

**Submission
No 36**

INQUIRY INTO DRUG AND ALCOHOL TREATMENT

Organisation: Addiction Medicine Network (NSW membership) of The Royal
Australian College of General Practitioners (RACGP)

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NSW DRUG AND ALCOHOL TREATMENT INQUIRY SUBMISSION

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Submission to the General Purpose Standing Committee No.2

Inquiry into Drug and Alcohol Treatment Policies

**By the Addiction Medicine Network (NSW membership) of the Royal
Australian College of General Practitioners (RACGP)**

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Summary

Due to the wide scope of this inquiry, this submission has been limited to respond primarily to those Terms of Reference items where we believe we may best assist the Committee. As expert General Practitioners and Addiction Specialists we welcome the chance to participate in this inquiry and to meet at any future point in time with members of the Committee or their representatives to discuss these issues or others raised in the Terms of Reference to this inquiry.

Key recommendations presented in this submission are as follows.

Recommendation 1: It is recommended that the Committee investigate the role of taxation and regulation in deterring and preventing harms from tobacco and alcohol.

Recommendation 2: It is recommended that the Committee investigate the costs of Opioid Substitution Therapy to consumers, prohibitive regulations surrounding the dilution of takeaway doses and the stream-lining of opioid prescribing regulations nationally.

Recommendation 3: It is recommended that the Committee quarantine the budget for drug and alcohol treatment services from other medical service uses to provide budgetary certainty and ensure the success of programs.

Recommendation 4: It is recommended that the Committee investigate improving funding for integrated care of those with co-morbidities as well as ensuring specialised services are sufficiently funded.

Recommendation 5: It is recommended that the Committee investigate the models based on a Harm Minimisation approach such as those successfully used in France, Portugal and that the strategies for managing the non-medical use of prescribed pharmaceuticals in Washington State and Tasmania be considered for implementation in NSW.

Recommendation 6: It is recommended that the existing reason for involuntary detention remain for the reason of risk of “Serious Harm” and not be lowered to risk of “Harm”.

Recommendation 7: It is recommended that the current Act’s criteria for assessing persons for detention and treatment are appropriate and should remain unchanged.

Recommendation 8: It is recommended that the mandatory use of Naltrexone implants be removed from the proposed Bill.

Background

In November 2012 a NSW Legislative Council Committee established an inquiry to investigate the treatment options for drug and alcohol in NSW and suitability of the reforms proposed in the *Drug and Alcohol Treatment Amendment (Rehabilitation of Persons with Severe Substance Dependence) Bill 2012*.

Dr Hester Wilson is a Fellow of the Royal Australian College of General Practitioners, a Fellow of the Chapter of Addiction Medicine in the Royal Australian College of Physicians and has extensive clinical experience working with AOD and mental health co morbidity. She has worked in primary health care settings for the last 20 years including working in East London with the homeless as a primary health clinician and for 7 years at the Kirketon Rd Centre, a centre providing primary care for injecting drug users, street sex workers and at risk youth in Kings Cross, Sydney. She was Acting Medical Director at the Sydney Medically Supervised Injecting Centre in Kings Cross in 2009-2010. She currently works at the Langton Centre as an Addiction Staff Specialist and in private general practice in Newtown, Sydney, where she has a high case load of clients with AOD and mental health co morbidity.

Dr Simon Holliday is a General Practitioner in Taree, regional NSW. He is a Fellow of the Royal Australian College of General Practitioners, a Fellow of the Chapter of Addiction Medicine in the Royal Australian College of Physicians and a Fellow in the College of Remote and Regional Medicine. He also works as a staff specialist at the Drug and Alcohol Service in the Lower Mid North Coast (LMNC) sector of Hunter New England Local Health District (HNE Health). Simon is a published researcher into issues involving the prescribing of opioids for pain and dependency in the primary care setting.

As experienced drug and alcohol clinicians we appreciate the opportunity to contribute to policy development and support a number of changes in the proposed Bill. The Terms of Reference for this inquiry are broad and we welcome the fact that this inquiry has such a wide scope.

For this submission we do not respond to each of the Terms of Reference items, but welcome meeting with the Committee at any point to provide further information.

Terms of Reference Preamble – Deterrence and Treatment

One of the most important methods of deterrence involves taxation. Taxation reform is an evidence-based policy with improved individual and public health outcomes linked to improved revenue collection. A state excise on tobacco would deter smoking especially amongst the most dependent and the young. Likewise, volumetric taxation on alcohol content, as against the form of drink, will create better health outcomes. Taxation should be actively extended to illegal tax-free tobacco, "chop-chop" and private alcohol manufacturing such as home brew kits.

