Office of the Public Advocate

Support issues for Victorians with an ARBI who are in contact with OPA

a discussion paper

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Plain English summary

Who this paper is about

- People who drink too much alcohol can get a bad brain injury
    - This brain injury can stop the person from looking after themself properly
- People with a brain injury need support from services
    - They might need help with somewhere to live and to stop drinking too much
- VCAT is a tribunal in Victoria. Like a court, it can make rules for Victorians.
    - VCAT can make an order that a person with a disability needs to have a guardian
    - VCAT makes a guardianship order if the person with a brain injury cannot properly work out important decisions because of their brain injury
- VCAT can make a person from the Office of the Public Advocate (OPA) the guardian.
    - Sometimes the guardian is a family member.
- VCAT says in the order what kinds of decisions the guardian can make

What a guardian does

- The job of the guardian is to make important decisions for the person
    - The guardian listens to what the person says they want
    - The guardian's decision must get the person the best possible result
- VCAT can order the guardian to make decisions about three different kinds of help for the person:
    - having somewhere good to live
    - getting more healthy and staying healthy
    - other support from services
- Because of their brain injury, the person will usually need help from a lot of people and services
- A case manager's job is to help make sure the person with a brain injury has the services they need.
    - The case manager makes sure people from different services work together properly
- Case managers and guardians work together to make sure the person gets enough help

Why this paper was written

- Providing good services to people with a brain injury is hard
- Victorians who have an injury to their brain from drinking alcohol do not have enough good services or places to live
- VCAT is giving more people with a brain injury a guardian
- A guardian can't make decisions that will fix things if there are not enough services
- OPA wants things to be better for Victorians who have an injury to their brain from drinking alcohol
- This paper talks more about these problems
- More talking and action needs to happen to fix these problems
- The government has changed the law so that some people with a brain injury can get the help they need
- The government has to also change other things so more people get help
- OPA will listen to others and then say what it thinks needs to be done about these issues

Introduction

OPA guardians are experiencing increased numbers of complex cases involving a person with an alcohol related brain injury (ARBI). This brain injury can cause significant cognitive impairment which seriously affects the person's instrumental reasoning and adaptive social and personal functioning and behaviour. Community visitors have also raised concerns about related problems in Supported Residential Services (SRS). OPA's recent experience is that the specialised drug and alcohol service system is highly stressed with long waiting lists and relatively scarce service or support options. Some of the affected people are uncooperative or self-discharge from service interventions before recovery or without enough supports. There is considerable frustration in hospital emergency departments, specialised and mainstream services and affected families. It is likely that the lack of support options, combined with the difficulty of dealing with people who are unable to control their consumption of alcohol, contributes to a propensity for the affected people to end up in the criminal justice system. They would then be confronted by coercive supervisory or other requirements they might be unable to comply with because of their cognitive impairment.

The law used for dealing with some of these issues, the *Alcoholics and Drug-dependent Persons Act 1968*, had human rights and other shortcomings that made it unworkable. The *Severe Substance Dependence Treatment Act 2010* replaces the 1968 *Alcoholics Act* from 1 March 2011. This law reform will permit better and more targeted systems and enforced treatment options. The *Treatment Act* also creates a new advocacy and monitoring role for OPA. The former government's stated view was that the Act's compulsory treatment powers would only apply to a very small number of people. While this law reform is welcome, better results cannot occur without additional resources for the treatment and support system.

In Australia, alcohol consumption is currently at a twenty-year high. Diverse health and welfare services, and other social measures, respond to the different problems associated with alcohol consumption. There are three different (overlapping) sets of consequences for individuals and communities associated with intoxication, dependence, and the regular use of alcohol. An individual may regularly get severely intoxicated, without becoming dependent. Other individuals may develop serious medical conditions from regular drinking, without becoming intoxicated or dependent. The different sets of problems intersect for some individuals. Increased alcohol consumption leads to increased incidence of problems. For example, cirrhosis rates and police and ambulance interventions related to alcohol are increasing. Australia's police commissioners advised government that currently sixty per cent of police work relates to alcohol consumption. While some younger people are drinking more, it is older age groups that have the greatest incidence of high risk drinking, with more women at risk than men in most age groups. Alcohol related hospitalisations are increasing, with Victoria having the highest rate of increase. Only one-in-five people with a severe alcohol dependency are getting treatment services. Aged care services now support individuals with a life-long history of alcohol dependency. Drug and alcohol treatment services must also deal with older people entering their services.

