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Inquiry into the Social Services Legislation Amendment (Drug Testing Trial) Bill 2019

September 2019

About The Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of over 17,000 physicians and 8,000 trainee physicians across Australia and New Zealand. The RACP represents physicians from a diverse range of disciplines relevant to this inquiry, including but not limited to addiction medicine, public health medicine, occupational and environmental medicine, rehabilitation medicine, oncology, clinical pharmacology, toxicology, gastroenterology, and internal medicine.

RACP members see first-hand the many and varied harms caused by addiction when treating their patients in Australia's addiction clinics, rehabilitation centres, liver clinics, cancer wards, and hospital emergency departments. It is on the basis of this expertise and experience, as well as a comprehensive review of the evidence base, that we provide our submission to this Inquiry.

Submission

The Royal Australasian College of Physicians (RACP) and its Australasian Chapter of Addiction Medicine (AChAM) welcome the opportunity to contribute to the Senate Community Affairs Legislation Committee's inquiry into the Social Services Legislation Amendment (Drug Testing Trial) Bill 2019.

The RACP and its AChAM made submissions to previous related inquiries into the Social Services Legislation Amendment (Welfare Reform) Bill 2017[1] and into the Social Services Legislation Amendment (Drug Testing Trial) Bill 2018.[2] Representatives from the RACP and its AChAM also participated in public hearings for these inquiries.

Since the Drug Testing Trial Bill which is the subject of the present inquiry largely replicates the Social Services Legislation Amendment (Drug Testing Trial) Bill 2018, this submission reiterates our strong opposition to the proposed drug testing trial and our grounds for doing so.

Despite being the peak body representing Australia's addiction medicine specialists, the RACP and its AChAM were not consulted on the measures proposed by the Bill prior to their announcement in the 2017-18 Budget. If consultation had occurred, the RACP and the AChAM would have advised that this drug testing trial is clinically inappropriate and not designed in a way that will address issues of substance dependence. Our strong advice is that this trial should not go ahead and that this Bill should not progress. It is likely to be a costly exercise that will not deliver on its stated objectives and will cause harms to vulnerable people.

The RACP and the AChAM remain strongly opposed to this drug testing trial on the basis that it is not evidence-based, goes against previous expert advice provided to the Government on the matter, and is likely to be clinically harmful to people suffering with drug and/or alcohol addiction. These proposals will also further marginalise a population that already experiences a greater burden of physical, psychological and social ill health. The end result is likely to be a worsening of substance use disorder that will have ripple-out effects for the wider community.

We would like to bring to the attention of this Committee that addiction, health and social care experts and medical organisations more generally including the RACP and its AChAM, the Australian Medical Association (AMA), the Royal Australian and New Zealand College of Psychiatrists (RANZCP), St Vincent's Health Australia, and the Rural Doctors Association of Australia are united in their opposition to this drug testing trial. Not only will this policy be a waste of resources, money and opportunities, we are concerned that the measures would in fact cause considerable harm to a highly vulnerable and stigmatised population and merely add to the already long queue of people waiting to access treatment voluntarily.

Over many years, the RACP, the AChAM, the Australasian Faculty of Public Health Medicine (AFPHM), the AMA and many other reputable organisations and experts in the field of addiction medicine have repeatedly identified the underfunding of drug and alcohol treatment services as a matter requiring the urgent attention of successive governments. Sustained, long-term funding to increase the capacity of drug and alcohol services to meet the demand for treatment, combined with real and persistent efforts to reduce disadvantage and inequities within society, is the only real solution to reducing substance dependency.

