Submission No 17

INQUIRY INTO DRUG AND ALCOHOL TREATMENT

Organisation: Sydney Medically Supervised Injecting Centre

Date received: 28/02/2013

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The Director
General Purpose Standing Committee No. 2
Parliament House
Macquarie St
Sydney NSW 2000

28th February 2013

Dear Sir/Madam,

RE: NSW Drug and Alcohol Treatment Inquiry

Attached please find a submission to the NSW Legislative Council, General Purpose Standing Committee No. 2, on behalf of the Sydney Medically Supervised Injecting Centre (MSIC).

Sincerely,

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Medical Director

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NSW Legislative Council
General Purpose Standing Committee No. 2
Inquiry into Drug and Alcohol Treatment

Background to Sydney Medically Supervised Injecting Centre:

The Sydney Medically Supervised Injecting Centre (MSIC) is a harm reduction health service. It was the first supervised injecting centre in the English Speaking world, and remains the only service of its kind in Australia. There are now over 90 supervised injecting centres around the world, mostly in Europe.

Supervised injecting centres reduce death and injury associated with injecting drug use, primarily through effective clinical intervention in the event of drug overdose. There has never been an overdose death reported in any supervised injecting centre anywhere in the world. Such services work as local solutions to local problems, and are beneficial to their local community by taking drug injecting and discarded injecting equipment off the streets and into a health service. Further, they make contact with a vulnerable population who are often long term injecting drug users, with high rates of homelessness and other physical and psychiatric comorbidities – and these people can then be referred on for further treatment and care. They Sydney MSIC is best considered as part of a continuum of care, and represents just one part of a comprehensive system needed to address injecting drug use in our society.

The Sydney MSIC was independently evaluated for the first decade of its operation. Eleven reports from five different organisations were published, all showing that the service meets its aims in a cost effective manner and without adverse events. Additionally, a recent review by the Drug Policy Modelling Program of UNSW showed that there were more than 130 published papers internationally on supervised injecting centres, with research indicating some positive outcomes in relation to overdose risk, at risk injecting practice, improved access to drug treatment, improved amenity and reduced crime.

The Sydney MSIC is broadly supported by the medical field, including the Australian Medical Association, Royal Australasian College of Physicians, Royal Australia and New Zealand College of Psychiatrists, Royal Australian College of General Practitioners, and Australasian College for Emergency Medicine.

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The Sydney MSIC is also supported by relevant academic institutions across Australia, including the National Drug and Alcohol Research Centre, Kirby Institute, National Centre in HIV Social Research, National Drug Research Institute and National Centre in Education and Training on Addiction.

The service is run by UnitingCareNSW.ACT, the arm of the Uniting Church responsible for community services and advocacy on social justice issues. The Sydney MSIC receives funding from the Confiscated Proceeds of Crime.

The following is a response to each of the terms of reference:

1. *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:*
   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:
      The need for appropriate human research, ethics and Therapeutic Goods Administration approval for use of new treatments in clinical trials
      The current body of evidence and recommendations of the National Health and Medical Research Council

The Sydney MSIC supports a view of health as more than just the absence of disease, as espoused in the World Health Organisation constitution, and as a 'state of complete physical, mental and social wellbeing'. We support health services that are ethically delivered and where the rights of the patient are recognised and respected. We believe that all care should be patient centred and evidence based. Further, we believe that drug dependence is best dealt with as a health issue rather than a legal one.

The Sydney MSIC acknowledges that there is a far higher burden of drug and alcohol morbidity and mortality amongst those more disadvantaged members of our society. It is the experience of Sydney MSIC that our clients have a far higher prevalence of significant trauma, abuse and neglect in their backgrounds that the general population. For many of our clients, intergenerational cycles of drug use,

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unemployment, poverty and marginalisation have been the norm rather than the exception.

Of the approximately 10, 000 referrals made by staff at the Sydney MSIC about half have been for specialist addiction treatment. For many of our clients, their level of addiction tends to be on the more severe end of the spectrum. Available evidence shows that opiate pharmacotherapies (methadone and buprenorphine) have the highest rates of retention in treatment. Sydney MSIC has a full time clinical nurse consultant who is employed as a referral coordinator. This job ensures the service is well integrated with available treatment services in the local area and kept up to date with all available options. We have negotiated a priority pathway into treatment at a local pharmacotherapy service, and we also routinely refer clients to residential rehabilitation, counselling and detoxification, noting that detoxification is not considered a treatment in and of itself.

