ST VINCENT'S HEALTH AUSTRALIA
UNDER THE STEWARDSHIP OF MARY AIKENHEAD MINISTRIES

Social Services Legislation Amendment (Welfare Reform) Bill 2017

Submission to the Senate Community Affairs Legislation Committee

August 2017

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1. Introduction

1.1 Our commitment to people with substance use disorders

St Vincent's Health Australia has been providing health care in Australia since our first hospital was established by the Sisters of Charity in Sydney in 1857. The first five Sisters arrived in Australia in 1838 with the vision of Mary Aikenhead, founder of the Order, to serve all in need of care with a particular commitment to the poor and vulnerable.

We believe every person has an inherent dignity. We are committed to advocating for those who are marginalised, facing poverty and vulnerable to poor health outcomes including people with addictions.

Based on our mission, the expertise of our clinicians, and our commitment to excellence through evidence-informed practice, we:

- treat substance use disorders through a health framework;
- encourage people with substance use disorders to access treatment by creating an environment free from stigma and discrimination; and
- support efforts to enable people with substance use disorders to attain stability and security, as this assists them in their treatment, rehabilitation and reconnection with society.

As part of our holistic care for people with substance use disorders, we welcome and share the Government's desire to address disadvantage and unemployment experienced by people with substance use disorders.

1.2 Our experience in addiction medicine

St Vincent's has a long history of working with people with substance use disorders. The Sisters of Charity pioneered the first combined clinical and academic program for the treatment and study of alcohol dependence at St Vincent's Hospital in Melbourne in 1964 and at St Vincent's Hospital Sydney in 1971.

Our public hospitals are now recognised leaders in health service provision to people with substance use disorders. At St Vincent's Hospital Sydney, our services are:

- Multidisciplinary care for inpatients, outpatients and via hospital liaison.
- *Gorman House*, a 20-bed medically-supervised detoxification ward with a new assertive community outreach care programme.
- *Rankin Court*, an outpatient opioid pharmacotherapy treatment and psychosocial support service to 320 people at any one time.
- A *Stimulant Treatment Program* and *S-Check Clinic* which provides counselling and support services, group therapy and screening services.
- Specialist telephone-based counselling and referral services.

The addiction medicine services provided at our Melbourne public hospital are:

- Multidisciplinary care for inpatients, outpatients and via hospital liaison.

- *Depaul House*, a 12-bed medical-residential withdrawal unit.
- The longest-running drink-driver education program in Australia.
- Recovery and Support Program (RaSP) – an eight week day program for people with alcohol or other drug and comorbid mental health conditions.
- Addiction Medicine Outpatient Clinic

1.3 Our submission

Our submission addresses Schedules 12, 13 and 14 of the *Social Services Legislation Amendment (Welfare Reform) Bill 2017*. It also provides advice – based on the expertise of our clinicians – on alternative approaches to leverage the welfare system to assist people with substance use disorders into treatment.

This submission has been developed with the input and support of our addiction medicine services in NSW and Victoria. Our addiction medicine services are led by addiction medicine specialists, who are fellows of the Royal Australasian College of Physicians (RACP) Chapter of Addiction Medicine.

St Vincent's Health Australia also supports the submission from the RACP.

1.4 Our position

St Vincent's Health Australia does not support Schedules 12, 13 and 14 of the Bill. We urge the Senate not to support these Schedules.

We have strong concerns about the impact these changes will have on a very vulnerable patient group of St Vincent's. Further, our clinicians reject any involvement in monitoring or reporting compliance under these measures as it would undermine the therapeutic relationship between health professional and patient that is critical for effective treatment.

St Vincent's Health Australia believes the changes enacted through Schedules 12, 13 and 14:

- reflect a misunderstanding about the nature of substance use disorders in that fundamentally they fail to recognise addiction as a health issue;
- are not evidence-based and are likely to exacerbate addiction issues rather than improve rehabilitation outcomes;
- appear to be punitive in intent rather than supportive, and will further stigmatise people with addictions - a known barrier to treatment uptake; and
- would lead to increased financial hardship for this vulnerable group who already face multiple and entrenched disadvantage.

This package appears to have been developed without an appropriate level of clinical and expert input. We offer our expertise in addiction medicine to develop alternative policies that are supported by the evidence to assist people with substance use disorders to access treatment and reengage with employment.

