Submission No 44

INQUIRY INTO DRUG AND ALCOHOL TREATMENT

Organisation: Hepatitis NSW

Date received: 13/03/2013

The Director

General Purpose Standing Committee No. 2

Parliament House

Macquarie St

SYDNEY NSW 2000

To whom it may concern

Re: Inquiry into drug and alcohol treatment

Hepatitis NSW is an independent, community-based, non-government health promotion charity funded by the NSW Ministry of Health. We provide information, support, referral and advocacy for people affected by hepatitis C in NSW. We also provide workforce development and education services both to prevent the transmission of hepatitis C and to improve services for those affected by it.

We strive to be representative of people affected by hepatitis C and work actively in partnership with other organisations and with the affected communities themselves to bring about improvements in quality of life, information, support and treatment, and to prevent transmission of the hepatitis C virus (HCV).

It is estimated that approximately 226,700 Australians are currently living with chronic hepatitis C[1]. 49,500 people living with HCV have moderate to severe liver damage, with an additional 6,300 people having cirrhosis[2]. In NSW, it is estimated there are between 86,000 and 87,000 people

[1] The Kirby Institute, *HIV, Viral Hepatitis and Sexually Transmissible Infections in Australia: Annual Surveillance Report 2012*, p7.
[2] Ibid, p14.

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currently living with chronic hepatitis C[3], while there were 3,273 hepatitis C notifications in NSW in 2012[4].

Hepatitis NSW has a strong interest in the Terms of Reference currently being considered by the Committee. This is because more than 80% of people in Australia currently living with chronic hepatitis C acquired it through sharing injecting equipment for illicit drugs. In fact, approximately 89% of all new infections are the result of sharing injecting equipment.[5]

Consequently, Hepatitis NSW engages in education and prevention activities with people who inject drugs, and healthcare and other professionals who work with these communities, as we seek to minimise the transmission of hepatitis C amongst this group. We also provide a range of other services, including the Hepatitis Helpline and Prisoner Helpline, which involve direct contact with people who currently, or have in the past, injected drugs.

This means that we are aware of many of the concerns of these communities, and that as an organisation we have an interest in ensuring that these communities are treated fairly and with respect. These concerns are of particular importance when examining questions such as whether compulsory treatment should be imposed on people who have drug or alcohol dependence, and examining the relative merits of different models of drug law reform which are adopted by other jurisdictions.

As a general principle, Hepatitis NSW believes that people who have chronic hepatitis C, who are at risk of contracting hepatitis C, who inject drugs or who have injected drugs in the past, should be

[3] Ibid, and Ministerial Advisory Committee on AIDS, Sexual Health and Hepatitis C Sub-Committee, *Hepatitis C Virus Projections Working Group: Estimates and Projections of the Hepatitis C Virus Epidemic in Australia 2006*, p75.

[4] NSW Ministry of Health, Hepatitis C notifications in NSW residents, 5 February 2013 (www0.health.nsw.gov.au/data/diseases/hepc.asp).

[5] Hepatitis C Virus Projections Working Group: Estimates and Projections of the Hepatitis C Virus Epidemic in Australia 2006, Ministerial Advisory Committee on AIDS, Sexual Health and Hepatitis (Hepatitis C Subcomittee), October 2006.

provided with information, education and support, and allowed to make their own health decisions, rather than be subject to compulsory treatment orders.

In this submission, we make detailed comments in relation to Term of Reference 3, which considers the issue of compulsory treatment generally, Term of Reference 6, which looks at the comparative approaches adopted to drug law reform by different jurisdictions, and Term of Reference 7, which focuses on the *Drug and Alcohol Treatment Amendment (Rehabilitation of Persons with Severe Substance Dependence) Bill 2012*, as introduced by Mr Fred Nile MLC.

Although we do not make detailed comments on the other four Terms of Reference, we do make short comments on particular issues raised by these topics. All 7 Terms of Reference are addressed in separate sections on the following pages.

Finally, Hepatitis NSW makes 4 main recommendations in relation to this inquiry:

> **Recommendation 1: Hepatitis NSW does not support further expansion of the use of naltrexone implants in NSW as part of treatment for drug and/or alcohol treatment generally, and does not support the use of naltrexone implants as part of compulsory treatment under legislation.**
>
> **Recommendation 2: Hepatitis NSW does not support the further expansion of compulsory treatment of persons with drug and/or alcohol dependence, both for ethical reasons and because there is insufficient evidence to justify such expansion.**
>
> **Recommendation 3: Hepatitis NSW does not support the strategies and models for responding to drug and/or alcohol addiction adopted by either Sweden or the United Kingdom. Hepatitis NSW instead recommends that the Committee further consider the model adopted by Portugal with respect to drug laws and medical support.**

Recommendation 4: Hepatitis NSW does not support passage of the Drug and Alcohol Treatment Amendment (Rehabilitation of Persons with Severe Substance Dependence) Bill 2012.

1. **The delivery and effectiveness of treatment services for those addicted to drugs and/or alcohol, including naltrexone treatment, with reference to the welfare and health of individuals dependent on illicit drugs and the impact on their families, carers and the community having regard for:**
    a. **The need for appropriate human research, ethics and Therapeutic Goods Administration approval for use of new treatments in clinical trials**
    b. **The current body of evidence and recommendations of the National Health and Medical Research Council.**

We do not propose to comment on the delivery and effectiveness of the wide range of treatment services which are available to people who have dependence on alcohol and/or other drugs across NSW today. However, given the issues which surround its use, and the fact that it is a key component of the *Drug and Alcohol Treatment Amendment (Rehabilitation of Persons with Severe Substance Dependence) Bill 2012*, we would like to make specific comments about the use of naltrexone implants.

Hepatitis NSW notes that naltrexone implants have not been approved for human use in Australia by the Therapeutic Goods Administration (TGA). As stated by the National Health and Medical Research Council (NHMRC), this is "due to a lack of results from clinical trials demonstrating their pharmaceutical quality, safety and efficacy."[6] As a result, naltrexone implants are only currently used by a small number of private practitioners under the TGA's Special Access Scheme.

Even with this narrow distribution of naltrexone implants within Australia, Hepatitis NSW is concerned about the potential impacts of these devices on people seeking treatment for their drug and/or alcohol dependence. As noted in the NHMRC Literature Review looking at Naltrexone Implant Treatment for Opioid Dependence, "[t]he short-term nature of adherence poses a problem

[6] National Health and Medical Research Council, statement on naltrexone implants, NHMRC website, accessed 1 March 2013.

as the person's opioid tolerance will have reduced, potentially increasing the possibility of overdose. An increased risk of overdose has been reported after cessation of oral naltrexone… and this risk may extend to naltrexone implants."[7]

Indeed, Dr Alex Wodak, the former Director of the Alcohol and Drug Service at St Vincent's Hospital, has expressed significant concerns about the potential consequences of naltrexone implants: "We know they're risky because I've seen with my own eyes patients who have had life-threatening complications soon after having a naltrexone implant… We also know that a number of deaths have been reported in Australia and around the world soon after naltrexone implants."[8] These may arguably include the deaths of Ms Grace Yates and Mr James Unicomb at the Psych 'n' Soul private naltrexone clinic in Sydney, which were examined by the NSW State Coroner in 2012.[9]

Given these significant concerns, and the lack of TGA approval, Hepatitis NSW agrees with the Royal Australasian College of Physicians (RACP) in its position statement on naltrexone treatment where it states that: "until suitable product(s) have undergone normal regulatory assessment procedures and are licensed with the Therapeutic Goods Administration (TGA**), unregistered products should not be used on a routine basis** and a range of safeguards are required to protect patients, their families, and health professionals"[10] (emphasis added).

In fact, the first recommendation from the RACP Position Statement reads:

> "*Unlicensed treatments should generally be reserved for clinical trials. If ever considered as a 'second-line' option for patients with terminal conditions not responding to conventional treatments, applications should be made and promptly considered by independent experts*. Treatment with unlicensed long-acting naltrexone products should only be considered as a second-line

[7] National Health and Medical Research Council, Literature Review: Naltrexone Implant Treatment for Opioid Dependence, 2010, p5.
[8] As reported in ABC News online, October 22 2012, "Questions raised over wider naltrexone use".
[9] NSW State Coroner's Findings 27th September 2012.
[10] Royal Australasian College of Physicians, Position Statement on Naltrexone Treatment, 17 November 2010.

