Families and Friends for Drug Law Reform (ACT) Inc.

committed to preventing tragedy that arises from illicit drug use

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INQUIRY INTO THE PROVISIONS OF THE DISABILITY DISCRIMINATION AMENDMENT BILL 2003

BY THE

SENATE LEGAL AND CONSTITUTIONAL LEGISLATION COMMITTEE

SUBMISSION OF

FAMILIES AND FRIENDS FOR DRUG LAW REFORM

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I. INTRODUCTION

1. Families and Friends for Drug Law Reform opposes the enactment of the Disability Discrimination Amendment Bill 2003[1] that would amend the Disability Discrimination Act 1992 to permit discrimination against those addicted to illicit drugs unless they are in treatment. The substantive justifications that the Government has put forward are unconvincing, namely, the danger posed to others by addiction to illicit substances and that the Bill would stimulate those dependent on illicit substances to enter treatment. Provisions in the parent act already serve to protect the reasonable concerns of employers and others and the provision that links non-discrimination to treatment is likely to have little or no therapeutic benefit, probably the reverse. The Government has provided no competent assessment that the Bill will have beneficial effects.

2. In addition to these main defects there are a number of uncertainties of key concepts in the Bill such as whether someone who is addicted is in treatment, whether maintenance treatments are acceptable treatment and whether someone remains addicted. In spite of its proclaimed aim to the contrary, in practice the Bill will almost certainly intensify the discrimination against people with HIV or hepatitis C.

3. We sketch some of the appalling discrimination that illicit drug users already suffer. They are subject to pervasive discrimination compared to others who are ill and even to those addicted to other substances. The present discrimination includes being subject to criminal sanctions that no other addicted person is and having access to medical interventions limited on political grounds rather than health ones. The Bill if enacted will intensify the discrimination.

4. Finally, the submission identifies a number of key assumptions that appear to underlie the Bill, namely that it is permissible for government rather than those who are competent in the caring professions to determine the acceptability of treatments

1. http://www.aph.gov.au/Senate/committee/legcon_ctte/disability/.

for addiction; that freeing someone from addiction is the objective that should override all other objectives in the treatment of someone who is addicted; that people should be penalised if they do not taking responsibility for their addiction; and that people with addiction may be dealt with by government in ways that are inconsistent with civilised standards of rationality. Families and Friends for Drug Law Reform takes issue with these assumptions. In particular the submission argues that illicit drug users are deprived of the right that we should all enjoy to be dealt with rationally.

5. Families and Friends for Drug Law Reform is grateful to the Committee for the opportunity to make this submission. There are aspects that it would like to amplify and therefore requests the opportunity to provide oral evidence to the Committee.

II. JUSTIFICATION FOR DISCRIMINATION THAT THE BILL WOULD ALLOW

6. The Bill allows discrimination against people who are addicted to illicit substances. In doing this it singles out addiction to illicit substances from addiction to all other substances and in indeed from all other addictions. Addiction or dependence is a health disorder. The generally recognised criteria that are used for dependence on illicit drugs are the same criteria as are used for all psychoactive substances: the *International Classification of Diseases* (ICD) of the World Health Organization and the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association. These criteria are set out in the Attachment. The similarity in the criteria stands as recognition by the most eminent authorities that the effects of dependence on illicit substances are similar to dependence on other psychoactive substances such as alcohol and tobacco. What is there to justify the Australian Government proposing and this Parliament adopting such a huge difference in approach as contained in the Bill between people with the same medical disorder?

7. The Government seems to be putting forward four grounds to justify its discriminatory proposal:

(A) Concerns of employers and business operators;

(B) The fact that New South Wales has passed similar legislation;

(C) Danger posed to others by addiction to illicit substances; and

(D) It would stimulate those dependent on illicit substances to enter treatment.

Each of these reasons is examined.

A. Concerns of employers and business operators

8. In his second reading speech, the Attorney-General stated that there were "concerns of employers and business operators about" the law as it stands, namely "that it may be unlawful under the Disability Discrimination Act to discriminate against a person solely on the ground that the person has an addiction to or dependence on a prohibited drug." The Bill is justified, so the argument goes,

because a section of the community, namely employers and business operators, disagrees with the law and wants to be able to discriminate against those addicted to an illicit drug. This is a raw political justification for the amendment that contains no rational justification for the discrimination sought nor reasoned argument that the proposal is consistent with an accepted moral standard.

B. New South Wales Government passed similar amendments

9. In a similar way the Attorney-General also points to the consistency of the Government's proposal with legislation already passed in New South Wales. "New South Wales government," he stated, "has already passed amendments to state anti-discrimination laws, providing that it is not unlawful to discriminate against drug addicts in the workplace." That another jurisdiction has legislated to permit discrimination is another raw political justification for the Bill. Pointing to a wrong somewhere else does not justify doing wrong oneself.

C. Danger to others posed by addiction

10. The Attorney-General asserts as a justification for the Bill that discrimination against those addicted to illicit drugs may be necessary to protect the rest of the community from the danger that they pose. The second reading speech describes these highly significant assertions in only the following sketchy terms:

> "The government believes that people operating a business or a club should not have to face discrimination claims by drug addicts when trying to keep the work or social environment safe from other people's behaviour. The general community also has a reasonable expectation that it can be lawfully protected from the harms and risks posed by another person's illicit drug addiction."

11. There are two principal objections to this justification of discrimination. In the first place someone who is addicted to an illicit drug is not necessarily a danger to the work or social environment and, secondly, the Act as it stands already protects the interests of employers and the community in the case of conduct of anyone who threatens the safety of others.

