



Harm Reduction Victoria 

Health Rights • Human Rights • Harm Reduction

## **Severe Substance Dependence Treatment Bill 2009**

**Submission from Harm Reduction Victoria**

**To**

**Scrutiny of Acts and Regulations Committee**

**Enquiries to:**  
Damon Brogan  
Executive Officer  
Harm Reduction Victoria  
Ph: (03) 9329 1500  
Email: [damonb@hrv.org.au](mailto:damonb@hrv.org.au)

## Introduction

Harm Reduction Victoria Incorporated (HRV) is an incorporated community organisation with a mission to advance the rights and health of Victorians who use, or have used, illicit drugs. Since 1987, Harm Reduction Victoria (formerly *VIVAIDS Inc*) has worked with government, service providers, other civil institutions and drug users to reduce drug-related harms such as overdose, blood-borne viral diseases, criminalisation and social marginalisation. Our health promotion approach involves peer education and peer empowerment, as well as workforce development for other professionals who work closely with drug users. We also seek to represent the experiences, needs and aspirations of people who use drugs in public education and advice to government and access the health and human service sector in general.

We trust that the Committee will be open to the following considerations of the human rights and practical impacts of the SDT Bill 2009 from the viewpoint of the individuals and communities potentially most directly affected by this legislation, were the Bill to be enacted. We also trust that the Scrutiny of Acts and Regulations Committee will forgive the lack of legal expertise evident in our submission.

**HRV** submits that the Bill is incompatible with several of the Human Rights referred to in the Victorian Charter of Human Rights and Responsibilities, the most salient of which are:

Section 12: Freedom of movement

Section 21: Liberty and Security of the Person

Section 10: Right not to be subjected to torture and cruel, inhuman or degrading treatment

Section 13: Right to privacy

Section 24: Right to fair hearing

Section 8: Equality

The most serious of the limitations on human rights proposed in this Bill involve Section 21 (*'liberty and security of the person'*) and Section 10 (*'the right not to be subjected to torture and to cruel inhuman or degrading treatment'*). The Bill proposes to introduce involuntary detention and "treatment" on persons with severe substance dependence in circumstances where it is necessary as a matter of urgency to save their life or to prevent serious injury to the person's health. As such action engages the rights embodied in both Section 21 and Section 10 of the Charter, this submission will address these two together.

**Limiting the liberty of person and imposing medical treatment without consent** represent, we argue, the most serious of human rights infringements and, as such, should not be undertaken lightly. Section 7 of the Charter indicates that, in a free and democratic society, any such limitations must be based on overwhelming evidence that a higher order need exists (e.g. the right to life), that less restrictive and less coercive means of addressing that need are unavailable; that there is evidence of beneficence / efficacy of the proposed intervention and that the imposition of civil detention and treatment without consent follows due process (i.e. it is transparent and accountable, open to review and appeal, the subject has access to adequate representation and there is judicial or administrative oversight). HRV contends that the Bill proposes to limit these rights without meeting most of these conditions.

In the Report on the Community Consultation for the 2008 Review of the Mental Health Act (Victoria) (Vic Gov, 2009) "*Liberty Victoria notes that any involuntary treatment regime must respect the human rights of people [with mental illness]. According to Liberty Victoria, this 'requires, at a minimum, that people [with mental illness] are presumed to have legal capacity unless it can*

clearly be demonstrated that they are incapable of providing informed consent to their treatment or care'.<sup>1</sup>

Again "Section 10 c of the Charter on 'Protection from torture and cruel, inhuman or degrading treatment' makes clear that a person must not be subjected to medical treatment without his or her full, free and informed consent. It is significant that this right is stated in this section of the Charter as freedom from torture is considered one of the few inviolable or 'non-derogable' human rights. At the very least, medical treatment without consent must be considered one of the most serious Charter rights that should not be limited lightly."<sup>2</sup>

These quotes, from Submissions 161 and 163 to the Community Consultation for the 2008 Review of the Victorian Mental Health Act (Vic Gov, 2009) with other submissions, make the point that the key human rights issue here has to be **the legal capacity of the individual to make free and informed consent to medical treatment**. and that no involuntary medical treatment should be imposed upon an individual unless it is demonstrated that they are not legally capable of free and informed consent.

As the key human rights issues at stake with this Bill are exactly the same as those referred to in the review of the Mental Health Act (MHA), HRV wishes to make two major observations:

1. There should be a community **consultation and review of the human rights implications of the SDT Bill** just as robust and inclusive as that conducted with regards to the MHA. Indeed, critics of the MHA Review process e.g. Dr David Webb<sup>3</sup> criticise this review for having been conducted in-house by DHS and not by the Law Reform Commission and, most significantly, because the views of the community likely to be most affected by the legislation were neither sought nor included. Harm Reduction Victoria therefore requests that the Committee suspend any further processing of this Bill until a full and proper review, including consultation with the affected community, has taken place.
2. The Minimum criterion in the limiting rights of the individual under Section 10 c (and by implication Section 21) of the Charter must be changed in this Bill from "*inability to make decisions about their dependency*" to the test required in the Charter that the subject lacks legal "*capacity to form and communicate free and informed consent to treatment*".

