JULY 2011 NZ DRUG FOUNDATION POLICY BRIEFING ON

Welfare Reform and Substance Use

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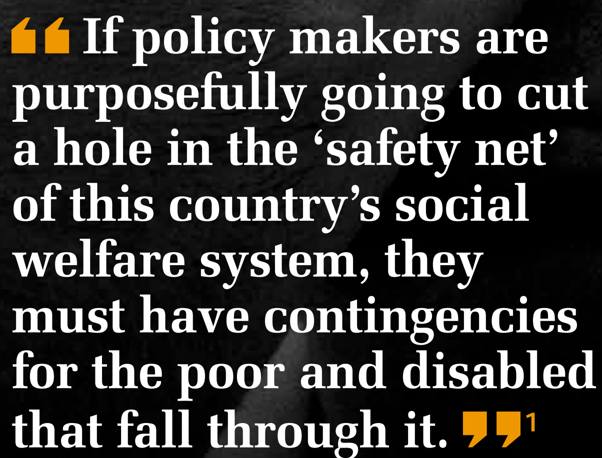


“If policy makers are purposefully going to cut a hole in the ‘safety net’ of this country’s social welfare system, they must have contingencies for the poor and disabled that fall through it.”[1]

[1] Hogan SR, Unick GJ, Speiglman R, Norris JC. Social Welfare Policy and Public Assistance for Low-Income Substance Abusers: The Impact of 1996 Welfare Reform Legislation on the Economic Security of Former Supplemental Security Income Drug Addiction and Alcoholism Beneficiaries. J Sociol Soc Welf. 2008;35(1):221-245.

Background

This briefing has been influenced by our guiding principles, including a commitment to evidence-based best practice and policy, and harm minimisation, in its broadest sense. Information about the Drug Foundation is appended to this policy briefing.

THIS POLICY briefing has been developed by the New Zealand Drug Foundation in response to the release of 'Reducing Long-Term Benefit Dependency', a report to the government by the Welfare Working Group (WWG).[2] It reflects the Drug Foundation's particular concerns about the recommendations made by the WWG to address the complex issue of substance use in people receiving welfare assistance.

The WWG was asked to make practical recommendations on how to reduce long-term welfare dependency for people of working age, in order to achieve better social and economic outcomes for people on welfare, their families and the wider community. While we strongly endorse the WWG's recommendation for more rapid access to publicly funded drug and alcohol rehabilitation services, we have major concerns with the overall thrust of its recommended approach towards addressing alcohol and drug use in people receiving a welfare benefit.

We also suggest that improved access to drug and alcohol services be made a high priority for all New Zealanders with problematic drug and alcohol use, not just for those people receiving welfare benefits. Currently, there is a huge gap between the level of existing drug and alcohol services and the level of need. In 2008, the National Committee for Addiction Treatment estimated that the capacity of addiction services needs to at least double to enable those most severely affected by addiction to gain timely access to treatment.[3]

“We strongly endorse the WWG's recommendation for more rapid access to publicly funded drug and alcohol rehabilitation services for people on welfare.”

[2] Rebstock P et al. on behalf of the Welfare Working Group. Reducing Long-Term Benefit Dependency. Wellington, February 2011.

[3] National Committee for Addiction Treatment. Investing in addiction treatment: a resource for funders, planners, purchasers and policy makers. Christchurch, 2008.

Key concerns about the Welfare Working Group's recommendations

“The use of a graduated sanctions regime for people with drug or alcohol dependency will lead to the further impoverishment of an already marginalised population and the reduced likelihood of successful treatment outcomes.”

ACCORDING to the WWG, the primary objective of its recommended approach to substance use and abuse in people receiving benefits is ‘to ensure drug and alcohol dependence issues are addressed so that people can sustain employment and provide a safe environment for their children’. The Drug Foundation believes that this is a worthy objective but that the approach proposed by the WWG will fail to achieve this objective. We expand on why we believe this to be the case in the sections that follow. Furthermore, our review of the evidence leads us to conclude that the use of a graduated sanctions regime for people with drug or alcohol dependency that fail to meet a ‘stronger set of rules and obligations’ will lead to adverse consequences, including further impoverishment of an already marginalised population and the reduced likelihood of successful treatment outcomes.