The RACP and the AChAM have a significant number of expert members who would welcome the opportunity to contribute to the development of evidence-based policies that facilitate access to drug and alcohol treatment services, providing individuals with the best chance of recovery and a return to

[1] https://www.racp.edu.au/docs/default-source/advocacy-library/racp-submission-senate-inquiry-welfare-reform-bill.pdf
[2] https://www.racp.edu.au/docs/default-source/advocacy-library/20180417_racp-submission_drugtestingtrialbill2018_cpacapproved.pdf

full social participation. The RACP has developed a range of evidence-based policy recommendations in relation to reducing the harms of alcohol, appropriate use of opioids and other addictive prescription medicines, and the health benefits of good work that can help strengthen existing Government's policies to help address drug or alcohol dependency among welfare recipients.[3]

While very supportive that more needs to be done to help people overcome drug or alcohol addiction and where possible go on to secure employment,[4] the evidence indicates that the measures proposed will not be effective and will not deliver on the Bill's stated aim to "improve a recipient's capacity to find employment or participate in education or training by identifying people with drug use issues and assisting them to undertake treatment". It is our careful assessment, that drug testing will have an adverse rather than positive impact on achieving that outcome.

The RACP holds that the prevention agenda and the large body of scientific evidence on 'what works', needs to be given more careful consideration in any mix of evidence-informed policy reforms. The RACP would welcome an opportunity to present that body of evidence and related recommendations to the Federal Government. In the meantime, the RACP and the AChAM cannot support this drug testing trial and call for this Bill to be opposed in its entirety.

At the heart of our strong opposition to this trial is the fact that it fails to recognise that addiction is a serious and complex health issue which is difficult to overcome and that recurring instances of relapse are inherent to the nature of the disorder. Despite the Treatment Fund of $10 million announced by the Government[5] to provide additional treatment support to those impacted by this Bill, this trial does not acknowledge or address the severe shortages of available addiction treatment, support services and qualified health professionals across Australia.

The Government holds recent data on welfare recipients who have self-identified as having substance use problems. In 2016-17, 22,133 temporary exemptions from mutual obligations were granted to 16,157 people due to substance dependency.[1] This is a significant, easily identifiable cohort who should be the focus for referral into drug and alcohol treatment. Notably, the number of people in this group outweighs the total number of people who will participate in the drug testing trial and it is unclear what, if any, existing process is in place to facilitate access to treatment for this group, or how many may already be in treatment. In the RACP's view, the money to be spent on the proposed drug testing trial would be more effectively spent on improving access to drug and alcohol treatment services for those already identified than on an ineffective and stigmatising drug testing trial.

The Government was advised in 2013 by the Australian National Council on Drugs (ANCD) in their Position Paper on Drug Testing[2] not to proceed with random drug testing policies given *"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*". The paper concluded that "*drug testing of welfare beneficiaries ought not be considered"* and drug testing is "*more likely to increase harms and costs".*

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[3] These are available from the RACP website: https://www.racp.edu.au/advocacy/division-faculty-and-chapter-priorities/chapter-of-addiction-medicine and https://www.racp.edu.au/advocacy/division-faculty-and-chapter-priorities/faculty-of-occupational-environmental-medicine/health-benefits-of-good-work

[4] The RACP is highly supportive of more being done to help people improved their chances of employment. There is a large body of evidence of the negative impact unemployment has on both physical and mental health. The evidence can be assessed at the RACP position statement on realising the health benefits of work.

The RACP Position Statement on realising the health benefits of work, developed by our Faculty of Occupational and Environmental Medicine, provides recommendations in relation to how government, business and medical and allied professionals can achieve this end. Further information about this work can also be found on the Faculty's webpage dedicated to achieving the health benefits of good work.

[5] https://www.dss.gov.au/benefits-payments/drug-testing-trial

No explanation has been provided as to why that advice is being ignored, nor why the poor results from similar trials in other countries have seemingly not been heeded. As was the case with the previous Bills, there has been no genuine consultation with addiction medicine specialists, nor with the alcohol, tobacco and other drug sector more generally or the wider health sector as far as we are aware. The health sector again asks why?

Our reasons for strongly opposing this drug testing trial are summarized below. Appendix A provides additional information and evidence about the rationale for the RACP and its AChAM's strong opposition to this drug testing trial as was outlined in our previous submission to the Inquiry into the Drug Testing Trial Bill 2018. Appendix B lists a number of key issues that require clarification from the Government on the Drug Testing Trial Bill 2019.