**It is not reasonable, or consistent with the Charter** for civil detention and medical treatment without consent to be imposed without the person being clearly demonstrated to be legally "*lacking the capacity to make free and informed consent to the treatment*" and without the treatment being shown to be sufficiently necessary in the immediate circumstances and adequately beneficent. Both are questionable in this instance.

#### **Need not established: dependence per se does not limit capacity for consent**

HRV, which has advocated for the health and rights of illicit drug users in Victoria since 1987, can conceive of no circumstances where a person's substance dependence *in and of itself*, could be deemed to limit their capacity to make free and informed decisions about treatment. While it may be, perhaps, theoretically possible for these circumstances to

---

<sup>1</sup> Submission 163, (Liberty Victoria) Report on the Community Consultation for the Review of the Mental Health Act, DHC, Victorian Government, July 2009

<sup>2</sup> Submission 161, (Dr David Webb) Report on the Community Consultation for the Review of the Mental Health Act, DHC, Victorian Government, July 2009

<sup>3</sup> Ibid

occur, HRV does not accept that sufficient evidence has been established to enact legislation which abrogates the most inviolable of human rights in this manner. Under Section 7 of the Charter, the onus should be on the proponents of this legislation to conclusively establish such evidence before a certificate of human rights compliance is granted. Harm Reduction Victoria strongly supports the submission from the Human Rights Law Resource Centre on this issue.

We provide the following hypothetical examples of situations where an individual might conceivably be subject to an application for detention and “treatment” under this Bill, but where it would be incorrect to assume that they were legally incapable of forming consent or that their incapacity to form consent is due, largely, to their severe dependence.

### **Examples:**

- An alcohol dependent person may be informed by their medical advisors that if they do not stop drinking, they will incur severe and potentially life-threatening liver damage. However, such a person would NOT be deemed incapable of forming free and informed consent to treatment, and therefore it would not be appropriate to detain and treat him or her under this legislation. A person has the lawful and guaranteed human right to refuse medical treatment and to exercise their autonomy, even if it results in serious injury or death.
- A person may be experiencing a psychotic episode as a result of methamphetamine use, and be considered a danger to themselves and / or others. They may, as a result of their temporary psychosis, be unable to make a free and informed decision about treatment. However, this person may not be seriously substance dependent at all, in which case this (SSDT) legislation should not apply. Even if the person were methamphetamine dependent, it is not their state of dependence that renders them incapable of consent; rather, it is their impaired cognitive function or current state of mind. If protective custody and / or assessment and treatment are indicated, this could be achieved by the Mental Health Act, the Guardianship Act or some other instrument, but not the SSDT Bill. The risk to their health or to the safety of others is independent of the question of whether they are drug dependent.
- A young person with an acquired brain injury (ABI) may be drinking alcohol and taking drugs to the point where he/she is at risk of serious illness. The young person may be dependent on alcohol and/or cannabis and/or benzodiazepines and his/her current level of intoxication in conjunction with an ABI may be such that he/she is deemed legally incapable of giving informed consent. Again, however, it is not his/her *dependence, in and of itself* that results in this incapacity; it is his/her temporary intoxication and pre-existing brain injury that limits his/her capacity to form consent. Under these circumstances, the SSDT legislation should not apply, as his/her capacity for consent is independent of his/her state of drug dependence.

HRV submits that it is up to the proponents of the Bill to establish empirical evidence that circumstances exist where a person's substance dependence is either a significant factor in posing a risk of death or serious injury to health or that dependence can diminish a person's capacity to give or refuse consent to treatment. The hypothetical situations above should not meet the standards required to limit human rights under Sections 10 and 21 of the Charter. Yet, it is precisely the above kinds of situations, we suggest, that are in the minds of many of those advocating this legislation, particularly where young people and individuals with mental illness and cognitive impairment are involved.

### **“Inability to make a decision about treatment”: Insufficient cause to limit human rights.**

Harm Reduction Victoria does not accept the proposition that “*being unable to make a decision about their treatment (for dependence)*” should be considered sufficient cause to invoke civil detention and medical treatment without consent. Being “*unable or unwilling to make a decision about treatment*” is ONE of the DSM IV criteria which, in conjunction with a sufficient number of OTHER criteria, MAY indicate a diagnosis of substance dependence. This, however, is not a black-and-white matter. The diagnosis for dependence covers a complex of inter-related phenomena. Being deemed by another person “unable or unwilling to make a decision about treatment” (as in the DSM IV) could cover a huge number of people, including people who smoke tobacco, people dependent on caffeine and/or other substances and people who consume alcohol daily. Although their continued use of a substance to which they are habituated may pose serious health risks, this is *not* sufficient cause to warrant abrogating the right to liberty of the person, freedom from medical treatment without consent, or the diminished right to privacy that a treatment order under this Bill would entail. Only incapacity to form free and informed consent, together with immediate and serious need (e.g. imminent threat of death or very serious illness) should warrant such measures.