1. Addiction to illicit drugs does not necessarily endanger the safety of others

12. Safety of others goes to the heart of the case for allowing discrimination yet the Government offers no more than the bare assertion that there is a necessary connection between addiction to illicit drugs and danger to the rest of the community. Implicit in this assertion is a further one that addiction to illicit drugs poses a substantially greater danger to society than addiction to other substances. Rational policy formulation demands credible evidence of these factual assumptions yet none is provided.

13. In fact there is much evidence that people addicted to illicit drugs can be effective members of society capable of shouldering onerous responsibilities in work, family and otherwise. The illicit status of illicit drugs is a strong disincentive to well-functioning members of society speaking out about their own addiction but in the past there are many distinguished names who have been addicted to drugs that are

now illicit. For example, Sir Arthur Conan Doyle was dependent on cocaine. A significant but small minority of the caring professions are known to have maintained a demanding professional life in spite of having become addicted to opiates or other drugs to which their work had given them access. An addicted user of, say heroin, with sufficient means to have reliable access to the pure drug is unlikely to show any level of social dysfunction on account of his or her addiction. This is borne out by experience in the United Kingdom where it has always been possible to supply heroin on a maintenance basis to those with an opiate dependency. As of about two years ago there were some 200 who were receiving maintenance supplies of heroin there.

14. The Australian Government has, of course, ruled out the conduct of a trial to determine whether that medical intervention should be permitted again in Australia. (It ceased in the years after the Federal Government's prohibition of the importation of heroin in 1953.) Nevertheless the careful assessment in the last ten years of trials of heroin prescription in Switzerland and The Netherlands provide clear and strong evidence that responsible social functionality is possible for opiate dependents who continue to receive a maintenance dose of heroin.

15. This solid evidence is consistent with the experience of members of Families and Friends for Drug Law Reform. While the social functionality of many drug dependent family members is significantly impaired the group is aware of examples of family members who have held down a job to the full satisfaction of their employer, who are successfully engaged in demanding studies or who are examples of good parents who compare more than favourably with other parents who are not drug dependent.

2. The Act already protects the rights of others in the case of behaviour that endangers others

16. The effects of many drugs (illicit or otherwise) and the dysfunctional life-style of many people who are dependent on illicit drugs may render those people unsuitable for particular forms of work or be grounds for other discrimination against them. This possibility is recognised in at least the following way by the Act as it stands and without the need for the proposed amendment:

> (a) Conduct like intoxication on the job can be a ground for terminating employment whether or not the person suffers from the disorder of addiction to the substance. This is clear under the act as it stands because the "condition" of intoxication is not embraced by the definition of "disability". That term includes only "a disorder, illness or disease that affects a person's thought processes, perception of reality, emotions or judgement or that results in disturbed behaviour" (s. 4(1)).
>
> (b) It is permissible to discriminate against a person with a disability such as an addiction in relation to a particular employment "if the person because of his or her disability would be unable to carry out the inherent requirements of the particular employment" or if the person "would, in order to carry out those requirements, require services or facilities that are not required by persons without the disability and the provision of which would impose an

unjustifiable hardship on the employer" (s. 15(4)). The Act includes similar exceptions permitting discrimination against those with a disability becoming commission agents, contract workers, partnerships, qualifying to practice a particular profession, trade or occupation and people with a disability seeking the service of an employment agency (ss. 16(3), 17(2) 18(4), 19(2) and 21(1)).

(c) The Act as it stands recognises the right to discriminate indirectly against people with a disability where it is reasonable to do so. This is of relevance to people addicted to an illicit drug who are convicted of a criminal offence. A very high percentage of those in prisons have a problem with substance abuse (and often a related mental disorder). In the words of the act it is possible that "a substantially high proportion" of those addicted to an illicit drugs would have a criminal record compared to those who are not so addicted. To discriminate against an illicit drug user because of his or her criminal record would not be an impermissible indirect discrimination if the person discriminating shows it was "reasonable having regard to the circumstances of the case" (s. 6).

D. Enforcement of treatment of certain addictions

17. The Bill permits discrimination against people addicted to an illicit drug but not against those "undergoing a program, or receiving services, to treat the addiction to the drug". The Governments seems to see permitting discrimination against those who are addicted as providing a desirable incentive for such people to seek out treatment. According to the Attorney-General's second reading speech, "The government recognises that it is important to ensure that people with drug problems seek and maintain treatment."

18. There are big assumptions about human behaviour behind this notion. They include that:

(a) addiction to illicit drugs is psychologically and medically different from addiction to other substances;

(b) people who are addicted to illicit drugs can be cured;

(c) permitting discrimination will be an effective spur to illicit drug users to enter treatment; and

(d) the pressure on those addicted will be of benefit to the addicted people, their family and the rest of the community.

If assumptions such as these are incorrect the Bill could have very harmful consequences. Good intentions or even "common sense" does not make up for the lack of a reasoned argument supported by the best expert evidence.

19. Addiction – any addiction - is a chronic relapsing disorder. It is said that on average someone addicted to heroin will make 13 failed attempts to stop taking the drug before they succeed. It is also a disorder with its own severe penalties such as those mentioned in the criteria for substance dependence that are set out in the

attachment. The extent that legislated penalties such as the Bill proposes will materially assist the user in the long and onerous task of overcoming their habit is uncertain to say the least. Like anyone else, users have lots of things going on in their life. Getting treatment for addiction may be just one of several important things on their agenda. For the moment other things may well have greater urgency – other things such as poverty or depression that are among the recognised risk factors for substance abuse.

