Drug problems in Western Australia: a review of noncriminal mechanisms to regulate drug users by use of the Health Act 1911

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Introduction

There is a dearth of literature and case material about non-criminal legal mechanisms that regulate drug users in Australia.[2] We might surmise this may be due to an oversight, a lack of interest in the rights of drug users, or due to an over-preoccupation with the application of criminal regulatory mechanisms. Surprisingly, in a number of recent publications concerned with legal mechanisms to control drugs and their use, there is no discussion of the system of control, by notification, that operates in Western Australia (WA) and a number of the other States.[3] This omission seems to have arisen, at least in respect to WA's system, by a failure to have understood the key role played by the *Health Act 1911* (the Act) as an instrument of drug policy.[4]

Discussion of non-criminal legal mechanisms is pertinent as since the early 1980s there have been a number of proposals to decriminalise the use of a number of classes of drugs.[5] Recently serious consideration has been given to a trial scheme in the Australian Capital Territory (ACT) to prescribe heroin as a form of treatment for people with opiate-related drug problems.[6] As such a trial would require a legislative framework and administrative structure, it is opportune to consider the system of non-criminal controls of drug users that has operated in this State since 1958, to highlight issues associated with schemes designed to identify and control drug users and regulate their access to prescription drugs.

This paper briefly reviews the characteristics of the notification system that has operated in WA since 1958, with particular reference to the administrative procedures instituted under the *Drugs of Addiction Notification Regulations 1980*[7] (the Regulations) and will consider whether the rules of procedural fairness could be implied to way the regulations and the associated "register of notified addicts" is operated.

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[1] Published in E-Law – Murdoch University Electronic Journal of Law, 1994, 1(3).

[2] The pejorative term "drug addicts", frequently used to refer to this population of individuals, will only be used in this paper in context of the legislative meaning given to this term

[3] Carney T. *Drug users and the law in Australia*. Law Book Co, Sydney, 1987; Fox R & Mathews I. *Drugs Policy: Fact, Fiction and the Future*. Federation Press, Annandale, NSW, 1992.

[4] For instance, the *Australian Health and Medical Law Reporter*, CCH Australia, Sydney, at 23-700, only refers to the *Poisons Regulations 1965*.

[5] Australian Foundation on Alcoholism and Drug Dependence. *Social Policies on Drugs, Alcohol, Cannabis, Heroin: A discussion paper*. AFADD, Canberra, 1982; Kirby MD. *Drugs, Problems of reform and living it down. Address to AFADD National Drug Institute, Brisbane May 1983*. Law Reform Commission, Canberra, 1983; Fox R. "Examining existing drugs policies." (1990) 1(3) *Criminology Australia* 10; Rolfe JL. *Background issue papers to International Conference On Drug Control: Legal Alternatives and Consequences, Melbourne, November 1989*. Victorian Drug Rehabilitation and Research Fund, Melbourne, 1990; Woltring H. "Examining existing drugs policies: the 1988 UN Convention - help or hindrance?" (1990) 1(4) *Criminology Australia* 19; Carney T, Drew L, Mathews J, Mugford A & Wodak A. *An unwinnable war against drugs: The politics of decriminalisation*. Pluto Press, Leichardt, NSW, 1991.

[6] Australian Capital Territory, Legislative Assembly, Select Committee on HIV, Illegal Drugs and Prostitution. *Second interim report: A feasibility study on the controlled availability of opioids*. ACT Legislative Assembly, Canberra, 1991; Bammer G et al. *Feasibility research into the controlled availability of opioids*. (2 Vols). Canberra, National Centre for Epidemiology and Population Health, Australian National University, 1991; Bammer G. "Is a trial heroin treatment program in the ACT feasible?" (1992) 4(2) *Criminology Australia* 16; Hartland N, McDonald D, Dance P & Bammer B "Australian reports into drug use and the possibility of heroin maintenance." (1992) 11 *Drug & Alcohol Review* 175; Bammer G, Douglas B, Moore M & Chappell D. "A heroin trial for the Australian Capital Territory? An overview of feasibility Research." In Heather N, Wodak A, Nadelmann EA & O'Hare P (eds). *Psychoactive drugs and harm reduction: from faith to science*. London, Whurr Publishers, 1993.

[7] Which re-enacted the arrangements established by the *Notification of Diseases (Non-Communicable) Regulation 1958*. *Government Gazette*, 29 April 1958, p. 769.