### **Other problems with “capacity to make a decision about treatment”**

As well as failing to incorporate “*incapacity to form free and informed consent*” as the minimum necessary condition for involuntary treatment (under civil detention), the current wording in the Bill about “*capacity to make decisions about their treatment*” is in itself problematic. Such a statement presupposes, HRV argues, that if the person did have the capacity to make decisions about their treatment, they would choose to undergo treatment. However, since people frequently and freely choose *not* to undertake all kinds of medical treatment, even in serious circumstances, it is fallacious to assume that the dependent person would necessarily choose to undergo treatment even if they were capable of reaching such a decision. The subtext of the Bill suggests that the person is “*incapable of reaching the same decision about their treatment as other parties might prefer*”.

Additionally, if an individual is capable of forming a decision about treatment, there can be no reason to assume that “detoxification” [sic] or enforced withdrawal would constitute his or her choice of treatment modality. While a wide variety of treatment forms and methods are recognised in the medical literature, the definition of “treatment” proposed in the Bill is very limited, consisting primarily of detoxification or involuntary withdrawal. Any treatment order under this Bill would therefore involve depriving a person of their liberty and imposing a medical treatment upon them according to another person’s values and interests, which may well contravene those of the individual. This is patently unjust and arbitrary.

### **Choice, efficacy, beneficence and values**

In Victoria and elsewhere in Australia, a wide range of voluntary treatment modalities for substance dependence syndrome exists. Some of these are based upon widely divergent theoretical models of substance-dependence that respond to differing sets of values. Substance dependence is not a simply defined disease, like diabetes or smallpox; rather, it is a *spectrum* disorder or syndrome, a collection of related but dissimilar symptoms and situations, to which some of a broad set of characteristics (DSM IV) will apply. Substance dependence includes the use of different types of substances that affect different individuals in different ways; dependence may signify physical or psychological symptoms or both. In addition, there is potentially a wide range of different patterns of use, with an equally wide

range of different social, legal and health sequelae. Dependence involves such a broad range of substances and such a complex set of interactions between pharmacology, social environment, personal choice and cultural values that it is entirely appropriate that treatment options are voluntary and diverse.

### **Treatment models and paradigms current in Victoria**

- The *disease model of addiction* [sic]. This model defines substance dependence as a neuro-adaptive disorder that, for some individuals, is permanent and characterised by loss of personal control over the use of the substance. In this instance, dependence is described as a chronic, relapsing condition. Currently, among drug treatment practitioners and consumers, there is general acceptance of aspects of this model as a useful means of describing *some* of the patterns of substance dependence exhibited by *some individuals*, which may assist in dealing with *some* dependence-related problems.

However, there is no scientific consensus that this model:

(a) adequately or accurately reflects the biochemical, psychological or social dynamics of substance dependence as a generalised pathology,

(b) inevitably applies to all dependent individuals, or

(c) applies to all cases of substance dependence involving any one substance (e.g. all cases of alcohol dependence, all cases of heroin dependence, etc).

The *disease model of addiction*, in its purest form, holds that the only effective treatment is life-long abstinence which, logically, proceeds from initial “detoxification” from the substance. This is the conceptual model for substance dependence referred to in the Alcoholics Anonymous tradition. At the time of the enactment of the ADDA in 1968, this was probably the most widely accepted theory of substance dependence in Australia<sup>4</sup>.

- *The Harm Reduction or Continuum of Harms* model. This is not so much a theoretical model but rather the intellectual basis which informs and underpins pragmatic approaches to the problems associated with substance use and substance dependence. This approach recognises that substance use and dependence syndrome cover a very wide array of substances and circumstances and that a wide range of different biological, pharmacological and social processes are involved. It situates all substance users somewhere along a ‘risk continuum’ or ‘scale of potential harm’, depending upon subjective and objective measures of harm (including risk of morbidity and mortality).

At one end of this continuum, an individual may use a substance occasionally and/or recreationally and experience few if any noticeable harms. Further along the scale,

---

<sup>4</sup> “The New South Wales, Victorian and Tasmanian Acts were enacted at a time when confinement and abstinence were popularly understood to be best treatment for alcoholism and Tasmanian Acts were enacted at a time when confinement and abstinence were popularly understood to be best treatment for alcoholism and drug addiction. Few substantive changes have been made to the Acts over the years, bringing them into some tension with current treatment philosophy and practices. “ *ADCA Research Paper 14, Compulsory Treatment in Australia*; Pritchard E, Maguvin J, Swan A; Turning Point Alcohol and Drug Centre 2007, p xii

a person's substance use may be associated with more harmful results including spending more money than they can afford or, as with tobacco use, exposing them to increasing risk of ill-health. Still further along the scale, a person's substance use may involve significant harms or risks to others, e.g. driving under the influence, relationship difficulties, etc or it may lead to criminal activities and trouble with the law. At the other end of the spectrum, a person's substance use may lead to a range of severe consequences, including liver damage, high risk of overdose, exposure to a blood-borne virus, drug related psychoses, etc.

