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A Community Legal Centre

Submission to the Scrutiny of Acts and Regulations Committee regarding the Severe Substance Dependence Treatment Bill 2009

About Fitzroy Legal Service

Fitzroy Legal Service ('FLS') provides free legal services to community members with limited financial resources and/or experiencing other vulnerability/ disadvantage within the legal system. The work of FLS includes: free legal advice clinics five nights per week; casework in criminal, family, discrimination, and victims of crime matters; duty lawyer services at the Neighbourhood Justice Centre; advocacy work on behalf of client base including community legal education, community development activities and policy/ law reform.

A significant proportion of FLS service users have illicit drug dependence issues. In addition to core activities, FLS has been funded since 2005 by the Department of Human Services to provide dedicated services to this community through the Drug Outreach Lawyer position.

Summary of concerns & recommendations

FLS submits that the Bill unjustifiably intrudes on the following protected human rights as recognized under the Charter of Rights and Responsibilities (Vic):

- right to liberty and security of person
- recognition and equality before the law
- right to a fair trial
- right to life
- freedom of movement, privacy and reputation
- protection from torture and cruel, inhuman or degrading treatment
- right to humane treatment when deprived of liberty

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Infringements on these rights through the operation of this Bill will be of a most serious nature, including sustained loss of liberty and forced withdrawal treatment despite existing capacity. Our concerns are as follows:

- The evidence base underlying the apparent purpose of the Bill in achieving harm reduction outcomes is of great concern. The sources referenced by the Minister are in fact equivocal in their findings, and do not in our submission justify the relevant infringements on human rights or show no less restrictive means are reasonably available to serve the same purposes.¹
- The criterion legitimising detention and treatment are drafted to include an extraordinarily wide category of persons. As such, reassurances that only a small number of persons will be affected are not reflected in the terms of the Bill as they stand.
- Protective mechanisms cannot provide adequate protection where the criteria against which review occurs are so broad. It is inadequate to presume that the presence of ‘red tape’ will ensure human rights protection in principle, and particularly where orders may remain valid despite failure to comply. Similarly the absence of significant funding for involuntary civil detention will not prevent its proliferation at some future time should there be a significant demand.
- The acknowledgement through the terms of the Bill that an affected person retains legal capacity in all regards save in regard to their substance dependence and right to refuse withdrawal treatment is discriminatory in its terms and capable of arbitrary application (for example, technically a tobacco smoker can be captured by the terms of the Bill).
- The Minister for Health has described ‘severe substance dependence’ and detention/ treatment under the Bill as discrimination on the basis of impairment as a protected attribute under the Equal Opportunity Act 1995.² In the absence of strong and reliable evidence to show the proposed measures will benefit the detained person, we submit the discrimination should be impugned as an unacceptable infringement of human rights on discriminatory bases.

In light of these concerns, expanded upon below, we make the following recommendations to the Committee:

1. That the proposed involuntary civil detention and treatment approach is found to be incompatible with the Charter

¹ Endorsing Submission of the Federation of Community Legal Centres in relation to this Bill.

² Statement of Compatibility in Hansard, Thursday 10 December 2009, p 4580.

2. That recommendations are made, should such an approach prevail in terms other than those presently proposed, that the following aspects of the Bill are addressed:
 - (a) criteria of treatment and detention narrowed to suspend rights only in relation to urgent threat to life with further definition of how such threat should be defined beyond the ordinary (though often serious) risks associated with substance dependence
 - (b) period of detention limited to that necessary for such urgent threat to abate and purpose of detention to be limited to the same
 - (c) that a range of treatment options be made available in such context as opposed to involuntary withdrawal treatment only
 - (d) that an order be invalid should the various oversight procedures outlined in the Bill fail to take place
 - (e) that procedures be put in place to automatically notify and provide legal aid to legal practitioners to defend any applications put forward
 - (f) that priority be given to funding voluntary residential rehabilitation in relation to which significant waiting periods presently apply
 - (g) that the categories of persons who are able to lodge applications for detention and treatment orders with the Court be narrowed significantly

Inadequate evidence base to support involuntary detention and treatment of non-offenders

Involuntary detention and treatment of a person in relation to whom guardianship, mental health and criminal laws do not apply represents a significant departure from accepted practice in the alcohol and other drugs field. Consent is ordinarily required in relation to all medical treatment. That substance dependence causes individuals to make decisions harmful to their health, welfare, and life is a concern shared by the community broadly. Measures to engage with these concerns include harm reduction, harm minimisation, family support, and community education activities. Additionally, where illicit substances are involved, policing models are engaged, and, where relevant and appropriate, therapeutic jurisprudence responses.

It is our submission that the approach set out in the Bill represents a departure from accepted practice that is not predicated on adequate evidence. A consistent theme of the referenced reports is the lack of empirical evidence to support civil detention as an effective intervention resulting in rehabilitation or long-term behavioural change. Given the nature and duration of human rights contravention involved, we submit that anecdotal evidence that some people may be assisted by involuntary civil detention and treatment is wholly inadequate. We endorse the submissions of the Federation of Community Legal Centres in this context.

