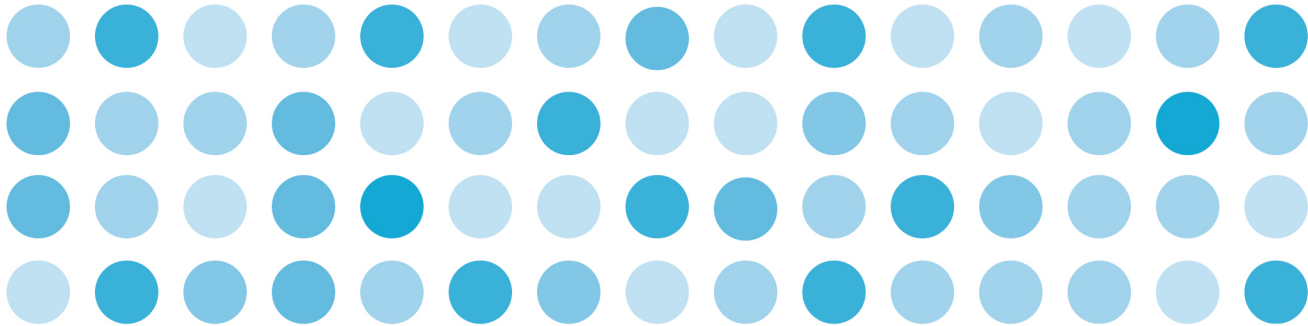


25-26 October 2010
Melbourne Cricket Ground



Anex 2010
**AUSTRALIAN
DRUGS
CONFERENCE**
Public Health and Harm Reduction

Euan Donley





ALLIEDHealth



**Removing Liberties of a person with Alcohol
Dependency Presenting Frequently to a Hospital
Emergency Department:
A Case Study.**

Euan Donley

Angliss Hospital Emergency Dept

Social Worker Psychiatric Triage



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ISSUES TO CONSIDER

- Common type presentation for busy emergency departments
- Fluctuating compliance and motivation
- Possible poor service response
- Ethical issues regarding rights of self-determination
- Single case study
- This is a summary!





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“JD”

- Aged in his mid twenties
- Nil formal PHx psychiatric
- Lives alone, semi-supportive mother
- Unemployed, few supports.



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FIRST PRESENTATION

- BAL 0.21. BIBA after calling from the street. Lived alone for last year. Recurring homelessness. PHx alcohol use since age 8 and heavy drinker by 16. One slab full strength beer per day, or bottle vodka. Nil other AOD currently but PHx poly substances.
- Referred to AOD and crisis housing. Discharged.



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NEXT PRESENTATION

- Couple of months later, BAL 0.47. First of 21 presentations for that year. Each time BIBA and ‘medically cleared’. Most times intoxicated and homeless.
- Over coming weeks much negotiation with AOD services who were having difficulty with engagement (no on site AOD). Continued negotiation with housing services but same.





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CONTINUED PRESENTATIONS

- Began to overdose on panadol while intoxicated. Would present to ED intoxicated, impulsively suicidal, and homeless.
- Seen multiple times by psychiatric triage (aka: ECATT). Not suicidal and willing to attend detox.
- Admitted to detox. Discharged self after 2 days.





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MORE PRESENTATIONS

- Drunk and suicidal. When sober - Nil mood disorder evident. Nil psychosis. Nil thought disorder. Denies suicidal.
- Minor success – found out corrections officer was involved – *“I’m trying to get him into detox and housing support”*. Offences while intoxicated.



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TRIED ADMITTING JD

- Attempted to admit to hospital for detox. Absconded after 2 days. Attempted again. Waiting in SSU 4 days with nurse special and 1 hour before transport arrived, absconded to closest bottle shop.
- Admitted again to detox but discharged self before end of treatment.





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MORE OVERDOSES

- All while intoxicated, not planned, remorseful, and requesting detox. Showed insight and displaying, at that moment, judgement. Psych triage noted AOD issue and not psychiatric. Long debate ensued. Essentially declining psychiatric bed and did not feel sectioning warranted.
- Referred to HARP. Referred to complex care. Poor engagement.
- Attempted neuropsychology referral. Needs to be sober one week before assessment.
- Intubated at another hospital then discharged.





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WE GET SOMEWHERE

- Acute ward admitted and he stayed a little while. Neuropsychologist agreed to see despite not being detoxed.





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N-PSYCH FINDINGS

- Significant alcohol, cannabis and amphetamine use last 4 years.
- Left school year 8. Intellectual functioning extremely low. Impaired construction skills. Oriented but slow. Poor organisational and planning ability.
- Working memory impaired. Poor behavioural regulation. Impulsivity, disinhibition, poor self-monitoring.
- ? ABI from substance misuse, but may be suffering acute withdrawal.
- Strengths – give time for activities, focus on one activity at a time, structured environment.



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PLAN

- We didn't get to it because he discharged himself at own risk and ward medical team did not feel sectioning was warranted.





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BACK 2 WEEKS LATER

- BIBA after being found intoxicated near train tracks.
- Cleared by Psych.
- We went to VCAT and OPA.



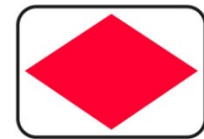


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WHY WE ARGUED VCAT

- Substance misuse may have resulted in brain injury, or was so significant it was continually impairing his functioning and judgment.
- This impaired his decision-making.
- The least restrictive options had been well and truly worn out.
- There is a significant risk of death by misadventure (overdose, hypothermia, trains).
- He required further testing and treatment.
- Secure accommodation should be made for discharge purposes, and an administrator should pay for this.



OFFICE OF THE
PUBLIC ADVOCATE



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WE ARGUED ABOUT...

- Proving a disability
- Is alcohol use enough of a reason to remove self-determination?
- There are no detox facilities that will lock him up for treatment
- Once detoxed, there are no guarantees he will stop drinking
- This may escalate anti-social behaviour
- There is no guarantee he will stay in his accommodation



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OUTCOME

- Some initial representations, no escalation of behaviours.
- Stayed at supported residence (2 years known).
- Joined sporting club.
- Saving \$10- a week to go on interstate holiday.
- Briefly did volunteer work (cleaning)
- Off/reduced alcohol
- Affect improved.
- He's not dead.
- Not been back to Emergency Dept in years.





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POINTS OF INTEREST/CONCLUSION

- Must be significant foreseeable risk
- Suitable under limited circumstances, such as this one outlined.
- Forced short-term detox unlikely the answer.
- Possibly community or rehabilitation based treatment.
- Worth opening new dialogue about (new bill being considered)
- Medium to long term intervention/not a quick fix.
- Thank you!