Within this paradigm, the role of treatment or clinical interventions is to assist the individual to move away from the severe end of the spectrum and towards a reduced level of risk and harm. The approach recognises, therefore, that people are able to move either way along the spectrum and that it is not necessary for abstinence to be achieved for an intervention to have benefit. Under the *Harm Minimisation* principles of National Drug Policy since 1989, this adaptive approach to substance use has been the dominant paradigm in Australia, without any prescriptive dogma as to what specific interventions are required.

Some minority and lay commentators (as well as potential applicants for orders under this Bill) may regard *substance dependence* itself as a significant harm and place it towards the severe end of the scale. Others may consider dependence a complicating factor that *can* propel individuals towards the severe end of the spectrum but which does not necessarily equate to serious harm *per se*. For instance, a person may be dependent upon tea or coffee and require multiple cups a day to feel functional, but that is unlikely to equate to severe harm. Even opiates, which are well known to result in dependence following regular use, *can* be used in a dependent fashion over a lengthy period of time, without significant health risk, provided the individual has access to a reliable source and is able to consume the drug under optimal circumstances<sup>5</sup>.

Because the Harm Reduction approach encompasses an open and wide range of pragmatic responses to people's substance use, (including but not limited to abstinence) it is less prescriptive or doctrinaire than the Disease Model of Addiction. It recognises that detoxification and maintenance of abstinence may be desirable and achievable in some, but not all circumstances and that objectives other than abstinence have merit in reducing the risk of a range of potential drug related harms.

***It is important to note that there is no one, universal model of substance dependence to which all practitioners or consumers subscribe. Rather, there is respect for diversity and difference of views across the AOD sector.***

## Types of interventions

- *Counselling, Cognitive Behavioural Therapy, Psychotherapy* etc. Cognitive-behavioural therapies are among the most widespread approaches to substance use. However recent research indicates that the advantage conferred by this form of treatment in comparison to alternative treatment modes is minor<sup>6</sup>.
- *Detoxification, medicated and non-medicated.* There is increasing scientific consensus that detox on its own is of little real value in achieving either long-term

---

<sup>5</sup> Boeri, M. W. (2004). "“Hell, I’m An Addict, But I Ain’t No Junkie”: An Ethnographic Analysis of Aging Heroin Users." *Human Organization* 63(2): 236-245.

<sup>6</sup> Magill M., Ray L.A. (2009) Cognitive-behavioral treatment with adult alcohol and illicit drug users: a meta-analysis of randomized controlled trials. *Journal of Studies on Alcohol and Drugs*: 2009, 70, 516–527.

abstinence or sustainable reductions in drug-related harms<sup>7</sup>. A recent review which compared short-term and longer-term treatment models found that interventions which regularly and systematically support and monitor the patient's progress over an extended period of time generally lead to better outcomes<sup>8</sup>. In a voluntary setting, however, detoxification has been shown in some studies to be a useful step, for some types of individuals, towards achieving either abstinence or significant reductions in harmful / risky substance use. There is no significant or rigorously derived evidence that involuntary detox in civil detention has sufficient efficacy or beneficence to be ethically sustainable as a “treatment” in its own right (see Values and Ethics below). Indeed, De Paul House, the Drug and Alcohol withdrawal service at St Vincents Hospital, has for the last year or so discouraged clients from accessing its detox service unless some other, longer term form of treatment, such as voluntary pharmacotherapy, is also planned.<sup>9</sup>

- *Replacement therapy* – short-term withdrawal or maintenance. For example, Opioid Replacement therapy (ORT) for people dependent upon heroin and other opioids; nicotine replacement gums, patches and inhalers for smokers; lower potency / longer acting benzodiazepine maintenance and reduction / withdrawal regimens for people dependent upon short-acting benzodiazepines e.g. *Zanax*.
- *Relapse prevention medication*. For example, Acamprosate and Naltrexone for alcohol dependence; Naltrexone for opioid dependence (not TGA approved and highly contentious).
- *Peer and/or Group support*. For example, group therapy, NA and AA Fellowships
- *Therapeutic residential communities*. Long term rehabilitation programs traditionally based on abstinence only objectives. More recently, some TCs have included replacement medication but these hybrid TC models remain novel.

Current treatment for substance dependence can involve elements or combinations of any of the above interventions. Services wedded to the *Disease Model of Addiction* and abstinence objectives will generally not offer long-term replacement pharmacotherapy. However, the use of replacement pharmacotherapy for “weaning off” in the short-term is increasingly accepted as part of the “medicated detox” regimen to treat opioid dependent individuals in withdrawal services, even when long-term maintenance pharmacotherapy is frowned upon.

“As no single treatment is effective for all individuals with opioid dependence, sufficiently diverse treatment options should be available”(WHO, 2004:1)<sup>10</sup> **There is no one intervention that treatment providers, consumers or the scientific community recognise as appropriate or efficacious for all substance users in all situations of substance dependence. However, despite the diversity of acknowledged treatment models and the fact that, of all treatment modalities, involuntary withdrawal (detox) in civil detention is supported by the least abundant or rigorous evidence in the literature, involuntary withdrawal is the principle ingredient of the “treatment” defined by and proposed by this Bill.**

## Values and ethics

<sup>7</sup> *Compulsory Treatment in Australia, ADCA Research Report 14, Turning Point 2007*

<sup>8</sup> McKay J.R. (2009) Continuing care research: what we have learned and where we are going. *Journal of Substance Abuse Treatment*: 2009, 36, p. 131–145.

