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Inquiry into Social Services Legislation Amendment (Welfare Reform) Bill 2017

Executive Summary

The Royal Australasian College of Physicians (RACP) welcomes the opportunity to contribute to the Senate Community Affairs Legislation Committee's inquiry into Social Services Legislation Amendment (Welfare Reform) Bill 2017.

The RACP is the largest specialist medical college in Australasia, and trains, educates and advocates on behalf of over 15,000 physicians and 7,500 trainee physicians across Australia and New Zealand. The RACP represents physicians from a diverse range of disciplines relevant to the measures contained in the Welfare Reform Bill, including but not limited to addiction medicine, public health medicine, occupational and environmental medicine, rehabilitation medicine, oncology, clinical pharmacology, toxicology, gastroenterology, and internal medicine.

RACP members see first-hand the many and varied harms caused by addiction when treating their patients in Australia's addiction clinics, rehabilitation centres, liver clinics, cancer wards, and hospital emergency departments. It is on the basis of this expertise and experience, as well as a comprehensive review of the evidence base, that we provide our submission to this Inquiry. We have restricted our comments to schedules 12, 13 and 14 of the Bill, as these are the sections specifically related to our expertise.

The RACP and its Australasian Chapter of Addiction Medicine (AChAM) strongly oppose the measures contained in schedules 12, 13 and 14 of the Bill and urge they not be pursued. While very supportive that more needs to be done to help people overcome drug or alcohol addiction and where possible go on to secure employment, the evidence indicates that the measures proposed will not be effective and will not deliver on the Bill's stated aims. Not only will this policy be a waste of resource, money and opportunity, we are concerned that the measures would in fact cause considerable harm to a highly vulnerable population and merely add to the already long queue of people waiting to access treatment.

The proposed measures fail to recognise that addiction is a serious health issue, and one that is difficult to overcome where recurring instances of relapse are inherent to the nature of the disorder. The proposed changes do not take this into account, nor do they acknowledge or address the severe shortage of available addiction treatment and support services across the country.

The government was advised as recently as 2013 by the Australian National Council on Drugs (ANCD) in their Position Paper on Drug Testing[i] not to proceed with random drug testing policies. The Paper clearly stated 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 practice could have high social and economic costs*". The paper concluded that "*drug testing of welfare beneficiaries ought not be considered"* and drug testing is "*more likely to increase harms and costs".*

No explanation has been provided as to why that advice is now being ignored, nor why the poor results from similar trials in other jurisdictions has seemingly not been heeded. There has been no genuine consultation with addiction medicine, nor with the alcohol, tobacco and other drug sector more generally or the wider health sector as far as we are aware. During the one meeting the RACP was recently asked to facilitate between the President of AChAM and personnel from the Department of Social Services (DSS), our very strong opposition to these measures was reiterated. We note however that no advice on the proposed measures was sought by the DSS during that meeting, and no answers provided to our many questions.

Instead of pursuing these, at best ineffective and at worst directly harmful, measures we call on the Australian Government to appropriately invest in alcohol and drug treatment services and suitably trained workforce and work with experts in the field of addiction medicine and alcohol and other drugs to develop evidence-based policy that will effectively address drug and alcohol dependence and support people on the path back to health and employment.

Schedule 12 - Establishment of a drug testing trial

1. Addiction: A serious health issue

The measures detailed in schedule 12 of the Bill fail to recognise the nature of drug addiction; which is a health issue with complex biological, psychological and social underpinnings. Drug addiction is a chronic relapsing, remitting disorder characterised by drug seeking and use that is compulsive, difficult to control and persists despite harmful consequences[ii]. The diagnostic term 'substance use disorder' in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) refers to recurrent use of alcohol or other drugs that causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. Substance use disorder is defined as mild, moderate, or severe.

