**Submission No 30**

# INQUIRY INTO DRUG AND ALCOHOL TREATMENT

**Organisation**: Drug Free Australia

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# DRUG FREE AUSTRALIA

submission to

NSW Parliamentary Inquiry

Drug and Alcohol Treatment

*Authorised by the Drug Free Australia (NSW) Management Committee*

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# PRELIMINARY CONSIDERATIONS

Drug Free Australia argues that all political discussion of NSW drug policy and of each of the Terms of Reference for this Parliamentary Inquiry must stay within the parameters set by the Australian community's' almost univocal disapproval of illicit drug use and decriminalisation/legalisation of illicit drugs as evidenced by community surveys. These surveys reliably reflect community values and should not be discounted and should underpin policy goals.

Importantly the DFA position is also supported by the published evidence and this forms the substantive argument that refutes much of the evidence of those who wish to decriminalise/legalise drug use or who take a harm minimisation position that declares that detoxification does not work and harm minimisation policies, such as needle exchange, supervised injecting facilities and widespread use of methadone have resulted in significant benefits to the community. We also argue that harm minimisation policies are not only not supported by the evidence, but are founded on a set of values such as . . . drug users have a right as a lifestyle choice to use drug free from interference, abstinence is an infringement of drug users rights and is coercive and that deterrents do not work and that drug use should be decriminalised or legalised. Not only are these value positions not supported by the community, they lack evidence to support them and are flawed in that they result in policies that create more harm than they mitigate.

In this submission Drug Free Australia specifically challenges both the evidence and the values that support funding for needle exchange programs, supervised injecting facilities and methadone treatment and provides evidence for the proven effectiveness of recovery-based treatment such as residential programs and naltrexone implants that accord with the values and outcomes demanded by the community.

## I. WHAT ARE AUSTRALIAN ATTITUDES TO ILLICIT DRUG USE?

Every three years the Australian Federal Government surveys 25-26,000 Australians on their attitudes to illicit drug use and illicit drug policy. In 2010, it is very evident that the vast majority of Australians do not approve of the regular use of illicit drugs such as heroin, cocaine, speed, ice, ecstasy or cannabis, as seen in Table 12.2, p 157 of the 2010

National Drug Strategy Household Survey.

**Table 12.2: Approval of regular drug use, drug thought to be of most serious concern and drugs thought to cause most deaths, people aged 14 years or older, 2007 to 2010 (per cent)**

| | Approval of regular drug use by adults | | | Most serious concern for community | | | Drug thought to cause most deaths | | |
|---|---|---|---|---|---|---|---|---|---|
| Drug | 2007 | 2010 | | 2007 | 2010 | | 2007 | 2010 | |
| Tobacco | 14.3 | 15.3 | ↑ | 17.2 | 15.4 | ↓ | 40.6 | 36.5 | ↓ |
| Alcohol[(a)] | 45.2 | 45.1 | | 32.3 | 42.1 | ↑ | 29.4 | 29.4 | |
| Cannabis | 6.6 | 8.1 | ↑ | 5.7 | 4.5 | ↓ | 1.3 | 1.0 | ↓ |
| Ecstasy | 2.0 | 2.3 | | 6.0 | 5.5 | | 5.2 | 3.9 | ↓ |
| Meth/amphetamines[(b)] | 1.2 | 1.2 | | 16.4 | 9.4 | ↓ | 5.3 | 4.6 | ↓ |
| Cocaine/crack | 1.4 | 1.7 | | 8.3 | 6.1 | ↓ | 6.8 | 5.0 | ↓ |
| Hallucinogens | 1.7 | 2.4 | ↑ | 0.5 | 0.9 | ↑ | 0.6 | 0.4 | |
| Inhalants | 0.8 | 1.0 | | 1.4 | 1.3 | | n.a. | 0.7 | |
| Heroin | 1.0 | 1.2 | | 10.5 | 11.4 | ↑ | 9.8[(c)] | 15.9[(c)] | ↑ |
| Pharmaceuticals[(d)] | 13.4 | 22.4 | n.a. | 1.4 | 2.2 | n.a. | 1.1 | 1.5 | n.a. |
| None of these | n.a. | n.a. | | 0.3 | 0.4 | | n.a. | n.a. | |
| Other | n.a. | n.a. | | n.a. | n.a. | | n.a. | 0.3 | |

(a) Question asked as 'excessive drinking of alcohol' for 'most serious concern for community'.
(b) For non-medical purposes.
(c) Other opiates are included with heroin for 'drug thought to cause most deaths'.
(d) Additional pharmaceuticals were included in the 2010 survey, so 2007 and 2010 data are not directly comparable. For this reason, significance testing was not done for these variables.

**Reasonable Inference – Australians want drug users drug-free**

If the legislature is entrusted with legally and practically shaping the community according to what Australians approve or disapprove, it appears quite clear that the overwhelming majority of Australians:

a. Do not accept or approve of illicit drug use in their community
b. Would want the legislature, by reasonable inference, not to decriminalise or legalise drug use or to imply that they condone the use of illicit drugs
c. Would want the legislature, by reasonable inference, to prioritise facilitating drug users becoming drug-free and to reduce that level of illicit drug use in the community.

## II. WHAT ARE AUSTRALIAN ATTITUDES TO DRUG INTERVENTIONS?

The 2010 National Drug Strategy Household Survey asks Australians what their attitudes are towards the various illicit drug interventions available in the community.

Table 13.10: Support[(a)] for measures to reduce the problems associated with heroin, people aged 14 years or older, by sex, 2004 to 2010 (per cent)

| | Males | | | Females | | | Persons | | |
|---|---|---|---|---|---|---|---|---|---|
| Measure | 2004 | 2007 | 2010 | 2004 | 2007 | 2010 | 2004 | 2007 | 2010 |
| Needle and syringe programs | 52.9 | 63.7 | 65.2 | 56.2 | 70.2 | 71.8 | 54.6 | 67.0 | 68.5 ↑ |
| Methadone maintenance programs | 55.9 | 64.9 | 66.2 | 60.1 | 70.5 | 72.3 ↑ | 58.0 | 67.7 | 69.3 ↑ |
| Treatment with drugs other than methadone | 58.4 | 66.2 | 67.5 | 59.9 | 70.9 | 71.3 | 59.1 | 68.5 | 69.4 |
| Regulated injecting rooms | 39.4 | 47.7 | 49.7 | 40.3 | 52.1 | 53.3 | 39.8 | 49.9 | 51.5 ↑ |
| Trial of prescribed heroin | 27.6 | 32.2 | 34.6 ↑ | 24.0 | 33.6 | 35.0 | 25.8 | 32.9 | 34.8 ↑ |
| Rapid detoxification therapy | 72.7 | 76.8 | 75.9 | 74.1 | 80.9 | 80.0 | 73.4 | 78.8 | 77.9 |
| Use of Naltrexone | 69.2 | 73.5 | 75.1 | 66.8 | 76.0 | 75.8 | 68.0 | 74.7 | 75.5 |

(a) Support or strongly support (calculations based on those respondents who were informed enough to indicate their level of support).

It is clear that while Australians compassionately support harm reduction interventions, there is greater support for the two interventions, detox and Naltrexone, which seek to get drug users drug-free.

**Reasonable Inference – Australians support harm reduction but give higher support to interventions which get drug users drug-free**

a. It is clear that Australians are compassionate toward drug users. While clearly not wanting illicit drug use in their community as indicated above, up to 70% support harm reduction measures aimed at reducing the harms of heroin use
b. In giving greater support for detox and Naltrexone, there is further confirmation that Australians prefer users to be drug-free
c. Any support for harm reduction interventions should not be construed as Australian support for that approach to harm reduction which maintains that drug users be maintained for life, with no goal of becoming drug-free
d. Drug Free Australia will contend that community support for the harm reduction measures as indicated in the above table would be significantly lower if it were not for the fact, as will be demonstrated in this document, that Australians have been consistently misinformed about the supposed success of these various harm reduction measures

## III. AUSTRALIA'S HARM REDUCTION IDEOLOGY AT ODDS WITH AUSTRALIANS

As seen above, the vast majority of Australians do not approve of the regular use of illicit drugs, and yet Australia's policy of harm reduction, operative since 1985, is premised on the notion that drug use should be accepted by Australians, nor does it focus on getting users off drugs. 'Harm reduction' is defined by the International Harm Reduction Association as,

> . . .efforts to reduce the health, social and economic costs of mood altering drugs without necessarily reducing drug consumption'.

Within Australia there is a continued discouragement of drug users becoming drug free. Dr Richard Matthews of NSW Health, giving evidence to the 2004 Legislative Council Inquiry into the Inebriates Act 1912 stated that,

> . . . we need to define "success". If success is abstinence, then there are fairly poor results for most types of dependence . . . There is good evidence, for instance, about the effectiveness of methadone maintenance in reducing crime, reducing seroconversion and reducing death, if they are your outcome measures. But if abstinence is your outcome measure, there is not terribly good evidence about anything much. It is a question of the definition of success.[1]

In the same Inquiry, Dr Richard Mattick from the National Drug and Alcohol Research Centre said,

> We have another problem when we think about drug dependence as a community. That is, that we would like to cure it. We do not think of curing necessarily other diseases such as diabetes, schizophrenia, depression or hypertension. Unless the community can get out of the notion that we will cure this disorder and only manage the other ones we will be left with a situation where we are always looking for a therapeutic ideal. It is a real problem in this area. We want to cure and we are not going to get it. We have good methods of management as we do for other disorders.

Drug Free Australia notes that drug dependence is something from which a great many do indeed recover, negating Professor Mattick's equation of drug dependence with diabetes or schizophrenia. Yet this is a philosophy entrenched within the Australian ATOD sector.

Leaders of the harm reduction movement want Australia to move on to the next step, getting rid of the prohibitions against drug use that the Australian community supports so strongly. Australia's most prominent proponent of harm reduction both nationally and internationally, responsible for introducing it to Australia in 1985, wants currently prohibited drugs made legal for personal use.