The WWG's main recommendations relating to substance abuse in people receiving welfare assistance are not supported by the scientific evidence or the experience of the treatment sector in New Zealand and internationally. Rather, they appear to be driven by ideology and assumptions about the nature of substance use, addiction and welfare dependence that are fundamentally misguided. This policy briefing aims to highlight the flaws in the WWG's report as they relate to addressing substance use and abuse and to suggest constructive and viable alternatives that, from our experience, are more likely to have the desired outcome of ensuring that drug and alcohol dependence issues in people receiving welfare are appropriately addressed, without exacerbating the poverty and exclusion that is already a significant issue for this population.

Most people who use drugs do NOT have addiction or dependence issues

It is important to acknowledge that only a small minority of all people who use drugs can be categorised as having problematic drug use, addiction or dependence. This is especially the case for the most widely used illicit recreational drug in New Zealand – cannabis. Nearly half the adult population has used cannabis at some point in their lives, while approximately one in seven, or the equivalent of 385,000 people, are current cannabis users.[4] Australian research has estimated that only about 10% of cannabis users meet the criteria for dependence.[5]

Of particular concern is the WWG's failure to adequately differentiate between drug use that is problematic (and could impact on ability to work) and occasional recreational drug use that does not constitute a barrier to employment and has no impact on capacity to work. This is somewhat like assuming a person who occasionally has a glass of wine in the evening should be treated the same as a person who has a drinking problem. By placing undue reliance on the role of employment-related drug testing, the WWG's proposals have the potential to create a new barrier for a group of people whose drug use doesn't compromise their workplace safety or productivity but are erroneously categorised as

4 Ministry of Health. Drug Use in New Zealand: Key Results of the 2007/08 New Zealand Alcohol and Drug Use Survey. Wellington, 2010.

5 Hall W. Challenges in reducing cannabis-related harm in Australia. Drug and Alcohol Review 2009; 28(2): 110-116.

NEARLY HALF THE ADULT POPULATION HAS USED CANNABIS AT SOME POINT IN THEIR LIVES

APPROXIMATELY **ONE IN SEVEN**, OR THE EQUIVALENT OF 385,000 PEOPLE, ARE CURRENT CANNABIS USERS

having a drug issue, subsequently labelled as such and subject to sanctions.

Employment-related drug testing cannot determine intoxication or impairment

Employment-related drug testing is associated with a host of practical, legal and ethical issues that appear to have not been given due consideration by the WWG. As employment-related drug testing lies at the heart of determining whether or not a person meets the 'stronger set of rules and obligations' proposed by the WWG, we believe that it is useful to expand on some of these issues here.

"The WWG's proposals fail to differentiate between people with problematic drug use and those for whom occasional drug use does not constitute a barrier to employment."

Drug testing can have significant negative consequences for both employers and employees. A major concern is that employment drug testing fails to determine intoxication or impairment levels.[6] Drug testing also fails to differentiate between recreational substance use and problematic substance use. As such, an occasional cannabis user could test positive despite their drug use having taken place more than one week ago, outside of work hours, and having no bearing on current workplace safety or productivity.

Other problematic aspects are that employment-related drug testing often cannot differentiate between illicit or prescribed drugs, and the testing methods themselves are of variable reliability. There are also serious legal and privacy considerations that may arise. For example, an employee may need to disclose details of their personal medical conditions to their employers, and employers may face legal challenges, given the problems with the reliability of testing. Furthermore, the more that people know about someone's addiction history, the less likely they are to give them a job even if they are suitable for the position (see demand-side challenges below).

Another consequence of work-related drug testing is that it often drives people to change their behaviour to more harmful drug use that is less detectable, such as a shift from the occasional use of cannabis to more frequent alcohol binging sessions, as alcohol has a much shorter detection period.[7]

Drug testing should be used sparingly and only as part of a comprehensive alcohol and drug programme, with appropriate safeguards, clear policy and procedures, and with the provision of education and counselling.[8]

Substance use in recipients of welfare – separating myth from reality

The extent to which problematic substance use occurs in recipients of welfare has been widely overstated. Problematic substance use is much less widespread among welfare recipients than originally thought and far less common than other serious barriers to

"A positive drug test is not an indication of a drug problem and no indication that the person needs help or treatment."

[6] National Centre for Education and Training on Addiction. Responding to Alcohol and Other Drug Related Issues in the Workplace: An Information and Resource Package. NCETA, Adelaide, South Australia, 2006; Pidd K, Roche A. Drug Testing as a response to Alcohol and Other Drug Issues in the Workplace. Information & Data Sheet 4. Workplace Drug & Alcohol Use Information & Data Series. NCETA, Flinders University, June 2006.

