The Alcohol Mandatory Treatment Act: evidence, ethics and the law

use of a medical intervention to deal with a perceived social problem should concern clinicians

Summary

- The Northern Territory *Alcohol Mandatory Treatment Act 2013* (AMT Act) permits mandatory residential alcohol rehabilitation for up to 3 months.
- International guidelines and human rights law confirm that mandatory rehabilitation should only be used for short periods.
- Evidence concerning the efficacy of long-term mandatory alcohol rehabilitation is lacking, and minimal data concerning the efficacy of the scheme have been released.
- Specific legal issues also arise concerning the AMT Act, including its potentially discriminatory application to Aboriginal and Torres Strait Islander peoples.
- The program only permits referral by police, despite the fact that it is ostensibly a medical intervention. Use of a treatment as a method of effectively solving a public intoxication problem is highly dubious, and should be of concern to the medical community.
- Given that more cost-effective and proven measures exist to combat alcohol dependence, the utility of the AMT Act is questionable.

High rates of alcohol-related harms have long troubled the Northern Territory, with per capita alcohol consumption levels about 50% higher than the Australian average, and alcohol-attributable deaths occurring at 3.5 times the national rate.[1] The *Alcohol Mandatory Treatment Act 2013* (NT) (AMT Act) is the latest measure introduced to combat this issue, permitting "civil commitment" of individuals for residential alcohol rehabilitation for up to 3 months. Civil commitment for alcohol and other drug (AOD) dependence is the "legally sanctioned, involuntary commitment of a non-offender into treatment".[2]

We contend that there is little evidence of the scheme's efficacy, and that the NT Government could adopt more cost-effective alternatives that would not involve the dubious application of a medical intervention to reduce public intoxication, with its concomitant legal and ethical issues.

The *Police Administration Act 1981* (NT) provides that, where a person is apprehended by police three times for public intoxication over 2 months, they must be referred for assessment by a senior assessment clinician (SAC) in accordance with the AMT Act. Under the AMT Act, the SAC — who is not required to be a medical doctor — must assess the individual within 96 hours and then request a mental health assessment or make an application to the Alcohol Mandatory Treatment Tribunal (the tribunal). The tribunal need not follow the SAC's assessment report recommendations, but can make a mandatory treatment order in relation to the person if they meet the same criteria used by the SAC; in particular, that "the person's alcohol misuse is a risk to the health, safety or welfare of the person or others"; "there are no less restrictive interventions reasonably available to deal with this risk"; and "the person would benefit from a mandatory treatment order" (s 10 of the AMT Act).

The NT is not the first Australian jurisdiction to introduce civil commitment laws to combat alcohol dependence. Victoria replaced its *Alcohol and Drug-dependent Person's Act 1968* with the *Severe Substance Dependence Treatment Act 2010*, which significantly reduced the amount of time that a person could be detained for the purposes of treatment; it now allows for detention and treatment of a person experiencing severe substance dependence for up to 14 days.

New South Wales replaced its *Inebriates Act 1912* with the *Drug and Alcohol Treatment Act 2007* and, in 2013, introduced the Involuntary Drug and Alcohol Treatment Program, which allows for initial detention of "identified patients" for 28 days, with an option to extend treatment to 3 months. An inquiry conducted into the operation of the original Inebriates Act, which had permitted civil commitment of patients dependent on alcohol for up to 12 months, described this legislation as "essentially punitive rather than therapeutic, treating dependence on a legal and widely available drug — alcohol — as if it were a criminal offence, and using 'treatment' as a means of social control rather than for the benefit of the person".[2] Tasmania's *Alcohol and Drug Dependency Act 1968* is presently under review.

The updated NSW and Victorian statutes remove extended periods of incarceration, providing improved protection of patient rights, better reflecting international best practice. For example, the Victorian legislation allows detained patients the right to obtain a second opinion from a registered medical practitioner with relevant expertise in substance dependence. Conversely, the appropriateness of the AMT Act is questionable, given the paucity of evidence for lengthy civil commitment in treating alcohol dependence and the Act's limited protection of individual rights.

Evidence, ethics, human rights and international guidelines

Evidence for the use of civil commitment in treatment of alcohol dependence is limited. A systematic review concluded there was little evidence for civil commitment of AOD-dependent people, noting most research suffered from methodological limitations.[3] This built on a comprehensive systematic review that determined there was no reliable evidence comparing efficacy of compulsory residential treatment with that of voluntary treatment among non-offenders.[4] An Australian National Council

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on Drugs report similarly concluded that "the empirical evidence for the effectiveness of compulsory treatment is inadequate and inconclusive".[5]

In the absence of evidence, expert consensus provides useful guidance on acceptable use of civil commitment. The World Health Organization advises that treatment for AOD emergencies should be for short periods only, and that the patient should be released on completion of withdrawal.[6] Where an individual becomes "severely mentally disabled", civil commitment can only be justified when an effective treatment program and adequate facilities are available, the period of commitment is limited, and the individual's involuntary status is subject to periodic review.[6] The United Nations Office on Drugs and Crime (UNODC) considers short-term detention permissible where individuals are at serious risk of harming themselves or others, but compulsory clinical interventions should cease once the acute emergency has been avoided and autonomy re-established.[7] Regarding long-term mandatory treatment, the UNODC concluded that:

