Submission
No 5

INQUIRY INTO DRUG AND ALCOHOL TREATMENT

Organisation: FamilyVoice Australia

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Submission

on

Drug and Alcohol Treatment

to the

General Purpose Standing Committee No 2

Legislative Council

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1. Introduction

On 21 November 2012, the General Purpose Standing Committee No 2 of the Legislative Council of the Parliament of New South Wales resolved to inquire and report on the effectiveness of current alcohol and drug policies in New South Wales with respect to deterrence, treatment and rehabilitation.

The Committee has called for submissions which are due by 1 March 2013.

The Committee is due to report by 29 August 2013.

2. Harm minimisation or a drug free society?

Before analysing specific deterrence, treatment and rehabilitation services for illicit drug problems consideration needs to be given to the fundamental policy approach to illicit drugs.

> The current *National Drug Strategy 2010-2015* states that:
>
> *The overarching approach of harm minimisation, which has guided the National Drug Strategy since its inception in 1985, will continue through 2010–2015. This encompasses the three pillars of ... demand reduction, supply reduction and harm reduction, which are applied together to minimise harm.*[1]
>
> *Harm reduction works to reduce the adverse health, social and economic impacts of drug use on communities, families and individuals.*

Harm reduction includes needle and syringe exchange programs, a medically supervised injecting centre, and "*the provision of chill-out spaces, water, information and peer support and emergency medical services at events where drug use may be occurring*".[2]

Two comprehensive reports by committees of the House of Representatives have called for the replacement of the harm minimisation policy.

2.1 Road to Recovery - 2003

In September 2003 after a three and a half year inquiry, the Standing Committee on Family and Community Affairs issued, on 8 September 2003, a very significant report on illicit substance use in Australian communities. The report, entitled Road to Recovery, had as its key recommendation (122) that "*the Commonwealth, State and Territory governments replace the current focus of the National Drug Strategy on harm minimisation with a new focus on harm prevention and treatment of substance dependent people.*"[3]

Harm minimisation has been one of the key principles of Australia's drug strategy since 1985. It has been used to justify a range of measures that tolerate the use of illicit drugs while attempting to minimise particular harms to drug users, such as overdosing, contracting infectious diseases and other adverse side effects. Many of the supporters of harm minimisation stress the impossibility of significantly reducing the level of illicit drug use and often tend to ascribe harm to the illicit nature of the drugs consumed rather than to the substances themselves. Harm minimisation measures implemented or proposed in Australia include needle and syringe exchanges, injecting rooms, heroin prescription, methadone substitution, liberal cannabis laws and testing kits for ecstasy.

The Committee's recommendation, if implemented, would refocus our drug strategy towards preventing new users from taking up illicit drugs and providing effective treatments aimed at cessation of substance abuse for those who are chronic substance abusers.

In regard to treatment for heroin addicts, the Committee recommended (52) that the ultimate objective of methadone maintenance must be to assist users to become abstinent from all opioids and that priority be given to treatments, including naltrexone, that focus on abstinence as the ultimate outcome (54). The committee also recommended that, as a matter of urgency, the Commonwealth fund a trial of naltrexone implants, coupled with the support services required for efficacy, and that naltrexone be placed on the Pharmaceutical Benefit Scheme for the treatment of opioid dependence.

The Committee was impressed with the beneficial results from therapeutic communities, such as those run by Teen Challenge. It recommended (56) funding to establish such communities throughout urban and rural areas in every State.

The Committee recommended that heroin prescription trials not proceed (57).

The myth, often propagated by advocates of liberal drug laws, that cannabis use is relatively harmless was seen as a major problem, and as one factor in the widespread use of cannabis, especially by young people. The Committee accepted the weight of evidence that there are serious dangers to physical and mental health associated with regular cannabis use and called for urgent development and dissemination of cannabis cessation strategies. (61-63)

Labor MPs Graham Edwards, Julia Irwin and Harry Quick unfortunately dissented from the Committee's report on key recommendations, defending the longstanding focus on harm minimisation, supporting injecting rooms, prescription heroin trials and methadone maintenance without any abstinence goal, and opposing the Committee's support for naltrexone and therapeutic communities.

Significantly, and to her credit, Labor MP and former ACTU head, Jennie George not only refused to join her colleagues in their dissent but in her own additional remarks strongly endorsed the view that "*prevention and treatment of substance abuse should be enhanced*". She stressed "*the urgent need for further research into the use of naltrexone given that many people are now 'parked' on methadone maintenance programs.*" She accurately described opioid dependency as a "*chronic, relapsing disease*" that cannot be wished away. Society has an "*obligation to provide the necessary support for people seeking to break their dependency*".

