MINISTRY OF HEALTH
MANATŪ HAUORA

Health Report number: 20120521

Action required by: **29 May 2012** File number: **HC45-04-20-7**

Health report

To: Hon Tony Ryall

Title: Drug testing of beneficiaries

Executive summary

i. You are meeting with Welfare Reform Ministers on 29 May 2012. At that meeting, you were due to discuss a Ministry of Social Development (MSD) paper proposing that beneficiaries who fail pre-employment drug tests, or who refuse to apply for jobs requiring drug tests, are either directed to drug treatment if they are assessed to be dependent users, or are sanctioned with reductions in benefit payments if they are non-dependent ('recreational') users. That paper has been deferred. You and other Ministers may now be invited to informally discuss the proposal in the context of a wider discussion on social obligations. The proposal was an election manifesto commitment.

ii. The proposal could have the benefit of identifying people with dependent drug use who would not have been identified otherwise. Addressing those people's drug use may make them more employable and help achieve the Government's social welfare objectives. Additionally, some 'recreational' users at the lower-end of drug use may respond to sanctions by reducing drug use and finding work with the associated health benefits these bring.

iii. The Ministry has worked with MSD over several months to support the manifesto commitment and resolve a number of issues to make the proposal as workable as possible. The Ministry, however, has a number of remaining concerns.

iv. Sanctions for 'recreational' users may undermine the objectives of the proposal, result in waste of health resources, and have an ambiguous overall effect on people's health and overall welfare. One risk is that people overstate the extent of their drug use in order to be assessed as dependent and, therefore, avoid sanction, resulting in many more people being referred to treatment they should not be eligible for. Another risk is that the increase in demand may mean that District Health Boards do not achieve waiting list targets to be introduced from 2012/13 unless additional capacity is funded.

v. The Ministry of Health's best estimate of the cost of this proposal to Vote Health, including investment in additional capacity, is between $1.3 million and $3.2 million per annum if people truthfully reveal their drug use, and between $4.6 and $11.6 million per annum if 10 percent of frequent drug-using beneficiaries successfully overstate their drug use. This compares to estimated savings of $7.1 million per annum from people moving off benefits.

vi. The Ministry has encouraged MSD to investigate a number of alternatives to significant financial sanctions such as drug education, addressing people's barriers to accessing treatment, smaller financial sanctions, or using money management (beneficiary budget control). These alternatives may achieve much of the employment gain but with fewer health and cost risks. It may also be possible to trial the proposal in one region, for example Auckland, and to monitor some of the financial risks. These alternatives warrant investigation.

Health Report number: 20120521

The Ministry recommends that you:

a) **Forward** this paper to Minister Bennett for her information. Yes / No

b) **Note** the issues raised in this paper for your meeting with Welfare Reform Ministers. Yes / No

c) **Seek** Ministers' agreement for the Ministry of Social Development and the Ministry of Health to investigate alternative options to the proposed sanctions. Yes / No ?

Don Gray
Deputy Director-General
Policy Business Unit

Minister's Signature:

Date:

Ministry of Health Contacts:

Withheld under Section 9(2)(a) privacy of natural persons.

Health Report number: 20120521

Purpose

1. This report outlines a number of concerns the Ministry has about Ministry of Social Development (MSD) proposals to sanction beneficiaries who fail pre-employment drug tests. You were due to meet with the Welfare Reform Ministerial Group on 29 May 2012 to discuss the proposal. We understand the drug testing paper has been withdrawn. You and other Ministers may be invited to informally discuss the proposal before you receive the draft Cabinet paper in June. The final paper is due to Cabinet in mid-July.
2. You may wish to raise these concerns with Welfare Reform Ministers.

