REPORT OF PROCEEDINGS BEFORE

GENERAL PURPOSE STANDING COMMITTEE No. 2

INQUIRY INTO DRUG AND ALCOHOL TREATMENT

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At Sydney on Wednesday 3 April 2013

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The Committee met at 11.15 a.m.

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PRESENT

The Hon. M. A. Ficarra (Chair)

The Hon. J. Barham
The Hon. D. J. Clarke
The Hon. J. A. Gardiner
The Hon. S. Moselmane
Reverend the Hon. F. J. Nile
The Hon. H. M. Westwood

CHAIR: I welcome all of you to the first public hearing of the General Purpose Standing Committee No. 2 inquiry into drug and alcohol treatment. The inquiry is examining and reporting on the effectiveness of current drug and alcohol policies with respect to deterrence, treatment and rehabilitation. Before I commence with questions I acknowledge the Gadigal people, who are the traditional custodians of this land. I pay respect to the elders past and present of the Eora nation and extend that respect to other Aboriginals that are present. Today is the first of three hearings we plan to hold for this inquiry. The Committee will hear today from representatives from the Fresh Start Recovery Program, National Drug and Alcohol Research Centre, the University of New South Wales, Mission Australia, the Australian Drug Law Reform Foundation, the Network for Alcohol and Drug Agencies and Family Voice Australia.

I shall make some brief comments about procedures for today's hearings. Copies of the Committee's broadcasting guidelines are available from Committee staff. Under these guidelines, while members of the media may film or record Committee members and witnesses, people in the public gallery should not be the primary focus of any filming or photography. I remind media representatives that you must take responsibility for what you publish about the Committee's proceedings. It is important to remember that parliamentary privilege does not apply to what witnesses may say outside of the evidence at the hearing. I urge witnesses to be careful about any comments they may make to the media or to others after you complete your evidence as such comments are not protected by parliamentary privilege if another person decided to take action for defamation.

Regarding adverse mention, Committee hearings are not intended to provide a forum for people to make adverse reflections about others. The protection afforded to Committee witnesses under parliamentary privilege should not be abused during these hearings. I therefore request that witnesses focus on the issues raised by the inquiry terms of reference and avoid naming individuals unnecessarily. Witnesses are advised that any messages should be delivered through the Committee staff. Could everybody please turn off your mobile phone for the duration of the hearing. I now welcome our first witnesses, from the Fresh Start Recovery Program.

JEFFREY IAN CLAUGHTON, Chief Executive Officer, Fresh Start Recovery Programme Western Australia, and

ALEXANDER GEORGE BRIAN O'NEIL, Medical Director, Fresh Start Recovery Programme Western Australia, affirmed and examined:

TERRENCE DAVID BEAUCHAMP, Fresh Start Recovery Programme, New South Wales, and

CHARLIE POPOV, sworn and examined:

CHAIR: Would any one of you care to make an opening statement before we move to questioning?

Dr O'NEIL: I thank the Committee for the privilege of being here. I am a medical practitioner and I hold roles in manufacturing and design of medications, as a treating doctor and as medical director within Fresh Start. The patient who is going to talk—

Reverend the Hon. FRED NILE: Could you please speak up?

Dr O'NEIL: I have a reputation of being a gynaecologist and making sure nobody can be hear what is being said behind the door. I will speak up. The work with Fresh Start involves a commitment to try and improve the treatment of addicts around this country but also internationally. That is a commitment to improve recovery medicine or the concept of patients wanting to recover. When people walk through the door of any addiction specialist's office there are two things they are seeking: some are seeking comfort because they are withdrawing and they need some valium or opiates to keep them comfortable and others are coming with their families saying I want to change my whole lifestyle.

The medicine to support the ones who want to change their whole lifestyle has almost been excluded from everybody in the eastern States. It has not been excluded from the people in Western Australia. It is interesting to ask: what is going on in the country? I will let the Committee ask the questions. There is enormous public support in Western Australia for the concept of recovery. It has become almost a movement and that movement is slowly spreading to the eastern States. We are asking for support in that movement.

CHAIR: I was impressed by the number of university collaborators including the University of Western Australia, Curtin University, Edith Cowan University and Murdoch University. Can you take us through how you devised this university collaborative approach, setting up the clinical trial and the level of trialling that you do in terms of level of significance?

Dr O'NEIL: My own role has been as a surgeon and with a strong interest in procedures. Thirty years ago I started a private organisation to improve common procedures, which meant I could improve day management and obstetrics and gynaecological procedures. That involved employing pharmacists and pharmacologists. Starting 28 years ago that led me to work with Curtin University and Professor Sunderland. I had a group of students going through doing PhDs. If I go back 25 years ago I started working with the drug and alcohol authority in Perth to look after the methadone mothers because methadone mothers coming through King Edward Memorial Hospital were not being well looked after. I took them down to my surgery and looked after them. It gave me a strong commitment to this area of medicine. In the area of opiate management with methadone mothers there is an enormous amount of reform necessary and I can go into detail if you like. That gave me a strong area of interest.

I was already working with Professor Sunderland but 17 years ago Professor Sunderland and I started talking about bringing buprenorphine in, which is a partial agonist, thereby moving from an agonist to a partial agonist. Then we got excited by naltrexone. Together we took a young graduate, Yandi Liu, who was just finishing his PhD—I was working with him and Professor Sunderland—and we set up a project and worked for three years at Curtin University. That allowed us to develop microspheres, develop formulations and put the formulations in mice and rats, but most specifically rats. We proved that if we made an injection with microspheres we could achieve good naltrexone levels for a month. If we did implants it looked as if it was going to go on for many months. I was very disappointed and upset because I wanted to make the injections last many months but I couldn't.

I made a commercial decision to explore the implants because the patients needed long-term treatment. I started the actual treatment of patients at the same time. In other words, we employed Yandi in 97-98 and I started treating patients in 97-98. I started the treatment accidentally because I asked the drug and alcohol authority to take over these patients but they did not so the workload fell on myself. Curtin University was largely involved in the formulation and development work and they have continued to be involved in that. The University of Western Australia [UWA] became involved when we started planning clinical trials.

The clinical trials started with audits by the university in 1998, one year after we started our service delivery. Those audits were paid for by the Western Australian Government. The publications that grew out of those audits resulted in a randomised controlled trial paid for by the Western Australian Government in 1999 to look at detoxification. We looked at detoxification and whether it was safer to do detoxification on the government unit, where you lock people up for a week or 10 days, or whether we should do it as a rapid outpatient treatment.

Those results were published in 2005 in the journal and the randomised control trial showed that 11 per cent of patients failed to turn up for their detoxification if they waited two days. If they waited, as they had to, in the government department for two weeks, they lost 70 per cent; 35 per cent they lost in the two-week waiting period and 35 per cent ran away before the treatment was finished. So it showed the effectiveness of treatment on the spot. That cost more than $1 million to fund. It was a very well run trial.

We then went on to continue to treat people and produce about 30 publications and started our first randomised control trials [RCT]—we started our GMP facility in 2005 and that obviously involved TDA approval of the facility. We went on to do a randomised control trial in 2006-07. That was published in 2009. When you hear of Cochrane reviews, the Cochrane review was done in 2008 just before the two main RCT trials were published. So the people who did the Cochrane review have subsequently gone on to publish to say they now have sufficient evidence. So that is significant.

CHAIR: It is a high level epidemiological.

Dr O'NEIL: Yes. I hope that answered your question. I hope I have not taken up too much time.

CHAIR: That is fantastic. I want to get right out in the open because some of the critics—I will mention him because he has written it in one of the submissions and said it publicly. Dr Alex Wodak criticises you for being the medical director for Go Medical Industries and claims that the patients you treat lack the knowledge, and that you may have a conflict of interest. How do you address those claims? Let us get it out into the open.

Dr O'NEIL: Sure. If you talk about the conflict of interest, all doctors have a conflict of interest because they are committed to whatever they are committed to. In Alex's case it will relate to drug legalisation. As you get towards drug legalisation you accidentally start impacting patients. You meet a patient who is in a certain stage of life and you assume that he wants to stay in that stage of life, whereas the patient who puts up his hand and says, "I want to change my whole lifestyle". Drug legalisation does not allow you to change your whole lifestyle. It only allows you to be comfortable where you are at. Most of the people presenting to us make it. So Alex has done a great deal for supporting the people who want to be at a certain place but in terms of allowing people to change their lifestyle, his philosophy and the harm minimisation philosophy that Australia has taken up, I want to make a very strong statement to this Committee. The statement is that there are two groups of patients: those who want to change their whole lifestyle and give up their drugs, and those who want to continue their drugs.

When the Australian politicians have got together and said that harm minimisation will be our best policy, it is like running a company and saying, "Gosh, we will not aim at target number one because we will aim at target number two because we will never reach target number one." That is a great failure in our system. It is time that each of you—you are politicians so you need to be absolutely committed to support people who want to give up their addiction. Alex is not and Alex makes it clear he is not in all that he says and in all that he writes. This is not me criticising Alex; it is just criticising the target because our targets are two different targets. There is no point in undermining me because of having a different target.

CHAIR: Would the patients that you treat be aware that you are the medical director of a company that has invested quite a lot of money to bring naltrexone implants to the level of commercialism they are now?

Dr O'NEIL: People know that I have been inventing. People know that I have been committed. People know that I have been struggling. People know that one day maybe I will make a profit, but I probably will not be alive at that stage.

CHAIR: It will not be for a while. I was involved in pharmaceuticals for many, many years.

Dr O'NEIL: I have been running a company for 30 years and never paid dividends to any of our family members. I could carry on to make a public statement about that but there is no point. Our dividends are the patients like Mr Popov who were sitting on our bench a week ago. Maybe if the whole country works together and we get this product registered, we will stay ahead of the Americans and the Russians.

CHAIR: In terms of the level of care and supervision that is required for the monitoring of the patients that you treat with naltrexone implants, their care and attention while you are treating them and the ongoing care, what can happen, because there is always a fear of patients going back to using drugs and perhaps overdosing post the implant period? Can you take us through what care and concern, what risks are involved in each one of those, the selection of the patient, the treatment with implants and post implant?

Dr O'NEIL: I think the big problem in treating heroin addicts is that when you detox them you take somebody who has a chance of death, which is 25 deaths per 1,000 patient years, and after detoxing you raise that up to 50 or sometimes even 100 per 1,000 patient years after detoxing. So if you take people to the farm you make take them up to a higher death rate or a higher risk of death than before you actually detox them. With naltrexone implants for a period of about six to nine months the risk of death is below one per 1,000 patient years so you have dramatically reduced the risk of death. It is not so much the first six or nine months; it is the second year.

It is the year after I have put the implant in that I am most worried, and that is where we need the most support from State and Commonwealth governments. When we have people flying all the way to Perth for treatment I want to make sure that we have a relationship with big doctors in New South Wales. That is why we have asked Mr Beauchamp to start being a full-time worker to remind these guys to come back. We are trying to work with local governments to encourage people to build up the same sort of recovery movement in New South Wales as we have seen in Western Australia. But we are very keen to—we are employing 60 or 70 staff, even though we have not always had the funds for it, to try to make sure that we can follow up with these people.

CHAIR: I know that other Government members want to ask questions, but I am aware that Mr Charlie Popov has come specifically to deliver us probably a message. Mr Popov, would you like to say anything, given that you are a successful advocate and a patient who has been through the naltrexone program?

Mr POPOV: I would not say successful at this stage, but last Tuesday I flew into Perth after many detoxifications in Sydney. I tried the program for about a month. They put me on suboxone; it just was making me feel terrible. I did not even like the way I was treated there at the clinic. It is just like going to a drug dealer. That is my personal opinion. I was at a clinic in Liverpool. The fact is that if it was not for my family I would be dead. When I arrived in Perth I was all scabbed up. Even about an hour prior to having the naltrexone implant with the other patients who were outside waiting, I was there asking them if they knew anyone where I could get some, like for the last time. Then I was a little bit ill obviously after having the implant for the first two days but I can show photos. I have photos posted on Facebook where I have gone out on a bike ride on Sunday in Perth, enjoying the weather, and at a barbecue with friends.

