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COMPULSORY DETENTION UNDER THE ALCOHOLISM AND DRUG ADDICTION ACT 1966: AN ADDICTION TO SOCIAL CONTROL?

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COMPULSORY DETENTION UNDER THE ALCOHOLISM AND DRUG ADDICTION ACT 1966: AN ADDICTION TO SOCIAL CONTROL?

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Alcoholism and drug addiction continue to blight our modern existence. The law operates to regulate destructive social influences, and drug dependencies are no exception. The author examines the Alcoholism and Drug Addiction Act 1966 with special attention to the underlying ethos of compulsory detention, identifies the appropriate legislative objectives, and considers how those might be best achieved. The current definitions of 'alcoholic' and 'drug addict' are for example too broad, and the criteria for committal and discharge confusingly inexact.

The author advocates, among other things, an express recognition of patient rights modelled upon those in the Mental Health (Compulsory Assessment and Treatment) Act 1992. The author also considers the importance of individual culture to medical treatment, and how the 'least restrictive alternative' ethic might operate to determine a patient's course of treatment. The law in this area requires considerable revision to meet the needs of those it seeks to aid and protect. Existing legislation describes itself as an attempt to make better provision for the care and treatment of drug dependents. It fails in various ways identified by the author to fulfil its proclamation.

The text of this paper (excluding contents page, footnotes, bibliography and annexures) comprises approximately 14, 600 words.

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You have asked me how I feel about whisky. Alright, here is just how I stand on this question:

If, when you say whisky, you mean the devil's brew, the poison scourge, the bloody monster that defiles innocence, yea, literally takes the bread from the mouths of little children; if you mean the evil drink that topples the Christian man and woman from the pinnacles of righteous, gracious living into the bottomless pit of degradation and despair; shame and helplessness and hopelessness, then certainly I am against it with all of my power.

But, if...when you say whisky, you mean the oil of conversation, the philosophic wine, the stuff that is consumed when good fellows get together, that puts a song in their hearts and laughter on their lips and the warm glow of contentment in their eyes; if you mean Christmas cheer; if you mean the stimulating drink that puts the spring in the old gentleman's step on a frosty morning; if you mean the drink that enables a man to magnify his joy, and his happiness, and to forget, if only for a little while, life's great tragedies and heartbreaks and sorrows, if you mean that drink, the sale of which pours into our treasuries untold millions of dollars, which are used to provide tender care for our little crippled children, our blind, our deaf, our dumb, our pitiful aged and infirm, to build highways, hospitals and schools, then certainly I am in favour of it.

This is my stand. I will not retreat from it; I will not compromise.

- Address to the legislature
by an anonymous Mississippi
senator in 1958.

INTRODUCTION

Guilty perhaps of a little over-dramatic oral delivery, the senator, nevertheless, accurately describes the paradox of prevailing social attitudes toward alcohol consumption. This same paradox is attested to and exploited by the talented slapstick comedian who plays the role of a hilarious drunk. He (it is usually he), knocks over ornaments, apologises profusely, repeats the entire glass-shattering experience, and then apologises profusely a second time. He stumbles about with slurred speech, clutches at furniture and other people, while at the same time getting all the laughs at the expense of his hapless co-stars.

This comic scene remains, however, only one side to the paradox. The tragedy comes when this socially acceptable, sanitised, itinerant and on-cue drunk is no longer on stage or screen, but in the home and community as an alcoholic family member. The co-stars are loved ones, and the jokes ring long and hollow. Laughter is replaced with emotional and physical distress.

There is no socially sanitised version of the drug addict[1] to parallel our laughable drunk. This fact merely goes to emphasise the uncanny quality of the paradox which *does* exist concerning alcohol.

This paper examines how our legal system should deal with those persons we describe as 'alcoholics' or 'drug addicts'. Indeed, the prefatory task of defining just who these people are is one of the first, difficult questions to resolve. New Zealand's Alcoholism and Drug Addiction Act 1966 (the "AADAA") established a regime whereby those persons labouring under the influence of alcohol or drug addiction may be detained in an institution. This paper will discuss and evaluate the social philosophy which underpins much of the AADAA. It compares the AADAA with a number of relatively new statutory regimes that deal with persons whom for a variety of reasons, require state protection or assistance. These include:

(a) the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the "MH(CAT)A");

(b) the Protection of Personal and Property Rights Act 1988 (the "PPPRA");

(c) the Children, Young Persons, and Their Families Act 1989 (the "CYPFA");

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[1] References to a 'drug addict' or 'drug addiction' are used by the writer as a residual category to contrast with 'alcoholic' and 'alcoholism'.

(d) the New Zealand Bill of Rights Act 1990 (the "BORA");
(e) the Health Commissioner Bill 1990 (the "HCB"); and
(f) various other foreign and international documents.

By focusing upon the philosophies reflected in, and effects mandated by these legislative changes, a number of fundamental issues arise. These are analysed at length and include :

(a) the justification for a compulsory detention regime and the effectiveness of coercive treatment techniques;
(b) the definitional question of who is an alcoholic or drug addict;
(c) the status of voluntary patients once in the system;
(d) patient rights;
(e) patient representation;
(f) review and appeal procedures;
(g) the appropriate treatment model;
(h) whether separate legislation dealing solely with alcoholism and drug addiction is necessary or appropriate; and
(i) how well the system caters for minority cultural input.

The general consensus is that the AADAA is in desperate need of revision.[2] Any comprehensive review must address the issues identified above. How they are resolved, however, is inevitably coloured by the fundamental objectives of, or focus which motivates the AADAA.

The current AADAA regime is purportedly based upon the treatment rather than the penal model.[3] This contrast in guiding ethic is described elsewhere as being between welfare and justice models. The MH(CAT)A is generally an example of the former, and the PPPRA the latter. Each contain certain shades and hues of the other. For example, patient rights and representation reflect penal or justice elements to the AADAA, while treatment choices and paternalism reflect welfare or treatment models. The following explores where the balance should lie, and accordingly, how the issues listed above might be resolved. First, however, there follows an outline of the current statutory regime.

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[2] B James *Review of the Alcoholism and Drug Addiction Act* (Unpublished paper, Task Force on Alcohol - Related Issues, 1984).
[3] Long title of the AADAA. See below part I A.

I THE AADAA: YE ALKIES, YE JUNKIES, YE DRAGONS GREAT AND SMALL

A *The Detention Process*

Its long title declares the AADAA to be:

> [a]n 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.

Detainees may be either voluntary[4] or involuntary.[5] One must be careful, however, not to label "voluntary" that which is in truth, coercive, due to the pressures and sanctions imposed upon a subject who makes the "wrong" decision.[6] Nevertheless, any person may, pursuant to s 8, apply to a District Court Judge and specify the institution he or she desires to be committed to. If the District Court Judge is satisfied:[7]

> ...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 the 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,... 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....

Involuntary patients may be detained upon an application made under s 9. A relative,[8] police officer, or "...any other reputable person..." may apply in the

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4 Section 8.

5 Section 9.

6 This is discussed further in part IV below.

7 Section 8(4).

8 Defined in s 9(8) to mean:

> ...a spouse, parent, grandparent, stepfather, stepmother, brother, sister, half-brother, half-sister, son, daughter, grandson, grand-daughter, stepson, or step-daughter.

This definition is superseded by that contained in s 2 of the PPPRA wherein:

> [r]elative, in relation to any person, means-
> (a) The spouse of that person, or any other person with whom that person has a relationship in the nature of marriage; and
> (b) A parent or grandparent of that person or of the spouse or other person referred to in paragraph (a) of this definition; and
> (c) A child or grandchild of that person or of the spouse or other person referred to in paragraph (a) of this definition; and
> (d) A brother or sister of that person, or of the spouse or other person referred to in paragraph (a) of this definition, whether of the full-blood or of the half-blood; and
> (e) An aunt or uncle of that person or of the spouse or other person referred to in paragraph (a) of this definition:
> (f) A nephew or niece of that person, or of the spouse or other person referred to in paragraph (a) of this definition:

prescribed form[9] for an order summoning the "...alleged alcoholic[10] to show cause why an order should not be made requiring him to be detained for treatment...."[11] The judge may issue a warrant for the alleged alcoholic's arrest if this is shown to be necessary to compel his or her attendance to be dealt with in accordance with the AADAA.[12]

Upon being satisfied with the truth of the application and the willingness of the institution to receive the person, the judge may issue the detention order sought.[13] No order is made, however, without the evidence of 2 medical practitioners to the effect that they believe the subject is an alcoholic, and that his or her "...detention or treatment... is expedient in his [or her] own interest or in that of his [or her] relatives."[14]

No person may be detained longer than 2 years.[15] Discharge, transfer and release on leave is regulated by s 17. Such decisions are made by the Minister of Health, supervising committee of an institution, superintendent or hospital board.[16] After 6 months a patient may apply to be discharged.[17] If refused, he or she may apply to the High Court.[18] The court may direct that a patient be released or released on leave, and may attach such terms and conditions as it thinks fit.

Anderson J summarised AADAA procedure in the case of *In re Sorenson.*[19] His Honour said: "[t]he jeopardy of the subject of the application is analogous to a person charged with a criminal offence carrying up to two years' imprisonment".[20] This is clear in the light of s 23, which declares that all provisions of the Summary Proceedings Act 1957 in respect of appeals from convictions or orders apply to any detention order made under the AADAA. They apply "... in the same manner as if the

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9 See SR 1968/211 for the prescribed forms referred to by the AADAA.
10 Section 3 of the AADAA provides that that Act applies to drug addicts in the same manner as it does when it refers to alcoholics.
11 Section 9(1).
12 Section 9(4).
13 Section 9(7). See below part III for a more detailed account of AADAA detention and discharge criteria.
14 Section 9(6).
15 Section 10(1).
16 Now known as Crown Health Enterprises.
17 Section 18(1).
18 Above n 17.
19 Unreported, 16 October 1989, High Court Hamilton Registry, AP 176/89.
20 Above n 19, 5.

person ordered to be so detained and treated or removed had been sentenced to detention within the meaning of the Summary Proceedings Act 1957."[21]

Anderson J opined that in addition to the express criteria, a further constraint exists upon exercising statutory discretions such as a detention order. This 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."[22] This is a clear reference to judicial review, and is consistent with s 18(6), a provision which preserves common law remedies, including a tort action for false imprisonment.[23]

B *The Criminal Justice Act 1985 - A Mysterious Omission*

In 1966, Parliament inserted s 48A into the Criminal Justice Act 1954 (the "CJA 1954") to coincide with the enactment of the AADAA. Subsection (1) of the amendment provided that:

> 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 [24] 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.

No parallel provision appears in the Criminal Justice Act 1985 (the "CJA 1985"). As a consequence, when the AADAA purports to deal with patients detained for treatment upon criminal conviction, it does so pursuant to a piece of repealed legislation.