What the Ministry of Social Development is proposing

3. An increasing number of jobs have pre-employment drug testing. Testing generally involves an on-site urine test. If this is positive, the sample is sent to a laboratory for confirmation.
4. Currently, beneficiaries who fail a pre-employment drug test are able to keep their benefit. MSD are proposing that these people be either directed to drug treatment if they are assessed as dependent users, or be sanctioned if they are 'casual'/ 'recreational' users.
5. For 'recreational' users, a first failure would result in a 50 percent reduction in benefit until the person verbally commits to stop using drugs. A second failure results in a 100 percent suspension of the benefit until the beneficiary can provide a clean test result (which could be about two weeks[1] for most drugs, but up to four weeks for heavy cannabis users). A third failure would result in a cancellation of the person's benefit. A person may then reapply for a benefit after 13 weeks. These are the same as existing sanctions for other work obligations like attending job interviews. MSD's diagram of the proposal is attached in Appendix 1. More information about drug assessment and treatment is included in Appendix 2.
6. The proposal is part of the Welfare Reform package aimed at getting 46,000 people off benefits. MSD estimates that about 600 additional people (1.3 percent of the overall target) could move off benefits each year as a result of the policy, although this seems to be based on untested assumptions.
7. The proposal was an election manifesto commitment:

   If a person doesn't apply for a job because a potential employer asks them to take a drug test, or if they fail such a pre-employment drug test, their benefit will be cancelled.

   National's proposed investment approach to welfare means providing more support for people who are capable of work, but are likely to remain on [a] benefit long-term without this assistance.

   As a result, those who suffer from drug addiction will be offered help and support to deal with their addiction. If there is doubt about whether a person suffers an addiction or is a recreational drug user, a National Government would be guided by expert professional medical advice.
8. The Ministry of Health's 2007/08 New Zealand Alcohol and Drug Use Survey suggests that about 10 to 20 percent of beneficiaries use drugs frequently enough to fail a first test[2]. MSD estimates that 40 percent of vacancies to which Work and Income refers people drug test applicants. Overall, the Ministry estimates that 4,000 to 5,000[3] beneficiaries could fail the first test per year.

[1] One week for the drugs to pass through the person's system and one week to receive test results.
[2] Based on the percentage of beneficiaries who use drugs at least every week. These percentages are consistent across the unemployment, sickness and invalids, and domestic purposes benefit categories.
[3] This assumes between 40 percent and 50 percent of jobs that Work and Income refers people to have drug testing in the future, and is based on historical drug testing rates.

Summary of the Ministry of Health's position

9. The Ministry is supportive of access to drug treatment services for people with dependent drug use. The proposal could have the benefit of identifying people with dependent drug use who would not have been identified otherwise. Addressing those people's drug use may make them more employable and help achieve the Government's social welfare objectives. Additionally, some 'recreational' users at the lower-end of drug use may respond to sanctions by reducing drug use and finding work with the associated health benefits these bring.

10. However, the proposed sanctions introduce a number of problems that might undermine the objectives of the proposal, result in waste of health resources, and have an ambiguous overall effect on people's health and overall welfare.

11. The Ministry has worked with MSD over several months to resolve these concerns and to make the proposal as workable as possible. The Ministry, however, has a number of outstanding concerns which are detailed below.

Ministry of Health's concerns

12. Beneficiaries can currently be sanctioned for not complying with obligations like submitting a job application or attending a job interview. Work and Income can easily observe these obligations and, therefore, enforce them.

13. It is not easy to observe whether someone is a dependent drug user or a 'recreational' drug user. By sanctioning only 'recreational' drug users, the proposal could encourage people to be assessed as needing drug treatment. This creates the following perverse incentives which increase health costs and undermine the proposal:

    a. Some 'recreational' users and dependent users could overstate their drug use to ensure they are assessed as needing treatment. An assessment involves an interview with an alcohol and other drug (AOD) clinician and some attempts by the clinician to verify the person's account of their drug harm – often by talking with the person's partner. Professionals in the addiction treatment sector have advised the Ministry that it would be easy to bias the assessment as people would need only to make sure their partners reiterate what they said in the assessment. Clinicians may be able to detect some people overstating their drug use if clinicians are made aware of this risk before the assessment, but professionals' views are that clinicians would be doing very well if they could detect even a third of those overstating their drug use. The ease of biasing the assessment means that the Ministry considers this to be a high risk.

