Drug Dependency Discrimination

Submission to the Inquiry by the

Senate Legal and Constitutional References Committee

into the

Disability Discrimination Amendment Bill 2003

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1.0 Introduction

1.1 Organisational Overview

The Disability Discrimination Legal Service (Victoria) (*DDLS*), is a state-wide community legal centre that specialises in disability discrimination legal matters. The service is located in Melbourne and provides legal information, education and training, advice, representation and policy/law reform services to Victorian's with disabilities and their associates. The Service employs three part-time staff: a Coordinator/Community Legal Educator, a Casework Solicitor and a Systems Administrator who are supported by volunteers and legal students. The DDLS is managed by a Management Committee, a majority of whom must be people with disabilities.

The DDLS is an active member of the National Network of Disability Discrimination Legal Services of the National Association of Community Legal Centres and as such contributes to the development of national action on issues of policy/law reform.

1.2 Drug Dependence[1]

What is Drug Dependence?

In regulating normal function, the human body creates many chemicals and has particular receptors that perform specific tasks within the brain including stimulating emotional and physiological responses to external stimuli and stabilising the normal range of emotions and feelings all people experience. Many drugs of dependence actually mimic these chemicals and interact with the central nervous system and largely determine the dependent person's resulting physiological and psychological response. The individual may have little or no control over this response to the drug.

By definition, drug dependence (as opposed to drug use alone) compels the user to continue to seek and use the drug of dependence, often overpowering the person's preference to cease or control drug use. Physical and/or

[1] This submission refers to the term 'dependence' rather than 'addiction', as it more accurately describes the compulsive physiological and psychological conditions associated with problematic drug use.

psychological dependence occurs after prolonged or heavy use over time and results in the need to take the drug consistently in order to function effectively and/or to prevent illness associated with withdrawal symptoms.[2]

Evidence indicates that the physical and psychological dependence resulting from extended use of particular substances can cause changes in the brain over time.[3] These changes can result in increased compulsive behaviour that may become more and more difficult for the individual to manage.
Whilst a person may make a choice to take a particular substance initially their capacity to exercise this same level of choice to cease or control drug use can be seriously compromised once a person becomes physically dependent.

Although there are many medical, social and legal definitions for drug dependence none of these definitions are universally accepted. The World Health Organisation (*WHO*) classifies drug dependence as:

> *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.*[4]

The diagnostic classifications provided by the WHO include that:

> *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:*
> *(a) a strong desire or sense of compulsion to take the substance;*
> *(b) difficulties in controlling substance-taking behaviour in terms of its onset, termination, or levels of use;*
> *(c) a physiological withdrawal state (see F1x.3 and F1x.4) 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;*
> *(d) evidence of tolerance, such that increased doses of the psychoactive substances are required in order to achieve effects originally produced by lower doses (clear examples of this are found in alcohol- and opiate-dependent*

[2] Drug info http://www.druginfo.adf.org.au/index.asp
[3] World Health Organisation "What do people think they know about substance dependence" www.who.int/substance_abuse/PDFfiles/sabuse_myths_full.pdf
[4] Excerpt from: WHO *The International Statistical Classification of Diseases and Related Health Problems, tenth revision, Classification of Mental and Behavioural Disorders: Clinical descriptions and diagnostic guidelines F10 – F19 Mental and Behavioural disorders due to psychoactive substance use*, (1983), pp 4-5.

individuals who may take daily doses sufficient to incapacitate or kill non tolerant users);
(e) 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;
*(f) 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.*

Most researchers in the developed world outside of the United States of America (*US*), tend to support the bio-psycho-social model for understanding the causes and nature of, and treatment for drug dependence.

1.3 Drug Dependency in Australia

Levels of Drug Use

Reports of the levels of drug use in Australia show that:

Approximately 23% of Australians reported using any illicit drug in the 12 months preceding the survey in 1998. Marijuana was the most common illicit drug used, with around two-fifths (39%) of those aged 14 years and over having used the drug at some time in their lives. Of those who have ever used marijuana, almost half had used in the past 12 months. Amphetamines had been recently used by around 4% of those aged 14 years and over, while 2% had used ecstasy/designer drugs, and around 1% had used heroin, cocaine, or injected an illegal drug, during the previous 12 months.
Rates of marijuana use, as for most illicit drugs, have increased over the past decade, although rates for other drugs are much lower than for marijuana. The five illicit substances most commonly tried in Australia were:
· marijuana;
· pain-killers/analgesics (for non-medical purposes);
· hallucinogens;
· amphetamines; and
· tranquillisers (for non-medical purposes).[5]

In terms of gaining some insight into the numbers of drug dependent persons, it is reported that in 2001 that there were approximately 100,000 opiate dependent Australians[6].

1.4 Case Law

Australia

[5] Miller M, Draper G 2001. Statistics on drug use in Australia 2000. AIHW cat. no. PHE 30. Canberra: AIHW (Drug Statistics Series no. 8), p 3.
[6] Law, M. *Hepatitis C Virus Projections Working Group: Estimates and Projections of the Hepatitis C Virus Epidemic in Australia 2002* National Centre in HIV Epidemiology and Clinical Research. April 2002.