We call for a decrease in the accessibility of alcohol and tobacco points of sale. A vast body of research has shown that an increase in alcohol sales and density of alcohol outlets is strongly linked to an increase in such problems as binge drinking, drinking and driving incidents, traffic crashes, pedestrian casualties, assaults and other types of violence, sexually transmitted disease and suicide (1, 2).

Recommendation 1: It is recommended that the Committee investigate the role of taxation and regulation in deterring and preventing harms from tobacco and alcohol.

Terms of Reference Item 1– The Delivery and Effectiveness of Treatment Services

For half a century, Opioid Substitution Therapy (OST) has been used to assist detoxification or maintenance for opioid, usually heroin, dependency (3). With over thirty Randomised Controlled Trials (RCTs) supporting it, there is a strong evidence base (4). State and Territory governments administer these treatment programmes and are responsible for the approval and regulation of the prescribers and dispensers of the programmes. The cost to consumers of OST needs to be reviewed. It is inequitable with an estimated 80% OST clients paying dosing fees which may range up to one third of their unemployment benefits (5). The Australian National Council on Drugs is publishing a multidisciplinary review into OST in March 2013 which should be examined by this inquiry (6).

Takeaway doses within an OST programme are an important part of the pathway back to a normal life. The dilution of these is important to minimise the risk to toddlers consuming them. The current State regulations surrounding these add unnecessary time and cost for dispensing pharmacists and so this safety feature has become prohibitive and is frequently omitted.

OST policies vary from State to State and consistent regulations and guidelines are required (7).

Recommendation 2: It is recommended that the Committee investigate the costs of Opioid Substitution to consumers, prohibitive regulations surrounding the dilution of takeaway doses and the stream-lining of opioid prescribing regulations nationally.

Terms of Reference Item 2 –The level and adequacy of funding

Funding is too low. While we recognise every sphere of government desires more funding, the addictions sector has a special case. The 1999 Drug Summit demonstrated how improved outcomes from the impact of drugs in society required a whole-of-government approach. In an environment of tight health budgets, there is a risk that any initiatives will have their funding reabsorbed into wider health budgets and redistributed elsewhere. Therefore drug and alcohol initiative funding should have a model which quarantines this funding from other medical use to provide budgetary certainty and ensure the success of programs.

Specifically, every NSW hospital should have designated beds for detoxification. Currently it is difficult to source these, especially rurally. Addiction services need to be funded for Clinical Liaison for in-patient care. This would help identify and manage substance aspects of acute admissions as well as educate the health staff.

Recommendation 3: It is recommended that the Committee quarantine the budget for alcohol and drug treatment services from other medical service uses to provide budgetary certainty and ensure the success of programs.

Terms of Reference Item 4 –The Adequacy of Integrated Services

Funding for services that provide care for individuals with alcohol, drug and mental health conditions are lacking.

There is a median waiting time for public pain clinics of 150 days (8).

Waiting times to get into some NSW public OST services recently reached two years (9).

General Practice is suitable site for care of complex illnesses.

Research into improving the general practice management of addictions would be advantageous, especially when linked to pain and/or mental health co-morbidities.

Recommendation 4: It is recommended that the Committee investigate improving funding for integrated care of those with co-morbidities as well as ensuring specialised services are sufficiently funded.

Terms of Reference Item 6 – Strategies Used in Other

Jurisdictions

It is useful to examine other models and strategies used in other jurisdictions for managing drug and alcohol treatment. A key factor that determines the strategies taken is whether the view on drug and alcohol management is based on “Harm Minimisation” or “Prohibition”. Australia has had much internationally recognised success from its Harm Minimisation approaches. For example, Australia has very low HIV rates as a result of its early uptake providing clean needles to injecting drug users. The Medically Supervised Injecting Centre in Sydney has reduced deaths, increased referral of people into treatment, and reduced the medical cost burden.

Other jurisdictions that appear to favour the Harm Minimisation approach, culturally accepted in Australia, include France and Portugal. France has an innovative model of open-access Buprenorphine for opioid dependency. This model has resulted in relatively low levels of diversion of medication (where patients provide their medication to others) and evidence suggests great improvements in death rates have occurred. (10)

The Portuguese model involved radical changes including drug decriminalisation with commensurate increase in health services. This strategy was in response to a significant drug problem in Portugal that due to the small size of the country had affected most families. Therefore there was a strong national acceptance of the need to intervene and a positive response to a referendum in the late 90's that led to a change of law in 2001 to decriminalise drug use. This has led to a vastly decreased incarceration rate for drug use, and increased engagement in treatment and a significant decrease in blood born viruses such as HIV (10).

