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

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IN THE DISTRICT COURT
AT HAMILTON

I TE KŌTI-Ā-ROHE
KI KIRIKIRIROA

FAM-2021-019-000734
[2021] NZFC 10464

IN THE MATTER OF	THE SUBSTANCE ADDICTION (COMPULSORY ASSESSMENT AND TREATMENT) ACT 2017
BETWEEN	WAIKATO DISTRICT HEALTH BOARD Applicant
AND	[LL] Person In Respect of Whom the Application Is Made

Hearing: 12 October 2021

Appearances: S Northey for the Patient
Nurse Practitioner L Leonard – Responsible Clinician

Judgment: 20 October 2021

RESERVED JUDGMENT OF JUDGE A J TWADDLE
[Reasons for Necessity to make Compulsory Treatment Order]

Introduction

[1] On 4 October 2021 Dr Garilov issued a compulsory treatment certificate under the Substance Addiction (Compulsory Assessment and Treatment) Act in respect of [LL] and Ms [LL] was detained for treatment at the Waikato Hospital.

[2] I reviewed the certificate on 12 October, and after interviewing Ms [LL] by means of video link, hearing from her responsible clinician Nurse Practitioner Louise Leonard, her key worker Andrea Simpson, and her sisters [AR] and [CL], considering a report from Dr Derby, and written submissions from Ms Northey, I determined the criteria for compulsory treatment were met and continued Ms [LL]'s compulsory status by making a Compulsory Treatment Order.

[3] I now give reasons for making the order.

Legal principles

[4] The purpose of the Act is set out in s 3, and is to enable 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 provides 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] A "severe substance addiction" is defined in s 8 as meaning 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 two 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.

[7] The subsection 2 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.

[8] 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: see s 9.

[9] Section provides that compulsory treatment is necessary only if voluntary treatment is unlikely to be effective in addressing the severe substance addiction.

[10] It is clear there is a high threshold for the making of a compulsory treatment order. The use of the word "severe" in ss 3, 7, 8, 9 and 10 is to be interpreted as meaning a person's addiction or impairment of ability to make informed decisions, has gone beyond what must be given significant weight and has reached a stage where the condition or impairment is of critical importance.

Evidence

Ms [LL]

[11] Ms [LL] was strongly opposed to a compulsory order being made with the consequence she would have to go to Nova in Christchurch for treatment. In a written statement produced at the hearing, Ms [LL] said she should not have to go to Nova, for these reasons:

- She did not see herself as a danger to herself;
- She is happy to engage with CADS in the community (eg in a group or one-on-one);
- She is willing to take breath tests regularly to show she was dedicated to remaining sober;
- Taking her out of her own environment would only make things worse;
- A lot of the things that were said about her were exaggerated; she did not have much to do with her family so they did not know what went on in her house;

- Much of the evidence was only supposition;

- She is able to look after herself, for example by cooking, cleaning, attending her personal affairs and hygiene;

- She is 40 and should be able to live her life as she wants.

[12] Ms [LL] said she lives in [location deleted] with a partner. She likes reading and doing jigsaw puzzles. At present she has difficulty using her legs and needs a walker to assist her.

Dr Derby

[13] In a report dated 29 September 2021 in support of an application for a warrant to authorise the police to take Ms [LL] to hospital, Dr Derby, the Waikato Area Medical Director said:

(a) Ms [LL] suffers from severe, chronic and enduring alcohol use disorder (including use of ethanol and methanol) which significantly impacts on her ability to function in multiple domains. The disorder is of such severity she is experiencing marked decline in her wellbeing, with markedly impaired mobility, self-care and cognitions. She is unable to care appropriately for herself and is dependent on others. She is at exceptionally high risk of inadvertently injuring herself due to falls or complications related to her substance abuse, and of prematurely dying;

(b) As a result of their long held concerns about Ms [LL]'s alcohol dependence, and her unwillingness to engage with community alcohol services, in July 2020 members of her family applied for Ms [LL] to be assessed under the Act. A medical assessment was completed, but Ms [LL] hid from a clinician, a required notice was not served and the formal assessment process was terminated. After this, Ms [LL] refused to engage with CADS clinicians and requested discharge from CADS;