2. Schedule 12

This Schedule would establish a two-year trial of random drug testing of up to 5,000 new welfare recipients in three sites from 1 January 2018.

2.1 Lack of evidence, cost and technical challenges

Evidence

St Vincent's Health Australia is concerned that there is no evidence base to support this proposal and no expert advice appears to have been sought in its development.

In 2013, the Australian National Council of Drugs – the Commonwealth's key independent advisory body on alcohol and drug issues at that time – reviewed the evidence for drug testing and concluded:

> *'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.'*[1]

The Minister for Social Service's Second Reading Speech described the intent of this Schedule as being to: 'strengthen requirements for jobseekers who may have substance abuse issues and to provide improved pathways for them to pursue appropriate treatment.'

However, the clinical advice of our addiction medicine specialists is that the assumption that people with substance abuse disorders will change their behaviour to meet new welfare compliance arrangements is not evidence-based. Part of the clinical definition of substance use disorder is that people continue to misuse drugs or alcohol despite knowing there will be negative consequences.[2]

Further, St Vincent's Health Australia does not support mandating participation in treatment because the evidence does not support it. A recent systematic review of effectiveness of mandatory treatment approaches concluded that:

> *'Evidence does not, on the whole, suggest improved outcomes related to compulsory treatment approaches, with some studies suggesting potential harms. Given the potential for*

[1] ANCD, 2013, *ANCD Position paper: Drug testing*, accessible at http://www.atoda.org.au/wp-content/uploads/DrugTesting2.pdf
[2] National Institute on Drug Abuse: Understanding Drug Use and Addiction. https://www.drugabuse.gov/publications/drugfacts/understanding-drug-use-addiction

human rights abuses within compulsory treatment settings, non-compulsory treatment modalities should be prioritized by policymakers seeking to reduce drug-related harms'

(Werb et al, International Drug Policy 2016)

Alignment with the National Drug Strategy 2017-2026

The new *National Drug Strategy 2017-2026,* outlines what constitutes evidence-based practice to reduce demand for drug and alcohol – in the Box below. This strategy was released in July this year after an extensive consultation process with the alcohol and drug treatment sector, research institutes and governments. The *National Drug Strategy* does not recommend drug testing as evidence-based approach, nor does it recommend it be considered.

Evidence of Good Practice

Demand reduction requires a comprehensive approach involving a mixture of regulation, government initiatives, community services and treatment services.

Strategies that affect demand include:

- reducing the availability and accessibility (such as price mechanisms for alcohol and tobacco);
- improving community understanding and knowledge, reducing stigma and promoting help seeking;
- restrictions on marketing, including advertising and promotion;
- programs focused on building protective factors and social engagement;
- treatment services and brief intervention;
- targeted and culturally appropriate approaches to high prevalence population groups and regions at increased risk of exposure to and harm from alcohol, tobacco and other drugs;
- addressing underlying social, health and economic determinants of use; and
- diversion initiatives.

(National Drug Strategy 2016-2026, p. 10)

Increasing stigma and impacts

St Vincent's Health Australia is concerned that the proposed trial will increase stigma and anxiety for people with substance abuse disorders which will exacerbate addiction issues rather than address them.

The impact of stigma on drug users' willingness to engage in treatment and other health services is well documented.[3] It is also recognised in the *National Drug Strategy* which notes the importance

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

that 'any policy responses do not unintentionally further marginalise or stigmatise people who are at higher risk of experiencing alcohol, tobacco and other drug-related harm'.[4]

We are concerned that the trial could reduce access to treatment services through anxiety among drug users – even outside the trial locations – that their welfare payments may be affected if they seek help. The proposed trial arrangements are complex and will be challenging for some jobseekers with particular barriers to understand, for example, people with cognitive impairments or low literacy. Misunderstanding among jobseekers, drug users and the community is likely to be high.

Further, the anxiety around random drug testing itself may increase problematic drug use. Anxiety is associated with, and a known contributor to, substance abuse disorders. We note that the stress and anxiety that drug testing may provoke in some drug users is likely to increase violence and aggression towards Department of Human Services' staff administering this program.

Poor cost-effectiveness

We note that the financial implications of this Schedule have not been disclosed by the Government. We also note that no additional funding for treatment services has been allocated as part of this proposal. Further, there are no provisions to financially support jobseekers to engage in treatment – for example, assistance with travel costs or to meet the costs associated with some treatments (for example opioid substitution therapy which costs around $42 a week).

