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

10th April 2018

Dear Committee Members,

**Re: Submission to the Inquiry into the Social Services Legislation Amendment (Drug Testing Trial) Bill 2018**

Thank you for the opportunity to comment on the proposed amendments to the **Social Services Legislation Amendment (Drug Testing Trial) Bill 2018**. The Bill proposes the establishment of a drug testing pilot program for recipients of welfare across three locations: Canterbury-Bankstown (NSW), Logan (QLD) and Mandurah (WA).

As senior researchers with longstanding expertise in social policy issues relating to alcohol and other drug use, our assessment is that the proposed amendments are poorly conceived and counterproductive. They are not based on reliable research, and there are no grounds for adopting drug testing of welfare recipients as a measure to reduce alcohol or other drug use or related harms. On the contrary, these measures have the potential to increase harm, including stigma, marginalisation and poverty. They also engage human rights, without sufficient – and sufficiently evidenced – justification. There are several other conceptual errors and problems, especially regarding the nature of the 'problem' that the Bill purports to address, and what the Bill is likely to capture. The Bill is also likely to be subject to challenge for various reasons including procedural fairness. These various concerns are detailed below.

## Background and previous Senate Committee report

In 2017 a number of changes to Australia's welfare system were proposed. Schedule 12 of the Social Services Legislation Amendment (Welfare Reform) Bill 2017 ('the original Bill') contained a proposal to drug test welfare recipients. Schedules 13 and 14 were related proposals, in that they purported to remove exemptions from mutual obligations for alcohol or other drug dependence and to establish new rules regarding what constitutes a 'reasonable excuse' for not meeting a mutual obligation requirement.

In June 2017, the Commonwealth Senate referred the provisions of the original Bill to the Senate Community Affairs Legislation Committee for inquiry and report ('the original committee'). Public submissions were sought and obtained, two public hearings were held and a report was finalised in September 2017. The first three authors of this submission made a submission to the original committee. Our original submission was

confined to the proposal in schedule 12 – to drug test welfare recipients. We strongly opposed the proposal on the grounds that the proposed amendments were poorly conceived and counterproductive, and that they had the potential to increase harm, including stigma, marginalisation and poverty.

One section of the original committee's report deals with the proposal to drug test welfare recipients. It noted that a number of concerns were raised by research, legal, policy and welfare experts, in both submissions and oral evidence, regarding the proposal to establish drug testing trials. These included: 'a lack of evidence to support the use of drug testing; the cost, availability and reliability of drug testing; availability of treatment services to meet potential increased demand; and reliance on delegated legislation to set out significant detail about the operation of the trial; and income management'.[1]

The proposal to drug test welfare recipients did not gain support in the Senate, and was dropped from the original Bill.[2] A proposal to drug test welfare recipients is now being again proposed, this time via the Social Services Legislation Amendment (Drug Testing Trial) Bill 2018. According to the statement of compatibility with human rights that is part of the explanatory memorandum accompanying the Bill, the trial has two objectives:

- Maintain the integrity of, and public confidence in, the social security system by ensuring that tax-payer funded welfare payments are not being used to purchase drugs or support substance abuse;

- Provide new pathways for identifying recipients with drug abuse issues and facilitating their referral to appropriate treatment where required.

Many of the concerns raised in our original submission and by other experts in submissions to the original committee remain. They have not been overcome in this Bill. Indeed, the two dissenting reports annexed to the original committee report noted that the proposed measures were the subject of 'unanimous' concern from experts and representatives from relevant sectors. It is not clear how these various concerns were assessed or why many expert and sector submissions were rejected in the original committee report.

Moreover, an earlier review of evidence on the impact of drug testing welfare recipients, conducted in 2013 by the Commonwealth's then peak advisory body, the Australian National Council on Drugs, 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

[1] Commonwealth of Australia (2017). Report of the Community Affairs Legislation Committee; Social Services Legislation Amendment (Welfare Reform) Bill 2017 [Provisions]. Canberra, p. 14.
[2]https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/FlagPost/2018/March/Drug_testing_bill_2018

> serious ethical and legal problems in implementing such a program in Australia. Drug testing of welfare beneficiaries ought not be considered.[3]

It is not clear why this advice, from the Commonwealth's peak advisory body, has been ignored.

We also note that Philip Alston, the Special Rapporteur on extreme poverty and human rights, has previously corresponded with the government about the original proposal and raised a number of serious concerns on human rights grounds.[4] When the Special Rapporteur asked who had been consulted about the proposal, the government suggested[5] that it had 'spoken to numerous stakeholders in trial sites and a range of drug and alcohol services and peak bodies, and related experts across the country'. As far as we are aware, the details of who was consulted – and what consensus was reached, if any – have not been made public. If the government has consulted with experts and other key stakeholders from the alcohol and other drug sector, and found support for the proposal, this would be at odds with most submissions to the original committee inquiry. Also, many other concerns of the Special Rapporteur have not been adequately addressed. We revisit some of these concerns below.

## Experts do not agree on key alcohol and other drug issues

The Bill uses a range of different terms to describe the problems it aims to address. These include: substance 'use', substance 'misuse', substance 'abuse', 'drug misuse issues', 'drug abuse issues' and substance 'dependency'. The use of these different terms across both the Bill and accompanying materials (the explanatory memorandum and statement of compatibility with human rights) is significant for a number of reasons.

