UNSW AUSTRALIA | NDARC National Drug & Alcohol Research Centre

Community Affairs Legislation Committee
Australian Parliament
Via email: community.affairs.sen@aph.gov.au

11th April, 2018

Re: Submission to the Inquiry into the Social Services Legislation Amendment (Drugs Testing Trial) Bill 2018

Thank-you for the opportunity to provide comment to the Community Affairs Legislation Committee on the proposed Bill.

We applaud any efforts to encourage, facilitate and/or improve an individual's opportunity to seek appropriately tailored help and treatment for a drug dependence. Like many other chronic relapsing medical conditions, ongoing care and treatment along with the necessary social, family and community support systems, inclusive of vital income support is an essential part of this. However, we have major concerns with the proposed bill.

Were this to truly be a 'trial', then it must conform to the usual standards of evidence-generation (including Australian codes of responsible research conduct). As described in the Bill, the trial is wholly inadequate in this regard.

In the alternative, if this is a covert way of enacting a policy, already rejected by the Senate last year, there are substantial grounds for objection (as detailed in our previous submission to the Senate Community Affairs Legislation Committee, 2nd Aug, 2017). These include: that the Bill misunderstands the nature of drug dependence; the aims are poorly aligned to the mechanisms; the policy contributes to further poverty and structural inequity; there is insufficient existing alcohol and other drug treatment; the Bill has the potential to increase harm; and the Bill infringes human rights, and lacks procedural fairness.

1. Were this to truly be a 'trial'…
The generation of evidence to inform future policy is important, and a principle that we support. Such evidence-generation efforts, however, must conform to the usual standards of research trials, and codes of responsible research conduct.[1]

It is well known that there is no current evidence of the effectiveness of drug testing welfare recipients. In 2013 the Commonwealth's then peak advisory body – the Australian National Council on Drugs – reviewed evidence on the impact of drug testing welfare recipients and concluded that

> *There is no evidence that drug testing welfare beneficiaries will have any positive effects for those individuals or for society, and some evidence indicating such a*

[1] NHMRC and ARC "Australian Code for the Responsible Conduct of Research" (2007). https://www.nhmrc.gov.au/_files_nhmrc/file/publications/r39_australian_code_responsible_conduct_research_150811.pdf

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> *practice could have high social and economic costs. In addition, there would be serious ethical and legal problems in implementing such a program in Australia. Drug testing of welfare beneficiaries ought not be considered.*[2]

However, a trial of such a program would indeed add to the knowledge-base and potentially suggest effective ways to improve the health and social outcomes of welfare recipients. But the Bill is wholly inadequate to this task.

Specification of target population

In order to conduct such a trial, the target population must be clearly specified (otherwise referred to as inclusion/exclusion criteria). The current draft Bill presents a complete muddle of the target population, with a diversity of terms including substance 'use', substance 'misuse', substance 'abuse', 'drug misuse issues', 'drug abuse issues' and substance 'dependency'. There is no clarity of target group (and hence problematic specification of trial outcomes, see below). People consume drugs for all sorts of reasons, the majority of which is not problematic use. Given the procedures outlined in the draft Bill, anyone with a first positive drug test will be subject to income management measures. This would therefore include people who show no signs of drug problems, or drug dependency nor require assessment and treatment. Thus a large proportion of non-dependent, non-problematic drug users will be subject to income management as a result of a single positive drug test, with no apparent benefit, and only significant costs and infringement of human rights, including the right to social security.

If, however, the target group for the trial is people who are experiencing drug dependency (the appropriate group for assessment and treatment, and other forms of support), then a way to actually detect these individuals (beyond a single random drug test) is essential.

A trial protocol, and clearly defined outcome measures

A research protocol is essential, which specifies the primary (and possibly secondary) trial outcomes. At present, the Bill specifies the aim as: "improve a recipient's capacity to find employment or participate in education or training by identifying people with drug use issues and assisting them to undertake treatment" (Explanatory Memorandum). This suggests that the trial outcomes will be measured in terms of access to treatment (treatment entry, treatment retention); employment rates; and training rates. Yet it is not clear if these are indeed the outcomes being measured in the trial. Furthermore, trials need to also measure unintended consequences and other associated outcomes, such as increases in stigma, reduced opportunities for employment, further exacerbation of individual's circumstances (eg increased hardship).

Clear specification of the measure of 'effectiveness' is essential. If 5% of people attain employment under the trial, will that be regarded as a positive outcome? Research studies must clearly articulate (before the study commences) the measures of success. It is a funny kind of search for evidence that does not define its measures of success.

Research practices are documented in a trial/research protocol. For example, given that

[2] *ANCD Position paper: Drug testing* http://www.atoda.org.au/wp-content/uploads/DrugTesting2.pdf

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participants will be "randomly" chosen, the randomisation schedule and procedures associated with it need to be documented. There are usually also provisions for stopping a trial in the event of serious unintended negative consequences, and these are specified in a trial protocol.