While this paper mainly focuses on problems related to the consumption of alcohol, some of the people who misuse alcohol also use other drugs. These other drugs include pharmaceuticals and illicit drugs such as heroin and amphetamines. Some people also engage in *chroming* or *huffing*, which involves the deep breathing of solvents in paints or substances such as petrol and acetone. The patterns of drug use change over time. For example, the abuse of tobacco, cannabis and amphetamines has declined in Australia. New drugs with unknown long-term consequences are also emerging. While some overall rates of drug use are declining there is also heavier use amongst some users, with an earlier age of onset, and greater frequency of use. Some of the people who misuse alcohol also use stimulants so they can drink more alcohol for longer. Multiple drug use, which is increasing, complicates treatments and other responses.[1]

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[1]Steve Allsop, "Justice Colloquium on Reducing Alcohol and Drug Related Harm" (Melbourne, 29 October 2010).

Some especially troublesome problems for people and services dealing with people with an alcohol addiction and a related brain injury are a consequence of the person's brain injury. Serious brain injury commonly creates mental health problems such as adjustment disorders, depression, and anxiety which can then lead to further drug and alcohol abuse. The symptoms of brain injury can resemble those of psychosis and dementia. Acquired brain injuries in general often lead to problems with impulse control, social skills and self-awareness. These problems may make a person agitated and their behaviour difficult, disruptive, inappropriate or aggressive. The aggressive behaviour can be verbal and physical aggression directed against the self, other people and objects. It may be confined to sporadic explosive outbursts or be always present as constant irritability and anger. An acquired brain injury also often leads to a lack of motivation and inactivity.[2] There are particular syndromes associated with alcohol consumption such as Korsakoff's syndrome which is a set of symptoms including significant memory loss and confabulation to fill in the gaps in memory. It is these brain injury related behaviours, the loss of the ability to remember, plan and organise, and the lack of insight into these issues, that create the difficulties.

Mainstream drug and alcohol treatment approaches are based on voluntary participation in cognitive behaviour therapy. People with an ARBI will usually not stop drinking and the effectiveness of cognitive behaviour therapy based is highly limited by the cognitive impairment associated with the person's brain injury.

A loss of legal capacity may also follow from the cognitive impairment associated with a significant brain injury. The Victorian Civil and Administrative Tribunal (VCAT) may make an order appointing a guardian for a set period to make health care, accommodation and service access decisions, and an administrator to make financial decisions for people with an acquired brain injury who lack legal capacity. The person must be found to have an immediate need for a substituted decision maker on major life matters for an order to be made. In Victoria, OPA is the guardian of last resort. OPA guardians are representing increasing numbers of people with an acquired brain injury, many that are alcohol related. During 2009/10 nineteen percent of OPA guardianship cases involved a person with an acquired brain injury, the second highest incidence for a disability type after dementia (thirty-five per cent).[3] While there is often an expectation from service providers and family members that the guardian will somehow resolve the problems surrounding a particular individual, in most cases there are no immediately achievable solutions that a guardian can realise. There are systemic problems, which defy easy or speedy solutions.

The purpose of this paper is to describe the issues affecting Victorians with ARBI who are in contact with OPA, and some of the consequences of these issues, using a case study approach. This is a step towards identifying and clarifying the problems, and seeking solutions. It is hoped this paper prompts further discussion and helps instigate the development of collaborative solutions.

[2] "Acquired Brain Injury and Mental Illness: Issues Paper," (State of Victoria, Department of Human Services, 2004), p. 6.

[3] Office of the Public Advocate, "Office of the Public Advocate Annual Report 2009 -10," (Melbourne: 2010), p. 6. A steep increase in new cases began in 2008/08 when new guardianship cases for a person with an acquired brain injury increased to twenty-two percent. The previous year the same rate was fifteen per cent.

