



Office of the Public Advocate

The National Drug Strategy 2010 - 2015

Consultation Draft December 2010 Submission

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Contact: John Chesterman

Manager, Policy and Education

John.Chesterman@publicadvocate.vic.gov.au

Prepared by: Mark Feigan

Policy and Research Officer

Office of the Public Advocate

Level 5, 436 Lonsdale Street, Melbourne, Victoria 3000

PO Box 13175 Law Courts, Victoria 8010. DX 210293

Tel: 1300 309 337 Fax: 1300 787 510

www.publicadvocate.vic.gov.au



1. About the Office of the Public Advocate

- 1.1 The Victorian Office of the Public Advocate (OPA) is an independent statutory office working to protect and promote the rights, interests and dignity of people with a disability. OPA performs and supports a number of roles including the provision of advocacy, investigation and guardianship services to people with cognitive disability. In the last financial year, OPA's staff provided guardianship services to almost sixteen-hundred Victorians. During 2009/10, nineteen per cent of these guardianship cases were for a person with acquired brain damage, including very many cases where the individual's impairment was alcohol related. After dementia, acquired brain damage was the second most common disability condition of people under OPA guardianship, following a steep increase in recent years.¹
- 1.2 Another significant function of OPA is its oversight and support of the Community Visitors program. Community Visitors are volunteers who are empowered by law to visit Victorian accommodation facilities for people with a disability. They monitor and report on the adequacy of the services provided to residents and patients, and are currently visiting 185 supported residential services (SRS). Community Visitors are reporting increased problems within SRS associated with the growing admission of people affected by the adverse consequences of alcohol and other drugs. Most staff employed within SRS are not sufficiently trained or qualified to deal with the complex health and behaviour support needs of people seriously affected by alcohol and other drug misuse, including those needs associated with brain damage and loss of capacity.
- 1.3 OPA's role and work provides a unique perspective on disability and service provision. This submission highlights OPA's key areas of concern regarding the framework for action on alcohol and other drugs. This submission does not provide a comprehensive analysis of the framework as a whole. Rather, it is confined to particular matters raised by OPA's direct experience, relevant to the framework of the *National Drug Strategy*. The overarching issue is the specific and extensive needs of the growing group of individuals with cognitive impairment and loss of capacity, resulting from brain damage associated with alcohol and other drug misuse. There are a series of implications of the needs of this group for Pillar Two (demand reduction) and Pillar Three (harm reduction). In summary, OPA believes that it is necessary to raise the particular needs of this group within the framework, and to specify relevant actions.

¹ Office of the Public Advocate Annual Report 2009/10, Melbourne, pp. 6-7.



2. Summary of Recommendations

2.1 This submission makes eight recommendations which are listed below. This submission also contains discussion of these recommendations further below.

RECOMMENDATIONS

1. That the harm of loss of capacity is emphasised as one on the significant harms associated with drug misuse (p.6). The harm should be listed as an additional point and could be described in the following terms:

The cognitive impairment and loss of capacity associated with brain damage from alcohol and drug misuse have serious functional consequences which can severely limit the affected individual's capabilities, recovery, and relationships.
2. That the strategy, in the contexts of strong partnerships and integrated services approaches (p. 11), specifically refers to the needs of the group of people affected by brain damage and loss of capacity as a group that requires additional and specific measures because of the unlikelihood of their full recovery and reintegration.
3. The challenges for individuals, families, services and communities (pp.12-14) should also refer to the growing prevalence of cognitive impairment and loss of capacity associated with alcohol and other drug misuse. The strategy should note that this trend causes a diverse range of social and service challenges including those that impact upon: accommodation, aged care, case-management and disability services; detoxification and treatment services; and substituted decision-making and guardianship systems.
4. That the following *Action* is added to **Pillar 2: Demand reduction, Objective 2: Reduce misuse of drugs in the community** (pp. 20-22).

Investigate, develop and resource best practice approaches for reducing the misuse of alcohol and other drugs by individuals affected by cognitive impairment and loss of capacity due to brain damage that is the result of their drug misuse.



5. That a further action for reducing misuse of drugs refer to the need for appropriate compulsory treatment legislation which safeguards the human rights of people who require coercive treatment due to alcohol and other drug misuse.
6. That the following *Action* is added to **Pillar 2: Demand reduction, Objective 3: Support people to recover from dependence and reconnect with the community** (pp. 22 - 23).

Develop a comprehensive approach to the impact of cognitive impairment and loss of capacity, resulting from brain damage associated with alcohol and other drug misuse, upon the design of treatment and post treatment support services, and the system pathways.
7. That the last action (p. 23) concerned with improving linkages and coordination should also specifically refer to the disability sector.
8. That the following *Action* is added to **Pillar 3: Harm reduction, Objective 3: Reduce harm to individuals** (p. 28).

Develop coordinated measures to prevent, assess and manage the impact of cognitive impairment and loss of capacity, resulting from brain damage associated with alcohol and other drug misuse, and make available appropriate supports to the individuals affected.