Cost benefit analysis. Government initiatives are usually judged according to weighing up the costs against the benefits accrued. Is there a cost-benefit analysis built into this trial? (and if so, what data will be collected, how will all relevant benefits and harms be quantified, what is the duration of the follow-up)?

Other standard features of evidence-generation
There are a number of other, standard features of an evidence-generation program. These include:

- Ethics approval – as with any research conducted in Australia, approval is required from an appropriately constituted Human Research Ethics Committee (see NHMRC Guidelines; and the Australian Code for the Responsible Conduct of Research[3]), including Informed Consent procedures.
- A suitably qualified, independent research team is required.
- Audit (trial monitoring) – a central feature of research integrity is ongoing monitoring of trial compliance with the protocol and any associated procedures.

2. In the alternative, if this is a covert way of enacting a policy…
If this is policy by stealth, we have numerous and serious concerns with the proposed Bill.

The Bill misunderstands the nature of drug dependence. This is not a wilful condition, it is a medical condition. Drug dependence is a medical condition, with chronic relapsing features, akin to asthma and diabetes. And like asthma and diabetes, the condition is exacerbated by social, psychological and environmental factors oft-times beyond the individual's control.

Throughout the Bill, drug dependence is treated as if it were a voluntary choice made by people. In many instances, drug use is voluntary and largely recreational. We assume that those people taking drugs recreationally, who may be randomly selected to be drug tested, will have no difficulty abstaining from drug use into the future. We are, however, gravely concerned for those people with a drug dependence, which has led to physical, psychological and social impairment. For these people, cessation of drugs in the absence of ongoing care and treatment is largely not possible. The currently full treatment system (see below) means that the majority of these people will have to wait, and be subjected to further drug tests which they will likely fail given their medical condition.

The "reasonable excuse provisions" is one example of how this Bill fails to understand the nature of drug dependence. "Reasonable excuse provisions" will apply but not where the reason is wholly or substantially attributable to drug or alcohol use. This is the same as suggesting that if a patient with cancer fails to attend for a chemotherapy session (due, for

[3] NHMRC and ARC "
https://www.nhmrc.gov.au/_files_nhmrc/file/publications/r39_australian_code_responsible_conduct_research_150811.pdf

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example to pain or inability to travel as a result of the cancer), they are penalised because it is the cancer that has prevented their attendance.

The aims are poorly aligned to the mechanisms, and the policy contributes to further poverty and structural inequity: income management plans for those who return a single positive drug test do not align with the overall aims of the trial ("improve a recipient's capacity to find employment or participate in education or training by identifying people with drug use issues and assisting them to undertake treatment").

Poverty is a major issue for many people with drug dependencies. Structural determinants of health (societal structures and inequality that produce marginalisation and poor health outcomes) reside outside of an individual, or her or his own control. Even amongst people with drug dependencies who have sought treatment, research has shown that income-poor clients (including those on welfare) prioritise costs associated with treatment (such as dispensing fees and GP visits) over basic needs such as food and accommodation, and are often compelled to access emergency relief services.[4] This is a highly vulnerable population. Any policy that actually increases inequality or contributes to these structural determinants reduces the health outcomes. The removal of welfare payments is precisely such a policy. There is no evidence that keeping people in poverty decreases consumption of substances, or improves health.

Treatment for alcohol and other drug problems is highly cost effective[5]. But there is simply insufficient treatment available in Australia[6]. Indeed, due to current budget allocation and availability of services, we treat less than half the number of people who are suitable for and seek treatment in any one year[7]. So while referral to treatment for those dependent on drugs is an excellent idea in principle, there are no resources to provide that additional treatment at the present time. If not covered under the currently funded drug treatment services across Australia, who is expected to fund the rehabilitation or counselling fees recommended by the Department of Human Services' contracted medical professional?

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[4] Rowe, J. (2007). A Raw Deal? Impact on the health of consumers relative to the cost of pharmacothery. A report for the Salvation Army. Available at: http://www.salvationarmy.org.au/Global/News%20and%20Media/Reports/2008/4-raw-deal-book.pdf

[5] Ettner, S., Huang, D., Evans, E., Ash, D., Hardy, M., Jourabchi, M., et al. (2006). Benefit-cost in the California treatment outcome project: does substance abuse treatment "pay for itself"? *Health Services Research, 41*(1), 192-213; Moore, T., Ritter, A., & Caulkins, J. (2007). The costs and consequences of three policy options for reducing heroin dependency. *Drug and Alcohol Review*, *26*(4), 369-378

[6] Ritter, A. & Stoove, M. (2016) Alcohol and other drug treatment policy in Australia. *Med J Aust*, 204 (4): 138; Ritter, A., Berends, L., Chalmers, J., Hull, P., Lancaster, K. & Gomez, M. (2014) *New Horizons: The review of alcohol and other drug treatment services in Australia*, Final report submitted to the Commonwealth Department of Health. Sydney: Drug Policy Modelling Program, NDARC, UNSW. Available at: http://www.health.gov.au/internet/main/publishing.nsf/content/FD5975AFBFDC7013CA258082000F5DAB/$File/The-Review-of-alcohol-and-other-drug-treatment-services-in-Australia.pdf