[7] Ibid.

[8] http://www.alcoholandwork.adf.org.au

> **Problematic substance use is much less widespread among welfare recipients than originally thought and far less common than other serious barriers to employment.**

employment. The WWG report cites a single unpublished survey by the Ministry of Health purporting to show that 32% of beneficiaries reported using illegal and recreational drugs (excluding alcohol, tobacco and BZP party pills) compared with 18% of the non-beneficiary working-age population. We urge caution in relying on the findings from this solitary unpublished survey as a basis for major policy decisions. It is important to note that the survey does not differentiate between recreational drug use and problematic drug use. It also fails to address the complex issue of causality. If more beneficiaries are using drugs, it could well be that this is precisely because of their inability to find work. For such people, drug use is not a barrier to finding work – it is a consequence of their not finding work.

Internationally, there is very little evidence for significantly higher rates of substance abuse among welfare recipients than non-welfare recipients when socio-demographic factors are controlled for. A recent review indicates that substance abuse among welfare recipients is not a major cause of continued welfare dependency.[9] There is, therefore, a real risk with the current proposals of net widening, where a large population of people with unproblematic drug use find themselves negatively labelled and forced into unnecessary treatment, swamping already strained resources and further diminishing their chances of contributing positively in society.

Other research has found that only a minority of substance users receiving welfare meet the diagnostic criteria for serious drug use disorder.[10] In the most extensive analysis of substance abuse and dependence among welfare recipients, just 3.3% of welfare recipients satisfied the DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, 4th ed.) criteria for drug abuse or dependence.[11] It is this minority who warrant attention, not the larger proportion of people whose drug use is non-problematic.

The available evidence refutes the WWG's claim that recreational drug use is a barrier to employment for an increasing number of people. With the possible exception of a small minority of people with serious drug dependency, substance use in welfare recipients is not the main barrier to their employment. Other far more important barriers exist in this population. These include factors such as concomitant psychiatric illness, poor physical health, limited educational skills, childcare concerns, transportation difficulties and language barriers.[12] Major international studies have found no statistically significant relationship between substance use and any employment-related outcomes but have demonstrated that other factors related to work experience, education and child-rearing demands are robust predictors of welfare and work trajectories.[13] Problematic substance use in people receiving welfare clearly requires a mix of services in addition to treatment.

Economic sanctions can lead to worse outcomes in people with underlying addiction

We hold grave concerns over the punitive approach that underlies the WWG's recommendation to cut benefits

9 Metsch LR, Pollack HA. Welfare reform and substance abuse. The Millbank Quarterly. 2005;83(1):65-9.

10 Jayakody R, Danziger S, Pollack H. Welfare reform, substance use, and mental health. J Health Polit Policy Law. 2000 Aug;25(4):623-51.

11 Grant B, Dawson D. Alcohol and drug use, abuse and dependence among welfare recipients. American Journal of Public Health. 1996;86(10):1450-4.

12 Metsch & Pollack, 2005; Butterworth P, Fairweather AK, Anstey KJ, Windsor TD. Hopelessness, demoralization and suicidal behaviour: the backdrop to welfare reform in Australia. Aust NZ J Psychiatry. 2006 Aug;40(8):648-56.

13 Schmidt L, Zabkiewicz D, Jacobs L, Wiley J. Substance abuse and employment among welfare mothers: from welfare to work and back again? Subst Use Misuse. 2007;42(7):1069-87.

to those who fail to attend treatment or fail to successfully complete a course of treatment. Coercive punitive approaches have been considered elsewhere and were either abandoned or led to adverse outcomes.[14]

The previous UK government's plan to introduce benefit sanctions for problematic drug users who failed to take up access to drug treatment[15] was scrapped following the election of a new government in May 2010. In part, this decision followed major concerns about issues relating to coerced health treatment, its potential to impoverish people who use drugs and that fact that it pathologises problem drug users rather than focusing on the barriers they face in accessing paid work.[16]

In the United States, the introduction of social welfare policy reforms during the mid-1990s that were intended to promote personal responsibility in people with addiction did not meet many of the original goals – a substantial proportion of people that formerly received benefits suffered increased economic hardships.[17] Furthermore, the burden of providing support to these people shifted to other sources, including non-governmental and voluntary community organisations. A more recent American report detailed how drug testing coupled with sanctions in people receiving welfare assistance was costly, ineffective and hurt families in the states where it had been tried.[18]

