Mandatory Welfare Drug Treatment in Australia

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In 2017 and 2018 Australia almost implemented laws to require unemployed people to undertake mandatory drug testing and treatment. Debate about linking welfare with mandatory drug treatment suffers from the complexity and paucity of research specifically about the efficacy of mandatory welfare drug treatment. This allows the possibility for mandatory welfare drug treatment to remain on the political horizon. This article situates the Australian proposal to introduce mandatory drug treatment for the unemployed within the relevant research literature. It concludes that the literature shows there is little chance of efficacy if welfare is linked with mandatory drug treatment. Instead, cost ineffectiveness and perverse outcomes are more probable than treatment efficacy.

Keywords: addiction; consent; coercion; drug abuse; drugs; law; mandatory treatment; random testing; unemployment; welfare

I. INTRODUCTION

Australia came close in 2017 and 2018 to enacting laws for trials to require unemployed people to undergo drug testing and treatment. Each time the proposal was blocked in the Senate. The policy has been on the political horizon since 2014 and continues to have a place in Australian politics. An analysis of the available evidence is warranted given the legislative impasse concerning the merits or otherwise of a welfare drug testing and treatment trial and because it remains the policy of the government moving into the 2019 federal election. However, there is a paucity of research specifically about the efficacy of linking welfare with mandatory drug treatment as documented by a Senate Community Affairs Legislation Committee. This allowed the government to press the need for trials to fill the research gap in the available evidence.

With limited research specifically linking welfare with mandatory drug treatment, much of the literature is instead concerned with mandatory treatment in the context of criminal justice systems. While mandatory treatment in criminal justice systems has had some positive results, the efficacy and cost-effectiveness of programs is also questioned by experts. What little research is available about the efficacy of linking welfare with mandatory drug treatment is at best unsettled. Overseas jurisdictions provide little or no evidence of efficacy when they have linked welfare with mandatory drug treatment, generally resulting in the abandonment or floundering of the programs. This enabled the government to claim that Australian welfare conditions were unique and, unlike the overseas experience, the Australian trials would not be

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2 Commonwealth, Parliamentary Debates, Senate, 7 December 2017, 10042 (Slade Brockman).


4 Senate Community Affairs Legislation Committee, Inquiry into Social Services Legislation Amendment (Drug Testing Trial) Bill 2018 (11 April 2018) 7–9.


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punitively.7 Framed in this way it is difficult to make sense of the available literature8 which added impetus to the government case for a trial. Complicating this further is an absence of uniform terminology, disciplinary standpoints, jurisdictional nuances, institutional and methodological heterogeneity which can render comparisons complex at best and frequently meaningless. This article attempts to make sense of the relevant literature by taking account of the dynamics imposed by these factors to locate the Australian proposal within it. The article begins with an overview of the proposed Australian trial to locate it within the relevant literature. This is followed by a review of the available evidence concerning the efficacy of mandatory drug treatment programs including the literature concerning the efficacy of mandatory drug treatment programs in Australia’s criminal justice systems. The article concludes that there is little chance of efficacy – however efficacy may be defined – if welfare is linked with mandatory drug treatment. Instead, cost ineffectiveness and perverse outcomes are more probable than treatment efficacy.

II. AN AUSTRALIAN MANDATORY WELFARE DRUG TESTING AND TREATMENT TRIAL

A. The Australian Proposal

The literature on mandatory drug treatment refers to coerced treatment,9 coercion in substance abuse disorders,10 compulsory drug treatment,11 compulsory drug detention centres,12 forensic addiction therapy,13 involuntary drug treatment/intervention,14 legally mandated addiction treatment,15 and quasi-compulsory treatment.16 These terms are not synonyms and are instead related but not necessarily comparable concepts. They involve differences in degrees of choice, coercion, consent, referral source, and service type. They are also evaluated through heterogenous disciplinary methods with little consensus as to what counts for efficacy. Just where the proposed Australian Government trials fit within this literature is crucial to making sense of the evidence.

At the time of writing (2019) the Social Services Legislation Amendment (Drug Testing Trial) Bill 2018 (Cth) had stalled in the Senate. It was preceded by the Social Services Legislation Amendment (Welfare Reform) Bill 2017 (Cth) introduced into the House of Representatives and read a first time on the 22 June 2017. The 2017 Bill was complex and intended to amend several Commonwealth Acts dealing with the administration and provision of welfare. It was so complex it included 18 Schedules of proposed amendments including “Schedule 12 – Establishment of a Drug Testing Trial”. Before the 2017 Bill

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reached the Senate it was referred to the Senate Community Affairs Legislation Committee which reported six days prior to the Bill being presented and read a first time in the Senate on 12 September 2017.\textsuperscript{17}

The 2017 Bill was also considered by the Senate Standing Committee for the Scrutiny of Bills which reported on 6 September,\textsuperscript{18} and the Parliamentary Joint Committee on Human Rights which reported on 17 October 2017.\textsuperscript{19} It took until 21 March 2018 before the Senate would agree to the Bill with amendments before returning the Bill to the House of Representatives. When the 2017 Bill finally passed both Houses on the 27 March 2018 it excluded among other measures those contained in Sch 12 to establish trials to drug test and require drug treatment for the unemployed.\textsuperscript{20} However, the new laws did include the related measures in Schs 13 and 14 of the Bill providing for the removal of exemptions from mutual obligations due to drug and alcohol use and the tightening of reasonable excuses for non-compliance due to drug and alcohol-related reasons which commenced on 1 July 2018.\textsuperscript{21}