> "In many countries it is time to move from the first phase of harm reduction – focusing on reducing adverse consequences – to a second phase which concentrates on reforming an ineffective and harm-generating system of global drug prohibition."
> Dr Alex Wodak; Paper presented to the 15th International Conference on the Reduction of Drug Related Harm

Dr Lucy Sullivan, a Drug Free Australia affiliate, makes the relationship between harm reduction and drug legalisation explicit.

> The rationale behind the harm minimisation policy we actually have is that the psychopathic drugs *need not* cause harm (can be purely recreational), and therefore should not be illegal, and hence harm minimisation policy should concern itself only with drug users who have slipped over the line into abuse. On this premise, only the second component of a balanced harm minimisation policy should, logically, be activated. The possibility that the chosen policies may result in greater prevalence of usage is, therefore, inconsequential. That they may, hence, result in higher overall levels of harm is ignored or denied.

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[1] Legislative Council; Report on the Inebriates Act 1912 p 76
https://www.parliament.nsw.gov.au/Prod/parlment/committee.nsf/0/2578557b574b0450ca256f000000123b/$FILE/06%20Inebriates%20Report%20-%20Chapter%205.pdf

Many leaders of the harm reduction movement in Australia are seeking government support for new harm reduction interventions which show little interest in getting users off drugs, but rather perpetuate their drug use while spending large amounts of tax-payer funds for programs to keep them safe while their use continues. These include further injecting rooms and heroin prescription trials.

The Australian community, in its disapproval of illicit drug use, has the right to shape its community how it wishes, democratically of course through the legislature, however harm reduction has been working against their desire for a drug free community with its opposed ideology. Drug Free Australia expresses the concern that the legislature has allowed itself to be unduly influenced by self-promoting 'experts' in drug policy who work against the community's desires re drug policy, but who gain their inordinate influence via overstating and misrepresenting the value of harm reduction interventions to the public and legislature.

As previously discussed, Australians are compassionate and want to ensure that drug users will remain safe from drug harms until they become drug free, but Drug Free Australia believes most Australians would be disturbed by the current Australian harm reduction emphasis that puts no real emphasis on recovery.

# Terms of Reference 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

Drug Free Australia expresses concern in this submission regarding the inordinate overuse of methadone, where we believe there is a valid place for the treatment but where that valid place has been subverted by an ideological undermining of recovery and an overdependence on the treatment, thus prolonging drug use careers. We note that with heroin alone the average length of injecting was 5 years, yet with methadone the average length of injecting was over 20 years.[2]

## I. OVERSTATED CLAIMS FOR METHADONE'S EFFECTIVENESS

In concert with our response to Terms of Reference 2 below, where we describe considerable inaccuracies and errors in what is reported to the public about needle exchanges and the Sydney Medically Supervised Injecting Centre, there is also considerable overstatement of the effectiveness of methadone. The material below is taken from Drug Free Australia Fellow, Dr Ross Colquhoun's review of methadone effectiveness.

> According to the report of the New South Wales Chief Health Officer, "Health-related behaviours: Methadone/buprenorphine program use" methadone maintenance is declared to be an effective treatment for opioid dependence. Further, it is claimed that while methadone is the major treatment used in Australia, the risk of overdose death is substantially reduced in opiate-dependent people who are enrolled in methadone treatment (Warner-Smith at al., 2000) and that a recent study based on court appearance records in NSW shows that methadone maintenance programs are effective at controlling crime (Lind et al, 2004).
>
> However, recent research shows that these claims are not supported. Mattick, Breen, Kimber and Davoli (2009) in a review of the research literature, stated that while methadone maintenance remains the most researched treatment for this problem, and despite the widespread use of methadone maintenance

[2] Kimber *et al*, Survival and cessation in injecting drug users: prospective observational study of outcomes and effect of opiate substitution treatment. BMJ 2010;340:c3172

treatment for opioid dependence in many countries, it remains a controversial treatment+ whose effectiveness has been disputed.

The results of the study showed that “methadone appeared statistically significantly more effective than non-pharmacological approaches in retaining patients in treatment and suppressing of heroin use as measured by self report and urine/hair **analysis but not statistically different in criminal activity or mortality”** (Mattick et al., 2003).

Moreover, of those in the methadone treatment group 37% tested positive to other opiates. None of this group tested negative for opioids although some were involved in out-patient rehabilitation programs. Included in the no-treatment group were those who were treated with placebo medication, withdrawal or detoxification, drug-free rehabilitation and no treatment or wait-list controls. It would be expected that those receiving no-treatment would continue to use opiates and yet 25% of this group (all of whom were not receiving replacement therapy) were opiate free. The conclusion to be drawn is that even if minimal treatment is available many more are able to become drug free compared to the very few who are maintained on methadone even after many years of treatment and the inclusion of other interventions. A study conducted in Scotland and reported in the press confirms the very low recovery rates for people on methadone showing that “97% were still taking methadone or illegal drugs three years after receiving their first dose” (Wormersle, 2006).

In a Cochrane review of the clinical research of Mattick and colleagues (2009) report that “Methadone can cause death in overdosage, like other similar medications such as morphine, and for this reason it is a treatment which is dispensed under medical supervision and relatively strict rules”. However, there is a large black market for methadone and a lack of adherence by practitioners to the Guidelines for Prescribing Methadone severely compromises the safety of those who are put on this treatment treatment as evidenced by recent coroner’s reports ( Lowe, A., 2011; Bucci, N., 2012).

**They conclude that “evidence on reduction of criminal activity and mortality from clinical trials is lacking” and that “a number of measures (e.g., of other drug use, physical health, and psychological health) were too infrequently and irregularly reported in the literature to be usefully integrated in the quantitative review.”**

## References

.Bucci, N. **Methadone death** prompts call for overhaul. The Age, Oct 18, 2012

Colquhoun R. M. Open Label Trial of Naltrexone Implants: Measuring Blood Serum Levels of Naltrexone. Libertis Academicus, (in press), 2013

Colquhoun, R. M. The Use of Methadone or Naltrexone in Treatment of Opiate Dependence: An Ethical Approach. Journal of Global Drug Policy and Practice, 2012

Colquhoun, R. M. The Use of Naltrexone in the Treatment of Opiate Dependence. Lambert Academic, Germany, 2010
Dengenhardt, L., Randell, D., Hall, W., Butler, T., Burns, L. Mortality among clients of a state-wide opioid pharmacotherapy program over 20 years: Risk factors and lives saved,. Drug and Alcohol Dependence (2009).
Ghodse, H, Corkery, J., Ahmed, K., Niadoo, V., Oyefeso, A. and Schifano, F. Drug Related deaths in the UK. Annual Report, 2010.
Kimber J, Copeland, L., Hickman, M., Macleod, J., McKensie, J., De Angelis, D. and Robertson, J. R. Survival and cessation in injecting drug users: prospective observational study of outcomes and effect of opiate substitution treatment. British Medical Journal, 2010.

Lowe, A Coroner cautions on methadone. The Age, February 21, 2011

Mattick RP, Breen C, Kimber J, Davoli M. **Methadone maintenance therapy versus no opioid replacement therapy for opioid dependence (Review).** Cochrane Review. Cochrane Library. Issue 3, 2009
Pilgrim JL, McDonough M, Drummer OH. A review of methadone deaths between 2001 and 2005 in Victoria, Australia. Forensic Sci Int. 2013 Feb 15. pii: S0379-0738(13)00034-0. doi: 10.1016/j.forsciint.2013.01.028.

Rosen, D., Smith, M. L. and Reynolds, C. F. The Prevalence of Mental and Physical Health Disorders Among Older Methadone patients, American Journal of Geriatric Psychiatry, Vol6 (6), 2008.
Wormersle, T. .Methadone programme fails 97% of heroin addicts. The Sunday Times, October 29, 2006

## II. EFFECTIVENESS OF NALTREXONE IMPLANTS

Drug Free Australia here acknowledges Dr George O'Neil's presentation at Parliament House in 2012 for the following information.

The literature indicates the following:

- 56% of detoxed users relapse within 36 days, with mortalities[3]
- In the 1st year post residential rehab, overdose mortality is 50/1000 p/yrs[4]
- In contrast , Kelty & Hulse 2012, showed post detox opiate overdose mortality with Naltrexone Implants of 1/1000 p/yrs[5]
- Implant Naltrexone is 25 times more efficient at preventing opiate overdose deaths in the first 120 days post detox.[6]
- The risk of opiate overdose death can be reduced for 1 year with Naltrexone implants from above 50/1000 p/yrs to >1/1000 p/yrs
- The risk is higher, in excess of 50 per thousand per year, for American and British addicts recently discharged from inpatient detoxification[7]

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[3] Sannibale *et al* (2003) Aftercare attendance and post-treatment functioning of severely substance dependent residential treatment clients. Drug and alcohol review, 22, 181-190
[4] Capelhorn *et al*, Methadone Maintenance and Addicts' Risk of fatal heroin overdose . Substance Use & Misuse, 31(2), 177-196, 1996
[5] Kelty & Hulse, Examination of mortality rates in a retrospective cohort of patients treated with oral or implant naltrexone for problematic opiate use. *Addiction,* ***107, 1817–1824***
[6] Ibid.
[7] Capelhorn *et al*, Methadone Maintenance and Addicts' Risk of fatal heroin overdose . Substance Use & Misuse, 31(2), 177-196, 1996

- Patients who detox in jail or residential rehab have an extremely high risk of death, which can be prevented by Naltrexone implant administration
- Average rehab cost in NSW is $117/day $6000 would buy 51 days but implants with detox and 9-12 months protection at <1/1000 p/year mortality is at a $6000 cost.
- Ceasing methadone is 77 times safer if supported with implant naltrexone. Post detox mortality 0.6/1000 p/yrs vs. 46/1000 p/yrs.[8]

Considerations arising from the above are that the more legal and illegal opiate dependent persons in a community, the more people are at risk of being attracted into that community. Australia's selection of Harm Minimisation first and recovery as a second line of treatment has damaged detox, rehabilitation, recovery services and research funding for recovery.

The NSW Government has not, to this point in time, given adequate choices to drug users by not funding Naltrexone implants.