While MSIC staff will be guided by client preference and would not wish to reduce available treatment options for clients, rapid opiate detoxification and naltrexone implants would not be routinely recommended. Apart from a lack of evidence for their benefit, there is some evidence of harm and we note the findings from a recent Coronial investigation into the Psych n Soul clinic here in Sydney. We would also note available guidelines from NSW Health regarding the experimental nature of these treatments and lack of approval for their use by relevant regulatory authorities. Staff at MSIC would ensure that any client inquiring about these treatments was provided with information about associated risks as well as appropriate treatment alternatives.

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

There are approximately 19,000 people receiving opiate pharmacotherapy in NSW, and more who are opiate dependent and trying to get on treatment. It is said that waiting lists for opiate pharmacotherapy is certain areas, such as the Hunter, are up to 2 years. For those who do get into public clinics treatment is provided free, however once a client moves to a pharmacy, or for those dosed in private clinics, the costs are considerable. The dispensing fee /copayment cost means people are out of pocket $7-10 *per day*. Those on opiate pharmacotherapy are generally considered a

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low income population, and $210 - $300 each and every month for treatment of their chronic condition is very expensive. Investigation into reducing out of pocket costs for people receiving opiate pharmacotherapy is needed.

There are a range of residential rehabilitation services, some of which charge only a proportion of whatever social security benefit a client is on, others of which have an upfront payment which can be considerable. An issue for us here at the Sydney MSIC is that we have considerable experience of clients attending a service for management of their drug withdrawal, but not being able to access a residential rehabilitation service afterwards. A gap of some weeks or months invariably means that the person returns to their drug use. Better integration of such services would represent a worthwhile investment, such that immediately after detoxification a client could be transferred for ongoing rehabilitation and care.

Previously, in order to enter any residential rehabilitation or therapeutic community, clients had to not only have ceased all illicit drug use, but also ceased all pharmacotherapy. Given the evidence for pharmacotherapy is so clear, the lack of available rehabilitation services for such clients is inappropriate.There is now capacity for the We Help Ourselves program to provide methadone dosing within their service, assisting clients to stabilise their methadone while in a supportive residential environment. The potential exists for the person to reduce their dose later on if this is appropriate. This service represents a new opportunity, and we have referred a number of clients there. Further investment in such services would be worthwhile.

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

We would point to WHO guidelines which clearly state that 'in line with the principle of autonomy, patients should be free to choose whether to participate in treatment'. The only exception to this is of course where mental illness means a person poses a significant threat to themselves or others. We would also note the words of the United Nations Office on Drugs and Crime discussion paper *From coercion to cohesion: Treating drug dependence through health care, not punishment*'. It is noted here that '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 standards as voluntary-based

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treatment. Human rights violations carried out in the name of "treatment" are not compliant with this approach.'

There can be some confusion regarding the terms mandatory versus coercive. Here in NSW court diversion programs such as Magistrates Early Referral into Treatment and Drug Courts provide a viable choice for people to enter treatment instead of incarceration. This is an important initiative to reduce the numbers of people in custody for drug related crimes. However Sydney MSIC would not support the compulsory treatment, without consent, of people purely on the basis of their drug dependence.

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

This is an important area and one where systems issues can be responsible for less than ideal patient care. If we are to improve the treatment of those with co-existing mental health and D&A issues, better integration and communication between these services is essential. It is exactly because of the problems in this area that Sydney MSIC applied for, and was successful in obtaining a Commonwealth Substance Misuse and Service Delivery Grant to employ a fulltime Mental Health Nurse Coordinator for three years. This position began in October 2012, and aims to:

- improve staff capacity to assess and address mental health issues;
- improve specialised assessment of clients with mental health issues;
- improve the coordination and care of such individuals;
- and enable appropriate communication between local services and MSIC.

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

There are many studies, and practical examples, that show provision of information alone doesn't tend to change human behaviour. This is because there can be many barriers to change, as well as many 'enablers' that support and perpetuate the original behaviour. The academic field of health promotion proposes various theories

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to explain and predict behaviour change. These can be invaluable in increasing the chances of successful program implementation.

Education campaigns that promote fear and are seen to overly dramatize negative consequences may be ineffectual. So while education programs regarding the effects of drugs are often considered non-controversial, they can be of limited value. The opportunity cost should also be considered. Funds spent on an ineffective education program could be better spent on addressing underlying causes.

