EDITORIAL NOTE: CHANGES MADE TO THIS JUDGMENT APPEAR IN [SQUARE BRACKETS].

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IN THE FAMILY COURT
AT HAMILTON

I TE KŌTI WHĀNAU
KI KIRIKIRIROA

FAM-2020-019-000116
[2021] NZFC 7274

IN THE MATTER OF	SUBSTANCE ADDICTION (COMPULSORY ASSESSMENT AND TREATMENT) ACT 2017
BETWEEN	WAIKATO DISTRICT HEALTH BOARD Applicant
AND	[PW] Respondent
AND	[AB] Other Party

Hearing:	8 July 2021
Appearances:	A-M Beveridge for the Patient Dr T Singh – Responsible Clinician A Simpson – Key Worker No appearance by or for the Other Party
Judgment:	23 July 2021 at 11.00am

RESERVED JUDGMENT OF JUDGE D A BLAIR
[Reasons for Compulsory Treatment Order]

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[1] On 8 July 2021 a half day hearing occurred before me about whether [PW] will be subject to a compulsory treatment order pursuant to the Substance Addiction

(Compulsory Assessment and Treatment) Act 2017 ("the Act"). This was by way of an application for review pursuant to s 29(c) of the Act. The application for s 29(c) review came about as a result of a compulsory treatment certificate dated 18 June 2021, pursuant to s 23 of the Act.

[2] At the conclusion of the hearing I decided the grounds for making the order were satisfied and made the order accordingly, advising that a decision as to reasons would be reserved.

[3] Prior to the hearing there had been a first call of the matter on 28 June 2021, at which time [PW] had sought an adjournment for the purposes of obtaining a second opinion assessment pursuant to the Act. A written second opinion by Dr Akhtar dated 5 July 2021 then became available for consideration at the hearing. Dr Akhtar was not at the hearing.

The legal structure

[4] Section 3 of the Act sets out the purpose:

> **Purpose**
>
> The purpose of this Act is to enable persons to receive compulsory treatment if they have a severe substance addiction and their capacity to make decisions about treatment for that addiction is severely impaired, so that the compulsory treatment may—
>
> (a) protect them from harm; and
>
> (b) facilitate a comprehensive assessment of their addiction; and
>
> (c) stabilise their health through the application of medical treatment (including medically managed withdrawal); and
>
> (d) protect and enhance their mana and dignity and restore their capacity to make informed decisions about further treatment and substance use; and
>
> (e) facilitate planning for their treatment and care to be continued on a voluntary basis; and
>
> (f) give them an opportunity to engage in voluntary treatment.

[5] Section 7 sets out the central criteria for a compulsory treatment order. It provides:

> **Criteria for compulsory treatment**
>
> A person may be subject to compulsory treatment under this Act only if—
>
> (a) the person has a severe substance addiction; and
>
> (b) the person's capacity to make informed decisions about treatment for that addiction is severely impaired; and
>
> (c) compulsory treatment of the person is necessary; and
>
> (d) appropriate treatment for the person is available.

[6] Section 8 sets out the definition of "severe substance addiction", providing:

> **Meaning of severe substance addiction**
>
> (1) A severe substance addiction is a continuous or an intermittent condition of a person that—
>
> (a) manifests itself in the compulsive use of a substance and is characterised by at least 2 of the features listed in subsection (2); and
>
> (b) is of such severity that it poses a serious danger to the health or safety of the person and seriously diminishes the person's ability to care for himself or herself.
>
> (2) The features are—
>
> (a) neuro-adaptation to the substance:
>
> (b) craving for the substance:
>
> (c) unsuccessful efforts to control the use of the substance:
>
> (d) use of the substance despite suffering harmful consequences.

[7] Section 9 addresses a person's capacity to make informed decisions, with reference to this factor as it sits within the s 7 criteria. It provides:

> **Capacity to make informed decisions**
>
> For the purposes of section 7(b), a person's capacity to make informed decisions about treatment for a severe substance addiction is severely impaired if the person is unable to—
>
> (a) understand the information relevant to the decisions; or

(b) retain that information; or

(c) use or weigh that information as part of the process of making the decisions; or

(d) communicate the decisions.

[8] Section 10 requires that a compulsory treatment is to be a measure of last resort. It provides:

> **Compulsory treatment to be option of last resort**
>
> For the purposes of section 7(c), compulsory treatment is necessary only if voluntary treatment is unlikely to be effective in addressing the severe substance addiction.

