Media Release

Drug Testing Welfare Clients – a fraught approach

SANDAS and the South Australian non-government drug and alcohol services we represent do not support the drug testing of welfare recipients. People receiving benefits are already at a significant disadvantage experiencing poverty and related social and health issues. Introducing drug testing into an already complex situation raises a number of significant questions and concerns. These include but are not limited to:

Alcohol and other drug use is a health issue, this strategy is not an evidence-informed health response. Drug testing stigmatises all welfare recipients, and stigma is one of the most significant barriers to attending treatment.

Stopping or reducing payments to already poor and marginalised people may have a number of unforeseen negative outcomes. They may choose to use new and emerging substances that do not show up on tests but are more dangerous or use prescription drugs illicitly. Testing may result in them dropping out of the welfare system and moving into the black economy where they may be subject to exploitation from unscrupulous employers, illegal means (theft, dealing, etc.) or be easier to exploit by others involved in crime. What are the implications for those already in the justice system (e.g., on remand, undertaking drug diversion programs, subject to child welfare orders etc.) that may not have been considered. Nor has there any indications of what happens whilst a person is on a wait list for treatment.

The implication in the Budget documents that a person with a lifelong disability 'acquired as a consequence of their drug use' could lose their disability payment is fraught with problems as drug use, mental health issues and chronic diseases often co-occur. Who decides a disability is because of alcohol or drug use, how will causation be established and what is the burden of proof as to causation? Who bears the cost of the medical tests involved in ascertaining causation? How will this apply to those with acquired diseases such as cancer, dementia and chronic diseases given the associations between alcohol and these disabling diseases?

Given that relapse is common during treatment, how will relapses be managed? Will AOD services be expected to jeopardise a therapeutic relationship with a client if they are tasked with notifying breaches?

Children or other family members may be impacted by the loss of payments/benefits because their parents/carers are no longer in the system. This may impact on children's schooling, access to health services, and parental access.

Introducing such testing will also give rise to process issues. What role will Centrelink have in reporting drug use to other services (courts, corrections/justice, child protection)? How would such a role fit with privacy laws and rights? Where people are subject to reports made by Centrelink will they have a right to see this advice? If the advice was wrong how would a person be able to challenge such advice? This may raise significant human rights implications?

There are further concerns that drug testing is fraught with many issues in its own right. Tests do not identify intoxication only past use and possibly exposure. These include maintaining a chain of evidence consistent with legal requirements, achieving

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compliance with testing standards in Centrelink offices and addressing problems related to false positives and sample contamination.

Drug testing incurs significant costs per test (including secondary/confirmation testing under laboratory conditions to eliminate false positives). These costs may offset any savings. To date there has been no details released of a cost benefit analysis having been undertaken to show testing could save money. In New Zealand and American states where this type of testing has been trialled testing has been shown to result in no cost savings.

Given that there are known to be false positives in drug testing how will an appeals processes work if a test is wrong? Where/what is the burden of proof and who will bear the cost burden of such appeals? How will people be supported to undertake an appeal? Will a person who tested with a false positive be compensated?

There is also emerging evidence that tests may give a false positive based on secondary inhalation (cannabis) or absorption through the skin (methamphetamine and some other drugs). Where a person tests positive but lives/works in a place where drugs are used how will positive tests arising from secondary exposure be distinguished from personal use?

Finally, and perhaps most critically alcohol and drug services are chronically underfunded and cannot meet the demand we already have from voluntary clients. Having an influx of involuntary clients would further overburden the system. The Australian Government has given no indication that it will increase funding of treatment places sufficiently to meet this increased demand. The Federal Government needs to work with the alcohol and other drug sector when developing welfare reforms if they are to result in better outcomes for people affected by alcohol and other drug-related issues.

SANDAS and our members would welcome the opportunity to meet with the Ministers of the relevant portfolios to discuss how a better managed approach to addressing alcohol and drug use amongst marginalised Australians can be developed.

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