Crucially, there is an extensive body of literature to suggest that the nature and meaning of concepts such as 'substance abuse', 'dependency' and 'addiction' are complex, contested and by no means settled.[6] For example, there is significant debate about what dependency (sometimes also called 'addiction') 'is', how it 'works' and whether certain kinds of behaviour (such as certain crimes) should be characterised as addictions.[7] The field of alcohol and other drug research is also characterised by a distinct lack of consensus about the nature and origins of alcohol and other drug 'effects' and 'harms'.[8]

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[3] *ANCD Position paper: Drug testing* http://www.atoda.org.au/wp-content/uploads/DrugTesting2.pdf
[4] The first relevant correspondence was in October 2017: http://www.ohchr.org/Documents/Issues/Poverty/OL-AUS-17-10-17.pdf (Accessed 30th October 2017).
[5] This appeared in the government's response to questions posed by the Special Rapporteur on extreme poverty and human rights: http://www.ohchr.org/Documents/Issues/Poverty/OL-AUS-5-2017.pdf (Accessed 4th April 2018).
[6] See, for example: Fraser, S., Moore, D. & Keane, H. (2014). *Habits: Remaking Addiction*. Basingstoke: Palgrave Macmillan; Fraser, S., & Seear, K. (2011). *Making disease, making citizens: The politics of hepatitis C*. Aldershot: Ashgate; Karasaki, M., Fraser, S., Moore, D. & Dietze, P. (2013). The place of volition in addiction: Differing approaches and their implications for policy and service provision. *Drug and Alcohol Review, 32,* (2), pp. 195-204; Keane, H. (2002). *What's wrong with addiction?* Melbourne: Melbourne University Press (an imprint of Melbourne University Publishing).
[7] Keane, H. (2016). Technological change and sexual disorder. *Addiction*, *111*, pp. 2108-2109.
[8] Duff, C. (2013). The social life of drugs. *International Journal of Drug Policy*, 24(3), pp. 167–172 at p. 169.

There are significant debates, as well, about whether habitual alcohol or other drug use should be treated as a criminal problem; or an illness or disease; or a social policy problem.

There are competing views among experts on the value and reliability of different models of addiction, including the brain disease model of addiction.[9] For instance, in 2014, 94 experts were signatories to an open letter to the prestigious journal *Nature*, in which they challenged claims by other experts about addiction, thus highlighting the complexity and contestation in the field.[10] Key concepts of addiction such as agency, responsibility, rationality and choice are contested. Similarly, there has been significant contestation and debate about appropriate terminology in the alcohol and other drugs field. One of the most notable examples in recent years involved attempts to revise and update the *Diagnostic and Statistical Manual of Mental Disorders* – a key text of the American Psychiatric Association (subsequently published as the *DSM-5*). The DSM-5 contained major revisions related to substance use, which were the subject of significant controversy, criticism and debate.[11] These debates are important for several reasons. Writing about the DSM-5, for example, the second and third authors of this submission have noted that such 'changes are not just a matter of terminology but represent a redefining of addiction and a redrawing of its boundaries'.[12]

The confusion in terminology is significant because it represents, at the very least, conceptual confusion and inconsistency about what it is, exactly, that the Bill purports to target. Even despite the fact that there is disagreement among experts about what key terms such as 'dependence' mean, as noted above, there are obvious problems when references to mere 'use' of alcohol or other drugs are combined or conflated with references to 'dependency'. It is unclear how a trial could be conducted in circumstances where there is such conceptual confusion and inconsistency about all of these issues. As well, drug testing cannot distinguish between those who have significant drug problems and the potential to benefit from treatment, and those who do not.

## The formulation of 'the problem' is confused, narrow and misguided

There is also a large and important body of literature, including several peer-reviewed articles written by the authors of this submission, which highlights the importance of *problematisation* in alcohol and other drug policy.[13] A key insight of this literature is that

[9] Fraser, S. (2016). Articulating addiction in alcohol and other drug policy: A multiverse of habits. *International Journal of Drug Policy, 31,* pp. 6-14; Carter, A. et al. (2014). Control and responsibility in addicted individuals: What do addiction neuroscientists and clinicians think?. *Neuroethics*, 7(2), pp. 205–214; Hall, W., Carter, A., & Forlini, C. (2015). The brain disease model of addiction: Is it supported by the evidence and has it delivered on its promises? *The Lancet Psychiatry*, 2, pp. 105–110.
[10] Heim, D. et al. (2014). Addiction: not just brain malfunction. *Nature*, 507, 40. Available at: http://www.nature.com/nature/journal/v507/n7490/full/507040e.html (accessed 16th October, 2017).
[11] Two of the authors have written extensively about these debates. See: Fraser, S., Moore, D. & Keane, H. (2014). *Habits: Remaking Addiction*. Basingstoke: Palgrave Macmillan.
[12] Fraser, S., Moore, D. & Keane, H. (2014). *Habits: Remaking Addiction*. Basingstoke: Palgrave Macmillan, p. 45.
[13] Lancaster, K., Seear, K., Ritter A. (2017). Making medicine; producing pleasure: A critical examination of medicinal cannabis policy and law in Victoria, Australia, *International Journal of Drug Policy*, vol. 49, pp. 117-125; Manton, L. and Moore, D. (2016). Gender, intoxication and the developing brain: Problematisations

policymakers make assumptions, in the course of designing policies, about both the *nature* and *origins* of problems. Once these assumptions have been stabilised, particular solutions appear to become *obvious*. So, for example, 'a policy that offers training programs to women as a way to increase their representation in positions of influence *produces* the "problem" as women's *lack of training*'.[14]

As these ideas apply to the present Bill, we make two points. As noted above, the Bill purports to address multiple and potentially contradictory 'problems' (e.g. 'use' versus 'dependency'). In spite of the first point, the Bill conceptualises drugs as a key driver of problems – particularly, as a barrier to social and economic participation, and employment. While we acknowledge that alcohol and other drugs may be associated with reduced social and economic participation, including unemployment, the relationship is extremely complex. The Bill appears to treat alcohol and other drugs as a key inhibitor to participation and employment, in isolation from other factors, including: labour market conditions, access to education and training, poverty, housing security and homelessness, experiences of sexual assault and sexual abuse, family violence, trauma, stigma, discrimination, the impact of criminal records, and more. These systemic and structural factors are integral to social and economic participation and employment opportunities.