Scope

This paper is intended to describe and explore some of the current experience of OPA. This paper is not a review of guardianship or service practice. This paper also does not examine the new OPA roles under the *Severe Substance Dependence Treatment Act*. Describing the full range of drug and alcohol services, supports and initiatives to address different needs and target groups is beyond the scope of this paper. The approaches and practices of drug and alcohol services, and other significant stakeholders, and their relationships with OPA, are not closely examined. Some examples of interactions are outlined for the purpose of illustrating some of the issues being experienced by OPA guardians. The views and recommendations of these services and stakeholders have not been ascertained through this research and are not found in this paper. This paper is an invitation to other stakeholders to make comment, and provide an additional perspective on the problems being encountered by OPA. This paper, and any responses received, will help clarify the issues to inform an advocacy response by OPA. In further work OPA will develop and publicise its advocacy position on these systemic issues.

Guardianship

Guardianship is a core function of the Office of the Public Advocate, under the Victorian *Guardianship and Administration Act 1986* (the Act). Guardians must comply with the specified objects, powers and duties of the Act. Guardians use their substituted decision-making powers to arrive at an outcome which is in the best interests of the person they represent. As far as possible, it is must be the least restrictive result available in the circumstances. The decisions and actions must also take into account the wishes of the represented person as far as possible.

A guardian's role is different to that of a case manager, and the guardian should not provide case management. Where a case manager is necessary, or would be beneficial, it is part of the role of the guardian to obtain case management services for the person they represent. The different roles of guardianship and case management need to be clarified as soon as possible to help establish a positive working relationship.

The Act allows guardians to request police assistance to enforce a decision of the guardian upon the person with disability whom they formally represent through their powers. Police provide this assistance when the situation is life threatening or a written order has been made by VCAT under s.26 or s.27 of the Act. The actions of the police and the guardian in these circumstances are legally protected by the Act. Police also generally act to stop or prevent any breach of the peace.

Effectively, the guardian, with the oversight of VCAT, can make a decision using their guardianship powers that a person live in a particular facility, so that they can be administered particular services such as alcohol detoxification. They are detained in the sense that police can lawfully return them to the facility if they decamp from the service.

The central problem

The central problem affecting people with an ARBI is that they have insufficient access to stable long-term supported accommodation options and face considerable service access difficulties.[4]

People with ARBI often exhibit a cycle of difficult behaviour that might escalate over a period of about one month. Services and support staff who have not previously observed this full cycle of

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[4] In April 2004 the Victorian Alcohol & Drug Association released a report describing the lack of accommodation options for people requiring drug and alcohol services: Heather Carmichael and Victorian Alcohol and Drug Association, "Alcohol and Other Drug Supported Accommodation Programs in Victoria: A Program in Crisis?" (Uniting Care Moreland Hall and Victorian Alcohol and Drug Association, 2004).

behaviour may predict their own success, where others have failed, based on how the person first presents to them. Some people with an ARBI are practiced in managing perceptions to minimise the controls or restrictions placed upon them. They can also sincerely want to stop drinking and improve their lives but be unable to carry out this intention due to their impairment. In general, most interventions that are tried for people with an ARBI fail. Sometimes this succession of partial successes and failures is the best that can be achieved for the person within the available resources of the current system. Examples of the different hurdles and patterns affecting individuals in contact with OPA are discussed further below through seven case studies, drawn from recent guardianship cases.

In OPA's experience an increasingly frequent response to the imminent failure or cessation of the current intervention, such as hospitalisation, is the making of an application for a guardianship order. This order may be sought because the person with an ARBI will not comply with the objectively arrived at view that they need to stop or lessen their drinking. A frequent reason for a guardianship application following hospitalisation seems to be the lack of any available suitable accommodation following discharge. The general type of situation encountered by OPA guardians is illustrated below. The person at the centre of the interventions can be male or female and aged in their twenties or eighties. Actual individual cases involve many departures from this generalised illustration of the problem, as is discussed further below.

The general kind of situation encountered by OPA guardians

The person with an alcohol related brain injury wants to get drunk. The people supporting them are exhausted from years of dealing with the person's pleadings, threats and violence. The person leaves, gets lots of alcohol, and later falls down drunk and unconscious in a public place. They are then picked up by the police and admitted to hospital.

