Submission No 25

INQUIRY INTO DRUG AND ALCOHOL TREATMENT

Organisation: Family Drug Support

Date received: 1/02/2013

1300 368 186 FAMILY DRUG SUPPORT
Supporting families affected by alcohol and other drugs

28 February 2013

The Director
General Purpose Standing Committee No. 2
Parliament House
Macquarie St
Sydney NSW 2000

Dear Sir/Madam,

RE: NSW Drug and Alcohol Treatment Inquiry

Attached please find a submission to the NSW Legislative Council, General Purpose Standing Committee No. 2, on behalf of Family Drug Support (FDS)

Sincerely,

Tony Trimingham OAM

Founder and CEO

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NSW Legislative Council

General Purpose Standing Committee No. 2

Inquiry into Drug and Alcohol Treatment

Background to organisation making submission:

Family Drug Support (FDS) was established in 1997 to support families affected by alcohol and other drugs.

We operate the following services

a) National 1300 number – last year took 28000 calls from affected families (68% from NSW).

b) Support groups in 17 locations around Australia (9 in NSW).

c) Structured courses – Stepping Stones and Stepping Forward

d) Website – www.fds.org.au

e) Production of resources – Guide to coping and FDS Insight

f) Run community and school education programmes

g) Train volunteers – currently 140 on roster

h) Bereavement support

Attached is our Annual Report with details of our activities.

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FDS has received many Awards and accolades

a) Founder Tony Trimingham received an Order of Australia Medal

b) He won the Prime Ministers Award in 2008 for Excellence in reducing Drug and Alcohol harm

c) He was inducted into the Australian Drug Awards Honour Roll in 2013

d) He won the Australian Drug Foundation Individual Award in 2001

e) He won the Humanitarian Society Award for 'Law, Social Justice and Community' in 2005

f) He won the National Rolleston Award at the Melbourne Harm Reduction Conference in 2005

g) FDS won the National Prevention Award in 2008 at the National Drug and Alcohol Awards

h) FDS have received several other Awards and commendations

FDS has approximately 2500 subscribers and has held places on key bodies including ANCD, ADCA, and NADA over the past 17 years.

Tony Trimingham is in demand both nationally and internationally as a keynote presenter at major conferences. He has written a book 'Not My Family – Never My Child'.

FDS works in partnership with most treatment, education, drug user and research bodies across Australia and strongly supports the Australian Harm Reduction approach and the importance of evidence based policy. We advocate for families to have greater recognition, support and voice in policy. We believe that there is a need to reduce shame and stigma by responsible media reporting.

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The following is a response to each of the terms of reference:

1. *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:*
   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:

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

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

FDS does not believe naltrexone implants and rapid detox currently should be adopted due to the high rate of mortality, high cost, lack of international evidence of benefit and lack of long term benefit to clients despite the hype of success. We believe the entrepreneurial efforts of naltrexone promoters have damaged the potential benefits of naltrexone treatment.

Apart from a lack of evidence for their benefit, there is some evidence of harm and we note the findings from a recent Coronial investigation into the Psych n Soul clinic here in Sydney. We would also note available guidelines from NSW Health regarding the experimental nature of these treatments and lack of approval for their use by relevant regulatory authorities. Why naltrexone is particularly mentioned in this term of reference is perplexing especially when it is so controversial and most experts regard it negatively.

FDS supports a view of health as more than just the absence of disease, as espoused in the World Health Organisation constitution, and as a 'state of complete physical, mental and social wellbeing'. We support health services that are ethically delivered where the rights of the patient are recognised and respected. We believe that care should be patient centred and evidence based. Further, we believe that drug dependence is best dealt with as a health issue rather than a legal one.

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FDS supports a more balanced approach to funding and certainly agree that all models of treatment – including pharmacotherapy, should be better resourced. We should not leave harm reduction services – needle and syringe programs – out of the funding equations. Over 90% of alcohol and drug users are not seeking treatment at any time. These people and their families have rights to health and human rights resources.

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

Most of the drug budget goes to supply reduction measures rather than harm reduction measures, despite evidence of their efficacy. Most of the health budget goes to other areas, and despite high burden of disease, drugs do not receive their adequate share. Additionally, given the social determinants of health and our knowledge that it is the significantly disadvantaged who suffer disproportionately with opiate addiction especially, there is argument based on equity for improved health funding and improved access for D&A services.

Apart from this principle there is no evidence that mandatory or forced treatment is effective in the long term. We have seen many examples of full recovery, reduced drug use, control of drug use and better health after people have reached a point of determination. Strategies that keep people alive are critical for this to be achieved. FDS supports a non-punishment approach and particularly applauds drug courts and merit programs.