20. Discrimination that the Bill would permit could deprive a dependent user of financial or other support essential to maintain their social and economic functionality while they grapple with their addiction. Alienation from society at large already means that many drug find friendship and a support network only among other drug users. A drug user trying to get the better of a habit also has to struggle with the loss of that friendship and support. This double loss is one of the strongest causes of relapse. What the Bill will allow is action that may sever crucial non-drug links for a dependent user. That can be counted on driving them further into the arms of a drug using and criminal peer group thus turning a difficult situation into a disaster.

21. Supporters of the Bill will no doubt object that all these "mights" could turn out to be unfounded and that for many dependent users the treatment that the amended legislation spurs them into could be just what it needed to put everything right. This may be so for some but where is the evidence that the measure will do more good than the harms mentioned above.

22. What the Bill will do is to put actions that may well have disastrous consequences into the power of third parties such as employers and club managers who have next to no interest in the welfare of the addicted person and a stereotypical view of what addiction to illicit drugs entails.

23. In practical terms the uncertainty that the explanatory memorandum acknowledges about whether a person is "undergoing a program, or receiving services, to treat the addiction to the drug" is an incentive to shoot now and ask questions later. The chronic nature of addiction and the common pattern of dependent users moving in and out of one treatment or another creates uncertainty that a discriminator is in a far stronger position to take advantage of than the user. The Bill if enacted would send a message that it is OK to discriminate against those addicted to illicit drugs. It will reinforce the junkie stereotype. It will encourage discriminatory action against dependent drug users who for the most part are unlikely to have the resources or energy to pursue a complaint.

24. For all these reasons, defence of the proposal on the ground that it has therapeutic merit is a masquerade.

III. DIFFICULT DISTINCTIONS MADE BY THE BILL

25. Apart from the absence of a justification for the Bill that satisfies recognised rational standards of argument and evidence, the Bill makes a number of distinctions that pose difficulties for its administration or which reflect policy inconsistencies. These difficulties include:

(A) Discrimination is allowed on the ground of addiction to illicit drugs but not their use;

(B) Whether someone who is addicted is in treatment;

(C) Whether maintenance treatments are treatment;

(D) Whether someone remains addicted; and

(E) Circumvention of non-discrimination on ground of HIV or Hepatitis C status.

A. Discrimination allowed on ground of addiction to illicit drugs but not their use

26. The Bill focuses on the medical disorder of addiction to illicit drugs, not their use. This is explicable on the narrow scope of the legislation involved. It concerns discrimination for a disability. Addiction falls within the definition of a disability whereas drug use itself does not. We have already pointed out that the act as it stands helps protect the community from dangers that may be posed by illicit drug use in that the definition of disability in s. 4(1) does not include the condition of intoxication of anyone addicted or not.

27. Apart from a situation like this, Families and Friends for Drug Law Reform understands there are general legal constraints such as privacy and relevance under administrative law that can afford some legal protection against discrimination of a person who happens to use an illicit drug. This being the case, it is anomalous that the bill opens the door to discrimination against people who are addicted to particular substances but not affect protections that may exist for non-addicted people who use those same substances.

28. While minor compared to the anomaly of treating those addicted to illicit drugs differently from those with the same condition addicted to other substances, it adds to the evidence that the Bill is an ill thought out exercise in social policy.

B. Whether someone who is addicted is in treatment

29. Treatment is a key concept because under the Bill discrimination would still not be permitted against someone addicted to an illicit drug if they are undergoing treatment. The explanatory memorandum and the Attorney-General's second reading speech emphasise that a broad definition is used: "Paragraph (2)(b) describes drug recovery treatment in fairly broad terms, as it is recognised that legitimate treatment of drug addiction encompasses a wide range of programs and services, some of which may not involve medical treatment. . . . [P]rotection extends to people who are 'undergoing a program or receiving services to treat addiction to the drug'. The phrase 'receiving services' is broad enough to cover regular visits to a counsellor, priest or doctor to support their efforts to address the addiction. The protection would not extend to sham treatments – but ultimately the Human Rights and Equal Opportunity Commission investigating a complaint would have to be satisfied that the treatment is bona fide – as is appropriate."

30. While the definition of treatment may be broad it is also uncertain. There will be circumstances in which the addicted illicit drug user will not know with any

certainty whether he or she is in treatment. The point has already been made that the uncertainty is likely to work in favour of those minded to discriminate against drug users who will be able to discriminate first and talk later. The addicted drug user who has lost a job or has been otherwise further marginalised is likely to be in a very weak position to challenge the discriminatory action. Circumstances like these casts doubt upon the optimistic assertion in the explanatory memorandum that the "wide scope" of what is meant by treatment provides "the maximum benefit for people addicted to a prohibited drug."

C. Whether maintenance treatments are recognised as valid treatment?

31. Perhaps the most significant uncertainty about what is meant by treatment is whether under the Bill maintenance prescription of a drug on an indefinite basis is a legitimate treatment. The Bill refers to a program or services "to treat the addiction to the drug." On its face this may seem wide enough to cover maintenance therapies but doubt is cast on that interpretation by the explanatory memorandum. That states that "it is expected that the treatment would be in the form of a program or services that require a high degree of commitment to addiction recovery on the part of the person undergoing that treatment." This may not be wide enough to cover indefinite maintenance on a drug such as methadone, an artificial opiate that is medically prescribed. Such treatment both stabilises the social dysfunction of many who are heroin dependent and, allows those who find that they cannot overcome their addiction completely, to lead fully functional lives.