The hospital treats their immediate health needs, and the person is detoxified over the next three days. During this time the person is very aggressive and abusive, and the hospital struggles to deal with them. They are either held in a secure ward as a mental health patient, or *specialled* in the emergency department, which means constant close supervision and chemical restraint.

The person's family say they don't want them back when they are released. They can no longer cope with their behaviours. Because the person has no accommodation available upon discharge, and few options seem available, the hospital social worker helps the family to make a guardianship application to VCAT. A neuropsychological assessment indicates major brain impairment causing major deficits in memory and their ability to plan and organise. A guardian with powers relating to accommodation, health services, and other services is then appointed.

The hospital wants to discharge the patient whose ongoing disability related support needs must now be addressed, rather than their earlier acute health crisis. The person is effectively confined for another week in the emergency department. The hospital social work department is unable to find accommodation and the person is unable to return to their former home. The guardian applies for case-management support from the disability services program of the Department of Human Services to deal with their complex and multiple needs. The person goes on a waiting list for services, and they still have nowhere to live.

The hospital social worker again proposes an SRS which they have successfully used in the past. The managers and staff of the pension-only SRS reassure the guardian they will be able to look after the person. The guardian is sceptical given the person's history and assessments and refuses to agree to the decision to remove the person to the SRS. The guardian looks for suitable accommodation. After another fortnight of searching the guardian agrees to the person's placement in a different SRS. Five weeks later the guardian gets a call from the SRS saying they have to find a new place for the person to live. Their behaviours have escalated to the point where the unqualified staff can no longer deal with their drinking, smoking and threats to the other residents. The person ends up in hospital again for treatment for injuries from a fall and detoxification. The guardian reconsiders the options.

Residential aged care as a partial solution

For people of retirement age, residential high-level care services offer a possible solution. This is because the supports needs and behaviours associated with alcohol related brain injury resemble those associated with dementia. The nursing skills and training of high care nursing home staff means they are equipped to respond to the person's needs.

> Case Study One. Reginald refuses aged care.
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> Reginald's necessary care arrangements seem straightforward. He is eighty-three years-old. He needs high-level nursing home care because he is incontinent, has dementia underlying an ARBI, and is immobile. What is preventing him from accessing services is that he doesn't want to live in an aged-care facility. He is aggressively adamant that he wants to go back home.
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> He was removed from his squalid home to hospital. His wife died seven years ago but he now has an intimate relationship with Mary who lives down the street, whom he has known for many years. Mary is receiving case management support and psychiatric treatment. She is not drinking now, but has had problems with alcohol.
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> Arrangements for a transitional care program to assist Reginald's move into a nursing home in Melbourne's east could not proceed. His strong-willed behaviour and aggressive outbursts made him unsuitable. He can't go home because of his support needs and he won't be moved into aged-care. The difficulties in dealing with him have to be canvassed during the referral process. His admission to a nursing home will be against his will which means it will be very difficult for the staff of the facility. For the moment he must stay on the hospital ward. The guardian was appointed in August 2010 with accommodation, health care and access to services powers to help resolve the impasse.

While OPA deals with a diverse range of people with an alcohol related brain injury, many are aged in their forties or fifties. Some are much younger. Mainstream aged care services will not always be appropriate as many younger people will want a more age appropriate environment. The disability support needs of people with an ARBI can be met by DHS funding and Disability Services. To ensure that other more appropriate options are explored prior to the placement of a young person in an aged care service a protocol has been put in place. This protocol was implemented by the Department of Human Services (DHS) and the Aged Care Assessment Service (ACAS). This process is intended to benefit younger people having very high support needs associated with their disability. ACAS establishes eligibility for access to Commonwealth funded aged care services, and assists people to access the most appropriate services such as transition support, or full accommodation support. The Commonwealth funds aged care services through the Department of Health and Ageing.

Case Study Two. Julie needs a new home

Julie presents as an articulate and intelligent fifty-five-year-old woman. Her husband made a VCAT application in mid-2009 when he and their three teenage children could no longer cope. The guardianship order with accommodation and services powers was due to expire in September 2010 but her guardian sought its continuance. Her husband acts as administrator.

She is currently residing at an aged-care facility in Windsor, with her husband paying high daily fees to keep her there. While ACAS were able to do an assessment, and she is clearly in need of this kind of support, the new DHS/ACAS protocol has delayed her full acceptance into the aged-care system.

