Submission No 37

INQUIRY INTO DRUG AND ALCOHOL TREATMENT

Organisation: Australia Drug Law Reform Foundation

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GENERAL PURPOSE STANDING COMMITTEE No. 2

Inquiry into drug and alcohol treatment

Australia Drug Law Reform Foundation

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Summary:

Few families in NSW have not been touched by severe alcohol and drug problems. Yet the community's response to alcohol and drug problems is as dysfunctional as individuals struggling with severe alcohol and drug problems. Effective policies are known but ignored in preference to ineffective policies as poor policy is often considered good politics. The power of the drinks industry currently blocks effective alcohol policies. The fear of an electoral backlash blocks recognition that the 'War on Drugs' has failed. There are perceived to be 'no votes in alcohol and drug treatment' yet alcohol and drug treatment is about as effective as treatments for other common, chronic complex, relapsing and remitting conditions and far more effective and cost effective than drug law enforcement. Naltrexone implants are not registered for use in Australia by the appropriate regulatory authority (TGA) and evidence for their effectiveness and safety according to a 2011 NHMRC review is modest. Placing alcohol and drug treatment services under mental health was a serious error and should be reversed. Alcohol and drug treatment services are currently grossly underfunded.

Recommendations:

Recommendation #1More emphasis is needed on smoking cessation in alcohol and drug dependent persons.

Recommendation #2 Consistent with the national commitment to harm reduction, restrictions on the availability and the costs of nicotine replacement (including e-cigarettes) should be lifted to further reduce the prevalence and costs of smoking.

Recommendation #3 NSW should press for all states and territories to be able to influence Commonwealth alcohol tax policy to consider the health and well being of the community as well as just economic factors.

Recommendation #4 Alcohol taxes should: (i) increase slightly overall; (ii) move towards being volumetric (i.e. tax based on alcohol content); (iii) introduce hypothecations with a small part of the revenue directed to improved prevention and treatment.

Recommendation #5 Consistent with the national commitment to harm reduction, restrictions on the availability and the costs of nicotine replacement (including e-cigarettes) should be lifted to further reduce the prevalence and costs of smoking.

Recommendation # 6 Recognising the gross underfunding of alcohol and drug treatment, funding should be increased to improve capacity and improve quality or detoxification, rehabilitation, counseling, community support and medical treatment for citizens of NSW in the community or under the Department of Corrective Services.

Recommendation # 7 To protect the families (including children) of drink drivers, consider providing daily supervised disulfiram (Antabuse) for recidivist drink drivers as an alternative to license suspension

Recommendation # 8 Re-define illicit drugs as primarily a health and social problem and raise funding accordingly.

Recommendation # 9 Ensure that people with drug problems who seek help are able to easily obtain attractive, effective and evidence based assistance from support services (internet, telephone, self help); detoxification; residential rehabilitation; counseling; and medically assisted treatments (including methadone and buprenorphine) for citizens of NSW in the community or under the Department of Corrective Services.

Recommendation # 10 NSW should support national endeavors to reduce consumption of prescription opioids.

Recommendation # 11 Increasing the proportion of opioid dependent people in treatment in NSW including especially substitution treatment (methadone and buprenorphine) is likely to reduce the demand for and availability of opioids on the black market.

Recommendation # 12 Reduce or eliminate the use of short-acting benzodiazepines and where used medically, limit such use to three consecutive days.

Recommendation # 13 Accept that the primary objective of alcohol and drug treatment is to <u>improve</u> health and well-being. Where abstinence is achievable and is accepted as the primary objective of the patient, it should also be the primary objective of the clinician. Clinicians (and politicians) should have the serenity to accept what cannot be changed and the wisdom to distinguish between what can and what cannot be changed.

Recommendation # 14 The Alcohol and Drug treatment field should work with but not under Mental Health.

Recommendation # 15 NSW should call for a rigorous, independent national inquiry into the regulation of naltrexone implants and the use of the Special Access Scheme.

Recommendation # 16 NSW should over 10 years raise funding for alcohol and drug treatment to reduce the disparity with mental health services from one tenth to one half.

Recommendation # 17 NSW should clearly and explicitly reject compulsory treatment for people with alcohol and drug problems apart from possible use with oversight in individuals who lack capacity due to mental illness or cognitive impairment.

Recommendation # 18 NSW should over 10 years raise funding for alcohol and drug treatment to reduce the disparity with mental health services from one tenth to one half.