> treatment approach in patients who are not responding to conventional treatment, and who continue to actively use unsanctioned opioids in a highrisk manner such that "death is reasonably likely to occur within a matter of months, or from which premature death is reasonably likely to occur in the absence of early treatment". Heroin dependence also does not meet the criteria identified by Category A of the Special Access Scheme in Australia given the range and accessibility of effective evidence-based treatment options available to those seeking help. For example, patients already engaged in opioid substitution treatment who are no longer using opioids in a high-risk manner should not be eligible for this treatment approach." (emphasis in original).[11]

The reference to 'the range and accessibility of effective evidence-based treatment options' includes the much more commonly-used, and TGA-approved, Methadone Maintenance Treatment (MMT). Hepatitis NSW agrees that, for people in NSW seeking treatment for heroin addiction, MMT does not present the same level of risk, and has a far more established evidence-base, than naltrexone implants.

Given the concerns about naltrexone implants, and the existence of alternative treatment options, Hepatitis NSW does not support further expansion of the use of naltrexone implants within NSW. In particular, Hepatitis NSW expresses serious concerns about the potential use of naltrexone implants as part of mandatory treatment under the *Drug and Alcohol Treatment Amendment (Rehabilitation of Persons with Severe Substance Dependence) Bill 2012*, which will be examined in more detail under Term of Reference 7.

Recommendation 1: Hepatitis NSW does not support further expansion of the use of naltrexone implants in NSW as part of treatment for drug and/or alcohol treatment generally, and does not support the use of naltrexone implants as part of compulsory treatment under legislation.

[11] Ibid.

2. The level and adequacy of funding for drug and/or alcohol treatment services in NSW.

Hepatitis NSW does not have the time or resources to undertake a detailed analysis of the level or adequacy of funding for alcohol and other drug treatment services in NSW.

However, we would like to point out that this priority is simply one part of the equation when it comes to dealing with people who use illicit drugs. If we are to adopt a holistic approach to this issue, then as well as supply reduction, and demand reduction (which includes drug and alcohol treatment services), then we must also prioritise – and adequately fund – harm reduction. Unfortunately, the overwhelming proportion of investment in the three arms/pillars described above is weighted in favour of, firstly, supply reduction, and secondly, demand reduction. A mere 3% to 4% of total expenditure on the implementation of the National Drug Strategy[12] is invested in the harm reduction pillar. This does not appear to be a sustainable balance of funding.

From Hepatitis NSW's viewpoint, one of the key harm reduction priorities is to adequately fund and support needle and syringe programs (NSPs). NSPs have proven to be a remarkable public health success in terms of benefits in preventing HIV and HCV transmissions (and the transmission of other BBVs) in Australian populations of people who inject drugs. In fact, during the decade 2000-2009, it is estimated that Australia's NSP directly prevented 97,000 HCV and 32,000 HIV infections[13]. This is also a remarkably cost-effective project – during this ten-year period, gross funding for NSP services across Australia was $243 million, while this investment yielded healthcare cost savings of $1.28 billion.[14] The majority of these savings were associated with HCV-related outcomes. Over the long-term, even greater returns would be expected.

2009 modelling undertaken by Professor David Wilson at the Kirby Institute has demonstrated that, if the quantity of needles and syringes distributed were to be doubled, the rate of new HCV

[12] Ministerial Council on Drug Strategy, *National Drug Strategy 2010-2015: A framework for action on alcohol, tobacco and other drugs*, 25 February 2011.
[13] Wilson, Prof David, *Return on Investment 2: Evaluating the cost-effectiveness of needle and syringe programs* in Australia 2009. Sydney, National Centre in HIV Epidemiology and Clinical Research, The University of NSW.
[14] Ibid.

infections would be halved[15]. In short, if NSP outlets across NSW significantly increased the quantity and reach of sterile injecting equipment distributed among people who inject drugs, then the amount of new infections recorded in NSW could drop from 3,273 to less than 2000. This would not only be a major benefit for those individuals spared from chronic hepatitis C, but would have a multiplier effect in terms of reduced health costs, and improved productivity.

However, even if funding was increased for NSPs, in order to ensure their effectiveness the *Drug Misuse and Trafficking Regulation 2006* should also be amended to:

-Allow supermarkets, service stations and convenience stores to sell sterile injecting equipment and

-Remove the restriction on the distribution of sterile equipment by unauthorised persons so that peer distribution can be significantly increased, dramatically expanding the range of people receiving sterile injecting equipment on a day-to-day basis.

To conclude, we would make the point that this is not to suggest we oppose increases to funding for drug and/or alcohol treatment services, or reforms to improve their effectiveness. Instead, we would like to ensure that an equally important part of the 'puzzle', namely harm reduction in the form of NSPs, is not forgotten and also receives adequate funding and regulatory support.

[15] Ibid.

3. The effectiveness of mandatory treatment on those with drug and/or alcohol addiction, including monitoring compliance with mandatory treatment requirements.

Hepatitis NSW has concerns about the drafting of this Term of Reference. In particular, it only asks about the effectiveness of mandatory treatment. In our opinion, a much more fundamental question arises before the effectiveness of mandatory treatment can even be considered, and that is: whether and in what circumstances mandatory treatment may be ethical.

In considering this topic, we are attracted to the principles and framework adopted by Dr Alex Stevens, in his article "The ethics and effectiveness of coerced treatment of people who use drugs."[16] Dr Stevens approaches this topic by first distinguishing between compulsory treatment – in which the person involved has no opportunity to provide informed consent to such treatment – and quasi-compulsory treatment, "when drug users are given a choice of going to treatment or facing a penal sanction that is justified on the basis of crimes for which they have been (or may be) convicted".[17]

Dr Stevens then distinguishes between three types of persons who may use drugs, which, at least for considering this topic, are helpful:

i) Non-problematic drug users – who have not committed other, non-drug related offences and do not meet diagnostic criteria for drug dependence

ii) Dependent drug users – who have not committed other, non-drug related offences but do meet diagnostic criteria for dependence and

iii) Drug dependent offenders – who have committed other, non-drug related offences and who meet diagnostic criteria for dependence.

[16] Stevens, Alex, "The ethics and effectiveness of coerced treatment of people who use drugs", *Human Rights and Drugs*, Volume 2, No 1, 2012, International Centre on Human Rights and Drug Policy.
[17] Ibid, p9.

While we are attracted to this categorisation, we will instead use the descriptors: people who use drugs but who do not have drug dependence; people who use drugs and do have drug dependence; and people who use drugs, have drug dependence and have committed a non-drug related offence.[18]

Hepatitis NSW also agrees with the non-exhaustive range of ethical standards which Dr Stevens sets out on page 10 of his article, namely:

- "Avoidance of the infliction of harm on the person being treated (guaranteed in all codes of medical ethics since the Hippocratic oath)
- Informed consent (guaranteed both by codes of medical ethics and by the International Covenant on Civil and Political Rights, article 7)
- The prohibition of inhuman and degrading treatment or punishment (Universal Declaration of Human Rights, article 5; the International Covenant on Civil and Political Rights, article 7; and the Convention Against Torture, among others.)
- The right to freedom from arbitrary detention (International Covenant on Civil and Political Rights, article 9)
- The right to freedom of movement (International Covenant on Civil and Political Rights, article 12)
- Proportionality in sentencing. Classically, proportionality has been taken to mean that the harm caused by the punishment must be no greater than the harm that the offender has caused to other people. This principle is not yet included in UN instruments, but it is included in the European Charter of Fundamental Rights, article 49 of which states that '[t]he severity of penalties must not be disproportionate to the criminal offence'."[19]

When applying this framework to the three categories of persons outlined above, it is clear that there can be no justification for the compulsory or quasi-compulsory treatment of people who use

[18] Direct quotes from Dr Stevens will continue to use his original wording.
[19] Ibid, page 10.

drugs but who do not have drug dependence. For these people, whose only offences are drug consumption/possession, Hepatitis NSW strongly agrees with Dr Stevens that both compulsory or quasi-compulsory treatment in this situation would involve a highly unethical interference with their individual liberty, and would in fact constitute a form of punishment.[20]

Next, considering people who use drugs and who have drug dependence, we also agree with Dr Stevens in that it is difficult to overcome the ethical barrier that requires the informed consent of the person concerned before commencing compulsory treatment. This is particularly important if the treatment involved involves either mandatory detention in a facility, or compulsory treatment with drugs such as naltrexone (and especially so if treatment with these drugs can cause serious interactions with illicit drugs, possibly leading to death). As with people who use drugs and do not have drug dependence, it is also difficult to consider quasi-compulsory treatment to be ethical, because the restrictions on the freedom of the individual concerned could be significantly more onerous than the comparable punishment which would be provided simply for drug consumption or possession.