## III. ORCHESTRATED CAMPAIGN TO DISCREDIT NALTREXONE?

### NEPOD - 2001

In the 2001 National Drug Strategy Household Survey Naltrexone for the first time appeared amongst the survey questions addressing the Australian population's support for various interventions addressing heroin addiction. As may be expected from a population which does not approve of the regular use of heroin, cocaine, speed/ice or ecstasy (all below 3% approval) or cannabis (below 20% approval) as seen on page 9 of that year's Detailed Findings, Rapid detox received 80% approval with the newly posted Naltrexone coming in second on 75%, as compared to Methadone on 64%.

[8] Cornish *et al* (2010) Risk of death during and after opiate substitution treatment in primary care: prospective observational study in UK General Practice Research Database. BMJ. 2010 Oct 26;341:c5475

**Table 4.3: Support for heroin measures: proportion of the population aged 14 years and over, by sex, Australia, 2001**

| Measure | Males | | Females | | Persons | |
|---|---|---|---|---|---|---|
| | 1998 | 2001 | 1998 | 2001 | 1998 | 2001 |
| | | | (per cent) | | | |
| Needle and syringe programs | 46.3 | 57.8 | 53.6 | 60.2 | 50.0 | 59.0 |
| Methadone maintenance programs | 56.9 | 62.5 | 58.6 | 64.9 | 57.8 | 63.7 |
| Treatment with drugs other than methadone | 54.2 | 65.0 | 54.4 | 66.7 | 54.3 | 65.8 |
| Regulated injecting rooms | 32.3 | 44.6 | 33.9 | 45.6 | 33.1 | 45.1 |
| Trial of prescribed heroin[b] | n.a. | 35.9 | n.a. | 33.1 | n.a. | 34.5 |
| Rapid detoxification therapy | 61.3 | 79.1 | 59.2 | 80.7 | 60.3 | 79.9 |
| Use of Naltrexone[b] | n.a. | 75.4 | n.a. | 75.0 | n.a. | 75.2 |

(a) Support or strongly support.
(b) Not asked in 1998.

2001 was also the year that the National Drug Strategy Monograph 52 entitled NEPOD was released, comparing the effectiveness of methadone, buprenorphine, LAAM and most importantly, oral Naltrexone. The Naltrexone trials done by NEPOD had devastating results – against **57** other Medline Naltrexone trials over the last 25 years averaging **34%** retention at 6 months NEPOD averaged a pitiful 4% retention rate after 6 months. Regarding drug free outcomes at 6 months, **37** Medline studies averaged **52%** outcomes, but NEPOD an even more pitiful 5.6%. This study operationally appears to have done everything possible to get these appalling results. It further excluded Jon Currie's NEPOD-funded Naltrexone trial which had **62%** drug free outcomes at 6 months, rejection due to his insistence on a more rigorous abstinence testing procedure, that of a 'Naltrexone challenge' which would put individuals in the Naltrexone cohort into immediate withdrawal if they lied about not using heroin.[9] At closure, NEPOD investigators then informed the public through a heavily funded media campaign that oral Naltrexone was a failed maintenance pharmacotherapy. (See Appendix 1 for a full outline of all Medline studies cited above).

### Drs Wodak, Swan and Mattick - 2008

With the success of the Australian and Chinese implants being used by recovering Australian heroin users, misinformation on Naltrexone has been extant. On the 25th of November 2008, Dr Alex Wodak wrote 'How Did Naltrexone Slip Through the Regulatory Net?' in Crikey, "If there is uncertainty about treatment effectiveness and safety but there is a plausible case for providing the novel treatment, *rigorous research* meeting required scientific and ethical standards is required." As at the time of this statement, the following peer-reviewed journal studies had been completed.

[9] Personal conversation with Jon Currie by Gary Christian, Drug Free Australia 2003

**Blood naltrexone levels**

Arnold-Reed D, Hulse GK, Hansson RC, Murray SD, O'Neil G, Basso MR and Holman CDJ. (2003) Blood morphine levels in naltrexone exposed compared to non-naltrexone exposed fatal heroin overdoses. Addiction Biology, 8: 343-350. (Impact Factor: 4.953)

**Reduced overdose** (n=361)

Hulse, G. K., Tait, R. J. Comer S.D, Sullivan M.A. Arnold-Reed D & Jacobs I.G. (2005) Reducing Hospital Presentations For Opioid Overdose In Patients Treated With Sustained Release Naltrexone Implants. Drug Alcohol Dependence, 79; 351—357 (Impact Factor: 3.599)

**Reduced mental health events**

Ngo, H.T., Tait, R.J., Arnold-Reed, D.E., Hulse, G.K. (2007). Mental Health Outcomes Following Naltrexone Implant Treatment for Heroin-Dependence Progress in Neuro-Psychopharmacology & Biological Psychiatry , **31:** 605-612.

**Reduced hospitalisation for overdose** (n=836)

Ngo, H. T. T., Tait, R. J., & Hulse, G. K. (2008) Comparing drug-related hospital morbidity following heroin dependence treatment with methadone maintenance or naltrexone implant. **Archives of General Psychiatry,** 65 (4): 457-465. (impact factor 16)

**Reduced mortality**

Tait, R.J., Ngo, H.T.T., Hulse, G.K. (2008). Mortality in heroin users three years after naltrexone implant or methadone maintenance treatment. Journal of Substance Abuse Treatment, **35** (2): 116-124

**Tissue compatability**

Hulse GK, Stalenberg V, McCallum D, Smit W, O'Neil G, Morris N, Tait RJ. (2005) Histological changes over time around the site of sustained release naltrexone-poly(dl-lactide) implants in humans. Journal of Control Release. 2;108(1):43-55. (impact factor: 5.949)

**Biodegradability**

Hulse, G.K., Low, V.H.S., Stalenberg, V., Thompson, R.I., Tait R.J., Phan, C.T., Ngo, H.T.T., Arnold-Reed, D.E., (2008) Biodegradability of naltrexone-poly(Dl) lactide implants in vivo assessed under ultrasound in humans. Addiction Biology, 13, 364-372. (Impact Factor: 4.953)

**Dr Norman Swan**

A statement by Dr Norman Swan on The Health Report, 21st April 2008 reads, "This morning's edition of the Medical Journal of Australia has a *disturbing account of injuries* caused by what turns out to be the unapproved, unregulated use of a medication implant whose development at least in one case has been financially supported by the Federal Government." He went on to claim that Naltrexone implants were associated with higher rates of death, lower tolerance and fatal overdoses.

At issue were two papers:

Lintzeris N, Lee S, Scopelliti L, et al. Unplanned admissions to two Sydney public hospitals after naltrexone implants. Med J Aust 2008; 188: 441-444. (n=12)

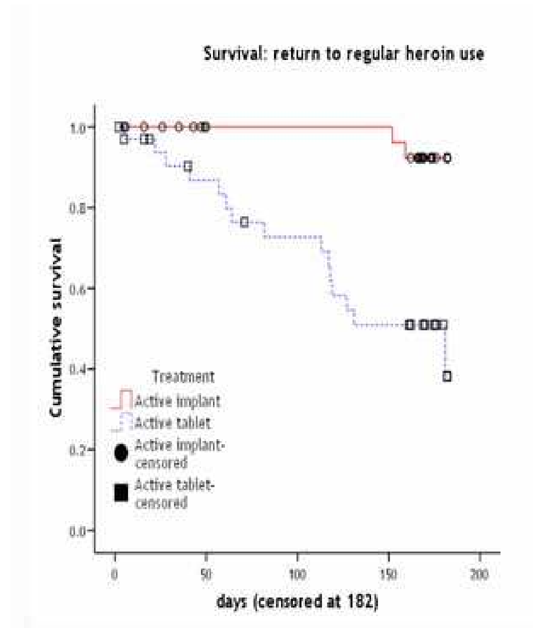
Gibson, A., Degenhardt, L., Hall, W., 2007. Opioid overdose deaths can occur in patients with naltrexone implants. Med J Aust. 186, 152-153. (NDARC n=5)

where the events cited were after the expected lifetime of the longest acting implant, after the implant had been removed or involved the use of other drugs other than heroin, and failure to examine whether the implant was of Chinese or Australian manufacture.

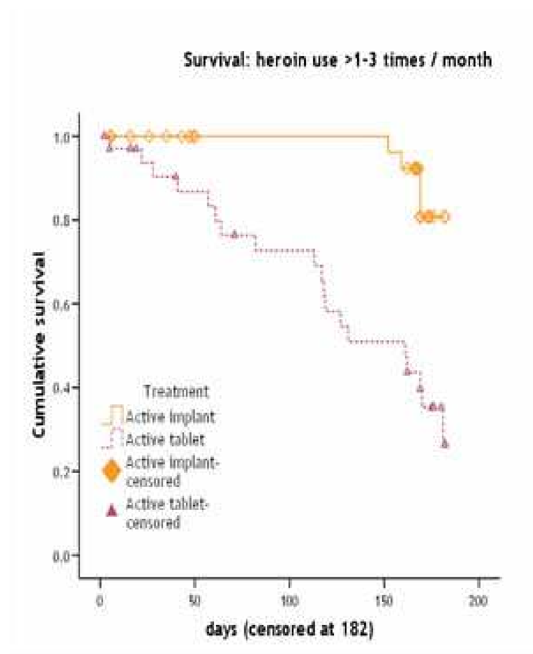
In an attack on the manufacturing quality of the GoMedical implants in April 2008 Dr Alex Wodak, et al in the Medical Journal of Australia April 2008 claimed that, "(s)ome of the implants used in Australia are produced locally, while others are manufactured overseas. There are doubts about the quality of manufacture, as well as deficiencies in the safety and efficacy." This again is misinformation aimed at the influential medical community which ignored the fact, surely well-known to the lead author, that the GoMedical implant is manufactured in a TGA approved purpose-built facility, as well as measuring up to the Good Manufacturing Code of the TGA to obtain Institutional Ethics Approval and for Clinical Trials (Annex 13).

Further, relating to the Naltrexone implant's treatment efficacy assessment, Dr Alex Wodak stated in an ABC broadcast on 31 January 2006 that, "in medicine we have a strict rule these days that until a new medical intervention has been carefully researched**,** we take the attitude that it is ineffective and unsafe until proven otherwise." The NHMRC funded a double blind randomised study from 2003 and completed 2007, where the results had been presented in 2008 at the International Society on Addiction Medicine in Cape Town, South Africa. Despite this, in June 2008 on Lateline Dr Wodak said of the research, "The paper has not been published yet in a scientific journal and so therefore it's the equivalent of hearsay in a legal, in a court of law" inferring that there was no evidence for the effectiveness of implant Naltrexone. Below are the results of the study.