The first case in Australia to really address the issue of whether a drug addiction constitutes a disability was heard in the Federal Court in November 2000. The complainant, Mr Marsden, was a member of the Coffs Harbour & District Ex-Servicemen & Women's Memorial Club Ltd (CHDEWM). At the time, Mr Marsden was suffering from opioid dependency – a fact that was known to the management of the CHDEWM. Following several incidents between the Mr Marsden and Club's management, Mr Marsden was expelled on the basis of conduct unbecoming of a member. Mr Marsden responded with legal proceedings, claiming that he had been unfairly discriminated against. He claimed that his dependence on opium was a disability, and that the Club's decision to revoke his membership was primarily based on his drug addiction.

Initially the matter was referred to the Human Rights and Equal Opportunity Commission (HREOC) Inquiry Commissioner who decided that Mr Marsden had not been unfairly discriminated against. The complainant appealed the decision to the Federal Court, contending that HREOC had failed to properly contextualise the meaning of disability. Justice Branson in the Federal Court agreed with the appellant's submission concluding that the HREOC had wrongly given the meaning of 'disability' an entirely medical intonation without construing it in reference to Mr Marsden's drug dependence. The Court decided that the Inquiry Commissioner's order should be set aside and the matter be remitted for further consideration. Although the Federal Court's judgment failed to clarify whether or not drug dependence constitutes a disability, it can be inferred from Branson J's decision that a person's drug dependence may in some circumstances invoke the protection of anti-discrimination law.

More recently in New South Wales, the Administrative Decisions Tribunal heard a similar case involving an employee of the City of Botany Bay Council (CBBC). The applicant, Mr Carr had been an employee of the CBBC for several years, performing mainly labour intensive tasks. During the course of his employment, Mr Carr had been registered in a methadone program to assist in his rehabilitation from a prior heroin addiction. However, in order to

maintain a relatively "normal" existence, Mr Carr needed to take regular and periodic doses of methadone.

After his employer discovered two jars of methadone, Mr Carr began experiencing several difficulties at work including: having his methadone put on display for all other co-workers to see, having his dependence on methadone reported to the remaining staff members and being transferred without notice.

In 2002, Mr Carr brought an action against the CBBC under the *Anti-Discrimination Act 1977* (NSW) claiming that his drug dependence constituted a disability. The respondent's legal representative structured their case on arguing that drug dependence is not a form of disability within the meaning of the Act. In particular, persons who are undergoing treatment for drug dependence do not exhibit the manifestly obvious behaviour required to constitute a disability. The Anti Discrimination Tribunal rejected this argument, stating that the purpose of the Anti-Discrimination Act did not emphasise such unreasonable limitations. It was noted, "[t]he fact that a person who suffers from a disorder feels "normal" and is able to lead a "normal life" while taking appropriate treatment does not mean that he or she no longer has a disability."

Although this was a tribunal hearing which lacks precedential value, it provides some indication as to the likely direction the courts would take if presented with a similar fact situation. It is interesting to note that the respondent never questioned whether or not drug dependence constituted a disability, but rather the extent to which a person's behaviour must be manifested. The tribunal's decision to reject this line of argument indicates a strengthening trend throughout the judiciary that drug dependence inflicts both a medical and social disability which requires legal protection.

United States of America

In December 2003, the United States Supreme Court handed down its decision involving an alleged act of discrimination against a drug dependent employee. The appellant, Joel Hernandez, was employed with the Raytheon Co as a baggage handler. After testing positive for the use of cocaine, Mr Hernandez was given the ultimatum of having his employment terminated, or voluntarily resigning.

Shortly after resigning, Mr Hernandez sought treatment to recover from his cocaine dependence. He then reapplied for his position at Raytheon Co which was flatly rejected. Mr Hernandez then brought an action against Raytheon Co for discriminating on the basis of his prior drug addiction. Counsel for the Raytheon argued that their decision not to reemploy Mr Hernandez was not discriminatory but rather based on a disparate no rehire policy. The Supreme Court ultimately agreed with the respondent's counsel, concluding that Raytheon did not discriminate on the basis of Mr Hernandez's prior drug addiction.

The relevance of this case to the current submission is the classification the American courts were prepared to give to drug dependence. All the way up through the appellants courts, it was never questioned whether or not drug dependence could constitute a disability, but whether or not the no-rehire policy was of itself, discriminatory. When looking at these decisions more closely, it is apparent that the United States jurisdiction is shifting in its hard-line political stance on drugs, to recognising that it can constitute a disability.

Canada

In 1998, the Canadian Federal Court of Appeal was asked to consider whether terminating the employment of a drug dependent employee was an act of discrimination. In this case, Appellant Bank had a policy requiring new and existing employees to submit a urine sample for drug testing. The Canadian Civil Liberties Association (CCLA) complained to the Canadian Human Rights Commission alleging that the policy was in direct contravention of the *Canadian Human Rights Act*. Under section 25 of the Act, it makes it

unlawful to discriminate against anyone based on a disability, which includes a drug addiction (s. 3). The appellants argued that the Act was not designed to protect those people dependent on illegal drugs, thereby providing grounds to uphold the appeal. The court held that the *Canadian Human Rights Act*, which is essentially a piece of beneficial legislation, was not intended to be read so narrowly. In a practical sense, those people who are drug dependent are most likely to be dependent on an illegal substance rather than one permitted by law.

