Submission No 28

INQUIRY INTO DRUG AND ALCOHOL TREATMENT

Organisation: St Vincent's Hospital, Inner City Health Program, Alcohol & Drug Service

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NSW Legislative Council
GENERAL PURPOSE STANDING COMMITTEE No. 2

INQUIRY INTO DRUG AND ALCOHOL TREATMENT

Submission by
Inner City Health Program
Alcohol and Drug Service
St Vincent's Hospital, Sydney

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St Vincent's Hospital Darlinghurst has been providing a range of specialist alcohol and other drug services for more than 30 years. Current services include a 24-hour state-wide telephone advice, information and brief counselling service; inpatient and outpatient care; a specialist stimulant early intervention and treatment program; a 20-bed residential withdrawal unit; and an opiate substitution therapy program for 320 people.

In response to the terms of reference of the inquiry, we ask that the information below be considered. We would be willing to participate in any public hearing of the matter.

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**

Effective, evidence based treatments should be delivered to the population by trained and supervised professionals.

The Therapeutic Goods Administration has adequate provisions for protection of the public of NSW and their guidance on the consideration of new medications and devices should be followed.

As such only interventions for which there is already adequate evidence should be supported by the NSW government.

Where important practice gaps are identified, these should be filled through a program of rigorous ethical research in accordance with National Health and Medical Research Council (NHMRC) guidance.

At present the weight of evidence supports:

- Maintenance pharmacotherapy such as opioid substitution therapy with methadone or buprenorphine for the management of opiate dependence.
- Early interventions such as screening and brief intervention for risky (non-dependent) alcohol use.
- Public health approaches to minimise harms associated with substance use to the individual and community. Interventions include needle-syringe programs for people who inject drugs and drug consumption rooms.
- Structured psychosocial support for the management of substance use disorders.
- Supported withdrawal and post-withdrawal care, including medications for the management of withdrawal symptoms and to prevent relapse (eg oral naltrexone and disulfiram for alcohol dependence).

Oral naltrexone tablets are listed on the Pharmaceutical Benefits Scheme for the treatment of alcohol dependence. Any use outside this context is not supported by evidence. There is no evidence of effectiveness of oral naltrexone maintenance therapy for opiate dependence; data are limited by low rates of retention and small numbers of comparable studies[i].

There is insufficient evidence of the safety and efficacy of naltrexone implants, as demonstrated by the international benchmark publication, the Cochrane review[ii] and a subsequent NHMRC 2011 review [iii]. The NHMRC's position statement on naltrexone implants is consistent with scientific standards, should be supported. Naltrexone implants are an experimental product and should only be used with demonstration of safety and efficacy and in the context of a robust ethical and well conducted randomised controlled trial.

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

Drug and alcohol treatment services should be funded on a transparent basis, based on health needs and prioritised towards cost-effective care, in parity with other health needs. Current funding levels are low (for example 2009/2010 NSW Drug and Alcohol budget was 142.5 million out of 15.1 billion NSW Health budget, representing less than 1% of the total budget, even though the burden of disease due to drug and alcohol problems accounts for 12% of the burden of disease).

While important progress has been made in NSW for drug and alcohol treatment services, a number of important gaps exist. For example, there are an estimated several thousand opiate dependent people not currently in treatment – the cost-effectiveness of this intervention has been well established. For example the cost of one-year's pharmacotherapy maintenance is approximately a tenth of that for incarceration[iv]; re-incarceration mortality rates are decreased with methadone treatment[v].

Furthermore, the majority of interventions address dependent and high consumption drug and /or alcohol use: more investment is required in early intervention.

Alcohol use is of particular concern – more investment in treatment and early intervention, as well as efforts for health promotion and prevention of high risk drinking – if NSW is to reach its goal outlined of reducing total risk drinking to less than 25%[vi].

NSW's lead in nation-wide population based needs modelling, The National Drug and Alcohol-Clinical Care and Prevention (DA-CCP) Planning Model, will go some way to identifying the type and distribution of treatment services that should be provided in NSW. These will need to be adapted to local epidemiological and socio-demographic contexts and targeted interventions will need to ensure accessibility and uptake among high risk and socially excluded groups (including homeless, Aboriginal and other populations).

The Inner City Health Program (ICHP) Alcohol & Drug Service (ADS) of St Vincent's Hospital runs one of the two Stimulant Treatment Programs in the State. Evaluation of the service suggests effectiveness of this intervention in attracting and maintaining in treatment a hard-to-reach and at-risk population with complex needs. Waiting lists are long however, there is a growing range of psychostimulant and other emerging psychoactive substance use disorders (including of the novel

synthetic cannabinoids). More investment is required for the treatment of psychostimulant use disorders, expanded to include the increasing range of licit and illicit psychoactive substances.

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

There is growing experience with new models of mandatory treatment in NSW, including Involuntary Drug and Alcohol Treatment under the new act (commenced in 2012) and Drug Courts, the most recent of which opened in February 2013. Such approaches require stringent ethical, legal, and clinical evaluation before expansion.