The discussion of these issues will be used to argue there are serious shortcomings in the operation and effect of the notification system, because it deters people who use drugs from seeking medical treatment as they may be notified as addicts, that many medical practitioners will be reluctant to treat drug users, and if doctors were willing to treat notified addicts they are significantly constrained in their capability to do so.

It will be concluded the WA notification system invades privacy and affronts principles of natural justice as it fails to include procedures to review decisions to notify, register or de-register and that by severely restricting choice of doctor and choice of treatment, it has the effect of supporting coercive treatment of drug addicts.

Administrative features of the notification system

The inviolable ethical duty of medical practitioners to maintain the confidentiality of disclosures of their patients is overridden by the Regulations. This qualification of the doctor-patient relationship involves the balancing of two concerns. Firstly, the right to privacy and the correlative duty upon medical practitioners to maintain confidence; and secondly, a public interest in the epidemiology of diseases and medical conditions and the protection of the community from harm that may result if individuals afflicted by such conditions were left untreated. The acquisition of data derived from the doctor-patient, though contentious, has been described as

> *"the conflict is not between good and evil, but between two principles of equal merit. [Knox] suggested that the individual's right to privacy also needs to be qualified in order to protect society which confers the right: 'Neither a concern for the individual nor a concern for mankind may hold absolute sway over the other'."*[8]

The Act contains the foundations for three compulsory notification systems with respect to (a) "notifiable diseases" (s 3), (b) "dangerous infectious diseases" (s 248), and (c) "prescribed conditions of health" (s 289B).

The first two systems are concerned with the notification of a wide range of infectious diseases such as leprosy, cholera, HIV/AIDS and hepatitis. The third system covers three "prescribed conditions of health" - non infectious stages of syphilis,[9] cancer[10] and addiction to drugs.[11]

Under the Act the Governor-in-Council is delegated with the power to issue regulations, conditioned by the objects of Part IXA of the Act.[12] The limits on the scope of such a delegated power are determined by reference to the enabling statute,[13] s 289C (a) - (d), ie that any regulations may only apply to prescribed conditions of health, excluding non-infectious diseases, and may "not require any person to submit to treatment without his consent".[14]

A "prescribed condition of health" is defined in s 289B of the *Health Act 1911* as

> *"such disease processes and physical or functional abnormalities as are prescribed conditions of health to which this Part applies, but does not include any infectious disease".*

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[8] Keppel S. "Use of personal health information by third parties for research purposes." (1992) 7 *Auckland University Review* 1, 11.
[9] Health (Venereal Diseases) Regulations 1973. *Government Gazette*, 2 March 1973, p. 587.
[10] Health (Notifications of Cancer) Regulations 1981. *Government Gazette*, 27 July 1981, p. 3065; Health (Cervical Cytology Register) Regulations 1991. *Government Gazette*, 3 January 1992, p. 16.
[11] Drugs of Addiction Notification Regulations 1980. *Government Gazette*, 26 September 1980, p. 3313.
[12] Ibid.
[13] Pearce DC. *Delegated legislation in Australia and New Zealand*. Butterworths, Sydney, 1977.
[14] *Health Act 1911*, s 289C (d).

There is some difficulty in analysing the term "prescribed condition of health" because it is debatable whether drug addiction can be accurately described as either a disease process, or a physical or functional abnormality, as contemporary research into drug use suggests much more complex mechanisms of drug dependence.[15]

The Regulations are given a wide scope through the definition of "drugs" in the Act[16] and by including "drugs of addiction" as the substances in the Eighth Schedule to the *Poisons Act 1964*. The list of Eighth Schedule drugs, so called drugs of addiction, includes both licit opioids such as morphine, codeine and pethidine and illicit opioids such as heroin and illicit non-opioids, such as cannabis, psilocybin and LSD.

The definition of drug addiction embodied in s. 3(2) (a) - (c) of the Regulations, replicates the 1957 World Health Organisation definition of drug addiction,[17] as recommended to State health departments by National Health Medical Research Council at its 43rd session, in May 1957.[18]

Sub sections 3(2) (a) to (c) of the Regulations set up three mutually exclusive forms of dependence that may result from use of a drug addiction or a substitute:

- a "state of periodic or chronic intoxication produced by consumption" (s. 3 (2) (a);
- a "desire or craving to take a drug" (s. 3 (2) (b); or
- a "psychic or physical dependence" (s. 3 (2) (c).

This arrangement produces the curious result that while an individual may be addicted to one drug, the notification by a medical practitioner refers to the person as addicted to all drugs as in the Regulations the term "a drug of addiction" is used in s. 3(2), whereas the term "addicted to drugs" is used elsewhere: ss 3(1), 4(1). It is arguable that though an individual may have a dependence to a specific drug, eg heroin, it does not follow that he/she will be dependent on any of the other drugs contained in the Eighth Schedule.