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

FDS does not support mandatory, coerced or compulsory treatment for addiction. We would point to WHO guidelines which clearly state that 'in line with the principle of autonomy, patients should be free to choose whether to participate in treatment'. The only exception to this is of course where mental illness means a person poses a significant threat to themselves or others. We would also note the words of the United Nations Office on Drugs and Crime discussion paper 'From coercion to cohesion: Treating drug dependence through health care, not punishment'. It is noted here that 'Drug dependence treatment without the consent of the patient should only be

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considered a short-term option of last resort in some acute emergency situations and needs to follow the same ethical and scientific standards as voluntary-based treatment. Human rights violations carried out in the name of "treatment" are not compliant with this approach.' This message was conveyed by the address to Australia at the National Press Club by the US drug czar Gil Kerlinkowski.

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.

Of course this is a key area that affects some families and we support integration of services and policy. The system is getting better and governments have implemented recent policies that have meant fewer people 'falling through the cracks'.

A distinction should be made between major mental illnesses such as schizophrenia from depression which while debilitating does not have acute and severe consequences. Less than 8% of callers to our telephone line report mental illness or dual diagnosis whereas chronic drug users often experience some depression. The notion that you 'have to be mad to use drugs' is one that we dispute and adds to negative impacts for users and families. We also dispute that drug use inevitably leads to mental health illness.

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.

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.

The proposed reforms identified in the Drug and Alcohol Treatment Amendment Bill 2012.

Australia has had a national harm reduction approach dating back more than 25 years. Harm reduction recognises that many people throughout the world continue to use psychoactive drugs. Harm reduction aims to reduce the economic, social and health related harms associated with the use of drugs. It may complement those approaches designed to prevent or reduce overall levels of drug consumption. There is overwhelming scientific evidence to show that harm reduction interventions are successful and cost effective.

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FDS believes than an ongoing commitment to harm reduction principles is essential.

Specific examples of harm reduction programs in Australia include the Needle and Syringe Program (NSP), Opiate pharmacotherapy (also referred to as opiate substitution treatment and opiate Replacement Treatment) and the Sydney Medically Supervised Injecting Centre. Given the key health related harms associated with injecting drug use are blood borne virus transmission and drug overdose, these harm reduction programs are discussed in more detail as to their evidence base. Australia should certainly take note and learn from other countries experience and take note of positives and negatives from other jurisdictions. The experience of Portugal in decriminalising drugs is one we could learn from. Singling out Sweden and the UK from all other jurisdictions suggests a bias in the terms of reference which is not helpful.

Needle and Syringe Program NSP:

In Australia the NSP has made a significant contribution to the prevention of Hepatitis B, Hepatitis C and HIV/AIDS transmission. The rate of HIV infection among people who inject drugs in Australia has remained around 1%, compared to other countries where prevalence rates can exceed 50%.

In NSW alone it was estimated in 2009 that NSP programs had prevented 23, 324 cases of HIV/AIDS, 31, 953 cases of Hepatitis C infection and resulted in a saving of $513 million in health care costs.

While the prevalence of Hepatitis C infection among people who inject drugs has reduced in the last 5 years, it is still estimated that approximately 50% of people who inject drugs have hepatitis C infection. Cirrhosis and liver failure from chronic hepatitis C infection have become the biggest cause of liver transplantation in NSW and across Australia.

Modelling work done at the NCHECR (now Kirby Institute) estimated that in order to halve the number of new hepatitis C infections, the distribution of NSP would need to double.

We need to increase NSP to reduce incident infections and we need to scale up HCV treatment to reduce prevalent infections.

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Opiate replacement treatment ORT:

Opiate replacement treatment (ORT) has been an effective opiate addiction treatment for many years in Australia. In NSW public treatment places increased substantially after the 1999 NSW Drug Summit. ORT has been shown to very significantly improve health outcomes for the individual (reduced risk of BBV transmission, reduced risk of fatal overdose, reduced risk of suicide), and improves outcomes for the community (reduced criminal activity, reduced drug use), and it is cost effective. ORT has been shown to be superior in treatment retention when compared to all other opiate dependency treatment modalities.

The World Health Organisation, UN Office of Drugs and Crime, and UNAIDS have put together a comprehensive package of interventions for HIV prevention, treatment and care for people who inject drugs, and the first two of these (out of nine) are NSP and ORT. Indeed the WHO lists essential medicines, related to the priority health care needs of the population. These medicines are selected with due regard to public health relevance, evidence on efficacy and safety, and comparative cost-effectiveness. Methadone is considered an essential medicine.