Our reasons for strongly opposing this drug testing trial:

- This proposed drug testing trial fails to recognise the nature of drug addiction. Addiction is a health issue with complex biological, psychological and social underpinnings; it is not a personal choice. Repeated drug or alcohol use leads to structural and functional brain changes that challenge an addicted person's self-control and interfere with their ability to resist intense urges to take drugs. In addition, recurring instances of relapse are inherent to the nature of addiction.
- These is no evidence that this drug testing trial will work, on the contrary, there is evidence that it could do harm. For example, there is a real concern that people could shift their choice of drug to one that isn't being tested for, which in some cases might be more dangerous, for example synthetic cannabis or synthetic opioids such as Fentanyl. Another significant risk is that individuals suffering from substance use disorder may divert their drug use toward prescription drugs which may or may not have been prescribed to them directly and this is a significant concern given that, after tobacco and alcohol, prescription drugs cause the highest numbers of drug related deaths in Australia.[3]
- The Government has not provided enough information about the tests it plans to use for these trials. It is worth noting that immunoassays have a number of shortcomings, especially around false positive and false negative test results. For example, many psychiatric drugs including anti-psychotics and antidepressants can cause false positive immunoassay results for amphetamines in particular. These psychiatric drugs are commonly prescribed so individuals subject to these drug tests could have a positive immunoassay result despite not having used illicit drugs. It would therefore be incredibly unfair to subject them income management for 24 months or to charge them for a retest for a false positive caused by a prescribed medication.
- Trials by their nature need to be representative of the broader context so that valid conclusions can be drawn and findings generalised. Having trials exclusively conducted in regions with higher risk of substance use issues and dependent on the availability of treatment services as well as the capability to administer the other components of the Bill will not accurately test the feasibility or effectiveness of the proposed measures, nor will the results be able to inform any nationwide roll-out.
- The proposed drug testing trial would not only be expensive but population drug testing is an unreliable way of identifying those who have substance use problems. There are distinct differences between recreational and dependent drug users. Drug testing will not be able to distinguish between those who have clinically significant drug problems and recreational drug users who don't meet DSM criteria for substance use disorder and do not require treatment services.
- Referral to treatment services of all of those who test positive will be a waste of scarce resources and will impact on services which are already stretched beyond their capacity – potentially impacting on those people who are already waiting and motivated to engage in treatment voluntarily.

- We do not believe the $10 million Treatment Fund proposed by the Government is an adequate measure to address these issues in the trial sites as it is a one-off funding commitment which does not provide sustained funding and will therefore have workforce implications in the longer term.
- Access to quality treatment, delivered by a suitably trained workforce, is fundamental for anyone struggling with addiction, and this should be the major priority for policy development and investment in this area. Key organisations in the health and welfare sector including the RACP have called for a boost of at least $1 billion per year to address unmet demand for Alcohol and Other Drug treatment services.[4] Doctors having to monitor and report on their patient's adherence to their mandatory treatment could negatively affect the patient-doctor relationship and trust, which are critical to successful drug and alcohol recovery.

In addition, whilst the RACP and its AChAM do not have the appropriate expertise on welfare issues to provide comment on whether income management as proposed in the Bill comprises effective welfare policy, we are concerned by the potential negative impacts of income management on the physical and mental health of welfare recipients struggling with substance dependency.

Income management does not address the root causes of addiction, and the nature of the disease means that people will often find ways of bypassing the constraints. We know that people with addictions are unable to modify their behaviour, even if they know there are going to be negative consequences, and that includes being placed on income management for a positive test.

The context within which income management is imposed is a significant factor that needs to be considered – we are concerned that imposing income management on a vulnerable group struggling with substance dependency and co-morbid mental health problems, who very often have little or no support themselves, without good social or community supports being put into place, may cause increased levels of anxiety and push vunerable people over the edge.