We do diverge on one point from Dr Stevens' analysis here, and that is to say that Hepatitis NSW does envisage, at least hypothetically, that there could be some limited circumstances in which the threat of immediate, serious harm to the health of the person concerned could potentially be a justification for mandatory treatment in some cases. However, this would be essentially a medical decision, made on their assessment of the prospects of immediate, serious self-harm, and done within very narrowly defined circumstances. It would not cover potential harm to others (which, in any case, would be difficult to assess, by anyone and including medical professionals), or the risk of possible commission of criminal offences (which is a non-medical consideration), both of which are

[20] Hepatitis NSW also believes that consumption/possession of illicit drugs should be decriminalised, so as not to bring these people into contact with the criminal justice system in the first place, although we acknowledge that this question is not directly being considered by this inquiry.

potential criteria for compulsory treatment in the *Drug and Alcohol Treatment Amendment Bill 2012*.[21]

Finally, turning to the question of people who use drugs, have drug dependence and who commit non-drug related offences, we agree once more with Dr Stevens, in that it would be unethical to apply compulsory treatment to these people because it is impossible to obtain unqualified, informed consent in this situation. As with people who use drugs and have drug dependence, this is important when the mandated treatment involve either physical detention or implantation of drugs like naltrexone.

The question of quasi-compulsory treatment is more complicated, because the person concerned may be considering quasi-compulsory treatment as an alternative to a longer or more onerous legal punishment, and potentially prison sentence, for their offences (which are more serious than simply drug consumption or possession).

In this context, we endorse the basic pre-conditions listed by Dr Stevens[22] in his article:

- "That the person is offered the choice not to enter treatment (without being punished for taking this choice by facing a more severe penalty than he or she would otherwise have received).
- That the person is offered a choice between forms of treatment that are adequate and humane, according to his or her individual needs and wishes.
- That the constraint on the person is subject to due process (e.g. the right to know what he or she is accused of, and the right to challenge any such accusations).
- That the person is not punished for failing in treatment. Relapse is frequent among dependent drug users and is, indeed, one of the diagnostic indicators of dependence. It should not be used as a reason for punishment, although it may be the occasion to rescind the opportunity to enter treatment and implement the alternative penalty.

[21] This issue is considered in more detail under Term of Reference 7 (see pages 32-46).
[22] Stevens, op cit, p 13.

- That the treatment takes place in a setting that is the least restrictive of liberty that is necessary for the objectives of treatment (*not* for the objectives of punishment).
- That the period of any judicial order to remain in treatment is limited, subject to review and of no longer duration than the usual punishment for the offence."

It is clear from looking at this set of criteria that quasi-compulsory treatment will only be ethical for a small amount of people who use drugs, have drug dependence and who commit non-drug related offences, who choose this option through unqualified and informed consent.[23]

That is not the situation with the current *Drug and Alcohol Treatment Amendment Bill 2012*, which both fails to be an alternative to legal punishment, and which does not offer the person concerned the ability to refuse treatment. These failures alone are sufficient reason to oppose that Bill.

Based on this discussion, Hepatitis NSW believes that compulsory treatment can only ever be ethical where it involves dealing with the threat of immediate, serious self-harm, as determined by a qualified medical professional, and quasi-compulsory treatment is only ever ethical when offered as an alternative to a legal sentence/imprisonment AND is chosen by the person involved with unqualified, informed consent.

Nevertheless, merely because it may be ethical in some circumstances, does not necessarily mean it is effective, and we will now consider the evidence (or lack thereof) for the effectiveness of compulsory or quasi-compulsory treatment.

Overall, there appears to be no substantive, broad-based study which shows that compulsory treatment is more effective for non-problematic drug users, or drug-dependent non-offenders, than relying on people voluntarily seeking out, and undergoing, treatment.[24] This is both because the

[23] Hall also agrees with this analysis: "The most ethically defensible form of legally coerced treatment for drug dependent offenders is probably the use of imprisonment as an incentive for treatment entry" Hall, W The role of legal coercion in the treatment of offenders with alcohol and heroin problems. National Drug and Alcohol Research Centre, Technical Report No 44, 1995, University of New South Wales.

[24] Klag, S, O'Callaghan FV, Creed P. The use of legal coercion in the treatment of substance abusers: An overview and critical analysis of thirty years of research. Substance Use Misuse 2005; 40 (12): 1777-1795.

majority of research in fact focuses on quasi-compulsory treatment for people who have drug dependence and who have committed non-drug related offences, rather than compulsory treatment[25], and because the current level of knowledge "is based on small, non-empirical, single-site studies that have serious conceptual and methodological problems."[26] There is certainly not sufficient evidence of the high level of 'effectiveness' of this type of treatment which would be required to overcome the serious ethical hurdles identified above.

When turning to the issue of quasi-compulsory treatment for people who have drug dependence and have committed non-drug related offences, there does seem to be some evidence that this form of treatment can be effective for some people. For example, Anglin has found that treatment can have a positive effect on a person's substance use behaviour despite being their participation commencing as a result of quasi-compulsory methods.[27] Indeed, Stevens himself writes that, the research "suggests that [quasi-compulsory treatment] can be as effective as treatment that is entered voluntarily, but is not generally more or less effective than such voluntary treatment."[28]

However, one crucial factor which these and other studies have identified is the client's internal motivation – that is, even if the person concerned commenced treatment through 'quasi-compulsory' means, they actually wanted to treat their drug or alcohol dependency.[29] Stevens agrees: "One reason why [quasi-compulsory treatment] seems to have similarly positive results to voluntary treatment is because, when ethically carried out, it is not necessarily damaging to the patient's motivation to change."[30] It should be remembered that, with quasi-compulsory treatment, these are people who are selecting treatment rather than alternatively accepting a potentially more

[25] Mugford, R and Weekes, Dr John. 2006. Canadian Centre on Substance Abuse, Fact Sheet on Mandatory and Coerced Treatment, p3
[26] Perron, BE and Bright, CL. The influence of legal coercion on drop-out from substance abuse treatment: Results from a national survey. Drug Alcohol Depend. 2008. January 1; 92(1-3): 123-131.
[27] Anglin, DM (1988). *The efficacy of civil commitment in treating narcotic addiction*. In Leukefeld, DSW, Tims, FM (eds) Compulsory treatment of drug abuse: Research and clinical practice. Rockville MD: National Institute of Drug Abuse, Division of Clinical Practice.
[28] Stevens, op cit, p14.
[29] Simpson, DD, Joe, GW, Rowan-Szal, GA (1997). Drug abuse treatment retention and process effects on follow-up outcomes. Drug and Alcohol Dependence, 47, 227-235.
[30] Stevens, op cit, p14.

serious legal punishment. It should also be noted that people in these circumstances may actually have wanted to treat their dependency but it is only through initial contact with the criminal justice system that they became aware of, or had simple access to, these services/treatments (which may be the case in jurisdictions which do not operate on harm reduction principles).

In conclusion, Hepatitis NSW believes that compulsory treatment is only ethical where it aims to prevent immediate, serious self-harm for the person involved (as assessed by a medical professional). Quasi-compulsory treatment is only ethical for people who have drug dependence and have committed non-drug related offences, in limited circumstances; including that the treatment involved would be less serious than any legal sanction which might be applied, and that the person is provided with the option of taking this more serious legal punishment if they did not wish to be treated. The evidence also shows that quasi-compulsory treatment can be effective in these limited circumstances, but does not justify further expansion of compulsory, or quasi-compulsory, treatment beyond these narrow confines.

Recommendation 3: Hepatitis NSW does not support the further expansion of compulsory treatment of persons with drug and/or alcohol dependence, both for ethical reasons and because there is insufficient evidence to justify such expansion.

4. **The adequacy of integrated services to treat co-morbid conditions for those with drug and/or alcohol addiction, including mental health, chronic pain and other health problems.**

As with Term of Reference 2 (and 5, below), Hepatitis NSW does not have the time or resources to undertake a detailed assessment of the adequacy of integrated services to treat co-morbid conditions for those with drug and/or alcohol addiction.

However, we would like to point out that, in addition to mental health and chronic pain, one of the most significant co-morbid conditions in this area, particularly for people who inject drugs, is hepatitis C. As stated in the introduction, it is estimated that more the 226,700 Australians are living with chronic hepatitis C. The vast majority, in fact approximately 82% of all Australians living with chronic hepatitis C, acquired HCV as a result of sharing equipment used to inject illicit drugs. Of the almost 10,000 new infections which occur across Australia each year, it is estimated that roughly 89% occur through blood-to-blood contact between people sharing equipment used for injecting illicit drugs. Therefore, any health service which responds to the needs of people who have a dependence on illicit drugs must also provide services directly, or referrals to appropriate services, related to hepatitis C.

In practice, this means that people who are accessing treatment for drug and/or alcohol treatment should also have access to the following (whether provided by that service provider directly , or through referrals to other, more appropriate services):

- Testing for hepatitis C. Given that injecting drug use is a high risk factor for the transmission of HCV, all services should be able to provide either directly, or indirect access to, HCV testing (noting that the test must be voluntary, and its timing should be carefully considered, in close consultation with the patient).
- People who discover they have chronic hepatitis C should be provided with access, or referral, to medical professionals who specialise in this area.