[9] Section 32(1) is the mechanism by which the Court must determine, whether in relation to the patient, the criteria for compulsory treatment are met and whether to make an order. Section 32(2) provides:

> (2) If the Judge is satisfied that the criteria for compulsory treatment are met, the Judge may, having regard to all the circumstances of the case, continue the compulsory status of the patient by making a compulsory treatment order.

[10] Section 75 requires interview of the patient before the hearing of the application for review and it must occur not later than seven days after the application is filed in the Court. This requirement was satisfied by the first calling of the matter on 28 June 2021.

[11] The responsible clinician, Dr Singh, community alcohol and drug services social worker Andrea Simson, and Mr [PW] himself all gave evidence at the hearing.

Summary of Mr [PW]'s recent background

[12] Mr [PW] was first admitted to the Nova Star treatment centre, pursuant to the legislation at the time, in 2015. Records indicate he stayed there five and a half months, then self-discharging to attend his [parent]'s funeral. There was an immediate relapse to his use of alcohol.

[13] On 25 February 2020, a s 29(c) review application was heard before me, at which time Mr [PW] took a position of consent to the compulsory treatment order sought. The order was made. Mr [PW] then stayed at Nova Star for the extended period of 112 days. He was discharged on 3 June 2020 and returned home to [location deleted], where he quickly relapsed back to daily drinking.

[14] Subsequently, Mr [PW] was admitted for planned alcohol withdrawal treatment in Waikato Hospital on different occasions. He had presented on two occasions to the emergency department at Waikato Hospital for assistance with alcohol withdrawal and confusion. An admission from 24 June 2020 to 8 July 2020 led to him being sent to a rest home for four weeks. Reports indicate that upon discharge he quickly relapsed. In August 2020 Mr [PW] was with the emergency department and then on 22 January 2021 for support with alcohol withdrawal symptoms. He was again admitted for planned alcohol withdrawal management on 10 February 2021 for two weeks, then followed by four weeks of respite care.

[15] By 29 March 2021 he had again relapsed. Mr [PW]'s most recent alcohol withdrawal admission was on 26 May 2021 through to 9 June 2021, with a discharge plan of voluntary admission to Nova Star. Mr [PW] changed his mind and declined voluntary residential rehabilitation treatment and was therefore discharged home. His family had become exhausted and were not able to support him. He relapsed on the day of his discharge and continued to consume alcohol daily.

[16] Mr [PW] was admitted to the Henry Rongomau Bennett Centre on 18 June 2021 under the Act. This then led to the application for review pursuant to s 29(c).

The s 7 factors

Section 7(a) –severe substance addiction

[17] The advice put forward by the applicant is that Mr [PW] presents with a clear history of severe alcohol addiction. It is manifested by compulsive use of alcohol, development of tolerance (neuro-adaption), craving for the substance, unsuccessful

attempts to control the use of the substance and the use of it despite suffering harmful consequences.

[18] Dr Singh advises that Mr [PW]'s drinking following the 2015 admission has entrenched his addiction.

[19] Dr Singh spoke about the increased tolerance to alcohol and that more and more is required to produce the same result. Ms Simson's evidence is that prior to the most recent detox, Mr [PW] had been drinking during the night so as to reduce withdrawals and cravings. Mr [PW] disagrees with that assertion. Ms Simson spoke about a marked increase in Mr [PW]'s drinking over the last year. Her evidence was that she can say this because of the type of alcohol being consumed, the level of intoxication and the empty alcohol containers observed at the property.

[20] Mr [PW]'s position is that he has achieved most of what he has wanted to achieve since his last detox and that he is reducing his alcohol consumption. He says he is not "drinking drinking" and estimated no longer drinking every 15 minutes and now just once every 40 minutes. He advises he is "sipping" now. Despite saying at the hearing that he does not have cravings for alcohol, Mr [PW] took issue with one of the doctors he has dealt with having used the word "alcohol" to Mr [PW]. It made Mr [PW] think whether in using that word to him, they were trying to be mean to him or hurt him. On Mr [PW]'s own admission, at least implicitly, just the use of the word has an impact upon him.

[21] There have been attempts at detox and support for Mr [PW] since he was released from Nova Star in 2020. Those have been unsuccessful and he has resorted back to alcohol use.

[22] I find that the grounds for neuro-adaption and cravings are made out.

[23] There have been various unsuccessful attempts to control the use of alcohol. Those have been set out earlier in this decision. Dr Singh's advice is that any voluntary structure as now suggested by Mr [PW] at the hearing would be unsuccessful. Post detox plans have not been kept to. Through to the point of his admission to the Henry

Rongomau Bennett Centre in June 2021, Mr [PW] was still drinking. Efforts through 2020 and to that point in 2021 to control the use of the substance have not been successful. The factor of unsuccessful attempts to control use of alcohol is made out.

