

Background

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) provided a submission to the Committee's Inquiry into the Social Services Legislation Amendment (Drug Testing Trial) Bill 2019 and a RANZCP Fellow, Dr Shalini Arunogiri, who is the Chair of the Bi-National Faculty of Addiction Psychiatry Committee, attended the Inquiry's public hearing to give evidence on 2 October 2019.

The following questions were asked at the public hearing, and taken on notice:

1. Referring to the Australian National Ice Action Strategy, and the Australian National Audit Office's recent report 'National Ice Action Strategy Rollout', Senator Siewert asked how this trial should be evaluated if the Bill is brought into law.
2. Senator Urquart asked what the accessibility of addiction treatment services are in Australia, including how many places there are, what waiting times are like and what the cost is to access those services.

Those questions are answered below.

Question 1

Despite not supporting the drug testing trial, the RANZCP believes that if the trial were undertaken, it would need to be appropriately evaluated to understand the effect that the trial has on its participants. The Australian National Audit Office has recently criticised the Department of Health for not appropriately evaluating the National Ice Action Strategy [1]. As suggested by the Australian Auditor-General in relation to the National Ice Action Strategy, any evaluation of this drug testing trial should identify baseline performance information and progress should be measured against the goal and objectives of the trial [1].

The evaluation should focus on the impact that this trial has on improving numbers of people accessing alcohol and drug treatment services, as well as the impact that participating in the trial has on the mental health of the individuals involved.

The primary purpose of the evaluation should be to assess whether the trial met the a priori outcomes it was designed to achieve. As per the Submission from the Australian Government Department of Social Services, "the aim of the trial is to 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. The trial will test the effectiveness of decreasing substance abuse through random drug testing, in an effort to improve employment outcomes for trial participants" [2].

As such, the following primary outcomes would need to be evaluated:

- Employment outcomes
- Capacity to find employment
- Capacity to participate in education or training
- Decrease in substance abuse

A range of criteria for measuring each of these primary outcomes needs to be pre-determined, and the evaluation framework established, prior to commencement of the trial. It is recommended that consultation with expert stakeholders take place to inform these measures. For instance, how would substance use outcomes be defined and measured, and how would data be captured to assess this? How would capacity to find employment be assessed, and by whom?

Similarly, targets for 'success' or effectiveness need to be pre-determined prior to the trial. For example, what level of increase in employment would be considered a success? And what level of

reduction in substance use? Would substance use disorder outcomes (e.g. severity of dependence, complications) be relevant, or just the presence or absence of use itself?

A range of other information would also be pertinent to assess as part of the evaluation, particularly to consider the impact on the individual and their affected others. At a minimum, this should include markers of mental health and wellbeing, including measures of psychological distress, depression and anxiety symptoms, thoughts of self-harm and suicide, and quality of life. In addition, it would be important to clarify the impact of this trial on stigma, with inclusion of measures of perceived stigma and internalized stigma. All of these factors inform both the intended and unintended consequences of the trial.

A salient consideration is the ethical and legal frameworks that may apply to this evaluation. In order to comprehensively assess the above outcomes, information regarding individual participants may need to be sought from a variety of different sources, including governmental and non-government organisations. Access to this information without the voluntary, full and informed consent of participants may risk contravening Australian Privacy Principles. Further, given that any such evaluation of this trial would likely involve persons with mental illness (particularly those with addiction disorders) as research subjects, the evaluation framework should allow particular ethical protections for those who are vulnerable as a result of their mental illness [3]. Without making provision for such protections, those participating may be further stigmatised and isolated by the evaluation process.

Finally, cost and cost-effectiveness should be central to the evaluation. Incorporation of a health economics component will inform the overall costs of the trial, cost per participant (to the government) and cost per positive test. Final costs should be estimated for all treatment provided within the trial, and assessed in terms of cost per positive test. This should reflect costs charged by third party contractors in provision and conduct of drug testing services, ancillary costs such as transport and equipment, staff and salary costs (by the Department of Social Services or related parties), as well as costs relating to provision of treatment itself. Cost-benefit can then be determined more comprehensively at the completion of the evaluation.