The underlying causes of drug addiction can be primarily attributable to environmental factors such as trauma, abuse, a chaotic childhood or home, parent's use and attitudes, and peer and commercial influence, and also to biological factors including genetics, being male, and concurrent mental health disorders[iii]. Other determinants that impact on a person's substance use and dependency include inequity in their socio-economic status, housing status and security, and education. Substance abuse is a complex issue, not simply a personal choice. There are many reasons why people choose to try or take drugs – some highlighted above – however it should be understood that repeated drug or alcohol use leads to changes to the brain that challenge an addicted person's self-control and interfere with their ability to resist intense urges to take drugs. The proposed drug testing regime signals that, as compared with other health issues, our community has a lower understanding of and tolerance level for substance use disorder.

The distinction between someone needing to quit drugs (including alcohol) because of a clinical need and their personal motivation to quit also needs to be recognised. Evidence and clinical experience shows that behaviour change is key to overcoming substance dependency; successful drug treatment warrants some level of motivation from the individual involved to instigate and sustain this behaviour change. A 2016 systemic review found that current evidence on mandatory drug treatment is limited and does not suggest improved outcomes in general while some studies showed potential harms[iv].

Enforced, and potentially disempowering and punitive, measures such as those described in this Bill are unlikely to bring about sustained changes in patients' drug use behaviours and may even be counter-productive – potentially demotivating patients from actively engaging in treatment. Because of this, the RACP and its AChAM do not support mandatory drug treatment in the context of these reforms. Along with the evidence that this approach is ineffective, it also does not consider or address the underpinning macro-environmental influences and structural determinants leading to substance use and dependence.

2. Drug testing trials: The lack of evidence on their effectiveness

The drug testing regime proposed under schedule 12 of the Bill is not supported by current evidence. Evidence from similar programs in other jurisdictions has shown they have had little success in identifying welfare recipients with substance use issues.

In 2013, the New Zealand government instituted a drug testing program as a pre-employment condition among welfare recipients. In 2015, only 22 (0.27 per cent) of 8,001 beneficiaries tested returned a positive result for illicit drug use or refused to be tested[v]. This detection rate was much lower than the proportion of the population estimated to be using illicit drugs in New Zealand, for example, the 2015/16 survey found that 1.1 per cent of adults used amphetamine in the past year[vi]. Similar results were found in the United States. In Missouri's 2014 testing program, of the state's

38,970 welfare applicants 446 were tested, with 48 testing positive. In Utah, 838 of the state's 9,552 welfare applicants were screened with 29 returning a positive result[vii].

This lower detection rate was not explained and raises concerns over why this was the case. One concern is that people could be shifting their choice of drug to one that isn't being tested for, which in some cases might be more dangerous, for example synthetic cannabis.

Moreover, the cost of these programs was significant. The drug testing program cost the New Zealand government approximately 1 million NZ dollars[viii]; and Missouri and Utah spent around USD$336,297 and USD$64,000 respectively on their programs[ix].

It is clear that drug testing regimes are not only expensive but also fail to identify problematic drug use.

There have been cases where proposals such as these have faced legal challenges on the grounds of discrimination, the accuracy of the drug tests, and people's human rights. For instance, in both Canada and the UK, the proposal to drug test welfare recipients was rescinded before progressing to the next stage of implementation due to legal challenges[x]. Similar legal challenges are likely to be faced by the Australian government, given that welfare payments would be conditional on recipients agreeing to random drug testing.

With respect to the potential for these measures to cause harm, there is evidence indicating that denying benefits to people who are drug dependent could result in increases in poverty, homelessness and crime, and also lead to higher health and social costs[xi]. One quantitative study found that welfare recipients of a drug addiction and alcoholism disability plan whose benefits were terminated had increased rates of drug dependence and psychiatric comorbidities over time[xii]. By contrast, those welfare recipients who retained their benefits (due to the presence of another recognised disability) reduced their levels of drug use from 75% to 63%[xiii] [xiv].

