Committee Secretary

Senate Standing Committees on Community Affairs

24 September 2019

Social Services Legislation Amendment (Drug Testing Trial) Bill 2019 "The Bill"

Windana Drug and Alcohol Recovery (Windana) maintains concerns regarding the Bill which provides for trialling a drug testing regime in three regions of Australia, testing 5000 welfare recipients over two years. Whilst the intention of the Bill may be commendable, it is unlikely that the drug testing trial will elicit the intended results, with a significant risk of unintended adverse outcomes.

The funding allocated to this trial would be far more effectively spent on funding additional AOD treatment capacity to cater for existing unmet demand and through creating greater employment opportunities in low employment regions. Greater efforts to reduce stigma among jobseekers and those experiencing AOD dependency would lead to greater levels of help seeking and increased confidence in seeking employment.

About Windana

Windana Drug and Alcohol Recovery (Windana) is a leading Melbourne-based alcohol and other drug (AOD) treatment centre specialising in holistic, client-focused recovery programs. Clients choose from residential and a range of supportive community-based recovery and rehabilitation programs. We help people rebuild their lives in a safe, caring environment and support our clients wherever they are in the recovery process.

Windana provides family and youth-based services and is funded by the DHHS which necessitate compliance with the Child Safe Standards.

Does this work?

International examples of similar policy show little promise for the Bill.

- In 2017/18, the New Zealand model, where 47,115 were tested, resulted in 170 positive results amounting to 0.3% of the impacted population. The opportunity cost of this policy is significant, with the public paying for over 46,000 drug tests that netted a negative result;
- Various USA examples allow a drug test to be performed on welfare recipients in cases where there is a reasonable suspicion that illicit substances are being used. These examples involve screening thousands of welfare recipients and testing a smaller cohort who are under suspicion. In one example 38,970 were screened, 446 tested, with 48 providing a positive test.

These examples reveal that among the thousands of welfare recipients, only a small number test positive, highlighting an expensive process that detects only a fraction of the cohort as viable cases for treatment. There are more efficient means of generating greater access to treatment. The resources allocated to these processes could be more effectively apportioned to address the causes of disadvantage.

Punishing welfare recipients experiencing substance dependence

The Bill provides for various sanctions in cases where individuals produce a positive drug test result. In the first instance, welfare recipients are transitioned onto the cashless debit system, where 80 per cent of their benefits are corralled onto a debit card with limitations on the types of purchases permitted. The stated intentions are to reduce the availability of benefits which can be used to purchase alcohol or illicit substances, subsequently aiming to minimise alcohol and other drug (AOD) use

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among job seekers and purportedly improve job readiness. The Bill also seeks to capitalise on general deterrence, where jobseekers would self-regulate (reduce) substance use to avoid the risk of providing a positive drug test sample.

These notions are at odds with decades of evidence on what works in reducing substance use and associated harms and fails to effectively articulate a clear link between substance use and difficulties in job seeking.

The aims of this Bill are unlikely to be realised as the illicit drug market is highly fluid. It is both durable and adaptable to restrictive approaches; drug using populations modify their consumption patterns including the drugs they use to accommodate policy change.

Drug dependent individuals reluctant to engage in treatment may transition to other substances that cannot be detected through the available testing methods, potentially creating greater harms and reducing access to support services. Additional prescription medication may be sought, with the risk of contributing to the excessive pharmaceutical overdose toll (in Victoria, the Coroners Prevention Unit indicates that approximately 80 per cent of fatal overdoses involve pharmaceuticals[1]).

Another adverse outcome may be a reduction in the number of people receiving benefits, particularly among those experiencing substance dependence co-occurring with other morbidities such as mental illness, amounting to the use of highly punitive measures against acutely disadvantaged cohorts.

This policy may also drive occasional recreational substance users onto cashless debit, punishing infrequent users who do not require treatment. Such a measure is

[1] Coroners Prevention Unit. 2019. Overdose Deaths 2010 – 2018. Coroners Court Victoria.

unlikely to impact upon infrequent substance user consumption patterns nor improve employment prospects.

This policy runs the risk of punishing people experiencing chronic disadvantage while not reducing substance use nor improving employment outcomes.