Section 21 of the Acts Interpretation Act 1924 provides for such cases by saying that where an unrepealed Act (the AADAA) refers to a repealed Act (the CJA 1954), that reference is construed as refering to any subsequent enactment passed in

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21 Above n 19, 5.
22 Above n 19, 5.
23 Remedies and review procedures are considered below in part VII.
24 Section 3 defines 'drug addict' and is set out below in part III.

substitution (the CJA 1985). There appears to be, however, no provision in the CJA 1985 "...passed in substitution for..." s 48A.

Section 102 of the CJA 1985 expressly contemplates the situation where a person is subject to a sentence of imprisonment, but detained instead in an institution under the AADAA. Unfortunately, none of the CJA 1985 sentencing options appear to facilitate AADAA detention. Compulsory detention under the AADAA does not fit the community service model.[25] It is not periodic detention,[26] nor is it supervision. Supervision is described as being carried out by a probation officer, and is non-custodial.[27] Community care appears a likely candidate,[28] but s 53 provides that it cannot exceed 12 months,[29] and in all respects requires the consent of the offender.

Corrective training applies only to persons aged 16 to 20 years, and is limited to 3 months.[30] The remaining candidates are imprisonment[31] and preventive detention[32] which disqualify themselves by definition. Part VII of the CJA 1985 deals with persons who are mentally disordered or under a disability. A person suffers a disability, however, only if:[33]

> ... because of the extent to which that person is *mentally disordered*, that person is unable -
>
> (a) To plead; or
>
> (b) To understand the nature or purpose of the proceedings; or
>
> (c) To communicate adequately with counsel for the purposes of conducting a defence (emphasis added).

Mental disorder is defined as it appears in the MH(CAT)A, and s 4(d) of that Act expressly exempts substance abuse, without more, from grounds upon which the MH(CAT)A jurisdiction can be invoked.

If the omission of a s 48A replacement from the CJA 1985 was intended, Parliament may have contemplated that a person subject to criminal proceedings will also be made the subject of a s 9 AADAA application. After all, s 48A went on to

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25 CJA 1985 ss 29-36.
26 CJA 1985 ss 37-45.
27 CJA 1985 ss 46-52.
28 CJA 1985 ss 53-57.
29 Whereas s 10(1) of the AADAA 1966 provides for 24 months.
30 CJA 1985 ss 68-71.
31 CJA 1985 ss 72-74.
32 CJA 1985 ss 75-77.
33 Section 108(1).

expound s 9 detention criteria.[34] This, however, takes the initiative out of the court's hands. One way of remedying the situation would be to amend s 9 so that the court itself can also initiate s 9 assessment procedures. A more obvious path, however, is to amend the CJA 1985, and clarify under what authority a court can sentence persons to alcoholism or drug rehabilitation institutions.

II THE RATIONALE FOR COERCIVE TREATMENT TECHNIQUES

> *Then the Lord said to Cain, 'Where is your brother Abel?'*
> *'I do not know,' he replied. 'Am I my brother's keeper?'*[35]

A *Benevolent Coercion & Civil Liberties*

The AADAA and other compulsory detention regimes like the MH(CAT)A are predicated upon the assumption that it is permissible and proper medical practice to marginalise those persons considered a socio-medical threat to society. Article 5(1)(e) of the European Convention on Human Rights acknowledges this predicate, saying:

> 1. Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law;...
> (e) The lawful detention of persons for the prevention of the spreading of infectious diseases, of unsound mind, alcoholics, or drug addicts or vagrants....

What is it, however, that supports this assumption? The answer seems to lie in the assertion of social norms and paternalistic attitudes. Children, the intellectually handicapped and the mentally disordered plainly illustrate the fact there is nothing unusual about decision-making by proxy in medicine. Crafting a sensitive, yet practical focus for coercive treatment processes remains, however, exquisitely nebulous.

The moment one speaks in terms of state coercion, there arises "...a cloud of suspicion and vague disapproval from some quarters at least...."[36] Once one determines, however, that some people lack the capacity to make competent decisions

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34 CJA 1954 s 48A(3)-(4).
35 Genesis 4.: 9-10.
36 P Tucker *Am I My Brother's Keeper? The Coercive Treatment of Alcoholism In NSW* (Unpublished draft of paper, ultimate vehicle of publication unknown, Australia, 1991) 4.

vis-a-vis their own health and welfare, a duty to intervene may arise. In this regard, Tucker draws an analogy with the person who repeatedly attempts suicide.

While it is going too far, perhaps, to say that an ordinary individual's failure to intervene in a suicide attempt is negligent, the inaction of a police officer or trained rescue unit member might be. Similarly, therefore, the state and its medical employees or contractors may be under a duty to assist.(albeit coercively) an alcoholic or drug addict. If we fail to do this because we fear assaulting our own leftist, politically 'correct' rhetoric then we indulge ourselves at the expense of the less fortunate, and risk the 'guilt' of negligence.

The focus for utilising coercion ought to be, therefore, a sense of social responsibility. In 1983, the Salvation Army Research Unit opined that the AADAA is a necessary agent of legal coercion, because "... one of the marked characteristics of [alcoholism and drug addiction] is the denial [by] the patient that [he or she has] a problem."[37] Committal under the AADAA therefore takes on a paternalistic mantle fed, perhaps, by the court's inherent *parens patriae* jurisdiction still preserved in New Zealand by s 17 of the Judicature Act 1908.

Civil libertarians are quite correct to point out that the AADAA regime is motivated by social self-interest as well as social responsibility or concern for the individual. Two fundamental purposes underpin the compulsory detention of drug and alcohol dependants. These are:

(a) to treat dependant persons so they can again become productive members of society; and

(b) to provide a benefit to society.[38]

Other rationales declare that the purpose of an AADAA regime is to prevent drug related crime[39] or deter future criminal behaviour.[40] The connection between alcohol and drug related crime is well documented,[41] and these rationales fall easily within (b) above as benefits to society. Other related social costs mitigated by the AADAA include those incidental to road accidents and public health services.

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37 *The Alcoholism and Drug Addiction Act 1966* (Wellington Co-ordinating Committee On Alcohol, Wellington, 1983) 20.

38 TL Hafemeister & AJ Amirshahi "Civil Commitment For Drug Dependency: The Judicial Response" (1992) 26 Loyola of Los Angeles LR 39, 45.

39 *In re Lopez* 181 Cal App 3d 836, 839; 226 Cal Rptr 710, 712 (1986).

40 *In re Jiminez* 166 Cal App 3d 686, 692; 212 Cal Rptr 550, 555 (1985).

41 R & S Hayes "Criminal Justice & Public Health" (1988) 10 Australian Crime Prevention Council 7, 13.

A detention regime like the AADAA ought to contain carefully crafted procedural protections such as opportunities for review, patient representation, notice and information dissemination requirements, and an elucidation of both patient rights and state obligations. If these building blocks are placed thoughtfully and strategically within the new structure rather than left to form a type of lean-to appendage, then we can hope to achieve both the therapeutic and social objectives (a) and (b) above. Routledge neatly sums up these propositions, saying:[42]

> It is clear that the application of coercion in the form of committal to a treatment institution, and the consequent limitations on liberty and freedom which that involves, constitutes something of a paradox, when it is justified on humanitarian grounds. The retention of a provision for compulsory treatment brings with it a responsibility to ensure that its use is limited, that it is both necessary and warranted, and that sufficient safeguards for patients' rights are incorporated.

B *How Effective is Coercion?*

Through measures such as the California Civil Addict Program, New York Civil Commitment and the Federal Narcotic Addict Rehabilitation Act 1966, civil committal as a form of compulsory treatment has been legal in the United States for the past 27 years, a period similar to that in New Zealand. It is difficult to assess the respective therapeutic benefits of coercive and non-coercive techniques due to "... the prevailing pattern of clients having multiple treatment experiences...."[43] Overall, however, when definitions of 'success' and 'relapse' are controlled, there appears to be no significant difference between coerced and voluntary groups.[44]

More detailed statistics reveal that while coercion works, patient variables such as sex, ethnicity, region of birth and age affect treatment outcome. Essentially, those with more to look forward to, such as well-paid employment, marital or familial stability and other catalysts for self esteem constitute better candidates for recovery. Inner-city alcoholics and addicts do respond to treatment, but the incentives are

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42 M Routledge *Legal Coercion in the Treatment of Alcoholism* (Department of Health Management Services and Research Unit, Wellington, 1983) 4.

43 Leukefeld & Tims "Compulsory Treatment for Drug Abuse" (1990) 25 The Int'l J'nal of the Addictions 621, 624.

44 Above n 43, 627; above n 40, 4; G De Leon "Legal Pressure In Therapeutic Communities" (1988) 18 The J'nal of Drug Related Issues 625, 627; DF Chavkin "'For Their Own Good': Civil Commitment of Alcohol and Drug-Dependent Pregnant Women" (1992) 37 South Dakota LR 224, 248.

smaller.[45] Quite separate from treatment *outcome*, Dr GM Robinson (FRACP) also endorses the idea that indirect sanctions from relatives and employers, whether actual or threatened, are effective incentives for a person to *enter* treatment 'voluntarily'.

Mark also plays down the significance of treatment quality and available therapeutic options in favour of patient variables as determinants of treatment outcome. He overlooks, perhaps, the fact that therapeutic programmes and personnel must identify the incentives which exist, and focus their efforts accordingly. A good programme remains essential.

Some might contend that if coercive techniques are no more effective than voluntary treatment, we ought to simply repeal the AADAA and concentrate our efforts on voluntary patients. The fallacy of such an argument is that if carried out, all patients who had to be coerced into treatment and were then successfully treated would never obtain much-needed treatment. Evidence indicates that some involuntary patients undergo a motivational change once committed. Of such patients, Tucker referred to New South Wales' Inebriates Act saying: "[w]e have had letters from patients expressing gratitude for their commitment under the Inebriates Act".[46] Abandoning a compulsory regime would deny assistance to such persons.

C *Other Harmful Activities: Candidates for Coercion?*

Whether we adopt a penal or treatment model for a compulsory detention regime, the object remains social control. The issue, therefore, becomes one of methodology and the selection of targets. Alcoholism and drug addiction are plainly identified by the AADAA. What of anorexia, bulimia, and tobacco smoking with its attendant nicotine addiction and heart disease? All of these activities are harmful and habit forming. Certainly, there are informal agencies to assist those who are afflicted. But what distinguishes these addictions in order for them to escape formal, coercive sanctions, including compulsory detention?

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45 FO Mark "Does Coercion Work? The Role of Referral Source In Motivating Alcoholics In Treatment" (1988) 5 Alcoholism Treatment Quarterly 5, 14-15. For example, patient variables indicate treatment outcomes are more favourable for Black women than Puerto Rican women. Black women are found, in general, to have greater self esteem and perceived by both partners to their marriages to hold more power. The Puerto Rican woman is said to defer to the authority of her partner more readily, discouraging self-determination.

46 Above n 36, 7.

Doctor Ian Gibb expressed the view that the AADAA is "...unnecessary, obnoxious in principle and logically unjustifiable."[47] He points to lung cancer caused by excessive smoking saying:

> "[w]e do not certify and lock up heavy smokers and try to cure their addiction, nor do we certify them if they refuse to have their cancer treated. Why, therefore, do we do so with alcoholics?"