- People who discover they have HCV should also be provided with access to counselling services, including referrals to appropriate support services.
- All people who are being treated for drug addiction, and especially those who inject illicit drugs, should be provided with education about the risks of HCV transmission, and the transmission of other BBVs, as well as practical ways to reduce those risks.

Most importantly, these services need to provide appropriate information to people who have drug and/or alcohol addiction, and who are HCV positive, about their treatment options.

This is because hepatitis C can be successfully treated for most people. Existing 6 month treatments for people with HCV genotypes 2 and 3 provide up to an 80% chance of a cure. Existing 12 month treatments for HCV genotype 1, which is the most common genotype within Australia[31], provide an average 40-50% chance of cure. The Federal Minister for Health, the Hon Tanya Plibersek MP, announced on 19 February 2013 that the Government intends to list telaprevir and boceprevir on the Pharmaceutical Benefits Scheme in the near future. These new drugs significantly will increase the chances of cure for people with HCV genotype 1 to as much as 70-80% (and with potentially only 6 months' treatment duration).

However, it should be pointed out that current treatments involve injections of pegylated interferon, and oral ribavirin, and that the new treatments (telaprevir and boceprevir) will be taken in addition to this regime. Interferon, ribavirin, and indeed telaprevir and boceprevir, all come with significant side-effects. These side-effects can include anaemia, as well as depression and suicide. Some people also find that they are unable to work for extended periods during their treatment, and require a range of support structures in place before commencing treatment.[32]

[31] Approximately 53% of Australians living with chronic hepatitis C have genotype 1.

[32] Fortunately, future treatments for HCV, currently undergoing medical trials, will not involve pegylated interferon injections (and instead consist of all-oral regimens, potentially taken for periods of 24 or even 12 weeks). These new treatments, if and when they become available, will significantly reduce the range of negative side-effects, significantly increase cure rates, and will likely make treatment decisions, and treatment adherence, easier.

For all of these reasons, the decision to undergo treatment must be carefully considered by the person involved, in close consultation with the service provider and medical specialists. However, we believe that it is vital for drug and/or alcohol treatment services to provide this basic level of information – that treatments for hepatitis C do exist, and that for most people they are successful – to people who have discovered they have chronic HCV, because this may make it easier for them to deal with their diagnosis. And for those people who are in a position to commence treatment, and wish to do so either during their treatment for drug and/or alcohol addiction or immediately afterwards, pathways should be available to facilitate this treatment.

5. **The funding and effectiveness of drug and alcohol education programs, including student and family access to information regarding the legal deterrents, adverse health and social impacts and the addictive potential or drugs and/or alcohol.**

As with Terms of Reference 2 and 4, Hepatitis NSW does not have the time or resources to assess, in detail, the levels of funding provided to, or effectiveness of, the wide range of existing drug and alcohol education programs across NSW.

However, we note that the particular elements of drug and alcohol education programs which are listed above (legal deterrents, adverse health and social impacts, addictive potential), appear to reflect only one goal of drug and alcohol education. Specifically, these outcomes are all related to 'demand reduction', aimed at trying to limit the demand from people, and especially young people, to consume alcohol and/or other drugs.

Australia's National Drug Strategy has had a three-pillar approach to licit and illicit drugs governance, including alcohol, since its inception in 1985, and this approach has enjoyed by-partisan political support since that time:

1. *Supply reduction* is associated with interdiction and stopping and limiting the supply of drugs.
2. *Demand reduction* is concerned with strategies and actions which prevent the uptake and/or delay the onset of use of drugs, and support people to recover from drug dependence.
3. *Harm reduction* relates to strategies and actions that primarily reduce the adverse health, social and economic consequences of drug use.

Hepatitis NSW strongly supports demand reduction information, such as those described in this Term of Reference, being included in a comprehensive and well-rounded drug and alcohol education program, however, we strongly believe that these demand reduction strategies must always be accompanied by 'harm reduction' strategies as well.

By harm reduction, we mean that we accept there will always be some people who will use alcohol and other licit and illicit drugs, irrespective of legal deterrence, social/health impacts and addictive potential. For these people, drug and alcohol programs need to provide evidence-based education about ways to reduce the potential health and other risks which may be involved.

In terms of hepatitis C, the highest risk factor for virus transmission is sharing injecting equipment. In Australia, shared injecting equipment is responsible for almost 90% of new transmissions, while more than 80% of people already living with chronic hepatitis C have acquired the virus in this way.

Given we do not believe it is realistic to expect that injecting drug use will cease at any point in the near or medium-term future, this means the most effective way to reduce new transmissions of hepatitis C is to provide sterile injecting equipment, through needle and syringe programs (NSPs), AND to provide education to people about the risks of hepatitis C transmission from sharing equipment and the fact that using sterile injecting equipment reduces that risk.

Some people may express a moral or legal objection to this type of education, however, this active form of harm reduction is particularly important when we are aware that the average age of first injection in NSW is 19.44 years[33]: during the period 2008 to 2011, this average did not climb above 19.9 years[34]. More than half of these first injections involved heroin in every year from 2008 to 2011[35]. This means that appropriate education on the risks of viral hepatitis and other BBVs, and the best ways of reducing those risks, must be delivered to students and other young people before they reach the ages of 16 or 17.

This is reinforced by estimates which shows that the average time from first injection to transmission of hepatitis C can be 18 months, or even less[36]. That is, when people are young and first

[33] Phillips, Benjamin, and Burns, Lucy, *IDRS: Findings from the Illicit Drug Reporting System (IDRS), New South Wales Drug Trends 2011*, Australian Drug Trends Series No.74, NDARC 2012, p9.
[34] Ibid, p10.
[35] Ibid, pp9-10.
[36] Maher et al in 2006 found that, for recent initiates (people who have been injecting for two years or less at baseline, the mean time from age of first injection to seroconversion with HCV was 1.6

injecting they are more likely to share injecting equipment and therefore put themselves at risk of contracting hepatitis C. The best and most effective way to reduce the transmission of hepatitis C is therefore to provide blood awareness and drug and alcohol education to students and other young people, before they reach the ages of 16 or 17, covering the risks of hepatitis C transmission and other BBVs, and explicitly informing them that using sterile injecting equipment is one method to reduce that risk.

years. For new people who inject drugs who had injected for less than one year at baseline, the mean time to HCV seroconversion was 0.31 years, indicating a very small window of opportunity for prevention efforts. Maher, L, Jalaludin, B, Chant, KG et al. Incidence and risk factors for hepatitis C seroconversion in injecting drug users in Australia. Addiction 2006; 101:1499-508.

6. The strategies and models for responding to drug and/or alcohol addiction in other jurisdictions in Australia and overseas, including Sweden and the United Kingdom.

In this discussion, we will focus our discussion on the models adopted by Sweden and Portugal, and only spend minimal time in discussing the approach of the United Kingdom to drug policy.

The Swedish model is sometimes referred to as the 'vision of a drug-free society'. While this might reflect the aspiration – whether achievable, or, in our view, not – of the Swedish Government, Hepatitis NSW believes it is more accurate to describe the Swedish model as fundamentally a 'zero tolerance' approach.[37] This distinguishes it from the existing approach adopted by Australia and some other countries which, while aiming overall for harm minimisation, also explicitly include harm reduction as a part of their model. The Swedish model directly rejects harm reduction, the consequences of which are explored further below.

One of the major features of the Swedish model includes a highly punitive approach to drug law enforcement, not just against drug suppliers but also against individuals who use drugs. This extends to applying maximum penalties of up to 6 months imprisonment for even the most 'minor' drug possession offences ('ordinary' and 'serious' offences have much more severe penalties). Another key element of the Swedish approach is that it is highly-interventionist in terms of compulsory treatment for people who use drugs, including enforcing the compulsory treatment of people under the age of 20. Obviously, Hepatitis NSW is concerned about the ethical implications of widespread compulsory treatment, for the reasons discussed under Term of Reference 3, above. The goal of the majority of this treatment is abstinence – with rapid detoxification a particularly common form of 'therapy'.[38]

[37] This debate is expanded in the article: Hallam, Christopher, *What can we learn from Sweden's drug policy experience?* Briefing Paper 20, the Beckley Foundation Drug Policy Programme, January 2010.
[38] Hallam, op cit, p3.

The laws of Sweden also provide a range of powers of police to support this punitive and interventionist regime, including the ability to impose drug tests on individuals suspected of using illicit drugs, and of searching the bodies of those suspected of using illicit drugs.