Recommendation # 19 While advocates of Sweden's punitive drug policy emphasise the low levels of reported illicit drug use, they generally ignore the fact that Sweden's has high and rising drug overdose deaths compared to other countries in the EU. Sweden has less inequality than Australia and may provide better support to disadvantaged populations than Australia. Australia has little to learn from the drug policy of the United Kingdom.

Recommendation # 20 Australia has much to learn from Sweden's alcohol policy with higher taxation and less availability than Australia.

Inquiry into drug and alcohol treatment

Terms of Reference

That the General Purpose Standing Committee No 2 inquire and report on the effectiveness of current drug and alcohol policies with respect to deterrence, treatment and rehabilitation, and in particular:

1. The delivery and effectiveness of treatment services for those addicted to drugs and/or alcohol, including naltrexone treatment, with reference to the welfare and health of individuals dependent on illicit drugs and the impact on their families, carers and the community having regard for:

(a) The need for appropriate human research, ethics and Therapeutic Goods Administration approval for use of new treatments in clinical trials

(b) The current body of evidence and recommendations of the National Health and Medical Research Council

2. The level and adequacy of funding for drug and/or alcohol treatment services in NSW

3. The effectiveness of mandatory treatment on those with drug and/or alcohol addiction, including monitoring compliance with mandatory treatment requirements

4. The adequacy of integrated services to treat co - morbid conditions for those with drug and/or alcohol addiction, including mental health, chronic pain and other health problems

5. The funding and effectiveness of drug and alcohol education programs, including student and family access to information regarding the legal deterrents, adverse health and social impacts and the addictive potential of drugs and/or alcohol

6. The strategies and models for responding to drug and/or alcohol addiction in other jurisdictions in Australia and overseas, including Sweden and the United Kingdom

7. The proposed reforms identified in the Drug and Alcohol Treatment Amendment (Rehabilitation of Persons with Severe Substance Dependence) Bill 2012

The effectiveness of current drug and alcohol policies with respect to deterrence, treatment and rehabilitation:

General Comments.

 # (i) Nicotine

Tobacco is responsible for the death and disease of more Australians than any other psychoactive drug. It is also responsible for far greater costs to the economy than any other psychoactive drug. Half of all smokers will die from a tobacco-related cause. As the proportion of the Australian population who smoke has halved in the last quarter century, tobacco-related deaths have also been declining. The reduction of smoking has been the greatest public health triumph in Australia in the last half century. Most of this reduction was achieved by prevention policies including increasing the price of cigarettes, reducing the availability of tobacco, eliminating tobacco advertising and promotion and bans on smoking. As well as a reduction in the rate of initiation, the rate of quitting has also increased. Although most smokers quit on their own support for smoking cessation has contributed to the reduction in smoking prevalence. A major challenge for tobacco policy is to extend the benefits of low smoking prevalence to disadvantaged populations including Aboriginal Australians, prison inmates, alcohol and drug dependent persons and those with severe mental illness.

Recommendation #1More emphasis is needed on smoking cessation in alcohol and drug dependent persons.

Recommendation #2 Consistent with the national commitment to harm reduction, restrictions on the availability and the costs of nicotine replacement (including e-cigarettes) should be lifted to further reduce the prevalence and costs of smoking.

(ii) Alcohol

Almost every family in Australia has been touched by severe alcohol problems. Alcohol causes immense social and economic costs. These costs include considerable violent crime. Yet the prevention and treatment of alcohol problems does not receive the attention it deserves. Often bad policies are good politics. The alcohol industry blocks effective prevention measures. Governments and oppositions seem powerless to protect the public interest by standing up to the drinks industry. The division of commonwealth/state responsibilities complicates the problem of responding adequately to alcohol. The failure of the states (including NSW) to have any input into alcohol taxation by the Commonwealth represents 'vertical fiscal imbalance'. That is, poor commonwealth alcohol tax policy costs NSW a great deal (e.g. hospitals, prisons, courts, police). There is overwhelming evidence for the effectiveness of alcohol prevention policies including: (i) small increases in the price of alcohol; (ii) a volumetric tax for all alcoholic beverages; (iii) some decrease in the number of alcohol outlets; (iv) reversing the excessive liberalization of the conditions for alcohol outlets; (v) improved treatment, care and support for persons with

alcohol problems. NSW should have a voice on (i) and (ii) and has sole or major responsibility for (iii), (iv) and (v). Hypothecation of alcohol tax could provide adequate resources for improved prevention and treatment. Sadly, there are no votes in better alcohol and drug treatment. But politicians took the lead to increase funding for mental health services and will need to take the lead to sustainably increase funding for alcohol and drug treatment.