If anywhere, the answer lies in that complex web of social structures, norms, values and boundaries which flex and bend to tolerate only a certain proportion of testing activities. Our criminal code is a less flexible strand to the web, while tacit dress codes and etiquette are more tolerant. There are important social boundaries and less important ones. This is reflected in the sanctions imposed.

Some activities might also wield sharper, more irritating edges that sever the silken strands of polite society more readily than others. These stir the state to intervene and place the agent of such actions under coercive scrutiny.

It remains to be discovered, however, just why alcoholism and drug addiction wield more jagged, testing edges. A tenable explanation is that those silken threads which regulate acceptable interpersonal skills and competent social functioning are stretched with a little more tension than others. Those which regulate eating disorders and non-mind altering drugs may flex that much more because the damage is more confined[48] or physiological.

D *Responsibility For One's Own Actions: The "You Could Stop if You Really Wanted to" Debate*

1 *The names' of the beasts: what are 'alcoholism' and 'drug addiction' ?*

There is much conjecture about the causes of addiction, and this is especially so in relation to alcoholism. Indeed, the focus of debate has often been upon whether alcoholism is, or is not, a disease. The World Health Organisation (the "WHO") recognised alcoholism as a disease in 1948.[49] Various experimental studies have attempted to discover a genetic link to explain the old adage that alcoholism 'runs in the

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47 I Gibb "Alcohol and drugs" (1981) 14 October NZMJ 276, 276.

48 Dr Crawford "Alcohol and drugs" (1981) 23 September NZMJ 237, 237.

49 RE Kendell "Alcoholism: a medical or a political problem?" (1979) 1 BMJ 367, 367. The WHO included alcoholism in its 'International Classification of Disease'.

family'.[50] These experiments include comparing biological twins to differentiate between genetic and environmental influences.[51] A similar differentiation is achieved under adoption studies, wherein those with alcoholic parents and adopted by foster parents exhibited a higher incidence of alcoholism under some conditions.[52]

Traditional beliefs in free will and moral responsibility, however, also temper the inconclusive results gleaned from genetic studies. Casting doubt upon the disease model, one writer points to the simple fact that:[53]

> ... indicators of a steadily rising incidence of alcoholism are accompanied by a steadily rising consumption of alcoholic beverages by the population as a whole.

2 *Narcissism and alcoholism*

> *We aren't really virtuous unless we enjoy being so. There is an interior component, the psychological posture in which our virtuous acts cause us to be happy.*[54]

Without resolving the disease versus moral degeneracy debate, Warren Lehman developed a theory based upon an interrelationship between narcissism[55] and alcoholism.[56] It is, essentially, an environmental thesis. It does not, however, permit the addict to completely vacate responsibility for his or her actions. Lehman contrasts the simplicity and coherence exhibited by children and stage/screen humorists, with adult ideas of self regulation and ego, derived from Western theory.[57]

Lehman is, perhaps, mistaken to limit his analysis by reference to 'Western' theory. Alcohol and drug problems are not so confined. A more accurate articulation of his theory would be to contrast narcissism with the ego simpliciter, and the way in which our ego incoherently twists ideas of freedom, self, knowledge and action.

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50 National Society on Alcoholism & Drug Dependence Inc *Alcoholism: An Inherited Disease* (NSAD, New Zealand, 1985) 3; HW Goedde & DP Agarwal (eds) "Genetics and Alcoholism" in Progress in Clinical and Biological Research: Volume 241 (Alan R Liss Inc, New York, 1987) 4.

51 Goedde & Agarwal, above n 50, 7.

52 NSAD, above n 50, 4.

53 Above n 49, 367.

54 Aristotle - as discussed by W Lehman "Alcoholism, Freedom, and Moral Responsibility" (1990) 13 Int'l J'nal of Law & Psychiatry 103, 115. Lehman is a recovered alcoholic and professor of law at the University of Wisconsin Law School, University of Wisconsin-Madison.

55 Narcissus (derived from the Greek 'Narkissos') was a youth who fell in love with his own refection in water. Hence, 'narcissism' refers to self-love or self-possession.

56 Above n 54, 106.

57 Above n 54, 106-107.

In his essay *On Narcissism*, Freud wrote:[58]

> The charm of the child lies to a great extent in his narcissism, his self-contentment and inaccessibility, just as does the charm of certain animals which seem not to concern themselves about us, such as cats and large beasts of prey. Indeed, even great criminals and humorists, as they are represented in literature, compel our interest by the narcissistic consistency with which they manage to keep away from their ego anything that would diminish it. It is as if we envied them for maintaining a blissful state of mind - an unassailable libidinal position which we ourselves have since abandoned.

According to Lehman it is our loss, as adults, of the simple coherency we possessed as children, that "...constitutes the characteristic misery widespread in the modern West [nee world]."[59] Lehman's theory fits snugly with more traditional references to the importance of self esteem. In assessing the effectiveness of coercion, Mark refers to the impact of "...high self-esteem..."[60] upon treatment outcomes. In a paper criticising the US government's 'zero-tolerance' policy upon drug use, Gostin recommends instead, a policy based upon health promotion[61] and "...empowering vulnerable people...."[62]

The 'characteristic misery' of adulthood is a pain for which alcohol or other drugs appear the sovereign remedy. Therefore, "...if alcohol is your problem, you are not an alcoholic.... Alcoholism is a disease named after what appears to be its remedy."[63] This paper does not purport to resolve questions as to the true nature of alcoholism or drug addiction. Such is the focus of much on-going scientific and medical debate. Lehman's theory does, however, warrant serious thought.

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58 Freud "On Narcissism: An Introduction" (1961) 14 Standard Edition 73, discussed by W Lehman at above n 54, 107.

59 Above n 54, 107.

60 Above n 45, 15.

61 L Gostin " An Alternative Public Health Vision for a National Drug Strategy: 'Treatment Works'" (1991) 28 Houston LR 285, 292.

62 Above n 61, 294. 'Vulnerable' meaning those who are disadvantaged economically or educationally.

63 Above n 54, 113.

III DEFINING "ALCOHOLIC" AND "DRUG ADDICT"

> *Nor am I suggesting that we should all become teetotallers, though it is worth reflecting that if ethanol were a newly synthesised substance the Committee on Safety of Medicines would almost certainly not allow it to be administered to human beings.*[64]

With the gravity of forcibly depriving a person of liberty in mind, - especially by civil action - we must determine who ought to be brought within the grasp of the AADAA's compulsory detention regime.

A *Current Definitions*

Section 2 of the AADAA defines 'alcoholic' to mean:

> ...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 3 declares that the AADAA applies with similar effect 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.

To extract the lowest common denominator from current legislation, a person without any psychological dependence upon alcohol may be committed as an alcoholic because his "...persistent and excessive indulgence..." is of "...serious annoyance to others...." In its submission to the AADAA review undertaken in the early 1980s the Mental Health Foundation declared that "[n]o person should be compulsorily detained simply because they cause 'serious annoyance' to others."[65]

Why the word 'addiction' is included in s 3 but omitted from s 2 is a little mystifying. It could quite conceivably have read: "'[a]lcoholic' means a person whose *addiction* to alcoholic liquor..."; and hence been consistent with s 3. Without the irresistible desire for another drink that chemical dependence entails, a person's drug

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64 Above n 49, 371.

65 Mental Health Foundation *Recommendations for Reform* (Ministry of Health File Records, Wellington, Undated) 2.

problem is attitudinal, and more likely to respond to familial and social sanction than coercive medical treatments designed for addicts. This fact is clearly attested to by s 33 of the Evidence Amendment Act (No. 2) 1980, which relates to disclosure of patient communications by a medical practitioner to the court. Section 33 defines 'drug dependency' (in part) as a:

> ... state of periodic or chronic intoxication, produced by the repeated consumption, smoking, or other use of a...drug...detrimental to the user, and involving a *compulsive desire to continue consuming, smoking or otherwise using the drug or a tendency to increase the dose*...(emphasis added).

Any definition is the product of legislative philosophy or objective. Broad definitions such as those in ss 2 and 3 of the AADAA indicate a taste for state intervention and a potential for expansive social engineering. Narrower, more refined terms of reference, on the other hand, speak of a treatment model.

B *Criticisms; Proposals; The Broad vs Narrow Bun-Fight*

Senior Lower Hutt Probation Officer, Mr G More proposed a broader s 2 definition of 'alcoholic' to include "...weekend heavy drinkers, and drink/drive offenders".[66] Inspector Dave Kerr also advocated wider use of committal orders to divert offenders with alcohol or drug problems into a rehabilitation setting. In his view, "...anyone whose use of alcohol or drugs ends in a criminal offence or causes disharmony at home or work, has a problem"[67] for which he advocates AADAA processing. There certainly is 'a problem', but not one that warrants unleashing coercive technique.

The danger inherent in broadening the 'alcoholic' and 'drug addict' concepts in the way advocated by Mr More and Inspector Kerr is obvious. There is no room for such intrusive definitions in civil committal proceedings where the sanctions unleashed comprise compulsory detention for up to 2 years. Even a drink/drive offender should not be committed under criminal jurisdiction unless the offender is a true addict. If the driver is not addicted, then that person's problem is, again, behavioural and attitudinal. It is not medicinally remediable in the traditional sense.

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66 *The Dominion*, Wellington, New Zealand, 15 August 1983, 2.
67 Above n 66.

In 1983, the Departmental Task Force on Alcohol Related Issues (the "Task Force") advocated narrowing the AADAA definitions. In particular, it suggested deleting the phrase "...or serious annoyance to others..." from both ss 2 and 3. This is a good proposal. In order to sanction compulsory treatment under more clearly defined circumstances, the Task Force endorsed committal where:[68]

> (a)...an individual's drinking [is] serious[ly] injurious to his health; or...
>
> (b)...[is] a source of serious harm or suffering, including psychological or emotional harm, to others.

If "...an individual's...health..." also includes psychological or emotional harm, however, this should be made clear. The term 'addiction' also ought to be included. As noted above, if there is no addiction (with the associated symptoms of chemical withdrawal), then detaining such a person for alcohol abuse does not treat the real problem. Not being an addiction, the alcohol abuse is caused by social, economic or other emotional factors.[69] The writer also recommends that alcoholism or drug addiction which is 'likely' to cause serious injury should be retained from the AADAA.

The AADAA's s 3 definition of 'drug addict' ought to include a non-exhaustive list of relevant substances in addition to the "...intoxicating, stimulating narcotic or sedative drugs..." currently specified. These could, for example be "mind altering substances."[70] Otherwise, s 3 ought to be refined in a manner similar to that already advocated for s 2, and according to that which follows.

C *The MH(CAT)A and a 'Dangerousness' Criterion*

Section 2 of New Zealand's MH(CAT)A contains a narrower definition of mental disorder from that contained in the (now repealed) Mental Health Act 1969.[71] The MH(CAT)A provides, in part, that:

> 'Mental Disorder' in relation to any person, means an abnormal state of mind (whether of a continuous or an intermittent nature), characterised by

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68 Above n 2, 3.