Instead of pursuing this, at best ineffective and at worst directly harmful, drug testing trial, we call on the Australian Government to appropriately invest in alcohol and drug treatment services and a suitably trained workforce, and work with experts in the field of addiction medicine to develop evidence-based policy and plans that will effectively address drug and alcohol dependence in the community and support people on the path back to health and employment.

Appendix A: The rationale for our strong opposition to the Drug Testing Trial Bill 2019

Addiction: A serious health issue

This proposed drug testing trial fails to recognise the nature of drug addiction; which is a health issue with complex biological, psychological and social underpinnings. Drug addiction is a chronic relapsing and remitting disorder characterised by drug seeking, use that is compulsive, loss or impairment of control over use and which persists despite harmful consequences[5]. The diagnostic term 'substance use disorder' in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) refers to recurrent use of alcohol or other drugs that causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. Substance use disorder is defined as mild, moderate, or severe.

The underlying causes of drug addiction can be primarily attributable to environmental factors such as trauma, abuse, a chaotic childhood or home, parent's use and attitudes, and peer and commercial influence, and also to biological factors including genetics, being male, and concurrent mental health disorders[6]. Other determinants that impact on a person's substance use and dependency include inequity in their socio-economic status, housing status and security, and education.

Substance abuse is a complex issue, not simply a personal choice. There are many reasons why people choose to try or take drugs – some highlighted above – however it should be understood that repeated drug or alcohol use leads to structural and functional brain changes that challenge an addicted person's self-control and interfere with their ability to resist intense urges to take drugs. The proposed drug testing regime signals that, as compared with other health issues, our community has a lower understanding of and tolerance level for substance use disorder.

The distinction between someone needing to quit using drugs (including alcohol) because of a clinical need and their personal motivation to do so also needs to be recognised. Evidence and clinical experience shows that people with drug problems must see reason to change, must have or develop motivation to change, must have or develop skills to make these changes and must have a suitably supportive non-substance using environment to return to from treatment to instigate and sustain behaviour change. A 2016 systemic review found that current evidence on mandatory drug treatment is limited and does not suggest improved outcomes in general while some studies showed potential harms[7].

Enforced, and potentially disempowering and punitive, measures such as those described in this Bill are unlikely to bring about sustained changes in patients' drug use behaviours and may even be counter-productive – potentially demotivating patients from actively engaging in treatment. Because of this, the RACP and its AChAM do not support mandatory drug treatment in the context of this trial. Along with the evidence that this approach is ineffective, it also does not consider or address the underpinning macro-environmental influences and structural determinants leading to substance use and dependence.

Drug testing trials: The lack of evidence on their effectiveness

The drug testing regime proposed in this Bill is not supported by current evidence. Evidence from similar programs in other countries has shown they have had little success in identifying welfare recipients with substance use issues.

In 2013, the New Zealand Government instituted a drug testing program as a pre-employment condition among welfare recipients. In 2015, only 22 (0.27 per cent) of 8,001 beneficiaries tested returned a positive result for illicit drug use or refused to be tested[8]. This detection rate was much lower than the proportion of the population estimated to be using illicit drugs in New Zealand, for example, the 2015/16 survey found that 1.1 per cent of adults used amphetamine in the past year[9]. Similar results were found in the United States. In Missouri's 2014 testing program, of the state's 38,970 welfare applicants 446 were tested, with 48 testing positive. In Utah, 838 of the state's 9,552 welfare applicants were screened with 29 returning a positive result[10].

This lower detection rate was not explained and raises concerns over why this was the case. One concern is that people could be shifting their choice of drug to one that isn't being tested for, which in some cases might be more dangerous, for example synthetic cannabis.

We understand that this proposed trial focuses on illicit drugs. This presents the risk that individuals suffering from substance use disorder may divert their drug use toward prescription drugs which may or may not have been prescribed to them directly. This is troubling given that, after tobacco and alcohol, prescription drugs cause the highest numbers of drug related deaths in Australia.[11]

It is clear that drug testing regimes are not only expensive but are likely to also fail to identify problematic drug use in this context.

