Submission
No 10

INQUIRY INTO DRUG AND ALCOHOL TREATMENT

Organisation: Australasian Professional Society on Alcohol and other Drugs (APSAD)

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Submission from: The Australasian Professional Society on Alcohol and Other Drugs (APSAD)

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NSW Legislative Council, General Purpose Standing Committee No. 2

Inquiry into drug and alcohol treatment

Terms of Reference

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:

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

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

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

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

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

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

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

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Introduction

This is a submission from the Australasian Professional Society on Alcohol & other Drugs (APSAD). APSAD is the Asia Pacific's leading multidisciplinary organisation for professionals involved in the alcohol and other drug field. APSAD is dedicated to increasing the profile of the issues related to the use of alcohol and other drugs, through the dissemination of information from the wide range of professions involved in this field. In addition, we strive to promote improved standards in clinical practice and in research into this and allied subjects. It also provides a network of drug and alcohol professionals in Australia, New Zealand and the Asia Pacific.

Through its internationally recognised scientific journal, the *Drug and Alcohol Review*, and its annual Scientific Conference, APSAD provides a forum for the latest research on the nature, prevention and treatment of physical, psychological and social problems related to the use of psychoactive substances.

APSAD is dedicated to:

- promoting evidence-based improvements in the treatment and prevention of drug and alcohol-related problems
- raising awareness about the problems related to the use of alcohol and other drugs
- promoting best standards in research in the drug and alcohol field

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- providing development and support to professionals working in the drug and alcohol field.

Background

Harms from alcohol and drug use are a significant contributor to morbidity and mortality across Australia. The estimated burden of disease related to substance use in Australia is alcohol 2.3% (net effect), illicit drugs 2.0% and tobacco 7.8%[1]. The estimated costs of alcohol and other drug use in 2004/05 in Australia was $55.2 billion, of which alcohol accounted for 27%, illicit drugs 15% and tobacco 56%[2]. These costs relate to healthcare costs, road accidents, loss of productivity and crime.

Australia's response to substance use has been well articulated in the National Drug Strategy since the late 1980s. The current strategy: 'National Drug Strategy 2010-2015: A framework for action on alcohol, tobacco and other drugs'[3] outlines the three key pillars underpinning state and federal jurisdictional responses: *demand reduction*, *supply reduction* and *harm reduction*. The cross-jurisdictional consistency of approach across drug types remains important in reducing drug related harms. Australia continues to effectively use evidence-based public health measures and clinical interventions to reduce substance use. Some examples are banning tobacco advertising, plain packaging of cigarettes, reducing public places tobacco can be smoked and subsidising medication used to treat tobacco addiction, which are all supported by evidence of effectiveness.

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APSAD believes that considering appropriate responses to alcohol and other drug use, the following issues should be considered:

- While substance use occurs across all social classes, people with significant substance use problems are often marginalised, of low socio-economic backgrounds and have low levels of health literacy. Indigenous people are over-represented in drug and alcohol treatment presentations. Indigenous people are over-represented incarcerated at extremely high levels compared to the non-Indigenous population; not infrequently with problems related to substance use.
- Drug and alcohol addiction, or dependence, is a chronic medical condition. People with alcohol and drug problems often require a wide range of interventions over a long period of time. Strong linkages need to exist between the range of service types for patients to be able to experience continuity of care and smooth referral processes between treatment types.
- Treatment for drug and alcohol problems includes a range of service types (including assessment, withdrawal and post-withdrawal treatment, medication assisted treatment, day care, residential rehabilitation and drug counselling) provided by a range of clinical staff (including general practitioners, psychologists, addiction medicine specialists, addiction psychiatrists, nurses, nurse practitioners, pharmacists, social and welfare

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workers and drug and alcohol workers). The settings in which alcohol and drug treatment take place include within hospitals, primary health care and other community settings; and cover inpatient, day-patient, outpatient and other ambulatory care services.

- The provision of drug and alcohol treatment should occur within generalist health care settings and be supported by specialist drug and alcohol treatment services, across local health districts/networks, in non-government organisation settings as well as within Medicare Locals. Appropriate clinical responses to problems from substance use should ideally occur across all these settings.

- Treatment should fundamentally be based on evidence and demonstrated quality of treatment. Research into new treatments for addiction should occur under appropriate ethical research governance frameworks.

- Drug and alcohol services need to be adequately funded on an appropriate transparent funding formula. Current funding levels appear low given the related burden of disease (In 2003 alcohol and drug use accounted for an estimated 4.3% of the burden of disease in Australia, however, represent only 0.33% of health budgets[1].)