## Concerns about the accuracy of testing

Since compliance with assessment recommendations would be mandatory in order for a person to continue to receive welfare payments, assessments will need to be highly accurate and reliable. A number of submissions to the original committee raised concerns about the accuracy and reliability of drug tests, however, as well as the significant expenses and other challenges associated with conducting them.

Despite assumptions that drug testing is a highly objective science, research suggests that it has significant flaws.[15] Tests can generate both false positives and negatives, for

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of drinking among young adults in Australian alcohol policy. *International Journal of Drug Policy, 31,* (5), pp. 153-162; Bacchi, C. (2015) Problematizations in alcohol policy: WHO's "Alcohol Problems", *Contemporary Drug Problems*, 42:2, 130-147; Lancaster, K., Seear, K., & Treloar, C. (2015). Laws prohibiting peer distribution of injecting equipment in Australia: A critical analysis of their effects. *International Journal of Drug Policy, 26*(12), 1198-1206; Pienaar, K., & Savic, M. (2015). Producing alcohol and other drugs as a policy 'problem': A critical analysis of South Africa's 'National drug master plan' (2013–2017). *International Journal of Drug Policy*, 30(April), 35–42; Seear, K. and Fraser, S. 'The Addict as Victim: Producing the "Problem" of Addiction in Australian Victims of Crime Compensation Laws' (2014) 25(5) *International Journal of Drug Policy* 826; Seear, K. and Moore, D. (2014). Complexity: Researching alcohol and other drugs in a multiple world. *Contemporary Drug Problems, 41,* (3), pp. 295-300; Lancaster, K., & Ritter, A. (2013). Examining the construction and representation of drugs as a policy problem in Australia's National Drug Strategy documents 1985-2010. *International Journal of Drug Policy*, 25 (1), 81-87; Lancaster, K., Hughes, C., Chalmers, J., & Ritter, A. (2012). More than problem-solving: Critical reflections on the 'problematisation of alcohol-related violence in Kings Cross. *Drug and Alcohol Review, 31*, 925-927; Fraser, S., & Moore, D. (2011). Governing through problems: The formulation of policy on amphetamine-type stimulants (ATS) in Australia. *International Journal of Drug Policy, 22*(6), 498-506.

[14] Bacchi, C. (2018). Drug problematizations and politics: Deploying a poststructural analytic strategy. *Contemporary Drug Problems*, *45*(1), 3-14.

[15] See, for example: Moeller, K.E. et al. (2017) Clinical interpretation of urine drug tests: What clinicians need to know about urine drug screens, *Mayo Clinic Proceedings*, 92:5, pp. 774-796; Saitman, A., Park, H. and Fitzgerald, R.L. (2014). False-positive interferences of common urine drug screen immunoassays: A review,

example. The interpretation of tests involves a degree of subjectivity, and different technicians can reach different conclusions. It is not clear from the proposal what kinds of qualifications the testers would hold, nor whether they would be experienced – or required to be experienced – in conducting and interpreting tests of this type.

The Royal Australasian College of Physicians (RACP) was one of several expert bodies to make a submission to the original committee. Its submission contains a detailed summary of the many problems associated with drug testing. These include those noted above, but also some of particular concern regarding the chain of custody. The RACP submission also notes that not all states and territories have the necessary equipment and technology to conduct certain kinds of tests. It goes on to explain:

> 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 [an] appropriate chain of custody process plays [sic] 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.[16]

For reasons we explain in more detail below, these challenges will result in an increased risk of legal challenge to the drug testing regime.

Importantly, the original committee's report acknowledges the many concerns about the accuracy of testing. The report appeared to dismiss these concerns without explanation, however, noting simply that:

> In relation to the reliability of drug testing to identify and assist people with drug dependency problems, the Department of Social Services stated that the trial will focus on the detection of illicit drug use and is one part of a broader suite of measures being undertaken to assist unemployed people with drug dependence issues which impact on their ability to obtain employment.[17]

Respectfully, the segments of the Department's submission referenced in this part of the original committee's report do not address the question of the accuracy and reliability of the tests or the serious concerns expressed by the RACP.

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*Journal of analytical toxiciology*, 38:7, pp. 387-396; Hadland, S.E. and Levy, S. (2016). Objective testing – urine and other drug tests, *Child and Adolescent Psychiatric Clinics of North* America, 25 (3), pp. 549-565; Mackinem, M., & Higgins, P. (2007). Tell me about the test: The construction of truth and lies in drug court. *Journal of Contemporary Ethnography, 36*(3), 223-251.

[16] Submission of the Royal Australasian College of Physicians (RACP) to the Community Affairs Legislation Committee; Social Services Legislation Amendment (Welfare Reform) Bill 2017 [Provisions], 2017, p. 6.

[17] Commonwealth of Australia (2017). Report of the Community Affairs Legislation Committee; Social Services Legislation Amendment (Welfare Reform) Bill 2017 [Provisions]. Canberra, p. 15.

**Problems with the sanction for missing an appointment or refusing a test**

The proposal establishes a system via which welfare recipients will be notified of the need to present for a drug test, be tested, and then, if returning a positive result, be sanctioned. In the first instance, recipients may be sanctioned if they are notified of the need to attend an appointment and do not attend. In this instance, recipients will have their welfare payment suspended until they attend a rescheduled appointment. There is provision in the proposal for those who have a 'reasonable excuse' for missing their appointment to have their payment restoration backdated.

The proposal does not clarify whether the department or a relevant delegate is subject to a time limit, within which they must make a decision as to whether or not a reasonable excuse exists. The proposal also does not clarify whether the restoration and back payment of welfare is subject to a time limit, so as to minimise any period within which a welfare recipient will be without income support. It is also unclear whether additional resources will be provided to support decision makers to process reasonable excuse notifications and make timely determinations, with a view to minimising the risk that people will be unlawfully deprived of welfare payments for significant periods of time. It is also unclear how long participants will need to wait to attend a rescheduled appointment, and whether measures will be taken to address the likely delays in rescheduling that will be introduced into the system across the three pilot sites, as a result of the extra administrative burdens associated with this scheme.