As well as her long-standing alcohol related brain injury, Julie was also afflicted by an aneurism. Her own false belief is that she can manage her drinking. She doesn't see it as a problem. She would demand and cajole her family so that they would look after her, even when this became unbearable for them. Controlled drinking works for a time, but usually collapses after two to three weeks. Her aggressive and demanding behaviour escalates into violent kicking and punching, necessitating police intervention. Her family is burnt out. They can no longer manage the risk of harm that she poses to herself and to them. A succession of services have been unable to cope with her extreme demanding behaviour. Health and Age Assist, the aged-care placement agency, helps to find another service when the current arrangements once again fail due to her defiance.

Julie's disability support needs have been assessed. She will receive ten hours of weekly carer support through DHS disability support. This was approved in November 2009 but she remains on the DHS Disability Support Register, a waiting list for funding.

The current hope for Julie is that she will get a place at a new facility being opened by Wintringham.[5] It is an appropriate service, with skilled staff, that uses a controlled-drinking approach. Her husband likes the service but worries it is too far from her home and family. The proven quality of the service will probably outweigh that concern when Julie's guardian makes the decision about where she should live.

Supported Residential Services

Many people with an ARBI live in Supported Residential Services (SRS) because there are insufficient state managed and funded residential facilities. These privately run businesses generally do not have the qualified staff or expertise to manage the difficult, and sometime extreme behaviours of some people with an ARBI. This is because the more affordable pension-only SRS are solely funded from the fees paid out of the residents' pensions. Community visitors have observed how SRS accept people to live in the facility with little real awareness of the person's support needs. While there are examples of SRS that work very hard to properly support their residents many just ignore the looming problems. The problems associated with too little skilled support within the SRS are exacerbated by the lack of case managers. The inevitable occurrence of serious problems results in the person with an ARBI being moved out, usually to another SRS where the same thing happens again. The person is effectively homeless, as they do not have settled accommodation.

[5] The Wintringham organisation is an example of a Registered Housing Association which is responding innovatively to the needs of homeless people, including people with an ARBI. *Wintringham* ([cited 8 November 2010]); available from http://www.wintringham.org.au/.

Homelessness Services

Many people with an ARBI are either at constant risk of homelessness, or living in homelessness services. Homelessness services are funded and administered through the Housing and Community Building Division within DHS.

Case Study Three. Peter a little safer, still at risk

Peter is now fifty-three-years-old. His guardian has been involved in his life for the last three years, less so in the last six months. Peter probably used to earn a living from being a drug dealer, but that changed. His severe brain damage from long-term drug and alcohol abuse started to become evident fifteen years ago when his wife died. The impairment caused by his drug and alcohol abuse prevented Peter from fully grieving for her. He was not capable of the complex emotional response that might allow him to move on. His guardian feels that some vital aspect of his personhood was damaged at that point. Illicitness, drugs and alcohol follow him.

The new staff members of treatment and accommodation services express their surprise at the referral information given about his needs when they first meet Peter. He knows how to impress the staff of his next service or officials from the health department and never says no to services or requests. Whenever he is asked about his risky behaviour he produces condoms and clean syringes to show how he responsibly manages his HIV and Hep-C positive status. The new service staff invariably promise success in meeting Peter's needs. They tend not to read his file or appreciate the extent of his impairment or dangerous behaviour.

After about five-weeks the damaged part inside him winds tighter. Despite the support and efforts of those around him, Peter gets and consumes the drugs and alcohol he needs, sometimes provided by his daughter. After some mayhem, he absconds and later gets found unconscious on a tram or the street. This has happened fifteen times in the last year. The service staff telephone the guardian when Peter's drinking and drug-taking behaviour gets extreme. They call to say they are evicting Peter and that the guardian has to find somewhere else for him to live. There is nowhere else for Peter. The homelessness crisis services will not take him anymore. They were not equipped to provide the support he needed anyway. Even the specialist accommodation project especially funded to support people like Peter evicted him after eight months. He was too destructive to the health of the other residents.