32. The political acceptability of indefinite maintenance doses is very much at issue. In spite of many careful trials and years of clinical usage that show the efficacy of the medical prescription of methadone at maintenance levels on an indefinite basis, the Government majority in the report of the House of Representatives Family and Community Affairs Committee supported methadone only on the basis that "the ultimate objective [should] be to assist [opiate dependents] to become abstinent from all opioids, including methadone" (rec. 52). The majority concluded that "the need to help people on [methadone maintenance treatment] to move beyond it and on to abstinence is one of the most important issues to be addressed in relation to heroin addiction". In doing this the majority rejected the medical evidence put before it that sees methadone maintenance as the gold standard for opiate treatment.

33. The committees' recommendations are before the Government at the moment. It is distinctly possible that the Government will endorse the Committee's proposal regarding methadone maintenance. Such a decision would be consistent with reference in the explanatory memorandum of the present Bill to the need for a "high degree of commitment to addiction recovery on the part of the person undergoing that treatment". It is distinctly possible that in the near future with the present Bill enacted the Government will be able to argue that indefinite drug maintenance therapies like methadone maintenance do not constitute treatment that that shields someone addicted to an illicit drug from discrimination under the Disability Discrimination Act.

D. Whether someone remains addicted

34. Another grave uncertainty in the Bill is the determination of whether a person remains addicted. Addiction is a chronic disorder characterised by relapses. The success of even those treatments and other "services" designed to help drug users "overcome" their addiction is measured in terms of months being "drug free". Rarely are follow up surveys carried out more than 18 months to two years after the commencement of treatment. The term "recovering addict" often used in Alcoholics Anonymous and Narcotics Anonymous circles captures these chronic and relapsing characteristics. "Recovery" in an absolute sense is an ideal at the end of a long and rough road.

35. In contrast the Bill assumes a clear line can be drawn between whether anyone is addicted or not to an illicit drug: it permits discrimination to a "person [who] is addicted to the drug at the time of the discrimination" (s. 54A(1)(b)). Being abstinent at any particular time is not the same as no longer being addicted. This is another area where the legislation could be used to justify discrimination without any evidence of gain to the community, against dependent illicit drug users to their clear disadvantage.

36. The Bill also attempts to draw an unreal distinction between addiction to illicit drugs and addiction to other substances. Poly-drug use is common. Many drug dependent people will use a range of drugs many of which will be regular pharmaceuticals or legal recreational drugs like alcohol and nicotine. Those using stimulants will often alternate between consumption of a stimulant (an upper) and a depressant (a downer) only some of which may be illicit. Is the person addicted to an illicit drug? There is the question, too, of whether someone on a drug replacement therapy such as methadone or buprenorphine remains addicted to an illicit drug or has become addicted to those legally obtained drugs. Uncertainty about that issue would not pose difficulties if indefinite maintenance on alternative pharmacotherapies is regarded as legitimate treatment under the Bill but, as already discussed, that may not be the case. Such circumstances underscore the bankruptcy of the Bill from a therapeutic point of view.

E. Circumvention of non-discrimination on ground of HIV, Hepatitis C status and other disabilities

37. The Government makes the point that the Bill will not change the protection against discrimination accorded to people who have other disabilities related to their illicit drug use. A note in the Bill states that it "does not affect the operation of this Part in relation to a disability that is a medical condition (such as HIV infection or hepatitis C) that may be related to drug addiction."

38. In his second reading speech, the Attorney-General noted that:

> "The government is committed to a policy under the national HIV-AIDS and hepatitis C strategies of maintaining DDA protections for people with these conditions, and the bill reflects this priority commitment.

> "Under the bill, a person who has a drug addiction can still rely on the protection of the DDA in relation to discrimination on other grounds, such as mental illness or other disabilities."

39. In linguistic terms the Attorney-General is, of course, correct but in reality the change in law will gut the protections of the Act for those many people whose disability flows from their illicit drug use.

40. Illicit intravenous drug use is one of the principal if not the principal pathway by which hepatitis C and HIV are spread. There is also a particularly strong association between the illicit stimulants – particularly methamphetamines – and mental disorders. They and the stressful lives that drug dependent people are often under can aggravate mental disorders and even induce serious psychoses akin to schizophrenia. Indeed it is likely that the deepening crisis in mental health services around the country is in a large part attributable to the flood of these substances. Their availability markedly increased in association with the heroin drought around the beginning of 2001 when, according to intelligence revealed by the Australian Federal Police there was " . . . a business decision by Asian organised crime gangs to switch from heroin production as their major source of income to the making of methamphetamine, or speed, tablets".

41. The ineffectiveness of the attempt to quarantine those with hepatitis C and HIV from the effects of the Bill is evident when one reflects that the Bill will affect human beings each with a set of strengths, needs and other circumstances, not an abstract set of individual problems. Because of one reason or another such as self medication, a high percentage of people who have a mental illness have recourse to illicit drugs. Such an association will invite anyone who wants to discriminate against them to do so on grounds of their addiction. The Bill will also stand as an open sesame for discrimination when the likely link between the disability and illicit drug use is notorious as it is with hepatitis C.

42. The net result is that far from maintaining the protection of the present Act against discrimination on the ground of hepatitis C, HIV or mental illness, the Bill will provide a thick smoke screen for discrimination against a high proportion of those people in those categories.

IV. DISCRIMINATION THAT ILLICIT DRUG USERS ARE ALREADY SUBJECT TO

43. It is important that the Committee be aware of the existing depth of discrimination against illicit drug users. It is widespread and intense. A sample of high profile statements shows this. In September last year the Port Lincoln Mayor Peter Davis is reported to have said:

> ""I don't have a problem with the free needle exchange but the drug addict who wants to exchange a needle should be given a lethal injection. You want the trip of your life, in fact the last trip of your life? Not a problem, come on in and we'll deal with you" (ABC, 30/9/03).