**Return to most days/daily heroin use**




**Return to heroin use >1-3 times per month**




**The research**

Hulse G.K., Morris N., Arnold-Reed D. et al. Treating heroin dependence: Randomised Trial of oral or implant naltrexone. Archives of General Psychiatry: 2009, 66(10), p. 1108–1115 (Impact Factor 16)

Hulse, G.K., Hanh T. T. N., Tait R.J. (2010). Risk factors for craving and relapse in heroin users treated with oral or implant naltrexone. *Biological Psychiatry*. **68**: 296-302 (**5-Year Impact Factor:** 9.489)

Then in the Daily Advertiser, 11th April 2009, Prof Richard Mattick as Director of NDARC spoke of "the trial's small size (n=70) despite being published in one of the most prestigious peer-review medical journals globally and where to achieve a significant effect with a small sample size means there is a strong effect. This from the Director of the National Centre which published the study (n=5) on Naltrexone lack of safety in MJA where there was no denominator or information on implant type or location of manufacture.

Drug Free Australia's concern is that such misinformation on Naltrexone is not inconsistent with an orchestrated campaign by those within the pro-methadone lobby to discredit a competitor, using outright misinformation, an issue which begs investigation. If true, this would raise the question of whether methadone maintenance prescription has financed a substantial industry deriving financial proceeds from drug users who must continue to need prescription for the industry to survive and where the aim of the competitor Naltrexone, recovery, would eventually stifle the methadone industry. If the misinformation against Nalrexone has indeed been an orchestrated campaign, it will be that of a monopoly attempting to stifle a competitor, but not by fair or just means. These are serious matters for the stakeholders, the people of NSW, who in turn finance this industry through their State and Federal taxes.

# Terms of Reference 2

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

## I. PUBLIC AND POLITICIANS NOT BEING TOLD TRUTH ON THE EFFECTIVENESS OF NEEDLE EXCHANGE

For State or Federal politicians to make informed decisions on the best funding mix for illicit drug programs it is necessary for them to make their decisions on true and accurate information supported by published evidence regarding the cost effectiveness of each, rather than on demonstrably inaccurate information. Drug Free Australia therefore intends here to draw attention to its grave concerns about the high level of inaccuracy in the information on various harm reduction programs given by Australia's harm reduction lobby to the public and Australian politicians.

Appropriate examples are the two influential Federally-funded 'Return on Investment" reports measuring the cost-effectiveness of Australia's needle and syringe programs. The first 2002 study, widely publicised in the media, calculated that to that date there had been 25,000 less cases of HIV and 21,000 less cases of Hepatitis C (HCV) to that date as a result of Australian government investment in needle and syringe programs. The second 2009 report calculated a staggering 32,050 cases of HIV and 96,667 cases of HCV avoided between 2000 and 2009 which created a net saving, at lowest estimate of $1.03 billion from an investment of $243 million.

In neither of these reports was there any presentation of defensible data or statistically derived evidence on needle and syringe programs from rigorous studies, supporting any alleged success of such programs in averting HCV transmission, and where the evidence on the alleged success on HIV has in fact been scientifically inconclusive. A review of the evidence in 2006 by the highly prestigious US Institute of Medicine,[10] with its extensive panel of 24 scientists, medical practitioners and reviewers found that the study on which the first Return on Investment report was based could only 'monitor populations rather than individuals and therefore cannot establish causality' for NSPs.[11] It also stated that 'multiple studies show that (Needle and Syringe Programs) do not reduce the transmission of HCV.'[12] The second Return on Investment report had calculated the bulk of the billion dollar savings on 96,000 odd cases of HCV foregone as a result of NSPs without a shred of evidence regarding their effectiveness in reducing HCV transmission. The fact that NSPs have shown no effect with reducing HCV transmission was a fact well-known within harm reduction circles, as Australia's most prominent proponent of NSPs had written a journal

[10] US Institute of Medicine http://www.iom.edu/Reports/2006/Preventing-HIV-Infection-among-Injecting-Drug-Users-in-High-Risk-Countries-An-Assessment-of-the-Evidence.aspx

[11] Ibid, p 149

[12] US Institute of Medicine http://www.iom.edu/Reports/2006/Preventing-HIV-Infection-among-Injecting-Drug-Users-in-High-Risk-Countries-An-Assessment-of-the-Evidence.aspx p 149

article in 1997 bemoaning the lack of effectiveness re HCV transmission.[13] He had said 'Despite the success of the harm reduction/public health approach in controlling the HIV epidemic and slowing the spread of hepatitis B among IDUs in Australia, it appears not to have reduced the incidence of hepatitis C.' This admission nevertheless didn't stop the same proponent strongly promoting the 'success' of NSPs to the media when both spurious Return on Investment reports were released.

Added to this are the errors in the World Health Organisation's 2004 study on the effectiveness of needle exchanges on preventing HIV transmission by Wodak and Cooney.which found **6 of 11** relevant studies suggesting success. Swede Dr Kerstin Kall revealed in 2005 that one of the 6 positive studies assessed as such by Wodak and Cooney is marked inconclusive by its own author, another is invalid because it does not fit the criteria for inclusion, and a third is inconclusive on other demonstrable grounds. Two of the three remaining are the dubious ecological studies which the US Institute of Medicine declared as invalid in determining causality for NSPs apart from other interventions. This evidence from Dr Kall led the prestigious US Institute of Medicine to declare the success of needle exchanges inconclusive in 2006, changing from their previous position of unreserved support for the programs (see Appendix 2 for more detail).

Such lack of evidenced and stated claims of 'success' for illicit drug interventions should not and must not, in our view, be further countenanced in Australia by any State or Federal government and we implore this Inquiry not to simply take the word of so-called 'experts' in harm reduction regarding its programming without seeking a response from those promoting recovery.

## II. FUNDING THE MSIC FOR INADEQUATE OR NO OUTCOME

In light of the NSW Government having not funded the provision of well-proven, effective Naltrexone implants, Drug Free Australia is most critical of the funding, albeit from Proceeds of Crime, of the Sydney Medically Supervised Injecting Centre (MSIC), a service that offers virtually no demonstrated positive outcome but which could alternately fund Naltrexone implants with a 24 times greater impact on drug user mortality for the same dollars utilised.

The MSIC costs $2.8 million per annum, however the 2010 KPMG evaluation indicated the following outcomes relevant to drug user mortality:

- **No measurable impact on mortality** in the Kings Cross area (ie before the MSIC opened, Kings Cross OD deaths constituted 12% of all NSW OD deaths,[14] but after 8 years of MSIC operation the percentage remained at 12% - see KPMG report Table 3.1, p 19 below):

[13] Wodak, A.; "Hepatitis C: Waiting for the Grim Reaper" MJA 1997; 166: 284 http://www.mja.com.au/public/issues/mar17/wodak/wodak.html
[14] MSIC Evaluation Committee. (2003) *Final Report on the Evaluation of the Sydney Medically Supervised Injecting*

***Table 3-1: Opioid-related deaths***

| | 1998-99 | 1999-00 | 2000-01 | 2001-02 | 2002-03 | 2003-04 | 2004-05 | 2005-06 | 2006-07 | 2007-08 | 2008-09 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Kings Cross | 63 (13%) | 42 (12%) | 33 (11%) | 10 (7%) | 15 (10%) | 26 (16%) | 14 (10%) | 7 (12%) | 10 (12%) | 13 (13%) | 6 (9%) | 239 (12%) |
| Rest of NSW | 437 (87%) | 303 (88%) | 254 (89%) | 136 (93%) | 133 (90%) | 134 (84%) | 125 (90%) | 52 (88%) | 74 (88%) | 90 (87%) | 61 (91%) | 1,799 (88%) |
| **Total** | **500** | **345** | **287** | **146** | **148** | **160** | **139** | **59** | **84** | **103** | **67** | **2,038** |

*Source: NSW Division of Analytical Laboratories (DAL)*

Drug Free Australia notes that evaluations of the MSIC, which chiefly have been completed by colleagues of the MSIC's first Medical Director, have calculated from 4 (the first 2003 evaluation) to 25 deaths (SAHA 2008 evaluation) averted per year by the facility. Given the total number of ACTUAL deaths per year in Kings Cross ranging from between 10 and 26 for the whole of Kings Cross as seen from Table 3.1 above, and given that only a small fraction of injections in Kings Cross are in the MSIC (the sympathetic 2003 evaluation estimated 6,000 injections per day in Kings Cross[15] against only 150 injections daily in the MSIC), the inaccuracy of these 'saved lives'estimates can be plainly seen particularly where the SAHA evaluation calculated more lives saved per year in the MSIC than were actually lost in Kings Cross every year since 2001 except 2003/4. This highlights the point previously made about quite evidently erroneous estimates deriving from the harm reduction sector, used influentially with the public and politicians unaware of such obvious errors.

- No measurable impact on hospital presentations in the area around the MSIC – see KPMG Report p 20 where it notes that emergency presentations for overdose failed to reduce in line with emergency presentations at all other NSW hospitals, reduced by the heroin drought starting shortly before the MSIC opened in 2001:

> "Average monthly Emergency Department presentations associated with opioid poisoning also decreased following the commencement of the MSIC. However, the decrease observed was less pronounced for hospitals in the Kings Cross area (St. Vincent's Hospital and Sydney Hospital) than was observed for all other hospitals in the rest of NSW, . . . ."

- No impact on blood-borne virus transmission by the MSIC

> "In the absence of substantial data from the period prior to the MSIC commencement, it is not possible however to attribute any change in infection notifications to the operation of the MSIC."