69 This is discussed more fully in part VIII below.

70 Above n 2, 3.

71 That Act contained the following definition:

> "Mentally disordered"in relation to any person, means suffering from a psychiatric or other disorder, whether continuous or episodic, that substantially belongs to one or more of the following classes, namely:
> (a) Mentally ill - that is, requiring care and treatment:
> (b) Mentally infirm - that is, requiring care and treatment by reason of mental infirmity arising from age or deterioration of or injury to the brain:
> (c) Mentally subnormal - that is, suffering from subnormality of intelligence as a result of arrested or incomplete development of the mind.

> delusions, or by disorders of mood or perception or volition or cognition, of such a degree that it -
>
> (a) Poses a serious danger to the health or safety of that person or of others; or
>
> (b) Seriously diminishes the capacity of that person to take care of himself or herself.

A 'dangerousness' criterion places an evidential burden upon the applicant seeking the subject's committal, and thereby provides the subject with a significant protection.[72] While (a) and (b) above are in the alternative, the 'dangerousness' criterion has been satisfied by, among other things, an inability to care for oneself.[73] This is entirely logical.

It is the writer's opinion that the difference between 'danger' and the Task Force's terminology in part III B above is merely semantic. In the interests of legislative consistency and clarity, the 'dangerousness' criterion should be included in AADAA definitions.

D *Who Makes The Applications?*

Section 9(2) provides that where an application emanates from the police or a "...reputable person..."[74] rather than a relative,[75] the applicant must supply reasons why he or she is the applicant and not a relative. There is, therefore, a presumption in favour of relatives rather than anyone else being applicants. The reason for this is obscure. The AADAA does not elucidate what good, acceptable reasons are, nor is there any express indication of the effect where a court decides the reasons are inadequate. The answer might simply be that, in such circumstances, a relative must resubmit the application. Again, the rationale is unclear.

In 1989, Spittle and Longmore conducted a survey of relatives' opinions among the families of patients committed between 1983 and 1987 to an institution of the Otago Hospital Board.[76] 74 patients were committed, 63 of whom were male, and 11 female. 71 were alcoholic, 2 solvent addicts, and 1 an opiate addict. Only 20 applications were made by non-relatives.

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72 Chavkin, above n 43, 267. See however, below part III G regarding burden of proof.
73 *In re Evans* 408 NE 2d 33, 35-36 (Ill App Ct 1980).
74 Section 9(1).
75 See above n 8.
76 BJ Spittle & BE Longmore "Alcoholism Committal: The Relatives' Perspective" (1989) 67 Univ Otago Med Sch 57.

Relatives "...reported considerable involvement in the decision to apply for the committal but would have preferred this to have been less."[77] This preference accords with the view that a patient's family may be emotionally unprepared, or too distressed to make an application. This is supported by the survey which revealed that patients are often very resentful toward the applicant.[78] As a result, persons who ought to be made the subject of applications can go without much-needed professional help. A considerable amount of familial angst could be prevented by rethinking the s 9(2) presumption.

The families also recommended longer periods of hospitalisation and more frequent readmissions for relapses.[79] One should note, however, that if the current governmental ethos of transferring responsibility back to the community continues, (an example is the deinstitutionalisation of mental health services) then there may be some resistance to amending the s 9(2) presumption.

Pursuant to s 7(h) of the PPPRA any person may, with leave of the court, apply to have the court intervene in another's personal or property affairs. Those who do not require leave are:

> (a) A person who seeks the exercise of the Court's jurisdiction in respect of himself or herself:
> (b) A relative[80] or an attorney of the person in respect of whom the application is made:
> (c) A social worker:
> (d) A medical practitioner:
> (e) A representative of any group that is engaged, otherwise than for commercial gain, in the provision of services and facilities for the welfare of persons in relation to whom the Court has jurisdiction in accordance with...this Act:
> (f) Where the exercise of the Court's jurisdiction is sought in respect of any person who is a patient or a resident in any hospital, home, or other institution, the superintendent, licensee, supervisor, or other person in charge of the hospital, home, or other institution:
> (g) Where the exercise of the Court's jurisdiction is sought in respect of any person subject to a property order, the manager of that person's property.

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77 Above n 76, 57.
78 Above n 76, 57.
79 Above n 76, 58.
80 See above n 8.

Essentially, this is a list of those persons considered "reputable person[s]" in AADAA terminology[81] for purposes of the PPPRA. A positive aspect of s 7 is that it eliminates any presumption in favour of a relative being the applicant.

Voluntary patients are discussed fully in part IV of this paper. Subsections (b) to (e) are entirely relevant in the AADAA context, but subs (f) focuses unnecessarily upon the elderly and infirm. Subsection (g) could also be omitted from the AADAA and more simply dealt with under the PPPRA's subs (h). In such an amended form, the PPPRA's s 7 description of suitable applicants should be supplanted into the AADAA to replace "reputable person" from s 9(1) of the latter Act.

E *The Criteria For Committal*

Pursuant to s 9(6), 2 medical practitioners must certify that a person is an alcoholic. It is, therefore, partly for the benefit of the medical profession that the definitions be clear. Prior to making an order, however, the court must not only receive the requisite certifications, but also believe making the "...order for [the patient's] detention and treatment as such is expedient in [the patient's] own interest or in that of [the patient's] relatives."[82] This expediency criterion indicates that not every alcoholic or addict caught by ss 2 or 3 will be committed automatically. Granting the committal order sought by an applicant is a discretionary decision anyway. It is unclear whether the expediency criterion does any more than recognise this fact.

Section 9(7) refers to the court being satisfied with the "...truth of the application..." before it can make the order sought. Just what this means is also uncertain. Again, the detention order is a discretionary decision, made upon the basis of evidence adduced by the applicant and medical practitioners, to which the court attributes due weight. 'Truth' conjures up images of an utter 'certainty' or 'without doubt' standard of proof. Instead of providing that:

> ...the [District Court Judge] may, if he thinks fit, and if he is satisfied of the truth of the application...make an order requiring the alcoholic to be detained for treatment...

s 9(7) could simply say:

> ...the court may, upon the evidence of the application and in accordance with this Act, if it thinks fit,... make an order requiring the alcoholic to be detained for treatment....

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81 AADAA 1966 s 9(1).
82 Section 9(6).

On 12 February 1981 the National Consultative Committee on Alcoholism (the "NCCA")[83] wrote to Mr GF Gair, Minister of Health, enclosing proposed amendments to the AADAA. Aimed at providing medical practitioners with background information, the proposed s 9(6A) seeks to supply each practitioner involved with copies of the application and any supporting statements, and empowers the practitioner to interview "...the applicant and any other person who may be able to contribute information as to the health and conduct of the alleged alcoholic."[84] This appears a useful amendment, expanding the database of relevant information upon which a practitioner makes the assessment.

A proposed s 9A purports to improve the committal process by permitting one month adjournments, ostensibly for assessments, to a maximum of two months.[85] The value of this discretion, however, is questionable. Section 9(5) of the AADAA already provides a power to compel a person to undergo assessment by 2 medical practitioners. If other entitities such as the institutions of ultimate destination are to be brought into the assessment process, then they ought to be a part of the s 9 committal application. If not, then the proposed adjournments appear superfluous. This is especially so when s 9A provides for lengthy interim stays in outpatient or full-time custodial institutions during the adjournment. The assessment process must be streamlined and avoid unnecessary intrusion. Lengthy interim detention for assessment holds the potential to become a convenient receptacle for deferring hard cases.[86]

F *Discharge Criteria*

After 6 months a patient may apply for discharge.[87] Under s 18(3), a patient may be discharged *in toto* or upon terms, where continued detention is no longer expedient or is unlawful. In deciding whether to grant a discharge, the court may consider the fact any relative or friend is able and willing to take the case of the patient. This in fact modifies, or at least identifies one factor that determines what is, or is not,

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83 Members of the NCCA being: Justice AA Coates, former chairman, 1973 Royal Commission on Sale of Liquor; Major John Gainsford, superintendent, Salvation Army Bridge Programme, Wellington; Dr ME Vijaysenan, psychiatrist, Porirua Hospital; Dr N Walker, medical director, Mahu Alcoholism Clinic, Christchurch; Sir Charles Burns, medical adviser, National Society on Alcoholism & Drug Dependence; Mr A Johnstone, community services consultant, Alcoholic Liquor Advisory Council.

84 *Proposal To Amend the Alcoholism and Drug Addiction Act 1966* (National Consultative Committee on Alcoholism, Wellington, 1981) 2.

85 Above n 84, 2-3.

86 One might note, however, the lengthy assessment procedure in ss 8-16 of the MH(CAT)A where a patient can undergo preliminary assessment, 5 more days, and then a further period of 14 days after which a court can examine the patient upon appeal.

87 Section 18(1).

expedient under s 18(3). The crucial question is whether or not this same fact modifies the s 9(6) expediency test for committing a person in the first place. Logically, there is no reason why it should not. Its absence from s 9(6) is anomalous and easily rectified.

G *The Burden and Standard of Proof*

Section 9(1) provides that upon receipt of an application, the court may summon 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." When this is compared with s 9(7) under which the court must be "...satisfied of the truth of the application", just where the burden of proof lies is a little confusing.

Both the wisdom and the logic of placing the burden of proof on the subject and not the applicant in s 9(1) is questionable. In a criminal trial it rests with the Crown. This is so, even where the array of potential sanctions does not include incarceration. Why then, when civil proceedings are the precursor to involuntary detention should the burden of proof be reversed?

The United States Supreme Court pronounced that "...due process requires the *state* to justify confinement by proof...."[88] On the question of standard, however, US instruction is more diffuse. US courts juggle standards such as "...the preponderance of the evidence,"[89] "...clear and convincing proof..."[90] and "...beyond a reasonable doubt".[91]

Addington v *Texas* [92] addressed the question of the appropriate standard of proof when committing a mentally ill person. The court rejected the preponderance of evidence standard as an inadequate protection against erroneous committal. It also rejected the beyond a reasonable doubt standard and its concomitant analogy with criminal trials. Rather, the court endorsed an intermediate standard of clear and convincing proof. In making this decision, the court expressed the view that in civil committal proceedings there are continuous opportunities to review and correct an erroneous committal.[93]

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88 *Addington* v *Texas* 441 US 418, 427 (1979), (emphasis added).
89 See *People* v *Moore* 69 Cal 2d 674, 685; 446 P 2d 800, 807 (1968). This standard is equivalent to the Commonwealth's 'balance of probabilities'.
90 Above n 88, 433.
91 *People* v *Thomas* 19 Cal 3d 630, 632-633; 566 P 2d 228, 229; 139 Cal Rptr 594, 595 (1977).
92 Above n 88.
93 Above n 88, 429. Review proceedings are discussed in part VII below.

The writer unearthed no specific judicial consideration of the AADAA's standard of proof. Quite how one would, in practice, distinguish 'clear and convincing proof' from 'the preponderance of evidence' without, in actual fact moving to a standard of evidence 'beyond a reasonable doubt' is inscrutably recondite. The Commonwealth standard of proof on the balance of probabilities is clear and tested.