44. In May Magistrate Michael Frederick in sentencing a woman in Adelaide on a prostitution charge told her:

> "We dicks pay for your life. It's your choice to be a junkie and die in the gutter. No one gives a shit, but you're going to kill that woman who is your mother, damn you to death" (*Advertiser*, 1/5/03, p. 7).

45. In November 1999 Judy Sheindlin described as America's most popular television judge, is reported to have told a cheering audience in Brisbane that we should "Give 'em dirty needles and let 'em die" (*Courier Mail*, 17/11/99, p.12).

46. Hate filled comments against junkies appear on talk back shows and in letters to the editor around the country. Many of the comments are fuelled by fear and ignorance about the effects of drugs on people and how people became addicted. Whether born of malice, fear or ignorance, the prejudice that such statements indicate serve the same purpose of pushing illicit drug users to the margins. They are the lepers of our society. There can be no doubt that the Bill if enacted will fan this prejudice.

47. The tragedy that this represents is that illicit drug use is overwhelmingly a young person's problem. It is our young who are being pushed to the edge. Giving evidence to a parliamentary committee in 2001, Professor Wayne Hall commented that:

> "Population surveys indicate that lifetime cannabis use in the 14-19 year age group may be as high as 45 per cent. The use of ecstasy and amphetamine-type stimulants appears to be becoming more widespread amongst teenagers and people in their 20s. . . . Finally the age of initiation of those who experiment with drugs seems to be trending downwards."

The trend to younger initiation was confirmed by the 2002 Australian Drug Trends survey. It found that the mean age of first injection of an illicit drug was then 18.7 The mean age for the younger half (those under 25) of those surveyed was 16.3 years.

48. With high uptake of drugs in the teenage years it is evident that our drug policies are not working to keep illicit drugs from our children. Some ten per cent of those who experiment will continue to use and become addicted, many of them still in their teenage years. The path to addiction is for a proportion of the ten per cent a path to all those things that are so much feared: mental illness, social dysfunction and crime. That this should be happening to so many young is an inestimable loss to the whole community. Young lives are exposed to poverty, hardship, disease and death on a scale previously known in Australia only in war. In the public imagination a bad situation affecting a significant but still small percentage of young people is magnified into a widespread prejudice against young people generally. Young people are equated to drugs and crime.

49. A bitter irony is that the principal reason that the federal Government gives for opposing measures such as medically supervised injecting rooms and a trial of medically supervised heroin advocated by public health experts and others is that those measures would send the wrong message that would encourage drug use among young people even though such programmes may help those on them. Those addicted to illicit drugs are thus faced with being denied the benefit of interventions

for a disorder (addiction) that they picked up as a child on the ground that those interventions would encourage drug use among a new batch of children.

50. A further bitter irony is that many of the harms associated with illicit drug use appear to be aggravated if not caused by the official anti-drug policy rather than the effect of the drugs themselves. Official awareness of this developed in the past 18 years of so leading to the introduction of many measures such as the softening of the criminal law and procedure with regard to drug users. Many of these measures which fall under the banner of harm minimisation are in danger of being rolled back on the ground that they too are sending the wrong message and encouraging more drug use among the young. Even individual members of the present Government have stated that harm minimisation is no longer the Government's policy.

51. In spite of the criteria of addiction to different substances being the same whether or not the substance was an illicit drugs, addicted illicit drug users are dealt with in a radically different way to those addicted to other substances. Although this gap narrowed somewhat under harm minimisation it may widen again with many aspects of harm minimisation under attack.

52. In summary, addicted illicit drug users are subject to pervasive discrimination compared to others who are ill and even to those addicted to other substances. The present discrimination includes being subject to criminal sanctions that no other addicted person is and having access to a medical interventions limited on political grounds rather than health ones. The Bill if enacted will intensify the discrimination.

V. ASSUMPTIONS UNDERLYING CURRENT LAW AND PUBLIC POLICY

53. Families and Friends for Drug Law Reform calls on Parliament not to enact the Bill. It does so because the Bill will not add to community safety, because interests of employers and others are already protected by the Disability Discrimination Act as it stands and because the Bill would encourage an intensification of prejudice against the most marginalised section of our community. This should be enough, but Families and Friends for Drug Law Reform believes that in the interests of good public policy, for which Senators share responsibility, that the assumptions behind the Bill, already referred to in passing in this submission, should be laid out carefully for examination. These assumptions appear to be that:

(A) it is permissible for government rather than those who are competent in the caring professions to determine the acceptability of treatments for addiction;

(B) freeing someone from addiction is the objective that should override all other objectives in the treatment of someone who is addicted;

(C) people should be penalised if they do not taking responsibility for their addiction; and

(D) people with addiction may be dealt with by government in ways that are inconsistent with civilised standards of rationality.

A. Determination of treatments for addiction by government rather than those who are competent in the healing professions

54. A premise of the Bill already discussed is that those addicted to illicit drugs should be dealt with differently to those addicted to other substances and that they may be subject to discrimination in order to pressure them to submit themselves to treatment. This proposal is in the context of direct limitations that the Government already imposes on the medical interventions to treat addiction including opposition to medically supervised injection facilities and even the trial of medically prescribed heroin. There is also wording in documentation associated with the Bill that suggests endorsement of the proposal before the Government to rule out the use of indefinite maintenance therapies.