Recommendation #3 NSW should press for all states and territories to be able to influence Commonwealth alcohol tax policy to consider the health and well being of the community as well as just economic factors.

Recommendation #4 Alcohol taxes should: (i) increase slightly overall; (ii) move towards being volumetric (i.e. tax based on alcohol content); (iii) introduce hypothecations with a small part of the revenue directed to improved prevention and treatment.

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Recommendation # 7 To protect the families (including children) of drink drivers, consider providing daily supervised disulfiram (Antabuse) for recidivist drink drivers as an alternative to license suspension

(iii) Illicit drugs

(a) There is increasing recognition that the national and international criminalization of illicit drugs in the last half- century has been a comprehensive failure with rising deaths, disease, crime and corruption. The Global Commission on Drugs in 2011 and both Australia21 reports on illicit drugs in 2012 acknowledged the failure of drug prohibition. Mr Mick Palmer, former Commissioner of the Australian Federal Police, said in 2012 'Australian police are now better trained, generally better equipped and resourced and more operationally effective that at any time in our history, but, on any objective assessment policing of the illicit drug market has had only marginal impact on the profitability of the drug trade or the availability of illicit drugs.'

(b) Health and social interventions are much less expensive and much more effective than criminal justice interventions yet 75% of the $3.2 billion expended by the nine Australian governments in response to illicit drugs was allocated to law enforcement while only 17% was allocated to reducing demand (10%

prevention, 7% drug treatment) and only 1% to harm reduction (Moore, T.J. (2005). Monograph No. 01: What is

Australia's "drug budget"? The policy mix of illicit drug-related government spending in Australia. DPMP Monograph Series. Fitzroy: Turning Point Alcohol and Drug Centre). Again, bad policy has been good politics for several decades. Illicit drugs should be re-defined as primarily a health and social matter with funding raised to the levels currently allocated to drug law enforcement.

(c) Drug treatment has been substantially under-resourced in NSW for decades. The alcohol and drug field funding shortfall now is where mental health was a decade ago. Capacity should be expanded, quality improved and flexibility increased. Drug treatment should be treated like all other branches of the health care system and should be based on scientific evidence for effectiveness, safety and cost-effectiveness.

(d) Although there has been a heroin shortage in Australia since late 2000 resulting largely from decreased opium production in Burma, heroin production in Burma has been rising rapidly in recent years. As virtually all the heroin reaching Australia originates from Burma, this should be a major concern. Deaths from heroin and prescription opioid overdose have started to increase in Australia (360 deaths in 2007; 500 deaths in 2008; 612 deaths in 2009; 705 deaths in 2010). This is another reason to start increasing the funding for alcohol and drug treatment.

(e) Drug treatment is provided in NSW in an environment of prohibition. This distorts the way treatment is provided and evaluated. During alcohol prohibition in the USA (1920-1933), treatment for alcohol dependence disappeared. Treatment for alcohol dependence is not available in countries like Saudi Arabia where harsh punishment is provided for people caught drinking alcohol.

Recommendation # 8 Re-define illicit drugs as primarily a health and social problem and raise funding accordingly.

Recommendation # 9 Ensure that people with drug problems who seek help are able to easily obtain attractive, effective and evidence based assistance from support services (internet, telephone, self help); detoxification; residential rehabilitation; counseling; and medically assisted treatments (including methadone and buprenorphine) for citizens of NSW in the community or under the Department of Corrective Services.

(iv) Pharmaceutical drugs

(a) Prescription opioids and benzodiazepines are the psychoactive pharmaceutical drugs of most concern in Australia at present. Consumption of prescription opioids has been increasing for more than 15 years. Australia is following similar trends to the USA where high and increasing consumption of prescription opioids causes 15,000 overdose deaths/year and a large and increasing number of individuals seek help because of dependence on

prescription opioids. Prescription opioid overdose deaths are also increasing in Australia. This is a difficult problem requiring national leadership and involvement of commonwealth, state and territory departments of health.

Recommendation # 10 NSW should support national endeavors to reduce consumption of prescription opioids.