3. The harms from drug misuse

- 3.1 OPA notes that the context for the *National Drug Strategy* includes brain damage as one of the well known harms associated with alcohol and other drug misuse (p. 6). OPA's view is that while the existence of this harm is well known, the full range of consequences for individuals, families, services, and governments of the impact of loss of capacity associated with this condition is not fully appreciated, and as a result measures to deal with these consequences are under resourced.
- 3.2 The cognitive impairment associated with alcohol and other drug misuse has severe functional consequences for the affected individual. Serious brain damage 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 damage can resemble those of psychosis and dementia. Problems with impulse control, social skills and self-awareness can make the person agitated and their behaviour difficult, disruptive, inappropriate or aggressive. The affected individual loses the ability to remember, plan and organise, and lacks insight into his or her condition and behaviour.
- 3.3 The functional limitations caused by the cognitive impairment associated with brain damage may lead to the loss of an individual's legal capacity. The Victorian Civil and Administrative Tribunal (VCAT) can make guardianship and administration orders for people with a cognitive impairment. VCAT may appoint a guardian for a set period to make health care, accommodation and service access decisions. An appointed administrator can make financial decisions for people with brain damage who lack legal capacity.
- 3.4 OPA's annual report for 2009/10 noted the unsatisfactory demands upon OPA guardians representing people with a cognitive impairment resulting from alcohol and other drug misuse. 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).²
- 3.5 Guardians are confronted by complex situations with a lack of appropriate service options. 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 readily available solutions from a guardianship decision. There are systemic problems, which often defy the available solutions.
- 3.6 The affected individuals often exhibit a cycle of difficult behaviour that might escalate over a period of about one month. Some individuals are practiced in managing perceptions to

² Office of the Public Advocate Annual Report 2009/10, Melbourne, p. 6. A steep increase in new cases began in 2008/09 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.



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 initially tried for members of this group fail. Sometimes this succession of partial successes and failures is the best that can be achieved for the person within the design and available resources of the current system.

RECOMMENDATION ONE

That the harm of loss of capacity is emphasised as one on the significant harms associated with drug misuse (p.6). The harm should be listed as an additional point and could be described in the following terms:

The cognitive impairment and loss of capacity associated with brain damage from alcohol and drug misuse have serious functional consequences which can severely limit the affected individual's capabilities, recovery, and relationships.

4. Disadvantaged populations

4.1 OPA notes that the strategy identifies particular disadvantaged groups whose members can experience intergenerational patterns of disadvantage (p. 9-10). This issue is to be addressed by socially inclusive approaches. OPA suggests that the impact of brain damage and loss of capacity associated with alcohol and drug misuse particularly needs to be considered in relation to this issue, as brain damage is largely irreversible. Even with expert knowledge and services it is unlikely that every person will be successfully 'assisted to stabilise their lives, reintegrate with the community and recover from drug and alcohol problems' (Partnerships, p. 11). This intervention goal should be broadened so it is inclusive of people whose impairment means they will not fully recover and reintegrate with their past communities. At the same time, a positive vision for the people who will not fully recover must be articulated, and safeguards applied so that there is no abandonment.

RECOMMENDATION TWO

That the strategy, in the contexts of strong partnerships and integrated services approaches (p. 11), specifically refers to the needs of the group of people affected by brain damage and loss of capacity as a group that requires additional and specific measures because of the unlikelihood of their full recovery and reintegration.



5. Challenges for 2010-15

5.1 The strategy identifies particular challenges that have been prioritised for 2010-15 (pp. 12-14). OPA recommends the addition of a new explanatory point to the list of challenges, as follows.

RECOMMENDATION THREE

The challenges for individuals, families, services and communities (pp.12-14) should also refer to the growing prevalence of cognitive impairment and loss of capacity associated with alcohol and other drug misuse. The strategy should note that this trend causes a diverse range of social and service challenges including those that impact upon: accommodation, aged care, case-management and disability services; detoxification and treatment services; and substituted decision-making and guardianship systems.

6. Pillar 2: Demand reduction, Objective 2: Reduce misuse of drugs in the community

6.1 The loss of capacity accompanying brain damage has some consequences for treatment because the affected individual is often incapable of adequately comprehending their condition and making healthier decisions about their lives. The typical psychosocial behavioural therapy treatment approaches, including cognitive behavioural therapy, have limited application to many people with cognitive impairment.

6.2 The loss of capacity, detrimentally affecting the individual's ability to make sound judgements and decisions, may require externally imposed 'best interests' treatment interventions in some circumstances. Such coercive interventions should only occur when it can be shown to be justified because of the unreasonable risk of danger to the individual's health and social well-being, with other less restrictive alternatives having already been exhausted. Because coercive treatment necessarily involves a loss of freedom it is important that the strategy reinforces the need for action on developing and implementing effective legislative mechanisms and safeguards that fully incorporate human rights principles, including the right to treatment according to the principle that the least restrictive alternative should always be preferred.