55. All these positions assume the ethical permissibility for the Government to determine the appropriateness of treatment for people who are addicted to an illicit drug. Families and Friends for Drug Law Reform rejects this view. There is no ethical justification for the Government to limit the acceptability of medical intervention judged acceptable by the competent, caring professions. Competence goes to the heart of health care. It is an essential element running through the world wide codes of medical ethics. Under the Code of Medical Ethics of the World Medical Association International:

> "A physician shall in all types of medical practice, be dedicated to providing competent medical service in full technical and moral independence, with compassion and respect for human dignity."

56. Competence does not have a static content. To be competent, as those who are involved in health care should be, involves keeping abreast of developments in knowledge affecting their field in order to retain their competence. The Government and legislatures are not professionally competent in the area of addiction. Moreover, there is no indication that they have submitted the issues raised in the Bill to open and independent assessment by those competent in the relevant field.

B. Freeing someone from addiction as the overriding objective

57. The reference in the explanatory memorandum to the need for treatment to ". . . be in the form of a program or services that require a high degree of commitment to addiction recovery on the part of the person undergoing that treatment" seems to require that for treatment to be valid it must be focused on recovery from addiction. This appears based on a moral position that freeing someone from addiction should be the overriding objective. This differs from the standard medical approach to an illness or injury which is to manage the condition where a cure is not achieved so as to maximise the quality of life of the patient. This is the approach that is followed in the case of someone who develops a chronic heart condition or diabetes or who becomes a paraplegic as a result of a car accident. It matters not that the illness or injury may have been self induced as it may have been through bad life style choices or reckless driving.

58. The moral position of some within Christian churches holds that addiction to illicit drugs should be treated differently; to them both the consumption and

addiction are wrong. Freeing a person from addiction becomes more important than keeping that person alive or improving his or her social functioning.

59. According to Major Watters, chair of the Australian National Council on Drugs:

> "I believe addiction is a sin. I know it's a medical and psychological problem, but the Bible tells us that sin is falling short of our potential. It tells us we should not be mastered by things ... it also tells us to keep the body pure as it is a temple of the Holy Spirit" (*War Cry*, 22/5/99, p. 7).

60. Mr Paul Brazier, as head of the Australian Catholics Advisory Centre, has written that:

> "Heroin injecting is intrinsically evil and providing heroin injecting rooms with all the impedimenta that goes with them is formal co-operation in the evil acts of others and can never be justified" (*Courier Mail*, 1/11/99, p. 15).

61. The Rev'd Tim Costello has related similar views:

> "A Christian woman I know and respect told me she was totally opposed to supervised injecting facilities. I said 'how do you face the fact that last year 357 people died, many of them young'. She said, 'well, if they are on drugs, they are better dead'. Then she said 'I think Jesus would prefer them dead than addicted to drugs'. Now I don't think that is the view of many others who are against supervised injecting facilities, so I am not trying to generalise from her example, but she is not alone. At *The Age's* Vision 2000 session, Tony Abbott was asked why he was opposed to supervised injecting facilities, given the number of deaths, and he repeated exactly the same view. He said that people who are on drugs are virtually dead anyway."

62. Such views would justify an official policy that discourages or even legislates against treatments like indefinite methadone maintenance that leave people addicted even where there is strong evidence that the treatment keeps people alive and allows them to regain balance in their life.

63. It has to be accepted that even these ethical views should be taken into account in the political process. It is also to be sincerely hoped that the outcome of that process produces policies that are consistent with acceptable moral principles whether of a secular or religious origin. In a democracy, to deny anyone holding to a particular moral view from advocating an ethical position is to disenfranchise citizens on the grounds of their religious or moral views or, more likely, to force those views underground with those holding to them giving other or no reason in support of a particular policy. This latter possibility may be occurring in the case of the Bill given that the reasons put forward in support of it do not hold water.

64. If moral views are to be entertained in the political process they must be open to robust questioning about how the particular position advocated actually gives effect to the moral position put forward. The coyness by others that often accompanies an appeal to morality must be set aside when what is at issue is a policy affecting the whole community. To take Major Watter's comments as an example,

why is addiction (as opposed to the drug use that led to it) wrong in Christian terms and if it is wrong what in Christian terms justifies particular measures of social policy that impose onerous terms on particular addictions but not on others? Similarly, what is the basis for Mr Brazier's statement that heroin injecting is any more evil than taking any other addictive substance and how is the establishment of heroin injecting rooms an evil act that can never be justified when it appears that they help people who are addicted to keep alive and improve their health and social functioning? Do not those in Government do wrong if, in the face of evidence of these benefits, they stands in the way of the establishment of such rooms for those already addicted to heroin?

65. In the final analysis, you as legislators are likely to find that it is impossible to reach a decision that accommodates all moral positions. Families and Friends for Drug Law Reform believes that the line should be drawn when it comes to measures that are informed by the view that people who are on illicit drugs are virtually dead anyway. It appears to us that this is the case with the present Bill.

66. Families and Friends for Drug Law Reform utterly rejects that viewpoint as wrong. Among our members are those who have lost family members – people who would be alive today if interventions barred by that viewpoint had been available. Those members know that the family member they lost was still human and valued. Addiction was a burden for them all and, yes, the user and the family would have liked nothing better than that that burden be lifted but first and foremost the family wanted the human being they loved kept alive. Young people dying in alleys and or taking their own life because, having tried and tried again, they cannot shake off their habit is an affront to a society that calls itself civilised.

67. Many also view that situation as an affront to the Christianity. The Rev'd Tim Costello commented on the statements quoted above:

> "I know what they mean, but I must admit these statements shocked me, and it pushed me to think about values and faith. I realised that I fundamentally disagreed with them."