In other words, there is a substantial risk that participants will have their welfare payments terminated, and have to wait several weeks to be reinstated and back paid. No income support or other measures appear to be available in the meantime, and it is unclear what contingencies and additional resources are being mobilised to minimise these risks. These developments undermine the right to social security and the right to an adequate standard of living (respectively, Articles 9 and 11 of the International Covenant on Economic, Social and Cultural Rights). We note that in the statement of compatibility with human rights accompanying the Bill, these issues do not appear to have been addressed. Indeed, this statement notes that the Bill contains 'appropriate safeguards […] to ensure that job seeker's [sic] participating in the trial are still provided with the means to meet their basic needs and those of their families'. This appears to be a reference to the implications of sanctions for a first positive test (discussed below), the sanction for which is income management, rather than suspension of income. In other words, the statement of compatibility with human rights appears to address the human rights implications of *income management*, as opposed to *income suspension*.

The proposal also states that those who refuse a drug test without a reasonable excuse will have their payment cancelled. If they then make a new claim for a welfare allowance, they must wait a period of 4 weeks. For the reasons set out above, this measure also infringes human rights including the right to social security (Article 9) and the right to an adequate standard of living (Article 11). The fact that recipients will be left without income for at least 4 weeks is not addressed in the statement of compatibility with human rights.

**Problems with the sanctions after a first positive test**

On the first occasion that a person tests positive to a drug, they will be subject to income management. According to the statement of compatibility with human rights accompanying the Bill, income management:

> does not reduce the total amount of income support available to a person, just the way in which they receive it. Under Income Management, a majority portion of a job seeker's normal payment is quarantined and the remaining amount is paid into their regular bank account and is accessible as cash. Job seekers placed on Income Management under this trial will still be able to purchase items at approved merchants and pay rent and bills with their quarantined funds. However, the recipient will not be able to use their quarantined funds to withdraw cash, gamble, buy alcohol, tobacco products, pornography or cash-equivalent products (such as gift cards).

No rationale is offered for restricting access to legal products such as alcohol, tobacco or pornography, and no rationale is offered for restricting one's capacity to engage in the lawful activity of gambling. Importantly, the proposal contains no information outlining why these measures are necessary, how they relate to the 'problems' the Bill purports to address – such as drug 'misuse' – or how they are reasonable and proportionate means of achieving the Bill's objectives. As a reminder, the Bill's stated objectives are twofold:

- Maintain the integrity of, and public confidence in, the social security system by ensuring that tax-payer funded welfare payments are not being used to purchase drugs or support substance abuse;

- Provide new pathways for identifying recipients with drug abuse issues and facilitating their referral to appropriate treatment where required.

Neither objective relates to alcohol, tobacco, gambling or pornography. The income management regime thus constitutes an impermissible, disproportionate and unjustifiable incursion of rights.

It is also possible that some people subjected to income management will be regular consumers of alcohol or tobacco. Some of these people may experience difficulties (such as withdrawal) if they are banned from accessing these products. Nothing in the Bill or accompanying materials suggests that these people will be offered assistance and support, should they want it, to manage their transition away from lawful substance use. This is so despite the fact, noted earlier, that these implications are not connected to the central problems and objectives of the Bill. At the very least, if these measures are to be introduced, consideration must be given to further resourcing and support for those who want it.

We also have major concerns with the length of time people will be subjected to income management. The Bill states that people who return an initial (first) positive test will be subject to income management for a period of 24 months. The Bill and accompanying documents contain no explanation as to why this length of time was deemed necessary and thus it is not possible to make an assessment as to whether the measure is reasonable and proportionate. Based on available information, a 24 month period of income management for a single positive test is wholly disproportionate to the aims of the Bill.

Section 123UFAA (1B) of the Bill states that the secretary may – by legislative instrument – determine a period of income management of longer than 24 months. The explanatory memorandum to the Bill states that:

> The intention is to give the Secretary the discretion to extend the period of income management for longer than the 24 month trial period. For example, if a person continues to return a positive drug test during the 24 month trial period, the person will continue to be subject to income management after the drug testing trial ends. It is intended that this provision would be used where it is considered to be beneficial to a person's drug rehabilitation outcome to remain on income management for a longer period of time.

There are several problems with this proposal. First, we consider it to be an inappropriate delegation of power for which there is inadequate oversight and insufficient scrutiny. The circumstances under which the secretary may exercise her or his discretion are unclear, do not appear to require any evidence base and involve far less scrutiny than a Bill before the parliament. Second, the potential for income management to be extended beyond the 24 month period is not predicated upon a person continuing to test positive to drugs. Indeed, it is possible that some participants may have tested positive, been through treatment and returned negative drug tests, and yet continue to be subjected to highly intrusive income management processes based on the claim that it will be 'beneficial' for them. Although the explanatory memorandum contains no further detail on this point, we note that some approaches to alcohol and other drug dependency (such as 12 Step) understand it as a lifelong problem (and sometimes, a lifelong 'disease') from which a person never fully recovers. Depending on the nature and type of treatment prescribed, therefore, and the underlying concepts of dependence/addiction therein, there is a potential for ongoing income management based on controversial grounds. Income management in these circumstances would appear wholly illegitimate, disproportionate and unreasonable and would almost certainly be subject to legal challenge.

We also note that many submissions to the original committee inquiry noted that Australia's alcohol and other drug treatment system was overstretched and under-resourced and that the proposal to refer welfare recipients for treatment would likely burden the system further. There is thus a very high likelihood that some recipients subject to income management will not have commenced or completed prescribed drug treatment within the initial 24 month period, *through no fault of their own*. Recipients would effectively continue to be subjected to sanctions because of systemic failings including under-resourcing.