6.3 In addition to proper legislative mechanisms and safeguards there needs to be sufficient available services of the kind that will address the long-term impairment related needs of the person after completion of the initial short term detoxification interventions to stabilise their condition. The availability of brain injury and cognitive impairment assessment services is critical so that affected individuals can be identified and provided with appropriate treatment



and support. This means that long-term and intense case management and structured accommodation options are needed to reduce the affected individual's misuse of drugs.

6.4 The following case study illustrates some of the key points that have been made to this point.

Peter a little safer, but still not settled

Peter is now fifty-three-years-old. His OPA guardian has been involved in his life for the last three years, less so in the last six months. Because of the impairment caused by his drug and alcohol abuse Peter has not recovered from the death of his wife fifteen years ago. His life now revolves around intoxication and illicit behaviour.

Peter 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 asked about risky behaviour he produces condoms and clean syringes to show how he responsibly manages his HIV and Hep-C positive status. Invariably, new service staff predict their own 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 Peter starts to pursue the means to his intoxication again. Despite the support and efforts of those around him, Peter gets and consumes the drugs and alcohol he craves, sometimes provided by his daughter. After some mayhem, he absconds and later gets found unconscious on a tram or in the street. This has happened fifteen times in the last year. The guardian receives a telephone call from the service when Peter's drinking and drug-taking behaviour gets extreme. They say they are evicting Peter and that he has to be found somewhere else 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 be safe. Not using drugs and alcohol heavily is beyond his comprehension. He is incapable of stopping his self-destructive behaviour, because of his cognitive impairment. Peter has received the full range of expert neuropsychological assessment. The assessments and other support were funded through annual funding from disability services, made possible through the Victorian Multiple and Complex Needs Initiative. This enabled highly competent case management which helped the most. The time between destructive episodes became longer and services were persuaded to continue providing support. Peter needed coordinated services and an effective case-manager who understood him as he really was, not as he appeared upon his first presentation. He still does not have settled accommodation and remains at constant risk of homelessness.



RECOMMENDATION FOUR

That the following *Action* is added to **Pillar 2: Demand reduction, Objective 2: Reduce misuse of drugs in the community** (pp. 20-22).

Investigate, develop and resource best practice approaches for reducing the misuse of alcohol and other drugs by individuals affected by cognitive impairment and loss of capacity due to brain damage that is the result of their drug misuse.

RECOMMENDATION FIVE

That a further action for reducing misuse of drugs refer to the need for appropriate compulsory treatment legislation which safeguards the human rights of people who require coercive treatment due to alcohol and other drug misuse.

7. Pillar 2: Demand reduction, Objective 3: Support people to recover from dependence and reconnect with the community

- 7.1 OPA's experience is that guardianship applications are sometimes being made because of a lack of linked accommodation and support options available to individuals affected by a loss of capacity due to brain damage from alcohol and drug misuse.
- 7.2 Guardianship powers are being perceived as useful in situations lacking available options. Guardianship might not be appropriate in the circumstances, when it is really effective case management and suitable settled accommodation that are central to meeting the affected individual's needs. A guardian cannot command additional resources beyond what is already available, although a guardian's powers may help to clarify the issues and responsibilities.
- 7.3 The appointment of a guardian is also sometimes sought because a guardian may be granted powers to request police intervention to return a person to a place of treatment. This coercive power is sometimes being called upon because of the perceived lack of other lawful mechanisms for compulsory treatment. (See 6.2 and Recommendation Five above)
- 7.4 An individual's loss of capacity due to brain damage restricts their ability to reliably activate internal resources to combat their dependence issues. The strategy should promote the development of a comprehensive approach to the issues raised by cognitive impairment and loss of capacity. This is necessary because the current arrangements have not adequately addressed loss of capacity issues. Although the affected individuals have specific additional



needs, the actions currently identified in the strategy (pp. 22-23) are still relevant. Disability services which can respond to the impairment-related issues could be usefully mentioned.

RECOMMENDATION SIX

That the following *Action* is added to **Pillar 2: Demand reduction, Objective 3: Support people to recover from dependence and reconnect with the community** (pp. 22 - 23).

Develop a comprehensive approach to the impact of cognitive impairment and loss of capacity, resulting from brain damage associated with alcohol and other drug misuse, upon the design of treatment and post treatment support services, and system pathways.

RECOMMENDATION SEVEN

That the last action (p. 23) concerned with improving linkages and coordination should also specifically refer to the disability sector.

8. **Pillar 3: Harm reduction, Objective 3: Reduce harm to individuals**

8.1 While the impact of FASD has been appropriately and specifically addressed through the strategy (p. 27), the specific and extensive needs of the growing group of individuals with cognitive impairment and loss of capacity, resulting from brain damage associated with alcohol and other drug misuse, has not been similarly addressed. As was initially suggested the strategy needs to adequately address the needs of this group.

RECOMMENDATION EIGHT

That the following *Action* is added to **Pillar 3: Harm reduction, Objective 3: Reduce harm to individuals** (p. 28).

Develop coordinated measures to prevent, assess and manage the impact of cognitive impairment and loss of capacity, resulting from brain damage associated with alcohol and other drug misuse, and make available appropriate supports to the individuals affected.