It is worthwhile to note again that those who suffer significant morbidity and mortality related to drug use in our community are more likely to be those at the disadvantaged end of the socioeconomic spectrum. The social determinants of health, as described by Sir Michael Marmot and the World Health Organisation, are the conditions under which we live, work and play – and they critically influence our health. It is these social and economic conditions that determine not only our risk of disease and illness, but also our ability and capacity to respond. While the causes of drug and alcohol problems are complex, we do know that certain circumstances and childhood experiences make it more likely. Much more could be done in the area of early intervention, focusing on the first two to three years of a child's life. Programs that provide support to vulnerable families, improve parenting capacity, and promote resilience can reduce the risks of behavioural problems and problematic drug use as these children grow up. They represent a worthwhile investment.

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
The proposed reforms identified in the Drug and Alcohol Treatment Amendment Bill 2012.

Australia has had a national harm reduction approach dating back more than 25 years. Harm reduction recognises that despite efforts in supply and demand reduction, many people throughout the world continue to use psychoactive drugs. Harm reduction aims to reduce the economic, social and health related harms associated with the use of drugs. It may complement those approaches designed to prevent or reduce overall levels of drug consumption. A polarised debate sometimes occurs where advocates of harm reduction are seen as being pitted against those advocating abstinence, presuming the two approaches to be mutually exclusive. But harm reduction can embrace abstinence as a goal, the key is that a pragmatic

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approach such as harm reduction does not allow abstinence to be the only goal, exclusive of all others. There is overwhelming scientific evidence to show that harm reduction interventions are successful and cost effective.

Given key health related harms associated with injecting drug use are blood borne virus transmission and drug overdose, the evidence base for programs preventing these harms specifically are discussed in more detail.

Needle and Syringe Program NSP:

In Australia the NSP has made a significant contribution to the prevention of Hepatitis B, Hepatitis C and HIV/AIDS transmission. The rate of HIV infection among people who inject drugs in Australia has remained around 1%, compared to other countries where prevalence rates can exceed 50%.

In NSW alone it was estimated in 2009 that NSP programs had prevented 23, 324 cases of HIV/AIDS, 31, 953 cases of Hepatitis C infection and resulted in a saving of $513 million in health care costs.

While the prevalence of Hepatitis C infection among people who inject drugs has reduced in the last 5 years, it is still estimated that approximately 50% of people who inject drugs have hepatitis C infection. Cirrhosis and liver failure from chronic hepatitis C infection have become the biggest cause of liver transplantation in NSW and across Australia.

Modelling work done at the NCHECR (now Kirby Institute) estimated that in order to halve the number of new hepatitis C infections, the distribution of NSP would need to double.

Opiate pharmacotherapy treatment (methadone and buprenorphine):

Opiate pharmacotherapy has been an effective opiate addiction treatment for more than 40 years in Australia. In NSW public treatment places increased substantially after the 1999 NSW Drug Summit. Opiate pharmacotherapy has been shown to very significantly improve health outcomes for the individual (reduced risk of blood borne virus transmission, reduced risk of fatal overdose, reduced risk of suicide), and improves outcomes for the community (reduced criminal activity, reduced drug use), and it is cost effective. Retention in treatment and prevention of death and disability are primary markers of treatment efficacy. Opiate pharmacotherapy has been shown to be superior in both these markers compared to other opiate treatment modalities.

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The World Health Organisation (WHO), UN Office of Drugs and Crime, and UNAIDS have put together a comprehensive package of interventions for HIV prevention, treatment and care for people who inject drugs, and the first two of these (out of nine) are NSP and opiate pharmacotherapy. Indeed the WHO puts together a list of essential medicines, related to the priority health care needs of the population and selected with due regard to public health relevance, evidence on efficacy and safety, and comparative cost-effectiveness. Methadone is considered an essential medicine.

Recommendations made on behalf of the Sydney MSIC:

- An ongoing commitment to harm reduction principles is essential.
- An ongoing commitment to policy based on evidence rather than ideology is essential
- Evidence based harm reduction programmes should target vulnerable groups and ensure access to services adapted to their particular needs.
- Needle Syringe Programs must increase their capacity to reduce incidence of blood borne virus transmission
- Opiate pharmacotherapy public treatment places should be expanded and out of pocket expenses for private and pharmacy patients should be fully subsidised
- Consideration should be given to improved support / incentives for GPs who prescribe opiate pharmacotherapy and to pharmacies dispensing treatment in order to improve/expand the current opiate pharmacotherapy program
- Consideration should be given to subsidies for nicotine replacement therapy for clients on opiate pharmacotherapy– prevalence rates of smoking and thus smoking related morbidity/mortality are very high in this group
- Expansion of rehabilitation services should occur for people on opiate pharmacotherapy

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- Better access to and integration with mental health services for clients with D&A issues is needed

- Access to naloxone should be expanded in order to reduce the increasing numbers of accidental opiate overdose deaths in Australia

References available upon request