Another curious effect of the Regulations is that as they only encompass so-called "drugs of addiction", it follows that any individual dependent on a drug not in the Eighth Schedule (eg tranquillisers, sedatives and analgesics), could not be notified by a medical practitioner, even though such a person could satisfy any of the criteria in ss 3(2) (a) - (c).

The rules of natural justice in relation to notification

Is a medical practitioner making a decision under the authority of the Regulations bound to follow the rules of natural justice when he/she notifies a person suspected as being addicted to drugs? The Regulations oblige a doctor to notify within 48 hours a person who they become *"aware of or suspect"* is addicted to drugs: s. 4 (1). The 1988 amendment that added s. 4(3) introduced fines for

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[15] In it's 13th report the World Health Organisation Expert Committee On Addiction-Producing Drugs strongly recommended that the term "drug dependence", defined as *"a state arising from repeated administration of a drug on a periodic or continuous basis"*, should be the preferred nomenclature instead of the term addiction: *WHO Technical Report Series No. 273*. WHO, Geneva, 1964.

[16] *Health Act 1911* s 3(1) "Drug" means any substance, organic or inorganic, used as medicine, or in the composition or preparation of medicines, whether for external or internal use, and includes soap and perfumes, cosmetics, absorbent cotton wool and surgical dressings and also includes therapeutic substances.
This definition includes things not ordinarily regarded as having the meaning of a drug, but excludes legal drugs such as alcohol, tobacco and prescription drugs **not** in the Eighth Schedule that are addictive. (Tobacco was only removed from the s. 3(1) definition in 1990: *Tobacco Control Act 1990*, s. 38.

[17] *Expert Committee on Addiction-Producing Drugs, Seventh Report. WHO Technical Report Series No 116*. Geneva, World Health Organisation, 1957.

[18] Wall BP. *A study of persons notified as drug addicts in the State of Western Australia during 1980-1985*. Unpublished Master of Applied Science dissertation, Curtin University of Technology, Bentley, 1989.

contravention of s 4(1), ranging from $100 (first offence) to $500 (third offence).[19] It is submitted as the 1988 amendment is a penal provision, the courts are likely to interpret s. 4(1) narrowly and strictly.

As the general rule now is that there must be a clear legislative intention to exclude the application of the rules of natural justice, a decision to notify someone as addicted to drugs should, it is argued, involve a fair hearing (the maxim *audi alteram partem*) and must not involve bias by the decision-maker (the maxim *nemo debet esse judex in propria sua causa*).

> *"[I]t may be accepted that there is a common law duty to act fairly, in the sense of according to procedural fairness, in the making of administrative decisions which affect rights, interests and legitimate expectations, subject only to the clear manifestation of a contrary statutory intention."*[20]

It is submitted that neither the Regulations, nor Part IXA of the *Health Act 1911* contain a "clear manifestation" to exclude the rules of natural justice. In *Kiao v West* Mason J considered that the application and content of a duty to act fairly conditioned by a statute depended on the construction of the statute. This means therefore that

> *"the expression 'procedural fairness' more aptly conveys the notion of a flexible obligation to adopt fair procedures which are appropriate and adapted to the circumstances of the particular case."*[21]

By an amendment in 1984, four grounds were inserted into the Regulations by which entries may be deleted, after two years, from the register of notified addicts (the Register) by the Executive Director, Public Health (the Executive Director).[22] These grounds were:

a) if a person had died;
b) if the Director of the Alcohol and Drug Authority has advised an individual has ceased to use drugs;
c) if a false name had been used; or
d) if a person on the Register had no contact for a period of 5 years in relation to their use of drugs of addiction.

It is submitted that grounds (b) - (c) provide support for an argument for the rules of procedural fairness govern the WA notification system. As the Executive Director (in reality a delegate) is responsible for making entries into the Register, it is required that he/she

> *"act in good faith and fairly listen to both sides, for that is a duty lying upon everyone who decides anything ... They can obtain information in any way they think best always giving a fair opportunity to those who are parties in the controversy for correcting or contradicting any relevant statement prejudicial to their view".*[23]

This means there should be procedures so that each person who has been notified has the opportunity to contest the decision to enter his/her name onto the Register. This should include options for an independent second opinion from another medical practitioner and for review by an independent decision-maker.