As such, the current position in Canada is that drug dependence, whether it be a licit or prohibited substance, is regarded as a disability under the *Canadian Human Rights Act*. This reflects the progressive nature of the Canadian Government on the subject of prohibited drugs and its concern as a health and societal issue.

1.5 The DDA Amendment Bill (*DDAAB 2003*)

Following the *Marsden* decision in November 2000 a degree of uncertainty has been cast over the appropriate classification for drug dependence. While the Federal Court's decision to remit the matter for further consideration has tended to suggest that drug dependence could be classified as a disability, it is by no means conclusive. However, due to widespread misunderstanding of the implications of this decision, many have wrongly interpreted this as a revocation of employers' rights to terminate staff who are clearly addicted to illicit drugs.

In response to the concerns raised following the *Marsden* case and the release of the relevant draft recommendations of the Productivity Commission's Inquiry regarding the Disability Discrimination Act, the Attorney-General Mr Phillip Ruddock[7], has introduced the Disability Discrimination Amendment Bill 2003 (Cth), which proposes to lawfully allow discrimination on the basis of addiction to prohibited substances in the areas of employment,

[7] According to the Second Reading presented by the Attorney-General, Mr Phillip Ruddock, there were three main concerns which prompted introducing the Bill: (i) The lack of certainty for individuals and organisations covered by the DDA, (ii) business or club operators may face discrimination claims by drug addicts in an attempt to "keep the work or social environment safe from other people's behaviour", and (iii) the risks posed by another person's drug addiction

accommodation, education, club membership, sport, the administration of Commonwealth programs, and access to goods, services, facilities and premises.

2.0 International Law/Policy Regarding Drugs of Dependence

2.1 Human Rights Law

The following tables illustrate how the DDAB does not meet United Nations Human Rights Conventions and Declarations:

Declaration of the Guiding Principles of Drug Demand Reduction	
International Obligations	**Response to Obligations**
- Policies directed toward reducing the consumer demand for illicit drugs must observe human rights	- "Tough on Drugs" strategy ignores human rights
- Upholding the right to freedom from discrimination which is enshrined in international human rights law and also recognized by Article 7 of the UDHR	- DDAB permits discrimination against drug users
- Policies must promote individual health and well-being	- Promotes discriminatory practices likely to have a negative impact on health and well-being
- Policies must promote social integration	- DDAB permits lawful social exclusion in all areas of DDA

International Covenant on Civil and Political Rights (ICCPR)	
International Obligations	**Response to Obligations**
- Protect marginalized groups from unfair and unjust treatment	- The Bill further marginalizes drug users and discriminates on the

	basis of drug dependence
- Protect equal rights and access to goods and services	- The Bill removes rights and creates barriers to goods and services
- Ensure equal participation in civil, political, economic, social and cultural life	- The Bill makes discrimination based on drug dependence lawful with the likely impact being reduced political, economic, social and cultural participation
- Promote social integration	- DDAB permits lawful social exclusion in all areas of DDA

2.2 International Approaches to Drug Treatment

Several international organisations argue that 'tough on drugs' campaigns are ineffective. A better solution for drug dependence is to provide greater investment in drug dependence treatment.

World Health Organisation

Further, the World Health Organization aims to dispel the myth that investing in treatment for individuals who have drug dependence is a waste of public funds. The WHO provides that investing in evidence based treatment decreases both the negative health consequences and the social effects of drug dependence (for example, crime, economic burden and HIV infection). Treatment is proven to be a cost effective strategy that is also less expensive than imprisonment. [8]

United Nations

For drug dependency to be treated more effectively it should be addressed as both a health issue and as an ongoing problem. The United Nations

[8] WHO, 2004, What do people think they know about substance dependence, www.who.int/subatance_abuse/PDFfiles/sabuse_myths_full.pdf

Discussion paper 'Investing in Drug Abuse' compares addiction to other chronic illnesses, the difference being that the impact of the addiction on families and society.[9] The perspective taken is that addiction treatment providers must broaden their responsibilities and focus on socially important goals. Thus, it seems the best available options to address drug dependency are through;

- •ongoing treatment
- •by addressing the multiple problems that are risks (medical, psychiatric and social instability)
- •through social integration (as opposed to merely punitive sentences)
- •by providing treatment through combinations of continuing outpatient therapy, medications and monitoring

The underlying premise is that it is possible to combine both treatment and corrective approaches in order to address drug dependency. The two strategies are not mutually exclusive.

International Labour Organisation

The Bill is also inconsistent with the *International Labour Organisation (ILO)'s* Code of Practice on the management of alcohol and drug related issue in the workplace.[10]

This Code of Practice emphasises the preventative approach to drug and alcohol management. It further defines alcohol and drug related problems as health problems and establishes the need to deal with them, without any discrimination, like any other health problem at work. In this respect, counselling, treatment and rehabilitation are important. (Section 2.1.4) The DDA Amendment Bill is inconsistent to the ILO's Code of Practice as it treats drug dependency only as a matter of law and not a health issue.

[9] United Nations Office on Drugs and Crime, *Investing in Drug Abuse Treatment, A Discussion Paper for Policy Makers*, (2003).
[10] ILO Code of Practice on the management of alcohol-and-drug –related issues in the workplace (1996)

The Bill sits contrary to the Code of Practice in that it provides for lawful discrimination on the basis of drug addiction. Employees who are accused of having a drug addiction will not only have to prove they do not, or if they do that they are seeking treatment; but will thereby be publicly labelled a drug addict and potentially be subject to further discrimination as a result. Compulsory disclosure of one's addiction is not a practical step toward providing treatment for drug dependent persons, as they are less likely to be successful in their treatment if involuntarily made to attend. Of course if the person does not succeed in treatment they will be at risk of further discrimination.