Had the 2017 Bill passed to include Sch 12, the government would have randomly drug-tested 5,000 Australians receiving unemployment benefits or youth allowance from 1 January 2018 as part of trials in three districts: Canterbury-Bankstown, Logan, and Mandurah.\textsuperscript{22} New claimants of either Newstart Allowance or Youth Allowance in these districts were to be tested during Department of Human Services appointments and selected for testing based on a “data driven profiling tool” to “identify relevant characteristics that indicate a higher risk of substance abuse issues”.\textsuperscript{23} If selected, the person would be tested for the “presence of a testable drug in a sample taken … from the person’s saliva, urine or hair”.\textsuperscript{24} A testable drug was defined to include, “(a) methamphetamine; or (b) methylenedioxy-methamphetamine; or (c) tetrahydrocannabinol; or (d) opioids; or (e) another substance prescribed by the drug test rules for the purposes of this definition”.\textsuperscript{25} If the person selected for testing refused to comply with a notice to undertake a test then there would be a suspension of benefits for 28 days called a “drug test refusal waiting period”.\textsuperscript{26}

Penalties for returning a positive test result were to escalate. After an initial positive result, jobseekers would have 80% of their future payments placed into a cashless debit card, the jobseeker would also be subject to follow-up testing to continue receiving benefits. A second positive test would require counselling and rehabilitation “for the use of drugs”.\textsuperscript{27} This would be implemented by way of either a Youth Allowance Employment Pathway Plan or a Newstart Employment Pathway Plan. These Plans would in each situation require treatment if the person failed two or more drug tests, and had “undergone a medical, psychiatric or psychological examination in compliance with a notice given to the person”, and the ensuing “report of the examination given to the Secretary recommends that the person undertake treatment for use of drugs”.\textsuperscript{28} A third and final positive test would result in additional financial penalties up to cancellation of the benefit and with it a 28 day drug test refusal waiting period. In addition, where

\textsuperscript{17} Senate Community Affairs Legislation Committee, Parliament of Australia, n 7.
\textsuperscript{18} See generally, Senate Standing Committee for the Scrutiny of Bills, Scrutiny Digest, No 10 of 2017, 6 September 2017.
\textsuperscript{20} Social Services Legislation Amendment (Welfare Reform) Act 2018 (Cth).
\textsuperscript{21} Social Security Act 1991 (Cth) ss 542A(1AA), 542H(1AA), 603A(1A), 603C(1AA); Social Security (Administration) Act 1999 (Cth) ss 42C(4)(a), 42E(4)(a), 42H)(3)(a), 42N(2)(a), 42SC(2), 42U(3).
\textsuperscript{24} Social Services Legislation Amendment (Welfare Reform) Bill 2017 (Cth) Sch 12, Item 1.
\textsuperscript{25} Social Services Legislation Amendment (Welfare Reform) Bill 2017 (Cth) Sch 12, Item 1.
\textsuperscript{26} Social Services Legislation Amendment (Welfare Reform) Bill 2017 (Cth) cl 549EA–549EB (Youth Allowance), 623C–623D (Newstart).
\textsuperscript{27} Social Services Legislation Amendment (Welfare Reform) Bill 2017 (Cth) Sch 12, Items 4, 7.
\textsuperscript{28} Social Services Legislation Amendment (Welfare Reform) Bill 2017 (Cth) Sch 12, Items 4, 7.
a person returned a positive test more than once they would have to pay some of the cost of the test.29

Centrelink claimed that almost 10% of welfare recipients were expected “to test positive for cannabis,

ice or ecstasy in a new drug-testing trial”.30

Although the government backed down on Sch 12 of the 2017 Bill to introduce drug testing and mandatory
treatment for unemployed people it flagged an intention to continue to pressure the Senate on this
measure in the future.31 On the 28 February 2018, the government introduced and read for the first time
a Bill to replace what was previously proposed in the ill-fated Sch 12 of the Social Services Legislation
Amendment (Welfare Reform) Bill 2017.32 This new 2018 Bill was substantively the same proposal to
introduce drug testing and mandatory treatment for unemployed persons as the one previously rejected
by the Senate.33 The only difference between the 2017 and 2018 Bills was that the latter Bill provided
more detail. For example, although the 2017 Bill defined a “drug test trial area” as “an area prescribed
by the drug test rules for the purposes of this definition”, the 2018 Bill formally identified the three trial
districts (Canterbury-Bankstown, Logan and Mandurah).34 The 2018 Bill was passed in the House of
Representatives on the 13 August and introduced and read a first time in the Senate the next day. It was
read for a second time in the Senate on 6 December 2018 where the opposition announced its intention
to continue to oppose the Bill at which time debate was adjourned until 2019.35

B. Locating the Australian Welfare Drug Treatment Trials within the
Literature on Mandatory Drug Treatment

1. Mandatory Treatment?

While the term “mandatory treatment” can be used as a term of convenience to group treatments where
consent is involuntary, more precision is necessary to navigate the literature to situate the Australian
proposal within it. There are important differences between compulsory treatment, mandatory treatment,
and voluntary treatment that can be thought of by way of a continuum based on the degree of consent.
At one end is fully informed voluntary treatment and at the other compulsory treatment. From a medical
perspective the gold standard is fully informed voluntary treatment where the person freely chooses to
engage in treatment which would also include responding to the “underlying causes, or exacerbating
factors”.36 In other words treatment should be “holistic” because it is not only informed and consensual it
might also pay attention to social structures too through complimentary policies/programs/services.37 By
contrast, the defining feature of compulsory treatment is an absence of informed choice and an emphasis
on treating individuals without attention to the social structure. According to Pritchard et al compulsion
“is a dichotomous concept – either a person is compelled, or he/she is not”.38 For this reason, the lack of