There have been cases where proposals such as these have faced legal challenges on the grounds of discrimination, the accuracy of the drug tests, and people's human rights. For instance, in both Canada and the UK, the proposal to drug test welfare recipients was rescinded before progressing to the next stage of implementation due to legal challenges[12]. Similar legal challenges could be faced by the Australian Government, given that welfare payments would be conditional on recipients agreeing to random drug testing.

With respect to the potential for these measures to cause harm, there is evidence indicating that denying benefits to people who are drug dependent could result in increases in poverty, homelessness and crime, and also lead to higher health and social costs[13]. One quantitative study found that welfare recipients of a drug addiction and alcoholism disability plan whose benefits were terminated had increased rates of drug dependence and psychiatric comorbidities over time[14]. By contrast, those welfare recipients who retained their benefits (due to the presence of another recognised disability) reduced their levels of drug use from 75% to 63%[15] [16].

The Australian National Council on Drugs (ANCD) was formed in 2008 as a key advisory body to the Australian Government on drug policy. It comprised wide-ranging expertise, spanning academia, medicine, education, law enforcement, treatment services, families who have suffered loss, those who have been affected by drugs, the Indigenous community, and government.[17] In its 2013 position paper, it concluded that "the *small amount of (direct and indirect) evidence available seems to indicate that it is more likely to increase harms and costs, both to welfare beneficiaries and the general public, than it is to achieve its stated aims*". It also warns 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*." [18]

It is concerning that such clear and unambiguous advice from a leading expert advisory group is going unheeded and that policy measures are being proposed that go directly against its counsel.

Trial design: Skewed and unrepresentative

The RACP and the AChAM hold serious concerns over the way the proposed trials are being designed and the criteria used to determine the trial's three locations: the Canterbury-Bankstown, New South Wales; Logan, Queensland and Mandurah, Western Australia, regions. As stated in the Explanatory Memorandum for this Bill, "these locations were selected considering a range of factors, including crime statistics, drug use statistics, social security data and health service availability". Selecting trial locations based on these criteria engenders a significant selection bias which nullifies any possibility of these being true trials and removes any potential for them to deliver credible results.

Trials by their nature need to be representative of the broader context so that valid conclusions can be drawn and findings generalised. Having trials exclusively conducted in regions with higher risk of substance use issues and dependent on the availability of treatment services as well as the capability to administer the other components of the Bill will not accurately test the feasibility or effectiveness of the proposed measures, nor will the results be able to inform any nationwide roll-out.

The Government states that "*That is why this measure has been specifically designed as a trial—to build that evidence base.*" Given the above-mentioned skewing of the proposed trials, and the associated flaws that will thereby be inherent in any results, it is not plausible that these could help build meaningful evidence. The medical profession is perplexed by this retreat from sound science.

It is concerning that this proposal for a drug trial is still progressing despite it being conceded that the necessary drug testing technologies and treatment capacity in certain regions in Australia is simply not there. There will be significant issues because of the lack of suitable and available testing technology, treatment facilities places, and appropriately trained staff, and/or the distance from services for some. On these grounds alone, without a substantial investment in building drug testing capacity, and an urgent and much needed increase in funding to establish and support more addiction treatment services and workforce, any roll-out of such a system is bound to fail and waste significant healthcare resources and money.

Drug testing methods: Concerns about accuracy, reliability and expense

Population drug testing is an unreliable way of identifying those who have substance use problems. There are several inherent limitations in drug testing, such as limited detection periods and inadequate sensitivity and specificity, which may give rise to a false negative or false positive result. Although there is currently no clarity over the drug testing methods that will be used in the proposed trials, our experience suggests that this measure is likely to be expensive and unreliable. Drugs differ in their windows of detection[19]. Biological matrices such as urine, blood, sweat, oral fluids not only differ in their windows of detection for substances, but also in their sensitivity, specificity, time, and cost[20]. Urine has been the main biological matrix used for drug testing over the last several decades, while others have emerged as new testing methods have been developed. Each biological matrix and testing method has its pros and cons.