Specifically, the Code of Practice establishes that:

- •Workers and their representatives should have the right to expect that their right to privacy be respected and that any intrusion into the private life of the worker regarding alcohol or drug use is limited, reasonable and justified (Section 2.3.8)
- •Workers who seek treatment and rehabilitation for alcohol and drug-related problems should not be discriminated against by the employer and should enjoy normal job security and opportunity for transfer and advancement (Section 8.2.1)
- •Employers should have the right to take appropriate measures with respect to workers with alcohol and drug-related problems which affect, or which could reasonably be expected to affect, their work performance (Section 2.2.5)
- •'Safeguards such as sections 2.2.5 and 8.2.2 are already in legislation to protect employers, allowing to take thus the DDA Bill serves no purpose but to further discriminate against drug users – especially those who are addicted to drugs but who are nonetheless, competent at their job'[11]
- •The employer should adopt the principle of non-discrimination in employment based on previous or current use of alcohol or drugs, in accordance with national laws and regulations (section 10.1.1)

[11] Ibid

2.3 Domestic Policy

Australia has long been recognised as a leader in the treatment and management of drug dependence and in drug related harm reduction strategies. In recent years, this reputation has been diminished as increasingly punitive measures are instigated at a federal level.

Despite this, particular attention should be paid to the national drug diversion scheme and the operation of drug courts in the states and territories. These are a prime example of an effective strategy to monitor drug dependency without resorting to 'tough on drugs' measures such as the proposed DDA Amendment Bill, 'this approach represents a shift away from focussing purely on the criminal conduct of the offender, to addressing offenders' needs and the underlying causes of their offending, such as drug dependency, homelessness and unemployment'[12]

Drug courts operating in Victoria, New South Wales and Queensland provide a shift from punitive to therapeutic justice. Emphasis is given to community based treatments and increasing the accountability of the defendant.[13] Further, the courts are cheaper and more efficient than imprisonment, with wider societal benefits including; reductions in drug use, increases in employment and education, reunification of families and drug free babies.[14] Strategies like the drug courts represent a more practical, cost-effective and therapeutic way to combat drug dependency in society.

Law enforcement cannot be simply overlooked in the management of drug dependency, however, it is submitted that it is not the only solution. 'Policy makers should concentrate on determining the optimal mix of drug enforcement and treatment and the most appropriate remedies for minimising

[12] Hulls, R '*Victoria's New Drug Court*' Law Institute Journal (2002) 76 No 4, May
[13] McGlone, D '*Drug Courts: a Departure from Adversarial Justice*' Alternative Law Journal 28 (3) June 2003 136-140
[14] Ibid

any public health risks'[15] Law enforcement certainly plays a significant role in the deterrence of illicit drug usage, but this must be applied in accordance with other approaches, because strictly criminal sanctions are far too costly.[16] Furthermore, strictly criminal sanctions are not always ultimately effective, 'in no country where the death penalty applies for trafficking has the trafficking stopped'[17]

Decriminalising illicit drugs is certainly an avenue to be explored. If implemented, no doubt criminal activity associated with obtaining drugs will decrease, with the 'government [having] the options here of simply removing the wedge between import and street prices by decriminalising supply, or of greatly reducing the wedge by supplying addicts with cheap drugs of higher quality' as will overdoses and the social side effects of drug usage.[18] Similarly, the operation of safe injecting rooms in NSW and of criminal law diversionary schemes that steer drug dependents away from imprisonment, are valuable approaches that should be considered. Ultimately, a strategy based solely on law enforcement and other strictly punitive regimes, such as the *DDA Amendment Bill*, is likely to be ineffective.

2.3 International Policy Trends

International trends also show that combined health and social programs and treatment based strategies are more practical than strictly punitive 'tough on drugs' measures such as the proposed Disability Discrimination Amendment Bill.

Australia has in recent decades lead a less punitive combined health, legal and social approach to reducing drug-related harm. In contrast, international trends show that models based on the American 'zero-tolerance' regime prove unsuccessful, and that treatment based, progressive alternatives are significantly more effective. A Swiss trial allowed addicts to receive injections

[15] Weatherburn D & Lind B, '*Heroin Harm Minimisation: Do we Really have to Choose Between Law Enforcement and Treatment?*' Crime and Justice Bulletin (46) November 1999: 1-11
[16] Ibid
[17] Hyde, J 'Drugs: Time for a Rethink' Institute of Public Affairs, Review 53(3) 2001, 10-11
[18] Ibid

of pure heroin, three times a day, was remarkably successful. During the time period, the number of addicts involved in criminal activity dropped from 59% to 10%. Homelessness numbers dropped, employment figures rose, and there were marked improvements in health, 'new infections with HIV and hepatitis infections dropped sharply, and the annual death among the addicts fell by half'.[19]

Strictly punitive measures for combating drug dependency, at the expense of housing, education and health supports are unsuccessful, and the proposed DDA Amendment Bill reinforces this type of strategy. It marginalises drug dependent persons and overlooks treatment based remedies proven to successfully treat drug dependence.