The costs of the proposed testing followed by expert medical assessments will be very significant for a poorly targeted program. There is international evidence of low cost-effectiveness of drug testing (see the RACP submission). As an example, in 2015 the NZ government spent NZD$1m testing 8,001 people, with only 22 testing positive (0.27%).

Further, St Vincent's Health Australia notes that the testing will not identify people with alcohol use disorders. Alcohol is by far Australia's biggest substance-related harm issue, and the most significant contributor to lost productivity and unemployment.

We believe that those funds would be better spent on early intervention and drug and alcohol treatment services which remain underfunded relative to need.[5] An analysis prepared for the Federal Department of Health in 2014 estimated that fewer than half of those seeking alcohol and drug treatment in Australia are currently able to access appropriate treatment. This means between 200,000 and 500,000 Australians are estimated to need treatment but cannot access it.[6]

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[4] National Drug Strategy 2017-2016, p.26 http://www.health.gov.au/internet/main/publishing.nsf/Content/55E4796388E9EDE5CA25808F00035035/$File/National-Drug-Strategy-2017-2026.pdf

[5] Ritter, Alison, and Mark Stoove. "Alcohol and other drug treatment policy in Australia." Med J Aust 2016; 204 (4): 138.

[6] Ritter. A et al 2014, New Horizons: the review of alcohol and other drug treatment services in Australia, Drug Modelling Program at National Drug and Alcohol Research Centre.

Technical challenges

It is difficult to provide detailed comments on the technical limitations of drug testing as the Government has not disclosed what methodology will be used, or what drugs will be tested for. However, all on-site drug testing methodologies also have known reliability issues and can return false positives[7]. Some further examples of reliability issues are:

- Some prescription drugs such as anti-depressants show up in drug tests with a positive reading for methamphetamines.
- Cannabis can be detected in a person's system for many weeks. This means they could test positive as part of the trial (on first or repeat tests), even if they had taken action to cease their use.

For these reasons, interpretation of drug testing results should be undertaken by an appropriately qualified medical professional.

We note the provision in the legislation for drug testing companies engaged as part of the trial to change their result where there is evidence of a person having been legally prescribed a drug that has shown up in the testing.

However, we are concerned by media reports[8] regarding proposed implementation arrangements which include trial participants being required to provide confidential medical information about their medications to the Department of Human Services or third party private providers. These arrangements for identifying false positives appear to be burdensome for jobseekers and raise genuine privacy issues.

We are also concerned that people who are placed in the trial will substitute for drugs that cannot be tested for to avoid detection. For example, cannabis users may seek out synthetic cannabinoids which are readily available and highly dangerous, but cannot be easily tested for.

2.2 Proposed role of health professionals and health services in the trial

Assessments

Assessing whether a person has a substance use disorder, making a recommendation for treatment, and developing a treatment plan all require specialist expertise.

However, there is no requirement in the legislation for Department of Human Services 'contracted medical professionals' to have any specific qualifications relevant to addiction medicine and mental health. As such, we are concerned that these assessments would be undertaken without adequate

[7] *Workplace drug testing: evidence and issues*. http://nceta.flinders.edu.au/files/9814/1145/2032/EN455_NCETA_2011.pdf

[8] https://www.crikey.com.au/2017/07/21/drug-tested-welfare-recipients-forced-to-disclose-private-health-details/

levels of clinical expertise. This is particularly concerning as compliance with an inappropriate recommendation would become mandatory for that person to continue to receive their welfare payment.

We are also concerned that it appears an employment services provider would determine which specific treatment activities (e.g., residential rehabilitation, counselling, etc.) would go into a person's participation plan. Employment services providers are not health professionals and are not qualified to make these determinations.

In addition, we note that the legislation allows the Secretary to make a determination to continue a person's period of income management beyond 24 months where they believe it would be beneficial to their rehabilitation outcome. We are concerned that there is no requirement in the legislation that such a determination would be made on the advice of a qualified medical professional.

Monitoring compliance with the treatment plan

Under the proposed legislation, if a person who has mandatory treatment requirements fails to meet mandatory requirements to participate in treatment, they will be subject to the compliance framework (their payment will be suspended unless they have a reasonable excuse).