31 Commonwealth, Parliamentary Debates, Senate, 7 December 2017, 10042 (Slade Brockman).
32 Social Services Legislation Amendment (Drug Testing Trial) Bill 2018 (Cth). If passed the new law would have been known as
the Social Services Legislation Amendment (Drug Testing Trial) Act 2018 (Cth).
34 Social Services Legislation Amendment (Welfare Reform) Bill 2017 (Cth) Sch 12, Item 1; Social Services Legislation Amendment
(Drug Testing Trial) Bill 2018 (Cth) Sch 1, Item 1.
35 Commonwealth, Parliamentary Debates, Senate, 6 December 2018, 26–27 (Doug Cameron).
36 Australian Medical Association, “Harmful Substance Use, Dependence and Behavioural Addiction (Addiction) – 2017”
Treatment Policy in Australia” (2016) 204(4) Medical Journal of Australia 138, 138; Saloner and Barry, n 9, 448; Wild, n 8, 41,
46; Wild et al, n 15, 36.
37 Ritter and Stoove, n 36, 138.
38 E Pritchard, J Mugavin and A Swan, “Compulsory Treatment in Australia: A Discussion Paper on the Compulsory Treatment of
Individuals Dependent on Alcohol and/or Other Drugs” (ANCD Research Paper No 14, Australian National Council on Drugs, 2007) 4.
agency with compulsory treatment is generally considered to be a breach of human rights and is only regarded as justifiable for the immediate preservation of life or liberty.

Between the two extremes of compulsory treatment and informed voluntary treatment are mandatory treatments involving different degrees of coercion and consent. Wild identifies three forms of coercion in mandatory treatment programs: legal, formal and informal. Within these three forms of coerced treatment there are a great variety of programs. Programs based on legal coercion “include civil commitment, court-ordered treatment and diversion-to-treatment programmes, either as adjuncts or alternatives to criminal sanctions for substance-misusing offenders”. Legal coercion is the basis for criminal justice programs requiring the person to choose treatment or imprisonment and for this reason, Lunze et al refer to these types of programs as quasi-compulsory. They are quasi-compulsory, as treatment “is offered as a choice between incarceration and treatment with informed consent” and it takes place under “the threat of imprisonment if the person fails to comply” while also providing “an opportunity for people with drug dependence to accept some form of help”.

Treatments based on formal coercion are those that are based on institutional “strategies to facilitate treatment” as opposed to legal coercion. They include:

- Mandatory referral to employee assistance programmes providing addiction treatment – often following employer drug testing; or social assistance programmes that require clients to attend treatment to avoid losing government-provided benefits or custody of children.

Formal coercion may be distinguished from informal coercion because the former is based on institutional coercion while the latter derives from “interpersonal tactics (eg threats, ultimatums) initiated by friends and family members to convince substance misusers to enter treatment”.

On the basis of Wild’s treatment nomenclature, the proposed Australian mandatory welfare drug testing and treatment trials would fit within the category of formal coercion. Even so caution is needed here because framing coercion and choice along a continuum has the inherent risk of attributing a mix of coercion and choice that may not correspond with a subject’s lived experience of it. As Pritchard et al explain, “the persuasion and threats involved may be considered so great as to amount to force and may thereby be considered in fact to be compulsion”. In other words, the threat of losing unemployment benefits could be experienced differently by subjects with corresponding heterogeneity in terms of their choice and commitment to treatment. Coercion will have a bearing on treatment motivation and commitment in conjunction with the type of service being provided. Therefore, coercion is one of several factors central to an analysis of the literature be considered later in this article.

2. Treatment Service Type

The term “treatment” must be carefully considered because not all treatments are the same and nor is efficacy measured in the same ways. As Pritchard et al explain:

“Treatment” … encompasses many different interpretations. There are many types of treatment and considerable differences of opinion among service providers and other stakeholders (clients, policy makers, funders, etc) about which treatments are best for which type of client, and what successful treatment means.
According to the Australian Institute of Health and Welfare “treatment” for substance use disorders might include “detoxification and rehabilitation, counselling and pharmacotherapy, and are delivered in residential and non-residential settings”.\(^{50}\) For Lunze et al it might also include “motivational interview, short therapy, contingency management and behavioral therapy”.\(^{51}\) As noted above several experts maintain that best practice treatment can also include attention to social structure through services aimed at addressing “social stability factors – such as employment, positive family relationships and stable housing”.\(^{52}\) However, there is “a diversity of opinion about whether goals ancillary to reducing drug use, such as improved emotional wellbeing and family relationships, should be included as treatment goals”.\(^{53}\) Therefore the nature of the treatment tends to be shaped by the overall objectives. Objectives that might include “reduction or cessation of drug use, as well as improving social and personal functioning”,\(^{54}\) or they might be “to prevent anticipated harms and reduce actual harms associated with drug use”.\(^{55}\)

The 2018 Bill provided for the undertaking of treatment as part of an Employment Pathway Plan if a beneficiary failed a second drug test and has “undergone a medical, psychiatric or psychological examination” and the “the report of the examination given to the Secretary recommends that the person undertake treatment for use of drugs”.\(^{56}\) There is very little information about precisely how prescriptive an Employment Pathway Plan might be in relation to the nature of the treatment in the Bill or existing legislation.\(^{57}\) What little is known is publicly available from the Department. According to information supplied by the Department of Social Services:

> After a second positive test, the job seeker will be referred to a medical professional who will assess their circumstances and identify treatment options.