3. Health and Social Issues

3.1 A Health Focused Approach

As mentioned earlier in this submission, drug dependence is increasingly recognised by legislators and policy makers world-wide as a health and social issue. This obviously influences the development of policy that is medically and socially oriented, particularly with increasing evidence of the physiological process of dependence.

> *People with drug dependence have altered brain structure and function. It is true that dependence is expressed in the form of compulsive behaviour, but this behaviour is strongly related to brain changes over time, with repeated use of drugs.* [20]

Research shows significant changes in the functioning of the user's brain, caused by prolonged drug use, persists long after use is discontinued. These changes have many behavioural manifestations, most prominently the compulsion to continue use despite obvious negative consequences.[21]

[19] Shenk, J W '*Hooked on dogma; US Drug Warriors Ignore Switzerland's Success with Heroin Addicts'* The Washington Post, December 21, 1997
[20] WHO, 2004, What do people think they know about substance dependence, www.who.int/subatance_abuse/PDFfiles/sabuse_myths_full.pdf
[21] National Institute on Drug Abuse (NIDA), 2004, Principles of Drug Addiction Treatment; a research based guide

"Addiction" as referred to in the DDAB is not a medical diagnostic term, having been abandoned by the World Health Organization in the 1960s in favour of "dependence," which can vary in severity. [22]

According to the WHO:

> *Dependence is regarded by many as a discrete disease entity, a debilitating disorder rooted in the pharmacological effects of the drug, which is remorselessly progressive*[23].

As also mentioned earlier in this submission, there is no universally accepted definition of addiction.

3.2 Social Issues Influencing Drug Dependence

The reasons why some people may use and ultimately become dependent upon certain drugs are largely social and environmental. Some of the risk factors impacting upon young people that are associated with drug dependence in later life include:

- depression, suicidal behaviour, exposure to crime, risk of homelessness;[24]
- extreme economic depravation, family conflict, low literacy/limited education, social isolation;[25] and;
- a lack of appropriate community education about drug use and harm reduction.

Legislative measures aimed at discouraging drug use appear to be based on the assumption that drug use is solely the result of conscious decisions made by the user. Clearly, there are many complex factors at work, and many influences leading up to a person's drug addiction. The United Nations Office on Drugs and Crime[26] has urged that substance abuse treatments can and

[22] **Lexicon of alcohol and drug terms published by the World Health Organization,** http://www.who.int/substance_abuse/terminology/who_lexicon/en/ , 2004

[23] **Lexicon of alcohol and drug terms published by the World Health Organization,** http://www.who.int/substance_abuse/terminology/who_lexicon/en/ , 2004

[24] Bond, L, Thomas, L, Toumbourou, J, Patton, GC & Catalano, R, Improving the lives of young Victorians in our community: A survey of risk and protective factors, Centre for Adolescent Health, 2000.

[25] Hawkins, JD, Catalano, RF & Miller, JY, Risk and protective factors for alcohol and drug problems in adolescence and early childhood, Psychological Bulletin, 112, pp 64 – 105.

[26] United Nations Office on Drugs and Crime, *Investing in Drug Abuse Treatment, A Discussion Paper for Policy Makers*, (2003).

should be expected to improve the public health and social problems of patients, if a satisfactory scheme is to be established.

The Individual

The WHO recognizes that drug addiction is a brain disorder[27] that often effects and impairs brain structure and function. According to the WHO, while some people may be able to control compulsive behaviours, that are often associated with this type of brain disorder, it is simply not possible to control or take responsibility for the brain disorder itself. In many cases, the brain disorder will affect brain functioning in such a way that a person does not have the capacity to choose, to cease use or seek treatment. According to Dr Alan Leshner, chief executive officer of the American Association for the Advancement of Science:

> *The recognition that addiction is a brain disease does not mean that the addict is simply a hapless victim,. Having this brain disease does not absolve the addict of responsibility for his or her behaviour, but it does explain why an addict cannot simply stop using drugs by sheer force of will alone.*

It is only through effective treatment and recovery support that people experiencing drug addiction can follow the path, to restored health and functioning, and develop the capacity to take control over and responsibility for their actions. The DDAB is based on assumptions about drug dependency that fail to recognize that drug addiction is disabling in nature and particularly so for those who experience chronic dependence.

In addition, evidence suggests that there may be a genetic pre-disposition to dependency that may make it more difficult for some people to prevent compulsive behaviour**.**

Evidence indicates that the physical and psychological dependence resulting from the extended use of particular substances can cause changes in the

[27] World Health Organization, *What do people think they know about substance dependence? Myths and facts for policy makers responsible for substance dependence prevention, treatment, and support programs*, (2001).

brain over time.[28] These changes can result in increased compulsive behaviour that may become more and more difficult for the individual to manage.

Whilst a person may make a choice to take a particular substance initially, their capacity to exercise this same level of choice to cease or control drug use can be seriously compromised once a person becomes physically dependent.

The Social Context

The context within which most drug use and dependence occurs is social and not individual alone.[29] To a great extent, society encourages the use of legal and illegal substances, for a variety of reasons:

- Celebration and recreation;
- Curiosity and experimentation;
- Treatment: as clinically administered or in addition to conventional treatments for a variety of illnesses;
- Peer pressure: major influences on adolescent behaviour include rejection by peers, diverging from expectations of conventional social group;[30] and
- Vulnerable persons: a study suggests that where parent-child relationships are detached, abusive, uninterested, uninvolved, or "overwhelmed by other stressors", they are more likely to result in adolescent children adopting problematic substance use behaviours[31].