Recommendation # 11 Increasing the proportion of opioid dependent people in treatment in NSW including especially substitution treatment (methadone and buprenorphine) is likely to reduce the demand for and availability of opioids on the black market.

(b) Short acting benzodiazepines are a particular concern and are mainly used by young Australians. National policy is being developed for the benzodiazepines.

Recommendation # 12 Reduce or eliminate the use of short-acting benzodiazepines and where used medically, limit such use to three consecutive days.

1. The delivery and effectiveness of treatment services for those addicted to drugs and/or alcohol, including naltrexone treatment, with reference to the welfare and health of individuals dependent on illicit drugs and the impact on their families, carers and the community having regard for:

(a) The need for appropriate human research, ethics and Therapeutic Goods Administration approval for use of new treatments in clinical trials

(b) The current body of evidence and recommendations of the National Health and Medical Research Council

(a) It is important when considering drug treatment to recognize that drug dependence is a 'chronic, relapsing-remitting' condition. This means that for most people dependent on drugs like heroin, the condition lasts for many years and is often marked by periods of abstinence (remission) and sudden and often unpredictable returns to drug use (relapse). Relapse and remission occur with legal and illegal drugs. Relapse and remission also occur with many other chronic, complex, poorly understood medical conditions (e.g. asthma) and are not an indication of lack of will power or poor character.

(b) The alcohol and drug field is the most politicized area of medicine. The community generally respects the views of doctors, especially specialists. Doctors study for a basic medical degree, then spend years learning a specialty before spending decades providing treatment to thousands of patients, teaching, keeping up with advances and conducting research. But the community does not respect the views of doctors working in the alcohol and drug field. Doctors and other health care workers in the alcohol and drug field should receive the same respect as other clinicians working in other areas of medicine. No more but no less.

(c) Overall, the results of treatment for alcohol and drug problems are similar to the results achieved in many other areas of medicine dealing with chronic, complex, relapsing-remitting conditions such as obesity, diabetes, mental illness and hypertension. Many patients with alcohol and drug problems do improve. Some improve for only a short period, others for much longer. A lucky minority abstain from all drugs almost immediately following treatment and never relapse. Unfortunately, many lay people regard outcomes for a person undergoing treatment for an alcohol and drug problem who achieves less than complete and indefinite abstinence as a 'failure'. The same person often happily accepts major improvement short of total success for other medical conditions.

Recommendation # 13 Accept that the primary objective of alcohol and drug treatment is to <u>improve</u> health and well-being. Where abstinence is achievable and is accepted as the primary objective of the patient, it should also be the primary objective of the clinician. Clinicians (and politicians) should have the serenity to accept what cannot be changed and the wisdom to distinguish between what can and what cannot be changed.

(d) The placement of Alcohol and Drug Treatment under Mental Health in NSW and other states/territories in the last decade has made this difficult field even more difficult. The overwhelming majority of senior clinicians working in the alcohol and drug field (including psychiatrists) vigorously oppose this arrangement. Senior clinicians want to be able to relate closely to general practitioners, emergency departments of hospitals, public health and mental health. Alcohol and drug dependent people had already been struggling with severe stigma and discrimination. Now they also have to also struggle with the stigma and discrimination of having a mental illness. Few clinicians working in mental health have a public health perspective which is essential in the alcohol and drug field. One of the arguments for the mental health takeover of alcohol and drugs was to protect the funding for alcohol and drugs. However, there are a number of examples where funding allocated for alcohol and drugs has been used for mental health. The current arrangement simply does not work and some areas have already moved the alcohol and drug field out from mental health. The alcohol and drug field in NSW is happy to work with but not under the mental health field.

Recommendation # 14 The Alcohol and Drug treatment field should work with but not under Mental Health.

(e) Naltrexone treatment

(i) Naltrexone implants were inserted since about 2000 into thousands of young Australians even though 'Good Manufacturing Practice' (GMP) standards had not been achieved. No action was taken by the Therapeutic Goods Administration (TGA) then or since into the use of a device manufactured to standards which failed to meet GMP. Were patients informed that the product to be inserted into them did not meet TGA standards of manufacture?

(ii) As of 2013 naltrexone implants have not been approved for use in Australia by the TGA. These unapproved products have been inserted for many years into thousands of young Australians. No action was taken by the TGA then or has been since into the extensive use of an unapproved device. Were patients informed that the product to be inserted into them had not been approved by the TGA?