The Australian National Council on Drugs (ANCD) was formed in 2008 as a key advisory body to the Australian Government on drug policy. It comprised wide-ranging expertise, spanning from academia, medicine, education, law enforcement, treatment services, families who have suffered loss, those who have been affected by drugs, the Indigenous community, and government[xv]. In its 2013 position paper, it concluded that " the *small amount of (direct and indirect) evidence available seems to indicate that it is more likely to increase harms and costs, both to welfare beneficiaries and the general public, than it is to achieve its stated aims*". It also warns 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 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*." [xvi]

It is concerning that such clear and unambiguous advice from a leading expert advisory group is going unheeded and but that policy measures are being proposed that go directly against its counsel.

3. Trial design: Skewed and unrepresentative

The RACP and the AChAM hold serious concerns over the way the proposed trials are being designed and the criteria being used to determine the trial locations; the basis of health service availability, the ability to apply welfare quarantining and the use of a data-driven profiling tool. These criteria will lead to a significant selection bias which nullifies any possibility of these being true trials and removes any potential for them to deliver credible results. Trials by their nature need to be representative of the broader context so that valid conclusions can be drawn. Having trials exclusively conducted in regions with higher risk of substance use issues and dependent on the availability of

treatment services will not accurately test the feasibility or effectiveness of the proposed measures, nor will the results be able to inform any nationwide roll-out.

The Government states that "*That is why this measure has been specifically designed as a trial—to build that evidence base*" Given the above-mentioned skewing of the proposed trials, and the associated flaws that will thereby be inherent in any results, it is not plausible that these could help build meaningful evidence.

As was made clear during the Senate Estimates hearing on 31st May on this issue, a key reason for the trial sites being selected based on "*the availability of services*" is the recognition that not every location would be able to participate in a trial. As stated in the Hansard for that hearing "*Part of the information that is required in order to determine those [trial] sites is the availability of places*".

It is concerning that the proposal is progressing despite it being conceded that the necessary drug testing technologies and treatment capacity in certain regions in Australia is simply not there. There will be significant issues because of the lack of suitable and available testing technology, treatment facilities places, and appropriately trained staff, and/or the distance from services for some. On these grounds alone, without a substantial investment in building drug testing capacity, and an urgent and much needed increase in funding to establish and support more addiction treatment services and workforce, any roll-out of such a system is bound to fail and waste significant healthcare resources and money.

4. Drug testing methods: Concerns about accuracy, reliability and expense

Population drug testing is an unreliable way of identifying those who have substance use problems. There are several inherent limitations in drug testing, such as limited detection periods and inadequate sensitivity and specificity, which may give rise to a false negative or false positive result. Although there is currently no clarity over the drug testing methods that will be used in the proposed trials, our experience suggests that this measure is likely to be expensive and unreliable. Drugs differ in their windows of detection; those with high percentage of fat content can still be detected in urine weeks after their last use[xvii]. Biological matrices such as urine, blood, sweat, oral fluids not only differ in their windows of detection for substances, but also in their sensitivity, specificity, time, and cost[...]. Urine has been the main biological matrix used for drug testing over the last several decades, while others have emerged as new testing methods have been developed. Each biological matrix and testing method has its pros and cons.

Immunoassay and chromatography are the commonly used analysis methods. While immunoassay is a much less expensive analysis method, it can only provide qualitative results (i.e. present or absent) without the quantity shown[xix] but is subject to cross-reactivity and is not able to detect most of the synthetic drugs. Positive results based on immunoassays alone are referred to as "presumptive positives" and must be confirmed by gas chromatography/ mass spectrometry (GC/MS) or by liquid chromatography/mass spectrometry (LC/MS), when there are serious clinical or forensic ramifications of a positive test result. GC/MS and LC/MS are more accurate and reliable and are considered the 'gold standard' testing technologies for clinical and forensic purposes. GC/MS and LC/MS can also provide quantitative information on levels of a drug or metabolite in the matrix tested, though there are limitations to conclusions that can reliably be drawn from this additional information. Notwithstanding, in Australia the use of immunoassay is more common and reliance solely on immunoassay testing methods with their inherent limitations in testing welfare recipients in the manner proposed, would lead to many false negatives and false positive test results. If the government opts for the less expensive immunoassay analysis method, we would expect there to be associated risks of legal challenges with respect to the significant risk of false positive results.

