act, persons can only be detained in an institution certified under the Act. This does not allow for the range of treatment which may be appropriate for the treatment needs of individual clients. Much of the research in the area assumes that clients have available to them a range of service provision ranging from secure inpatient settings, if the client is a danger to self or others, to individual or group outpatient settings. Specifically, in discussing inpatient treatment, Galon and Liebelt (1997) quoting Hester (1994) claim that available studies suggest that for the majority of the addicted population, inpatient treatment is not superior to outpatient treatment.

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<sup>9</sup> Maddux JF. 1988. Clinical experience with civil commitment. *National Institute on Drug Abuse Research Monograph Series* 86: 35–56.

<sup>10</sup> World Health Organization. 1998. *WHO Expert Committee on Drug Dependence. Thirtieth Report*. Geneva: World Health Organization.

<sup>11</sup> Howard DL and McCaughrin WC. 1996. The treatment effectiveness of outpatient substance misuse treatment organisations between court-mandated and voluntary clients. *Substance Use and Misuse* 31(7): 895–926.

<sup>12</sup> Hiller, ML, Knight, KL et al. 1996. Post-treatment outcomes for substance-abusing probationers mandated to residential treatment. *Journal of Psychoactive Drugs* 28(3): 291–296.

However, there is some evidence that for severely affected individuals, long-term inpatient residential treatment is superior.<sup>13</sup>

### **4.3 Clinical views of compulsory treatment**

Clinical perspectives of compulsory treatment indicate that coercion has a predictably negative effect on the client-therapist relationship.<sup>14, 15</sup> Concerns include:

- the effect on the therapeutic alliance, including client perceptions that the role of the therapist is punitive and custodial, and client anger at the system aimed at the clinician
- difficulty with diagnosis because of client reluctance to disclose information such as unlawful drug use
- negative effect of involuntary clients on the morale of voluntary patients
- custodial role of the organisation including the need to involve police to retrieve patients who may abscond.

All these impact on the outcome of treatment. Howard and McCaughrin surveyed 330 non-methadone outpatient substance abuse treatment organisations in 1990 and found that those with more than 75 percent court-mandated clients had a higher rate of failure with treatment than those with 25 percent or fewer.<sup>11</sup>

Schottenfeld (1989) identifies the impediments to clinical success of involuntary treatment and suggests ways that clinicians and clients may be able to work collaboratively to minimise these effects.<sup>15</sup> However, he sees a return to the criminal justice system as a final response should these attempts not work. The ADA Act does not specifically allow a person committed under the Act to be re-referred to the justice system because of therapeutic failure.

## **5 PROBLEMS WITH THE ADA ACT**

### **5.1 Legal problems**

From a legal point of view, the ADA Act is problematic because of its inconsistency with modern civil liberties statutes, such as the New Zealand Bill of Rights Act 1990, and the compulsory assessment and treatment regime under the Mental Health (Compulsory Assessment and Treatment) Act 1992. There is also a fundamental question about the conditions under which society is justified in insisting on non-consensual assessment, detoxification or treatment. Should this be done in the interests of the person himself (or herself), or is it only justified when the person is a danger to others?

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<sup>13</sup> Galon PA and Liebelt RA. 1997. Involuntary treatment of substance abuse. *New Directions For Mental Health Services* 75: 35–45.

<sup>14</sup> Winick BJ. 1997. Mandatory treatment: An examination of therapeutic jurisprudence. *New Directions For Mental Health Services* 75: 27–34.

<sup>15</sup> Schottenfeld RS. 1989. Involuntary treatment of substance abuse disorders – impediments to success. *Psychiatry* 52: 164–76.

**Question 5**

Is dependence on alcohol and other drugs a significant enough condition for society to intervene to remove people's liberty in order to legally enforce assessment, detoxification and treatment? If so, under what conditions should this happen?

Some of the concerns raised about the current Act revolve around the period of detention. For example, the potential two-year period of detention which a person may be subject to under the Act has led some judges to note that, for a supposedly therapeutic piece of legislation, the Act is "somewhat draconian".<sup>16</sup>

Furthermore, under section 18 of the ADA Act, anybody ordered by the Court to be detained and treated at a certified institution must attend that institution for a minimum of six months before they can apply for a discharge. The existence of various appeal and review mechanisms for people subject to compulsory treatment under the Mental Health (Compulsory Assessment and Treatment) Act 1992 raises the question why similar mechanisms are not also available for people subject to compulsory treatment under the ADA Act.

**Question 6**

Should there be a minimum and/or maximum time for committal under any compulsory treatment legislation? If so, how should this time be determined and what controls do there need to be to protect patients?

Under section 25 of the ADA Act, escaping or attempting to escape from the institution, or failing to return to the institution after a designated period of leave is an offence, and under section 36 those found to have committed such an offence are liable to imprisonment for a term not exceeding three months or a fine not exceeding \$200 or both. In comparison, there is no equivalent offence of escaping from a psychiatric institution under the Mental Health Act. This is anomalous.

If a person who has voluntarily applied for detention in an institution is detained under the Act, they are subject to the same controls as an involuntary patient. This means that they could also be deemed to have committed an offence if they escape or attempt to escape from the institution.