[24] Mr [PW] has continued to use the substance of alcohol despite suffering harmful consequences. Mr [PW] has cirrhosis of the liver which I accept has been caused by his abuse of alcohol. Dr Singh advises his liver function tests are grossly impaired and Mr [PW] is at very high risk of his liver being further damaged. Enzyme related liver tests, the first having a normal range of 0 to 60 put Mr [PW] at a level 986. The second of those test types having a normal range of 0 to 55 put Mr [PW] at a level of 405.

[25] Dr Singh advises in the event Mr [PW] continues to drink, he will progress to complete liver failure. Complete liver failure is not compatible with staying alive. Mr [PW] would die.

[26] Other related issues with the damage to liver can be kidney damage and alcohol related dementia. There can be permanent brain damage.

[27] Ms Simson's evidence was that Mr [PW] has told her on numerous occasions that he can survive on 40 percent liver function.

[28] Mr [PW] explained in his evidence at the hearing his understanding about his liver situation. He acknowledged scarring of the liver and that there had been a lesion on the liver found through a CT scan, which he says was 14 millimetres in diameter. Mr [PW] spoke about attending ongoing CT checks around the lesion issue. Mr [PW] stated there are no physical concerns with his physical health but acknowledged he has been told his liver will decrease in function and the result could be early death.

[29] I find Mr [PW] continues to consume alcohol despite suffering harmful consequences. I accept the advice of Ms Simson that Mr [PW] has expressed that he can survive on 40 per cent liver function. This suggests a normalisation of liver damage for Mr [PW] and a belief he is still within manageable ranges with respect to his liver health. Despite acknowledging advice that a decrease in liver function could

result in early death, there is nothing about the situation that suggests Mr [PW] has, himself, managed to stop alcohol use despite those harmful consequences, actual and pending. At best there is very recent advice at the hearing about having reduced intake following the most recent detox admission. Even on Mr [PW]'s advice, he continues to drink at what may be harmful levels to his already seriously damaged liver. The ground of continuing to drink despite harmful consequences is made out.

[30] For the purposes of "severe substance addiction" I find compulsive use of alcohol, the satisfaction of all four factors in s 8(2), and that the addiction is of such severity that it poses a serious danger to the health and safety of Mr [PW] and seriously diminishes his ability to care for himself. I accept evidence about the diminished self cares of Mr [PW] because of his addiction. An example is nutritional neglect of himself caused by his drinking and intoxication.

Section 7(b) – Capacity to make informed decisions about treatment for the addiction is severely impaired

[31] Dr Singh's advice is that Mr [PW]'s capacity is severely impaired. Capacity is decision specific and in Mr [PW]'s case, it is about his alcohol use. Dr Singh and Ms Simson both emphasise Mr [PW]'s denial of there being an alcohol problem and that he does not feel he needs treatment and has to this point declined voluntary treatment. There is no acknowledged risk. Dr Singh advises in Mr [PW]'s case he cannot deploy his thinking processes with respect to the use of alcohol. Dr Singh advises the impairment for Mr [PW] has been to not be able to weigh and balance the information and arrive at the decision, thereby recognising the harmful consequences of addiction.

[32] Ms Simson advised in her evidence Mr [PW] has never acknowledged he has an alcohol problem. The point then becomes that without that genuine and actual acknowledgement, there is a gap in the information being understood by Mr [PW] relevant to his decisions.

[33] This issue was put to Mr [PW] at the hearing. It was put to him whether he has a severe addiction to alcohol, in response to which he said words to the effect, "yes I am". He explained this further by saying this is because he drinks alcohol. Mr [PW]

spoke about undergoing a slow reduction over time. Mr [PW] spoke about having achieved most of what he has wanted to achieve, that is to reduce his alcohol intake. In response to Ms Simson's advice that he has never acknowledged having an alcohol problem, Mr [PW] said this is because he has never been asked if he has a drinking problem, just told. In response to one question, Mr [PW] alleged that it is not him who has the problem, it is "you guys" who have the problem and that he is not breaking any laws.

[34] I find that Mr [PW]'s apparent acknowledgement that there is a drinking problem is recent and contextual to the hearing which occurred. It is not to the point where an acknowledgement by Mr [PW] about having an alcohol abuse issue could be a factor in his favour when the Court assesses his ability to understand the information relevant to the decisions and to go on to use it within a decision making process. There is a superficiality around any acknowledgement made, and counteracted by the suggestion that it is not Mr [PW] who has the problem, but others.