    b. Some people may substitute from drugs that stay in people's systems longer (or that people believe stay in their system longer), like cannabis, to shorter-stay drugs like methamphetamine, other amphetamine-type substances, or opiates which are more harmful. Some people may also substitute for drugs that are not detected by testing, such as synthetic cannabinoids and other new substances.

    c. Some people already in treatment and on a path to 'manageable' drug use rather than abstinence could be discouraged from reducing drug use if it means they could be reassessed as a 'recreational' user. MSD has responded that people who decrease their use to 'recreational' levels will likely still be classified as being in-treatment, and not a 'recreational' user, and thus exempt from sanction. This, however, exacerbates the incentive to overstate drug use as a single assessment will be enough to avoid future sanctions.

    d. Some moderate drug users at the higher end of 'recreational' use may increase their drug use so that they are assessed as needing treatment. The Ministry considers this to be a lower risk, but it would result in poorer health outcomes for those people.

14. There are several other issues that relate to the effectiveness of the proposal:

a. People report[4] peer pressure, fear of the police, the lack of local treatment services, and the cost of treatment including transport to, and child care while at, treatment among the reasons why they do not receive treatment even when they want it. The proposal doesn't address the barriers to actually getting into, and remaining in, treatment.

b. MSD's proposal refers to dependent users and 'casual' or 'recreational' users. 'Casual' and 'recreational' suggests that people have good control of their drug use such that they could cease or reduce use easily. These are not categories used in the health sector as people's drug use spans a spectrum. A person who is assessed as being 'not dependent' and, therefore, is not referred to treatment may nevertheless have drug use that is difficult to manage. Many of these people would benefit from treatment and represent an unmet demand. These people would be sanctioned under MSD's proposal.

c. According to professionals in the addiction treatment sector, many people's relationship with drugs can be stronger than their relationship with family members. For these people, a loss in income can result in family violence, and continued spending on drugs at the expense of family members. This may be a risk for those with problematic drug use who are not prioritised for treatment. The costs of unmet need have not been included in the Ministry's estimates.

d. While some people may respond to sanctions by decreasing their drug use, MSD considers that about 18 percent of people that failed the first test will go on to receive a full sanction after a third test[5]. The loss of a benefit for a minimum of 13 weeks is a significant shock to a person's income and may cause hardship to the person and their children, as well as having negative impacts on others like landlords and creditors. There is also a strong correlation between people's standard of living and their health such that income sanctions are expected to have negative impacts on people's health. The Ministry considers that people may defer health care and increasingly present at emergency departments rather than primary care. MSD is also asking whether beneficiaries should compensate employers for the cost of failed tests which may add to people's financial hardship.

e. People who do not want to be in treatment may be disruptive in group treatments, decreasing the effectiveness of treatment for others.

Capacity of alcohol and other drug services

15. Mauta Raki, the National Addiction Workforce Development Centre, advises the Ministry that service providers might only be able to absorb up to a 10% to 15% increase in the number of new referrals before waiting lists begin to lengthen. This capacity will be less for those service providers who, to meet the introduction of waiting list targets from 2012/13, are already looking to make greater use of group sessions to shorten waiting times.