Consistent with best practice in principles of evaluation, we would recommend that the evaluation is conducted by an independent body (i.e. not the Department of Social Services) to promote transparency and minimize potential sources of bias. The independent body should be appointed through fair and transparent commissioning processes. Similarly, outcomes of the evaluation process (including cost-benefit analyses) should be publically accessible so as to foster transparency and accountability.

Question 2

In 2014, the 'New Horizons: The review of alcohol and other drug treatment services in Australia' final report ('New Horizons') stated that 'approximately 200,000 people receive AOD [alcohol and other drug] treatment in any one year in Australia' [4]. Additionally, there are 'between 200,000 and 500,000 people over and above those in treatment in any one year' [4]. There is therefore an established lack of treatment services for addiction disorders.

It is recognised that this lack of treatment services results in considerable waiting times for patients, especially for treatment in residential treatment facilities [5]. Those who are made to wait to access treatment are likely to lose their motivation to seek treatment [5]. Therefore, waiting times mean that fewer people are obtaining treatment and that the cost of addiction continues to impact on individuals and the community. Qualitative data from the National Patient Pathways Project suggest that waiting times are substantial across the country for a range of alcohol and other drug (AOD) services, but

particularly for residential rehabilitation [6]. Waitlists were cited by participants a key barrier to treatment access, and addressing waiting times was one of the key recommendations of the project [6]. The exact length of waiting periods is not clear and as such, the Parliamentary Inquiry into Crystal Methamphetamine (Ice) recommended that the Commonwealth Department of Health and Australian Institute of Health and Welfare work towards establishing 'an alcohol and other drug treatment waitlist item as part of the Alcohol and Other Drug Treatment Services National Minimum Data Set' [7]. This data is important for projecting the number of treatment services needed, as well as understanding how many people become unmotivated to seek treatment due to waiting times.

Costs for addiction treatment services vary, but that this could change based on the nature of the program, how much government funding was received for the program and the sex and age of the client, amongst other factors [8]. In addition to the financial cost of engaging in a treatment program, there are also costs associated with the disruption of relationships with family and support persons, as well as taking away from gainful employment to attend treatment programs. The AIHW publishes information contained in the Alcohol and Other Drug Treatment Services National Minimum Dataset (AODTS NMDS), relating to treatment provided to clients by publicly funded AOD treatment services, including government and non-government organisations. In Australia In 2017–18: around 130,000 clients aged 10 and over (a rate of 601 clients per 100,000 people) received treatment from 952 publicly-funded drug and alcohol treatment services across the country, a 9% rise since 2013–14 (119,000) [9]. Counselling is the most accessed treatment type (39%), with a minority (12%) accessing withdrawal management (otherwise known as detox) services [9]. In 2017–18, 6% (12,368) of closed treatment episodes with a main treatment type of rehabilitation were provided [9].

Based on our clinical experience, costs of AOD treatment depend on the type of treatment, and whether treatment is accessed through the private or public sector. Public sector treatment is largely delivered at no out-of-pocket cost to the consumer. Residential rehabilitation services, largely delivered by non-governmental organisations (NGOs) with some level of government support, were estimated to cost approximately \$117 per day, or a mean cost of \$6995 in residential rehabilitation treatment per episode, according to a 2005 New South Wales report [8]. In contrast, private sector costs can vary from between \$7,000 to \$30,000 per month [10].

There is an evidenced lack of addiction treatment services for people who need them. The RANZCP urges the Government to consider how best to meet this need, including by allocating the funding bookmarked for this drug testing trial to establishing more addiction treatment services.

Conclusion

The RANZCP thanks the Committee for the opportunity to respond to these questions on notice, and is willing to provide further information to the Committee as required. Should you require further information, please contact Ms Rosie Forster, Executive Manager, Practice, Policy and Partnerships

References

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