One disappointing aspect of the Report was its partial endorsement of needle and syringe distribution programs. At a cost of over $20 million to taxpayers nearly 32 million needles were distributed in the year 1999/2000. The Committee noted the claim, in the *Evaluation of Council of Australian Government's initiatives on illicit drugs: final report,* that needle distribution programs had resulted in the prevention of 25,000 cases of HIV and 21,000 cases of hepatitis C over the ten years from 1991. Nonetheless the Committee did recommend (66) that the Australian National Audit Office undertake a complete evaluation of needle and syringe programs assessing distribution, inadequate exchange, accountability and the impact on both HIV and hepatitis C.

The Committee expressed particular concern that the incidence of HIV and hepatitis C was escalating despite the quantity of syringes distributed. The Committee did not seem to be aware of the body of evidence demonstrating that needle exchanges actually increase the rate of needle sharing and that hepatitis C is spread among users of needle exchanges even when they refrain from sharing needles but share drug ampoules, water, cotton swabs, and other paraphernalia.[4]

2.2 The winnable war on drugs - 2007

Four years later in September 2007 the Standing Committee on Family and Human Services reported on its inquiry into the impact of illicit drug use on families.[5]

The report was scathing about the detrimental impact of the harm minimisation strategy:

> *The destruction of an individual's humanity by the use of illicit drugs is unarguable.*
>
> *What is required is policy to prevent harm to individuals from illicit drugs, not policy to merely reduce or minimise it.*
>
> *Prevention necessitates self-control and self-esteem. Thus policies need to be based on higher principles and morality. Those who promote harm minimisation say it has a morally neutral stance, stating that drug use is neither good nor bad.*
>
> *It is the prevalence of this amoral stance that has allowed the plight of families, particularly vulnerable little children, to be hidden victims of illicit drug use. The aim for these people is not to prevent harm but merely to reduce or minimise it.*
>
> *One witness, Ryan Hidden, told the committee:*
>
> *I survived harm minimisation, because it literally threatened to destroy my life and my family's life through the messages that it can implant into that structure and the way it threatened to tear us apart, literally. It was almost like that was its objective; it did not want me to escape my addiction, it wanted me to stay stuck there.*
>
> *Australia needs a prevention policy to protect her young and a rehabilitation policy to save those who slip.*[6]

The committee recommended that:

> *The Commonwealth Government develop and bring to the Council of Australian Governments a national illicit drug policy that:*
>
> *replaces the current focus of the National Drug Strategy on harm minimisation with a focus on harm prevention and treatment that has the aim of achieving permanent drug-free status for individuals with the goal of enabling drug users to be drug free; and*
>
> *only provide funding to treatment and support organizations which have a clearly stated aim to achieve permanent drug-free status for their clients or participants.*[7]

The committee also recommended that:

> *The Commonwealth Government:*
>
> *amend the National Pharmacotherapy Policy for People Dependent on Opioids to specify that the primary objective of pharmacotherapy treatment is to end an individual's opioid use; and*
>
> *renegotiate funding arrangements for methadone maintenance programs to require the states and territories to commit sufficient funding to provide comprehensive support services to meet the revised National Pharmacotherapy Policy for People Dependent on Opioids objective.*[8]

This recommendation is addressed to methadone maintenance programs that have no end goal of getting an individual free of opioid use.

The committee also called for the listing of naltrexone implants on the pharmaceutical benefits scheme[9] and for "a review of needle and syringe exchange programs to assess whether they are successful in directing drug users to appropriate treatment to enable them to be drug free individuals."[10]

On drug education, the committee called for the "reviewing and updating the National School Drug Education Strategy to re-iterate a commitment to a zero tolerance approach to illicit drugs and reflect the desire of parents for their children not to use illicit drugs."[11]

2.3 The Swedish model

The table below compares Australia and Sweden for annual prevalence of the use of various categories of illicit drug expressed as a percentage of the population aged 15-64. Prevalence in Australia compared with Sweden ranges from 262% (for amphetamines) to 3000% (for ecstasy) for use of particular drugs.[12]

	Prevalence as % of population aged 15-64 who have used in the last twelve months		
DRUG USED	**Australia**	**Sweden**	**Australia/Sweden%**
Opiates	3.40	0.23	1478%
Cocaine	2.1	0.5	420%
Cannabis	10.3	2.8	368%
Amphetamines	2.1	0.8	262%
Ecstasy	3	0.1	3000%

A review of Sweden's drug policy by the United Nations Office of Drugs and Crime concluded:

> *Following a short period of liberalization in the second half of the 1960s, Sweden has pursued restrictive drug control strategies that address both drug supply and drug demand.*
>
> *In parallel, Sweden has invested heavily in addressing the drug problem. Drug-related expenditures were equivalent to 0.5 per cent of GDP, the second highest proportion among all EU countries. This investment has paid off.*
>
> *The number of drug users in Sweden today seems to be smaller than it was before the advent of a concerted drug policy, starting in 1969 when the Government introduced a ten point programme against drugs.*
>
> *In 2006 6 per cent of the students age 15-16 had used drugs, down from 15 per cent in 1971.... While average levels of life-time prevalence of drug use among 15-16 years in Europe amounted to 22 per cent on average, the corresponding rate in Sweden was 8 per cent in 2003, before falling to 6 per cent in 2006...*
>
> *The ambitious goal of the drug-free society has been questioned not only outside the country but in Sweden itself, as a number of research papers on the subject attest. Nevertheless, despite several reviews of expert commissions, the vision has not been found to be obsolete or misdirected. As shown in this report, the prevalence and incidence rates of drug abuse have fallen in Sweden while they have increased in most other European countries. It is perhaps that ambitious vision that has enabled Sweden to achieve this remarkable result.*[13]

The 2006-2010 Swedish National Action Plan on Drugs was unanimously endorsed by the Swedish Parliament in April 2006. Cross party support for this policy is a notable feature.

> *All parties agreed that the overall goal of the Swedish drug policy remains to strive for a drug-free society.... There is a wide consensus about the overall goal of the drug policy, namely the drug-free society and its objectives: to reduce the recruitment of young people to drug abuse; to enable drug abusers to stop their drug abuse, and to reduce the availability of illicit drugs. ... The goal is outlined as follows: The drug policy is based on the right to a life with dignity in a society that guards the needs of the individual to feel safe and secure. Narcotic drugs should never be allowed to threaten the health, the quality of life and the security of the individual nor the general welfare or the development of democracy. The goal is a society free of drugs.*[14]

The new National Action Plan on Drugs (2011–15) like its predecessor further endorses the visionary goal of a society free from narcotics.[15]

2.4 Abandoning harm minimisation

The General Purpose Standing Committee No 2 should recommend that the current focus on harm minimisation be replaced with a focus on harm prevention and treatment that has the aim of achieving permanent drug-free status for individuals with the goal of enabling drug users to be drug free.

Specifically, the Committee should recommend to the government that it cease all financial support for harm minimisation programs including needle exchange, the medically supervised injecting centre and methadone substitution programs (unless these have as their goal a proven pathway to complete abstinence).

The Committee should recommend that the government investigate the detailed operation of the successful Swedish drug policy and adopt it as a model for a revised New South Wales Drug Strategy.

> ***Recommendation 1:***
>
> ***The Committee should call on the government to replace the current focus on harm minimisation with a focus on harm prevention and treatment that has the goal of enabling drug users to be drug free.***
>
> ***Recommendation 2:***
>
> ***The Committee should call on the government to immediately cease all financial and other support for harm minimisation programs including needle exchanges, the medically supervised injecting centre and methadone substitution programs (unless these have as their goal a proven pathway to complete abstinence).***
>
> ***Recommendation 3:***
>
> ***The Committee should call on the government to investigate the detailed operation of the successful Swedish drug policy and to adopt it as a model for a revised New South Wales Drug Strategy.***

3. Naltrexone

A 2010 literature review by the National Health and Medical Research Council (NHMRC) concluded:

> *While 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.*[16]

On 1 December 2011 Professor Warwick Anderson, Chief Executive Officer of the NHMRC issued a statement on naltrexone stating (in part):

> *NHMRC has been clear that some early studies on the efficacy and safety of naltrexone implants are promising. We have already funded over $18 million in research into addiction and substance abuse, including a clinical trial on the use of naltrexone implants. We fully recognise the importance of preventing and treating addiction.*
>
> *NHMRC is not blocking access to naltrexone implants. The Special Access Scheme is unchanged and provides a basis for access on a case-by-case basis for individual patients.*
>
> *I assure all parties that the NHMRC's interest is only in ensuring that the Australian community understands the evidence. More evidence is needed about the use of naltrexone implants in the treatment of addiction.*
>
> *I call on Australian researchers to consider how we can continue to build the body of evidence.*[17]

Since then there have been some further published studies on naltrexone, including a paper finding that "*the use of implant naltrexone can reduce all-cause mortality and opiate overdose during the first 4 months following treatment compared with patients treated with oral naltrexone*".[18]

Commenting on this study the UK *Substance Misuse Management in General Practice Clinical Update* observed that "*The evidence for long-acting implantable naltrexone is building*".[19]

In the light of this accumulating evidence careful use of naltrexone implants as part of an integrated program to treat opioid addiction should be continued.