Threatening beneficiaries that do actually have a drug addiction problem with economic sanctions suggests a failure to understand the fundamental nature of addiction. Addiction is a chronic and relapsing condition that has been strongly associated with people who have experienced serious social and economic disadvantage and have limited social capital. Even in the best of circumstances, many people with addiction undergoing treatment fail to complete their full course and relapse. It has been estimated, for example, that fewer than 10% of people with alcohol or opioid dependence experience continuous abstinence following treatment over the long term.[19]

A common scenario in the treatment sector is for a patient with drug addiction to relapse several times before eventually successfully completing treatment. Treatment needs to be carefully planned, appropriately suited and matched to individual need and circumstances and supported by comprehensive reintegration measures to enable drug-dependent people to lead a life that is no longer drug-centred. Most people with drug addictions experience relapses at times, although many do also have significant periods of stability and improvement. The relapsing nature of addiction has not been recognised by the WWG. It is crucial to understand the nature of addiction as this has significant implications for the way treatment outcomes should be measured.

Welfare recipients are among the most psychologically vulnerable people in society.[20] Many people receiving benefits with drug or alcohol dependency are already a marginalised group facing multiple social, economic and health challenges including concomitant mental illness. Expecting this group of

14 Hogan et al., 2008.

15 Secretary of State for Work and Pensions. No one written off: Reforming welfare to reward responsibility, Cm 7363. Norwich, July 2008.

16 Grover & Paylor, 2010.

17 Hogan et al., 2008.

18 Lewis M, Kenefick E. TANF Policy Brief: random drug testing of TANF recipients is costly, ineffective and hurts families. Center for Law and Social Policy. Washington DC, February 2011.

19 Sellman D. The 10 most important things known about addiction. Addiction. 2010 Jan;105(1):6-13. Epub 2009 Aug 27.

20 Butterworth et al., 2006.

Addiction is a complex disorder that is caused by multiple genetic factors interacting with multiple environmental factors. Even in the best of circumstances, many people with addiction undergoing treatment fail to complete their full course and relapse.

people to 'meet their obligations' – to successfully complete treatment for their addiction on their first attempt or else face the threat of benefit cuts – is grossly unrealistic and not based on the experience from the treatment sector. Administrative requirements placed on such individuals need to be sensitive to and not exacerbate their current circumstances.

There is little evidence that using economic sanctions can successfully induce positive behaviour change among welfare recipients with drug or alcohol dependency issues. Indeed, punishing some of the most vulnerable sections of society by removing subsistence level welfare benefits is likely to induce negative behaviour changes, including an increase in crime and drug taking.

The application of benefit sanctions as a coercive mechanism is premised on deterrence theory, which depends on the rationality of decisions to maximise utility. Yet some people with alcohol or drug dependency do not have the capacity or resources to rationally change their behaviour even if they want to, and most lack the personal resources and support systems to sustain such behaviour change. Addiction is also associated with changes in the brain and the way individuals perceive short- and long-term goals.[21] The evidence shows that the application of benefit sanctions will not have the intended effect of encouraging all dependent users into treatment. Rather, it will leave many of them with exceptionally low or no income – a situation that undermines their likelihood for successful treatment and leads to greater levels of poverty and marginalisation.[22] Economic sanctions have also been demonstrated to increase the proportion of people who become disconnected from contact with welfare and thus miss further opportunities to be identified, assessed and treated for their underlying addiction.[23]

Most worryingly, the WWG has not indicated the outcomes it envisages for those people who, on their fourth failure to 'meet their obligations', are to receive a 13-week stand-down from their benefit. It is essential to consider the full consequences of such a draconian measure. The impact of a total cessation of income impacts well beyond the individual concerned, having adverse effects on their family, community and, ultimately, to broader society. With no other means of income, many people with severe drug addiction who are deprived of welfare assistance will resort to illicit means of securing the money to finance their condition. Were such a recommendation implemented, we would fully expect to see an increase in theft, drug dealing, begging, homelessness and possibly domestic violence.

The link between drug and alcohol addiction and crime is well recognised. Indeed, addressing drug and alcohol issues is one of four priority areas in the government's Drivers of Crime Strategy. Yet the WWG's recommendations pertaining to substance use would lead to precisely the opposite outcomes that the Drivers of Crime Strategy aims to achieve. Imposing a stand-down period on welfare benefits for people with severe drug addiction in an attempt to coerce them into treatment will undermine

[21] Academy of Medical Sciences. Brain Science, Addiction and Drugs. London: Academy of Medical Sciences, 2008.