It is relevant to note that not all states or territories have access to GC/MS or LC/MS for clinical purpose. Sending biological matrices to another state for analysis would necessarily involve associated time delays, costs, and disruption to the chain of custody of the sample. The procedures necessary to ensure appropriate chain of custody process plays a large part in drug testing to ensure there cannot be any deliberate or inadvertent tampering of any sample and that all results reported relate to a particular donor. These involve the controls governing the documentation, collection, direct supervision in clinics, processing, storage, transportation, testing, analysis, and reporting of biological matrices. In the case of urine drug tests, samples would need to be collected by a trained clinician of the same sex, with direct supervision.

This will raise serious ethical and medico-legal questions where there is no therapeutic relationship based on voluntary treatment seeking. This is very different to systems that are in place in industries such as mining, aviation and other transport industries, where there is a clear need to ensure a drug-free work environment to protect public safety.

For any national rollout, a substantial investment in testing technologies and facilities, along with suitably trained staff to operate and manage the systems, would be needed in the states and territories.

Careful clinical assessment in interpreting any test results is of critical importance. The reading and interpretation of drug testing results would require medical practitioners with relevant clinical and technical expertise, especially in circumstances where there is a positive immunoassay result, to assess whether the recipient has a true positive test result and a substance use disorder. As various medications can lead to false positive results, taking the past patient medical history into consideration is a vital part of the assessment. It is thus important that assessment in interpreting any test results should be restricted to medical professionals with appropriate clinical and technical expertise. Similarly, specific treatment activities should be determined only by medical professionals with the appropriate clinical and technical expertise, and not by employment services providers. It is also important to note that people other than health practitioners should not be allowed to access people's private health information.

Without further details of the costs of these trials and estimates of the likely costs of any national roll-out, it is difficult to provide specific comments on this aspect of the proposals. However, considering the known costs of drug testing technologies available, the expense for the medical, administrative and support staff required, and the costs of the similar measures tried in other jurisdictions, it is clear that this policy will be an expensive undertaking. For example, based on current rates for clinical purposes in Australia, costs for gold standard urine drug tests can range between $550 and $950. Hair drug tests are also expensive – about $180 for each class of drug tested – and costs could easily reach $1000 if more than 6 types of drugs are tested for.

With the evidence on the ineffectiveness of these measures to identify people suffering substance dependency, severely limited access to facilities with the necessary standard of testing, the lack of available treatment services, and the significant concern that enforced treatment is often not effective, this measure does not represent a good use of taxpayer's money.

5. Alcohol and other drug treatment services: inaccessible, underfunded and overstretched

Alcohol and other drug treatment services in Australia are chronically underfunded and overstretched, despite compelling evidence of their cost effectiveness. The funding currently provided for alcohol and other drug treatment services is not commensurate with the needs of the population. For example in NSW, mental health treatments receive approximately 10 times the funding of alcohol and drug

treatments, despite the fact that these conditions account for similar amounts of the total burden of illness[xx]. A review in 2014 found that alcohol and other drug treatment services in Australia met the need of fewer than half of those seeking the treatment[xxi].

The RACP and the AChAM note that additional funding was provided to the drug treatment sector to support the National Ice Action Strategy, however this funding has not generally addressed the key needs of the drug and alcohol sector as its use is restricted under the terms of the funding agreement. The severe shortage of drug and alcohol rehabilitation services and specialists around Australia persists. According to evidence submitted to the recent NSW Government Inquiry into Drug and Alcohol Treatment, current shortages of treatment services in NSW span from youth treatment services, residential rehabilitation places to ancillary services (i.e. support for families of individuals affected by drug and alcohol use)[xxii]. Representations to the inquiry highlighted key workforce issues, in particular the insufficient numbers of addiction medicine specialists in NSW[xxiii] and poor retention of qualified staff due to a lack of service funding continuity. Access to quality treatment, delivered by a suitably trained workforce, is fundamental for anyone struggling with addiction, and this should be the main priority for policy development and investment in this area.