CHAIR: How many days after the implant?

Mr POPOV: I had it on Wednesday the 27th. Today would be seven days. My family has noticed a difference and I have not had any thoughts of using. Scientifically, I do not know how it works but Dr O'Neil first treated me back in 2002, 2003 and 2005, and I had probably nine years of clean and sober. I started a business and was going well and I got into depression. I fell back into the trap of drinking, then cocaine, then that led to heroin and I ended up at the South Pacific last August, the private clinic, which is a very lovely place but that did not work either. I relapsed after 18 days. Then I went to the Salvation Army in Surry Hills, and relapsed probably a week after that. Then I went to Concord, ward 64, got out and relapsed after two days. My father and my brother-in-law from Perth, who Dr O'Neil knows because he has treated me in the past—they said enough is enough, we need to settle this once and for all. Obviously the addict part of the brain, I did not understand this, but it is a disease.

You are fighting that you do not want to do it and then you are living guilt and shame. I have three children at home and I was on the knife's edge of losing my house, my business. If it was not for my family that stepped in—my brother is running my business now. My mum and dad paid my insurances. I still have to work things out with the ATO and all sorts of stuff. It is like a cyclone has come through my life. But doing this naltrexone implant, which I should have listened to my dad two years ago, I would not be here today. It works. I am living proof of that.

CHAIR: Did you have an implant beforehand when you say that—

Mr POPOV: No. The last one I did was 2005, 2003 and 2002 but it kept me clean for nine years.

CHAIR: That is a heart-wrenching story you have shared with us and we appreciate it is difficult for you to talk about these things publicly, but we admire you for doing so. Dr O'Neil, what sort of support services can we put in place to support someone like Mr Popov once he successfully went through in 2003, 2005 so that he would not end up back with you again? What could we be doing better?

Dr O'NEIL: I need to keep relating to the doctors here in Sydney because there are good doctors who are very keen to work with naltrexone. One of the biggest obligations on my shoulders is we had a fire in our factory, even though we reached GMP status. Our family has just invested in getting the factory rebuilt and that is occurring at present. In the meantime if Mr Popov was living in a closer setting his family might have persuaded him to come to Perth, but even just finding the one-way airfare can be a barrier at a time when everybody is under pressure. So the one thing I plead is patients need repeat implants six to nine months later, as soon as they start to feel any temptation to go backwards. That service of even finding a one-way airfare—

CHAIR: Sure, it is expensive.

Dr O'NEIL: Our CEO make speak to you and tell you our real expenses, but the barrier that stops patients from getting their next treatment until we have a service operating efficiently in Sydney will be just finding the one-way airfare. That is a relatively small thing to find but if you cannot find the one-way airfare the patients do not get across to us.

The Hon. SHAOQUETT MOSELMANE: Having listened to your few words at the beginning, you said that you have made a commercial decision to explore implants. I am just curious. Is your exploration based on commercial decisions or genuine research decisions that made you use naltrexone implants? Is it a commercial decision or a genuine research decision?

Dr O'NEIL: I must be doing both. I have a family with six children. I try to be practical. I have not gone broke. I have treated everybody coming past and did not go broke. I must be doing commercial as well as research; otherwise I would not be surviving, otherwise I would not be building what I am building, otherwise I would not be doing GMP manufacturing. The Americans thought, "Gosh, an injection would be so much nicer. The patients just comes off the street and any psychiatrist can put it in." An implant is not very difficult surgically. I can teach any young resident how to put in implants, but an implant allows you to start looking at technology that will get heroin addicts better for six months, a year, maybe two years, maybe three years.

The Americans have gone and spent billions of dollars to get their injection licensed. Their injection is now a 28-day injection of naltrexone. It is a good product, provided the heroin addict comes back every 28 days but in fact it starts to get pretty weak round about day 21. Its blood level is very low at day 21. I knew we had a much more serious problem with heroin addicts if you are going to get them better, so I developed a 100-day implant, then a 200-day implant, then a 300-day implant, and hopefully before I retire I will develop a 600-day or a 800-day implant or maybe even a three-year implant, because the changes required to change a whole lifestyle or a whole family involve three to five years, and you have two groups of addicts.

Charlie's family was a very good family, so he got very good value systems and so I only have to change the physiology really and he is straight back to a strong faith, straight back to a strong family, straight back to a strong work ethic. But those kids who are sick between 12 and 25, they are still growing and they have a growing up disorder, what psychiatrists call a personality disorder. They have not learnt to be honest, they have not learnt to forgive. The racial groups that we treat that are coming from Sydney, particularly the Aboriginal people—the people from Iran, the people from Lebanon, the people from Vietnam, fortunately most of those families from overseas are strong families and I have only to change the physiology—but with the

Aboriginal families the addiction starts at 12, 13, 14, 15 and you have a growing up disorder where you need to give a lot of care.

A one-month injection will not do it so I made a commercial decision—if you are going to work in this field it might take me 10, 15 or 20 years to develop this properly but I have to head in the implant direction. So it was a commercial decision. In terms of being paid commercially, I was thinking by the time I get to 30 years of work we might be able to start to get it together. But if we can get the whole Government and the community working with us, we have done now 28,000 patient-years of work. That work cost at least $300 million to do, to do that sort of research as a commercial organisation. We have done that during this 14-year period. It is a big project for a family to take on.

The Hon. SHAOQUETT MOSELMANE: I note you have a number of universities on board that support your research, but you base your conclusion on an estimate. You say, "If placed on a naltrexone implant, all patients stop injecting and from our experience we estimate …".

Dr O'NEIL: I will give you the reason why I use the word "estimate". In good science you do randomised control trials. But when you start trying to analyse patients five years after you treated them and you are relying on mobile phone numbers and you do not have government systems that will allow you to retrace heroin addicts, you would be lucky to find 30 per cent of them. We have analysed the 25 per cent, sometimes 30 per cent who are contactable. I can only tell you that five years after treating heroin addicts 95 per cent of the people who were interviewed—that is 300 people—were not opiate free, and that is five years later.

I picked this figure, 85 per cent, and turned the term into an estimate. The reason I changed from scientific statement to estimate is because I did not want to claim anything more than I could honourably claim when I had 70 per cent of patients I could not find. The fact I could not find them is that I do not have government systems. However, when I used the linked database system I could find every patient so we have lots of well-defined scientific information by using the linked database system, but it does not answer all the same questions I can get out of a questionnaire. I have been very conservative with what I claimed as estimates.

The Hon. SHAOQUETT MOSELMANE: In our background notes we have been advised that due to a lack of clinical trials, the quality, safety and efficacy of naltrexone has not been demonstrated. Does it concern you that you are using medication, an implant, naltrexone, that has not yet been, after many years, proven to work?

Dr O'NEIL: You are quoting sceptics.

The Hon. SHAOQUETT MOSELMANE: Yes, critics.

Dr O'NEIL: No, they are not even critics. They are sceptics. They have not read the literature. If you read the literature, the people who did the Cochrane review have now looked at the naltrexone work coming out of the United States, looked at the naltrexone work coming out of Russia, they have looked at the publications relating to our implants coming out of Oslo, they have looked at the publications coming out of Britain and they have looked at the work coming out of Perth and realise this whole business of sustained naltrexone work is now very well established.

The Hon. SHAOQUETT MOSELMANE: Also, the Therapeutic Goods Administration, the national regulatory body for therapeutic goods, has not evaluated or approved naltrexone implants for registered users. So it is not just sceptics.

Dr O'NEIL: Can I help interpret those, because you are asking the question? The TGA does not evaluate anything until I ask them to. When I ask them to I have to find half a million dollars, or in that order, and I will ask them at the right time. In the meantime, I am accumulating a whole lot of evidence, and the TGA and their representatives have come across to look at our manufacturing systems and have given a tick of approval since 2005. Those trials were done and specifically all the production systems and all the manufacturing systems were checked by the TGA. All of those documents and statements infer that the TGA has not been approving the actual manufacturing systems, so—

CHAIR: It is misleading?

Dr O'NEIL: A lot of misleading statements are being made. The TGA has worked freely. Everything I have done would be shut down within 48 hours if I was not complying for the last 14 years with the TGA requirements. At present, an unusual situation, the TGA approved the production of the product, they approved the quality system, they worked with the British Government to approve the quality system, the quality system has been approved and been transported into Britain and I had a fire in my factory. I still have the same team but I do not have the same factory. In the meantime, I part with my licence but I have the right to use the same team to make implants for my own patients and I cannot send them off to anybody else at the moment. The TGA knows I am using the same team, the same production systems, the same quality assurance systems we were using at that time. That is our current situation. Until the factory is finished I cannot apply for the licence again but all the comments you are reading infer that we did not work with the TGA.

The Hon. HELEN WESTWOOD: Thank you, gentlemen, for appearing before us this morning. If I could just go to that last point you were discussing with my colleague, the TGA approval. Could you just explain again or clarify for me whether or not the naltrexone implants are approved by the TGA for administration to patients?

Dr O'NEIL: Sure. There is a process to go and register products, and when you develop a totally new product from scratch, the average cost of going from where you start to where you finish is about $1.4 billion—I have put down $1.2 billion, but I think the correct quote is $1.4 billion. So it is a big job. You have to produce your goods properly. First of all, you have to develop a formulation, then you have to do some animal studies. Then you have to prove you have a formulation that will work. You have to start your initial clinical trials, and there is a way of doing that. Then you have to organise your randomised control trials and then a whole lot of trials that examine the efficiency of the product. The current status is when you look at 28,000 patient-years of work we are looking at death rates, and death rates are black and white. Some areas of measurement will be grey but in death rates, the risk of death is 25 times less if you use an implant compared to the registered product, which is oral naltrexone. The TGA already have that data in front of them and we have that data in front of us.

So what we tell the TGA is that we have got this guy who wants to detox. Do you want us to use the registered product or do you want us to use that will give him 25 times less risk of dying? They say you had better just treat him. That is what the special access is all about. At present, when I have a fire in my factory, the TGA says please do not ask us questions, if you are only producing for your own patients, we are happy for you to produce for your own patients. But when you want to start to make the product go medical instead of making the product as Dr O'Neil, then I have an obligation to work inside the TGA system.

The Hon. HELEN WESTWOOD: So you have TGA approval for administering implants to your own patients?

Dr O'NEIL: Yes.

The Hon. HELEN WESTWOOD: In New South Wales, for the purposes of that approval you have from the TGA to administer implants to your patients, are residents of New South Wales who go over there for treatment and then return they still considered your patients for TGA approval purposes?

Dr O'NEIL: That is right. I obviously had to interview Charlie. I obviously had to meet him and get to know what his problem was. Anybody I operate on is my patient. Sure, patients can travel interstate. I did not want to push the laws. I could potentially fly to Sydney and put the implants in, but then I have to check with the New South Wales Government, and that is more complicated. I have a whole infrastructure of nurses and doctors, so it is more practical to find a one-way airfare than to do that.

The Hon. HELEN WESTWOOD: One of our terms of reference goes to involuntary administration of naltrexone implants. Do you have a view on that?

Dr O'NEIL: I have very strong views, so let me state them. There are two groups of people who would like involuntary treatment. One is the wives and mothers and the other is the courts. There is no service for the wives and mothers here in Western Australia but many patients come through my door where the wives and mothers are saying this guy cannot stay in our house any longer if he does not have an implant, and I have to interview the two. They are what I call involuntary treatments. The wife says I will not have intercourse with you if you are not going to, and the mother says you are not going to stay in my house any longer. I have to sit down with this distressed family, but I am doing involuntary treatment. The patients who have involuntary treatment should have the full range of treatments that are available to them, with all the known information

about each of the treatments. There are a lot of good things about methadone and a lot of terrible things about methadone. There are a lot of good things about naltrexone and loss of terrible things. They should be fully informed of all the options.

With involuntary treatment that is when it is most important to say we have this new treatment out there called naltrexone. People are making these claims about it. This is the amount of evidence we have. This is methadone. This is fully registered. It is a bit like oral naltrexone being fully registered but being 40 times less efficient, that is stopping the deaths. You have to tell them about both. If you have involuntary treatment, you have to tell people the full range of things that are available, all the limitations of each of the things that are available. That is when you really need it. The people who really need involuntary treatment more than the courts is the families. The families should be able to go to doctors and say we really need this guy treated because we cannot support him in our family any longer. That is where I think involuntary treatment should start.