68. In his address to the 2003 remembrance ceremony for those who lose their life to illicit drugs that our group organises, Bishop George Browning, Anglican Bishop of Canberra and Goulburn, said:

> "I come to the podium to day with my own remembering of the Church. I am somewhat humiliated and ashamed that at times and in a moralistic way the Church has stood against changes to the laws of our society that might have improved the situation for people in this dreadful situation. I deeply regret that the Church, or agencies speaking for the Church, have stood against what may have been appropriate changes to the law. I am very grateful for courageous people who have undertaken new policies and new programs that have saved the lives of some and made the lives of others more life giving."

69. At the 1999 ceremony the Rev'd Gregor Henderson, then National General Secretary of the Uniting Church in Australia stated:

> "There is much in the world's approach to illicit drugs which needs repair.

> "It is not right to treat drug users as criminals, as outcasts, as people who are beneath compassion and love.
>
> "It is not right that people die from drug dependency, in alleyways or parks, in living rooms or hospital casualty wards.
>
> "It is not right that people die from unintentional overdoses, from highly toxic mixtures of drugs, from shared needles.
>
> "It is not right that people die when new approaches and treatments are available but governments lack the courage to permit them.
>
> "It is not right that society has been unable to find better ways of caring for drug users and moving them towards rehabilitation.
>
> "It is not right that some, the real criminals, profit from the importation and sale of illicit drugs.
>
> "It is not right that people, especially young people, are exploited mercilessly by the Mr and Mrs Bigs of the drug trade.
>
> "It is not right that parents of young drug users have great difficulty in finding help for their sons and daughters who are using drugs and for themselves as they want desperately to help them.
>
> "It is not right that parents are forced to break the law by allowing their drug-using offspring to inject safely at home in preference to throwing them out on the streets.
>
> "Surely it is time for a much bigger dose of compassion in relation to illicit drugs. Not all of us here share the Christian faith, but I trust we do know that Jesus Christ was a person of immense compassion who taught and showed that no-one is beneath God's care, and that therefore no-one should be beneath our care."

70. In summary, for three reasons Families and Friends for Drug Law Reform urges the Committee to address squarely the question of ethics in its consideration of the Bill. Any legislation should reflect acceptable ethical principles. Ethics should not therefore be dismissed as irrelevant. Indeed, this aspect of the Bill is highly relevant. Where, as it would appear to be here, competing ethical principles are at issue, the Committee should ensure that they are laid on the table and analysed. They should not be swept under the carpet.

C. Taking responsibility

71. Both the Attorney-General's second reading speech and the explanatory memorandum make the telling point that because the legal protection against discrimination is not removed for those in treatment, "the amendment ensures that people who are taking responsibility for their addiction cannot be discriminated against." This comment has both an ethical and a factual aspect. Families and Friends for Drug Law Reform accepts that we should all take responsibility for our conduct but believes that this is no more than a meaningless mantra unless examined in the particular context of addiction. Seeking to take responsibility and failing in the

attempt is a characteristic of addiction. The *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association that is set out in the attachment includes as a criterion of addiction "a persistent desire or unsuccessful efforts to cut down or control substance use."

72. Nothing is more disempowering and destructive of feelings of self worth than repeated failed attempts at "recovery" in and out of treatment that characterises the struggle of many who are addicted. Yes, taking responsibility for oneself is part of the picture but only part. As legislators you have a special responsibility to ensure that the legislative and policy settings facilitate that occurring: that they empower users and their families and not marginalise them as occurs so much now. Legislative and policy settings also need to take account of the facts of people's lives: that in many cases (though far from all) there are other serious dysfunctions in the lives of those addicted whether it be mental illness, sexual or emotional abuse or a whole string of other known risk factors. Unless these factors are being addressed in a co-ordinated way with the addiction the outlook with regard to addiction is dismal. On its face the Bill will set conditions that make it even more difficult for those addicted to an illicit drugs to get their life back in order. The Government has presented to Parliament no credible evidence that shows this conclusion to be wrong.

D. Denial of right to be dealt with in accordance with rational standards

73. Article 1 of the Universal Declaration of Human Rights proclaims that:

> "All human beings . . . are endowed with reason and conscience and should act towards one another in a spirit of brotherhood."

This article captures the linked elements of ethics (in conscience) and rationality. All of us are entitled to be dealt with ethically and to expect that others in their dealings with us will treat us rationally. We all have a corresponding obligation towards others, an obligation that weighs particularly heavily on those with responsibility for measures that impact on a lot of people. Rationality is linked to what we as humans learn about the world. Knowledge obtained through scientific investigation in the broadest sense may always be limited but is the path by which human beings have gained enlightenment about our surroundings and ourselves: about cause and effect. When we venture onto the road we expect other road users to behave in accordance with rational principles towards us; that they have an elementary knowledge of the principles of physics to judge braking and some understanding of the mechanics of their vehicle to assess its roadworthiness. We rely upon the rationality of the designers, builders and operators of an aeroplane that we step into and the competence (for that is an application of the principle of rationality) of health care workers when we submitted ourselves to surgery.

74. The sad truth is that illicit drug users are not dealt with rationally. Measures may be adopted in relation to them that are informed by acceptable moral principles yet those measures actually work against the achievement of the ethical ends sought. At least the person holding to the ethical position that it is more important to save a person from addiction than to keep that person alive is being honest if he or she

advocates measures that entail a higher level of overdose deaths. Others are more blameworthy who, while holding to a moral position that places priority on life, advocate those same measures in blind faith that they will help the situation. Good intentions are not enough. When taking action affecting others we are obliged to become as informed as we are able about the effect of those actions.