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[1] in 2002/03 the size of the health budget was $68,789 million4. Australian Institute of Health and Welfare. Health expenditure Australia 2007–08. Canberra: Australian Institute of Health and Welfare,

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- Drug and alcohol problems occur across a wide spectrum of severity – from mild to severe problems. Accordingly, a range of services is required to address drug and alcohol problems – including: public health and population prevention strategies; targeted prevention and early interventions for those with early or mild problems. This includes:
    i. screening and brief interventions in primary care settings;
    ii. treatment interventions targeting those with mild-moderate problems that can be delivered in primary care and generalist health settings by appropriately trained staff, or supported by specialist drug and alcohol workforce.
    iii. Specialist interventions, including assessment, case management and counselling treatment interventions for people with severe drug and alcohol problems, with complex co-morbidities (such as mental health, chronic pain, infectious diseases, homelessness), or special populations (including young people, Aboriginal or Torres Strait Island people, pregnant women, parents with alcohol or other drug

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2009. In that year $229.2 million was spent by the Federal and State governments on drug and alcohol treatment 5. Moore TJ. What Is Australia's "Drug Budget"? The Policy Mix Of Illicit Drug-Related Government Spending In Australia. *Drug Policy Modelling Project Monograph Series*. Fitzroy: Turning Point Alcohol and Drug Centre, 2005. which accounts for 0.33% of the Health budget that year.

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use problems). Such services are largely delivered by a specialist workforce, often, but not restricted to, tertiary settings such as hospitals and state funded community health settings.

Each of these levels has its own service and workforce requirements. Consequently, it is not appropriate to think of services for drug and alcohol problems as occurring in a single service sector. Rather, drug and alcohol services need to span public health, primary care, NGO and specialist sectors.

Issues regarding specific substances

The national drug strategy household survey, conducted every 3-4 years since the 1980s, provides data on current patterns of substance consumption[6]. The proportion of current tobacco smokers has declined from 29% in 1993 to 18% in 2010. Despite this decline, the number of smokers has remained stable between 2007 and 2010, at about 3.3 million. The proportion of people who reported drinking alcohol recently remains steady over time (81% in 2010). However, as the Australian population has increased, the number of people drinking at risky levels increased between 2007 and 2010. One in five people in Australia drink alcohol at levels that put them at risk of harm during their lifetime.

Recent illicit drug use increased in 2010, mainly due to increases in cannabis use (from 9.1% in 2007 to 10.3% in 2010), pharmaceuticals for non-medical

purposes (3.7% to 4.2%), cocaine (1.6% to 2.1%) and hallucinogens (0.6% to 1.4%).

Patterns of drug use differ by other population characteristics depending on the drug type of interest. In general, high proportions of Aboriginal and Torres Strait Islander peoples smoked tobacco, drank alcohol at risky levels and used cannabis in the last 12 months compared with non-Indigenous Australians, as did people living in the Northern Territory compared with other states and territories. People living in rural and remote areas were more likely to smoke and drink at risky levels, but less likely to use illicit drugs such as cocaine compared with those in urban areas.

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Responses to the Terms of Reference of the Inquiry

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

Treatment responses for people with drug and alcohol problems should be evidence based and delivered by health professional competent in the delivery of those services. This should ideally occur across sectors (primary health care, community care and acute care settings) by both generalist and specialist health care workers.

Effective, evidence based responses to people with substance use problems include withdrawal services (outpatient, residential and inpatient), post withdrawal support (counselling, day programs and residential rehabilitation treatment), opiate substitution treatment (methadone and buprenorphine maintenance) and other medication assisted treatment (naltrexone and

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disulfiram programs for alcohol dependent people), drug counselling (including psycho-education, motivational interviewing, and relapse prevention).

With regards naltrexone, oral naltrexone tablets are licensed by the Department of Health and Ageing Pharmaceutical Benefits Scheme for the treatment of alcohol dependence *"For use within a comprehensive treatment program for alcohol dependence with the goal of maintaining abstinence"* [7]. Their use outside of this context is off label use, and not supported by current evidence. Oral naltrexone is not an effective treatment for opioid dependence, due mainly to poor adherence [8,9]. There is insufficient evidence on both safety and efficacy of naltrexone implants for opioid dependence [10,11] .

The Therapeutic Goods Administation has an appropriate framework for the consideration of new medications and devices, inclusing establishing the safety and effectiveness of new medications. There is no reason that any other process should be considered for naltrexone implants.