[22] Grover & Paylor, 2010.

[23] Pollack HA, Reuter P. Welfare receipt and substance-abuse treatment among low-income mothers: the impact of welfare reform. Am J Public Health. 2006 Nov;96(11):2024-31. Epub 2006 Oct 3.

26.5%

JUST OVER A QUARTER OF ALL MĀORI HAD SUBSTANCE USE DISORDERS AT SOME TIME IN THEIR LIVES – TWICE THE NATIONAL AVERAGE OF 12.%.

the likelihood of successful treatment outcomes, exacerbate poverty and increase crime rather than decrease it.

Negative impacts for Māori

Currently, a disproportionately high proportion of working-age Māori are receiving welfare assistance compared with the non-Māori population. The WWG has identified better outcomes for Māori as a key objective of its proposed reforms. While this is to be welcomed, the WWG has failed to specifically consider how its recommendations to address substance use will impact on Māori, Pacific peoples and people living in more deprived neighbourhoods. These groups already experience disproportionate amounts of harm due to alcohol and drug use.[24]

Māori are twice as likely as other ethnic groups in New Zealand to have a substance use disorder during their lifetime. Just over a quarter (26.5%) of all Māori had substance use disorders at some time in their lives – twice the national average of 12.3%.[25] Furthermore, Māori currently do not receive sufficient help in terms of accessing treatment for drug or alcohol issues compared with non-Māori. The WWG's recommendations to remove subsistence-level welfare benefits for people deemed to be in breach of compliance with their obligations will have particularly adverse effects for Māori, Pacific peoples and the most socio-economically deprived sections of society. Rather than better addressing underlying addiction problems, the WWG's recommendations will drive even greater numbers from these population groups into poverty.

“Māori are twice as likely to have lifetime substance use disorders than other ethnic groups in New Zealand.”

Removing control over benefit payments: what is an inappropriate item and who decides?

As part of their approach to people receiving benefits with drug and alcohol issues, the WWG has recommended removing control a recipient has over their payment in some situations, including, for example, ‘to ensure that jobseeker support is spent on appropriate items which meet essential needs and not on inappropriate items such as tobacco or alcohol’. While we welcome the provision of budgeting services to all welfare recipients, the WWG's Dickensian suggestion to take away control over welfare benefits for the reason stipulated above needs serious reconsideration.

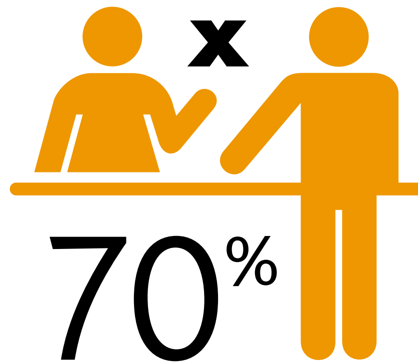
We have strong concerns over exactly what constitutes an ‘inappropriate item’ and who gets to decide. Would a service such as internet access be categorised as inappropriate? What about a mobile phone? With respect to alcohol and tobacco, are there quantifiable limits beyond which any spending is to be considered inappropriate or is any alcohol purchased by a beneficiary considered inappropriate? Would expenditure on fast food be acceptable? This is a slippery slope that we urge the government to refrain from embarking on.

“The impact of a total cessation of income impacts well beyond the individual concerned, having adverse effects on their family, community and, ultimately, to broader society.”

24 Ministry of Health, 2010.

25 Ministry of Health. Te Rau Hinengaro: The New Zealand Mental Health Survey. Wellington, 2006.

A UK SURVEY FOUND THAT TWO-THIRDS OF EMPLOYERS SAID THEY WOULD REFUSE TO EMPLOY A FORMER HEROIN OR CRACK-COCAINE USER, EVEN IF THEY WERE OTHERWISE SUITABLE FOR THE JOB.



70%

A SCOTTISH STUDY FOUND THAT OVER 70% OF EMPLOYERS WERE 'ABSOLUTELY CERTAIN THEY WOULD NOT EMPLOY SOMEONE ON A METHADONE PROGRAMME'.