The Hon. HELEN WESTWOOD: Are you aware of the coroner's inquiry into three deaths in New South Wales where naltrexone implants were implicated in those deaths?

Dr O'NEIL: The detox process is very important to understand. There are pure opiates and partial opiates—partial agonists is the medical term—and there are antagonists. If you take somebody from a full-blown habit with a heavy dose of methadone to a pure antagonist, and you do that with a heavy dose, you will have a very sick patient in intensive care. The understanding of how to do detoxes, to give an example, we had a patient fly in from Sheffield just going on four weeks ago. I took him to the airport to fly back to Sheffield the night before last. He was on 180 milligrams of Methadone a day with a letter from his doctor saying, "We cannot detox him in England, can you?" So he came to Perth and he had his implants six days after he arrived in Perth. He did not have vomiting; he did not have diarrhoea; he was not sick. You need to know how to do that safely, without just crashing in with a massive detox. In New South Wales the detoxes are heavier, more like going off a cliff. They have been criticised but it is not naltrexone implants, it is the detox methods. You need skilled doctors running a detox clinic. In the clinic concerned, you did not have skilled doctors running the clinic.

Mr CLAUGHTON: Comparing the two clinics, I think it is important to understand the size and scope of the Fresh Start Recovery Programme. We have about 65 people employed, full-time, part-time and casual; we have 90 volunteers who back up the work that we do; and we have workers and volunteers in three states—South Australia, Victoria and New South Wales, with a cooperative clinic in Queensland. As Dr O'Neil has explained, we have all the mainland states of Australia covered, for the purpose of the pre-detox and post-detox support that is required.

I think having a network and a systematic approach to the pre-detox and post-detox work that is needed and then backing it up with the psychological support that is required, the friendship and the relationship-building that is required as people find their feet again, that is all part of the process of supporting patients through that post-detox period. Without that, trying to do detoxes, trying to do naltrexone implants and so on, is almost impossible and I think will inevitably lead to trouble. That is the part of the organisation that we are consistently, day-by-day, trying to strengthen in Western Australia.

In fact, the reason we are in New South Wales speaking to you today is because we now have a small but dedicated group of people in New South Wales operating out of the Blacktown region. They are committed to helping support patients in New South Wales who have been to Perth, had the detox, come back with the implant and now need to start rebuilding their lives. It is a big job and to try to take it on on a commercial basis is impossible. Of the $18 million that we have billed patients over the last 15 years, we have written off $11 million of that. I have a provision for bad and doubtful debts of 50 per cent. It is not a commercial enterprise by any means.

We rely on a million dollars a year in donations, we rely on 90 volunteers who provide about $1 million dollars-worth of value, we rely on a dedicated staff of 65 people who probably add another million dollars in wages that I cannot pay them. When I say "wages I cannot pay them", I mean that they all put in far above what one would normally, because they are there with a purpose—to help support the work that we do. Without that sort of network, commitment and so on, it is pretty difficult to embark upon the process of getting people well. You might ask Charlie how long he has had an addiction for. You do not get over that with a simple detox and implant.

Dr O'NEIL: The person who assessed Charlie before his detox was running an Intensive Care Unit for 20 years and is a qualified anaesthetist. There would be three surgeons in that clinic backing Charlie up by the time we do the procedure. It is a very different type of medical emphasis. It is a medically orientated treatment but the clinic has only got half a dozen doctors helping and 90 other staff. There is the chaplain, the psychologist, the psychiatrist, the nurses—a whole lot of ancillary staff that work with people to support them in changing their lifestyle.

The Hon. JAN BARHAM: Some of my questions have been answered but I am interested in knowing how many people from New South Wales have travelled?

Mr CLAUGHTON: Out of the 8,100 patients on our books, 260 are from New South Wales postcodes. That is not entirely definitive because some people will travel to Western Australia and then pick up a Western Australian postcode and effectively reside in WA for a period. But we know that, of the people who claim to be from New South Wales, 260 people are on our records currently. Up to the end of February, 27 patients had travelled from New South Wales to Western Australia, so I am expecting about 40 to 45 people in the whole year.

The Hon. JAN BARHAM: So 27 this year have already travelled?

Mr CLAUGHTON: Yes, 27 in 2012-13 to the end of February. Extrapolating that, I would expect that to be around 40 to 45 people this year will travel from New South Wales.

Dr O'NEIL: Some are for alcohol and some are for opiates.

The Hon. JAN BARHAM: Can you explain the range of drugs that naltrexone is being used for?

Dr O'NEIL: There are about 4,000 deaths a year from alcohol in this country, as well as the 1,000 or so from opiates. Alcohol and opiates would be the main two but we are seeing, especially in Western Australia, a terrible epidemic with ice. We get a 70 per cent response in the first three months and these are people who are using $1,000 to $2,000 a day in amphetamines. We are seeing a good response, in terms of decreasing craving.

The Hon. JAN BARHAM: That is 70 per cent across the board, for all drugs? I have limited time and I have a few questions.

Dr O'NEIL: For the people who are on amphetamines, at least 70 per cent of them have stopped in the first month after going on implants. That is a very effective treatment but it is short-term.

The Hon. JAN BARHAM: What is the success rate with alcohol?

Dr O'NEIL: The success rate with alcohol, from our published work, is an 87 per cent decrease in hospital admissions in the group of people who come off alcohol. In the year after they have been treated, we have monitored the change in hospital admissions and noted that there is an 87 per cent decrease.

The Hon. JAN BARHAM: You were referring to the time for the implant, you are saying you are up to 90 days, is it? How long does the implant last? What is the minimum, maximum and average time?

Dr O'NEIL: Naltrexone comes out of the implant for an 18-month period and it has an extremely high level during the first four months, a moderately high level in the second four months and a modest high level in the third four months. In the first four months, it will stop above 90 per cent of people using opiates; in the second four months, it will be about 85 to 90 per cent.

The Hon. JAN BARHAM: Out of your 8,100 patients, do you have an idea of the timeframe, in terms of repeat implants, and how long?

Dr O'NEIL: The last big review we did showed that about half the patients have repeat implants and about half claim to get better with one implant. The people whose addiction started between 12 and 22 need repeated implants for four or five years.

The Hon. JAN BARHAM: When you referred to the services that you provide and the support from volunteers, to put a cost on a whole service, what would that be? Can you clarify the cost of the implant and whether there is an additional cost or is it inclusive to provide those additional follow-up services?

Dr O'NEIL: A global figure of 1,000 people being looked after per year for about $6 million, would mean a cost of about $6,000 per patient and the implant would form part of that. Implant costing is complex but I will say it costs more than a thousand dollars per implant when you are producing just a couple of thousand a year. When you start producing 10,000 a year, it gets down to about $700 an implant and if you produce 100,000 per year it probably comes down to $500 an implant. I am just trying to give you pictures.

The Hon. JAN BARHAM: I am trying to work out what the cost is.

Dr O'NEIL: It is $6,000 per patient.

The Hon. JAN BARHAM: It is $6,000.

Dr O'NEIL: That includes detox and—

The Hon. JAN BARHAM: And how much follow-up service is provided with that?

Dr O'NEIL: Usually people only need one implant in a year. The very sick ones need two implants in a year.

The Hon. JAN BARHAM: The follow up, you referred to the volunteers, the services, the counselling.

Dr O'NEIL: We are talking about 50 beds or more and a whole team of counsellors who are always available so that patients can always get appointments. The one thing that we have succeeded in doing is never running out of beds. Nobody has ever had to wait two or three weeks for an implant. We have got a service that is available, at least twice a week, for putting implants in.

Mr CLAUGHTON: From my perspective, I believe the service needs $8 million a year to run effectively or properly. We are slowly working our way towards that and we have increased our funding over the last four or five years from $3 or $4 million a year, to a budget in 2013-14 of $6 million. That is largely because of WA State Government support, which will provide about half of that. We then get patient fees and Medicare rebates of about $1.4 million, donations of about $1 million and so on.

The Hon. JAN BARHAM: That is to maintain 1,000 patients a year?

Mr CLAUGHTON: It maintains them at a level, gradually building towards what I would consider to be a safe and satisfactory level. We rely largely on volunteers to help bolster our numbers and our care but we still have a number of positions that we are unable to fund and which I would like to see funded, so that we can actually run the service at a standard which is generally acceptable by the community. I have estimated that, including the $1 million-worth of volunteer value that we get, we actually run an $8 million program.

The Hon. JAN BARHAM: I am interested in cost per service.

Mr CLAUGHTON: I believe it is $8,000.

Dr O'NEIL: There are 8,000 people who rely on us to give them a repair job whenever they ask, so we are maintaining 8,000 but we actually have to do a thousand new treatments a year.

Reverend the Hon. FRED NILE: Thank you for appearing before our Inquiry. You have made three recommendations: One, that the Government set up a fund to monitor the outcome of the patients traveling to Perth; secondly, you are asking the Government to fund patients going from New South Wales to Perth until a satisfactory service is established in New South Wales.

Dr O'NEIL: The situation I am in—and I make this as a personal plea—is that I have been on the phone to mothers who say, "We are saving up to fund the airfare". They then ring me two weeks later to say, "My daughter has died". I have been exposed to that situation half a dozen times. I do not want to be exposed to

that situation any more. I am saying that it is not unreasonable for me to come to governments and say: Can you pay one-way airfares and we will do the rest? We will look after the patients. But if you created a system of having a one-way airfare available for a service that is not available in New South Wales—

Reverend the Hon. FRED NILE: I understand that. I want to jump from that to why we cannot set up the program in New South Wales and have a trial program in New South Wales? What do we need to do to set up a trial program?

Dr O'NEIL: As soon as the factory is finished, I will be able to bring implants across here. The factory will be finished by November-December and the validation part of the factory will take until May. Between now and May next year I can provide a temporary service but my target is, your Committee will produce a report by November-December and I would be delighted to be working and taking our implants across here in trials and in service provision after May. If I can push the builders any faster or take any shortcuts, I will but the current estimate is that, by the time I have done all the building and revalidation, it will take us to May. So the service is dependent on what we can do in Western Australia between now and then and I do not have any other way around it.

Reverend the Hon. FRED NILE: That is because you supply the naltrexone implants. You cannot get them from anywhere else?

Dr O'NEIL: Not of the same level of quality that will last a long time. You can get injections from America that last four weeks and you can get implants from Russia that will last six weeks. But the problem with short-term implants is that you have a good naltrexone level but suddenly it drops. What we built into our design was we want to stop these deaths and the way that we have succeeded in doing that is to have a level that just goes slowly down. So my comment about the first four months, the second four months, the third four months, is that even in the third four months we stop the deaths from overdose, even if we have not stopped them using. So we will stop them using usually in the first eight months or nine months.

Reverend the Hon. FRED NILE: You are manufacturing a stronger naltrexone that lasts longer?

Dr O'NEIL: We have developed a different delivery system that goes down slowly. It does not go along and suddenly drop like a cliff; it goes down very slowly so that if the patient starts to use—if he is one of the patients who is still going to use—we are able to protect him from overdose for another six or eight months after he starts to use.

CHAIR: Your blood plasma levels go up and maintain and then slowly come down.

Reverend the Hon. FRED NILE: If we wanted to have a trial we would have to have people run it; we could not expect you to run it from Perth. I understand some New South Wales doctors have gone over to observe your program or work on it.

Dr O'NEIL: But what I am encouraging you to do is you can take 20 patients from Sydney tomorrow and I can treat them next week and you can see how they go and that will give you information about whether you want to invest properly in it in six months time. That is why I said if you just follow Charlie and the cohort that is being treated on a day-to-day basis they are unselected, but if you want to do it better you select half a dozen Aboriginal mums and send them across to us and then we can make a comment about treating Aboriginal mums. If you select a dozen young Vietnamese mothers or patients then you can comment on whether that helps the Vietnamese mothers. There are special groups of people and we would be delighted to look after them—we are already looking after them anyway.