<sup>9</sup> Private Communication, Profession John Currie, Senior Medical Officer, Sr Vincent’s Drug and Alcohol Service to Damon Brogan, Harm Reduction Victoria 2009.

<sup>10</sup> World Health Organization, United Nations Office on Drugs and Crime, Joint United Nations Programme (2004) Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention : Position Paper

Despite the supposed sovereignty of evidence-based practice, our understanding of substance use and dependence is not informed by science alone, and in many areas the available evidence from science remains inconclusive. Attitudes towards substance use and dependence are coloured by individual values, belief systems and moral concerns, which can vary considerably from one client to the next and from one practitioner to the next. For instance, some biomedical, religious<sup>11</sup> and lay ethicists hold substance dependence *per se* to be a moral evil, believing that it fatally detracts from an individual's sovereignty and dignity<sup>12</sup>. In this belief system, withdrawal is the only viable method of treatment and abstinence the only ethically acceptable treatment outcome. Although this is no longer the most commonly-held view, it still exists in some quarters and many adherents to the *disease model of addiction* view dependence and abstinence in the light of these moral valuations.

In the area of opioid dependence, the intervention with the most comprehensive body of supporting evidence with regards to efficacy is opioid replacement therapy (ORT), often referred to as “pharmacotherapy”. However, replacement therapy is an anathema to those above who hold that dependence *per se* is wrong because it side-steps the issue of abstinence and simply trades one form of drug dependence for another. On the other hand, there are some who accept ORT as an interim or short term measure, although they still regard abstinence as the only acceptable long-term treatment goal. The more widespread, harm reductionist viewpoint accepts ORT, with all its shortcomings, as the most appropriate treatment for long-term, problematic opioid dependence because of its demonstrated efficacy in terms of improved social functioning, improved physical health, reduced criminal activity reduced risk of overdose and reduced risk of blood-borne virus transmission, etc. The major shortcoming of replacement therapy, arguably, is that it is available for so few drug dependencies. Current research notwithstanding, no reliable replacement therapy currently exists for the treatment of methamphetamine, cocaine, alcohol or cannabis dependence. However, this does *not* mean that detoxification is the only available or appropriate treatment for these substances.

### **Immediate and pressing need**

The current expression of this Bill is dangerously vague in its definitions. While referring to “*risk of death or serious injury to health*” as well as “*inability to make a decision around treatment*” (for dependence), the definitions in the Bill do not require these threats to life and health to be immediate, nor does it define or quantify the meaning of “*serious ill-health*”. Without more clarity of definition, this term is open to arbitrary interpretation and may well constitute a general danger to the liberty of citizens. Most substances, from coffee and alcohol to prescribed medications and illicit drugs, involve *some* long-term risks to health that might be described as “serious”. Again, any person who injects drugs is at increased risk of exposure to a blood-borne virus such as hepatitis C or HIV/AIDS, which are “serious illnesses”. Anyone who smokes tobacco may be in danger of lung cancer or emphysema; caffeine is associated with cardio-vascular disease and, via peptic ulcers, stomach cancer, etc. However, few (if any) of these foreseeable health risks can, without qualification, be considered immediate, or of such significance to warrant civil detention and treatment without consent.

---

<sup>11</sup> “It is questionable whether the word ‘treatment’ can fairly be applied to a maintenance-based program where addiction is maintained for other trade-offs in lifestyle for the user or society at large. Treatment implies therapeutic intent to remedy the condition itself for the direct benefit of the patient. A maintenance program, whether methadone or heroin, does not address the primary symptoms, concentrating instead on secondary or even tertiary symptoms (see 3.1 above), which might be permissible if the patient was objectively shown to be ‘incurable’”. Rev Dr J.I Fleming, Dr G Pike, Southern Cross Bioethics Institute (Adelaide) Submission to SA Select Committee on a Heroin Rehabilitation Trial 1999.

<sup>12</sup> Ann Bressington, *Ethical and Moral Issues to be Considered Regarding the Supply of Prescription Heroin to Opiate Dependent Persons*. Drugaid of South Australia Ltd., 1998, unpublished report, 2.

Hepatitis C, which is extremely prevalent amongst injecting drug users, can have serious, life-threatening consequences in the long term. However, the majority of people with hepatitis C will die from causes other than from hepatitis C.<sup>13</sup> Similarly, heroin dependent people are up to 20 times more likely to die prematurely due to the risk of overdose, which remains a theoretical risk in the long term.<sup>14</sup> Short-term detoxification (withdrawal) is unlikely to change these sorts of long-term risks, as detoxification is relatively ineffective in bringing about long-term changes to alcohol and other drug using behaviours. *“Relapse following detoxification alone is extremely common, and therefore detoxification rarely constitutes an adequate treatment of substance dependence on its own. Simple detoxification or stopping opioid use is often insufficient: a therapeutic process is required”* (2004: 8).<sup>15</sup> Ironically, the risk of heroin overdose increases dramatically following periods of abstinence, such as imprisonment or detoxification, due to reduced tolerance. Here, the treatment modality described in the Bill would actually increase the immediate risk of overdose death.<sup>16</sup>