(iii) Dr George O'Neil, Medical Director, Go Medical Industries Pty Ltd, the manufacturer of naltrexone implants in Australia, has inserted these devices into thousands of young Australians. Did Dr O'Neil warn patients that he had a potential conflict of interest? Does Dr O'Neil warn audiences or readers of a potential conflict of interest when advocating for naltrexone implants?

(iv) Clinicians inserting naltrexone implants in Australia have generally used Category A of the Special Access Scheme because these devices have not been approved by the TGA and this scheme provides a mechanism for doctors to provide unapproved treatments for patients with a terminal illness and a short life expectancy. Category A patients are defined as 'persons who are seriously ill with a condition from which death is reasonably likely to occur within a matter of months, or from which premature death is reasonably likely to occur in the absence of early treatment'. As the mortality of heroin dependence is about 1-2% per annum, and as other recognised and effective treatments are available, this condition clearly does not satisfy the requirements of Category A of the Special Access Scheme. Why has nothing been done regarding this apparent misuse of a system designed for another and entirely legitimate purpose?

(v) There have been a number of deaths associated with naltrexone implants in NSW and a greater number of people who have survived after been admitted to hospital with life threatening complications following naltrexone implants. A 2012 NSW Coronial Inquest severely criticized naltrexone implant services provided by a Sydney clinic. The owner of the clinic has since been de-reregistered by the Psychology Tribunal. Why is this NSW Parliamentary committee considering the use of an unapproved device of uncertain benefit?

(vi) Commenting on the existing international and national naltrexone studies the NHMRC in 2011 noted that 'caution should be exercised in interpreting the results of these studies as the sample sizes were small, duration of treatment and follow-up was inadequate, the comparators are inappropriate and many studies report on the same base cohort'. No reputable researcher or clinician has challenged the findings of this review in a scientific forum. The NHMRC review concluded 'naltrexone implants are an experimental product and as such should only be used in the context of a well conducted RCT with sufficient sample size, appropriate duration of treatment and follow up, regular robust monitoring, provision of a comprehensive psychosocial treatment program, and with comparison to current best practice. Until these trials have occurred and the relevant data are available and validated, the efficacy of the treatment, alone or in comparison to conventional first line treatments, cannot be

determined'. Why is this committee considering the use of an unapproved device of uncertain benefit?

(vii) The use of naltrexone in the treatment of heroin dependence is attractive in theory. Research of high scientific and ethical standards should be conducted to determine the efficacy, safety and cost effectiveness of extended release naltrexone in the treatment of heroin dependence. Until research confirms that this is an effective and safe treatment, sustained release naltrexone (including implants) should not be used in NSW for the treatment of heroin dependence.

(viii) Australian clinicians have used naltrexone implants (also under Category A, Special Access Scheme) for a variety of conditions apart from heroin dependence. These include cigarette smoking and amphetamine dependence. The registration of these cases with Category A of the Special Access Scheme would have required these clinicians to claim that these conditions met the criteria ('serious illness with a condition from which death is reasonably likely to occur within a matter of months, or premature death is reasonably likely to occur in the absence of early treatment'). Why has no action been taken despite the apparent misuse of the Special Access Scheme?

(ix) In no other field of medicine do members of parliament presume that they have sufficient expertise to advocate for or against specific forms of treatment, especially while going against the views of the overwhelming majority of specialists in that field and against the NHMRC.

Recommendation # 15 NSW should call for a rigorous, independent national inquiry into the regulation of naltrexone implants and the use of the Special Access Scheme.

2. The level and adequacy of funding for drug and/or alcohol treatment services in NSW

Drug and alcohol services are inadequately funded. In 2003 alcohol (2.3%) and drug use (2.0%) accounted for an estimated 4.3% of the burden of disease in Australia, while tobacco and related diseases accounted for an additional 7.8% (Australian Institute of Health and Welfare 2009. Health expenditure Australia 2007–08. Canberra, Australian Institute of Health and Welfare). Health budgets are not allocated according to the burden of disease. In 2002/03 the health budget was $68,789 million of which $229.2 million was spent by Federal and State governments on drug and alcohol treatment, amounting to 0.33% of total national expenditure on health that year. That means that 0.33% is available for the treatment of conditions which account for 4.3% of the national burden of illness. In 2002/03, $558.9 million were allocated to law enforcement and $181.5 million to interdiction (Moore, T. J. (2005). What Is Australia's "Drug Budget"? The Policy Mix Of Illicit Drug---Related Government Spending In Australia. Drug Policy Modelling Project Monograph Series. Fitzroy, Turning Point Alcohol and Drug Centre). In 2004/05 the social costs of tobacco, alcohol and other drugs abuse was estimated at $55.2 billion (Collins, D. J. And H. M.