Efforts should be made to ensure access and availability of voluntary evidence-based treatment – while there are large treatment gaps such as in methadone maintenance treatment coverage, resources should not be diverted into involuntary or mandated treatment. Good quality voluntary treatment has generally been shown to be more effective, cheaper and earlier intervention than mandatory treatment.

Voluntary diversion programs such as the Magistrates Early Referral Into Treatment (MERIT) have been shown to have significant health benefits. More efforts are required to trial different models of voluntary treatment expanded to include at-risk and socially excluded populations such as Aboriginal people, and to include alcohol.

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

Although there have been a number of initiatives to integrate services for comorbid conditions (such as the *NSW Clinical Guidelines for the Care of Persons with Comorbid Mental Illness and Substance Use Disorders in Acute Care Settings 2009*) in practice, integrated service provision remains a challenge. Key areas requiring investment in coordination include: mental health, chronic pain, and cognitive impairment, and more work is required in linking specialist and primary care services.

Investment in new opportunities, such as provided by the newly established Medicare Locals, will allow for improved coordination between state and federal funders and specialist and primary care providers. This will require development of clear common objectives and referral pathways, and an investment in workforce training and service capacity building.

Drug and Alcohol Consultation Liaison services provide an important means for integration, but are essentially unfunded. Embedding drug and alcohol care in acute mental health community teams and embedding mental health care in drug and alcohol services will go a long way towards integrating mental health and drug and alcohol care. These initiatives require additional resources.

NSW Health runs a Drug and Alcohol Specialist Advisory Service through the St Vincent's Hospital ICHP ADS which is a round-the-clock state-wide telephone advice service for professionals. This service is challenged by limited investment in resources, as it relies on volunteer staff specialists contributing to a 24 hour on-call roster.

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

St Vincent's Hospital ICHP ADS runs the Alcohol and Drug Information Service is a 24 hour, 7 day a week helpline funded by NSW Health to provide support, information, crisis counselling and referral for alcohol or drug issues, and the 24 hour-a-day tobacco cessation promotion Quitline, available in several community languages. These services provide around 38.000 calls a year and are currently expanding into other social media. A linked initiative is the "Your Room" drug and alcohol consumer website. The services provided represent an opportunity for state-wide expansion of access to existing evidence based interventions, such as screening and brief intervention for risky alcohol and other drug use. These services could be used to expand the range of promotion, prevenition and early intervention services, including online services, targeting rural and remote populations and other socially marginalised groups. Resources should be allocated to test and pilot models of care using ADIS/Quitline.

The evidence base for the effectiveness of school based education programs is limited; further research is required before significant investments are made in this area. Findings from the National Drug and Alcohol Research Centre's school based 'preventure' intervention trial currently underway should be reviewed with interest.

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

There are a range of strategies and models for responding to drug and alcohol problems around the world. Some of these models (such as capital punishment) are at odds with Australia's human rights framework. Australia has shown global leadership in its public health response focusing on reducing substance-related harm in the community, and in placing the emphasis on delivery of evidence-based interventions. NSW should continue this approach.

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

The proposed reforms to the Bill cannot be supported. These non-evidence based amendments to the Act require considerable research before practice and policy decisions can be made.

Consideration needs to be given to the significant investment of resources required in researching the proposed interventions and in introducing such a Bill. This investment brings with it opportunity costs and likelihood of diversion of resources away from already identified evidence based intervention coverage gaps (such as the gap in coverage of opiate substitution therapy as mentioned above).

The following are of particular concern:

- The Bill proposes an involuntary outpatient program specifically for the purpose of implanting naltrexone. This is not supported by current scientific evidence. According to the

NHMRC 'Naltrexone implants are an experimental product and as such should only be used in the context of a well conducted randomised controlled trial with sufficient sample size, appropriate duration of treatment and follow up, regular robust monitoring, provision of a comprehensive psychological treatment program, and with comparison to current best practice.' [iii, p16]

- The Bill provides prescriptive details about care and treatment, and does not allow for tailoring of care based on the clinical situation. Attention must be paid to the human rights quality of the proposed intervention, and the dignity of the person.
- Community treatment orders in the drug and alcohol field do not have any evidence of effectiveness. Medico-legal implications have not been considered.
- The Bill proposes an extensive list of concerned persons who may also request an assessment by an accredited medical practitioner; this may result in a disproportionate application of the Act to some populations.
- The Bill proposes to increase the maximum timeframe that a person can be detained to 90 days for all persons in all situations and would not require an order of the Magistrate to increase the period of detention. Duration of detainment needs further research.
- The Bill proposes to expand the Act to allow persons between 16 and 18 to be subject to involuntary detention, care and treatment. It is unlikely that people under the age of 18 would meet the criteria for sustained and entrenched dependence. An integrated treatment approach tailored to young people is preferred.

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