A commerically available depot preparation of naltrexone (Vivitrol ™®, manufactured by Alkermes) is available in the USA but not in Australia. This preparation would be ideal for a local randomised controlled trial, conducted through an appropriate human research ethics framework, into the use of an antagonist depot treatment for opioid dependence.

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The National Health and Medical Research Council literature review on naltrexone [12] is consistent with the findings of a current Cochrane review on naltrexone implants [10] and a recent review article on the topic [11]. The position statement of the National Health and Medical Research Council [13] is appropriate given the lack of credible evidence on the safety and effectiveness of naltrexone implants.

NSW has been particularly innovative in setting clinical standards in drug and alcohol treatment and evaluating new programs and approaches to drug problems. Recent examples of developing standards include NSW clinical guidleines on drug and alcohol psychosocial interventions[14], withdrawal guidelines[15], co-morbidity guidelines[16] and guidelines for the management of substane use in pregnancy and the early years of the newborn[17]. Examples of evaluating services include evaluating hospital based consulatation-liaison drug and alcohol services, drug specific clinics for cannabis and amphetamine users, services targeting homeless people with mental health and drug and acohol problems and the Whole Family Teams, targetting families with parents with mental health and/or substance use problems with children at risk of harm.

The NSW Ministry of Health should be acknowledgened to the high level of coimmittment it sets in supproting evidenced based treatment for people with drug and alcohol problems.

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

The NSW Drug and Alcohol Budget in 2009/2010 was $140 million [18] . More recent funding enhancements include a $2.5 million per annum allocation to the non government organisation sector in 2012 and a $3.4 million enhancement in 2012 to the Local Health Districts, the first significant enhancement in a decade.

While the strength and leadership of the NSW Health in responding to drug and alcohol problems over the last three decades is laudable, the funding quantum ought to be considered in relation to the burden of disease of drug and alcohol problems.

The burden of disease from mental health problems in 2004/05 nationally was estimated as 27% of the total burden of disease. The burden of disease from alcohol and drug problems (including tobacco) was 12%. While few would argue that adequate resources exist to treat mental health problems in the community, the situation from people with drug and alcohol problems is even more dire. Mental health is funded at $1.171 billion in 2009/2010, eight-fold more than for drug and alcohol problems.

A NSW led and Federally adopted initiative, the Drug and Alcohol Clinical Care and Prevention Model, while still under development, will provide a robust evidence based method to estimate unmet need for drug and alcohol treatment and inform resources allocation to the addictions field. This is an ideal model for better planning and service development in identifying unmet needs.

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

An important benefit of mandatory treatment for drug and alcohol problems is that it can be used as an alternate option to jail. Incarceration costs are significant (for example $50,000-100,000 per person, per annum) and cannot address inmates' addiction problems. Jail on its own is not a 'treatment' for drug or alcohol use problems.

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

The high prevalence of coexisting mental health and drug and alcohol disorders is well established[19]. Patients with a comorbid mental health and substance use disorder (SUD) are more likely to have highly complex and complicated illness courses, a high dependence on clinical services and poorer long-term prognosis[20]. The diversity of mental health and substance use disorders and associated complex comorbidity within this population indicates a need for services which target different levels of care.

Ideal treatment for patients with mental health and substance use problems is recognised as integrated treatment – i.e. where patients accessing drug and

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alcohol services can have their mental health problems treated in the drug and alcohol setting and patients with mental health problems can have their drug and alcohol problems in a mental health setting.

Depending on the level of complexity of mental health and substance use problems and other co-occurring other medical and/or social problems, patients with co-morbid mental health and substance use problems may receive treatment in the following settings: primary care, hospitals, drug and alcohol services, mental health services and prisons.

Typically non-government organisations lack staff with adequate skills and or experience to manage patients with more severe and or complex problems. Post discharge planning is further complicated by a lack of settings with the skills and experience to manage patients with significant mental health and substance use problems. Support for this clinically complex population needs to be individualised and provided over time, as evidence indicates that treating these disorders and changing behaviour is an ongoing process, one which evolves and requires the right compilation of interventions and services [21-24].

Further many individuals with substance use disorders have complex chronic health problems, which require co-ordination of care and treatment services over a long period of time across a range of settings – including primary and specialist services delivered in both the public and NGO sectors. It is therefore important to position Drug and Alcohol services alongside mainstream health

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services, and to establish systems that raise the profile of Drug and Alcohol services across all sectors of the health system.