> ***Recommendation 4:***
>
> ***The Committee should support the careful use of naltrexone implants as part of an integrated program to treat opioid addiction.***
>
> ***Recommendation 5:***
>
> ***The Committee should support research into the efficacy of using naltrexone implants in conjunction with comprehensive psychosocial treatment, in comparison with other approaches to treatment.***

4. Drug and Alcohol Treatment Amendment Bill 2012

This Bill was introduced into the Legislative Council on 25 October 2012 by the Hon Fred Nile MLC.

The Bill would amend the *Drug and Alcohol Treatment Act 2007* to further provide for the involuntary rehabilitative care of persons with severe substance dependence.

In particular it would:

- extend the length of time for which involuntary detention for treatment could be ordered from 28 days to 90 days;
- extend the availability of involuntary detention for treatment to minors aged 16 or more;
- broaden the range of those who can seek an assessment of a person for involuntary detention for treatment; and
- broaden the grounds for an order for involuntary detention for treatment.

These measures could be of great benefit to persons who need assistance to get free of drug abuse. They should be supported.

The Bill would also provide for outpatient treatment with a naltrexone implant as an alternative to involuntary detention for treatment. This alternative to involuntary detention could be made available to persons who volunteer to be part of a carefully monitored research program, including appropriate duration of treatment and follow up, regular robust monitoring, and provision of a comprehensive psychosocial treatment program. This alternative could be made subject to a review after an appropriate period of time such as two years.

> ***Recommendation 6:***
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> ***The* Drug and Alcohol Treatment Amendment Bill 2012 *should be supported subject to the provisions regarding a naltrexone implant alternative forming part of a carefully monitored, finite duration research program.***

5. Endnotes

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1. Ministerial Council on Drug Strategy, *National Drug Strategy 2010-2015: A framework for action on alcohol, tobacco and other drugs*, p ii-p 1: http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/DB4076D49F13309FCA257854007BAF30/$File/nds2015.pdf

2. *Ibid.*, p 16.

3. http://www.aph.gov.au/house/committee/fca/subabuse/report.htm

4. Fred J Payne, "An Evidence Based Review of Needle Exchange Programs", Feb 2005 at: http://www.childrensaidsfund.org/showarticle.asp?id=246

5. *The winnable war on drugs: The impact of illicit drug use on families*, House of Representatives Standing Committee on Family and Human Services, September 2007: http://www.aph.gov.au/house/committee/fhs/illicitdrugs/report/fullreport.pdf

6. *Ibid.*, p ix.

7. *Ibid.*, p xxiii (Recommendation 8).

8. *Ibid.*, p xxiii (Recommendation 10).

9. *Ibid.*, p xxiv (Recommendation 11).

10. *Ibid.*, p xxiv (Recommendation 14).

11. *Ibid.*, p xxiv (Recommendation 15).

12. United Nations Office on Drugs and Crime, *World Drug Report 2012: Statistical annex: Tables: Prevalence of drug use among the general population*, at: http://www.unodc.org/documents/data-and-analysis/statistics/WDR2012/Prev_All_2012.xls

13. United Nations Office of Drugs and Crime, "Sweden's Successful Drug Policy: a Review of the Evidence", Feb 2007, p 51 at: http://www.unodc.org/pdf/research/Swedish_drug_control.pdf

14. United Nations Office of Drugs and Crime, "Sweden's Successful Drug Policy: a Review of the Evidence", Feb 2007, p 20 at: http://www.unodc.org/pdf/research/Swedish_drug_control.pdf

15. European Monitoring Centre for Drugs and Drug Addiction, *Country overview: Sweden:* http://www.emcdda.europa.eu/publications/country-overviews/se

16. National Health and Medical Research Council, Naltrexone Implants for Opioid Dependence: Literature Review, 2010, p 16: http://www.nhmrc.gov.au/_files_nhmrc/file/your_health/ps0005_naltrexone_implant_treatment_literature_review.pdf

17. Warwick Anderson, *More evidence is needed about the use of naltrexone implants in the treatment of addiction*, 1 Dec 2011, http://www.nhmrc.gov.au/media/notices/2011/more-evidence-needed-about-use-naltrexone-implants-treatment-addiction

18. Erin Kelty and Gary Hulse, "Examination of mortality rates in a retrospective cohort of patients treated with oral or implant naltrexone for problematic opiate use", *Addiction,* 2012, 107:1817-24: http://www.uqccr.uq.edu.au/media/80950/12.09.11_-_examination_of_mortality_rates_in_a_retrospective_cohort.pdf

19. *Substance Misuse Management in General Practice Clinical Update,* Jun/Jul 2012: http://www.smmgp.org.uk/download/smmgpupdates/2012/clin_2012_06.pdf