> Based on the recommendations of the medical professional, the job seeker may be required to participate in activities designed to address their substance abuse as part of their Job Plan. This participation will count towards their mutual obligation activity requirements.\(^{58}\)

What is clear is two-fold. First, any detection of a prescribed substance is going to be regarded as “substance abuse” whether or not it is substance abuse. This issue is considered later. Second, an initial assessment following a second positive test will be completed by “a medical, psychiatric or psychological examination” according to the Bill, or by a “medical professional” according to the Departmental advice.

In terms of treatment types, the Department of Social Services identified “examples” of suitable services in a submission to the Senate Community Affairs Legislation Committee:

Examples of treatment may include, but are not limited to:

- screening and brief intervention
- withdrawal management
- case management, care planning and co-ordination
- counselling
- day stay rehabilitation and other intensive non-residential programs
- residential rehabilitation
- aftercare/follow-up services

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\(^{51}\) Lunze et al, n 36, 11.

\(^{52}\) Ritter and Stoove, n 36, 138.

\(^{53}\) Pritchard, Mugavin and Swan, n 38, 7.

\(^{54}\) Australian Institute of Health and Welfare, n 50, 2.

\(^{55}\) Pritchard, Mugavin and Swan, n 38, 7.

\(^{56}\) Social Services Legislation Amendment (Drug Testing Trial) Bill 2018 (Cth) cl 4, 7, inserting new ss 544B(1AA) “Youth Allowance”; 606(1AA) “Newstart”, respectively.

\(^{57}\) See generally Social Security (Administration) Act 1999 (Cth); and Social Security Act 1991 (Cth).

\(^{58}\) Australian Government, Department of Social Services, n 22, 1.
The extent to which this range of possible service types might be available in a given trial district will depend on a combination of what is available and government procurement policy. The Department of Social Services submitted to the Senate Committee that:

Job seekers who test positive to more than one drug test in the 24 month period will be referred to a medical professional for assessment. The medical professional will be a person with expertise in drug and alcohol treatment. DHS will conduct a procurement process to engage medical professionals who can conduct assessments in each trial site.\(^{60}\)

Based on the available information (and in the absence of legislative detail to the contrary) welfare recipients will not be able to choose the type of treatment they receive. Instead, the treatment type will depend on what the procured expert recommends:

If the medical professional recommends treatment, the job seeker will be required to undertake the recommended treatment activities to address their substance abuse as part of their Job Plan. The medical assessment may recommend any type of drug or alcohol treatment that is appropriate for the job seeker’s individual circumstances.\(^{61}\)

Importantly, the Departmental submission recognised that relapse “is a common part of the recovery process”, and therefore failing subsequent drug tests would not result in penalties “so long as they continue to engage with case management and the treatment process”.\(^{62}\)

The foregoing raises several issues for further scrutiny. First, it suggests treatment would not necessarily be confined to abstinence but rather harm reduction or functional use. Functional use may be more complex to evaluate but comes with the advantage of being more realistic in terms of achievable outcomes.\(^{63}\)

Second, it raises questions about individual choice concerning treatment type which will have a bearing on perceived coercion and treatment commitment, and in turn efficacy. Third, it raises important questions about the capacity for individuals to refuse particular treatment service types without suffering punitive consequences based on the discretion of a case manager. Again, this has a bearing on perceived coercion and the likely commitment to treatment. Finally, it poses ethical questions for the treating professional about the possibility for divided loyalty. Each of these issues are considered later below.

### 3. Efficacy, Evaluation, and Cost-Effectiveness

Evaluation is notoriously complex in terms of drug treatment efficacy and cost-effectiveness.\(^{64}\) It can be problematic for several reasons. Notably there is no accepted measure for the success of programs because of the diversity of treatment aims, methods/types, and unknown differences in the effects of the coercion/motivation mix.\(^{65}\) Wild et al noted in 2016 that although retention is commonly used as a proxy for treatment success it has “generated mixed findings”.\(^{66}\) They found “most studies in this area merely assess whether or not clients were retained at a follow up assessment, and little research has investigated temporal patterns of dropout”.\(^{67}\) Similarly, Wiessing et al call for:

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60 Department of Social Services, n 59, 7.

61 Department of Social Services, n 59, 7.

62 Department of Social Services, n 59, 8.


65 Pritchard, Mugavin and Swan, n 38, 21.

66 Wild et al, n 15, 36.

67 Wild et al, n 15, 36.
An understanding of what services are being provided, in what form and the extent to which they are provided to individual users, including their views on the provision (where possible extending to enumeration of costs and if possible – in separate studies by specialist researchers – modelling of cost-effectiveness) is critical to the analysis of public health needs and whether these are adequately addressed.68 This absence of consensus about the efficacy and evaluation of mandatory treatments as well as the research heterogeneity allows some to claim coercion in treatment has had some success while others claim the opposite. When Wild reviewed the literature in 2006 he found “an impasse” such that in the United States “reviews of legal social control tactics concluded that coercion ‘works’ whereas non-US reviews have pointed to inconclusive findings and methodological problems that support a more cautious and critical stance”.69

Even in the more established realm of criminal justice diversion programs evaluation can be complex and problematic.70 Serious questions arise about what will count for efficacy and effectiveness especially when variables such as time are considered. For instance, the Australian Medical Association claims “most patients eventually improve, and even among those with problems severe enough to enter treatment services, around two thirds will achieve stable and enduring abstinence after 20 years”.71 The Department of Social Services stated it will evaluate the trials “to determine which aspects have been successful in addressing job seekers’ substance abuse and barriers to employment”, and to “assess the effectiveness of this kind of intervention in the Australian welfare context”.72 Any unintended consequences of mandatory treatment are expected to be discovered through the evaluation process to address them in “real time”.73 However, the Department concedes that although it will consult with stakeholders and will form a representative “Expert Reference Group” the specific details of an evaluation process “are yet to be confirmed”.74 In the absence of specific detail it is difficult to determine what will be efficacious and how efficacy will be evaluated. Hence the Senate Committee recommendation that the Department of Social Services should establish and publish the evaluation strategy of the drug testing trial prior to the commencement of the trial.75