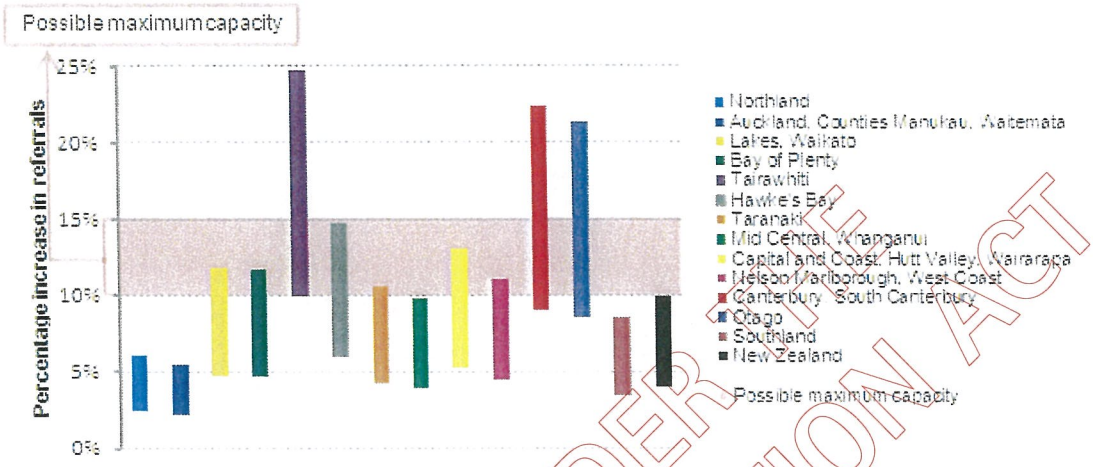
16. Nearly half of all drug tests are in the forestry and agriculture sector (42%), with construction (23%), transport (13%), and mining and energy (9%) being other industries in which drug testing is common.[6] Because these industries are more concentrated in certain regions – Tairawhiti has 4% of New Zealand's agriculture and forestry jobs compared to 1% of all jobs, for example – there will be particular pressure on some regions.

17. The bars in figure 1 show the estimated range of referral increases each year from people

[4] 2007/08 New Zealand Alcohol and Drug Use Survey.
[5] This estimate is based on the number of people that fail other welfare obligations like applying for jobs. It's not clear that modifying drug use will be as easy as applying for jobs. The percentage of people sanctioned may, therefore, be higher than MSD estimates.
[6] 2005/06 data from the Institute of Environmental Science and Research Limited (ESR).

with actual drug dependence by District Health Board (DHB) region[7] compared to the 10% to 15% increase that might be absorbed. For example, the estimated increase in referrals to AOD services in Tairawhiti ranges from 10% to 25%. Appendix 3 shows the increases with 10% of users overstating their drug use.

Figure 1: Estimated ranges of referral increases by DHB region

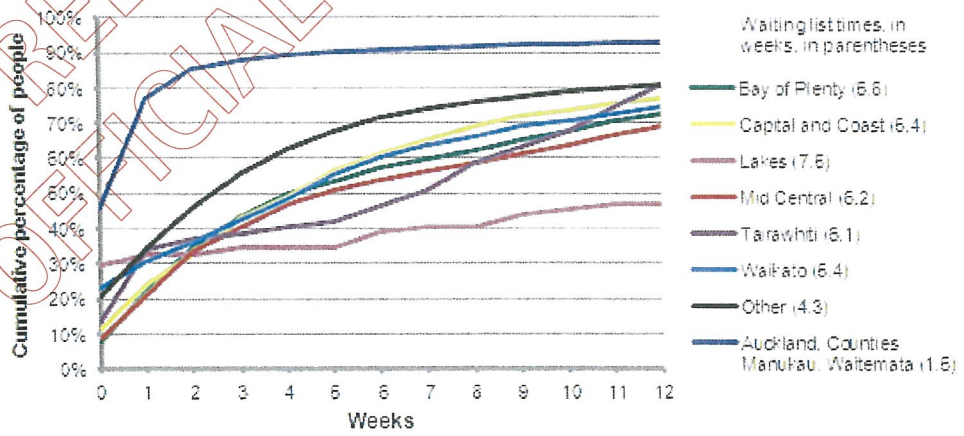


Data sources: The Ministry's Programme for the Integration of Mental Health Data (PRIMHD), Statistics New Zealand's Linked Employer-Employee Data table 18, ESR statistics.

18. The Tairawhiti, Canterbury and South Canterbury, and Otago regions are above the 10% to 15% 'ceiling'. Tairawhiti's 10% to 25% increase in demand is driven by having a higher-than-average proportion of jobs in industries where drug testing is common. Canterbury and Otago's increase in demand is due to having a low starting base: relatively few people are currently being referred to AOD services. Most other regions risk reaching the ceiling, with only the Northland and wider Auckland regions relatively well-placed to handle the estimated increase in referrals.