Additionally, we refer Committee Members to extensive evidence of increased risk of overdose for persons exiting prison.³ Australian research demonstrates substantially higher risk of drug-related death in the first two weeks following release.⁴ We note overdose prevention programs presently operate in Victorian prisons to provide education about reduced tolerance and the attached increased risk of overdose for injecting drug users on release. We submit correlating considerations must be taken into consideration under the present Bill, with further investigation of increased risk of overdose where persons are released from detention and withdrawal treatment against their will as a result of lowered tolerance and other matters connected with incarceration. This is particularly significant given the overarching purpose put forward in relation to this Bill of protecting life and promoting health.

Scope of criteria for treatment and detention

The requirement of ‘severe substance dependence’ referenced in section 8(2)(a) and defined in section 5 of the Bill is no stronger than the DSM IV criteria by which patients are diagnosed with *any* form of substance dependence.⁵ The presence of tolerance, withdrawal, and absence of capacity in relation to continued use, health safety and welfare actually reflect the lowest threshold of substance dependence. Therefore, section 8 (2)(a) covers an extraordinarily broad field and does not distinguish ‘severe substance dependence’ in meaningful terms. This arm of the criteria can adversely affect a very broad range of people as placing them *prima facie* within the scope of the Bill’s operation.

We submit significant concerns arise also in relation to the second arm of the test as provided for in section 8(2)(b), that is, ‘immediate treatment [assisted withdrawal] is necessary as a matter of urgency to save the person's life or prevent serious damage to the person's health’. There is no dispute that a very large number of substance dependent person’s health and life are at risk in a very real way. For example, transmission of blood-borne viruses, liver or kidney damage, heart attack, stroke, ever-present risks of overdose or brain damage. In our view, there is nothing in the Bill or commentary to provide guidance or justification regarding the practical limits of who will be affected by the Bill. It is our submission that removal of the second arm of the test may assist to tighten the criteria and everyday risks such as those outlined above should be explicitly excluded from triggering the section 8 criteria.

³ See Kariminia, A. Butler, T.G. Corben, S. Levy, M. Grant, L. Kaldor, J. (2007). Extreme cause specific mortality among adults who have served time in prison. *International Journal of Epidemiology*, 36, pp. 310-316. [RJ582] & Hobbs, M. Krazlan, K. Ridout, S. et al (2006) *Mortality and Morbidity in Prisoners after Release from Prison in Western Australia* 1995-2003. Research and Public Policy Series no. 71. Canberra: Australian Institute of Criminology.

⁴ Ibid.

⁵ See copy DSM-IV attached.

In relation to the additional criteria set out in the Bill, we note pursuant to the definition section that the only ‘treatment’ covered by the Bill is medically assisted withdrawal. As a large proportion of those individuals affected by substance dependence will not voluntarily engage in withdrawal from substance dependence, there is likely to be a large number of cases where ‘the treatment can only be provided through admission and detention’ and ‘there is no less restrictive means reasonable available to ensure the person receives the treatment’. As such, we submit that sections 8(2)(c) and (d) do very little to strengthen the criteria.

We submit our comments on the breadth of the criteria should be considered in light of the fact that any adult person may initiate an application for detention and treatment (most likely family police and workers in the field). The category of prescribed practitioners is broad also and includes a wide range of approaches and treatment preferences, as would be expected. The only protection that this Bill will apply to a ‘small group’ is the authorization of the senior clinician and the availability of beds. This is a mutable factor in the scheme, responsive to funding, community pressure, creation of new facilities; clearly it is not controlled by the level of unjustified infringement on the human rights of those affected and should not be based on an assumption of sensible practice in the sector alone.

Existing protections under the Bill

We submit that the protective mechanisms set out in the Bill are only as strong as the criteria which the decision makers engage with in their oversight function. We note also that in the mental health jurisdiction many protections that are legislatively in place do not occur in practice. We therefore recommend that a clause be added to make any order invalid in the absence of legislated processes applying.

Discrimination and the detrimental impact on the drug using community

It is FLS’s submission that involuntary incarceration in the absence of any specific wrong-doing, or actual loss of capacity to consent/not consent to treatment (which are conditional under criminal and mental health jurisdictions) based on severe drug dependence alone, is discriminatory. We have significant concerns that Bill will have a wide and harmful impact on drug users across the board for the following reasons:

- Service providers and family members are likely to be initiators of applications in respect of a person. This is likely to jeopardise the relationships of trust an affected person has built with service providers if there is a likelihood that an application for involuntary treatment could be made in respect of them. Similarly, a family member’s ability to make an application can cause a breakdown in the relationship between the affected person and their family and broader social supports. This can have devastating effects, including isolation, lack of access to vital health services, and unwillingness to seek assistance

when required. It is our strong submission that this approach is harmful to health and general wellbeing of drug dependent persons and in particular is contrary to the culture and practice of harm minimisation.

- We note that presently there is a lack of funding to meet the demand of people voluntarily seeking medically assisted withdrawal and residential rehabilitation. We submit that funding services to provide involuntary treatment is a misdirection of funds, and present concerns that individuals seeking voluntary treatment may be required to wait for longer periods. A further concern is that, in the absence of dedicated facilities, voluntary clients in residential facilities will be placed alongside involuntary clients, with potentially adverse impacts on their recovery process.

In conclusion, we submit that the aims and purpose of the Bill does not provide justification for the gravity of the contravention of basic human rights, the likely arbitrary application of the criteria of involuntary treatment, and the detrimental impact on health for a large group of people within the community.

We are grateful to the Committee for the opportunity to raise these concerns.

Yours faithfully,
FITZROY LEGAL SERVICE
PER:

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