Therefore, what can be gleaned from the legislation and the available Departmental policy is that the proposed mandatory treatment program:

- fits within the category of formal coercion (institutional rather than legal)
- is aimed at “substance abuse”
- efficacy will be concerned with successfully “addressing job seekers’ substance abuse and barriers to employment”
- choice and treatment compliance will be determined by a case manager in consultation with a treatment professional not necessarily the jobseeker
- types (ie the range of available treatments) in a trial district will be the product of service availability and government procurement policies
- affords an unknown degree of individual choice concerning treatment type and consequently its bearing on perceived coercion and treatment commitment
- poses ethical questions about the capacity for individuals to refuse particular treatment service types, and poses a potential for divided loyalties for treating professionals

69 Wild, n 8, 41.
71 Australian Medical Association, n 36, 4.
72 Department of Social Services, n 59, 10.
73 Department of Social Services, n 59, 10.
74 Department of Social Services, n 59, 10.
75 Department of Social Services, n 59, 11 [2.25].
These considerations have informed the following literature-based assessment of the potential efficacy of the Australian Government’s proposal to link welfare with mandatory drug treatment.

**III. ASSESSING THE EFFICACY OF MANDATORY DRUG TREATMENT PROGRAMS**

**A. Treatment Efficacy Using Formal Coercion – Welfare and Mandatory Treatment**

When the efficacy of mandatory addiction treatment programs was considered by the Senate Committee it found there was virtually no evidence to support linking addiction treatment with the provision of welfare. The Senate Committee Majority Report under the heading “Evidentiary Basis for the Trial” observed that there were submissions pointing to a lack of evidence “that drug testing welfare recipients would assist them to address their substance abuse issues” and “such a practice could have high social and economic costs”.76 However, the government Majority Report preferred the view instead that “the committee received some evidence to support a mandatory drug testing trial”, claiming “a 2002 systematic review of compulsory treatment revealed some studies that found ‘superior outcomes for clients receiving compulsory treatment compared with voluntary treatment’”.77 For this the government relied exclusively on two sources of evidence that were cited in a submission by the Kirby Institute to the Senate Community Affairs Legislation Committee,78 and part of the evidence provided by an expert concerning criminal justice programs where “individuals had been forced to make a choice between whether to undergo drug treatment or face significant consequences”.79 Therefore, it is appropriate to examine this evidence relied upon by the government starting with the two academic articles concerning mandatory drug treatment and then later the literature concerning some success in the “criminal justice space”.

The Kirby Institute80 was strongly opposed to the government proposal for mandatory addiction treatment in its submission to the Senate Committee. It submitted, “On the basis of existing scientific evidence, coerced or compulsory treatment is not an effective or efficient use of scarce resources”,81 and “In our opinion, the measures proposed in the Social Services Legislation Amendment (Drug Testing Trial) Bill 2018 are ill-advised, ineffective and potentially harmful”.82 In the course of its submission the Kirby Institute cited eight sources as evidence that mandatory addiction programs afford little or no probability of success. The cited literature included two articles subsequently relied on by the government to support its contention there was some evidence that forced treatment had positive outcomes. The articles were both literature reviews, namely a 2002 study titled “Compulsory Substances Abuse Treatment: An Overview of Recent Findings and Issues”,83 and a 2016 study titled “The Effectiveness of Compulsory Drug Treatment: A Systematic Review”.84
Neither of these studies advocated mandatory drug treatment. The leading author of the 2002 research has since published two further articles Wild 2006\textsuperscript{85} and Wild et al 2016.\textsuperscript{86} These later publications do not lend support to the case for mandatory treatment. In 2006 Wild concluded the evidence for mandatory treatments was ambivalent:

> To the extent that such evidence is not forthcoming, the use of legal or formal tactics to force a treatment system should be rejected. The onus should be on advocates of legal and formal social control tactics to formulate evidential and procedural bases for judging whether individuals experiencing social control tactics are fundamentally incapable of providing consent to treatment.\textsuperscript{87}

The 2016 article found, among other things, “widespread implementation of legal social controls has occurred around the world without conclusive evidence on its effectiveness”.\textsuperscript{88} Wild et al noted the main reason for the inconclusiveness was due to “findings reported in previous research testing associations between legal referral and client engagement may reflect previously unmeasured heterogeneity in treatment motivations”.\textsuperscript{89} In other words there was simply no way to evaluate programs with different aims, degrees of coercion, variation in individual perceptions of coercion, individual motivations, and treatment methods which can confound results.