In *Sorenson*, Anderson J compared the situation of an alleged alcoholic or drug addict under the AADAA to that of a person charged with a criminal offence carrying up to 2 years imprisonment. This might seem to support a criminal burden and standard of proof. However, His Honour's comments were merely descriptive of the AADAA. They cannot be interpreted as definitively encapsulating his opinion as to the correct burden and standard of proof for AADAA proceedings.

Furthermore, in *Pallin* v *Department of Social Welfare*,[94] the Court of Appeal held that proceedings under the (now repealed) Children and Young Persons Act 1974 are civil proceedings.[95] The case concerned a care, protection or control order over a seven year old child. Cooke J rejected the idea of "quasi-criminal" proceedings somewhere in between the civil and criminal even when (as with the AADAA) "...elements of criminal procedure under under the Summary Proceedings Act are employed."[96]

The philosophy behind compulsory detention also impacts upon this discussion of standard of proof. The criminal standard is a coincident of maintaining an alcoholism and drug addiction scheme based upon the penal model. If, however, the motive is to treat and rehabilitate persons, then a medical model is more appropriate. The latter fits more comfortably with the AADAA's self-proclamation as an Act designed to "...make better provision for the care and treatment of alcoholics and drug addicts."[97] The civil standard of proof, therefore, is applied with logical consistency. This is even more obvious once patient rights are recognised and adequately protected,[98] and an effective review procedure[99] injected.

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94 [1983] NZLR 266.
95 Above n 94, 275.
96 Above n 94, 269.
97 See above part I A.
98 See below parts V and VI.
99 See below part VII.

H *The PPPRA*

Respondents to Spittle and Longmore's study also favoured controlling the finances of a committed person under part III of the PPPRA.[100] The Family Court[101] has jurisdiction to grant a property order, appointing a manager to control a person's financial and property affairs.[102] This is possible where the subject of an application "...lacks wholly or partly the competence to manage his or her affairs in relation to his or her property."[103]

This is altogether reasonable. The PPPRA provides good protection for the subject, alongside specific provision contemplating the use of property orders for those persons admitted to "...any hospital, home or other institution as a patient or resident...."[104] Section 24 presumes the subject competent to manage property affairs until the contrary is proved, thereby placing the burden of proof correctly upon the applicant.

Section 25(3) protects the brave, eccentric or legally competent but stupid. It provides that the fact a person manages or plans to manage his or her affairs:

> ...in a manner that a person of ordinary prudence would not adopt given the same circumstances is not in itself sufficient ground for the exercise of [the court's jurisdiction].

Section 6 deals with personal rights rather than those over property and is of similar effect. Similarly, s 28 articulates two primary objectives of the Court, which underscore the subject's status as a person first, and patient or incompetent, second. This is lacking from the AADAA's current form. The PPPRA's primary objectives are:[105]

> (a) To make the least restrictive intervention possible...having regard to the degree of that person's lack of competence [; and]
>
> (b) To enable or encourage that person to exercise and develop such competence as he or she has to manage his or her own affairs in relation to his or her property to the greatest extent possible.

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100 Above n 76, 57.
101 "Court" is so defined in s 2.
102 Section 32.
103 Section 25(1)(b).
104 Section 27(1)(a).
105 Section 28(a)-(b).

An order may be over selected parts, or over all of a person's property.[106] It ceases to have effect upon (among other events) the death of the person subject to the order,[107] and where the Court reviews and discharges the order pursuant to s 87.

Section 10(1) of the PPPRA lists the kinds of order a court can make in respect of a person under that jurisdiction. 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..;[and]
>
> (g) An order that the person be provided with educational, rehabilitative, therapeutic, or other services of a kind specified in the order....

These provisions could, conceivably, encompass committal to a drug rehabilitation programme and make the AADAA redundant. The order would then have to specify all of the terms and conditions already articulated in the AADAA. More realistically, a court might utilise s 10 to commence involuntary AADAA committal proceedings without the need for a second application under that jurisdiction.

The writer does not advocate automatic application of the PPPRA to AADAA patients. Even where it is invoked, the presumption of competence remains, as does its prime directive in favour of making the least restrictive intervention possible. It is these underlying principles which ought to be supplanted into a revised AADAA to form part of its treatment model philosophy.

IV VOLUNTARY PATIENTS: "007, YOU WILL ACCEPT THIS ASSIGNMENT OR BE SENT UNDERCOVER TO THE SIBERIAN MINES!.... PLEASE TAKE YOUR TIME."

A *'Voluntary' Applications*

Pursuant to s 8, persons "...desirous of being received into an institution may make application..."[108] in writing, specifying the institution he or she desires to be

106 Section 29(2).
107 Section 34(1)(a).
108 Section 8(1).

committed to.[109] The Mental Health Foundation of New Zealand noted over 10 years ago, however, that :[110]

> [n]ot surprisingly, few such applicants are genuinely 'volunteers'. Applications under s 8 are usually made in response to family pressure or as a result of the applicant being presented with a choice between making the application or being sent to prison.

A *truly* voluntary patient may be one who attends a local meeting of Alcoholics Anonymous, or a similar group. Section 8's problem of thinly-vailed compulsion is compounded by the fact it requires no certification from a medical practitioner. If s 8 was intended to be a fast track path to committal, it succeeds. It succeeds, however, at great cost to the alleged alcoholic or drug addict. Despite s 8(1) requiring that the 'volunteer' appear in person, and that the court be satisfied the applicant "...fully understands the nature and effect..." of the application, he or she is still largely unprotected. Pressure from family or employer may, for example, still be influential when before the court. The concept of voluntariness is nebulous and the writer recommends that in accordance with the criticisms cited above, s 8 should be repealed.

Inserting a requirement for medical certification will help protect an alleged alcoholic or addict. Contrary to the opinions of TL Hafemeister, AJ Amirshahi and the court in *In re Walker* however, a medical examination does *not* serve "... to ensure that the action truly is voluntary...."[111] It might help determine whether a person in fact requires treatment, but is quite irrelevant to the issue of whether an applicant is actually acting voluntarily.

B *The Status Of Voluntary Patients Once Within The AADAA System*

Under s 8(2), the voluntary applicant must "...undertake to remain in the institution, for treatment for alcoholism, until he [or she] is released or discharged...." A patient might therefore revoke her consent as a voluntary patient after admission, but have no right to discharge herself. This contrasts with the rights of an informal psychiatric patient under the (now repealed) Mental Health Act 1969.[112] There appears,

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109 If s 8 is retained, a good amendment is that suggested by the National Consultative Committee on Alcoholism. This is to insert its proposed s 8(5) permitting the court (with the applicant's consent) to substitute another institution where the institution specified refuses to accept the applicant. If the applicant does not consent to this substitution, and the court wishes to make a committal order, then it proceeds as if a s 9 application were made.

110 Above n 42, 1.

111 Above n 36, 82; 71 Cal 2d 54, 59; 453 P 2d 456, 460 (1969).

112 M Routledge *Review of the Alcoholism and Drug Addiction Act - A discussion document prepared for the Task Force on Alcohol* (Department of Health Management Services & Research Unit, Wellington, 1983) para 4.2.

in fact, to be no distinction between voluntary and involuntary patients beyond the committal process. Once within the system, a 'voluntary' patient must wait out the 6 month period before seeking discharge, as must an involuntary patient.

Fagan and Fagan assert that "...it would be nonsensical to apply legal coercion to a voluntary self-referred patient."[113] In *Ex parte Lloyd*, Emery Lloyd had sought treatment for narcotic addiction. He agreed to "...submit to confinement at the [narcotic] farm for such period as was estimated by the Surgeon-General to be necessary to effect a cure of his addiction or until he ceased to be an addict within the meaning of the law."[114] Emery signed a document to this effect, and authorised those in charge of the farm to use any reasonable method of restraint to prevent his unscheduled departure.

Emery subsequently resisted his detention, and District Judge Ford found that Emery's continued confinement was contrary to the 5th and 13th Amendments to the Constitution of the United States of America. The 5th provides that "[n]o person shall...be deprived of life, liberty or property, without due process of law...," and the 13th that "[n]either slavery nor involuntary servitude, except as punishment for crime whereof the party shall have been duly convicted, shall exist within the United States, or any place subject to their jurisdiction."[115] The presumption in US jurisdictions is that a voluntary patient receives "...additional freedoms, including the ability to leave the facility."[116]

Although New Zealand is not subject to US jurisdiction or its constitution, the court in *Ex parte Lloyd* also held that continued confinement was contrary to the spirit of the law which authorised voluntary treatment. District Judge Ford characterised that law as 'charitable and benevolent' rather than 'penal or criminal'.[117] The AADAA's long title also reflects this spirit of charity and benevolence.

Therefore, if the writer's recommendation that voluntary committal be abandoned (above part IV A) is ignored, then a voluntary patient should remain as such post-committal, and have the right to discharge herself. If the institution or any other person feels the discharge is premature, they ought to commence involuntary committal proceedings under s 9.

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113 RW & NM Fagan "The Impact of Legal Coercion on the Treatment of Alcoholism" [1982] Journal of Drug Issues 103 as quoted in above n 41, 2.
114 13 F Supp 1005, 1005 (1936).
115 Above n 36, 83 fn 312.
116 Above n 36, 84; Chavkin, above n 43, 279.
117 Above n 115.

V CRAFTING A PLATFORM FOR THE ADDICT: THE RIGHTS OF THOSE COMPULSORILY DETAINED

A *Introduction*

In part III A above, we discussed philosophical shades to social control with which one can approach the AADAA. Patient status, as described by his or her rights, is a good indicator of just where the balance between treatment and penal models rests. Once compulsory detention is approved, our philosophical approach and level of true concern to assist the individual is partly revealed by our recognition of patient rights. Is there, for example, a right to treatment? What is arbitrary detention?

B *The New Zealand Bill of Rights Act 1990*

1 *Section 22 - arbitrary arrest or detention*

Section 22 of the BORA protects liberty of the person. It declares that "[e]veryone has the right not to be arbitrarily arrested or detained."[118] Article 5(1) of the European Convention on Human Rights (quoted above in part II A) similarly articulates a right not to be deprived of one's liberty unless it is prescribed by law, and for one of a list of specific purposes. Within that list, paragraph (e) permits the "...*lawful detention* of [among others]... alcoholics or drug addicts...."[119]

In its *Bozano Judgement*, the European Court of Human Rights (the "ECHR") interpreted 'lawful detention' to mean detention which is not arbitrary.[120] Hardly helpful to interpreting s 22 of the BORA! However, in its *Winterwerp Judgement* handed down 7 years earlier, the ECHR declared that committing a person to a psychiatric institution is not arbitrary if made in conformity with both the procedural and substantive requirements of domestic law.[121] It also held that European member states ought to operate in accordance with a principle of "...fair and proper procedure...."[122]

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118 Article 9 of the United Nations' International Covenant on Civil and Political Rights also preserves a right to freedom from arbitrary arrest or detention.

119 See above part II A.

120 ECHR Ser A, No III, p 23, para 54, 18 December 1986; discussed by MG Wachenfeld "The Human Rights of the Mentally Ill in Europe" (1991) 60 Nordic J'nal of Int'l Law 115, 141.