ORT is very well supported by the evidence, but can be unpalatable politically. There are unacceptable waiting lists for public treatment in some areas (over 2 years!) and so public places should be expanded. Also, public ORT very expensive for anyone receiving their Rx from a pharmacy rather than public clinic – hence review of dispensing fee recommendation

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Recommendations

- **Evidence based policy, and thus a continued commitment to harm reduction in dealing with drug use and related problems in NSW.**
- **An increase in NSP reach/availability in order to reduce prevalence rates of hepatitis C among people who inject drugs and continue to keep rates of HIV/AIDS at record low levels**
- **Policies and programs that increase access to, and uptake of, hepatitis C treatment in order to reduce the significant burden of disease associated with chronic hepatitis C**
- **Expanding existing ORT services, especially in areas where waiting lists for treatment is particularly high, e.g. Hunter area.**
- **A review of dispensing fees charged by pharmacists dispensing methadone –methadone is being provided free of charge from the Commonwealth, but because of dispensing fees, a patient may be individually charged up to $250/month.**
- **Incentives for GP ORT prescribers and pharmacies dispensing ORT in order to improve/expand the reach and effectiveness of ORT**
- **Support of GP ORT prescribers through a shared care approach**
- **Improved access to and integration with mental health services for AOD clients**
- **Improving focus on targeted AOD clients most at risk - GLBTI, Indigenous, and prisoners**
- **Expanded access to naloxone in order to reduce the increasing numbers of accidental opiate overdose deaths in Australia**
- **Consideration be given to nicotine replacement therapy subsidies for ORT clients – nearly 100% ORT clients smoke, and thus smoking related morbidity/mortality is particularly high for this group.**
- **Expansion of rehabilitation services available for people on ORT. Currently vast majority of rehab services will not allow entry to anyone on ORT, not even to stabilise on ORT. Given evidence for ORT is so solid, the lack of available rehabilitation services for such clients is not appropriate.**
- **More resourcing of family support services to ensure the voice of the family is heard**
- **Consideration to be given to clinical trials of heroin maintenance**

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FDS is very committed to families having a voice in drug policy and welcomes this inquiry. We are of the belief that alcohol and drug issues are complex and there are no silver bullets or formulas for success despite the ongoing lure of a masterstroke for the community, media and politicians.

We believe in these principles very strongly:

1. **All funded treatment and other services need to be evidence based and allowing for innovation through rigorous ethical trials.**
2. **Australia's proven harm reduction policy needs to be continued and in fact strengthened with more balance in resourcing to demand and harm reduction.**
3. **We need to adhere to ethical guidelines that apply across the health spectrum when we engage in treatment and care for people with alcohol and drug issues.**

In our experience drug use and recovery is a long process for both users and their families. Different approaches are needed at each stage of the process that are appropriate (see Stages of Change – Procheska and Di Clemente and Stages of Change for Families – in FDS 'Guide to Coping'.

The risk of death, disease, crime and other negatives and for FDS the overriding principle is to keep our family member safe and alive.

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References:

ANCD has position papers on NSP, naltrexone; expanding naloxone availability and sustained release naltrexone.

Return on investment 2: evaluating the cost effectiveness of needle and syringe programs in Australia 2009. NCHECR, UNSW Sydney

Dolan, K. MacDonald, M., Silins, E. & Topp, L. 2005. *Needle and syringe programs: A review of the evidence.* Canberra: Australian Government Department of Health and Ageing.

Kwon, J. A., Iverson, J., Maher, L., Law, M. G., & Wilson, D. P., 2009, 'The Impact of Needle and Syringe Programs on HIV and HCV Transmissions in Injecting Drug Users in Australia: A Model Based Analysis', *Journal of Acquired Immune Deficiency Syndromes*, 51(4), pp 462-469.

Illicit drugs policy: using evidence to get better outcomes: RACP document, available at: http://www.racp.edu.au/page/policy-and-advocacy/public-health-and-social-policy

Cochrane drug and alcohol library

- HIV prevention, treatment, and care services for people who inject drugs: a systematic review of global, regional, and national coverage (The Lancet, 2010)
- WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users (WHO 2009)

DPMP annotated bilbilgraphy on SIFs:
http://www.dpmp.unsw.edu.au/DPMPWeb.nsf/resources/Interventions/$file/SIF.pdf

DPMP accompanying bulletin on SIFs:
http://www.dpmp.unsw.edu.au/DPMPWeb.nsf/resources/Bulletin5/$file/DPMP+Bulletin+22.pdf

RACP position statement on Sydney MSIC: http://www.racp.edu.au/page/policy-and-advocacy/public-health-and-social-policy

WHO Guidelines for psychosocially assisted pharmacological treatment of opioid dependence

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