Again, Harm Reduction Victoria cannot conceive of instances where a person's dependence might place them at immediate risk of death or high-order harm. While there may be long-term risks of harm of varying magnitude, these are not able to be addressed by short-term medical interventions of any kind. As this Bill (fortunately) does NOT propose long-term treatment orders, these longer-term risks should not reasonably apply in the consideration of treatment orders under the Bill. Should any evidence of such real and pressing need be shown to exist by the Bill's proponents, it would then become necessary to change the wording and definitions in the Bill in such a way as to limit the application of compulsory treatment orders to only those sets of specific circumstances and to no others.

It is not sufficient for the proponents of this Bill to reassure the public that the intent is for the Act to apply to only a small number of persons per year. At this stage, it is impossible to anticipate how many people may be affected by the current Bill. Without more careful definition, it will be the personal perspective and interests of third parties, with their particular values and variable understandings of the affected individuals' situations, which may determine if and when civil detention and compulsory treatment is imposed.

### **Adverse risks from compulsory detention and treatment**

No medical treatment is without risks. In depriving any individual of the right to consent to their own treatment, the potential adverse consequences should always be considered and risk-managed.

- Compulsory, unwanted treatment will reduce the availability of treatment for voluntary patients in the community. Data on unmet demand for alcohol and other drug treatment services is difficult to interpret and collate, as agencies across Victoria offer different services and calculate unmet demand in different ways. In addition, unmet need is reported haphazardly at best through systems such as the Health Department's NSBIS and many agencies do not even record “wait lists” as such. There is abundant anecdotal evidence, however, that most treatment agencies are unable to meet current demand and that waiting lists for services (e.g. residential rehabilitation) may be up to several weeks or even months. An undersupply of withdrawal and in particular longer term rehabilitation services for people with alcohol and other drug dependence is regularly reported to Harm Reduction Victoria by service providers and industry informants. In many parts of

<sup>13</sup> Thomas DL. Et al (2000) The Natural history of hepatitis C. JAMA. 2000 Jul 26;284(4):450-6

<sup>14</sup> WHO, UNODC, UN Programme (2004) Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention : Position Paper 2004: 5

<sup>15</sup> IBID 2004

<sup>16</sup> Graham A (2001) *Coroner's Court Report on 'Unnatural deaths . . . Jan 1990 & Dec 1999'*

Victoria, there are no AOD treatment options available; in others only limited choices are available which may be inappropriate to the needs and circumstances of many individuals. HRV maintains that the very existence of involuntary treatment will further limit access for voluntary treatment.

- Involuntary treatment orders will increase the risk of drug overdose. A seven to 14 day period is more than sufficient to reduce an opiate user's tolerance so that the use of opiate drugs on discharge may prove fatal.<sup>17</sup>
- An unwelcome, imposed treatment regime under civil detention is, we submit, less likely than voluntary treatment to be effective and is much more likely to result in the individual being less favourably disposed towards treatment in the future. Research indicates that the 'therapeutic relationship' between client and practitioner is a key factor in successful treatment outcomes.<sup>18 19</sup> Mandatory treatment orders may thus reduce access to more appropriate, timely and successful treatment in the future.
- Parents, spouses and significant others who apply for treatment orders risk alienating the subject of the order, perhaps permanently. As family breakdown, social dislocation and anomie are described as being both poor-health outcomes in their own right and as predictors and magnifiers of future drug-related harms, involuntary treatment orders may result in increased harm for all concerned.

Harm Reduction Victoria submits, therefore, that not only must proponents of this Bill establish empirical evidence that there is a substantial need for legislation limiting human rights as well as evidence that the "treatment" proposed is likely to be efficacious under conditions of civil detention and non-consent, but also that the benefits of involuntary "treatment" outweigh the potential negative consequences. We suggest that the Turning Point Report on Compulsory Treatment, which provides an overview of contemporary research and practice, establishes that no such evaluations have occurred.

### **This is not criminal detention or court-referred treatment orders**

Some research points to benefits, in terms of the reduction of AOD related harms that have accrued to individuals who were able to access treatment or who were forced to detoxify when in corrective custody. Similar evidence of benefit is reported with respect to individuals referred by Police or by Drug Courts to assessment, counselling and/or treatment. It is vital that consideration of this Bill is not distracted by reference to such evidence.

In the case of treatment and detoxification for people in custodial detention, their liberty has been taken away because they have been found guilty of breaking the law, not because of any assessment of their legal incapacity to consent to treatment. This cannot be compared to civil detention and the imposition of medical treatment without consent, as the human rights issues are not comparable. There is also a great weight of anecdotal and experiential evidence suggesting that for every individual who is able to reduce long-term exposure to harm as a result of involuntary abstinence enforced by a correctional custodial sentence,

---

<sup>17</sup> Wodak A. (2001) Drug treatment for opioid dependence. *Australian Prescriber* Vol. 24 No. 1 2001

<sup>18</sup> Simpson D, Rowan-Szal G.A., Joe G.W. et al.(2009) Relating counselor attributes to client engagement in England. *Journal of Substance Abuse Treatment*: 2009, 36, p. 313–320.