**Problems with the process for disputing a positive drug test**

The statement of compatibility with human rights states that the 'contracted testing provider will be required to provide notice of the test results to the Department of Human Services'. It is not entirely clear how the welfare recipient will be made aware of the positive result, what form any notice provided to them will take, and what information it will contain. The Bill then contains a process via which those who test positive can request a re-test of the second part of the sample that was originally given. If the second test is also positive, the recipient will have to repay the cost of the test. Submissions made to the original committee inquiry suggest that this could amount to several hundred dollars in costs (to be deducted under a staged system detailed in the Bill). In addition, a person who tests positive may provide evidence to the drug testing provider of circumstances that may affect the result of the drug test.

Finally, section 123UFAA(1C) of the Bill provides that the secretary must determine that a person is not to be subjected to income management if they are satisfied that the regime poses 'a serious risk to the person's mental, physical or emotional wellbeing'. Section 123UFAA(1D) of the Bill provides that the secretary is not required to actively take steps to assess every trial participant for the purposes of section 123UFAA(1C). The secretary need only make such a determination 'once he or she is made aware of facts which indicate that being subject to income management may seriously risk a person's mental, physical or emotional wellbeing'.

Each of these steps ostensibly represents a check or balance of some kind on the exercise of power under the Bill. We have several concerns about each of these processes, however. First, as we have already noted, it is not clear whether drug test providers are required to have particular skills or expertise in this field. It is also not clear what kind of 'evidence' might be accepted as proof that a drug test was affected. What if a person believes that they had food or a drink spiked, for example, but has no 'proof' beyond their own account? Will evidence from the recipient be sufficient? What format will it need to take? How will these decisions be made and how will those impacted by the trial be advised of their legal rights in these respects? In an associated sense, it is not clear what additional informational and legal supports will be made available to recipients to assist them with these processes – including the process of challenging a positive drug test through the provision of supplementary information that might explain a drug test. Given the practical and legal complexities associated with these issues, at the very least, additional resourcing to community legal centres and/or legal aid offices must be considered, alongside an educational campaign to be widely publicised before the rollout of the measures and the introduction of testing so that people can receive legal advice about their options before they are subjected to any drug tests.

We are also concerned that the Bill delegates authority for important decision making to drug test providers. On the face of it, it seems that the only decisions the drug test provider will be asked to make are putatively 'expert' or 'scientific' ones, such as whether there are circumstances that might affect the result of the drug test (e.g. that the recipient of welfare was taking other prescription medication). In practice, however, the range of decisions being made by drug test providers are likely to be much more extensive, and may include decisions about the reliability and credibility of witnesses (including the

recipient themselves) and evidence that seeks to provide a context or explanation for a positive test. The claim that one's drink was spiked, for example, is not a purely scientific question, but may involve an assessment of the credibility of the witness and the reliability of that information, among other things. These constitute legal evaluations of evidence and are wholly inappropriate for delegation to a non-expert contractor.

We also have a number of concerns that pertain to procedural fairness. At the very least, procedural fairness requires that a person affected by a decision 'know the case sought to be made against him [sic] and to be given an opportunity of replying to it'.[18] Robert French, the former Chief Justice of the High Court of Australia, has argued that procedural fairness is 'indispensable to justice'.[19] As we note above, the materials accompanying the Bill make it clear that the drug test provider will notify the department of the test results, but are silent on the question of whether the recipient will receive those results, how much information will be provided to them and whether they will be given an opportunity to reply (the latter point is discussed below). At the very least, those who test positive should be given a complete copy of the test results, including any other relevant accompanying information (such as documents pertaining to the process by which the results were interpreted, policies or other relevant documents provided to drug test providers to assist them in making decisions), and – where appropriate – this information should be made available in different languages (for non-English speaking participants). We suggest that the requirements of procedural fairness also necessitate consideration of how this information will be communicated to participants experiencing cognitive impairment, literacy challenges or other relevant barriers.

The second component of procedural fairness, noted above, requires that a person be given the opportunity to reply to the case being made against them. The statement of compatibility of human rights states that a person may provide the drug test provider with evidence of circumstances that may affect the drug test and that the provider 'will consider this evidence when interpreting the result of the drug test'. Our reading of this statement suggests that welfare recipients would be expected to be aware of potentially relevant contextual information or other circumstances that explain a positive drug test and to provide this information to the test provider before the drug test has taken place.

There are several problems with this. First, welfare recipients may submit to a drug test in good faith and in the belief that they would pass the test. They would not, in other words, have considered it necessary to collate potentially relevant information in advance of such a test. For the same reason, they would also not know what information might be relevant or necessary. By way of illustration of how complex these issues can be, we draw to the committee's attention a recent peer reviewed article by Hadland and Levy that offers examples of how a false positive may be produced.[20] They note that with some sensitive tests, substances found in food – such as poppy seeds – may trigger an

[18] *Kioa v West* [1985] HCA 81; (1985) 159 CLR 550, 582 (Mason J).
[19] French, F. 'Sir Anthony Mason Lecture: Procedural Fairness – Indispensable to Justice?' (University of Melbourne Law School, 7 October 2010), <www.hcourt.gov.au/assets/publications/speeches/current-justices/frenchcj/frenchcj07oct10.pdf>.
[20] Hadland, S.E. and Levy, S. (2016). Objective testing – urine and other drug tests, *Child and Adolescent Psychiatric Clinics of North America*, 25 (3), pp. 549-565.

opioid screen (because they contain very low levels of morphine). Alternatively, some medications such as stimulants for ADHD can trigger an amphetamine screen.

The Bill appears to expect that welfare recipients would be both aware of these complexities and aware of them in advance of undertaking a drug test. The Bill places the onus on welfare recipients to be up to date with extremely complex scientific information and developments in alcohol and other drug testing, and to assess how these might affect their drug tests. In other words, a person who consumes a piece of poppy seed cake before a drug test will be required to know that in certain circumstances that might render a (false) positive and provide 'evidence' of this to the drug test provider before the drug test provider interprets the results. This is wholly impractical.

We do not see any provision in the Bill for individuals to challenge a positive test result by providing additional contextual information after the fact. If there is no provision for this, the Bill will almost certainly be subject to legal challenge and decisions may fail on the ground of procedural fairness.