For the WWG to suggest that recipients of welfare should not be allowed to purchase alcohol while the government's response to alcohol law reform indicates that it perceives the consumption of alcohol in moderation as a normal and socially beneficial activity is unfairly punitive and discriminatory towards beneficiaries. While the Drug Foundation has consistently called for stronger regulation on the sale and supply of alcohol, we do not believe that recipients of welfare should be singled out for severe enforcement measures when it comes to the risks posed by alcohol. Currently, alcohol is heavily promoted across society, and the greatest concentration of retail outlets is found in the lowest socio-economic neighbourhoods. Addressing these wider issues, including price, density of outlets and marketing, as opposed to attempting to enforce prohibition amongst a discrete group of beneficiaries should be the priority.

Demand-side challenges are significant barriers to employment

The WWG's report gives inadequate emphasis to the demand-side challenges that represent significant barriers to employment in welfare recipients who have used or continue to use drugs. Employer concerns and negative attitudes towards former and current drug users jeopardise chances of these groups finding work.[26] A UK survey found that two-thirds of employers said they would refuse to employ a former heroin or crack-cocaine user, even if they were otherwise suitable for the job.[27] A Scottish study found that over 70% of employers were 'absolutely certain they would not employ someone on a methadone programme'.[28] The proposals in the WWG report do little to combat this negativity that reduces the chances of recovered problem drug users finding work and coming off a benefit. To the contrary, the current proposals serve only to fuel negativity and social exclusion of people who use illicit drugs.

In many cases, successful treatment of problematic drug and alcohol use does not always mean an individual is fully abstinent. Furthermore, many people with opiate dependency maintain successful and productive lives while receiving prescribed methadone from the health service. UK National Treatment Agency figures for 2006–07 stated that just 3% of people who completed treatment for drug problems left drug-free (where this includes 'freedom' from prescribed substitution therapy).[29] It has been estimated that fewer than 10% of people with alcohol or opioid dependence experience continuous abstinence following treatment over the long term.[30] The WWG's proposals that promote enforced abstinence are contrary to the international evidence base for the successful treatment and management of dependent drug misuse.

[26] Singleton N, Lynam B. Policy forum – the other half of the equation: employers' readiness to recruit problem drug users. Drugs and Alcohol Today. 2009;9(1):7-11.

[27] Spencer J, Deakin J, Seddon T, Ralphs R. Getting Problem Drug Users (Back) Into Employment. Part two. London: UK Drug Policy Commission, 2008.

[28] Scott G, Sillars K. Employers' Attitudes to Hard-to-Employ Groups. Glasgow: Scottish Poverty Information Unit, 2003.

[29] Cited in DrugScope. No one written off – reforming welfare to reward responsibility. London, 2008.

[30] Sellman, 2009.

Summary and recommendations

IN 'Reducing Long-Term Benefit Dependency', the WWG has made a number of recommendations to address substance abuse in people receiving welfare benefits, with the specific objective of ensuring drug and alcohol dependence issues are addressed so that people can sustain employment and provide a safe environment for their children.

While the recommendation for more rapid access to publicly funded drug and alcohol rehabilitation services is welcome, the other main recommendations to address substance abuse are premised on fundamentally misguided assumptions about the nature of substance use, addiction and welfare dependency and not on the empirical evidence.

The threat of a graduated sanctions regime will not drive people with alcohol/drug dependency to modify their behaviour and has the potential to exacerbate poverty, increase crime and harden drug dependency in a group that is already marginalised.

Reliance on employment testing to determine whether people have met their obligations is seriously flawed. A positive drug test cannot differentiate between problematic and occasional drug use. It also fails to establish whether or not a person is intoxicated or impaired. As such, employment testing cannot differentiate between drug use outside of work that has no impact on workplace safety or productivity and problematic drug use causing intoxication or impairment at the workplace.

The rate of drug use in beneficiaries has been greatly overstated. Problematic drug use in this group accounts for only a small minority of people. Other barriers to employment such as co-existing psychiatric illness, lack of work experience or skills, childcare issues and demand-side challenges are of greater significance in this population and are more worthy of attention than drug use per se.

In considering the recommendations by the WWG on how to address substance abuse in people receiving welfare assistance, we urge the Ministerial Group on Welfare Reform to be guided by the scientific evidence and not base policy on flawed populist assumptions reflecting an ideology that drug users are best punished or coerced into treatment to become drug free.