It is also possible that as the Regulations to notify drug addicts were first introduced in 1958 in response to a Commonwealth request,[24] arising from obligations from Australia being a signatory to

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[19] *Government Gazette*, 14 October 1988, p. 4160.
[20] *Kiao v West* (1985) 159 CLR 550, 584 per Mason J.
[21] Id. at p. 585.
[22] *Government Gazette*, 9 November 1984, p. 3587.
[23] Lord Loreburn in *Board of Education v Rice* cited in Hotop SD. *Principles of Australian administrative law*. 6th ed. Law Book Company, 1985, p. 192.
[24] This was done through the National Health and Medical Research Council (NHMRC) at its 40th

various drug conventions, that fundamental common law rights may be implied to support the proposition that the Regulations should conform to the rules of procedural fairness. Is it possible to imply fundamental common law rights may arise through the Commonwealth being a signatory to international treaties?[25] This broad issue has been considered in relation as to whether the right to a trial without undue delay existed because the doctrine of fundamental rights was brought into Australian law through the Commonwealth being a party to the International Covenant on Civil and Political Rights. Kirby P observed that

> *"[a] more relevant source of guidance in the statement of the common law ... may be the modern statements of human rights found in international instruments ... adopted by organs of the United Nations, ratified by Australia and now part of international law."*[26]

However, a comment by the Full Court of the Federal Court that a decision-maker might *"properly take into account in a general way the existence of Australia's international obligations,"*[27] may mean a court may be prepared to imply fundamental rights when a person is notified because of a close connection between the legislation and international drug treaties signed by the Commonwealth, to satisfy adoption in domestic laws.[28]

Shortcomings in the notification system

The three forms of drug addiction specified in ss 3(2) (a) - (c) are vague and unclear. It is debatable whether the majority of doctors have the requisite experience or knowledge to identify and distinguish drug dependence due to either period or chronic intoxication, desire or craving, or psychic or physical dependence. To overcome these doubts guidelines should be issued setting out the criteria for each form of addiction and to clarify the degree of suspicion or knowledge that is required before the duty to notify is triggered. Such guidelines may also assuage concerns by doctors as to whether they may have breached the Regulations: s. 4(1).

Section 5(2) contains a curious distinction for removal of a person's name from the register of notified addicts, as it sets up a preferential method for de-registration after two years for individuals treated by the Alcohol and Drug Authority (ADA),[29] whereas persons who have had no "direct or indirect" contact with the Health Department "in relation to their use of drugs of addiction", can only be de-registered after five years.[30] Taken in conjunction with other factors, the provision in s. 5(2)(b) may support arguments that the Regulations may offend the scope of the enabling power in s. 289C(d) of the *Health Act 1911* as to compulsory treatment.

Ambiguity exists in s. 5(2), because while de-registration may occur after the expiration of two years if any of the four conditions arise, the inclusion of the words "for a period of at least 5 years" in s 5 (2) (d), suggests two contradictory results, ie de-registration after both two and five years in the case of persons who have had no contact with the Department.

It is submitted there is a lack of clarity as to the purpose of the system. Is it to identify persons with a prescribed condition of health (ie drug addiction), because such persons pose a risk to themselves

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session, held in November 1955.

[25] Cf Australia, Attorney General's Department, Committee of Review of Commonwealth Criminal Law (Gibbs J Chairman). *Final report*. Australian Government Publishing Service, Canberra, 1991: chs 15-18; Fox R & Mathews I. *Drugs policy: Fact, fiction and the future*. Federation Press, Annandale, NSW, 1992: ch 6; Manderson D. *Proscription and prescription - Commonwealth government opiate policy 1905-1937*. Australian Government Publishing Service, Canberra, 1987.

[26] *Jago v District Court of New South Wales and Ors* (1988) 12 NSWLR 558, 569.

[27] *Gunaleela and Ors v Minister for Immigration and Ethnic A ffairs and Ors* (1987) 74 ALR 263, 280.

[28] Ryan, *International law in Australia* 1984 pp 57-60 cited in Fox R & Mathews I. *op cit* p. 70.

[29] Section 5(2)(b): If the Director of the ADA advises the Executive Director the person who has been registered for two years or more has *"ceased to use drugs"*.

[30] Section 5 (2) (d).

and/or to the community? Or, is the purpose to regulate medical practitioners by preventing them prescribing certain classes of drugs to certain classes of individuals?