Reverend the Hon. FRED NILE: To save all that travel we could have a trial here in New South Wales. I am not saying a full clinic but a trial in New South Wales that would satisfy the health department.

Dr O'NEIL: If the New South Wales health department gives me permission I am happy to supply them with the implants we are making and treat 20, 30, 40 patients here. If that was something that the New South Wales Government and the health department agreed to I can do that legally. Legally what I have asked the TGA is for the importation of naltrexone to make up implants for my own patients with the same team that has worked with me before, and they have agreed to give me the right to import naltrexone specifically for my own patients. I cannot go back until the factory is rebuilt to ask for CoMedical to make the implants, which is a different process.

Reverend the Hon. FRED NILE: Would there be sufficient specialists in New South Wales to run a naltrexone trial?

Dr O'NEIL: There would be a lot of specialists in New South Wales who would like to work with us, so I am very confident of that.

Reverend the Hon. FRED NILE: You have been very successful in getting the funding from both Labor Governments initially and from the Liberal Government—I think you said in your submission $3 million per year and $3 million from patients' fees, donations and so on. They must do some assessment of your clinic if you are getting State Government funding.

Dr O'NEIL: We have got audits of our costs, we have got audits of the implant production costs, we have got audits of our clinical service; we can share all those audits with your Committee. Some of them need to be treated confidentially but certainly those audits can be shared. The thing that I would like to encourage is, for those that criticise, you have to start naltrexone work somewhere and we have been improving what we are doing because the Government has funded us for 15 years. The fact that the State Government in Western Australia recognised that there were medications for addicts to keep them addicted and medications to take them off addiction, the Government in Western Australia, the Labor Senator said to the Liberal Senator, "Now that naltrexone has been registered"—that is oral naltrexone—"will you pay for it?"

The Liberal member said, "Of course we will pay for it". So since a few weeks after oral naltrexone was registered for heroin addiction treatment the Western Australian Government has been offering free naltrexone to anybody who wants to give up their opiates. Because they were offering free naltrexone to anybody who was giving up their opiates they also had to turn around and say, "And if you want to use the implant naltrexone we will help that program as well". That has been consistent since 1999.

Reverend the Hon. FRED NILE: That is very good; you have had great cooperation from the Western Australian health department, obviously.

Dr O'NEIL: Yes, and every time there was a change from Liberal to Labor or Labor to Liberal our funding went up.

CHAIR: Thank you so much for appearing before the inquiry today. We thank all of you for your contributions. It is fantastic that you flew all the way from Western Australia; we appreciate it. Thank you, Mr Popov, for sharing your personal journey.

Dr O'NEIL: Can we invite any panel members who want to visit us to come any Saturday, if they want to fly on a Friday night, and just see what we are doing—or bring a special patient.

(The witnesses withdrew)

ALISON RITTER, Director, Drug Policy Modelling Program, National Drug and Alcohol Research Centre, affirmed and examined:

CHAIR: Welcome, Professor Ritter, thank you very much for attending our inquiry. Could you tell us whether you are representing a particular organisation or attending as an individual?

Professor RITTER: I am the Director of the Drug Policy Modelling Program, which is located at the National Drug and Alcohol Research Centre. I am also the Deputy Director of the National Drug and Alcohol Research Centre at the University of New South Wales. I have worked as a clinical psychologist—that is my discipline—treating people with alcohol and drug dependence in the 1980s for about 15 years and then worked within government, the Victorian health department, as a policy officer. I have now ended up in academia as a full-time researcher. So I have about 30 years experience in the field from a variety of perspectives.

CHAIR: The Drug and Policy Modelling Program, on page two of the submission you presented it stated that you are close to finalising a new Australian drug budget that will provide an updated estimate on Australia's treatment investment relative to law enforcement, prevention and harm reduction. That is a fairly holistic sort of approach. What can you tell us about that budget and how you arrived at it and your input?

Professor RITTER: It estimates the amount of spending by Federal government and by State and Territory governments across all sectors—police, health, education, welfare and social services—and its spending on dealing with illicit drugs; so it does not include alcohol or tobacco and it does not include things like hospital care for the consequences of drug use, it is only costs for actually dealing with drug use. The largest expenditure item is law enforcement. It will probably end up being around 60 per cent of the total spending by governments across Australia in relation to response to drugs is law enforcement and the treatment expenditure is likely to be quite small. In our previous estimate it was 17 per cent of the total budget, and the results are being released in the third week in June in Canberra. As I said, the treatment estimate is likely to be not dissimilar to our past estimate.

CHAIR: Without revealing what is in it before you launch it, is it showing any distinct sort of guidelines, directions for governments in terms of tackling the issue of alcohol and drug dependence in a different manner?

Professor RITTER: The piece of work stands as a simple descriptive analysis of what is currently spent. One can draw one's own conclusions from that. It does not tell you what you should spend the money on; it tells you what Australia currently spends its money on. The conclusions that I would draw, based on my experience, are that governments would have a better, more successful set of outcomes if they invested in treatment, whatever that treatment might be, than if they invested in law enforcement, and that the underfunding of treatment is a substantial problem across Australia—certainly not unique to New South Wales.

CHAIR: I read in your report that there is no systematic or independent endeavour to document the current levels of alcohol and drug treatment funding in New South Wales. Has any State actually been better at it?

Professor RITTER: No.

CHAIR: Why do you think that this has historically developed?

Professor RITTER: I think that analysing treatment funding is complicated because the funding is complicated. The really quick version is that the Federal Government funds agencies directly here in New South Wales through a grants program and through special purpose payments. The Federal Government also funds the New South Wales Government to provide funding to hospitals. So there is the hospital's stream of funding that the States determine the spread thereof; there are separate Federal grants; there is the State hospital funding; then there is the Pharmaceutical Benefits Scheme, and of course Medicare for medications and for primary care services; then there is direct funding by State Government to generally non-government organisations—therapeutic communities, residential rehabilitation—that bears no necessary relationship with the funding those agencies receive from the Federal Government through the grants program; and then there is of course philanthropy and private health insurance and patient co-payment. In that quick simple map you have got about five, six or seven different funding sources and most agencies cannot distinguish what funds what. It is terrible.

CHAIR: In my reading of alcohol and drug treatment here in Australia and overseas there seems to be a recurrent theme that we have not got enough qualified addiction medicine physicians and that this is an area that is lacking. Also, in reading your submission, retention of qualified staffing is difficult and ongoing funding in the continuity of programs and funding for those programs is difficult. Are these true interpretations of what I am reading?

Professor RITTER: Yes, I fully concur.

CHAIR: It is not very effective, is it?

Professor RITTER: No. The workforce is terrible. New South Wales is probably better than other jurisdictions in terms of the professionalisation of the workforce. The alcohol and drug clinical training is poor; it is not a specialty. It has not been a specialty within medicine until the recently established addiction medicine specialty so they were people who did not have a specialty. It is disliked by the medical community. It has also been taken up, if you go back in history, to the temperance movement. It has been taken up by welfare organisations as part of their brief so it has not been treated as a medical or a mental health problem; it has been treated through the welfare system and the welfare system is also a deprofessionalised area and there is enormous internal tension in our sector between the medicalisation of alcohol and drug use and disorders and the social science sort of welfare notion about alcohol and drug use and that tension is sometimes quite palpable between professional groups, which also then adds to a problem with our identity to government or within the broader community.

CHAIR: I promised that was my last question but I cannot resist. Is there a move within the Royal Australian College of General Practitioners [RACGP], the AMA and the specialty colleges of physicians to actually take addiction medicine seriously?

Professor RITTER: There is a relatively new addiction medicine specialty [AMS], which is within the Royal Australian College of Physicians, not within the RACGP. There were big arguments.

CHAIR: Argy-bargy.

Professor RITTER: And New South Wales has the highest number of addiction medicine specialists in Australia.

CHAIR: So it is promising?

Professor RITTER: Yes.

The Hon. DAVID CLARKE: Professor Ritter, in your report you say that your organisation supports the scientific view that naltrexone implants should not be available in New South Wales unless under trial conditions or until such time as the product has been proven safe?

Professor RITTER: That is right.

The Hon. DAVID CLARKE: Why should we not have a trial in New South Wales under proper trial conditions? You would support that?

Professor RITTER: Absolutely.

The Hon. DAVID CLARKE: You believe that there is sufficient evidence there of a positive nature?

Professor RITTER: No, I do not believe there is sufficient evidence yet of a positive nature but there are—

The Hon. DAVID CLARKE: To allow a trial?

Professor RITTER: To allow a trial?

The Hon. DAVID CLARKE: Yes, that is what I am saying?

Professor RITTER: Yes.

The Hon. DAVID CLARKE: Would you agree that there is sufficient evidence there from what we have seen in Western Australia and elsewhere at the very least to allow a trial here in New South Wales?

Professor RITTER: Yes, a registered trial.

The Hon. DAVID CLARKE: A registered trial?

Professor RITTER: With a clinical trial notification notice from the Therapeutic Goods Administration, absolutely, and it would be a really important and significant piece of work.

The Hon. DAVID CLARKE: And would you go so far as to say this: that we would be remiss, in view of the evidence so far, if we failed to do so? Would you go that far?

Professor RITTER: No. The evidence is not quite that compelling.

CHAIR: Good try, David—Perry Mason.

The Hon. DAVID CLARKE: But the evidence to date on the balance of probabilities is strong enough, you think, for there to be a trial under what you call trial conditions?

Professor RITTER: Clinical trial conditions. Can I just make a couple of comments? The first thing is: let us distinguish between the forms of sustained-release naltrexone. There are two different forms of sustained-release naltrexone. One of them is an implant—

The Hon. DAVID CLARKE: I am talking about the implant.

Professor RITTER: —that is planted under the skin. The other one is an intramuscular injection that is long acting; it lasts a month or so. All of the research from overseas, the randomised control trials, have been done on the injection. The drug is called Vivitrol; that is its trade name. It was registered in 2006 in America for the treatment of alcohol dependence. In 2010 it was registered for the treatment of heroin dependence, so there is a sustained-release naltrexone approved by the FDA in America and is in widespread use and those clinical trials are exceptionally promising.

The occasional sleight of hand occurs when it is not clear the distinction between sustained-release injectable naltrexone, Vivitrol current product, versus implants of which there were three, now there are only two. There is Go Medical from Dr O'Neil's clinic in Western Australia and then there is a Russian implant called Prodetoxon that is registered in Russia and been approved by the Russian equivalent of the TGA. The clinical trials of the implants do not demonstrate superior safety and efficacy of implant naltrexone over and above other known effective treatments. So a randomised trial comparing implant naltrexone with methadone maintenance showed no significant difference in treatment outcome published after the NHMRC completed their review.

The Hon. DAVID CLARKE: But you think it is worthwhile to proceed under trial conditions?

Professor RITTER: Yes.

The Hon. DAVID CLARKE: Thank you.

Professor RITTER: I think there is enough concern in the community and public rallying for it to be very important to resolve this question scientifically and in an independent fashion, yes, and I would strongly support a clinical trial, well monitored.

The Hon. JENNIFER GARDINER: I go firstly to the drug and alcohol clinical care and prevention model project. What is the budget for that roughly?

Professor RITTER: For the development of the model?

The Hon. JENNIFER GARDINER: Yes?

Professor RITTER: It was very, very small as this was a cost share program between the Commonwealth and the New South Wales Mental Health Drug and Alcohol Office and I believe it was in the order of $300,000 to develop that modelling tool.

The Hon. JENNIFER GARDINER: With respect to school-based drug education, you mentioned that the program with the highest level of support is the life skills training program. Could you just give us a thumbnail sketch of what that program is about and why it is so good?

Professor RITTER: I am not going to be able to do that. I can send you the details of the program; I am happy to do that. The drug education field is difficult because the ones that work are the generic ones not the ones that focus on drug and alcohol. That is the key message but I will send you the details of the program.

The Hon. JENNIFER GARDINER: Okay, thank you.

CHAIR: I am reading here about two significant developments this year in the United Kingdom, the establishment of Public Health England and also police and crime commissioners accountable to their local electorates. These are two new directions in the United Kingdom. What is your feeling on them?