19. Capacity problems will be exacerbated by waiting lists in some regions. Figure 2 shows the percentage of people admitted to treatment over time following a referral.

Figure 2: Waiting times from referral to treatment, July 2010 to June 2011



Data source: PRIMHD.

[7] The estimates are based the range of beneficiaries using drugs each week (10% to 20%) and the range of vacancies that drug test (40% to 50%), and assumes users do not overstate their drug use. Note that some DHB regions have been aggregated to match the Ministry's client and waiting time data with Statistics New Zealand's job data. Appendix 4 contains more information.

20. Between the increase in demand and the introduction of waiting list targets, the Ministry's view is that only the wider Auckland region (Auckland, Counties Manukau, and Waitemata) is relatively well-placed to cope with this proposal without additional investment in capacity. The Ministry estimates that 21 percent of the increase in treatment demand would come from Auckland.

21. Overall, if waiting times are to be maintained, the Ministry's best estimates[8] of the cost of this proposal are between $1.3 million and $3.2 million per annum if people truthfully state their drug use, and between $4.6 million and $11.6 million per annum if 10 percent of users successfully overstate their drug use. That is, about three quarters of the expenditure might be regarded as 'waste'. This compares to $7.1 million saved per annum in benefit payments assuming that MSD's estimate of 600 additional people moving off benefits each year is accurate[9] and they are receiving the maximum individual unemployment benefit of $11,900 before tax per year.

Discussions with MSD

22. The Ministry has raised these concerns, among others, with MSD. The Ministry suggested that MSD consider whether there were ways of encouraging people to change their drug use without creating a strong financial incentive for people to overstate drug use and undertake other risky behaviours.

23. Options include setting a lower sanction, for example 5% or 10% of benefits rather than 100%, using Money Management (budget control) instead, including drug education in work readiness programmes, or addressing people's barriers to accessing treatment (childcare, transport costs). It may also be possible to trial the proposal or alternatives in one region, for example Auckland, and to monitor some of the financial risks.

Minister's feedback on quality of report				
Very poor (1)	Poor (2)	Neutral (3)	Good (4)	Very Good (5)