The latter line of reasoning is fortified by requirements in ss 51A-51F of the *Poisons Regulations 1965*,[31] which prohibit medical practitioners prescribing drugs of addiction, other than methadone, as a treatment for notified drug addicts (s. 51B), unless the individual has been notified and the medical practitioner has been authorised to prescribe methadone (s. 51C). In practice general practitioners are rarely, if ever, so authorised because of a stringent assessment (s. 51D) and the imposition of conditions (s. 51E).

The case of *Cranley v Medical Board of Western Australia*[32] concerned a medical practitioner who had built up a practice in Perth over a 17 year period that principally treated drug addicts.[33] The outcome was a successful appeal against the Medical Board finding of *"infamous or improper conduct in a professional respect"*[34] because of alleged excessive or inappropriate prescribing of drugs to persons who were either notified addicts or had a history of dependence, as Dr Cranley successfully argued his practice was consistent with a harm reduction policy, an approach recognised by a body of respectable medical opinion.

Dr Cranley's practice had arisen in part as many of his patients experienced severe restrictions on their ability to legally obtain Fourth Schedule drugs, as many general practitioners were reluctant to prescribe to them. As Dr Cranley was prevented by the Poisons Regulations (s. 51B) from prescribing drugs of addiction to notified drug addicts he developed a practice that involved the prescription of diazepam (Valium), including in the form of ampoules for parenteral use and other Fourth Schedule drugs, such as Doloxene and Rohypnol.

It could be said Dr Cranley's practice exploited a weakness of the notification system in that while it prevented him from prescribing Eighth Schedule drugs, he was able to prescribe other drugs, including those in an injectable form, as a treatment outside the scope of the Regulations.

It should be noted that many of his patients were reluctant to participate in the ADA's methadone treatment program because it not only entailed notification as a pre-condition, but it was considered to be inflexible and impersonal. In addition to the stigmatisation of notification, participation in the ADA methadone program involved the taking of identification photos.[35]

An implication of the Cranley case is that it suggests the notification system had the effect of creating a quasi compulsory form of medical treatment for notified addicts, what Ipp J. described as the "orthodox treatment", largely available only through the ADA. The combined effect of this consequence and the earlier provision for de-registration if the individual had been successfully treated by the ADA, raises the question whether the notification system offends s. 289C(d) of the *Health Act 1911*.

Conclusion

While this paper has discussed a number of shortcomings in the WA system of notifying drug addicts, it has not sought to answer the underlying issue of the need for such a system. Implicit in an argument

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[31] Section 51AA imposes upon drug addicts a duty to disclose their status as a "drug addict" if they seek to obtain a drug of addiction from a medical practitioner. The "drug addict" in s 51AA logically refers to a notified addict, but as there is not duty for a doctor nor the Health Department to inform someone that he/she has been placed on the register of notified addicts, this provision places the individual in an invidious position.

[32] Unreported Judgement of Supreme Court of Western Australia December 1990. Appeal no 1211/1990.

[33] Dr Cranley gave evidence that since graduation in 1952, he had seen between 25,000 and 35,000 patients in regard to drug problems and that he had about 500,000 consultations with drug addicts. Id. p. 19.

[34] *Medical Act 1984*, s. 13(1)(a).

[35] This provision, justified to ensure accurate identification, occurs in methadone programs throughout Australia. However, this requirement is not covered in the *National policy on methadone*, Department of Community Services and Health, Canberra, 1993.

for a notification system is the notion that we ought to make choices that favour private interests over public interests. If such a choice was made it would mean

> *"a shift in authority away from largely public regulatory interests to those of private concerns together with a similar shift of decision-making power away from administrators and government towards the judiciary."*[36]

The imposition of the duty by the *Drugs of Addiction Notification Regulations 1980* on medical practitioners to notify drug users is flawed to the extent it depends on poorly defined criteria and involves a combination of subjectivity, careful judgement and a thorough understanding of the mechanisms of drug dependency.

There are also serious concerns about the shortcomings in the notification system due to the non-articulation of rights and the failure to follow the requirements for procedural fairness to protect those rights.

As an instrument of policy, notification of addicts does not achieve the aim of restricting the use of drugs that cause dependency, as it does not encompass drugs outside the Eighth Schedule of the Poisons Act known to result in dependency eg tranquillisers, sedatives and analgesics.

The system is also difficult to justify on public health grounds as either protecting the community or enabling the treatment of drug dependent persons, as there is persuasive evidence that notification deters people from seeking treatment from GPs. The continuation of a system as it is presently operates should be questioned.

[36] Baldwin R & Hawkins K. "Discretionary justice: Davis reconsidered." [1984] *Public Law* 570, 598.