The second source relied upon by the government was a 2016 literature review by Werb et al. This literature review only assists the government proposal to the extent it was silent on treatments based on formal coercion. Werb et al specifically excluded formal coercion from their research to focus instead on compulsory treatment where there is no element of choice.\textsuperscript{90} In other words, their research excluded programs akin to the Australian proposal. They concluded:

> There is limited scientific literature evaluating compulsory drug treatment. Evidence does not, on the whole, suggest improved outcomes related to compulsory treatment approaches, with some studies suggesting potential harms. Given the potential for human rights abuses within compulsory treatment settings, non-compulsory treatment modalities should be prioritized by policymakers seeking to reduce drug-related harms.\textsuperscript{91}

This is not necessarily a green light for the Australian proposal which should be considered according to the available evidence specific to treatments based on formal coercion. Even when the research specifically focuses on legal and formal coercion programs caution is required because referral type is not necessarily a proxy for client engagement. As Wild and others explain “it is unknown whether intervening among clients reporting low admission levels of treatment motivation [at 41] would improve meaningful client engagement”.\textsuperscript{92} Wild also reported:

> Support for expanding treatment options – even by using social control tactics – does not entail support for coerced treatment, however. Drawing a firm distinction between social controls (objective use of social pressure) and coercion (client perceptions and decision-making processes) allows us to formulate a parallel position that rejects treatment policies, programmes and associated practices that create client perceptions of coercion.\textsuperscript{93}

This is consistent with other research finding that coercion can diminish the “ability of individuals to participate jointly with their health service provider in the development of treatment goals and selecting treatment”.\textsuperscript{94}

\begin{thebibliography}{99}
\bibitem{85} Wild, n 8, 40–49.
\bibitem{86} Wild et al, n 15.
\bibitem{87} Wild, n 8, 46.
\bibitem{88} Wild et al, n 15, 40.
\bibitem{89} Wild et al, n 15, 40.
\bibitem{90} Werb et al, n 11, 2.
\bibitem{91} Werb et al, n 11, 1.
\bibitem{92} Wild et al, n 15, 40–41.
\bibitem{93} Wild, n 8, 45.
\bibitem{94} Pritchard, Mugavin and Swan, n 38, 27.
\end{thebibliography}
Client perception of coercion may also suffer due to the limited choice available to choose a suitable treatment type or service. As noted above, under the proposed Australian trial, the range of treatment service types will be determined by fortune in terms of a combination of local availability and government procurement policy. Also, welfare recipients will not be able to choose the type of treatment they receive. Instead, the treatment type will depend on what the procured expert recommends as part of the recipient’s Job Plan which may include “any type of drug or alcohol treatment that is appropriate for the job seeker’s individual circumstances”. This is at odds with Clinical Guidelines in New South Wales (NSW) and Queensland and unsupported by experts in the literature.

The NSW “Drug and Alcohol Withdrawal Clinical Practice Guidelines” stipulate that patients should “be advised as to the suitability and availability of services” and “have the right to choose from the treatment options that are available and considered appropriate by the clinician”. Similarly, the Queensland “Alcohol and Drug Withdrawal Clinical Practice Guidelines” which were modelled on those in NSW also require “the active involvement of the patient in planning treatment”. This is also the approach recommended by the relevant literature.

Saloner and Barry maintain that “People with opioid use disorders can and should make treatment choices for themselves”. Lunze et al go further and assert the inability to choose the type of treatment is as detrimental as a client’s choice to undergo treatment, and in either case could be a human rights abuse. Importantly, the NSW “Drug and Alcohol Withdrawal Clinical Practice Guidelines” caution against linking treatment compliance with punishment:

Do not set up an agreement so that it can be used against the patient in a punitive manner. Failing to follow an agreement is not in itself sufficient grounds for discharge from care.

As a consequence, the proposed formal coercion involved in linking welfare with treatment is at best risky in terms of treatment efficacy, however efficacy may be determined. This is because the degree of coercion is reasonably likely to undermine individual client commitment and motivation to treatment. The Australian Government also claimed there is research indicating mixed success with legal coercion in the “criminal justice space where individuals had been forced to make a choice between whether to undergo drug treatment or face significant consequences”. Therefore, it is necessary to look at the evidence concerning legal coercion in criminal justice programs.

B. Treatment Efficacy Using Legal Coercion – Criminal Justice Systems and Mandatory Treatment

After conceding “the criminal justice setting” is “different to the welfare context” the Senate Committee view was that there had been “positive results when participants are forced to make a choice between treatment and a less attractive alternative”. Government members on the Senate Committee quoted Professor Alison Ritter for the proposition that the Merit Program and police diversion programs are “very good” examples of programs where treatment is a “forced choice”. Ritter explained:

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95 Department of Social Services, n 59, 7.

96 Department of Social Services, n 59, 7.


99 Saloner and Barry, n 9, 448.

100 Lunze et al, n 36, 11.

101 New South Wales Ministry of Health, n 97, 16.

102 Senate Community Affairs Legislation Committee, Parliament of Australia, n 78, 8, citing Ritter, n 79.

103 Senate Community Affairs Legislation Committee, Parliament of Australia, n 77, 9.

In the context of a crime having been committed and treatment being a forced choice for that person to then make, the evidence is that these programs can be cost effective where that person makes the choice to undergo treatment instead of the original sentence that the magistrate or judge has made.105

Quite apart from the caveat that cost-effectiveness “can” be achievable “where that person makes the choice to undergo treatment”, government members were aware that evidence of treatment efficacy in the criminal justice system was at odds with the weight of submissions. Indeed, the Majority specifically commented “that these findings were not necessarily representative of the bulk of scientific evidence in this field”.106

A review of the relevant literature reveals that legally coerced drug treatment programs produce mixed results. In particular, in 2018 Kornhauser concluded, “While Australian evaluations indicate drug courts reduce recidivism more than conventional sanctions, certainty in these findings is tempered by mixed results and methodological limitations”.107 Mixed results and methodological limitations might be expected given the various stages where legal coercion might be applied in the criminal justice context. Following Spooner et al, Pritchard et al identify five stages where drug treatment might be applied in the criminal justice context:

- pre-arrest – before a charge is laid
- pre-trial – after a charge is laid, but before the hearing proceeds
- pre-sentence – after conviction, but before sentencing
- post-conviction – as part of sentencing
- prison pre-release – prior to release from incarceration108

Despite the considerable extent of their review of the literature in 2007 concerning the efficacy of the various State criminal justice programs operating at different stages, Pritchard et al were reluctant to reach conclusions on the efficacy of legally coerced treatments. At best they observed it “can sometimes be effective in reducing drug use (and crime) for some people”.109 Instead Pritchard et al called for a “comprehensive national policy on how compulsory treatment, in its many forms, is to be conducted” with consistent standards, “collaborative research”, and “standardised indicators for evaluation”.110 Systems aimed at minimising the high costs of crime and incarceration may be cost effective, but not necessarily cost effective when the mandatory drug treatment is aimed at minimising the cost of unemployment benefits. Therefore, while there is some merit to the government contention that “positive results” are possible “when participants are forced to make a choice between treatment and a less attractive alternative”,111 the evidence from criminal justice programs does not justify the introduction of trials in the context of welfare. To do so based on the evidence from criminal justice programs could mean that drug use is reduced for some unemployed people with no corresponding justification for the allocation of scarce resources or the potential risk of perverse outcomes.

C. Opportunity Costs and Perverse Effects of Formal Coercion

Even if there was evidence supporting mandatory treatment efficacy there is still a need to be mindful of possible opportunity costs and perverse effects. Wild warns that the literature focuses on trying to evaluate the benefits of coerced treatment without “acknowledging the potential for concurrent iatrogenic

105 Ritter, n 79, 8.
106 Community Affairs Legislation Committee, Parliament of Australia, n 77, 8, citing Dr Kym Jenkins, President, Royal Australian and New Zealand College of Psychiatrists, Committee Hansard, 23 April 2018, 26; Chris Twomey, Leader, Policy Development and Research, WA Council of Social Service, Committee Hansard, 23 April 2018, 41.
108 Pritchard, Mugavin and Swan, n 38, 31.
109 Pritchard, Mugavin and Swan, n 38, 104.
110 Pritchard, Mugavin and Swan, n 38, 93.
111 Senate Community Affairs Legislation Committee, Parliament of Australia, n 77, 9.
effects”. Wild provides two examples of iatrogenic effects. The first might be “equity in treatment access” because publicly funded programs may be “stretched to financial capacity”, and the second might be that “treatment providers may be unable to simultaneously adopt the roles of therapist and agent of social control”. Pritchard et al expressed similar concerns. They noted the potential for “net-widening, displacement from treatment, and discrimination against minority groups” and:

Considerations of fairness and propriety necessarily arise when motivated individuals are denied access to treatment because resources have been diverted to the treatment of others whose motivation and readiness to change may be low, or even non-existent.

While Bauld et al, after reviewing the evidence from the United Kingdom and the United States, observed “a welfare regime with increased sanctions and no additional support for PDUs (problem drug users), or complimentary interventions to encourage employers to consider providing jobs to this group, may be counterproductive” They elaborated claiming there is the increased risk that imposing welfare conditions on problem drug users may lead to more crime.

Of these concerns, the potential for net-widening and a blow-out of opportunity costs is reasonably foreseeable as this specific concern was expressed to the Senate Committee. As such, an important distinction is made in the literature between substance abuse, substance addiction, and functional substance use. The Australian Medical Association recognises that substance use disorders “can be divided into harmful use and dependence” and this may apply whether the substance is legal or illegal, though a disorder is not an inevitable consequence of mere use. The significance of this for present purposes is that the Australian Government proposal to link welfare with compulsory treatment means that it would force treatment upon people who do not have a substance use disorder. Random drug testing does not necessarily detect “barriers to employment” but rather tests whether there is substance use. This means that the pool of potential treatment subjects will be inflated by those who are not suffering a substance use disorder, and in particular it could inflate the pool with active jobseekers who are unaffected by their drug use. In other words, the proposed random testing within the three trial districts would also capture functional users or occasional users (so-called “recreational users”) and not just those persons who fail to meet welfare obligations due to a substance use disorder. The inclusion of people who do not have a substance use disorder may unnecessarily inflate the costs of the program as well as contributing to the problem of excess demand for scarce treatment services.

In anticipation of increasing demand for services, the government allocated an additional $10 million for treatment services:

This fund will be able to provide additional treatment support in trial locations where the existing state or Commonwealth supports and services are not sufficient to meet any additional demand as a result of the

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112 Wild, n 8, 42.
113 Wild, n 8, 42.
114 Pritchard, Mugavin and Swan, n 38, 23.
115 Pritchard, Mugavin and Swan, n 38, 25.
117 Bauld et al, n 116, 759 (quoting a “professional” interviewed for the study).
118 Senate Community Affairs Legislation Committee, n 4, 11–14.
119 Australian Medical Association, n 36, 1–2.
120 Australian Medical Association, n 36, 2.
121 Commonwealth, Parliamentary Debates, House of Representatives, 22 June 2017, 7427 (Christian Porter).
123 Australian Medical Association, n 36, 4.
124 Ritter and Stoove, n 36, 138.
125 Senate Community Affairs Legislation Committee, n 4, 12 [2.33].
trial. Where treatment is not immediately available, job seekers will need to take appropriate action, such as being on a waiting list. The specific details of the treatment fund will be determined in consultation with the Department of Health, Primary Health Networks and the drug and alcohol sector before the trial starts.\(^{126}\)

However, it is doubtful whether this increased funding would alleviate the pre-existing shortage of places available for those who already volunteer for treatment. Ritter and Stoove point out that “fewer than half of those seeking AOD treatment in Australia are currently able to access appropriate treatment” and consequently a “doubling of current resources would be required to address unmet treatment need”.\(^{127}\) According to the Australian Medical Association the pre-existing “lack of treatment services affects patient outcomes” because people “wait for extended periods to access treatment” adversely impacting on “motivation to engage in treatment”.\(^{128}\) For these reasons there are foreseeable risks that not only opportunity costs may blow out but there is also the real risk that any increase in dedicated funding could be wasted expenditure.