As previously discussed, by definition, drug dependence (as opposed to drug use alone) compels the user to continue to seek and use the drug of dependence, often overpowering the person's preference to cease or control drug use.

[28] World Health Organisation "What do people think they know about substance dependence" www.who.int/substance_abuse/PDFfiles/sabuse_myths_full.pdf
[29] Above n1, n2 & n3.
[30] Drugs and Health Protection Services, Public Health Division. Victorian Government Department of Human Services, "Involving Families in Alcohol and Drug Treatment", July 2000. pg 31.
[31] Ibid.

4. Specific Responses to the DDAAB

4.1 Drafting

In Australia, where the three arms of state power are theoretically separated, legislation is often the primary written expression of Parliament. That is, in most cases the written words of an Act will be the only means by which the judiciary can determine the true intention of Parliament. The Acts Interpretation Act 1901 (Cth) has reinforced this notion by only allowing the use of extrinsic meaning to determine the will of Parliament when the words of an Act are, prima facie ambiguous or in conflict with the purpose of the Statue.[32] As such, the terminology and the phraseology used to effect a legislative provision must be selected carefully and precisely as to accurately express the intention of Parliament.

4.1.1 Terminology

The terminology of a provision is of fundamental importance to accurately expressing the will of Parliament, and therefore in determining the interpretation of the judiciary. Words that are vague or ambiguous may require clarification through external sources, which can distort their true meaning and intention. The Disability Discrimination Amendment Bill has incorporated several words and phrases that are inherently unclear and open to socially contextualised interpretation. The result of enacting this legislation in its current state is that it will be exposed to critical legal challenges. The following terms could be subject to such definitional contests:

4.1.1.1 Addiction

Although the preferred method of interpreting legislation is to ascribe a word its ordinary meaning, this is contingent upon the word not having a more technical or precise definition, or being subject to various contentious or changing definitions. Section 54A(1), of the DDA Amendment Bill refers to those people suffering from a drug dependence as “persons addicted”. Aside from the social connotations (which will be discussed below) associated with

[32] Acts Interpretation Act 1901 (Cth), s. 15AB

the term “drug addicts”, the word “addicts” has no objective, scientific basis. To put it more simply, ‘what is an addict?’

To answer that question, most people would define an addict on social behaviour alone. Perceptions would say that an addict is a person who is maladjusted, introverted and out of touch with normalised society. However, it is apparent that people who suffer from drug addictions do not readily fit stereotyped preconceptions.

One attempt to define an addiction has been by separating it into two parts: mental and physical addiction.[33] The mental addiction subjugates the user into believing they have control over their dependence and that their use is an assistance in maintaining the normality of their lives. Yet the physical addiction is manifestly a physical dependence on the substance.

Another attempt to define addiction has been describing it as: the use of a drug for a reason other than which it was intended or in a manner or in quantities other than directed – a compulsion to take a drug to produce a desired effect or prevent unpleasant effects when the drug is withheld. It is clear from the dichotomy between the two definitions that the term “addiction” is open to definitional challenge.

Moreover, given the lack of consensus on the meaning of “addiction”, it is unsatisfactory to entrust employers and others to determine whether the subjects of this provision are, in fact, “addicts”. Employers who do attempt to invoke this provision, and terminate the employment of staff members they suspect of being addicts (based on their own perceptions of an addict) may be liable for unlawful dismissal claims.

However, despite the various offered definitions, “dependence” continues to be:

[33] Gold, P., <http://philgold.home.mindspring.com/htmls/Addict-def.html

> *…exceedingly difficult to define. The standard definitions of 'drug dependence', the WHO International Classification of Diseases and the Diagnostic and Statistical Manual of the American Psychiatric Association, are dimensional rather than dichotomous, in keeping with contemporary scientific conceptions. Arguments about addiction are likely to produce robust, lengthy and expensive debate in court. A judgment about the presence or absence of addiction in an individual can only be made on the basis of self-reported symptoms. Are individuals contesting discrimination made lawful by the DDAB likely to accurately describe their symptoms of addiction? Observations from independent witnesses or objective laboratory tests, such as urine analysis, are unlikely to assist the courts.*[34]

Surely the judiciary would be no more able to identify drug dependence than international medical communities.

Particular attention should be paid to the parallels between the *Americans with Disabilities Act* (ADA) and the proposed DDA Amendment Bill. The ADA, effective in 1992, similarly sought to exclude drug addicts from the protections afforded by the Act. The cases that stemmed from this decision illustrate why the DDA Amendment Bill may be difficult to put into practice.

Persons excluded from the protections of the ADA were those 'currently engaging in the illegal use of drugs.' The Shafer v Preston Memorial Hospital case found that the term 'currently' came to mean 'periodic or ongoing activity that has not yet permanently ended.'[35] Similarly, in the Baustain v State of Louisiana case a six week drug free recovery did not satisfy the statute requirement. [36] The underlying idea is that a person can still be deemed a current user even if they have not recently used drugs in a number of months or weeks. [37] Such problems are sure to arise in the scope of Australian employment if the DDA Amendment Bill is enacted. The American development in this area of law shows that excluding drug dependent people from the protections of an anti-discrimination bill is unworkable and inherently complex.