Two strategies of note for managing non-medical use of prescribed pharmaceuticals that have been implemented in other jurisdictions are worthy of consideration for implementation in NSW. These are as follows.

The USA is dealing with a prescription opioid "epidemic." In Washington State opioid analgesic prescribing guidelines were released in 2007 that recommended a second opinion if the opioid analgesic dose was over a specified amount. Compared to before 2007, by 2010 there was a decline by 27% in mean opioid dose prescribed, by 35% for doses over the specified amount prescribed and by 50% in the number of opioid-related deaths (11). Such simple regulatory changes should be considered in NSW.

The Tasmanian system of on-line, real time monitoring of S8 medications has been proposed to be implemented across Australia in order to prevent misuse and save lives while facilitating proper analgesic care to others. Disputation between the Federal and State and Territory governments need to be expediently dealt with.

Recommendation 5: It is recommended that the Committee investigate the models based on a Harm Minimisation approach such as those successfully used in France, Portugal and that the strategies for managing the non-medical use of prescribed pharmaceuticals in Washington State and Tasmania be considered for implementation in NSW.

Terms of Reference Item 7 – Proposed Bill

While we welcome that the Bill proposes an expansion of those who can request an assessment of a person potentially at harm, we have a number of concerns with a number of other key elements of the Bill.

1. **Part 2 Section 9a - Change of Involuntary Detention to protect from “Serious Harm” to only protect from “Harm”**

The lowering of the level for the reason for involuntary detention due to Serious Harm, to a lower level of Harm, is unwise. Involuntary detention should only ever be a method of last resort. Removing a person’s rights and freedoms is not a decision that should be taken lightly and therefore in a medical environment should only occur in the situation to protect from Serious Harm to themselves or others.

A change to a lower standard of “Harm” is an inappropriate over-response to managing drug and alcohol treatment. Additional to the civil liberty impact on individuals, this would also significantly increase the numbers of those incarcerated for drug and alcohol issues straining existing resources.

We are of the opinion that existing processes for treating those at Harm are sufficient and that incarceration is not appropriate and not of sufficient further benefit to warrant involuntary detention.

Recommendation 2: It is recommended that the existing reason for involuntary detention remain for the reason of risk of “Serious Harm” and not be lowered to risk of “Harm”.

2. Part 2 Section 9a – Removing the Risk of the Person

Committing an Offence

The Bill proposes in paragraph (3) (iii) that a person can be involuntarily detained, “*to remove the risk of the person committing an offence due to the person’s severe substance dependence.*”

Under this new proposal, any intoxicated person could involuntarily detained and taken into mandatory treatment for matters that should be subject to current police responses. For example, a habitual drinker about to drive a motor vehicle, or a street sex worker looking for business in a residential area in order to fund their addiction, under this proposal would qualify to be involuntary detention for treatment.

This proposed amendment though assumes clairvoyance on the part of those enforcing it in having to know if at some future point in time the person will actually in fact commit an offence.

There is great risk for this proposal to be inappropriately used as a form of policing against criminal activities, a way of detaining someone against their will but not having to use the criminal court system or a means to unjustly detain people who may just irritate those in positions of authority.

Recommendation 3: It is recommended that the current Act’s criteria for assessing persons for detention and treatment are appropriate and should remain unchanged.

3. Part 2 Section 15a – 15c – The Use of and Mandatory Use of Naltrexone Implants

With concerns raised earlier in this submission about the increased scope to detain more people for potential harm or potential criminal activity, the proposed Bill also forces these new detainees under the Bill into a choice of detention or mandatory outpatient treatment. These new and additional detainees will understandably wish to escape detention and are likely to opt for the outpatient treatment, which exposes them to a new risk.

It is proposed in the Bill that outpatients will be treated with the mandatory implanting of Naltrexone as a treatment method. As stated by the National Health & Medical Research Council literature review in 2010, *naltrexone implant treatment may show some efficacy as part of an integrated program, more research is needed.*

Naltrexone implants are an experimental product and as such should only be used in the context of a well conducted RCT with sufficient sample size, appropriate duration of treatment and follow up, regular robust monitoring, provision of a comprehensive psychosocial treatment program, and with comparison to current best practice. Until these trials have occurred and the relevant data are available and validated, the efficacy of the treatment, alone or in comparison to conventional first line treatments, cannot be determined.

As a result Naltrexone implants must not be considered to be part of a mainstream treatment and it is unethical to force people to take this experimental treatment.

Recommendation 4: It is recommended that the mandatory use of Naltrexone implants be removed from the proposed Bill.

For further information, please contact Dr Hester Wilson and/or Dr Simon Holliday

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