(c) Following ongoing concerns, in March this year Ms [LL] agreed to voluntary admission to Waikato Hospital in June for medically supervised detoxification. After that she was supposed to engage with CADS and be abstinent, but started to drink again shortly after returning home;

(d) CADS then tried to engage with Ms [LL] on numerous occasions and to encourage her to receive medical detoxification followed by admission to rehabilitation, but she continued to drink excessively and dangerously, did not engage with CADS and refused medical detoxification or admission to rehabilitation;

(e) Ms [LL]'s alcohol use disorder is of such severity and enduring nature that she has become markedly physically compromised. She has resorted to crawling on the floor as she is unable to safely stand, and has frequently urinated throughout her house. Due to the severity of her alcohol use disorder and the associated physical complications, Ms [LL] will experience premature death if she fails to address her disorder;

(f) Risk factors for Ms [LL] include:

(i) Continued excessive alcohol use. She has frequently drunk 250 mls (if not more) of methylated spirits per day;

(ii) Liver function tests indicate damage secondary to her alcohol consumption;

(iii) Continuing neurological damage (weakness, tremors) resulting in her not being able to walk safely or independently and causing her to crawl on the floor to change position;

(iv) Cognition impairment with a deterioration in her memory function, which is likely to be due to her significant alcohol consumption;

(v) Death from excessive alcohol consumption and associated alcohol induced physical damage (liver, neurological and most probably other organs);

(vi) Family harm violence by her partner, usually in the context of alcohol use;

(vii) Her exceptionally poor self-cares, poor hygiene, unhygienic environment secondary to chaos at home and the inability to care for herself;

(viii) Setting fire to her house as a result of smoking and leaving butts on the floor when intoxicated.

Nurse Practitioner Leonard

[14] Ms Leonard said:

(a) She met Ms [LL] for detoxification in 2019 and again in July this year, and noticed a significant deterioration in her physical and mental health;

(b) By June this year Ms [LL] had lost her mobility and was moving by crawling on the floor. She was admitted to hospital for seven days but did not fully engage with her treatment. Ms [LL] declined to go to respite care or rehabilitation on her discharge but went home and started drinking within a day;

(c) Between July and 4 October this year, Ms [LL]'s key worker visited her on 24 occasions in an effort to get her to engage but was unsuccessful;

(d) Ms [LL] said she was no longer drinking meths but was having nine standard drinks of alcohol a day;

(e) Ms [LL] said she was a social drinker but her drinking went well beyond that; she is severely addicted to alcohol and cannot control her drinking;

(f) Ms [LL] is able to retain some information about her disorder but does not understand the severity of it or the consequences for her mental and physical health of her disorder. She is not able to weigh up information and make sound decisions about treatment. She said she would use Antabuse but had been offered this in the past, and Antabuse would not be effective for a person drinking as much as she does, and she had said she would discharge herself from CADS after she left hospital;

(g) The degree of impairment to Ms [LL]'s physical health (balance and lack of ability to walk) and her cognitive ability is severe. If she continues to drink she could lose her remaining cognitive abilities;

(h) If a compulsory treatment order was made, the treatment plan would be for Ms [LL] to be transported to Nova Star Treatment Centre, Christchurch, on 19 October. A bed is available for her there. Should Ms [LL] regain capacity, and the compulsory treatment order is discharged, she would return to her home in [location deleted] and receive follow up care from CADS.

[15] In cross-examination Ms Leonard said:

(a) In view of her history, Ms [LL] cannot be treated in the community;

(b) If released from hospital, it is highly likely Ms [LL] would immediately relapse and begin drinking;

(c) Ms [LL] is not far away from requiring permanent care if not treated.

Andrea Simpson

[16] Ms Simpson's evidence was:

(a) Following medical detoxification and three weeks in rehabilitation early in this year, Ms [LL] declined respite care, went home and began drinking, including drinking meths;

(b) Since her discharge from hospital her physical health has declined; Ms [LL] is not able to walk unassisted, and for example had to crawl to the toilet, but also urinated on furniture and in her bed;

(c) In the last six months she had worked closely with Ms [LL] about voluntary treatment, but Ms [LL] and her partner declined to take part. Ms [LL] said she was "not going to be told what to do", she would go to rehabilitation "probably when her mind had gone", and "drinking was fun";