Immunoassay and chromatography are the commonly used analysis methods. While immunoassay is a much less expensive analysis method, it can only provide qualitative results (i.e. present or absent) without the quantity shown[21] but is subject to cross-reactivity and is not able to detect most of the synthetic drugs. Positive results based on immunoassays alone are referred to as "presumptive positives" and must be confirmed by gas chromatography/ mass spectrometry (GC/MS) or by liquid chromatography/mass spectrometry (LC/MS), when there are serious clinical or forensic ramifications of a positive test result. GC/MS and LC/MS are more accurate and reliable and are considered the 'gold standard' testing technologies for clinical and forensic purposes. GC/MS and LC/MS can also provide quantitative information on levels of a drug or metabolite in the matrix tested, though there are limitations to conclusions that can reliably be drawn from this additional information. Notwithstanding,

in Australia the use of immunoassay is more common and reliance solely on immunoassay testing methods with their inherent limitations in testing welfare recipients in the manner proposed, would lead to many false negatives and false positive test results. For example, it is known that the use of commonly prescribed psychiatric medications such as antidepressants and antipsychotics can result in a false positive test result for amphetamine with immunoassay testing. If the Government opts for the less expensive immunoassay analysis method, we would expect there to be associated risks of legal challenges with respect to the significant risk of false positive results.

It is relevant to note that not all states or territories have access to GC/MS or LC/MS for clinical purpose. 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 appropriate chain of custody process plays 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 of the urine passing into the container. This process is at best intrusive and may be particularly distressing for some people who may, for example, have been a victim of abuse.

This will raise serious ethical and medico-legal questions where there is no therapeutic relationship based on voluntary treatment seeking. This is very different to systems that are in place in industries such as mining, aviation and other transport industries, where there is a clear need to ensure a drug-free work environment to protect public safety.

For any national rollout, a substantial investment in testing technologies and facilities, along with suitably trained staff to operate and manage the systems, would be needed in the states and territories.

Careful clinical assessment in interpreting any test results is of critical importance. The reading and interpretation of drug testing results would require medical practitioners with relevant clinical and technical expertise, especially in circumstances where there is a positive immunoassay result, to assess whether the recipient has a true positive test result and a substance use disorder. As various medications can lead to false positive results, taking the past patient medical history into consideration is a vital part of the assessment. It is thus important that assessment in interpreting any test results should be restricted to medical professionals with appropriate clinical and technical expertise. Similarly, specific treatment activities should be determined only by medical professionals with the appropriate clinical and technical expertise, and not by employment services providers. It is also important to note that people other than health practitioners should not be allowed to access people's private health information.

Without further details of the costs of these trials and estimates of the likely costs of any national roll-out, it is difficult to provide specific comments on this aspect of the proposals. However, considering the known costs of drug testing technologies available, the expense for the medical, administrative and support staff required, and the costs of the similar measures tried in other jurisdictions, it is clear that this policy will be an expensive undertaking. For example, based on current rates for clinical purposes in Australia, costs for gold standard urine drug tests can range between $550 and $950. Hair drug tests are also expensive – about $180 for each class of drug tested – and costs could easily reach $1000 if more than 6 types of drugs are tested for.

With the evidence on the ineffectiveness of these measures to identify people suffering substance dependency, severely limited access to facilities with the necessary standard of testing, the lack of

available treatment services, and the significant concern that enforced treatment is often not effective, this measure arguably does not represent a good use of taxpayers' money.

Alcohol and other drug treatment services: inaccessible, underfunded and overstretched

Alcohol and other drug treatment services in Australia are chronically underfunded and overstretched, despite compelling evidence of their cost effectiveness. The funding currently provided for alcohol and other drug treatment services is not commensurate with the needs of the population. For example, in NSW, mental health treatments receive approximately 10 times the funding of alcohol and drug treatments, despite the fact that these conditions account for similar amounts of the total burden of illness[22]. A review in 2014 found that alcohol and other drug treatment services in Australia met the need of fewer than half of those seeking the treatment[23]. More specifically, this review found that approximately 200,00 Australians seek treatment each year and a further 200,000 to 500,000 Australians are unable to access the treatment they need.