75. There is a widely accepted view that our society would be a great deal better off if illicit drugs did not exist for non-medical or scientific use. Indeed that has been the first wish of many members of Families and Friends for Drug Law Reform. As an ideal a society free of such drugs has much to commend it. Families and Friends for Drug Law Reform accepts that. It is also aware that, having regard to their relative harms, there is a possible case for cannabis to be included among recognised recreational drugs like alcohol and tobacco. While there is a place for that debate the principle that we should deal with others in accordance with rational standards demands that first and foremost we should assess whether the measure taken to achieve acceptable ethical objectives are effective in doing so. Families and Friends for Drug Law Reform understands those objectives to include that:

(a) illicit drugs should not be available to young people;

(b) their use should be minimised as far as possible;

(c) those who become addicted should be helped to recover or otherwise regain stability in their life;

(d) the stress and fracturing of families that occurs through drug use should not occur;

(e) the community at large should not suffer through crime, fear and distrust that is a cancer in our society.

76. Unfortunately, the Government does not even apply basic principles of rationality to assess the effect of measures taken to make drugs less available: whether the net effect of the law enforcement in fact serves to increase the availability of drugs to our children by making the illicit trade extraordinarily profitable. As Families and Friends for Drug Law Reform has long pointed out, the Government has consistently declined to test its claims that seizures of drugs are producing an overall reduction in the supply. Drug seizures may be trending up but this is likely to be no more than an indication of the amount of drugs available. Only by publication of the estimates of drugs consumed – something that statisticians can do with reasonable accuracy – can the effectiveness of the seizures be judged.

77. Without the application of principles of rationality to the formulation of drug policy Families and Friends for Drug Law Reform fears that we are no better in terms of misery inflicted than those countries in Africa whose political leaders have refused to acknowledge the link between HIV and AIDs or our European forebears who enacted laws for the execution of witches. The Bill appears to reflect an abdication of rationality. Those addicted to an illicit drug will have infringed their human right to be dealt with rationally. The prejudice and discrimination that the Bill appears to pander to will indeed reinforce the position of those addicted to illicit drugs as the lepers of our society. In times past before the application of rational

principles brought enlightenment about the disease of leprosy there was a reasonable basis for that attitude. In our time with illicit drug users there is none.

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VI. ATTACHMENTS

A. Criteria for the diagnosis of substance dependence

ICD-10 (*International Classification of Diseases)***: Dependence Syndrome**
(WHO, *The ICD-10 classification of mental and behavioural disorders: Clinical descriptions and diagnostic guidelines* (Geneva, World Health Organizatin, 1992) pp. 75-76)

A cluster of physiological, behavioural, and cognitive phenomena in which the use of a substance or a class of substances takes on a much higher priority for a given individual than other behaviours that once had greater value. A central descriptive characteristic of the dependence syndrome is the desire (often strong, sometimes overpowering) to take psychoactive drugs (which may or may not have been medically prescribed), alcohol, or tobacco. There may be evidence that return to substance use after a period of abstinence leads to a more rapid reappearance of other features of the syndrome than occurs with nondependent individuals.

Diagnostic Guidelines

A definite diagnosis of dependence should usually be made only if three or more of the following have been present together at some time during the previous year:

(1) a strong desire or sense of compulsion to take the substance;

(2) difficulties in controlling substance-taking behaviour in terms of its onset, termination, or levels of use;

(3) a physiological withdrawal state when substance use has ceased or been reduced as evidenced by: the characteristic withdrawal syndrome for the substance; or use of the same (or a closely related) substance with the intention of relieving or avoiding withdrawal symptoms;

(4) evidence of tolerance, such that increased doses of the psychoactive substance are required in order to achieve effects originally produced by lower doses (clear examples of this are found in alcohol- and opiate-dependent individuals who may take daily doses sufficient to incapacitate or kill nontolerant users);

(5) progressive neglect of alternative pleasures or interests because of psychoactive substance use, increased amount of time necessary to obtain or take the substance or to recover from its effects;

(6) persisting with substance use despite clear evidence of overtly harmful consequences, such as harm to the liver through excessive drinking, depressive mood states consequent to periods of heavy substance use, or drug-related impairment of cognitive functioning; efforts should be made to determine that the user was actually, or could be expected to be, aware of the nature and extent of the harm.

DSM-IV (*Diagnostic and Statistical Manual of Mental Disorders*) of the American Psychiatric Association**: Criteria for substance dependence**
(American Psychiatric Association, *Diagnostic and statistical manual of mental*

disorders (DSM(IV)) (4th ed., Washington, American Psychiatric Association 1994) p. 181)

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

(1) tolerance, as defined by either of the following:

(a) a need for markedly increased amounts of the substance to achieve intoxication or desired effect

(b) markedly diminished effect with continued use of the same amount of the substance;

(2) withdrawal, as manifested by either of the following:

(a) the characteristic withdrawal syndrome for the substance

(b) the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms;

(3) the substance is often taken in larger amounts or over a longer period than was intended;

(4) there is a persistent desire or unsuccessful efforts to cut down or control substance use;

(5) a great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g. chain-smoking), or recover from its effects;

(6) important social, occupational, or recreational activities are given up or reduced because of substance use;

(7) the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g. current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption).

Specify if-

With physiological dependence: evidence of tolerance or withdrawal (i.e., either item 1 or 2 is present)

Without physiological dependence: no evidence of tolerance or withdrawal (i.e. neither item 1 nor 2 is present).

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