121 ECHR Ser A, No 33, p 17, para 39, 24 October 1979.

122 Above n 120, pp 19-20, para 45.

Procedure can be queried in two respects. The first complaint may be that it is simply not followed. The second: that the procedure endorsed by law is unfair. Wachenfeld addresses the former, saying:[123]

> [t]he point of insisting on procedural regularity is precisely to ensure that a right so vital as that of liberty is not taken away without the benefit of a thorough, fair procedure that is not only just but is seen to be just. The essence of a complaints-based human rights system is to protect the individual from governmental sleight of hand that 'gets it almost right'.

In regard to the latter, the point is that legitimising per se any detention prescribed by law whatever its form is to steal from article 5(1)(e)'s relatively toothless grip, the wherewithal to purchase itself some ill-fitting second-hand dentures. This latter criticism entails, in the case of legislation, a judicial challenge to the sovereignty of Parliament. That alone is a huge topic, and one which the writer does not intend to address here.

In *Re M*,[124] Gallen J considered the the case of a person committed pursuant to the Mental Health Act 1969. M challenged his detention, citing s 22 of the BORA. M had threatened to kill a woman with whom he was obsessed, and threatened violence toward Television New Zealand. Psychiatric evidence indicated that M laboured under delusions and was mentally ill.[125] Considering the application of s 22, Gallen J said:[126]

> ... the Judge is required to observe those principles that are imposed statutorily or which are accepted as being applicable within the system as a whole. To go outside those principles or to act on some other basis would in my view be arbitrary.... Looked at in that light, something is arbitrary when it is not in accordance with the law or which is not in accordance with the principles which the law regards as appropriate for discretion to be operated within.

Exactly what comprises 'arbitrary detention' remains somewhat elusive. Just what are those principles "...which are accepted as being applicable within the system as a whole"? Perhaps all we can be sure of, is that Gallen J would not ignore or alter any of the criteria imposed by statute. His Honour may, however, be persuaded to add criteria thereby making it more difficult to prove a detention is arbitrary.

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123 Above n 120, 151.
124 [1992] 1 NZLR 29.
125 Above n 124, 40.
126 Above n 124, 41 (emphasis added).

In *Re S*,[127] Barker J referred to the Mental Health Act 1969 saying:"[s]ection 66 makes it clear that detention is legal. Detention as a status is therefore not arbitrary per se."[128] That much is also made clear in s 22 of the BORA. His Honour goes on to say, however, that: "[t]he detention will become arbitrary if it is unprincipled, or is for a prohibited purpose."[129] Again, therefore, the judiciary refers to some implicit collection of 'principles' which remain unextrapolated.

2 *Section 11 - refusing medical treatment*

In *Re S*, a patient released on leave from a psychiatric institution objected to a condition of his release. This condition compelled him to submit to regular medication administered at his home by hospital personnel. S contested this condition, citing s 11 of the BORA. Section 11 provides that "[e]veryone has the right to refuse to undergo any medical treatment." Barker J considered that "'everyone' in respect of s 11 must mean 'every person who is competent to consent.'"[130] Being mentally disordered did not automatically deem a person incompetent, although these two things would commonly exist contemporaneously.[131]

Barker J held S to be incompetent, primarily because he failed to appreciate "... the significance of the treatment...,"[132] or his "... need for continuing treatment...."[133] The failure of many addicts to appreciate the fact that they 'have a problem' (adverted to earlier)[134] tends to indicate that s 11 would not permit them to refuse medical treatment.

Chavkin raises the possibility of a right to refuse treatment where drugs hold the potential for dangerous side effects.[135] In *Mills* v *Rogers*[136] the US Supreme Court also applied a competency test, whereby involuntary treatment is permitted only if it would have been accepted voluntarily by the patient were he or she competent to decide.The inherent danger here, is that a patient's competence might be assessed using the decision to refuse treatment as an indicator of incompetence.

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127 [1992] 1 NZLR 363.
128 Above n 127, 374.
129 Above n 127, 374.
130 Above n 127, 374.
131 Above n 127, 374.
132 Above n 127, 374.
133 Above n 127, 375.
134 See above n 37 and accompanying text.
135 Above n 44, 281.
136 457 US 210 (1990).

In New Zealand, s 6(3) of the PPPRA provides a good model for the courts to follow in this area. It provides that:

> [t]he fact that the person in respect of whom the application is made... has made or is intending to make any decision that a person exercising ordinary prudence would not have made or would not make given the same circumstances is not in itself sufficient ground for the exercise of [the court's jurisdiction].

Although an addict will rarely be 'competent' according to Barker J's analysis of s 11 of the BORA in *Re S*, the question of competence must remain *quite separate* from the individual decision to accept or refuse treatment.

In reference to s 11 and the BORA, this is an ideal place to note that rights and freedoms prescribed in that Act are expressly circumscribed in two important ways:

(a) Pursuant to s 4, no provision of any enactment passed before or after the BORA is impliedly repealed, revoked, or made invalid or ineffective "...by reason only..." that the provision is inconsistent with the BORA. However, when it can be given a meaning consistent with the BORA, that meaning is preferred.

(b) Section 5 provides for justified limitations upon any BORA right or freedom as is "... demonstrably justified in a free and democratic society."

Barker J could have simply utilised s 5 to limit the scope of s 11.

3 *Section 23 - rights upon detention*

Subsection (1)(a) of this provision confers upon a person arrested or detained pursuant to the AADAA or any other enactment the right to be informed promptly of the reason(s) for it. Further, subs (5) demands that a detainee be "...treated with humanity, and with respect for the inherent dignity of the person."

C *The MH(CAT) A: A Model for AADAA Review?*

1 *Part VI of the MH(CAT)A- patient rights*

Appointed in 1983, the Departmental Task Force on Alcohol Related Issues formulated 3 principles for consideration in altering the AADAA. Principle 1 endorsed compulsory detention, principle 2 narrower definitions, and principle 3 was a mandate

to develop provisions protecting the rights of AADAA patients "...comparable to those in the proposed Mental Health Bill."[137]

That Bill now constitutes the MH(CAT)A (in amended form). Part VI of that Act elucidates certain 'rights' for patients who are mentally disordered and subject to compulsory assessment and treatment. Each so-called 'right' is in fact described as an 'entitlement'. The reason (if any) for this contrast in terminology from the BORA is obscure. It may merely reflect, as the writer contends, the fact each Act is administered by a different government department. The MH(CAT)A is administered by the Ministry of Health, while the BORA is the property of the Department of Justice. If this is so, there is some scope for improved research upon the part of departmental draftspersons, so that unintentional inconsistencies are avoided. As the MH(CAT)A stands, a practitioner bereft of other ideas might contend that an 'entitlement' is something less than a 'right'.

A court would probably reject such a contention. The potential for the argument itself, however, is unfortunate. Rights are never absolute by definition, and must be weighed against community interests and the rights of other individuals. Entitlements must be similarly assessed, and a valid distinction with rights is increasingly inconspicuous.

Section 64 "entitles" every patient to a written statement of his or her "...rights as a patient."[138] It then "entitles" every patient to information updates on those "rights",[139] and "in particular", those "rights" listed in s 64 (2)(a) - (e).[140] The phrase "in particular" in s 64(2) indicates quite plainly that although ss 65 - 74 speak only of entitlements, there are *rights* listed outside of s 64.

In conjunction with s 5, s 65 entitles a patient to be treated with proper respect for his or her "...cultural and ethnic identity, language, and religious or ethical beliefs...;"[141] and proper recognition of "...the importance and significance to the patient of the patient's ties with his or her family, whanau, hapu, iwi, and family group...."[142]

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137 Above n 2, 2-3.
138 Section 64(1).
139 Section 64(2).
140 These include the right to review pursuant to s 16; the right to review by Review Tribunal pursuant to ss 79 or 80; and the right to appeal to the court under ss 83 or 84.
141 Section 5(a).
142 Section 5(b).

Section 66 entitles a patient to treatment, s 67 to have treatment explained before it is administered, and s 68 to be informed of the use of video or audio recording. A patient is permitted independent psychiatric advice pursuant to s 69, and legal advice pursuant to s 70. A patient is entitled to the company of others,[143] and at certain times to receive visitors and make phone calls.[144] He or she may receive and despatch letters pursuant to ss 73 and 74. With necessary, incidental amendments, these rights could be transposed into the AADAA regime.

2 Consent and the compulsory patient

Sections 57 - 63 of the MH(CAT)A establish a presumption in favour of obtaining a patient's consent to treatment before carrying it out. This does not apply in the first month of a detention order,[145] and the presumption may be abrogated where treatment is considered "...to be in the interests of the patient..."[146] by an independent psychiatrist.[147]

Evidence cited above demonstrates that coercion is an effective tool in treating alcohol and drug abuse.[148] A presumption in favour of obtaining patient consent is, therefore, of uncertain utility. The presumption might also denote an unwieldy procedure, because the responsible clinician who is familiar with the patient's case requires confirmation from an unassociated practitioner that his or her proposed course of treatment is "...in the interests of the patient."[149] On the other hand, if reasonably practical, this procedure could operate effectively to facilitate automatic second-opinions. If the s 59 mechanism can work smoothly in this way for practitioners dealing with alcoholics and drug addicts, then the writer endorses such an approach.

D *A Right to Treatment?*

This right is intimately connected with the purpose behind detaining a small percentage of the population for alcoholism or drug addiction. As noted above, s 66 of the MH(CAT)A entitles a patient to appropriate treatment and care. The ethos behind

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143 Section 71.
144 Section 72.
145 Sections 58 and 59(1).
146 Section 59(2)(b).
147 Appointed by a Review Tribunal (s 59(2)(b)).
148 See above part II B.
149 Section 59(2)(b).

such a right is to place a corresponding duty upon the state to address the question of appropriate treatment in individual cases, and to continually evaluate such treatment. The long title to the AADAA expressly refers to making better provision for the care and treatment of alcoholics and drug addicts. A set of patient rights could, therefore, comfortably admit a right to treatment. This also tends to confirm the appropriateness of a treatment model rather than a penal model.

VI ADVOCATES, INSPECTORS, LAWYERS, CALL THEM WHAT YOU WILL: THE CASE FOR PATIENT REPRESENTATION

A *Establishing A Right*

Section 35(2) of the AADAA provides that:

> [e]very person who is the subject of any such application shall be entitled to be heard and to give evidence and may be represented by a solicitor or counsel (emphasis added).

Hopefully, a court would interpret this provision as 'entitling' a patient to legal representation, and that 'entitlement' interpreted, in turn, as a right. To avoid any ambiguity, s 35(2) should be amended to follow s 70[150] of the MH(CAT)A. Legal counsel becomes increasingly important as patient rights are recognised and articulated. They help enforce those rights, and make review proceedings truly accessible.

Courts in the United States have held that those subject to sanction under the criminal justice system, have no right to counsel during their initial medical examination.[151] In *Johnson* v *Woods*,[152] the court held that this step in proceedings was a "...non-critical stage..." (when considering a right to counsel) because the medical practitioner acted diagnostically, and not as an agent of the applicant. One hopes this is true. Practice, however, may well prove otherwise. When a person's liberty hangs in the balance, the obligation to protect the interests of those least able to protect themselves must outweigh judicial expediency. The right to counsel, must, therefore, accrue on being required to undergo a medical examination under s 9(5).