'I am not dead yet' Peter tells the people trying to help him. Not using drugs and alcohol heavily is beyond his comprehension. He is incapable of stopping his self-destructive behaviour, because of his cognitive impairment. His accommodation and support service found him dealing drugs through his bedroom window. The courts dismissed the application made under the *Alcoholics and Drug-dependent Persons Act 1968* for his detention and compulsory treatment. The argument made for his freedoms, as expressed in the Human Rights Charter, carried greater weight than his vulnerability and needs. In the past few years, Peter has received the full range of expert neuropsychological assessment. The assessments and other support were funded though annual funding of $70 000 from an individualised support package from disability services. This was made possible through the DHS Multiple and Complex Needs Initiative (MACNI). This enabled the highly competent case-management which helped the most. The time between destructive episodes became longer and services were persuaded to continue providing support.

Peter did not need a guardian to make decisions. He needed coordinated services and an effective case-manager who understood him as he really was, not as he appeared upon his first presentation. For Peter's wellbeing, and for the effectiveness of the services trying to help him live a safer life, the case-manager needs to track and remember what works for him.

Case management

Guardianship involves making necessary decisions in the best interests of the person with an ARBI, while respecting their wishes where possible. It is not the guardian's role to arrange and coordinate services and service relationships to meet the person's needs. That is the role of a case manager. Effective case management was vital in Peter's case. It was enabled through the DHS Multiple and Complex Needs Initiative (MACNI), which now operates under the *Human Services (Complex Needs) Act* 2009.

Participation in MACNI is voluntary and specialist intervention is available for those sixteen years and older. People with an ARBI who have multiple and complex needs because of other conditions, such as an assessed mental illness, other substance abuse issues or forensic issues, may be eligible. Often the individual poses a risk both to themselves and to the community. MACNI can deliver a more effective and coordinated approach to supporting the individual. The intended result of this time-limited intervention is that afterward the person with an ARBI achieves some stability in health, housing, social connection and safety, and can be linked back into comprehensive ongoing support.[6]

A person with an ARBI who is not eligible for MACNI may still receive DHS Disability Support funding for case management following an application, assessment and registration process. Funding is allocated through the Disability Support Register DSR. As at 30 June 2010 there were 2,758 people recorded on the DSR who needed funding for Disability Services supported accommodation options, support to live in the community, or support for daytime activities.[7] These services are provided under the *Disability Act* 2006. Case management can be provided by DHS Disability Client Services or funded community based organisations.

Case Study Four. Anne has a home, needs case management

VCAT made a guardianship and administration order for Anne in September 2009. Guardianship focussed on risk management and harm minimisation, and tight control of her disposable income through State Trustees. She is fifty-three-years-old and is alcohol dependent with symptoms of ARBI. She was at risk of becoming homeless and her health and well-being are in serious jeopardy. Both her parents died when she was a young teenager. Her six adult children, and grandchildren, all live interstate. She would like to visit her family but she is not welcome because of her alcohol addiction, causing her much grief and depression.

Anne has been seriously abusing alcohol for more than ten-years, with limited periods of abstinence confined to attempts at detoxification. She returns to drinking on discharge. Her neuropsychological assessment indicated: low level functioning; cognitive impairment; executive dysfunction; difficulties with working memory, planning, organization and abstract reasoning; lack of insight; and severe levels of anxiety and depression. She requires significant support and is highly vulnerable. She is at serious risk of injury, assault and homelessness, and further alcohol-related harm. Case management was highly recommended to assist her in accessing treatment services and to provide structure to her life. This could lead to reduced opportunities for her to abuse alcohol, and increase her day to day functioning.

It was necessary for the guardian to move Anne from various Supported Residential Services on five occasions, in the last twelve months, due to her intoxication and associated behaviours. The instability compounded her personal insecurity, depression, grief, and continued intoxication. She had frequent hospital admissions, and episodes with police, as a result of falls and injuries while intoxicated. She has been admitted to the Alfred Hospital for detoxification several times.