Research from the field of alcohol and other drug testing also suggests that certain kinds of tests should be considered 'presumptive' rather than definitive and be confirmed only via a second test.[21] As we note above, however, the proposed Bill does not require a second test. We believe that there is a strong case for requiring an automatic test of the second part of the sample, at the state's expense. We acknowledge that charging a fee for a (positive) test of the second part of a sample might be justifiable, from a procedural fairness point of view, as an efficiency/recuperation of costs mechanism, in order to stop spurious review applications and because of the associated costs that would otherwise fall to the state in conducting second tests.

That said, there is a recognised need in the procedural fairness jurisprudence to balance efficiency with fairness. As regards the latter, the seriousness of the decision should be taken into account and, we suggest, the threshold for making a decision needs to be high. The scientific literature suggests that in certain circumstances, a first positive test is merely 'presumptive' rather than definitive and that a second, confirming test, should be undertaken. It is important to keep in mind that among other things, a positive test result negatively affects reputation and will lead to adverse implications (income management and/or worse). Furthermore, this impact falls on a vulnerable population (low income, may not fully understand the review process or legal system, and so on).

There is also some commentary from a Federal Court case that we believe is relevant to the present circumstances. In *Minister for Immigration and Ethnic Affairs v Pochi*[22], Deane J stated that a decision should be based on:

> some *rationally probative evidence and* not merely raised before it as a matter of *suspicion or speculation* or left, on the material before it, in the situation where the

[21] See, for example: Moeller, K.E. et al. (2017) Clinical interpretation of urine drug tests: What clinicians need to know about urine drug screens, *Mayo Clinic Proceedings*, 92:5, pp. 774-796; Saitman, A., Park, H. and Fitzgerald, R.L. (2014). False-positive interferences of common urine drug screen immunoassays: A review, *Journal of analytical toxiciology*, 38:7, pp. 387-396;
[22] (1980) 44 FLR 41

> Tribunal considered that, while the conduct may have occurred, it was unable to conclude that it was more likely than not that it had. (emphasis added)

Although we do not wish to conflate test results that are presumptive/non-definitive with the concept of mere suspicion/speculation, we suggest that there is a need for 'rationally probative evidence' before a decision of great significance to a vulnerable population is made. At the very least, this requires additional safeguards than exist in the present proposal.

We suggest that in the absence of appropriate measures (including the testing of the second part of the sample, at the state's expense, and the provision of an opportunity to provide contextual information after the fact if a positive test, and for the decision to be reviewed and overturned at no expense to the welfare recipient), the measures proposed in the Bill may well be subject to legal challenge as they appear to offend the principles of procedural fairness.

**Problems with the sanctions after a second positive test**

A separate and additional set of sanctions comes into play when a person tests positive to a drug for a second time. The statement of compatibility with human rights states:

> Recipients who test positive to a second drug test during the trial period will be referred to a suitably qualified health professional for assessment of their drug use issues and the recommendation of any treatment appropriate to the individual's circumstances. Based on the report from the medical professional, where appropriate, recipients will be required to complete one or more activities designed to address their substance abuse as part of their Job Plan, such as rehabilitation, counselling or ongoing drug testing.

It is not clear from the proposal what kinds of qualifications the contracted health professionals will have, and whether they will be required to have specific qualifications relevant to addiction medicine. Given the significant complexity associated with the field and the significant rights issues at stake, proper resourcing of appropriate experts will be essential. There are significant legal risks here.

Neither the Bill, the explanatory memorandum nor the statement of compatibility with human rights contains information on what kind of treatment might be offered. The explanatory memorandum to the Bill states that a recipient who tests positive will in certain circumstances be required to be assessed by a medical professional and if the professional recommends treatment, required to complete those treatment activities. The statement of compatibility with human rights then notes that 'These activities may include rehabilitation, counselling or ongoing drug testing'.

At the very least this makes it difficult to assess the feasibility of the Bill and the extent to which it is likely to meet its objectives. As we noted earlier, there is significant contestation in the alcohol and other drugs field about key issues. Different practitioners may reach different conclusions about whether or not a person has a drug problem

and/or requires treatment, as well as what kind of treatment would be appropriate and for how long.

All of this raises questions about the kinds of treatment activities that might be required and the evidence base for each of them – both individually and in combination. The statement of compatibility with human rights implies that different treatment activities or modalities, with potentially confused, contradictory and inconsistent conceptualisations of substance use and abuse, might be used together. The ordinary reading of the memorandum also implies, on the face of it, that some participants may receive only 'ongoing drug testing' as treatment. To be clear, although we do not endorse other forms of mandated treatment for the reasons described throughout this submission, the possibility that recipients will be subjected to uneven forms of testing and treatment obligations – with varying degrees of commitment and where some are more burdensome than others – speaks to the core problems with the proposed Bill. Moreover, it is not clear whether ongoing drug testing is a form of treatment.

A person is required to engage in 'available and appropriate treatment' (statement of compatibility with human rights). Presumably, then, a person will not be subject to further sanctions if treatment is either unavailable (because, for example, of resourcing limitations) or inappropriate. The publicly available documentation offers no further insights into what might constitute 'inappropriate' treatment. We note that some forms of treatment are underpinned by religious or other spiritual philosophies that may be at odds with the religious beliefs of recipients. At the very least a thorough assessment of these issues will need to be undertaken before the scheme is introduced, and steps will need to be introduced to ensure that religious and spiritual beliefs are respected. If not, decisions made under the Bill will likely be subjected to legal challenge.

According to the statement of compatibility with human rights:

> Job seekers who test positive to a second or subsequent drug test will need to be [sic] repay the cost of the test through a temporary reduction of their social security instalment. Consistent with the objective of trial, this repayment requirement is designed to discourage future drug use and potential positive test results.

