

OPA submission to the Review of the *Alcoholics and Drug-dependent Persons Act (1968)*

17th June 2004

1. Purpose

To provide input into the current proposed review of the *Alcoholics and Drug dependent Persons Act (1968)* (A&DPA1968).

2. About the Public Advocate

The Public Advocate in Victoria is appointed by the Governor in Council pursuant to the Victorian *Guardianship and Administration Act 1986* (GAA1986). The office represents the interests of people with a disability, aiming to promote their rights and dignity and to strengthen their position in society. It is a statutory office, independent of government and government services, and can highlight situations in which people with disabilities are exploited, neglected or abused.

The Public Advocate delegates his authority to his staff, who may be advocates, investigators or guardians. The office also coordinates the Private Guardian Support Program, the Community Visitors Program and the Independent Third Person Program in Victoria. Further material on the role of the office can be provided if required by consulting the Office of the Public Advocate's (OPA's) website: www.publicadvocate.vic.gov.au.

3. Interest in the *Alcoholics and Drug dependent Persons Act (1968)*

The Public Advocate has experience as being appointed by the Victorian Civil and Administrative Tribunal as guardian for many people who have an alcohol related brain injury. In some of these instances the person is in need of detoxification and ongoing care.

The experience of the office that the Drug and Alcohol service system tends to be inadequate in its capacity to respond effectively to the needs of clients with a cognitive impairment. Unlike other clients they may require some level of restriction to ensure that they receive adequate care.

Whilst the *Alcoholics and Drug dependent Persons Act (1968)* does have provision through section 11 for someone to be placed into a detoxification facility the experience of the OPA is that Guardianship tends to be used more frequently by services to enable the client to be admitted to a detoxification facility.

4. Reasons for use of guardianship to admit person for detoxification

There are a wide variety of reasons that a guardian may be sought to place a person with a cognitive disability in a detoxification facility. These include:

4.1. Life saving When the situation has reached crisis point for a person with an ABI admission to a facility for detoxification can be a way of saving the persons life if they are considered to be at significant risk.

4.2. Crisis: Admission for detoxification can be a way of defusing the pressure of the situation. This can often be in response to requests to exert some level of social control in order to remove the person from those who are distressed by the person's behaviour. This can be contrary to the interests of the person with ABI who may operate best in a familiar environment.

4.3. Assessment: To enable assessments to be carried out once the person is no longer intoxicated. These assessments may be important to plan for the future accommodation and support needs of the person. These assessments can include:- neuropsychological, mental health, aged care, general health

4.4. Carer respite: Admission can provide important respite for carers or service providers under stress who often have few alternatives to seeking a period of respite.

4.5. Access to services: In order to gain access to accommodation and/or support programs it may be necessary to have the person admitted for detoxification before they can be accepted into these services.

4.6. Restraint: Guardianship may also be sought to keep the person in detoxification as services either because services believe that the *Alcoholics and Drug dependent Persons Act* (1968) does not authorise them to be able to keep the person in the facility. Alternatively the facility may not be secure and so guardianship is sought to try and keep the person in a place where they cannot be compulsorily held for care.

Sally

Sally is 30 and has been an alcoholic since 16. Sally has a diagnosis of personality disorder, elements of an obsessive-compulsive disorder (OCD) as well as a marginal acquired brain injury (ABI). She completed Year 11 and did office work for several years before her lifestyle deteriorated to the point where she could no longer maintain employment or stable accommodation. At 24 she had a son who has alcohol foetal syndrome. He lives with his father and Sally is not permitted to see him unsupervised. Sally used to live at an SRS before it closed and then moved to another SRS. She had case management from SANS but wore out their workers. In cycles she will drink methylated spirits, lose consciousness and frequently be brought to hospital.

A Guardianship order was made to allow hospital to engage security to keep her at the detoxification facility. In this case according to the interpretation of the Magistrates' Court s11 of the *Alcoholics and Drug dependent Persons Act* (1968) allows a person to be taken to a D&A treatment centre but does not provide for a person to be prevented from leaving.

5. Problems with current provisions of the *Alcoholics and Drug dependent Persons Act (1968)*

In addition to these reasons there are a number of issues with the current provisions under *Alcoholics and Drug dependent Persons Act (1968)*, which cause people to use the guardianship legislation.

5.1. Limited awareness amongst drug and alcohol and disability agencies of the *Alcoholics and Drug dependent Persons Act (1968)* and the s11 provisions.

5.2. Problems obtaining medical report. - The medical report can be difficult to obtain within 48 hours in order to pursue a section 11.