Many people point to the rates of illicit drug use in Sweden as proof of the success of the zero tolerance approach. Hepatitis NSW agrees that in some respects the reported usage rates for various drugs are at or slightly below the averages of comparable countries. As reported by Hallam:

> -"In 2007, lifetime prevalence of cannabis use amongst young adults (15-34) was 18.1%, against an EU range of 2.9% to 48%...
>
> -Amongst all adults (15-64), the Swedish figure was 12.8%, against an EU range of 1.5% to 38.6%."[39]

The use of other illicit drugs is also slightly below the EU average, with the most recent estimate of 'problem drug users' at 29,513 people (or 4.9 'problem drug users' per 1000 inhabitants).[40] The overall rate of hepatitis C in the general population is also relatively low – a 2005 study of first-time blood donors found that the prevalence of HCV anti-bodies was 0.1%.[41]

However, Hepatitis NSW has several concerns with the Swedish drug model, some of which affect how the above data should be interpreted. For example, some people may refuse to disclose their drug-taking, even anonymously, in a country with such a strict, punitive regime. As Hallam writes:

> "Prevalence data are based on surveys of the general population, conducted by face to face interview of postal questionnaire. In a country where the authorities adopt such a restrictive posture in relation to drug use, and where community disapproval is so powerful, it would be somewhat surprising if

[39] Hallam, op cit, p7.
[40] European Monitoring Centre for Drugs and Drug Addiction Country Overview, accessed 1 March 2013.
[41] European Centre for Disease Prevention and Control, Technical Report: Hepatitis B and C in the EU Neighbourhood: prevalence, burden of disease and screening policies. September 2010, p 30. Although note that similarly low figures were also found in Spain and Germany, which have very different drug law policies.

> citizens *did* provide entirely candid replies: so it is very likely that the figures underestimate consumption" [emphasis in original][42].

This phenomenon could also apply to people coming forward for Blood Borne Virus (BBV) testing. People who inject drugs are a high-risk group for hepatitis C in any country, and Hepatitis NSW would be concerned about any regime which made people who are currently using illicit drugs reticent to come forward for testing because of a fear of either imprisonment or compulsory treatment. Even past drug users may be less likely to be tested for BBVs like HIV and hepatitis C if there is widespread stigma surrounding injecting drug use, caused by the punitive legal and medical regime which is in place. Indeed, this may explain why there appears to be a relatively high rate of late diagnosis of hepatitis C in people in Sweden[43], which, for a disease which can be cured for most people, can lead to significantly worse patient outcomes.

Adopting a punitive and highly interventionist treatment model, while potentially limiting the overall number of people who inject drugs, also has potentially negative consequences for those people who do go on to use illicit drugs. The zero tolerance approach, and explicit rejection of harm reduction, meant that from 1988 until 2006, needle and syringe programs (NSPs) were technically illegal in Sweden. Until last year, there were only two NSPs in the entire country, servicing roughly 5% of people who inject drugs,[44] with not a single NSP in the capital Stockholm, with a population of close to 1 million people, until the first was approved in mid-2012.[45] The lack of NSPs is likely a major explanation for why, although the overall rate of HCV may be low, the prevalence of HCV amongst Swedish people who inject drugs is very high – "the Swedish Institute for Infectious Disease Control

[42] Hallam, op cit, p7.
[43] Eurosurveillance, The epidemiology of hepatitis C virus infection in Sweden, Volume 13, Issue 21, 22 May 2008.
[44] Hallam, op cit, p8.
[45] Stockholm News, 3 July 2012. In contrast, NSW, with a population lower than Sweden's, has more than 800 NSPs.

estimates that 95% of [people who inject drugs] will test positive for hepatitis C infection within two years of initiating injecting."[46]

A further consequence of side-lining the harm reduction approach is that, once a person does use illicit drugs, they are proportionately more likely to develop problematic drug use. As Hallam points out:

> "The problem drug use prevalence is put at 0.45% by UNODC, slightly below the EU average of 0.51%. Nonetheless, UNODSC acknowledges that problematic drug use *as a proportion of overall drug use* is very high in Sweden. 1 in every 5 Swedish users is included in this category, compared with 1 in every 12 or 13 in the UK" [emphasis in original].[47]

This is likely because, once a person has started injecting drugs, they are less likely to seek assistance from a system which could then subject them to imprisonment or compulsory treatment. It should also be pointed out that, one of the most successful approaches to drug treatment, namely Methadone Maintenance Therapy (MMT), is actually limited by the Swedish parliament to a maximum of 800 people per year, and there are very strict conditions before people can access this treatment, including having tried other treatment methods (such as abstinence) unsuccessfully.[48] This is another limitation on the effectiveness of the Swedish drug model.

The final, major concern which Hepatitis NSW has about the Swedish drug model is that it involves the incarceration of people for even relatively minor drug offences. This raises a range of potential negative consequences for the person concerned – not only is imprisonment an independent risk factor for HCV transmission[49], it also exposes the individual to a range of other BBVs. Imprisonment can and does have other deleterious impacts on individuals, including the possibility of increased recidivism/committing other, non-drug related offences, lower long-term employment prospects,

[46] As quoted in Hallam, op cit, p8.
[47] Hallam, op cit, pp7-8.
[48] Hallam, op cit, p3.
[49] Hepatitis Australia et al, *Consensus Statement: Addressing hepatitis C in Australian Custodial Settings*, June 2011, p6.

dislocation from housing and other support structures, and disruption from family life and friends. We do not support a system which would impose these consequences on a person for the offence of drug possession for personal use.

Overall, while there may be slightly lower overall rates of illicit drug use in Sweden, the other consequences of their model mean that Hepatitis NSW would not support its replication in NSW.

This Term of Reference also seeks the views of people and organisations making submissions on the model for responding to drug and/or alcohol addiction adopted by the United Kingdom. In short, Hepatitis NSW does not support lengthy consideration of the UK approach, for the simple reason that it does not appear to have been as effective as other countries.

For example, as noted by Reuter and Stevens, "[t]he United Kingdom has the highest level of dependent drug use and among the highest levels of recreational drug use in Europe."[50] Indeed, the proportion of people with problematic drug use – at 9.3 per 1000 population – is almost double that of Sweden.[51] The United Kingdom also has relatively high numbers of drug-related deaths[52], and, while the number of people receiving treatment significantly increased between 1998 and 2004/05, so too did the use of custodial sentences, and their average length.[53] All in all, on the basis of this outcome, it is difficult to recommend adopting the UK model to drug regulation for translation to Australia.

The approach of a country which is of interest to Hepatitis NSW, however, is that of Portugal. Like many countries, Portugal experienced a significant increase in injecting drug use during the 1990s. However, more than most countries, especially in Western Europe, this was accompanied by very high rates of HIV transmission (and other BBVs) within people who inject drugs. As a result, in 1998, the Portuguese Government appointed a Commission for the National Strategy to Fight against

[50] Reuter, Prof Peter and Stevens, Alex, *An Analysis of UK Drug Policy*, UK Drug Policy Commission, 2007.
[51] European Monitoring Centre for Drugs and Drug Addiction, Country Overview United Kingdom, accessed 1 March 2013.
[52] Reuters, op cit, p1.
[53] Reuters, op cit, pp2-3.

Drugs to examine the question of what legal and medical approaches should be adopted with respect to this issue.

Based on the recommendations of this Commission, and following the agreement by the Parliamentary Agreement on Drugs, the Portuguese Government decided to adopt the 1999 National Strategy for the Fight against Drugs. This new Strategy represented a revolution in the Portuguese approach to drug policy and how it interacted with both the law and alcohol and other drug treatment. This strategy was based on 8 key principles: international co-operation, prevention, the humanistic principle, pragmatism, security, co-ordination and rationalisation of resources, subsidiarity and participation[54].

Significantly, the humanistic principle is defined as:

> "recognition of the human dignity of the people involved in the drug phenomenon and consequently an understanding of the complexity and relevance of the individual, his/her family and background, as well as an awareness of drug addiction as an illness and the consequent assumption of responsibility by the State in upholding the drug addict's constitutional right to health and the avoidance of social exclusion, without prejudice to his/her individual responsibility."[55]

Following the release of this strategy, the Portuguese Government passed Law 30/2000, which decriminalised drug possession for personal use, and which commenced on 1 July 2001. While the new law maintained the illegal status of using or possessing illicit drugs, it decriminalised possession of less than 10 'doses' of any drug. Those persons found with less than 10 doses would, rather than face a criminal sanction, instead be dealt with under an administrative procedure, heard by the Commission for the Dissuasion of Drug Use (CDT). The CDT is usually comprised of three people – a lawyer, a health professional and a social worker – and they can make a range of administrative decisions, including suspending the process (for those not considered addicted), through to

[54] Portuguese National Drug Strategy 1999, English translation supplied by the European Monitoring Centre for Drugs and Drug Addiction, pp18-20.
[55] Portuguese National Drug Strategy, op cit, p 19.

suspending the process if there is an agreement to seek treatment, imposing small-scale fines or requiring that the person periodically *attend* a certain place (for example, a place which provides counselling or an outpatient drug treatment centre)[56]. Note however, that periodic attendance does not involve mandatory detention, nor does it include compulsory therapies such as naltrexone implants, thereby distinguishing it from the *Drug and Alcohol Treatment Amendment Bill 2012*.

