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

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

Thank you for the opportunity to 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 with problematic alcohol and other drug issues. The following 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 related harms. Indeed they 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] however the demand for treatment in Australia exceeds supply.[2] We currently treat less than half of those who are suitable for and seek treatment in any given year.[3] Increasing referrals to treatment will only be effective if additional resources are provided to ensure treatment is actually available.

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 the current treatment shortfall, 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

[1] 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.

[2] 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.

[3] 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.

with a substance use dependency precisely because alcohol or other drug dependency is an illness that has as one of its criteria impairment in occupational functioning.

Compulsory drug treatment is a difficult issue and all three schedules contain compulsory treatment provisions. The literature on compulsory treatment indicates five different types of compulsory treatment approaches: 1) diversion programs which seek to divert offenders away from the criminal justice system 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 these models of compulsory or coerced treatment, the only one for which there is an evidence base is diversion programs.[4] Indeed available evidence suggests that the other forms of compulsory treatment not only fail to achieve the outcomes being sought but may actually result in harm.

A systematic review of compulsory treatment Wild et al (2002)[5] found that only two of eight studies found superior outcomes for clients receiving compulsory treatment compared with voluntary treatment, while the remaining six studies reported no difference in benefit. In a comprehensive review Broadstock et al. (2008)[6] concluded that there was no reliable evidence of the effectiveness of compulsory residential treatment for people who are mandated purely on the basis of their alcohol use or illicit drug use. A recent systematic review by Werb et al (2016)[7] 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 existing evidence, coerced or compulsory treatment is not an effective or efficient use of scarce resources.

Moreover there is no evidence that drug testing of welfare recipients (Schedule 12) is an effective approach. In 2013 the Australian National Council on Drugs reviewed the 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 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 drug treatment. The obligation 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.[9]

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4 Baker J and Goh D (2004) The cannabis cautioning scheme three years on: An implementation and outcome evaluation Sydney New South Wales Bureau of Crime Statistics and Research; Bright DA and Matire KA (2012) 'Does coerced treatment of substance-using offenders lead to improvements in substance use and recidivism? A review of the treatment efficacy literature' Australian Psychologist; Payne J, Kwiatkowski M and Wundersitz J (2008) Police drug diversion: A study of criminal offending outcomes Canberra Australian Institute of Criminology; Shanahan M, Lancsar E, Hass M, Lind B, Weatherburn D and Chen S (2004) 'Cost-effectiveness analysis of the New South Wales adult drug court program' Eval Rev 28(1) 3-27.

[5] Wild TC, Roberts AB, Cooper EL. (2002) Compulsory substance abuse treatment: An overview of recent findings and issues. *Eur Addict Res*; 8**:**84-93.

[6] Broadstock M, Brinson D, Weston A. (2008) The effectiveness of compulsory, residential treatment of chronic alcohol or drug addiction in non-offenders. In Health Technology Assessment Database: Health Services Assessment Collaboration (HSAC).

[7] Werb, D. Kamarulzaman, A., Meacham, M.C., Rafful, C. Fischer, B., Strathdee, S.A., Wood, E. (2016) The effectiveness of compulsory drug treatment: A systematic review. *International Journal of Drug Policy* 28, 1–9

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

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

We have also 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 of concern given compliance with an inappropriate recommendation would become mandatory for that person to continue to receive welfare payments. Under Schedule 13, the treatment would be chosen by an employment services provider rather than an addiction specialist, raising similar concerns regarding the adequacy of these provisions for effective assessment and referral.

Finally, poverty is a major issue for people with alcohol and other drug dependencies. Any policy that actually increases inequality reduces health outcomes. The removal of welfare payments is precisely such a policy. There is no evidence that keeping people in poverty decreases consumption of alcohol or other drugs or improves health. Schedules 12, 13 and 14 of the Social Services Legislation Amendment (Welfare Reform) Bill are ill-advised, ineffective and potentially harmful provisions.

Yours faithfully

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