Professor RITTER: They are extremely controversial and certainly the former is coupled with a movement towards recovery as the treatment outcome and agencies only being paid if they have successfully enabled their clients to be abstentious, which is extremely controversial when you are dealing with a chronic relapsing condition. For alcohol and drugs there is the recovery movement, which is then coupled with these two significant United Kingdom nationwide changes. Both of them are effectively the devolution of planning and service provision to much smaller local areas than previously and some people feel that local areas understand the needs of their community best and are best able to distribute the resources and other people believe that local planning does not have the macrovision or the connection necessarily with research evidence and so on to make it work well.

CHAIR: Do you think that it reflects a community frustration that in all the years we have been funding harm minimisation methadone treatment and the other treatments that we are not seeing appropriate statistics on recovery? Do you think this reflects an international frustration because I have been reading about Vancouver, Canada and when one looks at regions in the United States, the United Kingdom, what is happening in Western Australia or listen to talkback radio, people are frustrated that we are putting money in yet we are not seeing good outcomes for families and individuals?

Professor RITTER: Yes. I would not conflate harm minimisation with treatment outcomes; they are two quite separate things. I think there is personal tragedy and there is concern about the availability and access to treatment and in some cases the effectiveness of treatment; I agree with that, but it is also a lack of appreciation for the fact that this is a chronic relapsing condition and we do not have public debate about asthma or diabetes in this way. Why do we have public debate about drug and alcohol treatment in this way? I will answer my own rhetorical question. It is because people who experience problems with their substances are marginalised.

There is enormous stigma associated with it and the community cannot get its head around the idea that this is a lifelong condition that one needs to manage well in the same way as someone who has asthma and we do not penalise doctors for their inability to prevent someone with chronic asthma from presenting to a hospital multiple times throughout the course of their life. Why would we penalise or treat suspiciously drug and alcohol clinicians who continue to offer the best available treatments?

The Hon. HELEN WESTWOOD: Thank you, Professor Ritter, for joining us today. One of our terms of reference is to look at involuntary treatment with naltrexone implants. Do you have a view on that?

Professor RITTER: Involuntary treatment with naltrexone implants?

The Hon. HELEN WESTWOOD: Yes?

Professor RITTER: Naltrexone implants are not approved, are not demonstrated to be safe and effective until we have our clinical trial and involuntary treatment with an unproven, unsafe, unregistered medication is unethical and completely inappropriate.

The Hon. HELEN WESTWOOD: If this is not an appropriate question please let me know. I did not get real clarity from our previous witnesses around the treatment that is happening in Western Australia with naltrexone implants. I am not clear whether the TGA has approved treatment in Western Australia. Is it one of the clinical trials that we are referring to?

Professor RITTER: No.

The Hon. HELEN WESTWOOD: So it has not been approved?

Professor RITTER: It has not been approved. The implant needs to be registered as a medical device in the first instance and then it needs to jump through some hoops and I heard Dr O'Neil talking about the new factory. I have been to Western Australia and spent time in his clinic so I am quite familiar with the work that happens there. The device has not been approved and the only reason why he is able to do that is because he is using what is called the Special Access Scheme [SAS], which is a provision within the Federal legislation that says under conditions where the disease is life threatening one can use an unregistered drug or medical device if you believe it will save the person's life and it is generally reserved for very extreme circumstances and that is the—some people would call it the loophole that enables naltrexone implants to be provided in Western Australia and in Queensland and previously in New South Wales.

The Hon. HELEN WESTWOOD: Does that only require one medical practitioner to certify that their patient's life is at risk?

Professor RITTER: Actually I do not know what the conditions are for the Special Access Scheme, I am sorry.

The Hon. HELEN WESTWOOD: I ask that because in the submission that Dr O'Neil made to us he is suggesting that we recommend that New South Wales provide funding for the citizens of New South Wales to travel to Western Australia for treatment and then to fund the follow-up that is required here in New South Wales and I think for us to recommend that I would like to be very clear about the status of the work that is being done at Dr O'Neil's clinic.

Professor RITTER: I would not have thought that the New South Wales Government could actually—I mean, approval of medications in Australia is a Federal jurisdictional matter. Of course anyone can invest funds in a program, but it would not be consistent with best practice to do that.

The Hon. HELEN WESTWOOD: You mentioned that there were two sources of implants at the moment, Dr O'Neil's implant that he manufactures and the Russian implants.

Professor RITTER: Yes.

The Hon. HELEN WESTWOOD: Are there clinics in Australia that are also administering the Russian implants?

Professor RITTER: No.

The Hon. HELEN WESTWOOD: Only Dr O'Neil's implants would be administered to anyone in Australia, whether it is here or in Queensland where you said there is another clinic?

Professor RITTER: That is right. And they are the only two implants available across the world. Dr O'Neil's implants, Go Medical, are also being used in other countries as well.

The Hon. HELEN WESTWOOD: For a patient to receive an implant they need to undergo detox beforehand. Could you take us through the process that is required for an implant to be safely administered to someone who has an addiction to heroin?

Professor RITTER: Okay. I am just trying to do this quite simply. Heroin is an opiate that sticks really strongly to your opiate receptors and you become dependent because—I will use common language—you sort of silt up all of your opiate receptors. Then you need to use more in order to get the same effect because your opiate receptors are all full up. The administration of naltrexone or naloxone, or Narcan as it is registered, is short-acting naltrexone. If you have got your opioid receptors full of an opiate, whether it is heroin or

morphine or pethidine, whatever it might be, and you administer either naloxone or naltrexone it is stickier than the heroin and it immediately throws the heroin off one's opiate receptors. The consequence of that is a sudden and dramatic withdrawal syndrome where there is a lot of tremulousness, vomiting, sweating, diarrhoea, autonomic arousal and so on.

The administration of naloxone is used to reverse overdose, which is why it works so well. The administration of naltrexone on the other hand, because it is slower and longer acting, does not necessarily reverse the effects of the heroin quite as dramatically and immediately but it does cause this adverse reaction that I have just described. In order to commence a naltrexone treatment program where you are going to be taking naltrexone every day orally or you are going to have an implant you need to first have the opioids removed from your receptors. That takes between five and seven days if it is done as a normal detox, detoxificational withdrawal. It can be done more rapidly by administering naloxone.

A common cause of death in those circumstances is that the patient is not intubated, a tube is not put down their throat. They commence vomiting and asphyxiation on their own vomit as a result of the administration of naloxone in order to have what is called a rapid detox or an ultra-rapid detox, which is done under anaesthetic. You could wait seven days. You could get on to a naltrexone implant without going through a very risky, medically complicated process if you just waited seven to 10 days. Unfortunately, most people who use heroin find that difficult.

The Hon. HELEN WESTWOOD: Once the patient has the implant what other type of treatment would they need to support them to remain opiate free?

Professor RITTER: Obviously counselling and support for the significant lifestyle changes they need to change, the kind of social circumstances that they are in, the people that they are hanging out with, their employment circumstances. Often their living situation is fairly precarious, their finances are usually a mess and they have usually got legal charges pending. All of that they need help to work through to then create an opportunity for a new life and an opportunity to re-establish themselves within the community as a non-drug using individual. There is a lot of support, but that applies to any treatment that one is receiving; it is not unique to naltrexone.

The Hon. HELEN WESTWOOD: Would they also need any other pharmacological support?

Professor RITTER: No.

The Hon. HELEN WESTWOOD: And it is not appropriate for someone to have an implant and then to also be taking methadone?

Professor RITTER: No, that would not work because the implant would block the effect of the methadone.

The Hon. SHAOQUETT MOSELMANE: What is the difference between the Russian implant and the O'Neil implant? Are there different compounds within those implants? Are you aware of the differences?

Professor RITTER: Both of them have naltrexone in them, which is a really cheap drug. The naltrexone itself is very easy. Naltrexone is registered in Australia as an oral medication so you can get naltrexone relatively easy. The trick is the device that you use to enable the slow release. I cannot explain the technical differences between the two devices. The Russian implant does not last as long as Dr O'Neil's implant. It varies, but it is up to about two or three months. Dr O'Neil's lasts much longer. People have argued that that is the real disadvantage with Dr O'Neil's implant.

The implant blocks your opioid receptors completely so if you have a car accident or if you have a migraine that requires opiates or if you need any kind of pain relief you cannot use opiate-based pain relief. You can use non-steroidals and they give people anaesthetics in these situations and so on. There is an argument that it is preferable to have it shorter acting, which is why the registered product in America, Vivitrol, which is the sustained release injection and not the implant, has been designed to only last for one month.

The Hon. SHAOQUETT MOSELMANE: At page 4 of the Drug Policy Modelling Program submission under "Naloxone service provision" you say that drug policy experts have called for the removal of

scheduling and legislative barriers in Australia and you urge the New South Wales Government to follow. Can you identify the barriers that exist in New South Wales, if any?

Professor RITTER: In terms of the scheduling of the drug, that is a Federal issue. Quite recently doctors within New South Wales, and I believe Dr Marianne Jauncey is talking with you at some point—

The Hon. HELEN WESTWOOD: Tomorrow.

Professor RITTER: She will be able to talk through the availability of naloxone. It has been started to be prescribed by doctors within New South Wales. There was arguably a legislative barrier associated with it, but it appears that doctors can just prescribe drugs. The remaining complexity is good Samaritan legislation. The concern is that if one administers naloxone to a third party and one is not a doctor that one could be sued, I suppose. The Australian Capital Territory has good Samaritan legislation which protects people who offer life-saving interventions in circumstances from being subsequently sued. It would be helpful if New South Wales had that legislation not just for heroin overdose but for a whole bunch of things, like helping out at a car accident.

The Hon. SHAOQUETT MOSELMANE: On page 5 of your submission under "Needle syringe programs" you say, "There is a need for greater coverage and after-hours access to services (e.g. vending machines)." Are you proposing that New South Wales could introduce this system of vending machines for syringes?

Professor RITTER: New South Wales already has vending machines but there are a very small number of them. There is one in Kings Cross. There is one that has just been installed at the University of New South Wales that we are very pleased with.

Reverend the Hon. FRED NILE: There is one in Redfern.

Professor RITTER: Thank you.

The Hon. SHAOQUETT MOSELMANE: You are proposing to expand that?

Professor RITTER: Yes. There is no reason not to have multiple vending machines in appropriate locations where people inject drugs.

The Hon. DAVID CLARKE: Have the Aboriginal elders in Redfern been supportive of the vending machine in Redfern?

Professor RITTER: I actually do not know, sorry.

The Hon. DAVID CLARKE: Would you have concern if there were concerns or opposition from the community?

Professor RITTER: Indeed. I think one of the great challenges of good and effective policy in drug and alcohol is bringing the community with us. That is an enormous challenge for just about every drug and alcohol intervention, quite frankly. Look at alcohol taxation. How do we bring the community along with the most effective intervention for alcohol misuse, which is to increase its price?

Reverend the Hon. FRED NILE: I am bit surprised how offhanded you are in regard to the naltrexone implant program.

Professor RITTER: Offhanded?

Reverend the Hon. FRED NILE: How you just disregard it. You say it is not yet proven in its efficacy or cost effectiveness and yet there has been this program in Perth for 15 years funded by State and Federal governments with health departments who actually assess it. How can you be so offhanded about it?

Professor RITTER: They do not assess its effectiveness or its cost effectiveness, as you will see from the audit reports if you choose to look at them. What they assess is the number of people receiving treatment. But systematic outcome data collected independently and cost-effectiveness analysis has not been conducted on

that program, whereas it has on methadone maintenance and it has been on buprenorphine maintenance and it has on therapeutic communities. That is why the trial is so important.

Reverend the Hon. FRED NILE: I am all in favour of the trial. That is what I am hoping will come out of this inquiry. You said you visited Perth. Did you visit the Fresh Start Recovery Programme?

Professor RITTER: Yes, I did. George and I have talked many times and I am very aware of his program and how it works. I spent two days in the clinic with the patients. I have talked to people who have received implants, because it has important possibilities, but as a scientist I have to say it has to be proven.

Reverend the Hon. FRED NILE: Fifteen years is not long enough?