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*Centre.* Sydney: Mattick, RP; Kaldor, J; Lapsley, H; Weatherburn, D; Wilson, D. p 58

[15] MSIC Evaluation Committee. (2003) *Final Report on the Evaluation of the Sydney Medically Supervised Injecting Centre.* Sydney: Mattick, RP; Kaldor, J; Lapsley, H; Weatherburn, D; Wilson, D. p 58

Drug Free Australia has calculated that the MSIC hosts only enough heroin injections (about 150 per day) to account for the equivalent daily injections (at least three per day) of just 50 heroin users in total, where the mortality rate of 1% or 1 in every 100 per annum yields a mortality impact for the MSIC of just 0.5 lives saved per annum. For a cost of $2.8 million, the very low benefit for high cost is very evident.

## III. NALTREXONE IMPLANT MORTALITY REDUCTIONS 24 TIMES GREATER

In contrast, the funding for the MSIC at $2.8 million per annum would equivalently fund at least 400 Naltrexone implants ($6,000 annum each with mortality of 0.1% per annum) where foregone mortality of 3% of dependent heroin users yields 12 lives saved each year, a figure 24 times higher than the current mortality reductions as a result of the presence of the MSIC.

In this scenario the NSW Government achieves an outcome 24 times greater for the impact of each dollar spent by prioritising recovery. This calculation does not consider the impacts and savings from reduced crime, or that each person who becomes drug free contributes substantially to the wealth and welfare of the community compared to the very considerable costs for each person who stays dependent on opiates.

## IV. REDUCING GOVERNMENT COSTS VIA REHABILITATION

A self-evident assumption is that a rehabilitated drug user will cease activities which are a substantial cost to government and the community. These ceased activities, with their financial implications, would include:

1. Complete cessation of crime to fund drug habit (whereas 46% of methadone patients still commit crime while in treatment)[16]
2. No need for community-provided harm reduction provisions and welfare assistance
3. Cessation of policing requirements for that individual user
4. Cessation of interdiction for that individual user
5. Cessation of incarceration
6. Cessation of use of criminal justice system
7. Possible cessation of welfare costs for a sizeable majority
8. Cessation of need for ambulance and hospital assistance
9. Cessation of drug-induced road and work accidents
10. Cessation of recruiting new users

[16] Mattick RP, Breen C, Kimber J, Davoli M. **Methadone maintenance therapy versus no opioid replacement therapy for opioid dependence (Review).** Cochrane Review. Cochrane Library. Issue 3, 2009

By contrast, drug users supported by government to use drugs safely under the aegis of harm reduction still present considerable costs to the community from:

1. Ongoing crime to fund drug habit (whereas 46% of methadone patients still commit crime while in treatment)
2. Government-financed harm reduction and welfare provisions
3. Ongoing policing requirements for each individual user
4. Ongoing interdiction costs for that individual user
5. Costs of incarceration
6. Use of criminal justice system
7. Ongoing welfare costs for a sizeable majority
8. Need for ambulance and hospital assistance including BBV treatment
9. Costs of drug-induced road and work accidents
10. Continued recruitment of new users

With the substantial financial benefits flowing to the community from recovery, and where the 2005 Drug Policy Modelling Project Monograph 1 calculated $3.2 billion spent annually (2001/2) by governments on drug-related costs, it is clear that governments would do well to invest strongly in recovery.

Where mandatory rehabilitation is offered as an alternative to incarceration it is clear that there are immediate cost savings. The cost of incarceration ($70,000 per annum according to Turning Point's Drug Policy Modelling Project Monograph 1 – What is Australia's Drug Budget? p 21) would allow up to 18 months of rehabilitation even if residential rehab is funded at $50,000 per year, a more adequate figure than current funding. Non-residential rehabilitation via the psychosocial support of social workers in the community as per the South Australian Drug Beat program would allow 15 drug users to be assisted at $5,000 per person per year. The same funding would cover the cost of Naltrexone implants for at least seven recovering drug users even when professional support costs are added to the $6,000 per annum required for the implants. Thus on one cost saving alone, ie foregone costs of incarceration, government can begin reducing the drug user population with all the additional costs to the community likewise foregone.

In summary, the cost of incarceration would alternately fund:

- 1 residential rehabilitation place for 18 months (where needed for some)
- 2 residential rehabilitation places for 9 months each
- 15 rehabilitation places in community-based psychosocial support programs for 12 months
- 7 users offered Naltrexone implants for 12 months along with extensive psychosocial support

# Terms of Reference 3

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

As discussed at the response to the Terms of Reference 6, Sweden has made mandatory rehabilitation a central plank of its national drug policy for more than 30 years and has moved Sweden from the highest level of drug use in Europe to the lowest levels amongst OECD countries over that same period. The rationale of rehabilitating drug users before they recruit new users is intuitively sensible. However the key issue is whether mandatory treatment is as, less or more effective than voluntary treatment. Drug Free Australia acknowledges the Queensland Crime and Misconduct Commission's Research and Issue Paper 7 from October 2008 'Mandatory treatment and perception of treatment effectiveness', a review of recent reviews from which material here has been drawn.

## I. CIVIL LIBERTIES AND MANDATORY TREATMENT

One of the arguments used against mandatory treatment is that human rights or civil liberties are trampled when treatment is coerced. However Drug Free Australia supports mandatory treatment where it is an alternative to incarceration, allowing a more humane rehabilitation within the community rather than separated from it. Given that a prison sentence is mandatory, there is no change in the status of civil liberties where treatment is coerced as an alternative.

The other issue, that coerced treatment of offenders will open the way to enforced treatment of non-offenders, while not an issue for any Western countries, has been an issue of concern for various United Nations bodies regarding developing countries.

## II. PERSONAL MOTIVATION NOT NECESSARY FOR SUCCESSFUL TREATMENT

One of the main contentions against mandatory treatment is the belief that a drug user must hit 'rock-bottom' before they are motivated enough to make lasting changes to their drug use. Alternately there is the view that unless a drug user has invested considerable personal motivation in seeking help with their drug problem, a successful outcome cannot be expected. These concerns are proposed as arguments against coerced treatment.

Neither of the above concerns is practically verified. For instance, the Queensland 2007 OPAL study of non-custodial offenders found that 'respondents with severe drug abuse problems are more likely than those with less

severe drug abuse problems to recognise that they have drug abuse problems*, but they are not more likely to seek treatment voluntarily or perform better in treatment*.' Further, 'Our findings do not support the current treatment philosophy of waiting for people with drug and/or alcohol abuse problems to get themselves psychologically motivated and prove their readiness to receive treatment. On the contrary, the findings indicate that mandatory treatment seems a promising option to help offenders with drug and alcohol abuse problems.'[17] The same study found rates of satisfaction with treatment to be roughly the same for those undertaking voluntary treatment or mandatory treatment.

A major objection to mandatory treatment has been the 1982 Prochaska and DiClemente's trans-theoretical model whereby a person moves through five stages of behavioural change. Various studies use this model to argue against mandatory treatment, suggesting that a person must move naturally through the early stages before they will be motivated enough to seek help, but it is important to recognise that the model does not suggest that people in the earliest stages will not benefit from treatment, but rather that different treatment options may need to be available to change their motivation at any given stage.

While a literature review indicates that the severity of drug dependence is positively related to motivation for change, it is not related to treatment involvement or post-program success. Some studies indicated that while some clients may have been ambivalent about treatment objectives, an ambivalence which would be used by many services to debar them from involvement, their motivations can and do change once entering a program where they have learned more about their problem. Drug and alcohol users can be helped by programs to move to later stages of behavioural change, rather than awaiting the peak in motivation assumed to come after 'hitting rock-bottom.'

## III. POSITIVE OUTCOMES UNDER MANDATORY TREATMENT

The suggestion that legal coercion as an external motivation which undermines an all-important personal sense of autonomy and motivation is found to not necessarily be the case in the literature. Offenders under mandatory treatment may report perceived pressure but this does not correspond to lower motivational levels.[18] Two studies found that a third of their study group reported no feeling of legal pressure under mandatory treatment.[19]

[17] Queensland Crime and Misconduct Commission; 'Mandatory treatment and perception of treatment effectiveness, 'Research and Issue Paper 7 October 2008 p 2

[18] Stevens, A, Berto, D, Frick, U & Hunt, N 2006, 'The relationship between legal status, perceived pressure and motivation in treatment for drug dependence: Results from a European study of quasi-compulsory treatment', *European Addiction Research, 12*, pp. 197–209.

[19] Queensland Crime and Misconduct Commission; 'Mandatory treatment and perception of treatment effectiveness, 'Research and Issue Paper 7 October 2008 p 7

While some have suggested that family pressure is a superior motivation to legal coercion, the literature indicates that family pressure, rather, fluctuates more than legal pressure.[20]

Where it is assumed that positive treatment motivation will correlate with positive treatment outcomes, some studies have found that although mandatory treatment is associated with lower motivation, motivation does not significantly impact treatment outcomes.

> Ryan et al. (1995) found that legal coercion is positively related to external motivation but negatively linked to internal motivation. However, the best treatment outcomes are achieved by respondents who are high in both internal and external motivation. Maxwell (2000) also observed that people who are high in both perceived legal pressure and treatment needs are less likely to drop out. This study also found that offenders' treatment retention rates are related to the uncertainty and severity of the sanction. People entering treatment before sentencing or for minor offences are more likely to drop out.
>
> Similar results have been reported in an Australian study, which found that the length of suspended sentence is a significant predictor of the participants' retention (Freeman 2002). Freeman has suggested that the prospect of having a significant custodial sentence may motivate offenders to remain in the treatment program. A recent study conducted by Perron and Bright (2007) into persons under short-term residential (*n* = 756), long-term residential (*n* = 757) and outpatient treatment (*n* = 1181) also showed that those under legal coercion have lower dropout rates than other treatment groups. It also found that the outpatient group demonstrated the lowest rate of treatment effects (Perron & Bright 2007).[21]

Moving to the three recent literature reviews, it is observed that the findings from non-English literature were not as positive as those in the English literature.