[34] Wodak, Alex et al (2004), Is lawful discrimination against illicit drug users acceptable? Unpublished paper
[35] Shafer v Preston Memorial Hospital Corporation, 107 F.3d 274 (1997)
[36] Baustain v State of Louisiana 910 F.Supp. 274 (E.D. La 1996)
[37] 'Sharing the Dream: Is the ADA Accomodating All?' http://www.usccr.gov/pubs/ada/ch4.htm

4.1.1.2 "Receiving Services" and "Undertaking a Program"

Subsection 2(b) of the Bill provides grounds for which subsection 1 does not apply. It states that if a person who is addicted to a prohibited drug is undergoing a program or receiving services to treat the drug addiction, then any act of discrimination based on that person's drug addiction will be unlawful. While this provision does afford some protection to persons that come within the scope of subsection 1, its effect is somewhat undermined by the definitional ambiguity of the phrases, "undergoing a program" and "receiving services."

Firstly, neither the Bill, the explanatory memorandum nor the second reading speech provide any indication to the type of program or services that are necessary to qualify for the exemption. Does a drug dependent person need to be seeking treatment through an officially registered program or is something will a higher degree of discretion acceptable? For instance, it has been suggested by the Human Rights and Equal Opportunity Commission that regularly seeing a counsellor, priest or doctor is acceptable form of treatment.

Secondly, the Bill gives no indication to the extent or frequency a drug dependent person must be attending treatment. The phrase "undergoing a program or receiving services" seems to suggest that treatment is being received on a regular and periodic basis. However, given the ambiguous nature of the terms, 'program' and 'services', it is impossible to determine with any certainty, the regularity of such treatment.

The importance, however, of understanding dependence extends beyond difficulties with legislation and judicial interpretation. It helps to explain why a drug dependent person may have difficulties maintaining abstinence without treatment, and why simply threatening to deprive a drug user of rights is

unlikely to achieve its desired effect. According to the National Institute of Drug Abuse:

> *Psychological stress from work or family problems, social cues (such as meeting individuals from one's drug-using past), or the environment (such as encountering streets, objects, or even smells associated with drug use) can interact with biological factors to hinder attainment of sustained abstinence and make relapse more likely.*[38]

Clearly, such understanding is crucial to developing programs that successfully treat drug dependence.

4.2 Existing Defences make the legislation unnecessary

According to the Second Reading Speech given by the Attorney-General, Mr Phillip Ruddock on the 3rd December 2003, the purpose of the Bill is *inter alia*, to "keep the work and social environment safe from other people's behaviour."[39]

There is a deeply entrenched social perception that drug dependent people are a danger to the rest of society. It is commonly believed that the majority of injecting drug users, use in public places, yet statistics show that only 14% do so. It is also commonly believed that most drug dependent people resort to a life of crime to fund their habit, yet studies have show that those people who do commit crimes to support their habit were actively involved in criminal activities before they used illicit drugs.

Hypothetically, if an employee was found to be using illicit drugs in the workplace, there are several existing legal avenues that could be taken to affect the same result as the proposed Bill.

Firstly, and perhaps most obviously, the use of illicit drugs is a criminal matter and one that should be handled by the appropriate authorities. The

[38] National Institute on Drug Abuse (NIDA), 2004, Principles of Drug Addiction Treatment; a research based guide
[39] Commonwealth, *Hansard*, House of Representatives, 3rd December 2003, 23171 (Phillip Ruddock, Attorney-General)

Government has, through that passing of State and Federal legislation, undertaken the task of protecting society against the use, trade and distribution of illegal drugs. Accordingly, an employee who was found to be dealing with an illegal substance in any capacity would be liable for criminal prosecution.

Secondly, and a point which goes to the heart of the Bill, is that illicit drug use that affects an employees performance could simply be dealt with internally by the business. It is generally accepted that illicit drugs have the potential to incapacitate the user, if only for a period of time. To the extent that a drug dependant employee's use of drugs interfered with their work so that their performance was sub-standard, the matter could be dealt with as a work related matter. Whether it is written into the employee's contracts or merely implied, a minimum level of performance is required. Such that a person's drug use compels them to fall below that standard, they would be in breach of their contractual obligations and liable for lawful termination.

Finally, and importantly, under the DDA, there are existing defences relating to the concepts of:

- Whether the discrimination was 'reasonable in the circumstances'
- Whether accommodating disability constitutes an 'unjustifiable hardship'
- Whether the person can perform the 'inherent requirements' of employment

4.3 Invariable impact upon "associates"

According to section 2(2) of the proposed Amendment, a limitation has been incorporated to exclude "associates" from its effect. What this means is that a person whose employment is terminated on the basis of their addiction to an illicit substance will not have a secondary impact on those closely connected. As the Homeless Persons Legal Clinic points out in their submission to the Inquiry:

> *While it only seems reasonable that a person not proximally connected with another's drug abuse not be affected, the reality of the situation that a deleterious impact is*

inevitable. People who are drug dependent do not exist inside a vacuum, completely detached from the environment around them. They can be people who have partners or children who are reliant on their support, whether it be financial or emotional. As a consequence of this, "associates" of drug dependent people will inevitably be harmed by the effect of this Amendment. For instance, as it was noted in the Explanatory Memorandum, the Amendment makes it lawful for a drug dependent father or mother to have his or her employment terminated (or his or her residential lease terminated) if suspected of being drug dependent.[40]

This would invariably have a harmful effect on any child that was reliant on their parents.