<sup>19</sup> Joe GW, Simpson DD, Dansereau DF, Rowan-Szal GA (2001) Relationships between counseling rapport and drug abuse treatment outcomes. *Psychiatric Services*, 2001 Sep. 52 (9):1223-9.

there are many more whose outcomes are much bleaker. The outcomes for people already in the prison system, for instance, are not reassuring in terms of reduction in problematic AOD use or improved long-term health. Besides exposure to the drug-saturated criminal milieu of the “corrections” system, the loss of dignity and empowerment following incarceration and the deprivation of liberty generally undermines autonomy and the capacity to secure better health and to make positive changes in life.

In the case of court or police referrals, these are voluntarily entered into by the individual (having pleaded guilty to criminal charges) as an alternative to a criminal charge or conviction and sometimes a custodial sentencing. Additionally, most cases of court and police referral to AOD services do not involve involuntary detoxification or loss of liberty. Usually referral to treatment involves assessment, counselling and on-going medium-term monitoring, and sometimes pharmacotherapy. These are very different to the “treatment” defined in the Bill, i.e. 14 day involuntary withdrawal. In a small number of court-referred cases, individuals may elect to attend residential rehabilitation / therapeutic community programmes. Again, these are alternatives to custodial sentencing, so any loss of liberty involves very different human rights considerations to those applying to Civil Detention. Significantly, these are generally long-term programs, not the short term detoxification prescribed as treatment in the Bill. Neither the courts nor the police refer individuals to involuntary detoxification treatment per se. These are options that the offender may consider *voluntarily* after mandated referral to an AOD assessment and treatment service.

### **Summary: Most regressive legislation**

The Alcoholics and Drug Dependent Persons Act of 1968 was a regressive piece of legislation. The conception of “drug dependence” and “treatment for dependence” imbedded in the Act was outmoded in its own time, as was the acceptance of homosexuality as a psychiatric disorder and / or a criminal condition. This current Bill may have addressed many of the procedural problems with ADDA Act before the social and legislative reforms of the 1970’s and 1980’s, but it is based upon these same outmoded and value laden conceptions, i.e. that dependence by definition undermines the autonomy of individuals and their capacity to consent to treatment, that abstinence is the only acceptable outcome and that detoxification is necessary and efficacious in all situations. In contrast to the more sophisticated and comprehensive understanding of the social, biomedical and behavioural dynamics of substance dependence as a spectrum disorder and the debate around treatment aims and philosophies that comprises the current discourse, this Bill retains the ADDA’s adherence to a monolithic *Disease Model of Addiction*, with its same recourse to the one treatment regimen, i.e. compulsory withdrawal (detoxification).

Following the enactment of the Victorian Charter of Human and Civil Rights, it is surprising and disconcerting to encounter a legislative instrument that challenges our understanding of rights to this extent. This is not 1968! The denial of personal liberty and the imposition of medical treatment without full and informed consent represent the abrogation of the most non-violable of the rights enumerated in the Charter. While rights are not absolute, they should only be limited with great care and in the face of overwhelming need. The minimum condition that should permit medical treatment without consent is, we believe, the inability through incapacity to make full and informed consent. This Bill does not attain that standard of care, requiring merely “Inability to make a decision about treatment (for dependence).

This triggering mechanism is a corruption of the criterion listed in the DSM IV diagnostic manual which states “*being unable or unwilling to make a decision about their treatment*”. Even this, on its own, should be insufficient to form a diagnosis of substance dependence; it is imperative that a number of other conditions and symptoms must also be present. Reliance on this (abridged) DSM IV diagnostic criterion in the Bill lends itself to circular logic, i.e. “*the person must by definition be incapable of making [the right] decision about*

*treatment because they are drug-dependent. And because they cannot make [the right] decision], they must be ipso facto substance dependent.” In other words, “We know they are drug-dependent, because they won’t make the right decision”.*

This gate could theoretically be opened to practically anyone perceived to be substance dependent. Any legislative instrument embodying a definition of dependence as a condition warranting civil detention and the imposition of a medical treatment against the patient’s wishes must constitute a grave general threat to human rights and to the particular rights to liberty, privacy and freedom from torture enshrined in the Charter and the principles of active citizenship, autonomy and equality outlined in the *Disabilities Act 2006*. The only just reasons for imposing medical treatment must be (as well as critical and immediate need) the incapacity, through impairment, of the ability to give free and informed consent. There is simply no evidence that dependence on a substance (rather than mental illness or cognitive disability) reduces a person’s capacity in any way to form consent.