> Some German studies reported negative effects of legal coercion on treatment retention, and results from Dutch research generally indicated that QCT did not significantly decrease the crime rate. However, QCT residential treatment in both Holland and Switzerland generally produced more positive results. The researchers concluded that their review of both English and non-English literature suggested that offenders under QCT did not perform worse in treatment than those under voluntary treatment.[22]

Drug Free Australia notes that the US' NIDA review of mandatory treatment had this to say:

> A large percentage of those admitted to drug abuse treatment cite legal pressure as an important reason for seeking treatment. Most studies suggest that outcomes for those who are legally pressured to enter treatment are as good as or better than outcomes for those who entered treatment without legal pressure. Those under legal pressure also tend to have higher attendance rates and to remain in treatment for longer periods, which can also have a positive impact on treatment outcomes.[23]

We see nothing within Australian culture which would preclude the success of mandatory treatment. It is used already as an alternative to prison with the consent of the detainee. We would however recommend to the NSW Government that it commission a NSW-wide or Australia-wide Galaxy/News/Morgan poll asking a question along these lines, 'Do you support mandatory rehabilitation for repeat illicit drug offenders as an alternative to prison?', in order that the government ascertain Australian views to mandatory treatment.

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[20] Ibid.

[21] Ibid

[22] Ibid p 8

[23] National Institute of Drug Abuse, Principles of Drug Abuse Treatment for Criminal Justice Populations 2006 p 18

# Terms of Reference 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. POST-TRAUMATIC STRESS DISORDER, DEPRESSION AND SUBSTANCE ABUSE: A CASE FOR INTEGRATED TREATMENT

The following section of Drug Free Australia's submission is an amended chapter taken from the book by Ross Colquhoun entitled "The Use of Naltrexone in the Treatment of Opiate Dependence".

Most health professionals are aware of the link between mental illness, including Post-traumatic Stress Disorder (PTSD) and Depression and Substance Abuse Disorder (SAD) and Dependency. Research outcomes, including studies of opiate addicts undergoing treatment, demonstrate the validity of this impression. Most would also be aware that to successfully deal with one the practitioner should also be able to deal with the other. However, most of us have a number of questions about how this occurs, what is the prevalence of co-morbidity, what comes first and how should we tackle the problem, concurrently or separately. Notwithstanding, most practitioners would not deny the need for the development of integrated treatment programs

In general there seems to be a high concordance for PTSD, Depression and Substance Use Disorder. About 44% of PTSD patients also suffer Substance Abuse Disorder (SAD) as a co-morbid condition. For an adolescent group exposed to violence high co-morbidity was found between PTSD and Depression as 29% of those with Depression also had symptoms of PTSD and 62% with PTSD met the criteria for Depression (Dean et al., 2003). Among Vietnam Veterans the most prevalent co-morbid condition was SA or dependence for 75% of the sample (Creamer, Burgess and McFarlane, 2001). Findings indicate that 80% of patients with lifetime PTSD, also suffer from lifetime Depression, another anxiety disorder or substance abuse or dependency (Foa et al., 2000). Lifetime prevalence rates for alcohol abuse or dependency for men with PTSD is 52%, while for woman the rate is 28% (Foa et al., 2000).

What emerges from the research is that there are clear gender differences in both the incidence and aetiology of PTSD, Depression and SAD. The incidence of exposure to traumatic events is high and is most prevalent among men, and this is found across cultures (51% of women, up to 84% of men) (Creamer, Burgess and McFarlane, 2001). Women, however, have a tendency to be more prone to suffering PTSD as a consequence of the trauma, although other factors such as pre-existing mental health problems and substance abuse tend to make people more susceptible. Lifetime prevalence of PSTD is twice as high among women, at 10.4%

compared to 5% for men (Deykin and Buka, 1997; Foa, et al., 2000). Women suffer Depression in the adult population at twice the rate of men.

There are also clear differences between the types of trauma that predict PTSD between men and women. For men accidents and witnessing others suffer injury or death predict PTSD, while for women, rape and sexual assault are more likely to lead to PTSD. The coincidence of PTSD and substance abuse/dependency, while much higher than in the general community, show clear gender differences. For women, lifetime prevalence of PTSD occurs in 2.2% to 5% of the general population, while it occurs 40% of the time for women dependent on alcohol or other drugs (Deykin and Buka, 1997). PTSD has also been linked to higher rates of criminal behaviour and substance use, which both have a higher incidence among the male population (Creamer, Burgess and McFarlane, 2001).

It was believed that among the 5% to 21% of women in the community, who have alcohol related problems, rates of childhood sexual abuse (CSA) would be much higher compared to the general population and that the link between child sexual abuse and substance abuse was well established. Rates of CSA among this treatment group were reported as ranging from 20% to 84%. Among a group of Swedish women it was found that 9.8% of the sample had experienced childhood sexual abuse and that this predicted alcohol dependency or abuse for those who had been abused before age 13, but not for those who experienced CSA before age 17. Childhood sexual abuse also significantly increased the risk for lifetime diagnosis of anxiety, but not D epression (Spak, Spak and Allebeck, 1998). In an Australian study it was found that childhood sexual abuse was not by itself a predictor of alcohol abuse. Rather alcohol abuse was predicted by other factors such as perceptions of a cold and uncaring mother, physical abuse in childhood, sexuality, and having an alcoholic partner (Fleming, Mullen, Sibthorpe, Attewell and Bammer, 1998). In both studies the researchers indicated that this was not a simple relationship, but that a range of other complex factors in the woman's background contributed to alcohol problems and that childhood sexual abuse alone is not a causative factor. They also indicated that more severe cases of CSA may be related to alcohol abuse.

However, the incidences of people who suffer psychological trauma due to a single traumatic event tend not to use substances to cope unless there is a tendency to use substances before the incident. Studies of flood victims indicated that while there was a high incidence of substance abuse before the event, no new cases were reported 16 months after, despite significant symptoms of PTSD and Major Depression. Vietnam Veterans appear to have very high levels of substance dependence, just as those who have been the victim of long-term abuse. In each case there seems to be a need to avoid or minimise the psychological pain associated with trauma and this is a learned response developed over time.

When looking from the other angle, similar gender differences emerge with Substance Use Disorder. The ratio of men to women diagnosed with SAD is about four to one, however there seems to be quite different aetiology. Men tend to develop PTSD as a result of trauma associated with drug use and there also seems to

be a correlation between the characteristics of those who are more likely to become dependent on substances and those who are more prone to experiencing trauma. Men were 1.4 times more likely to have PTSD after the onset of substance dependence (Deykin and Buka, 1997). On the other hand, there is a tendency for women to become dependent on substances as a result of trauma. More females than males (58.8% compared to 27.8%) experienced trauma before chemical dependence (Deykin and Buka, 1997). This is confirmed by my clinical experience over 10 years (Colquhoun, 2010).

For some years attempts have been made to integrate mental health and D&A services with little success. Mental illness is accepted as a disease and that treatment and recovery are not only desirable, but demanded by those with mental illness and their carers.

**It seems that harm minimization/reduction (HR) policies and a denial of the link between mental illness, and the rejection of the disease model of substance dependence by advocates of the notion that drug use is a legitimate lifestyle choice and that recovery is an outmoded and unacceptable construct has created an artificial divide that hampers the introduction of effective treatment, especially abstinence-based approaches.** However, the evidence of the link between mental illness and substance abused is conclusive and the idea that people self-medicate using drugs is well supported. It is also well established scientifically that drug dependency alters the person's brain structures and reduces the capacity to make good decisions and to jeopardise their lives in the pursuit of their drug. Much of the denial of these facts is influenced by the desire to decriminalise drug use. As such it is seen as a political program that is not supported by evidence and is driven by the values of the HR group.

To deny treatment for those who seek it, especially when substance abuse is accompanied by mental illness is to impose an ideologically driven policy that is highly prejudicial to this group who want a drug-free alternative,

Studies show that not only is naltrexone an effective treatment, but more so when assessment and treatment of psychological problems is integrated into the program. Moreover, the evidence shows that mental health and other drug use tends to improve, while those who continue with their substance abuse, including methadone become worse**. In 2006 Dean, Saunders and colleagues reported on findings from a RCT comparing a group on naltrexone to a group on methadone and showed that participants who received naltrexone did not exhibit worsening of depressive symptoms and in participants attending all follow-up assessments, there was a trend for those receiving naltrexone to exhibit an improvement in depression over time compared with the control (methadone) group. Participants who were adherent to naltrexone treatment exhibited fewer depressive symptoms than those who did not or were on methadone. They concluded that depression need not be considered a common adverse effect of naltrexone treatment or a treatment contraindication and that engaging with or adhering to naltrexone treatment may be associated with fewer depressive symptoms.**

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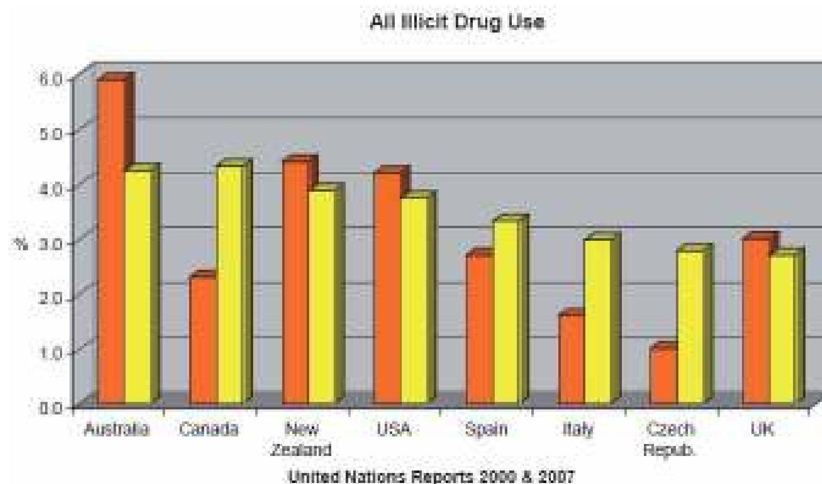
# Terms of Reference 5

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. EDUCATION MATERIALS TEACHING HOW TO USE ILLICIT DRUGS SAFELY

The Australian Drug Foundation (ADF) has for many years worked with State Government Education Departments in guiding their approach to drug and alcohol issues education. Within NSW ADF materials have been sponsored by NSW Police Blue Light discos and at various times have been made available to schools at the behest of various regional Directors of the NSW Education Department, which has received very negative publicity from the Daily Telegraph.

ADF's educational philosophy for schools, which remains entrenched in many State curricula, is that students should be taught how to use alcohol and illicit drugs safely. This clearly militates against Australian disapproval of illicit drug use. It may also be part of the explanation as to why Australia has had the highest use of illicit drugs in the developed world as per graph below derived from the United Nations World Drug Reports from 2000 and 2007.