> Evidence of the therapeutic effect of this approach is lacking… It is expensive, not cost-effective, and neither benefits the individual nor the community. It does not constitute an alternative to incarceration because it is a form of incarceration… With sufficient voluntary treatment resources, appropriate referral for treatment from the criminal justice system, and community mobilization, the residual need to use this form of compulsory/involuntary treatment should decrease until it is not used anymore at all.[7]

These conclusions reflect human rights and ethical considerations regarding mandatory treatment. Generally, coercive treatment is not permitted under the international right to health, which includes rights to control one's health and body, and to be free from non-consensual medical treatment.[8] States must refrain from applying coercive medical treatments, unless on an exceptional basis (such as treatment of mental illness).[9] Restriction of individual rights may be permitted, but state parties bear the burden of justifying such serious measures, which must be proportional to the perceived public health threat.[9] Ethicists have also concluded that if temporary mandatory treatment for the purpose of creating autonomy may be ethically justifiable — but restoration of autonomy must be "the end of any moral argument for mandatory treatment".[10]

Specific issues concerning the AMT Act

Some welcome changes are being made to the AMT Act following a 6-month review.[11] Criminal sanctions for absconding from treatment have already been removed, and the NT Government is presently debating whether to broaden referral pathways into the scheme (for example, through allowing medical practitioners to refer individuals to the program). However, concerns remain regarding the lack of evaluation of the program; the use of what is ostensibly a medical intervention to target a social problem; opacity around tribunal proceedings; the potentially discriminatory application of the scheme to Aboriginal people; and the scheme's questionable cost-effectiveness.

To date, no formal evaluation of the clinical effectiveness of the program has occurred. The government has provided short vignettes containing patients' success stories and has released reports containing numbers treated, but with no indication of post-discharge relapse rates.[12,13] Given the aforementioned paucity of evidence for civil commitment, this lack of evaluation is concerning.

It is also disturbing that the scheme is openly targeted at "chronic drinkers who are publicly intoxicated"[11] — not all problem drinkers. This use of a medical intervention to deal with a perceived social problem should concern clinicians. Even if pathways into the program are expanded to allow medical practitioners to refer patients into the program, as the NT Government is debating, this will not address other shortcomings. Any police power of referral is worrying, particularly given acknowledged risks associated with delays in transfer from police custody to assessment facilities.[11]

The AMT Act also differs from other jurisdictions in that it is mandatory in respect of the coercive nature of its treatment regime and referral into the program; once a client is referred by police, the SAC has no discretion as to whether to refer them to the tribunal. It is troubling also that the tribunal could reach a different conclusion from that of the assessing SAC, and make a mandatory treatment order in the absence of medical support.

Proceedings of the tribunal are not published, reflecting a lack of transparency in this quasi-judicial process. Concerns have also arisen in relation to procedural fairness under the AMT Act; lack of an advocate or interpreter has previously led to invalidation of a tribunal decision on appeal.[14]

The AMT Act has also been criticised for de-facto discrimination against Aboriginal people. Reportedly, almost everyone assessed under the AMT Act is Aboriginal.[15] Homeless or itinerant individuals are much more likely to fall foul of the scheme. Homelessness rates among Indigenous Australians are up to four times higher than those of non-Indigenous Australians,[16] and the practice among them of staying in the "long grass" (living rough) has been well documented.[17] When read together with research confirming high rates of alcohol usage among homeless and itinerant Aboriginal people,[18] it is unsurprising they are more likely to be referred through the scheme than non-Aboriginal citizens.

The AMT Act may infringe s 9 of the *Racial Discrimination Act 1975* (Cwlth), by prohibiting enjoyment of a human right based on race, colour, descent, or national or ethnic origin. Although the scheme could constitute a "special measure" taken for the benefit of Aboriginal people, this would be difficult to justify given that the legislation was not written to apply specifically to Aboriginal people. The High Court of Australia recently determined that a law restricting possession of alcohol on Palm Island in Queensland did constitute a special measure, but in very different circumstances.[19] Given the AMT Act goes

well beyond restricting possession and severely limits the freedom of movement of affected individuals, a different determination could be reached in this instance. The proposed expansion of referral pathways into the program could mitigate this inherent discrimination, but as the legislation stands, legitimate questions remain regarding its application to Aboriginal people.

Finally, it is disquieting that around $27 million annually is being spent on a potentially discriminatory program lacking in evidence;[20] between July 2013 and June 2014, a total of 418 people were referred to the program, representing an approximate expenditure of $64 000 per person.[13] There are a number of more cost-effective interventions that could be implemented in place of the AMT scheme, which would represent a significantly less punitive approach towards AOD-dependent people in the NT.

Supply-side interventions, such as restrictions on alcohol pricing and hours and days of sale for licensed premises, have been shown to be effective in reducing harms associated with alcohol consumption.[21] Rather than punishing individuals for drinking, such restrictions are targeted at those who stand to profit from alcohol misuse. In respect of treatment interventions, capacity-building among primary health care organisations to manage AOD dependence is more readily justifiable than continuation of the AMT scheme, as the clinical and cost-effectiveness of this approach has also been demonstrated.[22] Implementation of any or all of these interventions using the significant funding allocated to the AMT scheme could see enormous benefits flow to the NT population more broadly, rather than providing for the temporary and likely ineffective compulsory treatment of a small number of people.

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