Submission No 15

INQUIRY INTO DRUG AND ALCOHOL TREATMENT

Organisation: The Addiction Treatment Foundation Inc

Date received: 28/02/2013

Effectively Treating Opiate Addiction

Addiction Treatment Foundation Inc

The history of the treatment of heroin addiction has shown that it is one of the most addictive and destructive of drugs. It continues to be the drug that is most often injected, and has the highest mortality rates among young people who use drugs. The years of lives that are lost to heroin far exceed years lost due to alcohol or nicotine addiction.

Developments in neuroscience have demonstrated that addiction goes far beyond self-indulgence. It is a disease that leads to a person continuing to use drugs despite knowing the very serious negative consequences of this behaviour. It is a disease that often leads to premature death. While some individuals are genetically predisposed to develop an addiction we now know that addiction is very much an effect of the drug that is used. Drug use over time causes multiple changes in the brain structure and renders a person incapable of resisting the compulsion to use. A compulsion that can destroy their lives and the lives of those who love them.

It therefore is incumbent on our community to actively discourage drug use particularly among our young people, to put in place deterrents to drug use, to ensure that the dangers of drug use are realistically portrayed, to reduce the availability and accessibility of drugs, and to provide treatment for those who become victims of addiction. It is also incumbent on us to use the latest advances, including pharamacotherapies, to treat them.

The introduction of methadone was an attempt to reduce the harm associated with heroin addiction. Research has shown that methadone tends to reduce heroin use, improve health outcomes and to increase retention in treatment. However, it is also more addictive than heroin and has negative long-term consequences in terms of health and social outcomes. Moreover, many people on methadone continue to use heroin and to develop addictions to other drugs. They also often find it very difficult to find or retain employment, they find it difficult to be emotionally available to their partners or children and their freedom is compromised; retention in these programs is also poor with less than 50% staying in the programs at 6 months. The record for the use of buprenorphine is even worse, despite the claims that this drug is a superior alternative maintenance medication to methadone. It is poorly accepted by most addicts, it is often abused and sold to others to be injected and the consequences of injecting the drug are frightening. Suboxone is buprenorphine with naloxone (similar to naltrexone but shorter acting) added to prevent the drug from being injected. Its introduction is an admission of the failure of buprenorphine as a maintenance medication. It now means that those injecting the drug are at risk of going into life-threatening withdrawal if they are currently using heroin or methadone.

When methadone was introduced it was meant to provide a means by which people could be stabilised and then moved from addiction to abstinence. These aims have clearly not been met, with people now having been on these drugs for 30 years or more and a black market in them thriving, meaning that they are often more accessible than heroin. Most

disturbing is the fact that health authorities have no idea how to get people off methadone or buprenorphine once its usefulness has expired. We now have around 47,000 people on agonist maintenance programs, which directly cost our community some $150m each year. As more people join these programs, albeit reluctantly given the lack of choice, one can only speculate what it will be like in 20 years time; “methadone on wheels” for the pensioners and tens of thousands of people condemned to a life of mundane routine and pointless existence?

In marked contrast to this sorry tale there is an alternative treatment that offers addicted people a choice, and a way out, to lead a normal life. There is now abundant evidence that naltrexone can be highly effective in terms of detoxifying people from heroin, methadone and other opiates.

Naltrexone is an opiate antagonist which can be used both for detoxification, and for long term recovery from heroin, methadone and other opiate addiction. There is now abundant evidence of the effectiveness of Naltrexone for the treatment of Opiate addiction. Clinics in Sydney, Melbourne and Perth have successfully detoxified thousands of opiate addicts, and the use of Naltrexone implants has enabled many of these people to resume normal life. Despite this, minimal support from Governments, especially from the eastern states, has prevented many people from being able to access these programs.

The NEPOD study conducted over 7 years and costing the Government some $3m was unequivocal in its findings that naltrexone used under sedation was not only highly effective, but cost effective in achieving detoxification. Recent research has also shown that in a setting with trained doctors and nurses it is also a safe procedure. The Commonwealth Government has published guidelines for the effective and safe use of naltrexone in this way and yet its use is very limited in favour of keeping people addicted to heroin and methadone. The number of people who complete *traditional* detoxification programs is very poor, especially for methadone with completion rates below 5%. Despite this Governments continue to fund these detoxification and maintenance programs that cannot be justified in terms of outcomes, either in terms of economics or the suffering it causes those who enter these futile programs.

It is also clear from the evidence that detoxification is only the start of the process of recovery and that the form of detoxification does not predict long-term outcomes. Naltrexone in the form of implants has now been shown to be effective in promoting long-term recovery from opiate addiction, with outcomes that far exceed the achievements of any form of treatment to date. Moreover, a large and growing body of research has shown that naltrexone is a very safe drug, with no known interactions with other drugs, it has very few and no significant side-effects, it is non-addictive, it produces no euphoric effect with no potential to be abused or diverted to a black market. While further trials need to implemented, the clinical experience of those who have been conducting these programs for many years now suggests that naltrexone when coupled with counselling can provide hope and a realistic alternative treatment for those who want to cease drug use.