(d) If sent home, Ms [LL] would not engage in voluntary treatment; she had been offered plans in the past but had not gone ahead with them;

(e) Ms [LL]'s partner and son are also alcohol dependant;

(f) Between 19 August and 21 September this year, police recorded five family harm incidents involving Ms [LL] due to alcohol related behaviour;

(g) In the week before she was admitted on 4 October, Ms [LL] and her partner drank meths because they had no money to buy gin or beer;

(h) Although Ms [LL]'s home was initially well maintained, in the last six months she had seen food, cigarettes and urine on the floor and the chairs had been urinated on. Ms [LL] said she had not showered for weeks on end before being admitted to hospital on 4 October;

(i) Ms [LL]'s cognitive ability is impaired in that while she says she will engage, she has no ability to follow through and carry out what she says she will do. She cannot weigh up the risks of harm associated with her continuing alcohol use and make decisions about what is in her best interests.

[17] In cross-examination, Ms Simpson said:

(a) She did not accept Ms [LL] formerly did not understand the seriousness of her position, but now does, and wants to take steps to change; she has been well aware of her position for some time but had done nothing to change;

(b) The benefits for Ms [LL] of going to Nova were she would have an extended time in a controlled environment to regain her cognitive capacity, develop insight and improve her physical health.

Ms [AR]

[18] Ms [AR] referred to Ms [LL] having a long history of substance abuse with marked deterioration in her condition in the last three years. Her physical health has been affected, she needs assistance to go to the toilet, cook and walk. She has tremors, cannot stand still and lives in squalor. She cannot understand the consequences of her behaviour. She has never undertaken rehabilitation voluntarily and has declined CADS help.

[CL]

[19] Ms [CL] said in the past her sister could make considered decisions; she had friends and could care for herself. Now her body shakes uncontrollably and she has no capacity to make decisions about her health. She has broken her wrist as a result of falling over, and has attributes her difficulty in walking to an injury she suffered 23 years ago rather than a result of her drinking. She is not likely to agree to voluntary treatment.

Ms Northey's submissions

[20] Ms Northey submitted:

(a) Ms [LL] does not have severe substance addiction; while she can drink alcohol every day, her consumption has reduced significantly since last year when she was drinking meths and significant amounts of alcohol; now she merely drinks socially;

(b) Ms [LL]'s alcohol use does not pose a serious danger to her health and she does not have a diminished capacity to care for herself;

(c) Ms [LL]'s capacity to make informed decisions about her treatment is not severely impaired;

(d) Compulsory treatment is not necessary; Ms [LL] is prepared to voluntarily engage in community services and should be given the opportunity to pursue that path.

Findings

[21] With respect to the statutory criteria, I find:

(a) Ms [LL] has a longstanding severe alcohol abuse disorder. She has habitually consumed large amounts of alcohol, craves for alcohol and cannot do without it. All attempts at controlling her use of alcohol in the past have been unsuccessful, and her use of alcohol has continued despite her suffering harmful consequences (liver damage, neurological damage including weakness in her legs, tremors, cognitive impairment);

(b) Ms [LL]'s alcohol addiction poses a serious danger to her health or safety in that it has caused liver and neurological damage, prevents her from caring for herself adequately, exposes her to family violence and to the risk of setting fire to her home;

(c) Ms [LL]'s alcohol consumption has affected her memory. She is not able to weigh up information as part of a decision making process, lacks insight into the severity of her condition, and lacks ability to make sound decisions about her need for treatment;

(d) Voluntary treatment is most unlikely to be effective in addressing Ms [LL]'s alcohol addiction. She has had the opportunity of engaging with CADS and undertaking rehabilitation in the past, but has not taken these opportunities. A warrant was required to get her to hospital for the purposes of the current application. Self-treatment with Antabuse is most unlikely to be effective. Ms [LL]'s condition has reached a critical stage. If not treated effectively, Ms [LL] faces living in a care facility or possible premature death. Compulsory treatment is a last resort, but the stage has been reached where it is the only option;

(e) The proposed treatment plan is appropriate.

Result

[22] For these reasons, I made a Compulsory Treatment Order.

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Judge AJ Twaddle
Family Court Judge | Kaiwhakawā o te Kōti Whānau
Date of authentication | Rā motuhēhēnga: 20/10/2021