Professor RITTER: It does not meet the standards for the Therapeutic Goods Administration [TGA]. If it had been long enough and Australia had a system where we said someone can treat for 15 years without collecting independent outcome data and that means we are going to register it then it would have met the criteria, but at present it does not meet the criteria for the TGA.

Reverend the Hon. FRED NILE: Has the TGA been involved with Fresh Start?

Professor RITTER: Indeed, and they were the ones that commissioned the National Health and Medical Research Council [NHMRC] review, because there had been enormous pressure for the TGA to act. They know that it does not at this point in time meet the criteria for safe and effective registration in Australia.

CHAIR: Do we need more data collection?

Professor RITTER: We need more data collection. That is also why Dr O'Neil is building a new factory.

Reverend the Hon. FRED NILE: I gather from Dr O'Neil's evidence that there is a huge cost involved in all that.

Professor RITTER: There is indeed.

Reverend the Hon. FRED NILE: Who pays for that? Do you expect the doctor in Perth to pay for that?

Professor RITTER: No, that is a problem. Drug companies pay for that process.

Reverend the Hon. FRED NILE: There is no drug company involved.

Professor RITTER: That is right. There are not actually enough people who are heroin dependent in Australia for anyone to make any money out of providing a new treatment.

Reverend the Hon. FRED NILE: It seems like there has been a barrier put up saying you must do this, it is impossible to do this and therefore you are not going to be registered. The whole profession has a negative attitude to naltrexone implants.

Professor RITTER: I do not know that the whole profession has a negative attitude. I can only speak as a researcher and as a scientist having reviewed the data.

Reverend the Hon. FRED NILE: I gathered because you are the director of the Drug Policy Modelling Program you are speaking on behalf of the profession?

Professor RITTER: I am speaking on behalf of the research community that I associate with, certainly not the profession. The Australasian Professional Society on Alcohol and Drugs may be able to speak on behalf of the profession.

Reverend the Hon. FRED NILE: Who do you speak for?

Professor RITTER: I speak for the research community.

Reverend the Hon. FRED NILE: In Sydney or Australia?

Professor RITTER: In Sydney.

Reverend the Hon. FRED NILE: It is an ad hoc body, is it?

Professor RITTER: It is not an ad hoc body. The National Drug and Alcohol Research Centre is a centre of research excellence funded by the Commonwealth Government. About half of our funds come from the Commonwealth Government and the remainder of the funds come from the National Health and Medical Research Council and the Australian Research Council.

Reverend the Hon. FRED NILE: I have always thought, being involved with Parliament for 32 years, that governments never give money to programs that they do not think are effective. It seems I have to think that the Labor Government in Western Australia and the Liberal Government are giving $3 million a year to a program that is not effective?

Professor RITTER: My own opinion is that governments do what is popular not necessarily what works.

Reverend the Hon. FRED NILE: You are critical of the governments as well?

Professor RITTER: Only the Western Australian Government.

Reverend the Hon. FRED NILE: You said the implants have been used in other countries?

Professor RITTER: That's right.

Reverend the Hon. FRED NILE: And Russia is making them. What other countries are using them?

Professor RITTER: The Russian implants are registered in Russia; they are not registered in any other country. America did want to develop an implant and started to develop one but then decided that the sustained release formulation, the injection, was preferable and better and hence that product has been registered. You probably need to ask Dr O'Neil how many implants he has provided to other country as he has been doing that.

Reverend the Hon. FRED NILE: You made that comment but I was not sure if you knew what countries?

Professor RITTER: I do not, no.

Reverend the Hon. FRED NILE: You said that there have been trials of the naltrexone implant that were not effective and failed: where were those trials?

Professor RITTER: That trial was conducted in the United Kingdom. That was the comparison between methadone and implant naltrexone. That used the Go Medical, Dr O'Neil's implant product, and found no difference between the two groups in terms of outcomes.

CHAIR: That was Hulse et al 2009?

Professor RITTER: No, that is Lob Meyer published in 2010, which was published after the National Health and Medical Research Council concluded their review.

Reverend the Hon. FRED NILE: There was no difference in the results between naltrexone implants and injections?

Professor RITTER: No. And methadone maintenance.

Reverend the Hon. FRED NILE: Comparing naltrexone implants with methadone maintenance?

Professor RITTER: That's right. There have been two further Russian trials published since the National Health and Medical Research Council review and both of those have compared naltrexone implants to a placebo and I can supply the Committee secretariat with those references if the Committee are interested.

Reverend the Hon. FRED NILE: One of the problems Dr O'Neil mentioned was the cost of the naltrexone implants. In your submission you say the Pharmaceutical Benefits Scheme [PBS] provide funding for treatment of alcohol dependence but not drug dependence—that seems to be a bit of a strange distinction.

Professor RITTER: My understanding of that is; when Naltrexone was registered in Australia it demonstrated its safety and efficacy and it was registered for both the treatment of alcohol dependence and the treatment of heroin dependence with the Therapeutic Goods Administration [TGA]. The next step in order for the Federal Government to provide subsidies through the pharmaceutical benefit scheme is that each drug needs to be demonstrated to be equally cost effective to the next best alternative. That cannot be demonstrated for naltrexone in the treatment of heroin dependence. It can be demonstrated for naltrexone in the treatment of alcohol dependence, which is why the PBS will subsidise someone's naltrexone medication for alcohol dependence whereas they will not subsidize it for heroin dependence.

Reverend the Hon. FRED NILE: I do not understand why they would have a policy to discriminate against drug users?

Professor RITTER: The intention is that the Pharmaceutical Benefits Advisory Committee [PBAC] only approves and pays for medications that are at least as cost effective as what they currently have available. That is the rule for all medications, it does not matter what the disorder or disease is. That is the way our medical system works.

CHAIR: The three platforms for the clinical trials are safety, effectiveness and cost effectiveness?

Professor RITTER: That is right.

CHAIR: But there have not been adequate clinical trials so that is not to say it could not occur in the future?

Professor RITTER: Absolutely not. If the trial was conducted independently and objectively—absolutely.

CHAIR: You need more data. If pharmaceutical companies do not derive any profit from it they are not going to invest millions. I say that as someone who came from the pharmaceutical industry: if there is no money in it you will not find them there. It is hard to fund clinical trials.

The Hon. JAN BARHAM: I am interested in the idea that the profitability factor is not there because of there not being enough heroin users. I was trying to obtain from Dr O'Neil the broader range of addiction application. If it is about alcohol, is it suitable for tobacco or prescription drug addiction then surely there would be a broad commercial application. Are there other drugs and methods more suitable?

Professor RITTER: Part of the reason why you would not use a naltrexone implant for the treatment of alcohol dependence is because you are blocking the opioid receptors unnecessarily. Naltrexone works for the treatment of alcohol dependence by reducing cravings. It is not the same mechanism as it is for heroin, which is to do with blocking your opioid receptors. It is quite a different mechanism of action for alcohol than it is for heroin. There are much more effective treatments for alcohol that do not have the risks that implants have associated with them. That is why there is no market for implants for alcohol dependence.

The Hon. JAN BARHAM: We are focusing on the quick fix rather than looking at issues around addiction.

Professor RITTER: Sure.

The Hon. JAN BARHAM: When you are talking about funding the broad range of services and the length of time that is required to sometimes unravel and rebuild someone's life, is that included in your funding model? Is this able to be factored in for governments to look at the real cost and cost effectiveness of providing that support?

Professor RITTER: The Drug and Alcohol Clinical Care and Prevention Model [DA-CCP] estimates how much the New South Wales Government would have to spend if it offered treatment to those who need it and want it in a comprehensive fashion according to best practice. There will be available, when that model is complete, an estimate of what should be spent in an ideal world in New South Wales on drug and alcohol treatment. It is likely to be double what is currently spent, if I was hazarding a guess.

The Hon. JAN BARHAM: The other thing is how do we deal with prescription addiction and poly drug use?

Professor RITTER: Sure.

The Hon. JAN BARHAM: With a lot of young people there is a trend for alcohol use and Xanax on top and then they end up in other trouble; usually in court with no memory. Poly drug use being a specific area of concern how do we relate to that?

Professor RITTER: The research community has let down policy-makers in this regard. Everybody is a poly drug user. I have not met anyone using heroin that is not using everything else at the same time and yet as researchers we persist in categorising people as single drug events. It is partly about the experimental method. What is really clear is that people use multiple drugs and often that is completely pragmatic choice—price and availability—all they want to do is get out of it. Our treatments need to be broad to address multiple substances simultaneously. The one substance that is likely to cause the greatest number of deaths in our patient group is tobacco.

The Hon. JAN BARHAM: With regard to prescription drug addiction, is it a fact that in Australia there is a strong regulation of prescription dispensing and tracking to ensure that—

Professor RITTER: No, we do not have a very good system. Prescription drug abuse is emerging as a significant and growing problem. One of the solutions is to have real-time monitoring. A report was done for Tasmania and Tasmania has been trying to lead the Federal intergovernmental committee on drugs to establish a real-time monitoring system across Australia.

The Hon. JAN BARHAM: Connected to allow doctors to check prescriptions?

Professor RITTER: Pharmacists actually do that, not doctors. There is Project STOP, which commenced in Queensland; it is compulsory in Queensland. It is voluntary for pharmacists to use it in other jurisdictions but that is not real-time, that is just a registration system. You could look it up and check whether that patient had already filled a script at another pharmacy within the previous week but it is not real-time, so it does not serve that immediate purpose.

The Hon. JAN BARHAM: The other complication being that people are able to obtain scripts under false identities so even real-time tracking is difficult?

Professor RITTER: Sure.

The Hon. JAN BARHAM: Are those issues being looked at?

Professor RITTER: Yes.

The Hon. JAN BARHAM: Are you able to provide any additional research if it was requested?

Professor RITTER: Yes, indeed.

The Hon. JAN BARHAM: Do you think there is enough opportunity for people with psychological issues who voluntarily want to seek support before they enter addiction, or during the build-up that leads to addiction, to access help?

Professor RITTER: I do not think so. It relates to where we started with de-professionalisation. There are very few clinical psychologists working in alcohol and drug counselling these days, it is largely alcohol and drug counsellors. That is partly because the sector does not have enough funds to employ the people with

masters or doctorate qualifications. The changes to Medicare, the Better Access scheme, where patients can receive six sessions from a clinical psychologist has increased access for our patient group to clinical psychology services but six sessions is a drop in the ocean when you are looking at someone's lifetime journey of changing their substance use.

The Hon. JAN BARHAM: Is there an age limit?

Professor RITTER: I do not think so.

The Hon. JAN BARHAM: Young people are able to access those services?

Professor RITTER: I believe so, yes.

CHAIR: On behalf of the Committee I thank you Professor Ritter for sharing your expertise with us. If anyone has any further questions they will be sent to you through the secretariat.

Professor RITTER: Of course they can. I am happy to supply any other documentation that we have not covered today. Thank you for the opportunity to appear before the Committee.

(The witness withdrew)

NICHOLE SULLIVAN, Clinical Practice Leader, Youth AOD Services, Mission Australia, and

MARTIN THOMAS, General Manager, Social Advocacy and Public Affairs, Mission Australia, sworn and examined:

CHAIR: Do you wish to make an opening statement?

Mr THOMAS: Yes, just a short statement. We have not made a long submission but I will touch on a few points. I thank you for the opportunity of being able to attend and appear before the Committee. I guess our true value is the on-the-ground experience that Mission Australia has dealing with young people who are dealing with addiction. We have operated drug and alcohol services through Triple Care Farm [TCF] for more than 20 years. TCF has a strong history of meeting the needs of young people with alcohol and drug addiction issues and reducing the impact of substance misuse in different areas of life. Building on the success of Triple Care Farm, we have opened two more youth wellbeing centres on the Gold Coast and in Dubbo.

