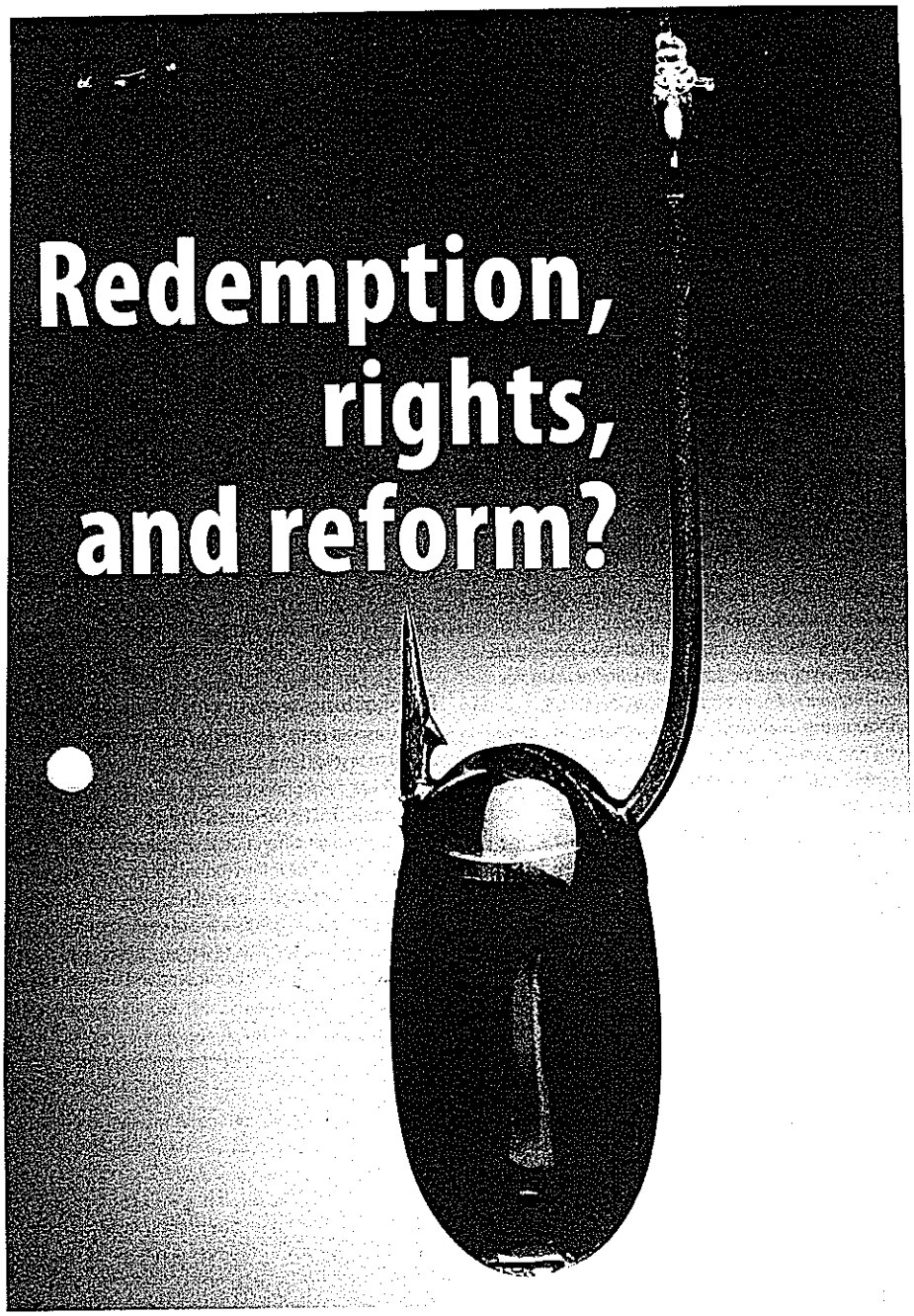
Redemption, rights, and reform?



By Maria Kazmierow, barrister and mediator

The genre of the celebrity addict is mainstream. There is no doubt that the journey to the bottom of addiction makes for compelling reading, given the number of recent "to hell and back (again)" biographies. Russell Brand and his *My Booky Wook;* Red Hot Chilli Peppers' Anthony Kiedis's *Scar Tissue* ; Keith Richards's *Life;* Ozzy Osborne's *I am Ozzy* to name a few. No doubt we await Charlie Sheen's contribution. Rehab and recovery lead to redemption – often.

For the seriously impaired alcoholic and/or drug addict, the addiction is challenging to beat. For concerned families and health professionals, the addiction is testing to treat. The need for compulsion to attend 'rehab' is self-evident in those seriously impaired cases.

The New Zealand legal system provides for compulsory treatment for chronic, seriously impaired drug and alcohol addicts. The statutory framework for voluntary and compulsory treatment is found in the *Alcoholism and Drug Addiction Act* 1966 (Act).