Patients with drug and alcohol problems frequently access other health services including Emergency Departments, other specialist medical services (such as gastroenterology, infectious diseases, pain services), maternity, surgical, mental health, justice health, Aboriginal health, primary health care, and community services including child protection, violence prevention, housing and employment. Effective links need to occur across services and service types. Four key strategies to develop and foster these relationships include:

a. co-ordination mechanisms (e.g. local health district steering groups, clinical networks, clinical protocol and workforce development groups, clinical review and liaison meetings);

b. workforce development strategies (e.g. specified cross-training programs, shared training opportunities, staff exchanges, joint student placement, cross sector supervision);

c. clinical protocols and processes (e.g. referral processes, clinical pathways, intake and assessment, treatment, discharge);

d. joint special clinical projects (e.g. specifically developed treatment programs, information sharing, evaluation and research).

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A particularly important approach for integrating care across health services for those patients with complex treatment needs has been the development and expansion of consultation-liaison service models within the Drug and Alcohol sector. These have been particularly effective in enhancing and co-ordinating care between the following:

- Drug and alcohol and emergency departments are particularly effective in reducing ‘bed block’ and waiting times in emergency departments, and responding to ‘frequent presenters’,
- Drug and alcohol services and mental health for those with severe substance abuse and mental health co-morbidity;
- Drug and alcohol services and gastroenterology and infectious diseases services in providing antiviral treatment for patients in opioid treatment programs with Hepatitis C,
- Drug and alcohol and maternity services, with drug and alcohol consultation liaison staff involved in the perinatal period and early childhood years.

There also needs to be continued emphasis upon strengthening links between the drug and alcohol sector and primary care sectors, and in enhancing the capacity of the primary health sector to manage patients with mild or moderate severity substance use disorders. This will be a key area for development as there is greater clarity regarding the arrangements for Medicare Locals.

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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

The evidence base for the effectiveness of school based education programs is limited. Extrapolation of findings of current studies should be done with some caution, due to the potential risk of education programs resulting in a negative effect in some populations. The majority of high quality studies on prevention programs are from North America.

There is some evidence for family based interventions for alcohol targeting young people [25], school based alcohol interventions include seem to have some positive effects [26], however there is significant heterogeneity of effects including a lack of consistently positive effects with uncertainly regarding the components that make some programs effective . There is some evidence for the effects of school base programs in preventing illicit drug use in the USA [27]. There is a lack of evidence for interventions for young people outside of school settings [28].

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

Strategies need to continue to be evidence based. Significant concern should be raised when drug policy is driven by ideology rather than evidence base. The strengths of Australia's response to drug and alcohol problems is its cross

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jurisdictional co-orientated approached, detailed in over two decades of the National Drug Strategies, encompassing Supply Reduction, Demand Reduction and Harm Reduction. Harm reduction interventions have successfully stopped a HIV epidemic in Australian injecting drug users, a fact few countries in the world apart from Australia can lay claim to.

Models from Europe deserve consideration. In particular, the Portuguese approach to drugs and alcohol[6 29] is worthy of review in the context of considering current British and Swedish approaches to managing drug and alcohol problems in the community.

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

The proposed amendments to the bill include the use of naltrexone implants. It is difficult to countenance the NSW Ministry of Health endorsing a process operating outside the current Pharmaceutical Benefits Scheme and Therapeutic Goods Administration approval process i.e. using an unlicensed product, off label, currently not manufactured according to good manufacturing practice product (GMP) for any type of drug and alcohol treatment, including involuntary treatment. There would appear to be very serious medico-legal risks in perusing such a process. APSAD does not support the use of unlicensed medical products outside of an appropriate research framework including an ethical governance

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structure. It is also unlikely other authoritative medical bodies (e.g. the College of Physicians) would endorse such a practice. It is also be unlikely doctors undertaking any current medical indemnity insurers would cover such a practice. There would therefore appear to be a serious number of significant risks in adopting such a practice.

The evidence base for the long-term effectiveness of involuntary treatment is limited and has not been established by controlled clinical trials. Under the previous NSW Act permitting detention of people with significant drug and alcohol problems, the 1912 *Inebriates Act*, homeless people and Aboriginal people were disproportionately over-represented in people detained under for involuntary drug and alcohol treatment[30 31]. Any widening of powers of people able to refer under this act therefore requires very cautious consideration to ensure adherence to an ethical process based in good medical treatment of addictions.

The World Health Organization Guidelines for psychologically assisted pharmacological treatment of opioid dependence recommend that treatment should not be compulsory [32]. The UNODC discussion paper on treating drug dependence states: 'drug dependence treatment without the consent of the patient should only be considered a short term option of last resort in some acute emergency situations and needs to follow the same ethical and scientific

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standards as voluntary based treatment. Human rights violations carried out in the name of 'treatment' are not compliant with this approach.' (pg iii)[33]

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