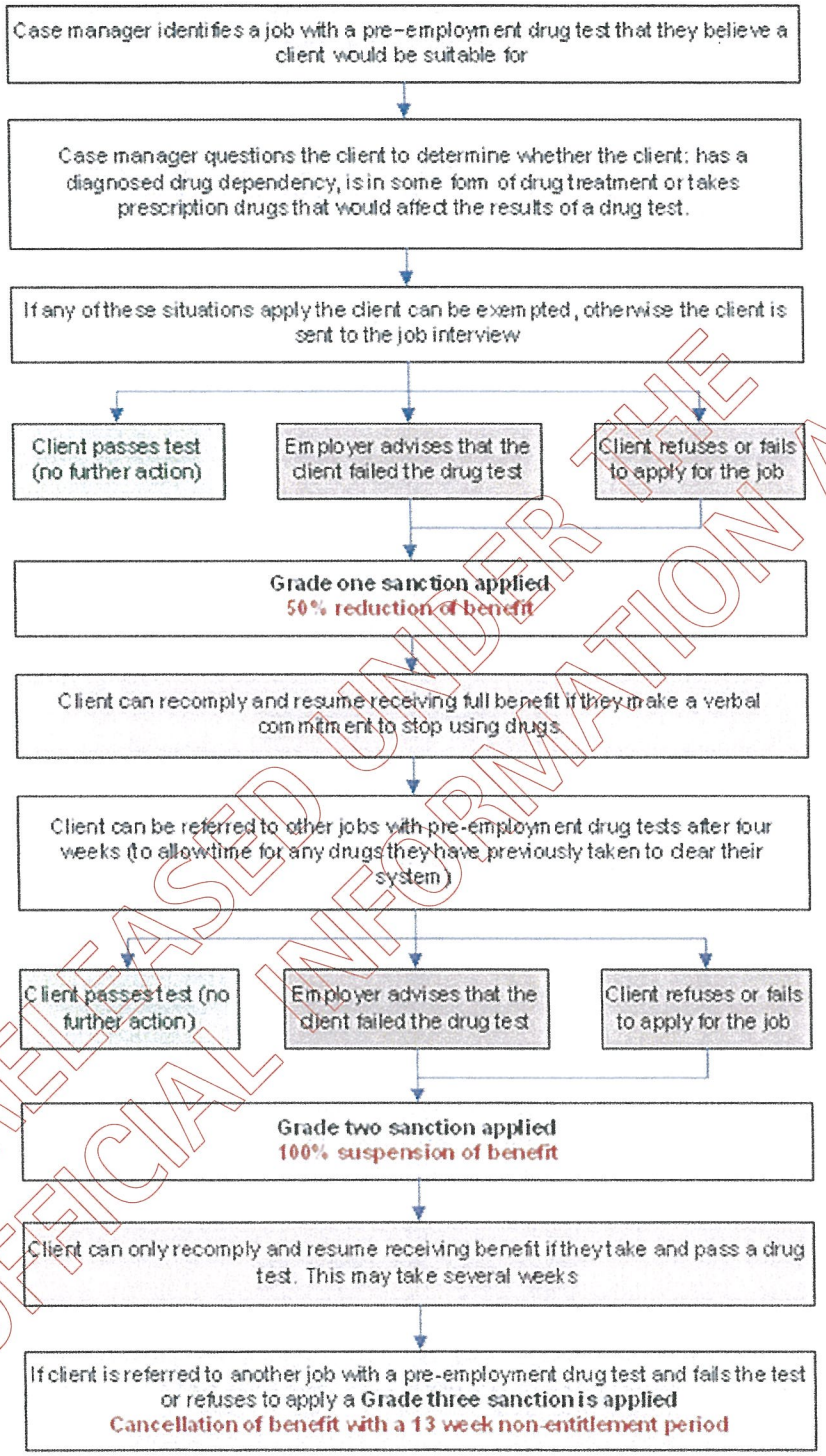
END.

[8] These estimates may underestimate the true costs as, although drug testing is unlikely to detect many alcohol users due to the short stay of alcohol in people's systems, people that are referred to assessment for other drug use may be assessed as having alcohol dependence. Appendix 5 contains a fuller description of the cost estimates. The only risk quantified in these estimates is the risk of overstating drug use.

[9] The estimate is based on highly uncertain assumptions about how many people will respond to sanctions with reduced drug use. It is also unclear how many of the 600 people are net additions to employment and how many simply displace other people, that is that the employer would have filled the job anyway.