There are distinct differences between recreational and dependent drug users. Drug testing will not be able to distinguish between those who have clinically significant drug problems and recreational drug users who don't meet DSM criteria for substance use disorder and do not require treatment services. Referral to treatment services of all of those who test positive will be a waste of scarce resources and will impact on services which are already stretched beyond their capacity – potentially impacting on those people who are already waiting for treatment. Exact data on waiting times is hard to obtain because it is dynamic – it may be as short as days to access in the private sector (which will be out of reach for people applying for welfare) to weeks or months for public services. Our members indicate that there is currently a 6-12 week wait for alcohol and other drug treatment (depending on the type of treatment required) in many jurisdictions. This raises ethical questions about the impact of adding those who may or may not be highly motivated to discontinue their substance use to the queue for treatment with others who are desperate for help and highly motivated to recover.

In terms of mandating treatment under these reforms, the RACP also has concerns that doctors having to monitor and report on their patient's adherence to their mandatory treatment could negatively affect the patient-doctor relationship and trust, which are critical to successful drug and alcohol recovery.

Schedule 13 - Removal of exemptions for drug or alcohol dependence

The RACP opposes measures outlined in Schedule 13 of the Bill, which proposes the removal of exemptions from the activity test and participation requirements under circumstances that are directly attributable to someone's drug or alcohol dependence.

Under the current arrangements, income support recipients of certain activity-tested payments may be granted a temporary exemption from their participation requirements in circumstances of temporary incapacity or special circumstances related to drug or alcohol issues. This existing arrangement adequately recognises and responds to addiction as a chronic remitting and relapsing health condition, and should be preserved.

The RACP notes the example provided in the Explanatory Memorandum to the Bill, that an exemption would not be granted in circumstances '*due to a major personal crisis because they (the income support recipient) have been evicted from their home due to drug or alcohol misuse*.' The RACP believes that in circumstances such as these, where people fail meet their participation requirements,

this change can only further exacerbate and entrench their difficult and disadvantaged circumstances. Such a scenario would increase the risk of entrenched poverty and generational disadvantage, and would fail to achieve any substantive health or other policy outcomes.

Subsection 603C (1AA) of the Bill raises significant concerns about the recognition of medical documentation, such as medical certificates or correspondence from a treating clinician, in the granting of exemptions. The RACP holds that it is inappropriate for formal medical documentation (and the expert medical opinion contained within) to be rejected as valid evidence in support of an exemption, particularly where an individual has suffered a significant addiction-related health episodes requiring hospitalisation or medical treatment. This selective approach to the consideration of medical documentation, whereby certain health conditions are excluded from recognition within reasonable excuse provisions, is highly concerning. It is also likely to lead to legal challenges on the basis of infringement of rights and arbitrary discrimination.

The RACP notes that the removal of exemptions is linked to the recognition of drug and alcohol treatment as an approved activity in an individual's job plan. That is, an income support recipient who is not eligible for an exemption from participation requirements due to drug and alcohol dependence may meet those requirements by undertaking drug and alcohol treatment.

The RACP does not support the receipt of welfare payments being made contingent on participation in drug and alcohol treatment, particularly when, as noted above, there is a known shortage of available treatment places. Conditional welfare payments are not an evidence-based approach to increasing participation in drug and alcohol treatment nor to improving treatment outcomes. This measure will likely merely result in increased numbers of people on waitlists for drug and alcohol treatment, already severe underfunded and struggling to help people recover from their addiction. It also has significant potential to increase the levels of anxiety and other adverse emotions among those being affected by this measure. This includes clinicians. Our members are telling us that these reforms will put them in a very difficult personal and professional position.

The RACP recommends that Schedule 13 of the Bill be opposed.

Case Study 1: Removal of exemptions

Andrew is in his late 30s and is in receipt of Newstart Allowance.