The WWG's proposals lead us to question whether social policy analysts and employment providers have the knowledge, skills and experience to determine drug or alcohol treatment issues so fundamentally. The Drug Foundation strongly recommends that mental health and addiction treatment specialists be closely involved when formulating a response to and acting on the WWG's recommendations.

We recommend that the Ministerial Group on Welfare Reform:

1. **SUPPORT** the WWG's primary objective of ensuring that drug and alcohol dependence issues in people on welfare are addressed so that people can secure and sustain employment and provide a safe environment for their children.
2. **ACCEPT** the WWG's recommendation for additional investment in drug and alcohol treatment services to address substance dependence for people on welfare and move immediately towards implementing this.
3. **ENSURE** that expanded drug and alcohol treatment services are appropriate and meet clinical best practice standards of quality.
4. **UTILISE** the comprehensive and authoritative Law Commission report on the Review of the Misuse of Drugs Act 1975 when addressing the recommendations by the WWG pertaining to substance abuse.
5. **NOTE** that one in five adults in New Zealand currently uses cannabis and that 80% of adults use alcohol, so abstinence is unrealistic and unsustainable.
6. **NOTE** that the extent to which problematic substance use occurs in welfare recipients has been overstated.
7. **RECOGNISE** the significant difference between occasional drug use that has no impact on workplace safety or productivity and problematic drug use and note the need to make a clear distinction between these groups.

8	**CONSIDER** the full practical, legal and privacy-related implications of pursing employment-related work testing.
9	**ENSURE** that treatment needs are addressed together with other more significant barriers to employment in this population such as concomitant mental health issues, childcare needs and educational barriers.
10	**GIVE** greater emphasis to demand-side challenges by educating employers about drug use, dependency and treatment and taking measures to reduce the current levels of discrimination and stigma faced by former and current drug users.
11	**GIVE** specific consideration to how the WWG's recommendations to address substance use will impact on Māori, Pacific peoples and those living in socio-economically deprived neighbourhoods.
12	**RECOGNISE** that the consequences of a proposed welfare stand-down period include an exacerbation of poverty, reduced likelihood of treatment success and an increase in crime and that these outcomes are directly contrary to the goals of the government's own Drivers of Crime Strategy.
13	**ENSURE** budgetary guidance and support is available to all recipients of welfare but reject the recommendation to remove the control a recipient has over his/her benefit payment just because they are deemed to spend it on officially defined 'inappropriate items' such as alcohol or tobacco.
14	**INVOLVE** mental health and addiction treatment specialists when formulating welfare policy that is designed to address substance use and abuse, to ensure that such policy is appropriate for those people it will affect and reflects best clinical practice.

"Let's get beyond the political rhetoric and let's have an informed discussion between the policy makers and the public based on the knowledge base so that decisions can be made on how we structure our preventative approaches to make a healthy society."

Professor Sir Peter Gluckman,
Chief Science Advisor to the Prime Minister

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About the Drug Foundation

AT THE HEART OF THE MATTER, NZ DRUG FOUNDATION.
Te Tūāpapa Tarukino o Aotearoa

The New Zealand Drug Foundation – Te Tūāpapa Tarukino o Aotearoa – is an independent trust with a national focus on minimising drug-related harm. This includes social and health harms caused by legal drugs, such as tobacco and alcohol, as well as illegal drugs, such as cannabis.

THE Drug Foundation advocates evidence-based policy on these issues and provides reliable and credible information to organisations and individuals.

The Drug Foundation recognises that drugs, legal and illegal, are a part of everyday life experience. Drugs and their use impact on many of us and on the people we care about. Harms to individuals and families include injury, disease, social, personal and financial problems and a reduced quality of life. Harms to society include unsafe communities, increased need for law enforcement, and high health and economic costs. For these reasons, the Drug Foundation is committed to reducing drug use and its harmful consequences. This commitment to reducing harm includes ensuring that any illicit drugs, if used, are used safely.

“Our focus is on advocating for policies that build a healthy society where there is the least possible harm from drug use. All efforts to control or reduce the harm from illicit drugs must be evidence based, socially just and maintain the rights of individuals and the aspirations of communities.”

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The Drug Foundation provides leadership and representation for our nationwide membership of organisations and individuals working on alcohol and drug issues. We take a lead role in networking and co-operation within the alcohol and drug sector. The Drug Foundation is a member of the International Harm Reduction Association, the International Drug Policy Consortium and the Global Alcohol Policy Alliance.

“Recipients of welfare should not be singled out when it comes to the harms from alcohol.”