4.4 Against public health measures

Drug and substance abuse is vastly becoming recognised as a health issue rather than an entirely criminal matter. There are many individual and societal factors that compel a person become drug dependent which are not reduced by the legal consequences.

With that in mind, the Disability Discrimination Amendment Bill 2003 (Cth), seems to run counter intuitive to our growing understanding of drug dependence and the prevention of drug related disease. Drug dependence is primarily a health issue and should be treated with such deference. To discriminate against a person entirely on the basis of their addiction to a prohibited substance serves to further marginalise drug dependent people, undermine their health and social status, and potentially increase their dependence on drugs. In addition it places at risk the very success of blood-borne disease prevention measures such as needle and syringe exchange programs due to the potential identification of users of such services as drug addicted persons by people such as employers, service providers and landlords who may then lawfully discriminate against drug users. Such disincentives to access public health measures aimed at disease prevention poses a potentially serious risk to the health and wellbeing of all Australians

[40] Lynch, P., p. 21

4.5 Negative educational impact

The social perception of a drug dependent person is primarily founded on a stereotype: an independent person whose decision to accept a life of drugs was an exercise of freewill. In a handful of cases, certain aspects of this profile are true and that drug dependence is a by-product of independent choice. However, in the majority of cases, a person does not 'chose' a life of drug dependency, but rather it is thrust upon them as a result of other social factors.

Unfortunately though, the stereotypical characterisation, which is set in the minds of most people has entrenched the dichotomy between "drug addicts" and rest of "normal society." People with drug problems tend to be viewed as outsiders whose responsibility it is to cure themselves of their addiction. The Disability Discrimination Amendment Bill 2003 (Cth) seeks to perpetuate this stereotype by further marginalizing drug dependent people. Enacting this Bill would only exacerbate the problem by promoting state sanctioned discrimination against drug users who do not seek treatment.

4.6 Barriers to services and treatment

A lack of places in treatment services compared to demand for treatment services in most areas of Australia reinforces that even those drug dependent persons who seek treatment may not be able to access it and may be adversely affected if they experience discrimination because they cannot seek treatment.

4.7 Against the aims of Anti-Discrimination Law

According to section 15AB of the *Acts Interpretation Act 1901 (Cth)* the content of each provision should be read consistently with the Act's purpose. In other words, there should not be any irreconcilable difference between the ordinary meaning of a provision and the underlying purpose of the Act. Obviously the Act will allow discrimination to occur for the purposes of encouraging people to seek treatment for drug addiction and not to prevent discrimination on the basis of disability.

5. Conclusion and Recommendations

The changes proposed by the *Disability Discrimination Act Amendment Bill* 2003 intend to lawfully allow people to discriminate against drug users in all facets of their life including: employment, accommodation, education, club membership, sport, the administration of Commonwealth programs and access to goods, services, facilities and premises.

Effectively, this will be done by specifically excluding – but not defining - addiction under the definition of 'disability' in the *Disability Discrimination Act*.

As highlighted in international jurisdictions, the hard-line stance on drugs, characterised by the USA 'war on drugs' approach, has proved to be unsuccessful. Australia should be heading toward an evidence-based treatment approach, rather than adopting a 'zero tolerance' position that targets drug users without providing the resources for treatment and support.

Additionally, drug addiction should be treated as a health issue and an ongoing problem that can't be remedied by a quick fix. Drug addiction should not be seen as a matter entirely based in criminal law. Rather, it should be placed in a health care and broader social context, taking into consideration that there are many reasons why people become drug dependent.

Clear policy is needed in relation to drug addiction and discrimination, particularly in legislative terminology. Unfortunately, the Bill has incorporated several words and phrases that are inherently unclear, ambiguous and undefined. The ultimate effect of this is that the provisions in which the ambiguous words are contained would be open to critical legal challenges.

The word 'addiction' is hard to define. It has an ever changing status because no conclusive definition has yet been developed and universally adopted.

The words ‘receiving services’ and ‘undergoing a program’ are equally as ambiguous. It is by no means clear what is meant by ‘undergoing a program.’ What constitutes a program for the purposes of the Bill? Because of this ambiguity, it is not clear as to what type of programs or services are necessary to qualify for the full protection of the DDA. Additionally, the Bill gives no indication to the extent or frequency with which a drug dependent person must be attending treatment.

The *Disability Discrimination Act Amendment Bill* does not reflect current international approaches and best practice toward drug dependence, based on evidence and medical, social and legal frameworks.

The DDLS makes the following recommendations:

Recommendation 1

That the Committee recommend that the Disability Discrimination Act Amendment Bill 2003 be withdrawn.

Recommendation 2

That the Committee recommend that the Government recommit to the harm reduction strategy and appropriately resource measures to provide and promote accessible, effective, evidence based treatment, education and prevention, and early intervention programs that meet individual needs.

Recommendation 3

That the Government recognise that dependency is not simply a matter of individual choice: that it stems from various societal and environmental factors; and recognise and address the links between poverty, ill health, unemployment, poor education and social exclusion and drug dependence.