The claim that the repayment sanction will act as a disincentive to further drug use has a number of flaws. First, there is no evidence provided in support of the claim. Second, and more importantly, this will take place without any offer of treatment (including mandated treatment). In other words, the mere fact of the second test – and the consequent threat of being required to repay costs to the state – is claimed to be a disincentive to drug use in circumstances where we are simultaneously being asked to accept that the recipient who tests positive twice has a drug 'problem', needs help to fix it, and requires (compulsory, non-consensual) medical treatment in order to overcome it. This represents an internally contradictory version of 'the problem' and its solutions, and raises questions about why it is that mandated treatment is necessary in the first place, especially as the Bill suggests that people can cease drug use on their own, without medical intervention.

## The evidence suggests the program will exacerbate harms, rather than alleviate them

The compulsion to submit to drug testing contributes to the stigmatisation of people who use drugs. International and Australian research demonstrates that stigmatisation contributes to a wide range of adverse outcomes for people with experience of problematic drug use, including poor mental and physical health, reluctance to engage with services, withdrawal from treatment, delayed recovery and reintegration processes, estrangement from family and friends, and increased involvement in risky practices such as the sharing of injecting equipment.[23]

Stigma must be taken seriously. Increasingly, the law is understood as playing a major role in the production of stigma,[24] and stigma is understood as a human rights concern.[25]

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[23] Lancaster, K., Seear, K., & Ritter, A. (2017). *Reducing stigma and discrimination for people experiencing problematic alcohol and other drug use,* Final report submitted to the Queensland Mental Health Commission. Sydney: Drug Policy Modelling Program; Ahern, J., Stuber, J. & Galea, S. (2007). Stigma, discrimination and the health of illicit drug users. *Drug and Alcohol Dependence*, 88: 188-196; Brener, L., von Hippel, W., von Hippel, C., Resnick, I. & Treloar, C. (2010). Perceptions of discriminatory treatment by staff as predictors of drug treatment completion: Utility of a mixed methods approach. *Drug and Alcohol Review*, 29: 491-497; Brewer, M.K. (2006). The contextual factors that foster and hinder the process of recovery for alcohol dependent women. *Journal of Addiction Nursing*, 17: 175-180; Buchanan, J. & Young, L. (2000). The war on drugs – a war on drug users. *Drugs: Education, Prevention and Policy,* 7: 409-422; Copeland, J. (1997). A qualitative study of barriers to formal treatment among women who self-managed change in addictive behaviours. *Journal of Substance Abuse and Treatment*, 14: 183-190; Digiusto, E. & Treloar, C. (2007). Equity of access to treatment, and barriers to treatment for illicit drug use in Australia. *Addiction*, 102: 958-969; Fraser, S., Pienaar, K., Dilkes-Frayne, E., Moore, D., Kokanovic, R., Treloar, C. & Dunlop, A. (2017). Addiction stigma and the biopolitics of liberal modernity: A qualitative analysis. *International Journal of Drug Policy,* 44: 192-201; Henderson, S., Stacey, C. L. & Dohan, D. (2008). Social stigma and the dilemmas of providing care to substance users in a safety-net emergency department. *Journal of Health Care for the Poor and Underserved*, 19: 1336-1349; Link, B., Struening, E.L., Rahav, M., Phelan, J.C. & Nuttbrock, L. (1997). On stigma and its consequences: evidence from a longitudinal study of men with dual diagnoses of mental illness and substance abuse. *Journal of Health and Social Behavior*, 38: 177-190; Livingston, J.D. & Boyd, J.E. (2010). Correlates and consequences of internalized stigma for people living with mental illness: A systematic review and meta-analysis. *Social Science and Medicine*, 71: 2150-2161; Livingston, J.D., Milne, T., Fang, M.L. & Amari, E. (2012). The effectiveness of interventions for reducing stigma related to substance use disorders: A systematic review. *Addiction*, 107(1): 39-50; Mak, W.W., Poon, C.Y., Pun L.Y. & Cheung, S.F. (2007). Meta-analysis of stigma and mental health. *Social Science and Medicine*, 65: 245-261; Radcliffe, P. & Stevens, A. (2008). Are drug treatment services only for 'thieving junkie scumbags'? Drug users and the management of stigmatised identities. *Social Science and Medicine*, 67: 1065-1073; Room, R. (2005). Stigma, social inequality and alcohol and drug use. *Drug and Alcohol Review*, 24: 143-155; Simmonds, L. & Coomber, R. (2009). Injecting drug users: A stigmatised and stigmatising population. *International Journal of Drug Policy*, 20: 121-130; van Olphen, J., Eliason, M.J., Freudenberg, N. & Barnes, M. (2009). Nowhere to go: How stigma limits the options of female drug users after release from jail. *Substance Abuse Treatment, Prevention, and Policy*, 4: 10; Weiss, M.G., Ramakrishna, J. & Somma, D. (2006). Health-related stigma: Rethinking concepts and interventions. *Psychology, Health and Medicine*, 11: 277-287.

[24] Seear K; Lancaster K; Ritter A, 2017, 'A new framework for evaluating the potential for drug law to produce stigma: Insights from an Australian study', *Journal of Law, Medicine and Ethics*, vol. 45, pp. 596 – 606.