Given the nature of our service experience in New South Wales, for this submission we have restricted our responses to only the terms of reference that we believe are most relevant to the services we provide. As you will see, our submission has responded to terms of reference 1 to 4 and 7. Likewise in terms of this initial opening statement I will, not surprisingly, keep my comments to those terms of reference as well. On term of reference 1 (a), Mission Australia fully supports the need for approval of treatments through a range of processes, such as those outlined in 1 (a). Our main concerns relate to the limited opportunity that is provided to the community sector or Community Services. Where there is an opportunity for research to happen, quite often it happens through a partner, such as an academic partner, and quite often when they do approach us the question and the nature of the research has already been set, and we are asked to provide support.

We believe that there is value within the whole of the sector in providing input into potential research and, most importantly, by giving clients or people with addiction some kind of input into the research that is undertaken, particularly if they have gone through a successful process and can look back and provide input into that. I think that is one the major points we want to make. Within our Triple Care Farm we certainly do evaluations which look at the effectiveness but we are itching with this treasure trove of information that we have over 20 years to also be able to put that into research and to inform the research debate that happens.

In terms of reference 1 (b) in relation to naltrexone treatment specifically, Mission Australia shares the concerns raised by the Australian National Council on Drugs about its uses that were endorsed in findings by the New South Wales Coroner on 27 September 2012. We also support calls by the Australian Injecting and Illicit Drug Users League that there needs to be a review and change to the availability of naltrexone, particularly as it relates to access through the Therapeutic Goods Administration's special access scheme category A. Obviously the Committee has heard a fair bit this morning on naltrexone. We are not clinical experts. Our major concern—and Ms Sullivan is here to give that on-the-ground input—is real issues of informed consent. Obviously an implant has a much longer term impact, which is preferred than say one-off treatments, so the process around that, we believe, is important and we would love to share more with the Committee on that.

Also, we believe there needs to be an assessment of less invasive—the naltrexone implants are quite high invasive. We believe that it, also for the individual, needs to be weighed up against less invasive treatments as well. In terms of reference 3, our experience working with a large number of young people who are referred to our services through the court system, success stems from empowering an individual to make choices about their treatment options. This includes offering a client-led approach that incorporates quality of life measures and reductions in the use of indicators, rather than a measure of success being linked to an arbitrary applied time frame. One of the problems with mandatory or involuntary treatment as we see it, apart from the lack of informed consent to participate, is that it can also result in inappropriate referrals to treatment. Again, I guess we are looking at the greater success of working with a young person in terms of their treatment and to have as much input from them as you possibly can.

So our submission talked about trying to balance up to give the greatest input to a person in having some input into their own treatment and a less top-down approach. We understand that there need to be court directions in some cases to get people to care who are unwilling, to get people to access services, but it would be our strong submission that as much as flexibility as possible can be built into the system to give people that unction on themselves. Even within some quite restrictive court orders we have found that if we can build in some self-input we get similar outcomes and similar successes to those who live there completely on their own

in terms of a voluntary nature as well. In terms of reference 7, in addition to the concerns about involuntary treatment, we have concerns about the inclusion of the new option for rehabilitation where it provides for naltrexone implantation.

Mission Australia is also concerned about the proposed amendments to the procedure for assessing persons for involuntary treatment, including by adding to the persons who can request an assessment and to the circumstances in which a person can be involuntarily treated. In our view S9A4 could and should maintain an individual's right to consent to assessment and their right to refuse treatment should not simply exist at the expiration of the dependency certificate. That is essentially the opening statement. Obviously we are happy to answer questions and certainly utilise Ms Sullivan's experience on the ground that we have as much as you can.

CHAIR: Part 3, "The effectiveness of mandatory treatment on those with drug and/or alcohol addiction"—concerns have been expressed in your submission on page 4:

> There have been recent changes with clients either attending for their assessment under supervision (including handcuffed)—

obviously Juvenile Justice clients—

> or the service being asked to attend the detention facility to complete the assessment there. These practices are not conducive to an effective or accurate assessment nor do they suggest informed consent. It is unclear whether this revised practice is the result of recent changes to the *Bail Act* but we are concerned about their impact on our ability to undertake assessments.

Can you expand on that for the Committee? Naturally, we do not have the knowledge on the ground of what happens.

Ms SULLIVAN: My apologies, I neglected to introduce myself before. I am the clinical practice leader for Mission Australia's youth alcohol and other drugs services, and I speak in my capacity as a registered psychologist. In answer to your question, we have noticed in treatment centres recently, over the past six to 12 months, young people are not given the opportunity to leave custody for the purpose of an assessment for drug and alcohol treatment. We are being urged to provide those assessments to young people while they are under heavy supervision, with guards present during a drug and alcohol assessment, with guards on the other side of what is not a soundproof wall. Often young people are in restraints or often we are urged as clinicians to travel to custodial settings in order to conduct an assessment for rehabilitation. It is our experience that those types of assessments are not appropriate. Those types of assessments do not yield accurate and clear pictures of a young person's experience or their need for treatment.

It is our experience that that sets up a relationship that is not conducive to recovery. Young people are not providing informed consent when they are in restraints—obviously anything other than being in custody is a better option—and often they are signing up for treatment which is not really in line with their own goals about where they are headed in terms of their drug use. I guess we are urging for more flexibility within the system, particularly for young people who are in custody and for young people to be able to access all of the different options around treatment from lesser restrictive care models through to more restrictive care models and be given opportunities to make informed decisions about which treatment option suits them best.

CHAIR: How long have you been working in the system? Is this a recent change?

Ms SULLIVAN: This is a recent change. I have been with Mission Australia for the past five years in youth residential rehabilitation treatment programs. It is a similar situation we are seeing across New South Wales. We have three centres in New South Wales, all with similar experiences.

CHAIR: Would there be concern about the safety of people like you and other therapists who are working with these young people? Why do you believe they have this seemingly heavy-handed approach?

Ms SULLIVAN: There are always questions of safety. We have protocols within the services to manage those issues of safety that keep clinicians and other staff, visitors and young people within our program safe. It is not a decision that we take lightly. We always have a telephone assessment with the young person prior to meeting them face-to-face. We always have two clinicians in a room and two exits to every room. We have security procedures at all sites. So it is not a decision that we take lightly, and these are the clients that we work with on a daily basis.

CHAIR: What sort of suggestions for change would you recommend to the Committee?

Ms SULLIVAN: Suggestions for change would be to allow young people who are in custody or who are in bail to have equal access to treatment in all different fashions, whether it be in custody itself—and there are some very good treatment models where treatment is provided in custody—or in the community when it is seen to be appropriate by the court. These decisions are not ours solely to make but we would like to see young people being able to access residential treatment post leaving custodial settings and in a streamlined fashion so that young people do not need to wait for long periods in the community before they are able to access residential treatment post release.

CHAIR: Are you finding that there are long periods that they are waiting before they can get residential treatment? What sort of time frames are we looking at?

Ms SULLIVAN: Without the use of day bail, without the use of young people being able to leave a custodial setting for the purpose of an assessment and then returning, young people are needing to wait in the community post release to be able to contact a service, conduct a telephone assessment, come to a face-to-face interview. It depends on how much the service is being used at the time and that wait time can vary between two weeks and eight weeks.

Mr THOMAS: That wait time can also depend on the availability of detox beds before people enter a residential program. Recent changes, budget cuts, have led to the closure of some detox beds. As we understand it, there is not a single bed in New South Wales for young people for detox.

CHAIR: I noticed that in part 2 of your submission on page 3, the recent reduction in the funding of detox beds. How hard is it to find a detox bed?

Mr THOMAS: I understand the waiting times are quite long. Again, Ms Sullivan would have the on-the-ground experience.

Ms SULLIVAN: There are no designated youth detox beds in the State. All of our three treatment centres utilise beds at Nepean youth drug and alcohol services at Nepean Hospital. They are adult beds in an adult ward that are supervised by the same medical staff who respond to adults in the process of detoxification. They are supported heavily by our youth drug and alcohol team but outside of that we are accessing beds in the Australian Capital Territory and Queensland.

CHAIR: You are talking about Juvenile Justice detox beds that we need specifically for young people.

Ms SULLIVAN: Specifically young people, not just Juvenile Justice clients but for young people from all parts of the community.

Reverend the Hon. FRED NILE: Did you say there is not one bed available?

Ms SULLIVAN: Not one designated youth detox bed.

Mr THOMAS: When you say recommendations to the Committee, I guess broadly speaking our recommendation is that when you give the power to the individual to have more input, the outcome actually improves so much more. We can provide data if the Committee would like on some of the comparisons that we have found because that links into how we evaluate it.

CHAIR: That would be very good if you could provide that to the Committee.

Mr THOMAS: I will make a note of that and provide it. But in your recommendations, if one of the outcomes is lifting the effectiveness of rehabilitation, obviously in any system there is punishment, there is rehabilitation. As you weight towards rehabilitation the ability to empower the individual will make a big difference.

The Hon. HELEN WESTWOOD: If I could just turn to that question that we have been talking about—and thank you both for your attendance today—the issue of the designated youth beds. Have there ever been designated youth beds in New South Wales.

Ms SULLIVAN: I guess I can only speak on my experience in the past five years and I have not had any knowledge of detox beds in the State in that five-year period.

The Hon. HELEN WESTWOOD: Have they been requested by advocates? Are you aware of that?

Ms SULLIVAN: Mission Australia is currently advocating for that process. We are putting together a research paper at the present time.

Mr THOMAS: But we have been over several years also. It is a consistent call in a number of meetings we have with government officials and Ministers.

The Hon. HELEN WESTWOOD: Have you ever been given a reason why designated youth beds have not been allocated?

Mr THOMAS: Not that I am aware of. I think it comes down to a funding issue more broadly.

The Hon. HELEN WESTWOOD: Perhaps I will put it on notice, but it would be good to know why it is inappropriate—I think it is probably obvious—that there be youth beds within an adult ward for detoxification purposes. The other area I was interested in, changes for young people within the juvenile justice system, how long ago did that happen, for them to be now restrained and to be guarded while you are carrying out your assessment and consultation with them?

Ms SULLIVAN: I have seen them in my practice over the last five years. We have seen an increased demand on our services to have young people being able to present for assessment in restraints and under heavy supervision. We have seen that in the past six to 12 months. We believe it to be linked to recent changes in the Bail Act but we cannot make that direct distinction.

The Hon. HELEN WESTWOOD: Was there any discussion with you as a service provider or advocate for young people?

Ms SULLIVAN: We advocate quite strongly to the Juvenile Justice centres about the need for appropriate assessment, which is around empowerment and engagement with the young person and developing rapport. We advocate quite heavily. Sometimes that has resulted in the young person not being available for assessment.

Mr THOMAS: But also at a national level and obviously a service level, we were not consulted, as far as I am aware, about changing the practice or changes in their impact.

The Hon. HELEN WESTWOOD: Perhaps you could outline to the Committee why you think it is inappropriate for young people to be so restrained and to be guarded while you are carrying out that assessment?

Ms SULLIVAN: At the time of assessment a few processes are happening. The first is around engagement with the young person, starting a relationship that is based on trust and, being equal parties, to bring something to the treatment process. That is difficult to do with someone who is in handcuffs. Another part of the assessment is around clinical assessment of need and talking to young people about whether not they are requiring a medicated detox program, for example. If young people are under heavy supervision by staff from the Juvenile Justice centre, they are not able to give an accurate picture of what their current drug use is while in custody.

That makes them very difficult decisions from the treatment program about how we can safely support them with the transition from custody into a residential rehabilitation program. To be quite frank, a young person presenting in handcuffs under heavy supervision is quite willing to say anything to get out of the current situation and into a less restrictive care setting, like a residential rehabilitation. Often we are not able to gauge an accurate history around drug use, an accurate picture about whether or not we are able to meet their needs, and whether or not we are the right treatment program for them.

The Hon. HELEN WESTWOOD: Do those statistics you were talking about cover this period where we have seen this change, or perhaps it is not long enough for you to assess whether or not they have been successful in their programs?

Mr THOMAS: I am not 100 per cent sure, but I will certainly check and will certainly wait, particularly in the last six or 12 months of the data we have available when it has been assessed.

The Hon. HELEN WESTWOOD: The issue you also raised on page 3 of your submission, it is also around young people and Juvenile Justice, and not being able to be day released. Do you think it is linked to the same issue?

Ms SULLIVAN: It is the same issue.