Andrew has had a problematic relationship with alcohol from the age of 12 when he was sexually abused. Since that time he has used alcohol to reduce the distress of intrusive memories, thoughts and reminders of the event. This has led to alcohol consumption becoming a coping mechanism. In recent times Andrew has suffered two alcohol withdrawal seizures, indicating that alcohol addiction has changed the functioning of his brain.

Andrew has a diagnosis of borderline personality disorder, and exhibits self-harm behaviour and suicidal ideation. Following a violent assault, Andrew was diagnosed with anxiety, depression, and post-traumatic stress disorder. He experiences agoraphobia with panic disorder when in public.

Andrew has engaged with drug and alcohol treatment services on several occasions, including psychosocial treatment services and multiple attempts at residential rehabilitation programs. Despite the agoraphobia he manages to attend appointments at Centrelink when he can, but is often unable to meet his participation requirements due to his alcohol dependence and its associated impacts. As a result, Andrew has at times had difficulty paying his rent, bills and buying food, resulting in significant stress and occasional homelessness.

Under Schedule 13 of the Bill, Andrew will no longer be able to apply and qualify for an exemption from his participation requirements on the basis of his alcohol dependence. Regardless of episodes of intoxication and withdrawal, he will be required to meet his participation requirements or risk losing his Newstart Allowance.

Under the new measures, Andrew will need to be referred to drug or alcohol treatment in order to meet his participation requirements. He has already attempted treatment several times in the past, but the recurring and episodic nature of his addiction means that he has continued to relapse. Given his long-standing dependence on alcohol as a coping mechanism and the observed changes in brain function, it is unlikely that treatment will bring about long-term recovery outcomes for Andrew.

Disclaimer: This case study contains patient information provided by a practising clinician to the Royal Australasian College of Physicians, and has been extended to consider the implications of the Bill. Identifying details have been changed to protect the individual's identity.

Schedule 14 – Changes to reasonable excuses

The RACP opposes the measures outlined in Schedule 14 of the Bill, which makes changes to reasonable excuses for participation failures. The proposed removal of exemptions is fundamentally stigmatising and vilifying of individuals suffering addiction; which in itself is a known barrier to seeking treatment and overcoming addiction.

Under current arrangements, episodes associated with drug or alcohol dependency are recognised as a reasonable excuse for failing to meet participation requirements. As with Schedule 13 of the Bill, the existing arrangement adequately recognises and responds to addiction as a chronic, relapsing and remitting health disorder, and should be preserved.

Schedule 14 of the Bill raises identical questions about the recognition of formal medical documentation or correspondence as outlined above. It is inappropriate for formal medical documentation (and the expert medical opinion contained within) to be selectively rejected as valid evidence in support of a reasonable excuse.

The RACP notes that, as with the removal of exemptions, this change is linked to the recognition of drug and alcohol treatment as an approved activity which would satisfy mutual obligations in an individual's job plan. As stated above, the RACP does not support the receipt of welfare payments being made contingent on participation in drug and alcohol treatment, particularly given the known shortage of available treatment places. This would be inappropriate in cases where treatment is provided in the context of clinically insignificant substance use. This measure is also likely to result in people languishing on waitlists for extended periods of time.

Furthermore, the RACP is seriously concerned that Schedule 14 provides for the application of financial penalties in cases where income support recipients do not participate in treatment. Again, this approach places vulnerable people at increased risk of poverty, homelessness and significant social and financial disadvantage.

The RACP recommends that Schedule 14 of the Bill be opposed.

Case study 2: Changes to reasonable excuses

Sharon is 42 years old and is in receipt of Newstart allowance.

Sharon is a single mother of two teenage daughters for whom she is the principal carer. Her personal history is marked by early childhood sexual abuse and trauma. Her schooling was interrupted and she has no formal employment history.

Sharon struggles with long-standing opioid, benzodiazepine, and alcohol dependence, linked to the abuse and trauma she suffered as a child. She has engaged with treatment on several occasions and is currently stabilised on opioid treatment therapy. She struggles however with increasing alcohol and benzodiazepine use, and associated intermittent intoxication and withdrawal symptoms.