As a practitioner who undertakes mental health instructions under the *Mental Health (Compulsory Assessment and Treatment) Act* 1992 (*Mental Health Act*) as part of a panel of lawyers rostered to do so, the comparison between the two Acts is a stark and difficult one. The conceptual gap between the two Acts is vast. A paternalistic and heavy-handed 'best interests' approach is noted in the Act. Absent is a 'least restrictive intervention' and protective patient rights' approach.

The evident deficits in the Act have been recently identified and analysed. The Law Commission's recent report recommending reform of the Act is clear and comprehensive. The report, *Compulsory Treatment for Substance Dependence: A Review of the Alcoholism and Drug Addiction Act 1966* (NZLC R118, October 2010) refers to the need for new legislation, with a focus on compulsory treatment for substance dependence, and systematically reviews the gaps in the Act.

Specifically, the identified issues with the Act are:

1) **Statutory detention period for compulsory treatment of alcoholics and drug addicts** – an extraordinary *two years* (section 10).
   a) The earliest opportunity for a "fit to be released" style review hearing is at six months by patient application to the Supervising Committee (section 18).
   b) After that, the only avenue for release by the patient is by application to the High Court (section 18).
   c) That being said, the practice of Supervising Committees is to review the status of the detained person on a monthly basis (initially), or less frequently where a patient is on extended leave in the community until discharge from the Act is deemed appropriate.
   d) The Law Commission noted that two years is well beyond the therapeutic value of compulsory treatment – six weeks. The Law Commission recommends that responsible clinicians may need to apply for an extension (of up to three months), if a person appears to be suffering from alcohol or drug-related brain injury. The legal jurisdiction for this will be with the Family Court.

2) **Medical certification for committal:**
   a) Currently, there is no requirement that certification be done by a specialist alcohol and drug practitioner. All that is required is that this be completed by two medical practitioners.
   b) The Law Commission recommended that the Director-General of Health should have the function of appointing suitably qualified practitioners to undertake assessments and issue certificates of dependence under the regime. It may be that specialist training and qualifications will be necessary for clinicians to undertake the function of authorised specialist and responsible clinician.

3) **Funding Legal Assistance:** Instructions to assist patients do not appear to qualify for legal aid in the same way as those compulsorily detained under the *Mental Health Act*. Where the patient has funds, they can buy in leverage to ensure their detention is the least restrictive intervention. For those unable to, there is no ability to pay for individual legal advice and representation to assist their circumstances.

4) **Safeguards to protect rights:**
   a) *Legal assistance* (as noted previously);
   b) *District Inspectors being appointed.* District Inspectors are not available under the terms o the Act. The Law Commission recommends th they be mandated to perform their protective function for those detained compulsorily und any new legislation;
   c) *Time frames & Family Court Judges* – the responsible clinician to make an application t detain and treat a patient. A Family Court Jud is recommended to review those assessed for compulsory treatment, within seven days of t application. Again, this process of checks and balances with the oversight of a Family Court

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Judge highly experienced in the parallel regime for compulsory treatment of the mentally ill, would assist greatly in protecting detainees;

d) A more accessible right to review by a Family Court Judge (and further review if circumstances change);

e) Access to the same patient rights as a patient under the *Mental Health Act*.

5) **Few Treatment Facilities certified:** There is little flexibility in the type of treatment programme available. That may impair programme delivery, given that faith and other values may conflict with a patient, and faith and other values can become part and parcel of the compulsory treatment programme. In general, the Law Commission, as part of its widespread consultation with the drug and alcohol dependence sector, noted the shortage of facilities currently, and likely underreporting (and therefore treatment) of substance abuse issues.

6) **Discharge planning and after care** – to be required of the responsible clinician, prior to the expiry of the period of compulsion, on a voluntary basis.

The Law Commission recommended that the Act should be repealed and replaced by a new regime for the compulsory treatment of severe substance dependence. The objective: to protect detainees from harm and restore their capacity to make decisions; to stabilise their health through medical treatment; to facilitate comprehensive assessment of their dependence, and facilitate the planning of ongoing voluntary treatment.

The recommended guiding statutory principles should be:

- That detention and compulsory treatment is only considered when least restrictive options will not enable treatment to be effectively given;
- The least restrictive intervention should always be used where a person is detained and treated;
- Interferences with rights of detainees should be kept to the minimum necessary; and
- The interests of the detailed person should be paramount in all decision making about him or h

For lawyers practising in the parallel regimes for the mentally ill and those whose capacity is impacted by alcoholism and drug addiction, the disparity between the regimes requires reform – sooner rather than later. The Law Commission's Report is an excellent pathway forward. The time for the reform of this legislative historical anomaly is overdue. Those in need of treatment deserve the comparable rights and protections given to those who are mentally ill and under compulsory detention for treatment.