Below is a sample of statements from the ADF website spelling out its educational philosophy.

> "There is no sign that humans are about to relinquish the pleasures of alcohol, tobacco, cannabis, heroin, and other favourite substances. Our major responsibility, I think, is to learn to manage drug use rather than pretend we can eliminate it, to limit the damage and the harms drugs cause to individuals and the broader society."
>
> "It (school education) should assist students to make sense of the world and to offer them access to the safest ways of interacting with drugs."
>
> "Schools can aim to help students to develop abilities they can use to reduce drug-related risks in their personal lives and within the community. They include knowing how to manage stressful times without resorting to drugs; how to reduce their exposure to drugs; how they can reject unwanted offers of drugs; and how they can use drugs in a manner calculated to run the least risk of harm."

> "Several drug issues are currently under consideration within the public sphere. They include the policy of harm minimisation; the legalisation and decriminalisation of marijuana; the proposed heroin trial; the morality and efficacy of substitution therapy, of needle exchanges, and lately, of the establishment of 'safe injecting' houses. I think a legitimate aim for drug education is to ensure that students can follow public discussions about those matters and take part in them. Ultimately young people will be enfranchised as citizens if they can participate in them and, as future voters, they will decide those matters."
>
> "We cannot expect to have drug-free schools until we have a drug-free society."

Most Australians would take issue with these statements, (and would be shocked that Australian school education materials openly teach this philosophy).

In Drug Free Australia's submission to this Inquiry, we believe that the safe use of drugs philosophy needs to be excised from any curricula where it may exist, and community educators who adhere to the safe use of illicit drugs, such as those provided by NDARC, be prohibited from contact with schools unless their education philosophy aligns with the desires of the Australian community which believes in there being no safe use of illicit drugs.

## II. STATE OF THE ART EDUCATION PROGRAM

In terms of the best genuine drug prevention alternative available to schools at the present, Drug Free Australia recommends 'The Truth About Drugs' as the most comprehensive and effective education resource. While produced by the Christian Science organisation, a full review of the materials by Drug Free Australia's Major Brian Watters found no religious or specifically Christian Science content or hooks in the resource.

Booklets for schools at http://www.drugfreeworld.org/download.html
Education lesson plans available at http://www.drugfreeworld.org/download.html
Documentaries available at http://www.drugfreeworld.org/download.html

# Terms of Reference 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

## I. SWEDEN

Dr Lucy Sullivan, a Drug Free Australia affiliate, in her 1999 review of Australian and Swedish drug policies, explains the drivers for Swedish drug policy.

> A comparison of drug policies in Sweden and Australia, and of drug usage and associated problems in the two countries, is highly suggestive of the comparative efficacy of the two approaches. ***Sweden**:* Sweden has, since the resurgence of psychopathic drug usage in the 1960s, adopted drug policies at various points in the spectrum of harm minimisation, and changed them in response to unpredicted outcomes (just as Australia so singularly has not). The first initiative, in the sixties, was a trial of the liberal prescription of drugs to those who claimed to be addicted, complemented by access to health care. The project was abandoned after three years because of the escalating numbers of participants, who were also found to be supplying the drugs they received to friends and traffickers. Despite ready access to drugs, the crime rate increased among those on the programme. From 1968, Swedish policy concentrated on law enforcement, treatment and education, with the goal a drug-free society, and there were increasingly severe penalties for infringement. However, in the 1970s it was again forcibly argued that it is counter-productive to target personal use. But by the mid-seventies, heroin had gained a footing for the first time, and the duty of society to intervene on behalf of the individual at risk again gained ethical precedence. Coercive care of adult drug abusers was introduced in 1982, but treatment is more generally an optional alternative to imprisonment. The coercion provided by the law and the care provided by treatment are used cooperatively. Methadone-assisted rehabilitation of heroin addicts has been implemented, with a strict limit on numbers. Drug use was criminalized in 1988, and a maximum penalty of six month's imprisonment for illicit drug use was introduced in 1993. Possession of small quantities of cannabis or amphetamines may result in only a fine, but possession of heroin or cocaine receives a strict term of imprisonment. Drug trafficking may be punished by 20 years imprisonment. Police target street trading so that known centres for obtaining drugs cannot develop. Schools and municipal social services provide extensive education against drug use. Harm minimization, in the Australian sense, has been rejected, on the grounds that such policies as needle distribution would convey an ambiguous message about society's attitude to drug abuse. The response to the HIV threat was to increase programmes of rehabilitation.

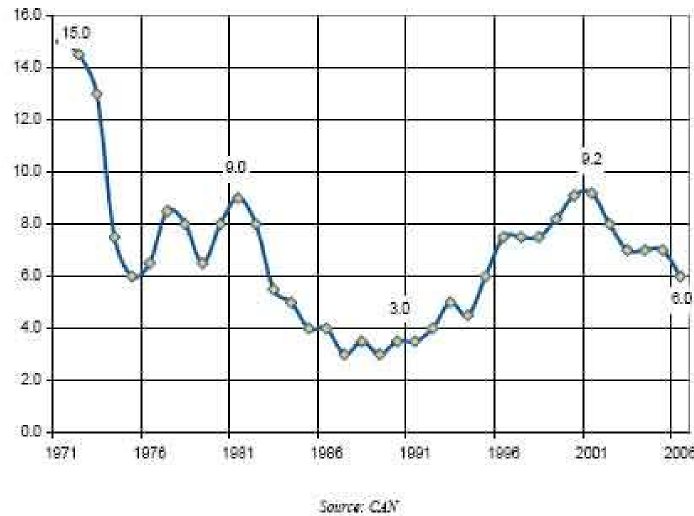
Drug Free Australia has continually emphasised the success of Sweden's recovery-based drug policy, where harm reduction is only ever tributary to abstinence-based outcomes.

Sweden's approach to harm reduction, such as methadone, is to make it available to only the most recidivist drug users, with adequately funded **mandatory rehabilitation** a feature of its drug policy. 95% of the Swedish public polled strongly support the nation's drug policy which has the support of all major political parties.

The result is that Sweden has moved from having the highest levels of drug use in Europe in the 60s and 70s to having the lowest drug use in OECD countries at the end of the 90s when worldwide comparisons first begun. The graph below shows student drug use dropping once the policy of drug education, mandatory rehabilitation and compassionate but responsible policing was introduced in the 80s. In the 90s, when Sweden was in recession and

drug rehabilitation spending was reduced, drug use can be seen to rise and then reduce once again when spending on rehabilitation was resumed.

**Figure 5:** Life-time prevalence of drug use among 15-16 year old students in Sweden, 1971-2006




The common objection that drug use most likely remained the same, but reporting of drug use decreased only out of fear of a more strongly enforced drug policy is shown to be false when actual drug offenses are compared to the above graph. The graph below of the reduction in drug offenses during the same period is indicative of real changes in drug usage during the same period.

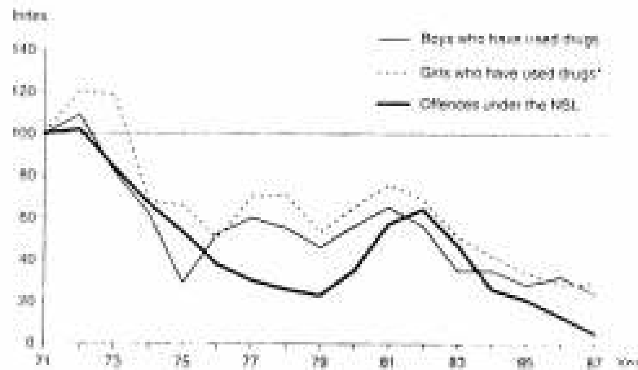
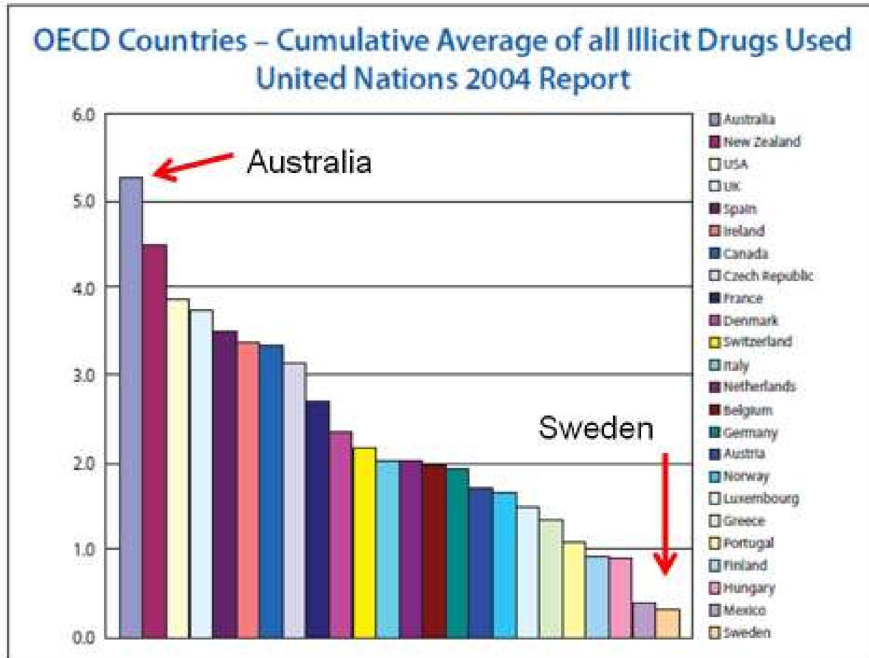