It is expected that this would require drug and alcohol treatment services to monitor and report compliance. Our drug and alcohol clinicians reject any such involvement in monitoring and reporting compliance under this trial. It would undermine the therapeutic relationship and trust that is critical to successful drug and alcohol treatment. In addition, monitoring and reporting compliance would be burdensome on already-overstretched public treatment services.

2.3 Punitive compliance arrangements

There are a number of compliance measures in the proposed trial arrangements that we believe will increase the financial hardship faced by this group, compound existing disadvantage, and make it harder for people to overcome substance use disorders.

These include:

- People who test positive would be required to pay for any positive tests, at a rate of up to 10% of their monthly payment, until fully repaid. A person with a substance use disorder who continues to test positive throughout the trial could experience a continuous reduction in their payment of up to $55 a fortnight. We note that the requirement for a welfare recipient to pay for compliance measures required under law represents a significant departure from established social security policy.

- A person who refuses to take a test will have their payment cancelled automatically, and cannot apply again for four weeks. This is a strongly punitive measure that does not take into account the anxiety that testing could provoke for some participants – particularly those with comorbid substance use and mental health problems – and does not allow the person to make a decision to reengage sooner than four weeks. Even if a person decided to come back even the same or next day for testing, they would lose four weeks of payment.

- If a trial participant fails to turn up for any appointment with Centrelink during the trial their payment will be suspended and not backpaid even when they re-engage. Again we note that this represents a significant departure from established social security policy for other income support recipients who fail to attend appointments.

3. Schedules 13 and 14

3.1 Schedule 13: Removal of exemptions for drug or alcohol dependence

Currently, welfare recipients with participation requirements can be granted temporary exemptions from requirements if they have a doctor's certificate attesting that they are incapacitated due to sickness or injury, or if there are special circumstances such as a personal crisis.

Schedule 13 would prevent temporary exemptions being granted where the reason is wholly or predominately attributable to drug or alcohol dependency or use.

On our reading of the legislation, this would relate to not just acute episodes of substance misuse, but also to secondary health problems associated with drug and alcohol use (of which there are many). For example:

- Someone receiving treatment in hospital for cirrhosis of the liver associated with alcohol use will no longer be able to access a medically-recommended temporary exemption.
- Someone recovering from a severe injury obtained while intoxicated would no longer be able to access a temporary exemption.

We also note with concern the example in the Explanatory Memorandum (p. 79) that an exemption would not be granted for a special circumstance 'due to a major personal crisis because they have been evicted from their home due to drug or alcohol misuse'.

In these circumstances, it is very hard to envisage that a person would be able to meet their participation requirements. Instead, it is likely that jobseekers with substance use issues in such circumstances will lose their payments, and face increase poverty and housing insecurity.

3.2 Schedule 14: Changes to reasonable excuses

Currently, jobseekers can be penalised for a range of 'participation failures'. These penalties are not applied where the person has a 'reasonable excuse'.

Schedule 14 provides that a jobseeker who uses a drug or alcohol dependence as an excuse for a participation failure will be offered treatment. If they take up treatment, it will count towards their participation requirements. If they refuse treatment and their substance use disorder causes them to not comply with participation requirements a second time, their payments will be suspended.

3.3 Combined impacts of Schedules 13 and 14

We believe that people with substance use disorders should not be treated differently under law than people with other disability and chronic illnesses. The statements of compatibility with human rights in the Explanatory Memorandum recognise this issue stating (in relation to Schedule 13, p.158):

This Schedule engages the rights to equality and non-discrimination because people who may have a disability or illnesses associated with drug or alcohol dependency (such as alcoholism) will be subject to differential treatment insofar as they will not be eligible for the exemption that people with another illness or disability could potentially access.

The statements argue that such discrimination is 'reasonable and proportionate' to 'achieve the legitimate objective of encouraging recipients to do all they can to support themselves through work, where they are able'. We do not agree with this position, as it assumes that people with substance use disorders are able to make a rational choice to change their behaviour.

As a healthcare provider working with people experiencing substance use disorders, we recognise that substance use disorders are complex, episodic and often chronic health conditions.

We are concerned that many people with substance use disorders are at very high risk of losing their welfare payment as a result of the changes in these two schedules.