Lapsley (2008). The costs of tobacco, alcohol and illicit drug abuse to Australian society in 2004/05. Canberra, Commonwealth of Australia).

In 2009/2010 the NSW state drug and alcohol treatment budget was $140 million (http://www.health.nsw.gov.au/mhdao/pages/default.aspx). The NSW mental health budget for 2009/2010 was $1,171 million. While few would accept mental health problems are adequately resourced, the burden of disease from drug and alcohol problems (including tobacco) approximates the burden of disease of mental health problems. Mental health funding, while inadequate, is approximately ten-fold greater than the drug and alcohol budget. These figures highlight how significantly under-funded alcohol and drug treatment is in NSW.

Recommendation # 16 NSW should over 10 years raise funding for alcohol and drug treatment to reduce the disparity with mental health services from one tenth to one half.

3. The effectiveness of mandatory treatment on those with drug and/or alcohol addiction, including monitoring compliance with mandatory treatment requirements

(i) The only times when compulsory treatment is used in medicine are when an individual's capacity is impaired by cognitive impairment or mental illness;

(ii) Cognitive impairment is managed well by Guardianship Tribunals and mental illness by the Mental Health Act;

(iii) These approaches can be and are used very successfully for people with alcohol and drug problems just as they are for people with other sorts of health problems;

(iv) Compulsory treatment is not more effective than voluntary treatment but it is more expensive, reduces the civil liberties of people with alcohol and drug problems and has a history of being often abused by authorities;

(v) Severely intoxicated persons can be at short - term risk to themselves and others. Short term (< 72 hours?) compulsory care may be justifiable if used selectively and with some oversight;

(vi) Alcohol and drug treatment in Australia is currently poorly funded by any objective measure - funding an expensive and not particularly effective intervention such as compulsory treatment would put further strain on an already limited budget for a condition which affects many families in Australia;

(vii) The need for compulsory treatment in mental health and the lack of need for compulsory treatment for people with alcohol and drug problems is another reason why mental health and the alcohol and drug field do

not fit well together;

(viii) Compulsory treatment in the alcohol and drug field is much more likely to be invoked for people of low socio-economic status than for people of high socio-economic status;

(ix) If the voluntary treatment sector is forced to contract as funding is shifted to involuntary treatment, a perverse incentive is created for people to develop even more severe problems in order to qualify for assistance;

(x) Expensive and cost ineffective involuntary treatment for a small number of possibly intractable people is likely to be at the expense of less expensive, and more likely more cost effective voluntary treatment for a larger number of people with less severe and more tractable problems;

(xi) If evidence emerges in future that compulsory treatment is more effective, safer and more cost effective than voluntary treatment, then this policy should be re-considered;

(xii) Diversion from the criminal justice system to alcohol and drug treatment should be supported provided that the offender: (a) can choose between these options; and (b) has a similar choice of options within voluntary treatment of comparable quality as community members who are not under the control of the criminal justice system.

Recommendation # 17 NSW should clearly and explicitly reject compulsory treatment for people with alcohol and drug problems apart from possible use with oversight in individuals who lack capacity due to mental illness or cognitive impairment.

4. The adequacy of integrated services to treat co‐morbid conditions for those with drug and/or alcohol addiction, including mental health, chronic pain and other health problems.

(i) Poor integration is not a significant factor in the treatment in NSW of patients who have mental illness and alcohol and drug problems. The main problem is the lack of capacity caused by gross under-funding, especially of the alcohol and drug sector. In an over crowded system, complex patients presenting with more than one problem will inevitably be treated after patients with simpler problems have been dealt with first.
(ii) There should always be room for trying to improve collaboration. Effective collaboration between the alcohol and drug field is very desirable, especially with general practice, emergency departments, mental health, pain services, general medicine and public health.

5. The funding and effectiveness of drug and alcohol education programs, including student and family access to information regarding the legal

deterrents, adverse health and social impacts and the addictive potential of drugs and/or alcohol.