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150 Section 70, (as amended by the recommendations in part V C 1 above).
151 Above n 38, 72.
152 323 F Supp 1393, 1398 (CD Cal 1971).

B *The MH(CAT)A & The Health Commissioner Bill*

The Health Commissioner Bill (the "HCB") contemplates establishing a Health Consumer Advocacy Service.[153] Advocates are appointed by the Health Commissioner,[154] to (among other things):

(a) promote consumer awareness of the Code of Health Consumers' Rights;[155]

(b) provide advice;[156] and

(c) receive complaints and assist aggrieved health consumers in pursuing any complaint resolution mechanism.[157]

The MH(CAT)A has already established a system involving 'District Inspectors' ("DI's").[158] Pursuant to s 76(9) - (11) (clinical reviews) and s 79(12) - (14) ('Review Tribunal'[159] review), a DI is to consult with the patient, ascertain his or her wishes, and consider whether an appeal to the Review Tribunal or Court is appropriate. Just how DI's will fit in with the Consumer Advocacy Service is unclear.

If mental health is the preserve of DI's, then some thought might be given to the differences in the DI and Advocacy Service mandates prescribed in the MH(CAT)A and HCB respectively. Is the disparity warranted?

Most psychiatric institutions now refuse to accept patients referred to them under the AADAA.[160] They no longer maintain alcohol or drug programmes,[161] leaving the Salvation Army 'Bridge' programmes in Auckland[162], Wellington, and Christchurch as the main committal destinations.[163] They are, therefore, outside of the DI mandate, and free to adopt the Consumer Advocacy Service Model.

An amendment to the HCB would focus advocate attention not just upon the proposed Code of Health Consumers' Rights but on all rights articulated in the BORA and the amended AADAA itself.

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153 Clause 20.
154 Clause 21(1).
155 Clause 22(a). The Code is currently under consideration and is outlined in clause 17.
156 Clause 22(f).
157 Clause 22(g)-(i).
158 Defined in s 2.
159 The functions of which are described in ss 101-104.
160 Dr GM Robinson (FRACP) - interview with writer on 1 September 1993.
161 Above n 160.
162 The Auckland programme is situated on Rotoroa Island, in the outer reaches of Waitemata Harbour.
163 Above n 160.

VII REVIEW PROCEEDINGS, APPEALS AND REMEDIES

A *Judicial Review*

Article 5(4) of the European Convention on Human Rights declares that:

> [e]veryone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful.

Pursuant to article 2(3)(a) of the International Covenant on Civil and Political Rights, each signatory[164] similarly undertakes:[165]

> [t]o ensure that any person whose rights or freedoms as herein recognized are violated shall have an effective remedy, notwithstanding that the violation has been committed by persons acting in an official capacity.

To be consistent with the fact a patient's condition changes, this right must be continuously, or at least periodically assertable. In New Zealand, decisions to commit and (refuse) release are judicially reviewable pursuant to statute,[166] and also that body of relevant public law. In essence, judicial review guarantees that a judicial authority, independent of the executive, medical practitioners and relatives, controls the process of initial and continued detention, and release.[167]

B *Clinical Review & Review Tribunals*

After 6 months, any patient, pursuant to s 18, can request the Minister of Health or the institution to discharge her. If refused, she can apply to the High Court.[168] No further application from a patient will be entertained until a further 6 months has elapsed.[169] As evidence shows that very few patients are detained for the maximum

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164 New Zealand is such a signatory. The BORA's long title indicates that it was enacted partly for the purpose of incorporating the terms of the International Covenant on Civil and Political Rights into domestic law.

165 [1990-92] 1 NZBORR xliv, xlv.

166 The AADAA s 9, the MH(CAT)A s 84, and the BORA s 27.

167 Wachenfeld, above n 120, 166.

168 Section 18(1).

169 Section 18(7).

permitted time of 2 years,[170] 6 months seem a little long. In fact, "[t]he length of stay data presented...indicates few patients remain in treatment after six months."[171]

When comparing the AADAA with the MH(CAT)A, the obvious question is whether a system of review tribunals ought to be instituted in the alcoholism and drug addiction regime. The AADAA does not provide for regular clinical reviews by the responsible doctor. This is a glaring inadequacy. Section 76(1) of the MH(CAT)A provides for a formal review 3 months after the date of a compulsory treatment order, and thereafter at 6 month intervals. The writer prefers intervals of 3 months.

The psychiatrist completes a certificate of clinical review,[172] and if fit for release, a patient is discharged from compulsory status.[173] If the patient is not fit for release, the certificate is copied to the Review Tribunal, patient, and others, all of whom are informed of the opportunity to appeal to the Review Tribunal. Such appeals take place pursuant to s 79 and may be upon application,[174] or upon the motion of the Review Tribunal itself.[175] There follows a right of appeal to the District Court.[176]

Review tribunals under the MH(CAT)A are, as yet, largely unproven. If they are transposed into an AADAA regime, they automatically make the rights to counsel, notice and information of paramount concern. These must be included in any reform of the AADAA. AADAA review tribunals could be appointed by the Minister of Health,[177] and include a barrister or solicitor to assist the tribunal in coping with the Act. More realistically, however, the volume of work generated for an AADAA tribunal could be efficiently dealt with by conferring upon MH(CAT)A tribunals a second jurisdiction. Psychiatric tribunals have been criticised in some jurisdictions for their medical bias,[178] but this is inevitable and axiomatic. It is not, in the writer's view, a criticism at all.

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170 M Routledge *Period of Detention* (Unpublished paper, Ministry of Health Management Services & Research Unit, Wellington, 1984) 1.
171 Above n 170, 2.
172 Section 76(3).
173 Section 76(5).
174 Section 79(1).
175 Section 79(2).
176 Section 79 (12). This is very often dealt with by the Family Court Division, and a similar role might be suitable under the AADAA.
177 See the MH(CAT)A s 101.
178 H MacDonald *Reviewing The Compulsory Status Of Psychiatric Patients* (Unpublished paper, VUW, 1993).

C *Other Avenues of Redress*

Laudably, nothing in the AADAA appears to prohibit private actions based in tort such as false imprisonment, battery, or intentional infliction of emotional distress. Section 18(6) expressly preserves common law remedies and their causes of action.[179] Just as any list of patient rights ought not to be exhaustive, preserving common law actions in this manner brings with it the flexibility and experience of the common law.

The MH(CAT)A's s 75 procedure for bringing a complaint that a breach of rights has occurred is also a good model for the AADAA. Unfortunately, s 75 applies only to those rights specified in part VI of the MH(CAT)A. This is inconsistent with formulating a non-exhaustive list of rights and, therefore, the AADAA (as well as s 75 of the MH(CAT)A) ought not be so confined.

D *Legal Aid*

Section 19 of the Legal Services Act 1991 makes legal aid available in court proceedings. However, for proceedings in a tribunal, the road to the cash is more treacherous. They must constitute proceedings in an:[180]

> ...administrative tribunal or judicial authority...where...the case is one that requires legal representation having regard to the nature of the proceedings and to the applicant's personal interest; and...the applicant would suffer substantial hardship if aid were not granted.

VIII MODES OF TREATMENT

A *The Least Restrictive Alternative*

Section 8 of the PPPRA endorses an ethic of making the "...least restrictive intervention [in the life of the subject] possible...." This ethic is consonant with the PPPRA's presumption of competence.[181] It is also consistent with a focus upon treatment rather than detention. Under the auspices of the AADAA, an ethic in favour of

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179 Section 18(6) provides:

> 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.

180 Legal Services Act 1991 s 19(e)(v)-(vii).

181 Sections 5 & 24 expound this presumption of confidence.

the least restrictive alternative (the "LRA") would regulate (among other things) choice of treatment, availability of leave, and the initial decision to commit. The last element is attested to by the Task Force's first principle, which said:[182]

> [c]ompulsory 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.

The LRA ethic also constitutes a bench-mark against which independent review of proposed treatments (to which the patient does not consent)[183] can be evaluated.

The LRA must be applied carefully, however. Hafemeister and Amirshahi record that the LRA principle has induced "...a considerable backlash...." [184] In the mental health context, it is associated with the premature return to the community of mentally disordered persons. If a release is premature, however, then it is not a viable alternative at all. The LRA is not a licence for more relaxed treatment options. It is designed, instead, as a license to reduce the intrusive quality of alcohol and drug addiction treatments as much as is reasonably practicable. The danger a patient poses to himself or herself and the community will *always* impact upon what is the LRA for a particular patient. Every patient should have known his or her own LRA assessment.

B *Community Treatment*

In accordance with the LRA, the validity of continued confinement in an institution depends upon the persistence of a condition that is untreatable in a less restrictive, yet practical setting. Dr GM Robinson sees considerable scope for community care of alcoholic and drug addicted persons.[185] To some extent, this is facilitated by the availability of prescription drugs such as 'antabuse'. These induce illness and vomiting if a patient subsequently consumes alcoholic liquor. Used in appropriate cases where the patient has also exhibited positive psychological change, Dr Robinson sees such drugs as quite effective. Each case must be considered separately to determine whether the drugs are appropriate. The treatment obviously relies upon antabuse or generics being ingested by the patient. A responsible and willing friend or relative might, in suitable circumstances, supervise this.

Community treatment will be appropriate in some cases. Treatment schemes should, after all, seek to empower the court with a full range of viable options. These

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182 Above n 2, 2.
183 See above part V C 2.
184 Above n 38, 85.
185 Above n 160.

the court (and medical personnel) can use to tailor an appropriate programme for each individual. Options may include outpatient orders or an order for particular treatment in a non-custodial context.

C *Aftercare*

When a patient returns to the same situation in the community which helped precipitate his or her addiction, the potential for recidivism clearly exists. Therefore, release ought to be also tied to rehabilitation. This is consistent with the state's purpose being one of benevolent intervention with a view to treatment and cure rather than punishment.[186] Leave ought to be carefully monitored and swiftly revoked when necessary.[187]

IX IS LEGISLATION INDEPENDENT OF THE MH(CAT)A NECESSARY?

A *The Issue*

The Mental Health Foundation of New Zealand has called for the AADAA to be repealed and incorporated within the framework of mental health legislation. A review of available sources discloses a number of advantages for retaining the AADAA. In this section, however, the writer outlines the various arguments, and evaluates each.

B *Arguments For & Against Retaining a Separate AADAA Regime*

One commentator asserts that "...alcohol and drug problems do not fit well into other areas of health service provision."[188] She contrasts the multidisciplinary approach required, with that used to provide mental health services. How much more multidisciplinary alcoholism and drug addiction treatment really is, however, is moot. The commentator offers no supporting evidence. Indeed, the MH(CAT)A Review Tribunals must include 3 persons, only one of whom must be a psychiatrist.[189] Further, under s 103 a Review Tribunal may call upon the expertise and knowledge of any person whose input is thought to be of assistance.[190]

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186 Above n 38, 93.
187 See above n 79 and accompanying text.
188 M Routledge *A & DA Act - The Need For Separate Legislation* (Unpublished paper, Ministry of Health Management Services & Research Unit, Wellington, 1983) 2.
189 Section 101(2). A second must be a barrister or solicitor.
190 Section 103(a).