5.3. Confusion over who can make an application. - It is not clear who is currently classified as a welfare worker under the *Alcoholics and Drug dependent Persons Act (1968)* and therefore who can make an application under section 11. Given the number of non-government services who fall outside the *Public Sector Management and Employment Act (1998)* there may be fewer government agencies who can apply than when the legislation was first enacted.

5.4. Section 11 does not allow the person to be held at the facility. For example in Western Hospital, Ward 1 a guardianship order has been used to authorise involuntary detention through use of security, as the Magistrate had previously observed the limits to the *Alcoholics and Drug dependent Persons Act (1968)* in respect of detention. This is despite the fact that the facility may be considered to have a duty of care to keep the person in the facility. This raises the question of whether guardianship should be used to admit a person to detoxification or should it only be used as an adjunct to s11 of the *Alcoholics and Drug-dependent Persons Act (1968)* to allow a person to be held in detoxification against their will?

This can be further complicated by staff practices varying in relation to how vigorously they will attempt to keep someone from leaving the facility. Indeed even when a guardian is appointed there is variation in the level of understanding of a guardians authority to consent to a person being held in the facility.

5.5. Responsiveness of the police It has also been the experience of OPA that police often do not see it as a significant priority to act upon a warrant in the event that one was sought to return a person to a facility.

5.6. Issue of consent The *Alcoholics and Drug-dependent Persons Act (1968)* appears to be silent on the issue of clients who are unable to give informed consent to treatment. The ability of a person to provide informed consent can be due to a cognitive disability or it can be due to being in a state of intoxication. In a recent case the Guardianship List of the Victorian Civil and Administrative Tribunal appointed a guardian to make a decision about a person being admitted to a facility for the purpose of detoxification. However upon appeal by OPA it was established that the person was unable to consent due to their level of intoxication rather than a cognitive impairment and the order was revoked.

5.7. Related legislation Since the *Alcoholics and Drug dependent Persons Act* (1968) was proclaimed a significant number of related legislation has been enacted which needs to be considered in how they relate to the *Alcoholics and Drug dependent Persons Act* (1968). These include the *Mental Health Act* (1986), *Children and Young Persons Act* (1989) and *Guardianship and administration Act* (1986). Indeed there has been one recent case where a person requiring detoxification was accommodated in an acute psychiatric ward as they were best placed to manage his behaviour. In this instance the client was placed there under section 11 of the *Alcoholics and Drug dependent Persons Act* (1968).

5.8. No secure facilities The fact that detoxification facilities are not locked means that it can be difficult to physically prevent a person from leaving.

5.9. No independent scrutiny of facilities There is also a lack of independent scrutiny of facilities through official visitors, particularly when the person has been sectioned by the court in absentia.

6. Broader issues relating to the current response of the drug and alcohol service system in relation to people with a cognitive disability.

In addition to the current problems with the use of s.11 of the *Alcoholics and Drug dependent Persons Act* (1968) or indeed guardianship, there are a number of issues this highlights in relation to the drug and alcohol service system.

6.1. Response of Drug and Alcohol system to clients with a cognitive disability

A fundamental issue is the extent to which the current range of services available in the Drug and Alcohol field adequately address the needs of clients who have a cognitive disability. The majority of people addicted to drugs and alcohol do not have a brain injury and are capable of making decisions for themselves. Consequently the current approach to treating addiction that relies upon the person voluntarily seeking out treatment can be problematic for clients who lack insight as a direct result of their ABI. Consequently the use of guardianship or s11 of the *Alcoholics and Drug dependent Persons Act* (1968) is contrary to the belief that people should take responsibility for their lives. It is often difficult for someone to be admitted to detoxification under a guardianship order. Drug and alcohol professionals are wary of guardians trying to arrange rehabilitation rather than the person themselves.

The reliance upon cognitive behavioural approaches in the treatment of addiction again means that this can be of limited benefit to a person with an ABI. In fact for many people with a cognitive disability the approach required is not related to treatment or rehabilitation but rather care and management of behaviours.

An example of this is Jan a 47 year old woman who was a chronic alcoholic, drinking two flagons of wine per day. Jan had been a very successful business woman. She was suffering end stage liver disease and the prognosis was that she would be dead in five months. Following a period in detoxification Jan now lives in a Supported Residential Service where she has controlled access to alcohol and there is also a strong partnership with the local police.

This lack of familiarity by drug and alcohol professionals with clients who have cognitive impairment leads to a number of difficulties. Most people following detoxification do not require supported accommodation or supports other than provided by community drug and alcohol counsellors. However people with drug and alcohol problems in addition to disability frequently use or demand community support services far in excess of what is available which may cause services to withdraw completely. Indeed homelessness can be a significant problem amongst this group. Related to this is the lack of case management for these clients can create a problem for achieving a co-ordinated response. This is further exacerbated by the fragmented nature of the service system. For example it is not possible to plan entry to detoxification in conjunction with a placement in a rehabilitation program following detoxification.