[35] There is an uncertainty whether Mr [PW] is able to retain information relevant to the decisions.

[36] I do find that given his inability to understand the information relevant to the decisions, it leads to an inability to weigh that information as a part of the process of making decisions.

[37] Mr [PW] is reasonably articulate and at least within the hearing process, could communicate his point of view.

[38] Sufficient criteria as per s 9 are satisfied to enable a finding that Mr [PW]'s capacity to make informed decisions about treatment for a severe substance addiction is severely impaired.

Section 7(c) – Compulsory treatment is necessary

[39] Section 10 sets the threshold for this enquiry, being compulsory treatment is necessary only if voluntary treatment is unlikely to be effective.

[40] Dr Singh's advice is that voluntary treatment will not be effective. He emphasises Mr [PW] has in the past not adhered to post-detox recovery plans and has recently declined a voluntary treatment structure which was proposed. Without compulsory treatment, the advice is Mr [PW] will continue to drink and his health is jeopardised. Dr Singh emphasised that Mr [PW]'s relatively stable presentation at the hearing was the result of having been in a controlled environment and not drinking.

[41] Ms Simson spoke about not having had much opportunity to deal with Mr [PW] in a therapeutic sense, owing to his ongoing intoxication when in his home environment. Ms Simson also advised in her evidence that Mr [PW]'s engagement with therapeutic structures has been very superficial.

[42] Dr Singh explained the recovery process hoped for. The period of compulsory treatment, being 56 days and potentially another 56 days, provides sufficient time to assist the brain to recover from the addiction and help break the cycle of drinking and cravings. The hope is that if Mr [PW] recovers some of his capacity as a result of compulsory treatment, it will provide a platform for him to make a decision to continue with abstinence post discharge from the treatment centre. Any such decision would be made when he is not under the influence of his addiction. The hope would be that Mr [PW]'s decisions will be to comply with post-compulsory treatment plans and supports.

[43] Mr [PW]'s argument that compulsory treatment is not necessary rests upon his alleged reduction in alcohol use and an offer at the hearing to arrange for his own supports. He says he is "over" the taste of alcohol and he does not like drinking any more. He spoke about intending to return to AA meetings and to see a counsellor based in [a second location]. As to why he has not been at the AA meetings, Mr [PW] spoke about the inappropriate nature of the people there, but then said he will go to the meetings but expressed concern about the unhealthy environment.

[44] Mr [PW] explained he wants to abstain from alcohol but it will take a few years. As I interpret the evidence, Mr [PW] does not have that time luxury in terms of his physical health.

[45] I find that voluntary treatment processes have been ineffective for Mr [PW] and his suggestion at hearing that he will reduce alcohol intake himself and attend AA meetings (despite not liking the people there) is very unlikely to be successful or adhered to.

[46] I find that a compulsory treatment order is necessary in view of the background and situation.

Section 7(d) – Appropriate treatment is available

[47] I record that Mr [PW] also spoke about his opposition to going to Nova Star, saying last time he was there he was abused, threatened with a weapon, and he questioned the type of people there. Mr [PW] alleges the place is unsanitary, the mattresses are soiled and the food is scraps you wouldn't feed a dog. If Mr [PW] had his way he says he would have the health department check every room.

[48] The evidence had the sense that Mr [PW] was attempting different angles of opposition to being sent to Nova Star and putting to the Court information or suggestions which he thought might be helpful to avoid the compulsory treatment order.

[49] Nova Star is an approved facility. A placement is available for Mr [PW] there.

[50] The grounds for the making of a compulsory treatment order are therefore made out. Having regard to all of the circumstances of the case, it is appropriate to make a compulsory treatment order pursuant to s 32(2) of the Act. I have had regard to the s 3 purposes.

[51] In reaching this decision, I have taken into account Mr [PW]'s view which, in reality, is that he should be left to his own devices. As he put it at one point, he is not breaking any law. However, this legislation is intended to provide compulsory treatment provided the criteria are satisfied and in doing so to protect a person from harm, stabilize their health and restore their capacity to make informed decisions. In Mr [PW]'s case, the criteria are easily satisfied. If Mr [PW]'s actual argument is that

he should be left at home to drink himself to life threatening liver failure, it is completely understandable his medical team cannot condone this or sit back and allow it to happen and nor could this Court resign itself to that outcome.

[52] It is hoped through this stage of compulsory treatment directed, Mr [PW] will come out of it on the other side ready and able to make meaningful and appropriate decisions about his future health, and not within the context of his debilitating addiction.

D A Blair
Family Court Judge