**IV. CONCLUSIONS ON MANDATORY ADDICTION TREATMENT**

Laws to require unemployed people to undertake mandatory drug testing and treatment have been on the political horizon since 2014 and were rejected by the Senate in 2017 and 2018. Debate about the efficacy of linking welfare with mandatory drug treatment suffers from a paucity of research specifically about the efficacy of welfare mandatory drug treatment. Similar programs in criminal justice have produced mixed results. Overseas jurisdictions provide no evidence of efficacy when they have linked welfare with mandatory drug treatment, generally abandoning or scaling back programs. Complicating this further is an absence of consensus about what constitutes efficacy and the degree of methodological heterogeneity rendering comparisons complex at best and frequently meaningless. Under these circumstances the government contended that because Australian welfare conditions are unique, and the program would not be punitive, trials were warranted.

Considering these complexities, this article assessed the potential efficacy of the Australian proposal to trial drug testing and the mandatory drug treatment of unemployed people. It did so by locating the Australian proposal within the relevant research literature to conduct a review of the available evidence concerning the efficacy of mandatory drug treatment programs including the literature concerning the efficacy of mandatory drug treatment programs in Australia’s criminal justice systems.

Properly located in the research literature the Australian trials fall between the extremes of compulsory treatment and informed voluntary treatment. Compulsory treatment is regarded as unsupported by evidence and a breach of human rights. Informed voluntary treatment is regarded as ideal. In between are mandatory treatments involving different degrees of coercion and consent. What matters more is the subject’s perception of the degree of choice and coercion rather than the form of coercion. This is because efficacy, among other variables is contingent upon the subject’s commitment to the treatment. Efficacy for the purposes of linking welfare with mandatory drug treatment was implied by the government to be functional use in the sense that jobseekers would not be punished for drug use itself but rather whether they engaged with treatment. This assessment would be made by a departmental case manager on the advice of a treating professional. Failure to engage with treatment would result in income management and then later still suspension of benefits. Therefore, any prospect of efficacy needs to consider these factors.

A review of the specific literature relevant to the Australian proposal indicates formal coercion addiction programs afford little or no probability of success. The relevant literature\(^{129}\) has since exhorted the Kirby Institute submission to the Senate inquiry that the evidence is that mandatory treatment “is not

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\(^{126}\) Department of Social Services, n 59, 8.

\(^{127}\) Ritter and Stoove, n 36, 138.

\(^{128}\) Australian Medical Association, n 36, 4.

\(^{129}\) See, eg, Bazazi, n 14, 1064–1065; Rafful et al, n 14, 1061; Saloner and Barry, n 9, 446–449.
an effective or efficient use of scarce resources”,\textsuperscript{130} and as such the Australian proposal is “ill-advised, ineffective and potentially harmful”.\textsuperscript{131} The other source of evidence relied upon by the government was based on mandatory drug treatment in the criminal justice system. Here there was evidence of mixed success in very specific circumstances.\textsuperscript{132} In other words, there was evidence of cost-effectiveness if a subject chose to engage with treatment as an alternative to incarceration. This is because the cost of treatment is generally cheaper than the cost of incarceration. Otherwise criminal justice mandatory treatment is not necessarily a predictor of efficacy in the sense that it might facilitate functional use which is an implied aim of the welfare proposal.

Instead the literature consistently warns of the risks of cost ineffectiveness, opportunity costs as well as perverse and unintended outcomes. In particular, cost ineffectiveness will result from any detection of a prescribed substance which will be regarded as “substance abuse” whether or not it is substance abuse. Cost ineffectiveness is also likely to result because welfare recipients will not be able to choose the type of treatment they receive thereby diminishing the “ability of individuals to participate jointly with their health service provider in the development of treatment goals and selecting treatment”.\textsuperscript{133} This is not only at odds with Clinical Guidelines in NSW and Queensland and unsupported by experts in the literature, the inability to choose the type of treatment is also regarded by some experts as tantamount to human rights abuse.\textsuperscript{134}

Random drug testing would lead to net-widening because it does not distinguish between functional drug use and drug addiction or drug abuse. Consequently, the program will not necessarily detect “barriers to employment”\textsuperscript{135} and will instead cause further problems. Among these further problems will be additional cost, and the potential for motivated individuals to be denied access to treatment because resources have been diverted to the treatment of others who may lack the motivation to change. Evidence based voluntary treatment programs are already oversubscribed with less than half of all motivated patients able to access suitable treatment. Therefore, any increase in funding targeted at mandatory treatment would suffer the defect of channelling scarce resources away from evidence-based voluntary programs.

For these reasons the literature shows that there is little chance of efficacy – however efficacy may be defined – if welfare is linked with mandatory drug treatment. Instead, cost ineffectiveness and perverse outcomes are more probable than treatment efficacy.

\textsuperscript{130} The Kirby Institute, n 80, 2.
\textsuperscript{131} The Kirby Institute, n 80, 2, 3.
\textsuperscript{132} Kornhauser, n 107, 76.
\textsuperscript{133} Pritchard, Mugavin and Swan, n 38, 27.
\textsuperscript{134} See, eg, Lunze et al, n 36, 11.