This decriminalisation was also supported by a dramatic expansion of drug and alcohol treatment centres (for those who wished to seek treatment, or who were referred to treatment through the CDT) as well as the further wide-scale roll-out of needle and syringe programs – with 1336 pharmacies (representing 48% of all pharmacies) providing NSP services.[57] These services complemented an existing education campaign with the theme "[s]ay no to a second-hand syringe." Portugal also ensured that opioid substitution therapy was commonly available: "[s]ubstitution treatment is widely available in Portugal, through services such as specialised treatment centres, health centres, hospitals and pharmacies as well as NGOs and non-profit organisations."[58] In 2010, 29,325 clients were registered in opioid substitution programmes.[59]

The outcome of this new approach to drug law and treatment has been, on the whole, a positive one. In terms of the founding cause for the new Strategy – the high number of HIV transmissions amongst PWID – the strategy has been an unmitigated success. The number of new HIV cases amongst PWID has declined from 1482 in 2000, to 116 in 2010.[60] While this still places the rate of new infections above the European average, this is nevertheless a significant decline within a difficult to target population that can engage in high-risk activities without adequate support. It has also been reported that "A downward trend can be observed also in the prevalence of HIV, HCV and

[56] European Monitoring Centre for Drugs and Drug Addiction, Drug Policy Profiles: Portugal, 2011.
[57] European Monitoring Centre for Drugs and Drug Addiction, Country Overview, October 2012.
[58] Ibid.
[59] Ibid.
[60] Ibid.

HBV among clients of drug treatment settings", which would be expected based on the above statistics.

In terms of problem drug use, the rate in Portugal is roughly the same as that in Sweden – between 4.3 and 5.0 per 1000 inhabitants.[61] Hallam notes that lifetime prevalence of cannabis use amongst young adults, and amongst all adults, was also lower in Portugal than Sweden in 2007, despite adopting a decriminalised approach.[62] This is not to say the picture is entirely positive – in recent years there has been some increase in lifetime cannabis usage reports, and "[d]espite the downward trend observed during 2002-2006, the most recent ESPAD study corroborates the findings of the HBSC/WHO study, showing increasing consumption of illicit substances since 2006."[63]

It is possible that the significant economic and social consequences caused in Portugal (like Spain and Greece in Southern Europe) by the Global Financial Crisis may have contributed to these increases. The GFC is also a potential problem in terms of ensuring that all the components of the Portuguese National Drug Strategy are adequately funded, with Budget pressure threatening financial support for widespread access to treatment, and funding for the CDTs. Nevertheless, the overall and problem drug use rates in Portugal remain roughly comparable to their EU counterparts, despite adopting a decriminalised approach.

Hepatitis NSW believes that the Portuguese model is worthy of further study and investigation by the Committee. This is not just because it has achieved a significant reduction in the transmission of BBVs, but also because it has done so without imposing mandatory detention or naltrexone implants of people who inject drugs, unlike Sweden (and unlike the provisions of the *Drug and Alcohol Treatment Amendment Bill 2012*). But above all, the Portuguese approach demonstrates that it is possible to deal with the question of illicit drug use without imposing terms of imprisonment on

[61] Ibid.
[62] Hallam, op cit, p 7.
[63] European Monitoring Centre for Drugs and Drug Addiction, Country Overview, October 2012.

people who use these substances, and therefore sparing PWID from the associated, negative consequences of incarceration.

There might not be a 'panacea' to the question of problem drug use, but Hepatitis NSW supports an approach which attempts to deal with this issue as a medical and not a legal problem. We are also in favour of drug policy models which do not simply focus on 'demand reduction' but provide adequate support to those people who do use illicit substances, including through the wide-scale provision of NSPs, rather than criminalisation.

In short, when comparing the 'strategies and models for responding to drug and/or alcohol addiction in other jurisdictions in Australia and overseas', Hepatitis NSW is far more attracted to the model adopted by Portugal than either Sweden or the United Kingdom.

Recommendation 3: Hepatitis NSW does not support the strategies and models for responding to drug and/or alcohol addiction adopted by either Sweden or the United Kingdom. Hepatitis NSW instead recommends that the Committee further consider the model adopted by Portugal with respect to drug laws and medical support.

7. The proposed reforms identified in the *Drug and Alcohol Treatment Amendment Bill 2012*

Hepatitis NSW does not support the *Drug and Alcohol Treatment (Rehabilitation of Persons with Severe Substance Dependence) Bill 2012* (the Bill), as introduced by Mr Fred Nile in the Legislative Council on 25 October 2012.

As discussed above under Term of Reference 3, Hepatitis NSW does not agree with the further or expanded imposition of compulsory treatment on people with substance dependence. We have serious concerns about the mandatory detention of those people, for periods of up to 90 days, while they are being treated. And we also have serious concerns about the use of naltrexone implants for people with substance dependence, as proposed in the Bill, especially as the only alternative for people seeking to avoid mandatory detention.

Hepatitis NSW makes the following, more detailed, comments about specific provisions of the Bill:

- *Hepatitis NSW does not support schedule 1, clause 1, of the Bill which would add the descriptor 'rehabilitative' after involuntary in the objects section of the existing Drug and Alcohol Treatment Act 2007 (the Act).*

We do not believe that compulsory treatment, involving either mandatory detention for periods of up to 90 days, or compulsory naltrexone implants, properly fits within a rehabilitation model, which generally involves the voluntary participation and informed consent of the person involved. Instead, we believe the current description in s3 of the Act – "to provide for the involuntary treatment of persons with a severe substances dependence" – is accurate, and there is no reason to amend it.

- *Hepatitis NSW does not support schedule 1, clause 2, of the Bill where it would add section 3(1)(f) to the Act ("to grant the police, and the staff of treatment centres, the necessary powers to achieve these objects").*

We do not support the further involvement or additional powers provided to police within an Act which is ostensibly aimed at the provision of compulsory medical treatment. The further involvement of law enforcement within this regime shifts the emphasis from a medical model towards a quasi-criminal model (even where no criminal offences have been created).

Hepatitis NSW also has concerns about the powers provided to the staff of treatment centres, especially as while the term treatment centre is defined in the Act, the concept of 'staff' is undefined, meaning that the Bill would give non-medical staff (eg receptionists, administrative staff, cleaners etc) powers under the proposed legislation. Our specific concerns with these provisions (especially schedule 1, clause 13 of the Bill) are discussed further below.

- *Hepatitis NSW does not support the introduction of a new definition of minor in the Act, meaning persons under the age of 16, as provided in schedule 1, clause 4 of the Bill.*

We have serious concerns about the expansion of compulsory treatment orders to apply to minors, meaning 16 and 17 year olds[64]. Hepatitis NSW supports the current prohibition on mandatory treatment orders in the Act applying to anyone under the age of 18. Even with the apparent safeguard of requiring parental or guardian consent (as outlined in proposed new section 11B, in schedule 1, clause 15 of the Bill), the imposition of mandatory treatment orders on 16 and 17 year olds is draconian and, we believe, not in best interests of those minors. There are other treatment options, including through voluntary treatment and treatment in the community, which are more ethical and more effective, and are strongly preferred in these circumstances.

[64] Given existing section 4 of the Act, the effect of the insertion of a new definition of minor (meaning under 16 years of age), would allow for compulsory treatment orders to apply to 16 and 17 year olds.

- *Hepatitis NSW does not support new section 9 of the Act, as proposed in schedule 1, clause 13 of the Bill, which expands the categories of people who may request an assessment.*

We have serious concerns about the dramatic expansion of the category of persons who can request an accredited medical practitioner to assess a person for possible compulsory treatment. In the existing Act, only medical practitioners themselves can request such an assessment, and that would appear be an entirely appropriate limitation. In the Bill this would be expanded to include:

> "(a) a medical practitioner,
>
> (b) a social worker,
>
> (c) a police officer,
>
> (d) a psychologist,
>
> (e) a member of staff of a community-based not-for-profit organisation that provides services that include the rehabilitation of persons with a severe substance dependence,
>
> (f) a member of staff of a private health facility (within the meaning of the *Private Health Facilities Act 2007*) that provides services that include the rehabilitation of persons with a severe substance dependence,
>
> (g) a close friend or relative of the person with a suspected severe substance dependence,
>
> (h) the primary carer, or any other care-giver, of the person with a suspected severe substance dependence,
>
> (i) the Director-General."