Psychiatric hospitals no longer have specific alcohol and drug treatment programmes. 'Bridge' personnel are both conversant with the AADAA system, and independent of the mental health establishment.[191] They are volunteer groups. There would, therefore, be significant practical difficulties in placing such a group under the control of the 'Director of Area Mental Health Services.'[192]

Perhaps the most significant stumbling block to incorporating the AADAA under mental health legislation is the fundamental criteria for committal under the MH(CAT)A. A person must be 'mentally disordered' before the sanction of compulsory detention can be imposed. If we broadened this definition to include alcoholics and drug addicts, we open the door to legislatively induced ignorance, prejudice, and embarrassment. Just labelling alcoholics or addicts 'mentally disordered' might discourage applicants from seeking treatment a loved one desperately needs. Those who might have sought treatment of their own volition may no longer do so. They could admit to having a drinking or drug problem, but are most unlikely to consider themselves 'mentally disordered'!

There will also be numerous instances within the MH(CAT)A, where specific departure from the terms and conditions of the Act are necessary to provide for ex-AADAA patients. This will be laborious, make the MH(CAT)A unwieldy,[193] and betray a duality which is already demonstrated by the current existence of separate legislation. There are similarities, and the writer has already indicated those which are appropriate for inclusion in a revised AADAA. Both Acts comprise compulsory schemes and deal with medical patients. For the reasons already elucidated, however, we must not push these similarities beyond their practical utility.

To some extent this discussion is academic. Section 4(d) of the MH(CAT)A provides that compulsory assessment and treatment orders may not be invoked against a person "...by reason only..." of substance abuse. Current legislative opinion, therefore, also favours a separate AADAA regime.

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191 R Thornton *Alcohol Abuse and the Mental Health Act* (Unpublished paper, Department of Health, Wellington, 1983) 3.
192 Defined in the MH(CAT)A s 2.
193 Above n 191, 3.

X CULTURAL IMPLICATIONS FOR ANY REVIEW OF THE AADAA

A *Family Group Conferences*

The definitions of 'mental disorder', 'alcoholic' and 'drug addict' each incorporate some sense of the impact a subject's behaviour has upon family and friends. The Maori response to such persons may, however, be somewhat different to that anticipated by the AADAA. A Maori approach might, for example, utilise concepts of iwi, hapu, and whanau in a way more akin to the family decision-making model under the CYPFA.[194] The family group conference need not, however, be limited in its application by culture.

Where a child or young person is found to be in need of care or protection pursuant to s 18 of the CYPFA, a family group conference is mandatory. In the context of an alcoholism and drug addiction regime, this is probably too inflexible. The AADAA usually processes adults, and family responsibilities wane with age.

The most appropriate course might be to designate a person to decide in each case whether a family group conference is appropriate. If such a system is established by statute, it ought to be funded by the state. This would include transport and accommodation costs for attending family members. Section 22 of the CYPFA defines who can attend conferences for the purposes of that Act. A similar list could be formulated for AADAA purposes. It would include the s 9 applicant, the subject's spouse, and any person who is a 'relative' pursuant to s 9(8) of the AADAA. A discretionary power may rest in the conference convener to preclude persons upon the basis that their presence is unnecessary or undesirable.[195]

In some cases, the conference may be able to persuade the subject that he or she has a problem and displace the siege mentality of denial which so many addicts exhibit. He or she may then seek treatment voluntarily. Section 9 could be amended to permit the court to adjourn and allow a conference to take place prior to medical assessment and to the making of an order. If the applicant is not satisfied with the conference outcome, a conventional s 9 application may resume.

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194 See ss 17-38 of that Act.

195 This is similar to the power of the Care and Protection Co-ordinator under s 22(1)(b)(ii) of the CYPFA.

B *Injecting A Little Colour*

In 1987, the Langford Oration of the Royal Australian College of Medical Administrators investigated the proposition of an integrated approach to health care, saying: "[t]he Government has recognised that its policies and practices need to take into account other (than Western) cultural views."[196] In 1986, the Department of Health (now the Ministry of Health) issued a memorandum to all hospital boards urging them to consider the principles of the Treaty of Waitangi (1840) as a basis for planning and policy.[197] Such a vague direction sets 'tokenism'-alarms ringing loud and true.

Recent enactments have, to a certain extent, realised the goal of legitimising the injection of cultural information into medico-legal proceedings. These include the CYPFA family group conference model, and the MH(CAT)A's declaration in support of:[198]

> (a)...proper respect for the patient's cultural and ethnic identity, language, and religious or ethical beliefs; and
>
> (b)...proper recognition of the importance and significance to the patient of the patient's ties with his or her family, whanau, hapu, iwi and family group, and the contribution those ties make to the patient's well-being.

Section 65 'entitles' a patient to be treated in accordance with the spirit and intent of s 5. No similar provision exists in the AADAA.

If tokenism is to be avoided, however, a practical legitimacy beyond mere rhetoric and lip-service must be attributed to Maori norms and tapu (along with those of other cultures). If an alternative Maori treatment is to gain legitimacy, however, it must prove itself credible and effective. This is a difficult task. The way to begin, though, is to broaden the cultural capacity of the AADAA. It must cater for all of society (as all health legislation must), or it will tend to strait-jacket society, and thus earn its contempt. Clause 22(c) of the HCB requires that consumer advocates have:

> ...regard to the needs, values, and beliefs of different cultural, religious, social, and ethnic groups, [and]...provide information and assistance to health consumers and members of the public for the purposes of -
>
> (i) [p]romoting awareness of health consumers' rights [; and]

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196 MH Durie *An Integrated Approach to Health and Health Care* (The Royal Australian College of Medical Administration, Auckland, 1987) 6.
197 Above n 196, 6.
198 MH(CAT)A s 5.

> (ii) [p]romoting awareness of the procedures available for the resolution of complaints involving a possible breach of the Code of Health Consumers' Rights:
>
> ....

The HCB thus commends to advocates an appreciation of both the individuality and diversity of their potential client base. This ethic is entirely appropriate for inclusion in a reformed AADAA.

XI CONCLUSION

The AADAA contemplates its use as a conduit for both those who are committed during civil proceedings, and those referred from the criminal justice system. The CJA 1985, however, does not contain a parallel provision to s 48A of the CJA 1954. This empowered a court to commit those subject to criminal sanction to an alcoholism or drug addiction centre instead. None of the CJA 1985 sentencing options appear to facilitate AADAA detention. If s 9 applications are to be made in such cases then the AADAA must reflect that intention. If not, s 48A should be reinstated.

A treatment model is the most appropriate ethic with which to approach AADAA reform. It is not a penal statute, but one characterised ostensibly by benevolence and a desire to cure. The AADAA certainly plays an important role in social control, and provides various benefits to society. Its focus, however, remains in treatment and rehabilitation.

The task of composing a new AADAA regime should also be guided by a collection of underlying principles that seek to shape the treatment model. The first of these is the LRA, adequately described above.[199] Community integration is a principle worthy of thought, but is probably subsumed by the LRA. The potential pitfalls of community care have been highlighted, and it should not, therefore constitute a prime objective. It remains one of a number of treatment options.

The PPPRA's presumption of competence, and the MH(CAT)A's ss 57-63 presumption in favour of obtaining informed consent speak of an underlying principle of 'respect for the patient's wishes'. Only when treatment remains necessary and the patient intransigent should benevolent paternalism enter the process.

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[199] See above part VIII A.

The more traditional 'best interests' principle precipitates an unfortunate propensity toward less consultation with the patient. It ought to be discarded in favour of 'respect for the patient's wishes'. This does not supplant coercive treatment techniques, which remain. Rather, it offers the patient an opportunity to acknowledge his or her drug problem and begin upon the road to psychological and physiological recovery. Patient rights also form an important part of patient empowerment, and help ensure appropriate and timely assistance.

Evidence shows that, in terms of treatment outcome, coercion is just as effective as non-coercive treatment techniques. It is an important tool, therefore, in treating those persons who will not enter treatment voluntarily. Why society subjects the human agents of certain activities to coercive remedy and not others is a difficult question. Perhaps some activities threaten social norms to a greater degree than others. The pervasive and cruel effects of alcoholism and drug addiction are socially destructive, and harm more than just those persons primarily afflicted. The AADAA's coercive technique, therefore, is both useful and effective.

The current AADAA definitions of 'alcoholic' and 'drug addict' should be narrowed to encompass only those who are chemically addicted. The committal criteria in s 9 refer to the 'truth' of an application, and the 'expediency' of making an order. The reference to truth is unfortunate and ought to be omitted. In regard to discharge, the willingness of a friend or relative in s 18(4) to supervise the subject feeds into the expediency test. If this also applies under s 9, that should be made clear. The NCCA's proposed s 9(6A), which seeks to provide certifying practitioners with more information is a quality amendment. The value of s 9A adjournments, however, is less clear.

Section 9(1) currently places the burden of proof upon the subject. This is unfortunate. The burden of proof ought to rest upon the applicant, and the appropriate standard of proof is the commonwealth's civil measure. The US distinction between 'clear and convincing proof', and 'the preponderance of evidence' the writer suggests, is purely academic and impractical. Given the reaction of relatives, the wisdom of s 9(2)'s presumption in favour of relatives making the applications is questionable.

Section 8 patients will rarely be true volunteers. This is implicitly recognised by s 8(2), which requires an undertaking from the patient that he or she will remain in treatment until discharged. If s 8 is retained, however, a voluntary patient must retain that status after committal and have the right to discharge herself.

Patient rights must be elucidated, and can be modelled upon those in the MH(CAT)A. Its s 75 complaints mechanism, however, requires broader application. If the Health Consumers' Advocacy Service is to act in the AADAA field, the advocates' mandate must also be broadened to encompass rights not expressly included in the proposed Code of Health Consumers' Rights. Important rights include those to information, representation and treatment itself.

Provision for itinerant clinical review of a patient's condition is a glaring inadequacy in the AADAA. Review Tribunals might also be appropriate as an intermediate adjudicatory body prior to litigation. How Review Tribunals operate under the MH(CAT)A should assist an assessment of their appropriateness for the AADAA context.

In regard to choice of treatment, the LRA principle provides a quality ethic against which one may determine the appropriate treatment for any particular patient. Community treatment may also be appropriate in some circumstances, especially when combined with drugs such as 'antabuse'.

New Zealand law exists in a culturally diverse setting, and any health care programme must attempt to cope with such diversity. The AADAA must, therefore, provide for the input of non-Western thought. The HCB and MH(CAT)A have begun upon this road. A review of the AADAA ought to continue this process, and confer upon minority New Zealand groups a legitimacy in all spheres of health care. In 1966 the AADAA began a commendable effort to improve the lot of alcohol and drug dependent persons. The writer's recommendations seek to continue this process.

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