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[6] http://www.dhs.vic.gov.au/operations/regional-operations-performance/multiple-and-complex-needs-unit
[7] Disability Support Register, how it works:
http://www.dhs.vic.gov.au/disability/supports_for_people/information,_planning_and_advocacy/how-we-provide-services-to-people

Case Study Four, *continued.*

The continuity of the guardianship relationship produced some stability while further efforts were made to obtain case management. This enabled a more tolerant and stable living arrangement, and better risk management resulting in fewer hospital admissions. Guardianship also enabled a second neuropsychological assessment at ARBIAS funded by DHS Multiple and Complex Needs Initiative, after a five-day detoxification hospital admission. Further interventions included: the development of a harm reduction drinking plan by a drug and alcohol service; temporary case management; active caseworker support to the temporary SRS accommodation; engagement in some daytime activities; and comprehensive health checks (e.g. liver function and optometry) undertaken at Monash Medical Centre. This series of interventions made possible a settled living arrangement in a new service. Anne agreed to move in when it opened as it provided her on-site services and a longer term solution to her itinerancy. Weekly visits from her Homeground Services caseworker helped her to prepare for her move.

Anne moved into her new home in September and was settling in. She has her own fully furnished and equipped bed-sitter. On site services and support are available. She was receiving five welfare checks a day. Anne's new accommodation gave her an opportunity to have a home of her own. It was a major lifestyle change that could substantially improve her wellbeing. Her addiction, associated risks, anxiety and depression and cognitive impairment still present significant challenges. She remains limited by her executive functioning, memory difficulties, and incapacity to plan and organise. Without regular oversight and support from a case manager Anne's living arrangement will be jeopardised. This was demonstrated when Anne recently left her new home and could not be found. It was once again possible that she might have come to serious harm.

A case manager would need to maintain regular contact with Anne and co-ordinate her support. They would help enable collaboration between the different services involved in meeting her needs. They could assist Anne to meet her goals including: attending AA meetings; participating in a Salvation Army choir; and reconnecting her with her church and with her children and grandchildren. Anne needs this kind of support.

Specialised drug and alcohol services

Most people with an alcohol related brain injury will have contact with specialised drug and alcohol services. The drug and alcohol service sector provide a range of assessment, treatment and support services to people with alcohol and/or drug use problems. These programs are overseen by the Mental Health and Drugs Division of the Victorian Department of Health. Drug and alcohol treatment most commonly refers to the medical treatment and related support provided for a short term to a substance-dependent person to assist them through the process of withdrawal and detoxification. The range of services provided is developed through the Rural and Regional Health and Aged Care (RRHACS) Policy and Funding Plan.[8] Accommodation, case management and other support may also be available from community alcohol and drug services after the initial treatment.

ARBIAS Ltd is one of the community alcohol and drug services funded to provide case management for people with an ARBI. It provides a range of other specialist services for this target group, including neuropsychological assessment and housing. It has a long waiting list for its services.

[8] See: http://www.health.vic.gov.au/drugservices/about/ab_funded.htm

Case Study Five. Martin pleads for his old life

Fifty-four-year-old Martin has been under guardianship and administration for three years, despite his continual objections. Nine years ago he was a high flyer in the finance sector, a very smart, successful and wealthy businessman. Now he spends his days writing letters pleading his case to get back to his old life. He does not understand that he has a problem, or that his next drinking episode could be fatal, because of his alcohol related brain injury. He uses his remaining cognitive reserve to make constant complaints about his current circumstances and restrictions. He successfully lobbies doctors, politicians, lawyers and others in his quest to get back his former lifestyle and they write him letters of support and appear for him. He wants to live in his own home again, but this seems impractical due to his significant impairment and very serious health concerns. He also has large financial problems after having incurred bills for an aged care bond, which can only be paid by selling his house.

His guardian and helping professionals are constantly diverted by his complaints, appointments, adjournments and demands. Because he cannot comprehend that he has a brain injury his eighth neuropsychological assessment of his functioning is about to be conducted. A series of guardians have had to make continual accommodation and health care decisions during the last three years. He absconds, gets drunk, and ends up disoriented or unconscious. It is often the police who find him and get him to help. He requires hospitalisation, because of the advanced cirrhosis of his liver, and complications including hepatic encephalopathy. When he is in this state he is confused and can go into a potentially fatal coma.