This list contains an incredibly broad range and large number of persons who could request that an assessment be performed, noting the severe potential consequences of a medical practitioner recommending involuntary treatment (detention for up to 90 days or mandatory naltrexone

implant). It is clear that such an extensive list opens the door to significant abuse and misapplication of these powers, with particular concerns that police officers could seek assessments leading to mandatory detention, rather than either cautioning or not prosecuting minor drug possession offences (and therefore significantly increasing the number of people detained in either the justice or 'medical' systems).

As outlined earlier, we also have significant concerns that proposed sub-sections 9(2)(e) and 9(2)(f) apply to members of staff of community-based not-for-profit organisations, or private health facilities, that provide rehabilitation services. Given the term staff is left undefined, this could mean that receptionists, administration officers and even cleaners of these organisations could request that medical assessments, leading to potential mandatory detention, be performed.

Even if these proposed sub-sections were narrowed to medical staff, this is still too broad in our judgment. It potentially fatally undermines the purpose of voluntary rehabilitation services – allowing the medical staff of these organisations to apply for assessments will be a significant disincentive to people with substance dependence from seeking voluntary assistance (potential clients of these services would be understandably disinclined to attend if they become aware that the service that is supposed to help them could instead seek an assessment leading to their mandatory detention).

Proposed sub-sections 9(2)(g) and 9(2)(h) are also too broad, allowing a wide range of family members, friends and carers to apply for assessments. The motivations of this large group of people will not always be in the best interests of the person with substance dependence.

Finally, proposed section 9(2)(i), when read in conjunction with proposed section 49A (contained in schedule 1, clause 45 of the Bill) would, in practice, mean that the Director-General could seek an assessment, as well as any member of staff of the Ministry of Health or any person, or any person or class of persons authorised by regulations, to which the Director-General delegates this power. That

is, there would be no restriction on the Director-General allowing all 500-plus Ministry of Health staff to be able to seek assessments, as well as currently unspecified classes of persons. This is far too broad and cannot be supported.

Hepatitis NSW strongly supports the current restriction in the Act, which is that only medical practitioners can seek assessments.

- *Hepatitis NSW does not support proposed sub-section 9A(3), as outlined in schedule 1, clause 13 of the Bill which expands the criteria for recommending compulsory treatment.*

We have serious concerns about the significant expansion of criteria upon which a medical practitioner can recommend that a person be issued with a mandatory treatment order. In particular, Hepatitis NSW does not support proposed sub-section 9A(3)(b)(ii) which states that one criteria is: "to protect others (including, but not limited to, children in the care of the person, or dependants of the person) from harm to their physical or mental health."

It is difficult to know on what objective basis a medical practitioner will be able to assess the likelihood of potential harm to others, and especially harm to the mental health of others (if a medical practitioner conducts an assessment as a result of a referral from a family member who alleges they 'cannot cope' with the person's substance dependence, would mandatory treatment be allowable because it would improve the referring family member's 'mental health'?)

An even more serious problem is raised by proposed sub-section 9A(3)(b)(iii), which would allow medical practitioners to recommend mandatory treatment "to remove the risk of the person committing an offence due to the person's severe substance dependence".

Given that the term offence is not defined here, and that possessing illicit drugs is an offence (and the misuse of prescription drugs can also be an offence), it is likely that this criteria will be satisfied

for most people with substance dependence. That is, a medical practitioner will be able to recommend mandatory treatment for all people with substance dependence on illicit drugs, irrespective of whether they are a threat to themselves or others.

If the intention is that this criteria only applies to non-drug related offences, then medical practitioners would not be in a position to assess this criteria in any event. Although the way that the clause is drafted – to remove the 'risk' of committing an offence – would in fact apply to everyone (as the only way to completely remove the risk of anyone committing an offence would be to detain them).

The fact that the criteria in proposed clause 9A(3)(b)(iii) – the risk of committing an offence – can then result in mandatory detention for up to 90 days for treatment – is in effect 'imprisonment'[65] on the basis of potential future crime. This is clearly unacceptable. We maintain that, if compulsory treatment is to be retained in the *Drug and Alcohol Treatment Act 2007*, the only criteria in this part should remain whether the treatment is necessary to protect the person from immediate, serious self-harm.

While discussing proposed sub-section 9A(3), we would also note that, with respect to sub-section (3)(d), in nearly all cases there will be more appropriate and less restrictive means for dealing with patients than the mandatory detention and treatment of the person with substance dependence. Treating a person in the community or voluntarily in a rehabilitation facility, rather than through compulsory treatment (either in detention or with mandatory naltrexone implant), should be the preferred standard of care. It is then up to the Government to ensure that these services are made 'reasonably available'.

[65] The Oxford Dictionary defines prison as "a building to which people are legally confined as a punishment for a crime or while awaiting trial." Even if people with substance dependence are detained in a medical facility, the fact that they are placed there on the basis of a potential future crime, and they are not legally allowed to leave, would make this de facto imprisonment in a criminal rather than medical sense.

- *Hepatitis NSW does not support the proposed Category A dependency certificate.*

We have significant concerns about the expansion of existing compulsory treatment orders through the new definition of Category A dependency certificates[66]. While some features remain the same, we are particularly concerned about the substantially increased time period of the certificates – rather than a 28 day order, which could then be extended, Category A dependency certificates apply for 90 days.[67]

While the form provided for medical practitioners to complete in schedule 2 allows them to replace 90 days with a shorter period, this is only included in a note, and it is presumed that 90 days will be the standard duration of a Category A dependency certificate.

Hepatitis NSW believes that this time period is too long, and, by removing an individual from their family, friends, community and potentially from employment, it will in fact cause significant harm to the individual receiving 'treatment', and exacerbate problems upon completion of treatment (whether successful or not). Our strong preference would be for retention of a 28 day maximum order with an extension only granted through application by a medical practitioner to a Magistrate, and then with a maximum duration of 3 months.[68]

- *Hepatitis NSW does not support the proposed Category B dependency certificate.*

We also have serious concerns about the proposed new Category B dependency certificates[69].

For reasons outlined earlier in this submission, we believe there are serious issues about the safety of naltrexone implants, and that to introduce the compulsory implantation of naltrexone through

[66] As introduced in schedule 1, clause 5, which amends the definitions in section 5 of the Act, and then expanded upon from clause 13, proposed new sub-section 9A(2) onwards in the Bill.
[67] As outlined in schedule 1, clause 16, proposed new sub-section 14(1) of the Act.
[68] Current section 35 of the Act.
[69] As introduced in schedule 1, clause 5, and outlined in more detail from schedule 1, clause 13, proposed section 9A(2) onwards.

mandatory treatment orders is both highly unethical, and seriously risks the health and indeed life of people with substance dependence. The use of naltrexone implants in the community by people who agree to them voluntarily carries significant risks – the mandatory imposition of naltrexone implants on people who do not wish to be treated in the first place (which is a pre-condition for Category B dependency certificates) is unacceptably dangerous.

This last point goes to a fundamental contradiction at the heart of this form of compulsory treatment. Despite only being issued after satisfying the criteria in proposed sub-section 9A(3)(c), which includes that the person is unable or unwilling to participate in treatment voluntarily, a Category B dependency certificate can only be issued after the person agrees in writing to have naltrexone implanted under his or her skin[70]. This appears to be based on the principle of consent, and yet the entire mandatory treatment regime is based on lack of consent. On what possible basis is the person who is the subject of a mandatory treatment order providing their written agreement?

Indeed, the way that proposed section 9A would operate, when read as a whole, seems likely to encourage people to agree to naltrexone implants as the only way for them to avoid being subject to mandatory detention (or quasi-imprisonment) for up to 90 days. It is not hard to envisage people being assessed by a medical practitioner, who says they are likely to be made subject to mandatory treatment, then 'bargaining' with the practitioner to stay out of compulsory detention (ie to 'beg' the practitioner to issue a Category B rather than Category A certificate).

These concerns are magnified in terms of proposed section 24A (in schedule 1, clause 37), which would allow a medical practitioner to discharge someone from mandatory detention and move to out-patient treatment, but only if the person with substance dependence 'agrees' to undergo treatment with naltrexone implants. The desire to leave mandatory detention would, for many people, outweigh any consideration of the risks involved with these implants.

[70] Schedule 1, clause 13, proposed sub-section 9A(5)(c) of the Act.

Given that the avoidance of detention would be their primary motivation, the person with substance dependence would not be interested in the potential risks of naltrexone implants, or what they would need to do during treatment to avoid personal harm. This decision, which would be, at least in part, placed on people with substance dependence would actually work to increase the negative outcomes for these same people, who would be given naltrexone implants when they are not in a position to understand the full consequences of that procedure.

The mandatory nature of the naltrexone implant, on top of the broader concerns around naltrexone implants (discussed under Term of Reference 1), mean that Hepatitis NSW cannot support any aspect of Category B dependency certificates.