[25] For a detailed overview of some of these issues, see the first author's submission to the Victorian parliamentary inquiry into drug law reform: https://www.parliament.vic.gov.au/images/stories/committees/lrrcsc/Drugs_/Submissions/126_2017.03.16_-_Dr_K_Seear_-_submission.pdf

Recent research suggests that alcohol and other drug-related stigma arises from a wide range of sources, that it can be long lasting (including across a person's lifetime), and that it carries a range of adverse health, social and economic consequences.[26] Stigma is a key cause of health inequalities. It has been said that stigma:

> thwarts, undermines, or exacerbates several processes (i.e. availability of resources, social relationships, psychological and behavioural responses, stress) that ultimately lead to adverse health outcomes. Each of these stigma-induced processes mediates the relationship between stigma and population health outcomes.[27]

Stigma can also delay or impede people's willingness to seek help or health care.[28]

Poverty is a major issue for people with alcohol and other drug use issues. There is no evidence that keeping people in poverty decreases consumption of substances, or improves health. People in receipt of welfare payments, especially Newstart allowance, experience poverty at higher rates than the rest of the Australian population: in 2014, almost 60% of those people below the poverty line relied upon social security as their main income.[29] The removal of welfare payments for affected people would only increase poverty, thereby exacerbating rather than reducing harms related to alcohol and other drug use. There is also evidence that drug testing can have other effects. Participants may find testing degrading, embarrassing and invasive, for example.[30]

The government has previously suggested[31] that the pilot will be subject to a 'comprehensive evaluation' that will among other things 'capture any unintended consequences in real time'. It is not clear whether such an evaluation would be designed to capture the stigmatising effects of drug testing, mandatory treatment and so on, nor how the stigmatising effects of the Bill would be identified. The Bill will certainly introduce, magnify and exacerbate stigma for those affected – not just those who test positive, but those subject to such a scheme more broadly – and is almost guaranteed to generate and reproduce harms. It is not clear how these effects can be avoided.

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[26] C. Lloyd *Sinning and sinned against: the stigmatisation of problem drug users*. (London: UK Drug Policy Commission (UKDPC), 2010); C. Lloyd, "The stigmatization of problem drug users: A narrative literature review". *Drugs: Education, Prevention, and Policy, 20*(2), (2013): 85-95.

[27] Hatzenbuehler, M. L., Phelan, J. C., & Link, B. G. (2013). Stigma as a Fundamental Cause of Population Health Inequalities. *American Journal of Public Health, 103*(5), 813-821.

[28] Hatzenbuehler, M. L., Phelan, J. C., & Link, B. G. (2013). Stigma as a Fundamental Cause of Population Health Inequalities. *American Journal of Public Health, 103*(5), 813-821; Link, B. G., & Phelan, J. C. (2001). Conceptualizing Stigma. *Annual Review of Sociology, 27*, 363-385; Schulze, B. (2007). Stigma and mental health professionals: A review of the evidence on an intricate relationship. [Conference Paper]. *International Review of Psychiatry, 19*(2), 137-155.

[29] Saunders, P., Bradbury, B., Wong, M., Dorsch, P., Phillips, J., & Crowe, C. (2017). Poverty in Australia 2016. Sydney: ACOSS and the Social Policy Research Centre, UNSW Sydney.

[30] Strike, C., & Rufo, C. (2010). Embarrassing, degrading, or beneficial: Patient and staff perspectives on urine drug testing in methadone maintenance treatment. *Journal of Substance Use, 15*(5), 303-312.

[31] In its response to questions posed by the Special Rapporteur on extreme poverty and human rights: http://www.ohchr.org/Documents/Issues/Poverty/OL-AUS-5-2017.pdf (Accessed 4th April 2018).

## The Bill engages human rights without adequate justification

In October 2017, Philip Alston, the Special Rapporteur on extreme poverty and human rights, wrote to the Government raising a number of concerns about welfare reforms under the Social Services Legislation Amendment Act 2017 (Cth) (No. 33 of 2017). Although many of the measures proposed in this Act go beyond those proposed in the present Bill, the Special Rapporteur did consider various human rights concerns with drug testing of welfare recipients. Among other things, the Special Rapporteur asked the government to advise on the following:

> What evidence is the Government relying on to justify drug testing as the best option for addressing substance abuse among the poor in Australia? What independent, medical advice has the Government relied upon in reaching this conclusion?
>
> To what extent has the Government assessed the drug-related measures as being the least-restrictive means to achieve the objectives of reducing substance abuse among the poor?

The Australian government responded on 15th January 2018.[32] In that response the government noted that it 'is focussed on making meaningful and evidence-based reforms'. As noted above, however, experts agree that the reforms are not supported by evidence. The government received that expert advice through the original committee process and these findings are detailed in the dissenting reports that form part of the original committee report.

The Special Rapporteur responded again on the 30th January 2018.[33] At that stage, for the reasons we outlined at the start of this submission, the measures had been abandoned. For this reason, the Special Rapporteur remarked that:

> I am pleased that these trials have been removed from the proposed legislation, given my view that such tests would have been incompatible with Australia's obligations under the International Covenant on Economic, Social and Cultural Rights (ICESCR).

We have reviewed the correspondence between the Special Rapporteur and the government, along with the statement of compatibility with human rights for the proposed Bill. Several of the Rapporteur's abiding concerns have not been addressed and the proposed Bill still appears to infringe several rights. We thus reiterate the Special Rapporteur's concerns. In addition, we note that:

- The Bill infringes several rights without sufficient justification;

[32] http://www.ohchr.org/Documents/Issues/Poverty/OL-AUS-5-2017.pdf (Accessed 4th April 2018).
[33] http://www.ohchr.org/Documents/Issues/Poverty/OL-AUS-1-2018.pdf (Accessed 5th April 2018).

- Alternatively, the statement of compatibility is insufficient and does not adequately address human rights considerations making it impossible to evaluate whether particular aspects of the Bill are compatible with Australia's human rights obligations;

- There is significant contestation in the field of alcohol and other drugs, as noted earlier, including about key terms and concepts of 'dependency'. The precise problems to be addressed by the Bill, along with its central objectives are confused and contradictory. A Bill that proposes significant infringements of human rights should be based on solid foundations. The proposed Bill is not.

**In sum, as senior researchers with longstanding expertise in social policy issues relating to alcohol and other drug use, our assessment is that the proposed amendments are poorly conceived and counterproductive. The Bill should be rejected.**

We also refer the Committee to the earlier submission (of Fraser, Moore and Seear) to the Inquiry into the Social Services Legislation Amendment (Welfare Reform) Bill 2017, where we raised similar concerns to those raised here. We would be pleased to provide additional information or the research references cited in this submission.

Yours sincerely,

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