UNSW AUSTRALIA | NDARC National Drug & Alcohol Research Centre

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

2nd August, 2017

Re: Submission to the Inquiry into the Social Services Legislation Amendment (Welfare Reform) Bill 2017

Thank-you for the opportunity to provide comment on the proposed amendments to the Social Services Legislation Amendment (Welfare Reform) Bill. We have grave concerns about the impact of these reforms on people who have problematic alcohol and other drug issues (and will also likely have flow on implications for their families). Three Schedules in the Bill contain measures directed at people with alcohol or other drug dependencies:

- Schedule 12: Establishment of a drug testing trial
- Schedule 13: Removal of exemptions for drug or alcohol dependence
- Schedule 14: Changes to reasonable excuses

There is no evidence that any of these measures will directly achieve outcomes associated with reductions in alcohol or other drug use or harms, and indeed have the potential to create greater levels of harm, including increased stigma, marginalisation and poverty.

Treatment for alcohol and other drug problems is highly cost effective[1]. But there is simply insufficient treatment available in Australia[2]. 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[3]. So while referral to treatment for those dependent on alcohol or other drugs is an excellent idea in principle, there are no resources to provide that additional treatment at the present time.

Under Schedule 13 of the Welfare Reform Bill, the government would stop paying people with alcohol or other drug dependencies unless they participated in treatment, applied for jobs or did training or study. Given that there is insufficient treatment available, it is not possible to achieve the first of these options. The second and third options (training or study) would not be feasible for a person with a dependency on substances, precisely because alcohol or other drug dependency is an illness that has as one of its criteria impairment in occupational functioning. Such requirements may set up already vulnerable and ill people to fail, resulting in further negative consequences.

Compulsory treatment is a difficult issue, and all three Schedules contain compulsory treatment provisions (failure to comply resulting in welfare payment suspension). There is a large and complex literature on compulsory treatment: which arises largely because of the variety of models or types that are being referred to. We identify five different types of compulsory treatment approaches, which are 1) diversion programs (including police and

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court programs) which seek to divert an offender away from a criminal justice system response and into a treatment/health care response; 2) civil commitment (involuntary commitment for health and safety reasons); 3) centre-based compulsory rehabilitation as practised in many Asian and South East Asian countries; 4) quasi-compulsory treatment provided in Europe; and 5). incarceration-based treatment (in-prison treatment programs). In Australia, we have comprehensive diversion programs, a number of civil commitment programs (such as the NSW IDAT program), and prison-based treatment. Despite the popularity of all these models of compulsory or coerced treatment, the only one for which there is comprehensive research showing positive effects is the diversion programs[4] (which apply only to offenders, and provide a forced choice). For other forms of compulsory treatment, there is evidence that they do not achieve the outcomes being sought.

For example, in a systematic review of compulsory treatment Wild et al (2002)[5] found that, in terms of drug use outcomes, only two of eight studies found superior outcomes for clients receiving compulsory treatment compared with voluntary treatment, whilst the other six studies reported no difference in benefit. Broadstock et al. (2008)[6] in their comprehensive review concluded that the area of compulsory treatment for people who are mandated purely on the basis of their alcohol use or illicit drug use, there is no reliable evidence pertaining to the effectiveness of compulsory residential treatment compared with any other treatment approach. Werb et al (2016)[7] in their systematic review concluded that "Evidence does not, on the whole, suggest improved outcomes related to compulsory treatment approaches, with some studies suggesting potential harms."
On the basis of the existing evidence, coerced or compulsory treatment is not an effective or efficient use of scarce resources.

There is no evidence that drug testing welfare recipients (Schedule 12) is an effective approach. 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 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.*[8]

There is also 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[9]. It is also occurring in Australian mining communities [10]. Testing technology cannot keep up with the number of new drugs on the market. So, if Schedule 12 goes 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.

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Poverty is a major issue for people with alcohol and other 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 alcohol and other 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.[11] This is a highly vulnerable population. Any policy that actually increase 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. These three Schedules all serve to increase structural inequality.

There are a number of other issues with the proposed Schedules. Drug testing (Schedule 12) 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. The compulsion to submit to drug testing (Schedule 12) contributes to the stigmatisation of people with substance dependencies and stigma is a known barrier to treatment-seeking.[12] Stigma is a fundamental social cause of health inequalities.[13] 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.[14] We have concerns about the 'contracted medical professionals' (Schedule 12) who would not 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. Under Schedule 13, the treatment would be chosen by an employment services provider rather than an addiction specialist, and raises similar concerns regarding the adequacy of these provisions for effective assessment and referral.

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.

Our view, as researchers and experts in drug policy, is that Schedules 12, 13 and 14 of the Welfare Reform Bill are ill-placed, ineffective and damaging provisions.

Yours sincerely

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Endnotes

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