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<sup>16</sup> See *Re Mrs M* [1993] DCR 673, 674.

**Question 7**

Should legislation for the compulsory treatment of people who are addicted to alcohol or other drugs include additional provisions to protect the committed person? If so, what additional protection do these people need?

The Minister's powers to direct patient affairs under the ADA Act (sections 13 and 17) also contrast with his or her powers under the Mental Health Act. Whereas the Minister may give directions under the ADA Act regarding the custody of any person pending an order for detention, and may order a patient's discharge, transfer, or release on leave, such judgments are exclusively exercised by health professionals under the Mental Health Act (sections 30 and 31). Again, this begs the question whether it is necessary or appropriate for the Minister to retain such powers under the ADA Act.

**Question 8**

To what extent should the Minister of Health be involved in the clinical management or transfer of people who are detained for treatment?

Another example of a troubling part of the ADA Act is section 9(6), which allows a district court judge to commit a person for compulsory treatment under the Act if "the making of an order for his detention and treatment as such is expedient in his own interest or in that of his relatives". While such orders may be made in the best interests of the person, and doing so accords with the paternalistic approach adopted by other statutes, it is questionable whether the coercive power of the state should be able to be exercised because it is "expedient" in the interests of the person's relatives.

**Question 9**

Is it appropriate for people to be compulsorily detained in the interest of their relatives? If not, what should the rationale for compulsory detention be?

In addition, people may see the definition of "relative" which excludes de facto or same-sex partners as anomalous in today's environment.

**Question 10**

Should de facto and same-sex partners have the same rights as direct relatives to be involved in involuntary committals? Are there other people who should also be specifically acknowledged to have these rights?

## **5.2 Inability to match treatment type to client need**

There is no actual provision within the ADA Act for treatment other than inpatient treatment for people committed under the Act. Most studies on treatment options for people with addiction problems indicate a range of treatment options matched to client need is necessary. Only by acting in technical breach of the law are some institutions able to match treatment options with client needs.

### **Question 11**

Should compulsory treatment be extended to treatment in non-institutional settings such as community programmes or day programmes?

## **5.3 Lack of certified institutions**

The practical problems with the ADA Act include the lack of certified institutions able and willing to provide treatment for certain people (notably those who have behavioural problems and require around-the-clock supervision).

In December 1996, a 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 receive a particular person for committal 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”.<sup>17</sup>

### **Question 12**

Should there continue to be a process of certifying institutions for the purpose of treatment under the Act, or should any agency be able to provide compulsory treatment?

## **5.4 Institutions unwilling or unable to accept clients**

Judges’ ability to detain a person under the ADA Act depends on both the existence of a certified institution and their willingness to take the client. In some cases, clients who may be difficult or who may not fit in with the existing clientele may be refused by the certified institution.

Other access-related problems include the fact that it may be difficult for young people to be committed for treatment under the Act because there are no certified institutions in their area prepared to accept non-adult clients. At present, however, places are generally found in out-of-region institutions for those young people unable to secure a treatment place at a local certified institution.

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<sup>17</sup> *Police v Barnes*, 13 December 1996, CRN 6054012657, per Ross DCJ.

**Question 13**

If it is decided that compulsory treatment should be continued, should all drug and alcohol treatment organizations be required to accept people referred by the courts? How would this work in practice?

## 6 COMMENTARY

The Ministry accepts that the practical problems experienced with the ADA Act may be compromising its usefulness. The Ministry also accepts that the compulsory assessment and treatment of any individual raises difficult cultural, ethical, legal, and political issues. In the particular context of the ADA Act, the Ministry notes that various aspects of the 33-year-old Act have attracted criticism from some quarters that the legislation is “draconian” and “anachronistic”, and does not fulfil its aim to “make better provision for the care and treatment of alcoholics and drug addicts”.

The Ministry also notes that research on the outcomes of compulsory treatment under the ADA Act is poor and often inconclusive.

There is clearly a need for a full review of the legal framework for the compulsory treatment of people with drug and alcohol problems.

The first step in this process is the distribution of this formal discussion paper for consultation purposes.

Models of comparable legislation to the ADA Act from other jurisdictions will also be studied. The Ministry notes, in particular, that the New South Wales Department of Health is currently reviewing its equivalent statute, the Inebriates Act 1912. Some of the work which is being done as part of this review may be able to be usefully applied to the New Zealand context.

Once this work has been done, and the submissions received have been analysed, officials will identify and develop options for legislative amendment to the ADA Act. Final decisions on how to implement the findings of the Ministry’s review will be made by the Minister of Health, in consultation with other Ministers as appropriate.

## 7 ADDITIONAL REFERENCES CONSULTED

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## **OPPORTUNITY TO MAKE SUBMISSIONS**

We want to know what you think about the way that the Alcoholism and Drug Addiction Act (1966) is working and what needs to be changed.

It would help in the analysis of submissions if you answered the questions highlighted in the text. However, additional comments on these questions or other issues related to the ADA Act are welcome.

**Please send your comments by Friday 23 April 1999**

ADA Act Submissions  
Policy Branch  
Ministry of Health  
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