(i) The highly regarded NSW Alcohol and Drug Education Programme (in the Education Department) has recently been closed. The work on alcohol previously undertaken by this department is now being undertaken by *Drinkwise*, an organization which is, in effect, a branch of the alcohol beverage industry.
(ii) Community and school based education is often assumed to be highly effective. Research evidence shows that the benefits are at best modest, delayed and transient. The expectations of the community and politicians are unrealistic. Counter-tobacco advertising has contributed to the reduction in prevalence of smoking but the claims made in this advertising were accepted as realistic by the community.

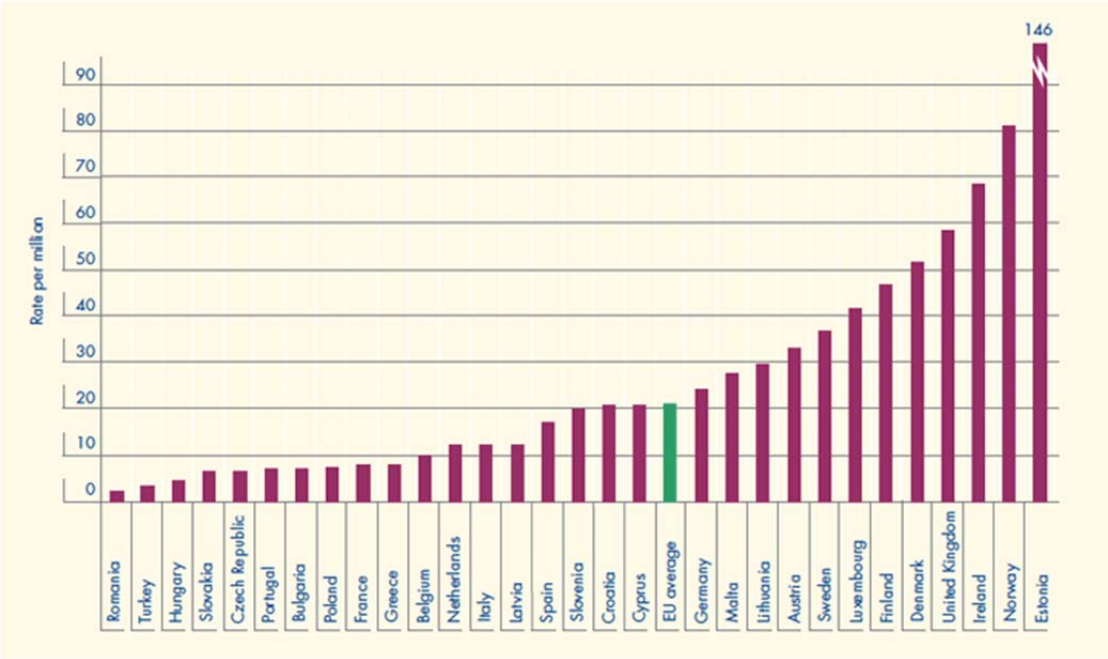
Recommendation # 18 NSW should over 10 years raise funding for alcohol and drug treatment to reduce the disparity with mental health services from one tenth to one half.

6. The strategies and models for responding to drug and/or alcohol addiction in other jurisdictions in Australia and overseas, including Sweden and the United Kingdom.

Sweden's drug policy is based on the unachievable goal of creating a drug free society. Drug prevention and education in Australia is aimed realistically at limiting experimental and occasional use. A 2006 report '*Sweden's successful drug policy: A review of the evidence'* argued that as Sweden's drug free approach had resulted in low levels of drug use, that these policies were therefore successful and should be adopted by other nations. In contrast, in the US there is a growing recognition that the harshness, expense, and ineffectiveness of U.S. drug prohibition, needs to be reviewed and alternative approaches including harm reduction, drug decriminalisation and drug legalization need to be considered.

In the late 1990s, the then Director General of the Swedish National Institute for Public Health spoke out against Sweden's tightly restricted use of methadone, stating that: "Mortality among heroin addicts is twice as high in Stockholm as in other European cities. The only treatment method that is reasonably effective, methadone, is held in check by Swedish drug policy."

(i) The United Kingdom had the 4th and Sweden the 8th highest per capita rate of drug induced deaths in the EU in 2009. In contrast, The Netherlands had the 25th highest rate. Although Sweden is often claimed to have a model which should be emulated by other countries, a vigorous debate continues in Sweden between supporters and opponents of harm reduction. Sweden is slowly adopting elements of harm reduction.