The only way that people with substance use disorders could meet requirements under Schedule 14 is if they are in continuous treatment or complete other job seeker requirements. However, as with diabetes, people with substance use disorders can relapse and most people have multiple attempts at treatment before they achieve longer term stability ("success"). During periods of relapse, people with substance use disorders are unlikely to be able to complete jobseeker requirements and, with the proposed changes to reasonable excuses, would lose welfare payments.

Through clinical experience we know that people with substance use disorders are unlikely to be motivated towards positive behaviour change through the threatened or actual loss of payments. Indeed, they can be more likely to continue with disordered use in a situation of stress and compounded disadvantage following loss of payments.

We note and welcome that drug and alcohol treatment will be made an eligible participation activity as part of this package. However, participation requirements for most jobseekers will be 50 hours per fortnight if the remaining schedules of this Bill are passed. Even people engaged in effective treatment would be unlikely to reach 50 hours per fortnight unless they were in a residential rehabilitation or inpatient setting. Waiting lists for these forms of treatment are long, and sometimes less time intensive forms of treatment are more effective. Jobseekers with substance use disorders who receive forms of treatment that amount to fewer than 50 hours per fortnight may be unable to meet other jobseeker obligations and could lose payments on that basis.

4. Alternative approaches

St Vincent's Health Australia does not support the reforms as they are proposed but we do believe there are other opportunities to use the welfare system to identify people with, or at risk of, substance use disorders and support them through appropriate early intervention and/or rehabilitation services.

For example, jobseekers could be referred to a drug and alcohol treatment service provider when there is a pattern of a number of temporary exemptions and/or reasonable excuses attributable to drug and alcohol misuse. These are both examples of existing flags within the welfare payments system that someone is struggling with their drug and alcohol use and which could be harnessed more effectively to direct people to appropriate health services.

Training and guidelines could also be provided to strengthen the capacity of people working in DHS and employment services to identify and refer people who might be experiencing problems related to substance use, so that we can intervene earlier.

Following a referral, the qualified drug and alcohol treatment provider could then engage with the individual in a therapeutic way, undertake an expert assessment of their needs and discuss possible treatment options.

As noted earlier in this submission, we welcome that drug and alcohol treatment will be made an eligible participation activity for jobseekers as part of this package. We support that change, but emphasise that treatment participation should be voluntary. We do not support mandating participation in treatment because the evidence does not support it. A recent systematic review of effectiveness of mandatory treatment approaches concluded that 'Evidence does not, on the whole, suggest improved outcomes related to compulsory treatment approaches, with some studies suggesting potential harms.'[9]

The approach that we have proposed would reflect evidence-based practice in drug and alcohol treatment which emphasises the importance of non-stigmatising therapeutic engagement. It would also be considerably more cost-effective than the proposed drug testing trial and could reach far more people in need of treatment.

[9] Werb, D et al. 2016. 'The effectiveness of compulsory drug treatment: a systematic review.' *The International journal on drug policy*, 28:1-9.

About St Vincent's Health Australia

St Vincent's Health Australia is the nation's largest not-for-profit health and aged care provider. We operate six public hospitals, nine private hospitals and 16 aged care facilities in Queensland, New South Wales and Victoria. Along with three co-located research institutes – the Victor Chang Cardiac Research Institute, the Garvan Institute of Medical Research and St Vincent's Institute of Medical Research – we work in close partnership with other research bodies, universities, and health care providers.

St Vincent's Health Australia has been providing health care in Australia for 160 years, since our first hospital was established in Sydney in 1857 by the Sisters of Charity. When the first five Sisters arrived in Australia in 1838 they carried with them the vision of their Founder, Mary Aikenhead, to reach out to all in need of care and particularly to the poor and vulnerable. It is the legacy entrusted to us by the Sisters of Charity that continues to inspire St Vincent's Health Australia to strengthen and grow our mission.

St Vincent's Health Australia employs around 18,400 staff and operates more than 2,600 hospital beds and 1,100 residential aged care places. In our hospitals, we provide more than 1 million episodes of care for patients each year.

We are a clinical and education leader with a national and international reputation in medical research. Our areas of expertise include mental health; drug and alcohol services; homeless health; prisoner health; heart lung transplantation; bone marrow transplantation; cardiology; neurosurgery; cancer; clinical genomics; HIV medicine; palliative care; respiratory medicine; and aged psychiatry.