The RACP and the AChAM note that additional funding was provided to the drug treatment sector to support the National Ice Action Strategy, however this funding has not generally addressed the key needs of the drug and alcohol sector as its use is restricted under the terms of the funding agreement. The severe shortage of drug and alcohol rehabilitation services and specialists around Australia persists. Access to quality treatment, delivered by a suitably trained workforce, is fundamental for anyone struggling with addiction, and this should be the main priority for policy development and investment in this area**.**

There are distinct differences between recreational and dependent drug users. Drug testing will not be able to distinguish between those who have clinically significant drug problems and recreational drug users who don't meet DSM criteria for substance use disorder and do not require treatment services.

Referral to treatment services of all of those who test positive will be a waste of scarce resources and will impact on services which are already stretched beyond their capacity – potentially impacting on those people who are already waiting for treatment. We do not believe the $10 million Treatment Fund announced by the Government is an adequate measure to address these issues in the trial sites as it is a one-off funding commitment which does not provide sustained funding and will therefore have workforce implications in the longer term. Staff of those services ask whether there is an expectation from Government that those testing positive in the trial will be given priority and in effect jump the queue.

Exact data on waiting times is hard to obtain because it is dynamic – it may be as short as days to access in the private sector (which will be out of reach for people applying for welfare) to weeks or months for public services. Our members indicate that there is usually a 6-12 week wait for alcohol and other drug treatment (depending on the type of treatment required) in many jurisdictions. This raises ethical questions about the impact of adding those who may or may not be highly motivated to discontinue their substance use jump to the queue for treatment with others who are desperate for help and highly motivated to recover.

In addition, we are concerned that this proposed trial does not align with the evidence of good practice presented in the Federal Government's own National Drug Strategy 2017-2026[24] which focuses on the three pillars harm reduction, supply reduction and demand reduction. The National Drug Strategy 2017-2016 lists effective strategies which include: [25]

- Improving community understanding and knowledge, reducing stigma and promoting help seeking
- Programs focused on building protective factors and social engagement

- Treatment services and brief intervention
- Addressing underlying social, health and economic determinants of use

The measures proposed in this drug testing trial target potentially highly vulnerable individuals by further stigmatising them, and this is in direct contradiction to the measures being proposed in the Government's National Drug Strategy 2017-2016.

In terms of mandating treatment under these reforms, the RACP and its AChAM also have concerns that doctors having to monitor and report on their patient's adherence to their mandatory treatment could negatively affect the patient-doctor relationship and trust, which are critical to treatment engagement, treatment adherence and successful drug and alcohol recovery.

Appendix B: Issues which require clarification in the Drug Testing Bill

In addition to the major concerns we have outlined in this submission, there are a number of issues which require clarification in the Drug Testing Bill 2019 including but not limited to:

- How will those testing positive in the trial be prioritised for access to treatment services in circumstances where there are people who have voluntarily sought treatment still waiting for access?
- How would those individuals who have tested positive to a second test and who are on waiting lists due to the unavailability of treatment be assisted particularly if they become distressed by the prospect of losing their accommodation or capacity to support their families?
- Will those individuals be subjected to ongoing drug tests despite the fact that they have not been able to access treatment?
- What qualifications, training and experience in drug and alcohol medicine would a Services Australia contracted medical professional who undertake assessments be required to have? We are concerned that neither the Bill nor the Explanatory Memorandum specifies that only highly skilled health professionals who specialise in addiction medicine will be contracted by the Government for this purpose.
- How would 'reasonable excuses' for failure to attend scheduled appointments with Services Australia be defined and assessed as part of this trial?
- How would the Government mitigate the risks of false positive and false negatives?
- When will consultation with the key stakeholders in the drug and alcohol sector take place on the exposure draft of the drug testing methods to be implemented and the rules?
- Does the Government have an expectation that drug addiction medicine specialists and other health professionals will agree to participate in this trial and if so, on what basis? What if this expectation is not fulfilled?

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