- *Hepatitis NSW does not support the conditions which accompany Category B dependency certificates.*

Even if the general principle of Category B dependency certificates could be supported, the conditions which accompany this proposed form of mandatory treatment reveal that this is a draconian and invasive type of intervention.

These certificates require the person with substance dependence to attend mandatory counselling (which would, primarily, be at the choice/referral of the medical practitioner)[71]. We believe that mandatory counselling with someone who the person with dependence has not chosen and may not wish to see limits any potential effectiveness of or benefits from this 'therapy'.

[71] Schedule 1, clause 13, proposed sub-section 9A(5) and 9A(6), and clause 21, proposed sub-sections 15A(1)€ and 15A(1)(f).

Category B dependency certificates also require mandatory, weekly drug testing of the person with substance dependence[72]. While this is arguable in terms of preventing adverse health outcomes (because of the inherent risks of naltrexone implants), the invasiveness of these types of requirements further strengthens our opposition to these certificates overall.

Hepatitis NSW also has concerns over the conditions of Category B dependency certificates which would cause a person with substance dependence to be detained because of 'punishable breaches' (as outlined in schedule 1, clause 21, proposed section 15B). In particular, the person could be sent to mandatory detention, and transferred to a Category A dependency certificate, for merely being in possession of alcohol, or for consuming alcohol, where alcohol may not be a drug of dependence for that individual[73].

Alternatively, the person may fail two of their weekly mandatory urine tests, something which would not be uncommon for people undergoing treatment for substance dependence (with relapses, and often multiple relapses, a common occurrence during treatment). In normal practice, failure of more than one urine test during treatment for alcohol and/or other drugs would not normally result in mandatory detention for up to 90 days, and we do not believe it should apply here.

- *Hepatitis NSW believes the safeguards outlined in the Bill are inadequate.*

If Category A and Category B dependency certificates were to be introduced, we believe that the current safeguards in the Bill would not be sufficient to protect the interests of people with substance dependence. For example, in schedule 1, clause 15, the proposed section 11A of the Bill

[72] Schedule 1, clause 21, proposed sub-section 15A(1)(c) requires people to submit to a weekly urine test, as well as sub-section 15A(1)(d) requiring them to "co-operate with any other measures for monitoring the person's substance use of other behaviour that are specified in the dependency certificate."
[73] This applies because of the interaction of proposed section 15B, and proposed section 20A as outlined in schedule 1, clause 29.

seeks to ensure that a dependency certificate will not be issued unless the person has been given a reasonable opportunity to seek legal representation before the certificate is issued.

While this principle appears sound, it may not assist some people with substance dependence in practice. Some people will defer to the medical practitioner making the assessment, or not challenge them, rather than seek independent legal representation. Others may not wish to discuss their illicit drug-related activities with a lawyer or legal aid service.

And there is no guarantee that the person with substance dependence will be able to access legal representation – that is dependent on legal aid funding, where the person lives, the time of the assessment and other factors. This applies even where the medical practitioner must bring the person before a Magistrate after issuing a Category A dependency certificate (ie mandatory detention)[74], there is no guarantee that the person will be able to access legal assistance.

Similar concerns apply with respect to proposed section 21A, in schedule 1, clause 30, which seeks to ensure that people subject to mandatory detention have unrestricted access to legal representation at all reasonable times. This is a welcome sentiment however it is unclear how this principle would be applied in practice (given the already described limitations in accessing legal aid).

Further, the supposed safeguard in schedule 1, clause 20, proposed sub-section 15(4), that people being treated or counselled at an out-patient treatment centre (ie people who are subject of a Category B dependency certificate) are entitled to competent and reasonable care, is not capable of being satisfied if the treatment which they are receiving (mandatory naltrexone implants) is actually putting their health and/or life at risk.

[74] Schedule 1, clause 16, proposed section 14A of the Act.

- *Hepatitis NSW does support the proposed new sub-section 20(4A) to preserve the rights and bodily integrity of a dependent person.*

We do believe that this additional clarification, that persons who are subject to a frisk search or ordinary search under section 20 of the existing Act shall have their rights and bodily integrity observed, would be a welcome addition to the safeguards of the existing Act.

- *Hepatitis NSW does not support the proposed restrictions in schedule 1, clause 29, which apply to people in mandatory detention and on naltrexone treatment.*

As discussed earlier, proposed section 20A in schedule 1, clause 29 would operate to place someone on a Category B dependency certificate in mandatory detention if they have alcohol in their possession, or to consume alcohol, more than once. However, the restrictions in this proposed section apply to both Category A and Category B certificates, and are extremely onerous.

For example, this provision would prohibit the possession, without reasonable excuse, the possession of objects which "in the opinion of the director of the relevant treatment centre, is able to be used by the dependent person… in assisting abuse of a substance."[75] Would this apply to spoons? Would this apply to soft drink cans? Or a range of other paraphernalia which can be used in drug-taking?

It also allows a treatment centre, in patient or out-patient, to confiscate "anything that, in the opinion of the director… could be detrimental to the good order of the treatment centre."[76] This is an incredibly broad subsection, and demonstrated how few rights are given to persons who are subject to either Category A or Category B treatment orders.

[75] Schedule 1, clause 29, proposed sub-section 20A(2)(b).
[76] Schedule 1, clause 29, proposed sub-section 20A(2)(c).

- *Hepatitis NSW expresses concern about proposed section 24(3)(e), and proposed section 24B(2)(e)which compels the Director-General to discharge a person from mandatory treatment.*

It is unclear what happens when the Director-General, or their delegate, exercises their responsibility under proposed sub-section 24(3)(e), which requires them to discharge the person with substance dependence from detention if they reasonably believe that the dependent person has committed an offence while detained for treatment. A similar provision exists with respect of mandatory out-patient (naltrexone) treatment, in schedule 1, clause 37, proposed section 24B(2)(e). Do these provisions apply to drug possession offences? And in this case, does the Director-General then report these offences to police?

As we have noted before, it is common for people with substance dependence to relapse, and to take additional drugs of dependence, including during treatment. It would appear to be unnecessarily criminalising people to have relapse during treatment result in referral to police and a subsequent criminal record, or even term of imprisonment.

- *Hepatitis NSW notes the post-rehabilitative care regime provided in proposed section 25A.*

We note that there is some merit in the post-rehabilitation support mandated in proposed section 25A (schedule 1, clause 38). In particular, proposed sub-section 25A(2) outlines a range of services or supports which would be valuable for persons who have recently completed treatment for substance dependence, including housing, assistance with employment, training and other supports.

However, we believe that these supports should not be provided as part of a mandatory treatment regime, but instead provided to all people who undergo voluntary treatment for alcohol and other drug dependency. We also note that some of these services would be required after mandatory treatment precisely because the individuals involved would have been removed from society for up

to 90 days, and therefore may lose accommodation, employment and other support structures which they previously had.

- *Hepatitis NSW does not support further periods of mandatory detention, as provided in proposed sub-section 25A(5).*

We do not support the provisions of schedule 1, clause 38 (proposed sub-section 25A(5)), which would allow the Director-General or their delegate to seek the re-assessment and then imposition of a potential new mandatory treatment order (in-patient of out-patient), if they reasonably believe that the person has used the substance of dependence within 90 days of completing the initial mandatory order.

Given the draconian nature of the mandatory treatment regime, whether detention for 90 days and/or compulsory naltrexone implant, we do not believe that there could be any justification for imposing such treatments on a person more than once. In such circumstances, we would support returning to more tradition, voluntary-based rehabilitation options, including Methadone Maintenance Treatment (MMT).

- *Hepatitis NSW expresses concern about the transitional arrangements in the Bill, especially applying to persons in mandatory detention at the time of commencement.*

We are particularly concerned about the transitional arrangements, in schedule 1, clause 47, under the heading "Application of amending relating to detention and treatment", and whether the operation of this provision would mean that persons currently detained for a period of 28 days or less would have their detention extended to 90 days without appropriate review. This transitional

provision should be clarified to ensure that the 28 day time limit remains on persons who are subject of a mandatory treatment order at the time of commencement.

Overall, given the range and severity of our concerns about the *Drug and Alcohol Treatment Amendment (Rehabilitation of Persons with Severe Substance Dependence) Bill 2012*, Hepatitis NSW does not believe that this Bill should be passed.

Recommendation 4: Hepatitis NSW does not support passage of the Drug and Alcohol Treatment Amendment (Rehabilitation of Persons with Severe Substance Dependence) Bill 2012.

Conclusion

We appreciate the opportunity to make a submission regarding drug and alcohol treatment in NSW.

Should you require further information please contact our Policy and Media Officer, Mr Alastair Lawrie

Yours sincerely

Stuart Loveday

CEO

Hepatitis NSW

Wednesday 13 March2013