Peter

Peter has a long history of treatment for psychiatric disorders of panic attacks and phobias. Peter is also significantly disabled by an alcohol related ABI from long standing abuse of alcohol. Peter physical health is very poor with a history of frequent hospital admissions.

A community based outreach support service provider sought the granting of a guardianship order so as to facilitate Peter's transition to supported accommodation. The Public Advocate was appointed guardian for Peter by the Tribunal in relation to decisions concerning his health care and accommodation. The State Trustees were appointed as that legal administrator for Peter.

The case manager arranged for him to be admitted and detained within a D&A treatment facility by s. 11 of the *Alcoholics and Drug dependent Persons Act* (1968). for detoxification treatment. At that time Peter's health was so poor that he was virtually unable to resist. Subsequently Peter was transferred and admitted to a private hospital. Upon the completion of his detoxification and stabilisation of his physical health it was arranged for Peter to be admitted to a Salvation Army hostel. The family had expected him to return home to continue to live with the elderly and frail mother. Whilst the necessity for the guardian to make an application for additional powers under section 26 of the GAA1986 was contemplated in the end this was not required as Peter consented to a trial in the hostel.

The fact that drug and alcohol issues are frequently present with other disabilities means that the service system needs to consider how it can more effectively meet the needs of this client group. Alcohol or drug addiction may be a form of self-medication in relation to other disabilities or pathologies or part of a cycle of pathology/addiction. The lack of effective working relationships with disability, mental health, ABI and more generic services such as Supported Residential Services highlights the need for a more co-ordinated response. Indeed if drug and alcohol services were able to provide a secondary consultation service to some of these agencies it could significantly improve the service available to these clients. Lack of knowledge about the drug and alcohol sector and services amongst disability professionals is also a significant issue.

6.2. Limited range of suitable voluntary services

These difficulties experienced in being able to access voluntary places intermediate or long term placement in accommodation or care facilities potentially places greater pressure on compulsory means of accessing detoxification facilities. Accommodation and community supports are not adequate to the demand. There are very few controlled drinking accommodation placements.

6.3. Compulsory admission to access services

Indeed as mentioned previously the compulsory admission to a facility for detoxification is often seen as a way of conducting assessments and put in place services. For example, Aged Care Assessment Service (ACAS) will not assess unless detoxification occurs first.

6.4. Limited access to services in rural Victoria

Rural Victorians are particularly disadvantaged in their ability to access detoxification services. For example clients from Hume, Loddon Mallee and Barwon South West need to travel to De Paul House in the city. This raises many problems including how to transport a reluctant client to the facility and the need to plan for the post discharge phase. It can also cause significant inequalities. For example a client in Wodonga may have to wait six months for a neuropsychological assessment. But if they are transported to Melbourne it can occur almost immediately. OPA is currently developing a protocol with DePaul house to address some of these recurring issues.

Jack

Jack lives in country Victoria in squalor. Within his community he is perceived as a public nuisance and frequently appears before the courts on drunk and disorderly charges. It is thought that he has an ABI but it is difficult to tell because he is rarely sober enough for any neuropsychological assessment. . He lives alone, has some family in a nearby town and believes that he is managing. Community supports are refusing to provide further services, as they do not consider that they can meet his needs and are concerned about occupational health & safety issues for their staff. Jack is verbally abusive towards staff and physically threatening. To access detoxification, Jack has to come to Melbourne to De Paul House at St Vincent's. De Paul House is not locked and Jack does not want to stay. A guardianship order is sought and obtained so as to provide a compulsive direction for Jack to remain at De Paul House for his treatment.

7. Specific questions raised by the Department of Human Services.

In addition to the range of issues already raised, the Department of Human Services has also requested that OPA respond to the following questions:

7.1. What do you see as the ethical issues in relation to compulsory treatment of people with severe drug or alcohol dependence?

Initially the Public Advocate would be interested to know whether there has been any research into the extent to which people with a cognitive disability have benefited from the current model of service provision in the Drug and Alcohol field. Have any studies been undertaken to assess the therapeutic benefits to persons with a cognitive disability from compulsory care as distinct from the voluntary approach? If it has been demonstrated that there were treatment benefits as a result of compulsory care that this option should only be considered if persons with cognitive disabilities were not accessing services by compliance or voluntary participation.