Currently Martin is living in a supportive SRS. The staff and management try to engage him in the community. They took him to one of the AFL finals matches and he had a good time. This is what the guardian would like to encourage; Martin getting out more and having a life. The more realistic option appears to be a locked dementia ward, which he would not accept. He made a complaint to the Disability Services Commissioner against ARBIAS as he thought it was an inappropriate service for him. He completely rejects the suggestion that he has an ABI or alcohol problems. Treatment approaches such as cognitive behaviour therapy are unlikely to work for him. Restricting him from drinking through strict environmental control appears to be the only option. The guardian receives many letters from Martin telling her to stop treating him like a prisoner.

Guardianship is not a panacea

While the legal powers of a guardian, and their authority, can be very useful for dealing with the situation of a person with an ARBI, they often defy all ready solutions. The person’s dependence and behavioural issues can overwhelm the responses that are offered.

Case Study Six. Andrew won’t stop using drugs

Andrew is twenty-one-years old. Although he drinks a bit he is mainly an illicit drug user. He is in a rehabilitation hospital because he suffered a hypoxic brain injury from a drug overdose. He can be very charming. He has a girlfriend and is the father of an eighteen-month-old-baby. There is a supervision order in place so he cannot access his child without proper supervision. He has an extensive criminal record, has been in prison and has current parole orders.

Now that his discharge is imminent planning must take place in order for Andrew to have somewhere to live. He can’t live with his mother. She has her own health problems and does not know what to do after years of struggling to look after him. His father is overseas. He regularly absconds and has to be returned via his guardian’s s. 26 powers under the *Guardianship and Administration Act*. He is very mobile, very active and very sociable. He thinks his only problem is being locked up.

The temporary urgent guardianship order recently went back to VCAT for review. The guardian was given full powers for a further twelve months. Andrew is well versed in dealing with the criminal justice system; he believes nothing can stop him. He candidly tells everyone that he intends to keep using drugs.

Case Study Seven. Terry is in limbo

Terry is fifty-five-years-old and has been an alcoholic his whole life. It seems he was consuming twenty to thirty standard drinks per day. When he was breathalysed a day after his last drink he still blew a BAC reading of 0.17. He has very little to say and seems very basic in his thinking. His guardian was only appointed in September 2010. He lived in a major regional town. Goulburn Valley Health made the guardianship and administration application after he kept absconding while hospitalised. The police return him to hospital via the guardian's use of their powers under s.26 of the Act.

Terry came to the attention of the health service some time after the death of his partner. Although she died more than a year ago he has failed to comprehend her passing. He makes lots of references to her as if she is still present in his life. His grief is difficult to address because he doesn't talk much, he doesn't want to acknowledge her death, and because he forgets due to his serious ARBI.

Terry is really confused and hospital isn't the right environment for him as he needs ongoing support. The staff and facility are not equipped to deal with him. Chemical restraint is used to restrain him but this means he is at increased risk of injury from falls, due to his unsteadiness from the sedation.

At the moment he can't go anywhere. A referral has been made to ACAS but other services must be considered according to the protocol between ACAS and DHS. He has a brother in another nearby town but the rest of his family live in another state. His guardian wonders if he should be moved into aged care interstate with the nearby family support he might find there. The family have been contacted and asked to suggest nearby suitable facilities. Meanwhile Terry is in limbo.

Next steps

While the process of guardianship is an important intervention guardians are not jailers. It is OPA's role to support services and actions that promote the rights of people with an ARBI, and to protect them from exploitation and abuse. Sometimes guardians can't make a decision in the situation of a person with an alcohol related brain injury, and they end up becoming an interim case manager.

The new *Severe Substance Dependence Treatment Act 2010* may permit better and more targeted systems and enforced treatment options from March 2011. The Minister stated that the Act's compulsory treatment powers will only apply to a very small number of people.[9] It is not clear how the lack of discharge options will be remedied without additional resources for the support system. The Victorian Human Rights Charter is relevant to these situations.

The Office of the Public Advocate will continue to explore how it can best promote and protect the rights and dignity of people with an alcohol related brain injury. Comments or views about the issues raised in this discussion paper should be forwarded to Mark.Feigan@justice.vic.gov.au (telephone 03 9603 9573). OPA will produce further work on these issues, and is looking forward to collaborating with organisations with knowledge and expertise in these matters.

[9] Legislative Council, *Parliamentary Debates, Severe Substance Dependence Treatment Bill Second Reading Speech*, 11 March 2010, p. 841.

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