[7] See Chapter 8: Ritter, A., Berends, L., Chalmers, J., Hull, P., Lancaster, K. & Gomez, M. (2014) *New Horizons: The review of alcohol and other drug treatment services in Australia*, Final report submitted to the Commonwealth Department of Health. Sydney: Drug Policy Modelling Program, NDARC, UNSW. Available at: http://www.health.gov.au/internet/main/publishing.nsf/content/FD5975AFBFDC7013CA258082000F5DAB/$File/The-Review-of-alcohol-and-other-drug-treatment-services-in-Australia.pdf

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While noting that the Bill attempts to deal with the problem of an already overstretched treatment system through "the commitment to undertake treatment" should treatment not be available, this again misunderstands drug dependency. In the absence of treatment, a person will continue to use drugs.

Drug testing is not drug treatment (as implied in one section when listing treatment activities to be incorporated into the Employment Pathway Plan "[t]hese activities may include rehabilitation, counselling or ongoing drug testing"). Furthermore, drug testing will not be able to distinguish between those who have clinically significant drug problems and those people who use drugs recreationally and do not require treatment services. How this is managed is not clearly articulated, and the potential to waste important resources (and move resources away from voluntary patients) is a major risk of the Bill.

We have concerns about the 'contracted medical professionals' who do not appear to be required to have any specific qualifications relevant to addiction medicine. The fact that these assessments would be undertaken without adequate levels of clinical expertise is particularly concerning because compliance with an inappropriate recommendation would become mandatory for that person to continue to receive their welfare payment.

*The Bill has the potential to increase harm***.** The compulsion to submit to drug testing contributes to the stigmatisation of people with drug dependence and stigma is a known barrier to treatment-seeking.[8] Stigma is a fundamental social cause of health inequalities.[9] Stigma has been shown to worsen stress, reinforce differences in socio-economic status, delay or impede help-seeking and lead to premature termination of treatment.[10]

There is evidence that when drug testing regimes are implemented, some people switch from better known drugs (those that are included in the testing regime) to lesser known drugs, which may be more harmful. Examples of this phenomenon can be seen in the UK, where synthetic cannabis-type drugs (known as 'green crack' because of its high harm) is being used in prison and correction settings where individuals are subject to mandatory drug testing, with the testing unable to detect these newer and arguable more dangerous psychoactive compounds[11]. It is also occurring in Australian mining communities [12]. Testing technology cannot keep up with the number of new drugs on the market. So, if the trial goes

[8] The effectiveness of interventions for reducing stigma related to substance use disorders: a systematic review. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3272222/

[9] Hatzenbuehler, M. L., Phelan, J. C., & Link, B. G. (2013). Stigma as a Fundamental Cause of Population Health Inequalities. *American Journal of Public Health, 103*(5), 813-821

[10] Schulze, B. (2007). Stigma and mental health professionals: A review of the evidence on an intricate relationship. *International Review of Psychiatry, 19*(2), 137-155; Hatzenbuehler, M. L., Phelan, J. C., & Link, B. G. (2013). Stigma as a Fundamental Cause of Population Health Inequalities. *American Journal of Public Health, 103*(5), 813-821

[11] Ralphs, R., Williams, L., Askew, R., & Norton, A. (2017). Adding Spice to the Porridge: The development of a synthetic cannabinoid market in an English prison. International Journal of Drug Policy, 40, 57-69. http://www.sciencedirect.com/science/article/pii/S0955395916303073

[12] Bright, S. J., Bishop, B., Kane, R., Marsh, A., & Barratt, M. J. (2013). Kronic hysteria: Exploring the intersection between Australian synthetic cannabis legislation, the media, and drug-related harm. International Journal of Drug Policy, 24, 231–237.https://www.ncbi.nlm.nih.gov/pubmed/23333135

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ahead, and some welfare recipients pre-empt the drug tests by switching to lesser known psychoactive substances, it is probable that greater harms will result.

The Bill infringes human rights, lacks procedural fairness. While not legal scholars, we note a number of concerns pertaining to the ways in the measures in the proposed Bill have the capacity to infringe human rights without sufficient justifications, as highlighted by the Special Rapporteur (OHCHR, extreme poverty and human rights). There is also a concern regarding procedural fairness in relation to how drug test results are communicated to participants and opportunities for special considerations and/or challenges to the drug test results. Please see the submission from A/Professor Kate Seear and colleagues at the National Drug Research Institute, Curtin University.

To reiterate:
Were this to be a 'trial' it must conform to the standards for evidence-generation.
In the alternative, if this is a covert way of enacting policy, it is ill-conceived, harmful and misguided.

We would be pleased to provide any additional information or the research references that we have cited herein. This submission may be made available to the public.

Yours sincerely

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