In 2004 "The Road to Recovery" report called for urgent trials of Naltrexone, yet this has still not been effectively implemented. While those who oppose the use of naltrexone call for trials limited funding was provided for an implant trial in Western Australia. This trial cost far more than was provided for in the grant, and it did not set out to answer some fundamental questions about the action of naltrexone. Further, an Australian Research Council grant application was submitted in 2006 a joint application from the PsychnSoul clinic in Sydney and University of Sydney researchers to look at these questions. Yet this application was rejected despite being a very strong proposal that followed publication of research showing the benefit of naltrexone implants among a group of addicts who were followed for 12 months (Colquhoun, Tan and Hull, 2005).

The RCT trial in WA conducted by Prof Gary Hulse and independently overseen showed a significant advantage in using naltrexone implants (Hulse, Morris, Arnold-Reed and Tait, 2009). Other RCTs from a number of other research groups from a number of countries have convincingly demonstrated the efficacy and safety of naltrexone. A recent review of the literate concludes that sustained release naltrexone is a feasible, safe and effective option for assisting abstinence efforts in opioid addiction (Kunoe, Lomaier, Ngo and Hulse, 2013)..

The critics ignore this evidence and continue to use arguments that have now been proven to be incorrect to oppose the use of naltrexone.

While authorities in the Eastern states continue to block funding for research and implementation of a naltrexone program, despite the overwhelming favourable clinical evidence, in Western Australia the Government has provided some $10m over 8 years to Dr George O'Neill's naltrexone program.
There is an urgent need to implement these changes to improve the way we treat heroin and methadone dependency, to provide wider choices for addicts and their families and to help those who cannot afford treatment.

The Addiction Treatment Foundation has raised over $50,000 to support research that has been conducted over 10 years into the effectiveness of naltrexone both for detoxification and recovery. We highly recommend that the NSW Government now fund on-going trials of naltrexone for detoxification and recovery from opiod dependence, including for those who are leaving prison for drug related crime and for those who want to be free of methadone dependence and for the recovery of those dependent on alcohol. The use of naltrexone should incorporate both in-patient and out-patient programs to facilitate recovery and to help people reintegrate into society as productive citizens.

Chair,
Addiction Treatment Foundation Management Committee

References:

Colquhoun, R, Tan, D.Y.K., and Hull, S., (2005). A Comparison of oral and implant Naltrexone outcomes at 12months. *Journal of Opioid Management, 1(5),* 249-256.

Commonwealth of Australia (2003). Road to Recovery. Report on the Inquiry into Substance Abuse in Australian Communities. [URL: www.aph.gov.au/house/committee/fca/subabuse/report/fullreport.pdf]

Department of Health and Aging (2004). National Evaluation of Pharmacotherapies for Opioid Dependence (NEPOD). Monograph Series No. 52. Report of Results and Recommendations. [URL: www.nationaldrugstrategy.gov.au/.../publishing.nsf/Content/1800A327CF9ECDD9CA25717A0015E6DC/$File/mono52.pdf]

Currie, J., Collins, L., Mudaliar, Y., Cox, P., Gaunt, L., Lutz, P., & Ward, H. (2000). Western Sydney Area Health Service Naltrexone project - Rapid induction onto Naltrexone: A randomised trial of anaesthesia-assisted versus sedation assisted techniques, and a comparison with conventional detoxification. Sydney: Western Sydney Area Health Service Drug and Alcohol Service (unpublished).

Hulse, G. K., Morris, N., Arnold-Reed, D. and Tait, R. J. Improving Clinical Outcomes in Treating Heroin Dependence: Randomized, Controlled Trial of Oral or Implant Naltrexone. *Archive of General Psychiatry.* 2009, Vol 66 (10):1108-1115.

Krupitsky, E., Nunes, E. V., Ling, W. Illeperuma, A., Gastfriend, D. R and Silverman, B. L. (2011). Injectable extended-release naltrexone for opioid dependence: a double-blind, placebo-controlled, multicentre randomised trial. The Lancet Volume 377, Issue 9776, 30 April–6 May 2011, Pages 1506–1513

Kunøe, N., Lobmaier, P., Ka˚ re Vederhus, J., Hjerkinn, B., Hegstad, S., Gossop, M., Kristensen O. and Waal, H. Naltrexone implants after in-patient treatment for opioid dependence: randomised controlled trial. *The British Journal of Psychiatry (2009) 194 (6),* 541–546

Kunoe, N, Lomaier, P. Ngo. H and Hulse, G. Injectable and Implantable Sustained Release naltrexone in the Treatment of Opiod Addiction. British Journal of Clinical Pharmacology (In Press)