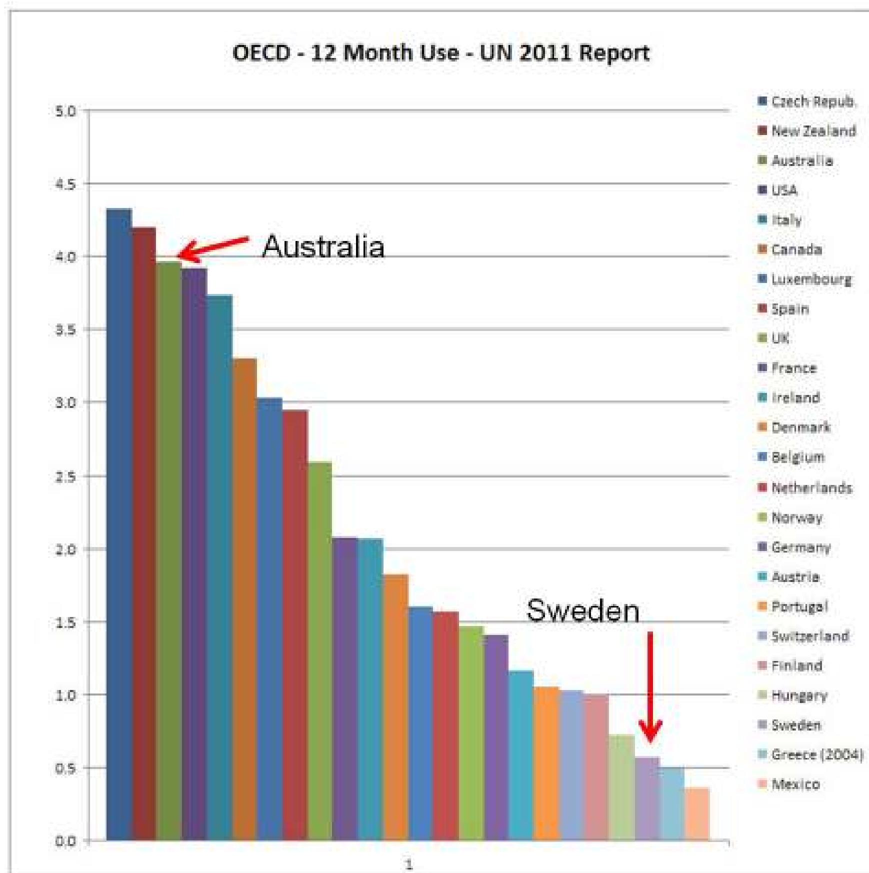

*Diagram 3. Pupils in grade 9 who have used drugs on some occasion and 16-year-olds** suspected, as 16- or 15-year-olds, of offences under the Drug Offences (Penalties) Act (NSL), 1971–1987. Index 1971=100*

* The reason for the girls' graph line being higher than the boys' is the percentages for 1971, when both indexes were put at 100. For most years, the percentage of girls who have tried narcotics is lower than the percentage of boys who have done so.

** Due to the introduction of a new age definition, the 1987 figure for persons suspected of drug offences is not comparable with figures in preceding years.

The graphs below show drug use for OECD countries from the United Nations 2000 and 2011 World Drug Reports where Sweden is the lowest in the OECD in the 2000 report and where it remains amongst the lowest (with the quality of Mexican statistics unknown).



The United Nations, in their 2007 publication, "Sweden's Successful Drug Policy: A Review of the Evidence" emphasised the success of the country's drug policy and its priority of prevention, education and rehabilitation. Objections that Sweden is culturally very different from Australia overlook the fact that standards of living and many other socio-economic factors are very similar. The objection that the Swedish public is more unified in its support of the country's drug policy is countered by the fact that so many Australians are just as united in their disapproval of regular illicit drug use, as discussed at the beginning of this submission.

## II. UNITED KINGDOM

An emphasis in the United Kingdom on harm reduction with no expectation of recovery, has as in Australia, led to some of the highest levels of drug use in the OECD. In the UN 2000 Drug Report the UK ranked fourth. However in 2006 a journal study by Dr Neil McKeganey et al which asked drug users what they most wanted from drug services found that 57% of drug users, mostly methadone patients, wanted to be assisted in becoming drug free. The abstract for this study gives better detail.

> In this paper we look at drug users' aspirations from treatment and consider whether drug users are looking to treatment to reduce their risk behaviour or to become abstinent from their drug use. The paper is based on interviews using a core schedule with 1007 drug users starting a new episode of drug treatment in Scotland. Participants were recruited from a total of 33 drug treatment agencies located in rural, urban and inner-city areas across Scotland. Our research has identified widespread support for abstinence as a goal of treatment with 56.6% of drug users questioned identifying 'abstinence' as the only change they hoped to achieve on the basis of attending the drug treatment agency. By contrast relatively small proportions of drug users questioned identified harm reduction changes in terms of their aspiration from treatment, 7.1% cited 'reduced drug use', and 7.4% cited 'stabilization' only. Less than 1% of respondents identified 'safer drug use' or 'another goal', whilst just over 4% reported having 'no goals'. The prioritization of abstinence over harm reduction in drug users treatment aspirations was consistent across treatment setting (prison, residential and community) gender, treatment type (with the exception of those receiving methadone) and severity of dependence. On the basis of these results there would appear to be a need for harm reduction services to be assiduous in explaining to clients the reason for their focus and for ensuring that drug users have access to an array of services encompassing those that stress a harm reduction focus and those that are more oriented towards abstinence.

This study got strong media interest and public support such that the current Conservative government has responded by now prioritising recovery. The passage below, from Dr McKeganey's book, "Drug Policies and Practice, provides good commentary on the Conservative Government's rationale, a rationale which Drug Free Australia ventures as being little different to the Australian drug policy milieu.

> Whilst harm reduction ideas have influenced the provision of drug treatment in the community (most notably in the growth of community-based substitute prescribing services) there has been no parallel growth in the abstinence-focused, residential rehabilitation sector. Over the period when community-based drug treatment services have expanded and the numbers of drug users in contact with those services have increased there has been a notable contraction of the residential rehabilitation sector within the United Kingdom. The Addiction Today magazine, widely circulated to those working in the drug treatment field, has been maintaining a regular tally of the number of residential rehabilitation centres that have closed within the United Kingdom over the last few years. That number presently stands at 20 (Boyd 2008, Lakhani 2009)"

The lack of provision of high-quality residential rehabilitation services within the United Kingdom is all the more striking when one recalls that both the NTORS study and the DORIS study identified the greater rate of recovery (abstinence) on the part of the residential rehabilitation services compared to the community-based drug treatment services. Within the DORIS study, for example, 6.4% of those drug users treated within the community were drug free for the 90-day period compared to 24.7% of those who were treated in a residential rehabilitation centre (McKeganey et al.2006). It is hard to avoid the conclusion that within the United Kingdom the drug treatment service that is provided with the least frequency is the one that is most closely associated with addicts becoming drug free. By comparison, the treatment that has the lowest rate of success (methadone maintenance) in terms of addicts becoming drug free is the one that is provided with the greatest frequency. By comparison the treatment that is most widely provided (methadone) is associated with the lowest likelihood of drug users becoming drug free.

Whilst methadone is perceived to be a much cheaper treatment than residential rehabilitation, it is questionable whether the economics are quite so favourable to prescribing if after long-term methadone provision the vast majority of drug users remain drug dependent. Within Scotland it has been estimated that the methadone programme may be costing the Scottish government in excess of £40 million a year but enabling less than 5 per cent of addicts to become drug free. On that basis the programme would need to be running for 5 years to attain the recovery rate being achieved within the residential rehabilitation sector (in excess of 25%). The accumulated cost of the methadone programme over that length of time would be £200 million which is a figure that would certainly sustain the development and funding of substantial residential rehabilitation provision. What may appear to be the cheaper treatment option (methadone) may actually turn out to be the more expensive option when one figures into the equation the very small percentage of drug users who will be enabled to become drug free on the basis of the treatment provided.

The May 2012 Review of the United Kingdom's 2010 drug policy changes reflect on the achievements of the new directions. The review states,

Our aim is to support people to achieve lives free from drug and alcohol dependence. Individuals, staff and services are responding to this challenge. Drug treatment outcomes are now improving with an 18% increase in the number of people leaving treatment free of dependence in 2010-11. Also, the strategy has maintained quick access to treatment with the average wait being only five days. These are promising results and we have put in place the building blocks for further success. To support the drive to recovery from addiction, last year we:

• worked with treatment professionals to change the ambition for the recovery system to one where being drug free is now the clear end goal;
• changed the incentives for treatment providers, developing new and innovative payment by results pilots for drug and alcohol in eight areas;
• developed our evidence base and advice on recovery, building a new relationship with the treatment sector through the Recovery Partnership and an expert group chaired by Professor John Strang of the National Addiction Centre;
• commissioned the Advisory Council on the Misuse of Drugs (ACMD) to provide advice on how people can best be supported to recover from dependence on drugs or alcohol through a Recovery Committee;
• put in place the building blocks to transform the commissioning and delivery of treatment and recovery services. The introduction of Public Health England in April 2013 and Police and Crime Commissioners in November this year will offer new opportunities for joint working to drive local health improvements;
• supported the treatment workforce. The Substance Misuse Skills Consortium brought together employers and professional groups to develop a suite of evidence-based tools to invest in and develop the skills of the 10,000 strong treatment workforce;
• continued to tackle drug misuse in prisons and by offenders. We launched five new Recovery Wings in prisons, invested in Integrated Offender Management to support recovery from prison back into the community and managed nearly 63,000 Class A drug users in 2010-11 through the Drug Intervention Programme, estimated to have prevented up to 680,000 crimes;

• worked to improve employment support for those in recovery. The Jobcentre Plus Offer enables staff to recognise the needs of benefit claimants in recovery and reflect them in their Jobseeker's Agreement, while the national Work Programme gives providers the freedom to offer more personalised support and provides immediate access for those leaving prison. In the next year, we will build on the success of the treatment system. We will continue to support individuals' recovery from dependence, the treatment sector and local commissioners by:
• taking recovery beyond the treatment system with employers, landlords, educational establishments, social services and others who can impact on the success of recovery;
• challenging the stigma that can be associated with dependence and that can act as a barrier to successful recovery;
• supporting commissioners to grasp the opportunity of joined up recovery services as the budgets from central government are pooled and devolved to local, accountable decision makers;
• supporting the development of funding models that incentivise the best outcomes for both individuals in treatment and wider society, such as Payment by Results;
• championing recovery by recognising the achievements of people that have turned their lives around and use their enthusiasm and inspiration to help turn around the lives of others.

Drug Free Australia commends the UK approach to the NSW Government.