Health Report number: 20120521

Appendix 1: MSD's proposal



Appendix 2: Drug assessment and treatment

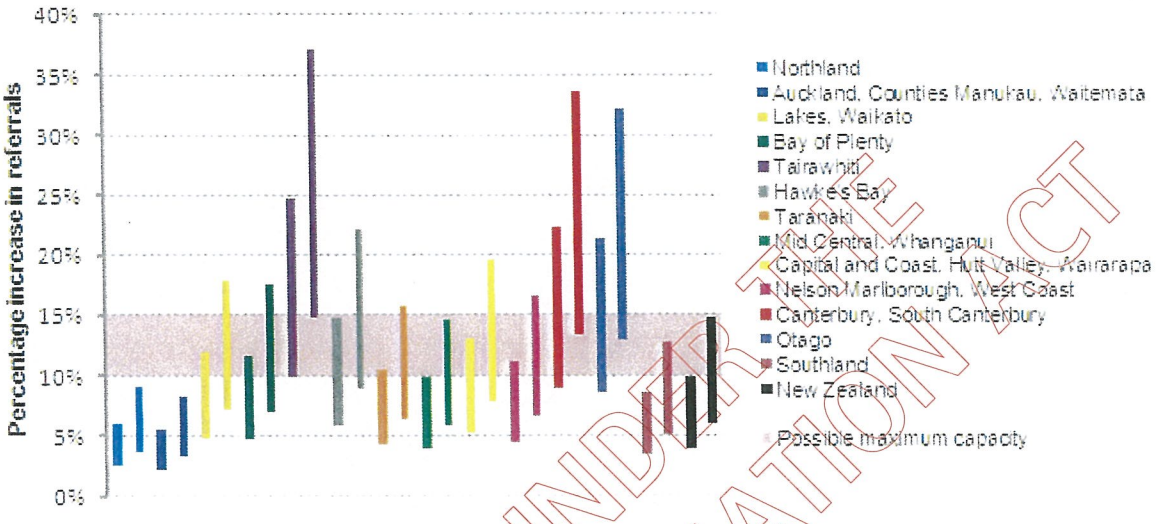
1. The level of a beneficiary's drug dependence is determined by an alcohol and other drug assessment. An addiction specialist conducts an assessment, and may refer a person for treatment which can range from individual or group counselling to residential treatment. Treatment services are provided by District Health Boards and residential treatment is provided in communities by non-Government organisations. About 14,000 people are assessed for, and referred to, treatment per year. A total of 38,000 people are receiving treatment at any time, some periodically over several years.
2. MSD has yet to confirm their policy for assessments. The Ministry has recommended that AOD clinicians continue to carry out assessments given their specialist training and expertise in diagnosis and referral. Because people can limit the impact of the first sanction with a verbal commitment to pass a second test, and to mitigate the costs of assessment, the Ministry considers that people should only be encouraged to get an assessment at the second fail or if they do not make the verbal commitment at the first fail since this may indicate a person has drug dependence.

Health Report number: 20120521

Appendix 3: Increase in demand for drug treatment

1. Figure A shows the estimated range of referral increases each year by DHB region.
2. The bars on the left of each pair are if no users overstate their drug use (the same as in Figure 1). The bars on the right are if 10 percent of users overstate their drug use.

Figure A: Estimated ranges of referral increases by DHB region



Data sources: PRIMHD, Statistics New Zealand's Linked Employer-Employee Data table 18, Institute of Environmental Science and Research Limited statistics.

3. Each region's demand increase is 50 percent higher if 10 percent of users overstate their drug use. Northland and Auckland move closer to, but remain below, the 'ceiling'. Regions with already high increases in demand like Tairawhiti experience large absolute increases in demand.

Appendix 4: Waiting times

1. Table A presents the current number of referrals and average waiting times from referral to treatment by region. Averages are calculated using twelve weeks as the value for any wait times longer than twelve weeks. This means that the averages may underestimate actual wait times particularly for regions with relatively more people waiting longer than twelve weeks.
2. Note that Waitemata serves the wider Auckland region.

Table A: Referrals and waiting times, July 2010 to June 2011

	Number of people referred	Average wait (weeks)
Northland	782	5.42
Auckland	73	3.80
Counties Manukau	280	4.15
Waitemata	4,691	1.35
Lakes	64	7.45
Waikato	1,305	5.43
Bay of Plenty	834	5.82
Tairawhiti	114	6.07
Hawke's Bay	529	4.50
Taranaki	467	5.32
Mid Central	521	6.16
Whanganui	328	3.45
Capital and Coast	434	5.42
Hutt Valley	188	3.27
Wairarapa	211	3.61
Nelson Marlborough	730	4.58
West Coast	138	3.25
Canterbury	622	3.68
South Canterbury	175	1.95
Otago	352	3.80
Southland	605	4.25
Total	13,444	3.61