### **Involuntary withdrawal is a cruel and unusual punishment**

Harm Reduction Victoria considers any involuntary imposition of withdrawal upon a severely substance dependent person to constitute a cruel and unusual punishment. The provisions in the Bill for medical treatment alleviating the symptoms of withdrawal do not assuage our concerns. The capacity or willingness of practitioners administering drug withdrawal regimes to adequately alleviate the suffering of withdrawal sickness is highly questionable in the lived experiences of many people who have undergone “medicated” detoxification. It is concerning that persons detained in police custody and on remand are subjected to involuntary withdrawal in this manner. That this should be imposed upon a person who has *not* been charged or convicted of an offence or subject to a criminal justice order we find abhorrent. To describe any such imposed treatment as “less restrictive” than the range of other treatments available in the community is, we respectfully submit, antediluvian.

### **No adequate consultation or review process**

While there was a publicly announced review of the ADDA leading up to the drafting of this replacement legislation, there has been no comprehensive process of facilitated review, as occurred with the review of Mental Health Act of Victoria in 2008 and 2009. Since the primary human rights considerations are the same (although the medical conditions are worlds apart), namely involuntary civil detention and medical treatment without consent, we contend that this legislation is premature. A certificate of compliance with the Charter of Human Rights should not be granted without an undertaking to conduct a rigorous review of the opinions and perspectives of those community members most likely to be affected by this Act. No such effort has been made to research and thoroughly evaluate the considerations of all the various stakeholders, and in particular consumers of AOD services and dependent users of alcohol and other drugs.

### **Where is the immediate risk that is amenable to 14 day treatment orders?**

Even if the threshold issue of incapacity through impairment to consent to medical treatment were to be adequately addressed by rewording sections of this Bill, the remaining absence of a demonstrated purpose sufficient to breach high order human rights has not been established. The definitions in Section (5) of the Bill describe treatment orders which are appropriate in cases where there is a need to prevent death and serious injury to health. This is so broad as to be highly problematic. In order that this “gateway” adequately limits the application of detention and involuntary medical treatment to situations of overriding need, the Bill, should it proceed, needs at the least to be re-worded so that only immediate

risk of death and immediate risk of ill health of the most severe kind are sufficient to warrant the consideration of a treatment order.

Were that done, HRV is of the opinion that the Bill would become redundant. There are, so far as we can determine, no conceivable circumstances whereby a person's dependence (not their psychosis, brain injury, or even temporary intoxication) either renders them unable to form free and informed consent to medical treatment or places them at immediate risk of either death or extreme ill-health. Where risks to life and health might exist, they are generally long-term risks and are not amenable to any short-term interventions possible within the 14 day treatment orders proposed in this Bill. Put simply, the overriding community need for legislation limiting these human rights has not been established and cannot be established.

In our opinion, therefore, this Bill could only result in the grant of treatment orders where the triggering mechanisms are misapplied and interpreted too liberally to be consistent with respect for the wishes, values and autonomy of the individual or with the rights to *freedom of the person* and *freedom from torture and cruel and unusual punishment* that are protected by the Charter. The granting of any treatment order following the enactment of this legislation would only be possible, we contend, where the presiding magistrate has an unsophisticated and antiquated comprehension of substance dependence and of what comprises appropriate treatment and/or where the magistrate is persuaded by the passions, interests and values of third parties, rather than those of the person subjected to the order. Such miscarriages are, we submit, conceivable and perhaps foreseeable, particularly where the subjected individuals are socially marginalised or traumatised by the process and where they are not supported by strong advocates who understand their circumstances. We contend that it is in the interests of justice and a humane society that this Bill is withdrawn.

### **Community needs should take priority.**

The real need in Victoria is for legislation guaranteeing the rights of individuals to access appropriate treatment services and appropriate treatment options. Currently, a person's treatment options depend almost entirely on the geographic accident of where one lives or presents. Where services do exist, they are under-resourced to the point that waiting lists of more than a month are common; in many areas, services simply do not exist. In many parts of Victoria, people who are dependent upon opioid drugs are unable to access ORT (one of the most rigorously evidenced treatment modalities in any branch of medicine) simply because local GPs, pharmacies, hospitals and health centres choose not to provide the service. In Wangaratta, for instance, none of the five local pharmacies is prepared to dispense buprenorphine or methadone (although these drugs are provided free by the Commonwealth) and people have to travel to Benalla for a dispensing service. There are only two train services per day covering the 60 km between the two towns, which means that those without their own vehicles must devote 80% of the business hours in each day in order to remain in treatment. This is rehabilitation in Victoria in 2010!?

While this Bill proposes to impose alcohol and drug dependence treatment [sic] upon individuals who don't want it and don't need it, every day tragedies continue to occur because people cannot voluntarily access the treatment services they require. As well as having potentially negative consequences for those detained and subjected to involuntary withdrawal, compulsory orders under this Bill will take vital resources away from people voluntarily seeking help. We suggest that this constitutes an ineffective and unethical allocation of resources. There is no need to trample on human rights; there is, however, an urgent and overriding community need for better resourced, better located and more easily accessed drug treatment services and options for substance dependent people in Victoria.

HRV Inc concurs with and endorses the submissions to SARC from Fitzroy Legal Service, the Human Rights Law Clearing House and the Confederation of Community Legal Centres (Vic) and the Letter to SARC from the Public Interest Law Clearing House (PILCH)

**D Brogan & J Kelsall**  
**Harm Reduction Victoria Inc.**