Stigma

The recent regulatory changes stymying substance dependence as a reasonable excuse diminish substance dependence as a serious medical issue. It creates a notion of wilful unemployment, promoting a narrative that people experiencing substance dependence have a choice and that they are remaining unemployed to prioritise voluntary substance use. The recent restriction on substance dependence being accepted as a reasonable excuse may be viewed by some as closing a loophole, a view at odds with the reality of substance dependence.

Substance dependence is not a choice. It is a medical condition, often exacerbated by the experience of trauma. Substance dependence costs lives. Stereotypes that create a negative perception of those experiencing substance dependence are enhanced and strengthened through the narratives and enaction of legislation which is premised on an unrealistic characterisation of substance dependence. It creates a deeper sense of stigma toward those experiencing dependence in the community, reduces help seeking behaviour including disclosure to families, friends and medical professionals.

The first step in the journey to recovery is to get help; increasing stigma, reducing help seeking behaviour impairs recovery. The carriage of this Bill would likely increase stigma.

High unemployment areas

The regions selected for the trial exhibit high levels of disadvantage, including a sheer absence of employment opportunities. Direct government intervention through stimulus, wage subsidies or infrastructure expenditure would be a more effective means of generating greater levels of employment. The selected regions are demonstrative of lack of opportunity for some cohorts highlighting systemic barriers and limitations, rather than individual fault. Government policy to address unemployment in low employment regions with disadvantaged cohorts should focus on systemic reform targeting local factors to increase opportunity coupled with a supportive community service framework.

Due diligence

The Bill and associated dialogue pertaining to this reform contain scant information on how the trial would be evaluated. The application of broad-based measures such as local employment data, AOD related harms, changes in offending rates and engagement with health and welfare services will not effectively ascertain the success of the program. Establishing a causal relationship on any or all of these factors would be tenuous.

Data on the frequency of positive drug samples and the portion of that sample that are referred to treatment may be of use; this data would need to be cross referenced with waiting times, treatment type applied (and whether the service user completed the course of treatment) and outcomes. Further linkages would need to be made between treatment outcome and potential employment. Identifying any additional services engaged through referral would also contribute positively. The cost of this process, including the opportunity cost in prioritising this cohort over those currently waiting to enter the treatment system would need to be considered in light of other options such as those noted under 'high unemployment areas' above.

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The data would need to account for external drug use patterns as well as industrial and demographic changes in the region.

An accompanying evaluation process should be outlined, which provides for an independent robust evaluation process.

Voluntary AOD service users – waiting with dependence

The AOD treatment sector is considerably overburdened, with wait times for some treatment types spanning beyond six months; research indicates that less than one in six people in need of AOD treatment receive treatment[2]. The lack of capacity in the sector to meet demand has contributed to less ideal circumstances such as the rapid growth of for-profit, unregulated treatment providers who advertise drug treatment support. The growth of this sector signifies both unmet demand and desperation within the community. Governments at all levels should prioritise policy initiatives that ensure that those most in need can readily access funded AOD treatment. The Bill runs contrary to this notion, prioritising referral capacity from a positive drug test over desperate families who have no option but an anxious wait or to pay for an unregulated overpriced treatment service.

The $10M AOD allocation to support this program, whilst welcome, would do little to stem this demand and should be allocated, irrespective of the success of this Bill, to support vulnerable community members.

[2] Lintzeris. N 2017. Helping drug users get back to work, not random drug testing, should be out priority. The Conversation.

Involuntary treatment

This Bill would compel certain job seekers into treatment. Benefits would be lost if they refused treatment, effectively amounting to involuntary treatment.

Involuntary treatment has a place within the AOD treatment sector. In Victoria, the *Severe Substance Dependence Treatment Act* 2010 provides for compulsory treatment in cases where there is an immediate and severe risk of dire harm, setting a high threshold in cases where treatment will be necessary to prevent proximate and severe harm. Windana has also supported the Victorian based *What Can Be Done*[3] proposal, which calls for a specific youth-based treatment facility in cases where other options for treatment have failed. In both cases, the threshold necessitating involuntary treatment is high, beyond that which would be applied in this Bill. To that end, Windana does not have confidence that the application of involuntary treatment is the most effective treatment intervention for this cohort.

Should you have any queries, please contact me.

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[3] See https://www.churchilltrust.com.au/fellows/detail/3887/Jennifer+Bowles%20

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