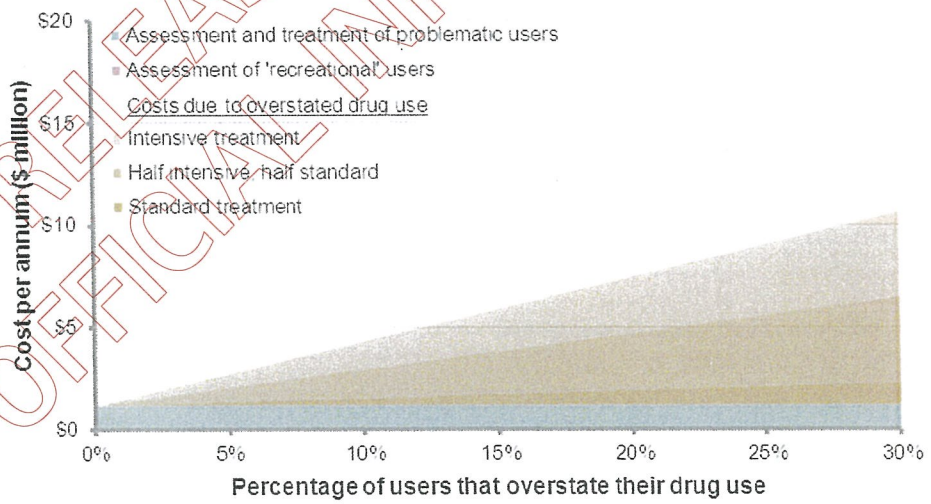
Data source: PRIMHD.

Health Report number: 20120521

Appendix 5: Cost estimates

1. The Ministry expects that about 20 percent of frequent drug users will have drug use that means they should be referred to treatment. This equates to between about 500 and 1,300 people per year. Of these, 95 percent are expected to need less-intensive four-week treatments involving a single group session and a single one-on-one session per week. The remaining 5 percent are expected to need more-intensive 12-week treatments involving three group sessions and a single one-on-one session per week.
2. Assuming that people do not overstate their drug use in order to avoid sanctions (paragraph 13a) and everyone who fails a second test seeks an assessment, estimated costs are between about $0.7 million to $1.8 million per annum. This equates to $1,300 per person with substance dependence problems. Eighty-nine percent of these costs are for people who, because of their actual drug use, would receive treatment if they had been referred in another way (eg, self-referral or GP-referral). Eleven percent of the costs are for assessing other drug users.
3. If frequent drug users overstate their use such that a further 10% are referred to more-intensive[10] group counselling, estimated costs increase to between $2.6 million and $6.5 million per annum – a 267% increase. This means the percentage of expenditure on actual problematic drug users decreases from 89% to 24%. That is, 76% of expenditure is on people who would not normally have been assessed or referred to treatment.
4. Figure B shows how cost estimates vary with the percentage of 'recreational' users that overstate their drug use using the mid-point estimate of 900 people needing treatment and assuming that service providers are able to absorb the increase in demand without additional investment in capacity.
5. Three scenarios are included: where 'recreational' users overstate their use enough to qualify for the standard treatment, where half receive the standard treatment and half receive the intensive treatment, and where all receive the intensive treatment.

Figure B: Drug assessment and treatment costs with spare capacity



[10] It seems reasonable to assume that those people who overstate their drug use will do so greatly in order to guarantee a referral to treatment. Both 'recreational' users and dependent users may be among those who overstate their drug use to ensure they are referred to treatment. Thus, the modelled 10% could be made up of people with actual dependence, but who don't need intensive treatment, with 'recreational' users overstating their drug use only to the point where they are referred to standard treatment.

6. For instance, if 30 percent of users overstate their drug use, costs increase by $1.1 million per annum if they are all referred to standard treatment, by $5.3 million if half are referred to intensive treatment and half to standard treatment, and by $9.5 million if they are all referred to intensive treatment.

7. The costings above assume that there is enough capacity in treatment services for people to be added to existing group sessions. Doing so would leave current waiting lists largely unaffected (although with the coming introduction of waiting list targets, service providers have already been looking to make greater use of group sessions to shorten waiting times).

8. If expected investment in additional capacity is included, estimated costs rise to between $1.3 million and $3.2 million per annum if people truthfully state their drug use, and between $4.6 million and $11.6 million per annum if 10 percent of users overstate their drug use.

9. Figure C shows how cost estimates vary with the percentage of 'recreational' users that overstate their drug use using the mid-point estimate of 900 people needing treatment and including estimated investment costs for additional capacity.

Figure C: Drug assessment and treatment costs with limited capacity