While not formally diagnosed, Sharon likely has borderline personality disorder, anxiety, depression, and long-standing attentional deficits with difficulty concentrating.

Sharon is socially isolated and under significant financial pressure. Her main concern is caring for her two daughters who are showing signs of emerging school failure, runaway behaviour, and exposure to sexual and drug related risks. Her undiagnosed and untreated anxiety is exacerbated by the stress of trying to support, protect, and provide for her family.

In the past, episodes of intoxication which prevented Sharon from meeting her participation requirements were attributed to her substance dependence and recognised as a reasonable excuse for not meeting her obligations on those occasions.

Under the changes outlined in Schedule 14 of the Bill, Sharon's acute episodes will no longer be recognised as a reasonable excuse for not meeting participation requirements. This will contribute significantly to the anxiety she feels about financial pressures and will make no allowance for the time needed for her to recover from intermittent episodes of intoxication.

Under the new measures, Sharon will be referred to drug or alcohol treatment in order to meet her participation requirements. She has already completed treatment several times in the past, but the chronic, relapsing and remitting nature of addiction has meant that she has relapsed on several occasions. Her anxiety is heightened by the fear of another unsuccessful attempt at treatment and the possibility that this could cause her to lose her Newstart allowance, putting herself and her daughters at increased risk of homelessness and poverty. There is a strong likelihood that she would turn to crime or prostitution in order to feed her children. She has severe anxieties that she will lose custody of her children.

Disclaimer: This case study contains patient information provided by a practising clinician to the Royal Australasian College of Physicians, and has been extended to consider the implications of the Bill. Identifying details have been changed to protect the individual's identity.

Conclusion

The RACP and AChAM oppose the measures contained in Schedules 12, 13, and 14 of this Welfare Reform Bill on the basis that they are not evidence-based, go against previous expert advice provided to government on the matter, and are likely to be clinically harmful to people suffering with drug and/or alcohol addiction. These reforms will also further marginalise a population that already experiences a greater burden of psychical, psychological and social ill health. The end result is likely to be a worsening of substance use disorder that will have ripple-out effects for the wider community.

Despite being the peak body representing Australia's addiction medicine specialists, the RACP and its Australasian Chapter of Addiction Medicine (AChAM) were not consulted on the measures proposed by the Bill prior to their announcement in the 2017-18 Budget. If consultation had occurred, the RACP and the AChAM would have advised that these measures are clinically inappropriate and are not designed in a way that will address issues of substance dependence. Our strong advice is that they should not be considered and that the measures in these 3 schedules of this Bill should not progress.

The drug testing trial in particular is likely to be a very costly exercise that will not deliver on its stated objectives.

Over many years, the RACP and the AChAM have repeatedly identified the underfunding of drug and alcohol treatment services as a matter requiring the urgent attention of successive governments. Sustained, long-term funding to increase the capacity of drug and alcohol services to meet the demand for treatment, combined with real and persistent efforts to reduce disadvantage and inequities within society, is the only real solution to reducing substance dependency. The Australasian Professional Society on Alcohol & other Drugs (APSAD) is supportive of the RACP's position and recommendations on this matter.

As stated as the start of this submission, the RACP represents a number of clinical specialties directly connected to treating people with substance dependence issues; not least the Australasian Chapter of Addiction Medicine (AChAM). Despite a statement made by a senior official within the Department of Social Services (DSS) during the Senate Estimates hearing on 31st May 2017, that "*an extensive consultation process is planned and underway in order that we obtain as much expert advice as possible*", there has been minimal indications of this from the RACP perspective. Indeed the RACP has only been asked by the DSS to facilitate one meeting for them with the President of the AChAM, Associate Professor Adrian Reynolds. During this meeting, no advice was sought by the DSS personnel on the overall policy or on the specific trials, nor were adequate answers provided to the questions asked by A/Professor Reynolds. Subsequent to this, advisors from Minister Porter's office requested a meeting with less than a day's notice. Although we welcomed the discussion, and were fortunate that two of our members were able to free themselves from their clinical work at such short notice, we do not consider two meetings, with minimal notice and no opportunity to invite input from our wider membership, to be "*extensive"* or well planned - especially in relation to a subject area that is both complex and sensitive.