Estimated mortality rates among all adults (15-64 years) due to drug-induced deaths

http://www.emcdda.europa.eu/online/annual-report/2011/diseases-and-deaths/4

The United Kingdom (9.0 per 1,000 population) has twice the number of drug users compared to Sweden (4.0 per 1,000 population). While drug policy is important, Sweden is a more rural and the United Kingdom is a more urbanized country. Inequality is more marked in the United Kingdom than Sweden. A rural and less unequal population is likely to result in lower levels of drug use. An analysis of the number of treatment services provided in a country according to the main drug responsible for admissions provides information on the drugs that are most problematic in terms of health and social consequences and need for intervention. Sweden has one of the lowest rates of binge drinking in the EU15.

Binge drinking

Alcohol consumption in Europe is higher in countries with low levels of alcohol taxation. Studies of binge-drinking also show occasional exceptions to the north-south pattern, in particular suggesting that Sweden has one of the lowest rates of binge-drinking in the EU15.

Alcohol also contributes to health inequalities within countries, a finding that is unsurprising given the concentration of risky alcohol use in lower socioeconomic groups and the greater mortality from directly alcohol-related conditions. For example, alcohol addiction in Sweden is the 2nd most important cause of inequalities in the burden of ill-health for men (7th for women), with

several other alcohol-related diseases such as ischaemic heart disease and self-inflicted injuries also prominent .

Drinking laws

Lowering the BAC level from 0.5g/L to 0.2g/L level in Sweden in 1990 led to a reduction of fatal alcohol-related accidents by between 8% and 10% Denmark reduced its BAC from 0.8g/l to 0.5g/l on 1st March 1998. There was some evidence for a reduction in all motor vehicle injury accidents and in accidents involving a driver with a BAC of greater than 0.5g/L in 1998, compared with 1997, but no change in fatal accidents.

In 1999, 82% of Australian motorists reported having been stopped at some time, compared with 16% in the UK and 29% in the US (Williams et al. 2000). The result was that fatal crash levels dropped 22%, while alcohol-involved traffic crashes dropped 36%, and remained at this level for over four years.

Australia should follow the example of Sweden in reducing the general BAC offence threshold from 0.05 to 0.02. Points made by those who advocate lower limits include:

- Studies on the effects of Sweden's lowering of the BAC limit have reported a 10 per cent reduction in fatal crashes related to drink driving after the change.
- Previous Australian experience in lowering BAC limits suggests that the effects on drink driving behaviour were quite far-reaching. For example, when the ACT reduced the BAC limit from 0.08 to 0.05, random breath testing (RBT) showed a 34 per cent reduction in the number of drivers with a BAC between 0.15 and 0.20, and a 58 per cent reduction in the number with a BAC above 0.20.
- The age-based risk evidence suggests that extending the current zero BAC requirement for novices to all drivers under 26 years of age would prevent a significant number of deaths and serious injuries per year across Australia.
- A prescribed zero limit has the advantage of not relying on drivers' perceptions of how much alcohol they can consume to stay under a legal limit.
- As well as providing motorists with greater certainty, adoption of a general zero (or 0.02) BAC limit would strongly reinforce the message that drinking and driving should be separate activities.

Recommendation # 19 While advocates of Sweden's punitive drug policy emphasise the low levels of reported illicit drug use, they generally ignore the fact that Sweden's has high and rising drug overdose deaths compared to other countries in the EU. Sweden has less inequality than Australia and may provide better support to disadvantaged populations than Australia. Australia has little to learn from the drug policy of the United Kingdom.

Recommendation # 20 Australia has much to learn from Sweden's alcohol policy with higher taxation and less availability than Australia.

7. The proposed reforms identified in the Drug and Alcohol Treatment Amendment (Rehabilitation of Persons with Severe Substance Dependence) Bill 2012

(i) This draft Bill proposes to enable compulsory treatment with naltrexone implants for persons with alcohol and drug problems. It is astonishing that serious consideration could be given for compulsory treatment using a device not yet approved in Australia by the TGA when a 2011 NHMRC review of the evidence for naltrexone recommended that this treatment only be used within the context of a rigorous scientific clinical trial.
(ii) It is even more astonishing that this Bill could be proposed in NSW after the very negative experience of naltrexone services in this state as highlighted in a 2012 Coronial Inquest.