The ethical issues relating to compulsory care requires consideration of the following:

- Whether the person is likely to benefit from the assessment and care offered.
- Their capacity to provide informed consent to assessment and care.
- Their capacity to comply and co-operate to the recommended care.
- There is no less restrictive way of the person receiving care.
- The person is at significant risk of injury or death if care is not provided.
- The need for a clear process for appeal and review when receiving compulsory care.
- There should be independent monitoring of the facilities where a person can receive compulsory care.

7.2. Is there a point at which people with a substance dependence no longer have the capacity to make their own decisions?

Yes, in relation to some people with a cognitive disability, whether that be intellectual disability, mental disorder or acquired brain injury, they may lack the ability to make reasonable judgements in relation to their person or circumstances. In some cases this may be as a direct result of the alcohol abuse. Determining that point as with any determination of the loss of capacity is in a prima facie sense determined by a clinical assessment. In the guardianship jurisdiction of the VCAT, the Tribunal requires medical, psychological or other expert evidence of actual disability and incapacity (amongst other evidence) however before making a guardianship order.

In addition to this group there may also be people who have a substance dependence which affects their capacity to offer informed consent because of their level of intoxication, but where there is no cognitive disability present.

7.3. Do you believe that there is any role for compulsory treatment of people with severe drug or alcohol dependence who are *non-offenders*? If so:

- **In what circumstances?**

As previously stated where the person is unable to provide informed consent either due to intoxication or an ABI, there needs to be a mechanism where care can be provided. Compulsory care should be provided on the same basis voluntary care in that there is some perceived benefit to the individual.

- **At what point should intervention occur?**

This will be subject to the individual concerned and should be driven by if it is felt that they would gain benefit from such a program. Other more pragmatic considerations may also need to be considered such as the level of risk they currently experience. (eg. Health concerns)

- **For how long?**

As long as some therapeutic benefit is gained for them from their participation, or to allow for establishing supports in the community that will support the individual.

- **What might ‘treatment’ involve?**

In the context of cognitive disability treatment may not be the goal but rather providing a structured environmental and behavioural management approaches with clear boundaries may be more effective than rational cognitive approaches. This may also involve limiting access to drugs and alcohol.

- **Under what legislative framework, and with what safeguards?**

As mentioned previously the option to assess and detain people involuntarily for the purposes of detoxification should occur under a revised *Alcoholics and Drug dependent Persons Act* (1968). As mentioned previously there should be very clear criteria for the use of such legislation with clear processes of appeal and review analogous to those operating under the *Mental Health Act* (1986) for involuntary treatment of a mental illness.

- **Who should be responsible for making decisions about whether a person receives involuntary treatment, where that occurs and when they are to be discharged?**

Consideration should be given to extending the *Mental Health Act* (1986) model of an authorised admissions officer should be the primary decision-maker subject to review and/or appeal in a tribunal.

- **What service system would be required to support such a mechanism and how would this differ from current alcohol and other drug services?**

There would need to be facilities that offer clients both initial assessment and ongoing care in a secure setting.

- **What are the legitimate goals of compulsory treatment, for example, saving lives, protecting the person and/or their community, respite, containment, or rehabilitation?**

The legitimate goals of compulsory treatment may vary for people with a cognitive disability in that their own ability to change or modify their behaviour may be limited. Consequently greater emphasis may need to be placed on the environment managing the behaviours of the person. The primary goal of compulsory treatment should be about acting in the best interests of the person with the disability. This may involve saving their life if there are serious health risks, which may require protecting the person. The primary goal should not be about protecting the community although this may be an indirect benefit. The issue of rehabilitation is problematic given the difficulties posed by a cognitive impairment to this process.

- **How many people do you believe might require such intervention in any one year?**

This will depend upon the extent to which the wide range of services in the D and A field are broadened to offer greater support to individuals who have a cognitive disability. We would expect that with similar rates of drug addiction amongst people with a disability that up to thirty clients in any one year may require some form of compulsory care or treatment. Indeed with a revised process that is widely known to the drug and alcohol file as well as disability and mental health this number could be larger.

8. Recommendations

- 8.1.** That the current *Alcoholics and Drug dependent Persons Act* (1968) be reviewed to update the provisions relating to compulsory assessment and care, so that clients who cannot provide informed consent either due to a cognitive disability, or intoxication can receive appropriate assessment and care. These changes should include clear processes for appeal and review.
- 8.2.** That guardianship is not an appropriate mechanism to admit persons with a drug or alcohol related problem to a facility for the purpose of an assessment or ongoing care.
- 8.3.** That the review needs to consider the relationship between other relevant legislation including the *Mental Health Act* (1986), *Children and Young Persons Act* (1989) and *Guardianship and Administration Act* (1986).
- 8.4.** That significant work needs to occur between the drug and alcohol agencies and a range of other service sectors including mental health and disability in order to develop appropriate service models of assessment and care.