The RACP and the AChAM have a significant number of expert members who would welcome the opportunity to contribute to the development of evidence-based policies that facilitate access to drug and alcohol treatment services, providing individuals with the best chance of recovery and a return to full social participation. The RACP has developed and released a range of evidence-based policy recommendations in relation to reducing the harms of alcohol, appropriate use of opioids and other addictive prescription medicines, and the health benefit of good work that can help strengthen existing government's policies to help address drug or alcohol dependency among welfare recipients.

The RACP is extremely supportive of more being done to help people improved their chances of employment. There is a large body of evidence of the negative impact unemployment has on both physical and mental health. The evidence can be assessed at the RACP position statement on realising the health benefits of work.

The health effects of work and unemployment are generally most marked in middle working-aged men, especially those with dependent families. However, it is not only the men themselves who suffer; the influence of unemployment extends to their children. Research into the impact of parental unemployment on children has found[xxiv]:

- A higher likelihood of chronic illnesses, psychosomatic symptoms and lower wellbeing for children in families where neither parent has worked in the previous six months
- Children living in households where the parents are not working are more likely in the future to be out of work themselves, either for periods of time or over their entire life; and
- Psychological distress may occur in children whose parents face increased economic pressure, sometimes resulting in withdrawal, anxiety and depression in the children or aggressive or delinquent behaviour and substance abuse

It's also recognised that work and mental health are closely linked. In western society a person's identity and self-esteem, as well as the respect they are afforded by others, is partly determined by the work they do. The relationship between work and mental health is complex. Suitable work has been shown to benefit people suffering from a wide range of psychiatric conditions. People with mental health problems are more likely to be out of work, and are more likely to experience insomnia, a downward spiral of long term work absence and unemployment, further deterioration in mental health and reduced chances of gaining employment, and to have higher rates of risk factors for psychological disorders[xxv].

The RACP Position Statement on realising the health benefits of work, developed by our Faculty of Occupational and Environmental Medicine, provides recommendations in relation to how government, business and medical and allied professionals can achieve this end.

The RACP strongly supports more being done to improve employment prospects for all Australian citizens including those with substance use issues. However, the RACP does not support the provisions of the Welfare Bill as it stands. It our careful assessment, they will have an adverse rather than positive impact on achieving that outcome. The RACP holds that the prevention agenda and the large body of scientific evidence on 'what works', needs to be given more careful consideration in any mix of evidence-informed policy reforms. The RACP would welcome an opportunity to present that body of evidence and related recommendations to the Federal government.

In the meantime, the RACP and the AChAM cannot support Schedules 12, 13 and 14 of the Bill and call for them to be opposed in their entirety.

[i] Australian National Council on Drug. ANCD position paper: Drug testing 2013. http://www.atoda.org.au/wp-content/uploads/DrugTesting2.pdf

[ii] National Institute on Drug Abuse: Understanding Drug Use and Addiction. https://www.drugabuse.gov/publications/drugfacts/understanding-drug-use-addiction

[iii] National Institute on Drug Abuse: Drugs, Brains, and Behaviour: the Science of Addiction https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/drug-abuse-addiction

[iv] Werb D, Kamarulzaman A, Meacham MC, Rafful C, Fischer B, Strathdee SA, Wood E. The effectiveness of compulsory drug treatment: A systematic review. International Journal of Drug Policy. 2016 Feb 29;28:1-9.

[v] Budget 17/18: Drug Testing Welfare, does it add up? PPE Society. http://www.ppesociety.org.au/wp/2017/05/budget-1718-drug-testing-for-welfare/

[vi] Amphetamine Use 2015/16: New Zealand Health Survey. https://www.health.govt.nz/system/files/documents/publications/amphetamine-use-2015-16-nzhs-dec16.pdf

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