The Hon. HELEN WESTWOOD: When you talk about the level and adequacy of funding for drug and alcohol treatment services in New South Wales, you talked about your concerns about adequacy of funding, particularly the recent reduction in funding and that it has resulted in the closure of a number of detox beds. When was that funding reduction and how did it manifest? Was it funding to you or was it funding to another service that provided the detox beds?

Mr THOMAS: It was across the sector, as I understand it. I think we should have some background papers and perhaps even some submissions I can make available that would inform our views on that decision. Otherwise I might be guessing beyond that the exact timing. But my understanding is it is not a defunding of a Mission Australia program as much as it is cuts across the budget generally.

The Hon. HELEN WESTWOOD: It would be the health budget? The detox beds would be within a health facility?

Ms SULLIVAN: That is right.

The Hon. SHAOQUETT MOSELMANE: Following up that issue of funding, can you elaborate on what other impacts the shortage of funding has had on the services, apart from detox beds?

Mr THOMAS: That is the main one from our point of view and, as we mentioned, in terms of detox, it delays the ability for us to take clients in. Also, where there is a delay, where they are waiting several months in some cases for detox, it affects their state of mind and has a big impact on our ability to succeed in having a treatment program that will be successful from a residential point of view. I am not sure if Nichole has others, but that is the main one that we have put our minds to for this that come from those cuts.

Ms SULLIVAN: The cuts to the detox beds are really important to us, and not just in New South Wales but, as I mentioned, we are accessing beds in the Australian Capital Territory and Queensland. That provides quite a drain on services to be able to reach so broadly as to cover that level of geography and support young people while they are waiting for those beds. It also puts a drain on families who are transporting young people around the country to access appropriate services. How some of the funding cycles impact treatment is that often they are short cycles—they might be 12 months or three years direct funding to our treatment services—and while decisions are being made as to whether or not to continue the funding, often there is a gap between one funding cycle closing and the announcement of a continuation. We are losing staff in that period. As Dr Ritter was saying, we are a deskilled sector. We find it very difficult to attract the right staff. I do not have a single clinical psychologist within my team. We are registered psychologists, so we are not masters level psychologists. During that time when funding is in a state of flux, we lose staff mainly to the government sector, and we are losing staff to other non-government organisations who are approaching anyone who is available at the time.

The Hon. SHAOQUETT MOSELMANE: You are clearly concerned about the naltrexone implants and the impact that has had. Do you see no value in applying naltrexone implants, given the witness statements we have heard earlier this morning?

Mr THOMAS: We could not give a clinical response. Our concern is where it is used, informed consent is transparent, and there are processes around that. Our major concern is that it is long term and it is more invasive than alternatives. I do not think it is necessarily appropriate for us to go into effectiveness versus others, but we have concerns that if a clinical trial is undertaken in New South Wales that within that process we have informed consent and there is a level of transparency.

The Hon. JAN BARHAM: In relation to access to services for young people—and, by the way, congratulations on your award and recognition, great work—the spread of services, you say you have to go interstate. I think you were on the Gold Coast before—

Mr THOMAS: Coffs Harbour, sorry.

The Hon. JAN BARHAM: That is not much of the State to cover. Are you aware of the need that is out there? Do you have any way of assessing through other channels what is the need and what is being met?

Ms SULLIVAN: Certainly our wait times vary. We know that families, particularly in rural and remote areas, have very limited access to drug and alcohol treatment. All of our treatment centres are in rural or remote areas in New South Wales in our attempt to respond to that need. I think the most disadvantaged parts of our community are those who are missing out on treatment options, Aboriginal young people, young people from low socioeconomic backgrounds and young people from country areas.

Mr THOMAS: I think beyond wait times and perhaps anecdotal information and the interaction through people that we have in other services we provide, we pick up a sense of it but nothing scientific in that sense.

The Hon. JAN BARHAM: Hopefully you will gain more information about that. I am also interested in voluntary access. Do you have a distinction about how many people come to you voluntarily, whether it is the young people or the families wanting that support, and is there a distinction about provision of service based on what you can provide? Are you managing to provide for Juvenile Justice?

Ms SULLIVAN: Two of our treatment centres were directly with Juvenile Justice and have specific funding arrangements with Juvenile Justice. Those centres provide treatment for young people who have been court-ordered to attend care. However, young people in those treatment centres have the opportunity to leave at any time. Often that results in them going back into custody or going back before the court. So I guess it is a very grey line as to whether their treatment is voluntary or involuntary. They are voluntary in that that they are choosing to be there rather than being in custody. We offer young people opportunities to make empowered decisions about their care at every stage of treatment and try to encourage that process to happen within the Juvenile Justice setting as well, and with courts and magistrates, asking them to ask young people about their own intentions as to treatment, what their wishes and desires are in order to have them coming along with us on that journey.

The Hon. JAN BARHAM: If someone comes to you in a voluntary way, not through the system, wanting to find a placement, what is the waiting time?

Ms SULLIVAN: The wait times are similar for Juvenile Justice clients or non-Juvenile Justice clients. Depending on what time of year it is, because we have specific closure periods—over the Christmas period and mid break—but they vary between two and eight weeks.

The Hon. JAN BARHAM: How do you find dealing with poli- and multidrug use and is that something that is taken into consideration when there is the idea that there needs to be an outcome in a set time? Do you find a problem with that?

Ms SULLIVAN: Yes, absolutely. Thirty per cent of our clients are using five or more substances. That is not including tobacco and alcohol, so five illicit substances, and they are using those in a chronic and chaotic fashion. We are required to achieve outcomes in a designated time period. That time period is sometimes decided by the court—for argument's sake, let us say 12 weeks, which is a short time to be able to unpack all the biological, social, psychological, spiritual and cultural issues that are connected with someone's drug and alcohol use and mental health issues. It seems quite arbitrary to have designated time periods on somebody's recovery.

Reverend the Hon. FRED NILE: I notice in the first part of your submission relating to Naltrexone treatment, you are not a clinical organisation so you are collating all the other bodies that are doing the assessments, I understand that. I am wondering whether Mission Australia, as an organisation, was aware of the Fresh Start Recovery Programme in Perth that has been going for 15 years now.

Mr THOMAS: We are certainly aware of it. I am not sure of what investigation or how many people have been across to look at it, but we are certainly aware of it, in terms of its understanding within the sector and any literature that is around.

Ms SULLIVAN: As a drug and alcohol treatment program and as an organisation, we weigh in quite heavily the voice of the consumer. We have engaged with AVIL and our concerns are echoing their concerns about the use of naltrexone implants.

Reverend the Hon. FRED NILE: You are aware that there are dozens of people who have no money who are trying to get to Perth to go through the treatment program, including aboriginal people?

Ms SULLIVAN: Only through the admission of Mr O'Neil.

Reverend the Hon. FRED NILE: They are making the choice, it is not compulsory. The Fresh Start Programme is voluntary and they have to pay a lot of money to get involved in that.

Ms SULLIVAN: One of my concerns is that this particular group of clients is comprised of the most heavily disadvantaged and vulnerable members of our society. I can see why they would be desperate to access treatment.

Reverend the Hon. FRED NILE: One of our issues, in our terms of reference, is whether there should be a trial, in New South Wales, of naltrexone implants and thus folk would not have to travel to Perth. It could be assessed by medical experts as to whether it is effective. Would you support such a clinical trial in principle?

Ms SULLIVAN: In principle I would support the consumer voice being at the forefront of any decision-making about clinical trials.

Reverend the Hon. FRED NILE: You are also critical of the mandatory involuntary treatment proposal. Are you aware of the Swedish rehabilitation program?

Ms SULLIVAN: Not directly the Swedish program but we have been given briefs on the involuntary drug and alcohol treatment model. My understanding is, that is informed by the Swedish model.

Reverend the Hon. FRED NILE: Are you aware that it is a six-month program in a secure sanatorium and the only mandatory section is the first section? Patients are then free to leave and, in fact, nobody leaves.

Ms SULLIVAN: Yes.

Reverend the Hon. FRED NILE: They continue with the rest of the program until they are completely cleared at the end of six months.

Ms SULLIVAN: Yes.

Reverend the Hon. FRED NILE: Do you think there is a possibility of a similar program in New South Wales? I know people think that for six months you are in jail, but it is only the first few weeks until they detox and no longer have the desire for drugs.

Ms SULLIVAN: What we have responded to in the terms of reference in our concerns is around the process of needing to have informed consent as part of the assessment process for involuntary drug and alcohol treatment. Our push is to ensure that consumers have proper informed consent about the processes which they are undertaking, that their voice is heard and that they are able to be empowered around those decisions.

Reverend the Hon. FRED NILE: In point 7 on page 4, you quote the Drug and Alcohol Treatment Act where it refers to, "severe substance dependence". Do you agree that there are some people who cannot make a voluntary decision because they are so addicted to heroin and the only future they have is probably an overdose? It becomes an option between an overdose death or mandatory treatment.

Ms SULLIVAN: I agree with you that some people require involuntary treatment in order to preserve their life. We support that. Our thrust and philosophy is that people should have as much ability to have their

voice heard in treatment as possible and that there is some flexibility within the system to allow them to have choice.

CHAIR: Thank you for coming in to represent Mission Australia and giving your expertise in evidence before this Inquiry. If you can provide that additional information, we would be grateful. Good luck with the selfless work that you are doing.

Mr THOMAS: Thank you for the opportunity, we appreciate it.

CHAIR: We could provide questions on notice to any of the witnesses. If that is the case, you will have a 21-day period to get back to us.

Mr THOMAS: I have notes on most of it. I should be able to provide it pretty easily, thank you.

(The witnesses withdrew)

(Luncheon adjournment)

ALEX WODAK, President, Australian Drug Law Reform Foundation, and

MARY OSBORN, Australian Drug Law Reform Foundation, affirmed and examined:

CHAIR: I welcome you to this drug and alcohol treatment inquiry. Thank you, Dr Wodak and Dr Osborn, for joining us this afternoon. The opportunity is afforded to you if you would like to make any opening statements. I know we have got your submission here in front of us but if you would like to make any opening statements feel free to do so.

The Hon. HELEN WESTWOOD: Just before the witnesses give an opening statement I would like to declare that I am a member of the Australian Drug Law Reform Foundation that Dr Wodak and Dr Osborn are here today as witnesses for.

The Hon. JAN BARHAM: I would also like to declare membership of the organisation.

Dr WODAK: Thank you for allowing us to speak to you. I would like to begin by pointing out something that must be apparent to all of you who do constituency work, and that is that alcohol and drug problems affect almost every family in Australia, yet researchers and clinicians around the world have a fairly strong consensus about what works and what does not work for both prevention and treatment of alcohol and drug problems and there is a strong feeling that we really should be doing better than we do. It is a legitimate question, I imagine, in this inquiry as to why we do not do better than we are doing.

I would submit that what really stops us is that bad policy is often good politics— that is the way things seem to work. Good politics, for example, is not standing up for the public interests against the drinks industry. Good politics is continuing to rely heavily on drug law enforcement when it is now clear that this is only marginally effective, often seriously counter-productive and usually cost-ineffective. What gets discussed and commented on are generally things that are known not to work, and that is really one of the reasons why we are here: because we do not get the outcomes that we want.

Law and drug clinical treatment is generally effective, safe and cost-effective; it is about as effective as most other treatments for chronic, complex, poorly understood, relapsing and remitting conditions—conditions that get better and get worse: conditions such as asthma, high blood pressure, type II diabetes, that is, adult onset diabetes. One of the reasons we do so badly with alcohol and drugs in the country is alcohol and drug treatment is grossly underfunded. New South Wales provides about $140 million for alcohol and drug treatment compared to 10 times that figure for mental health, and yet these two conditions—alcohol and drugs and mental health—account for similar amounts of death and disability, the so-called burden of illness.

In 2002-03 Commonwealth, State and Territory governments, in response to illicit drugs, allocated $3.2 billion, and 75 per cent of that went to drug law enforcement, 10 per cent to prevention, 7 per cent to drug treatment and only 1 per cent went to harm reduction. Yet, the return on investment for harm reduction and drug treatment is impressive; the return on investment for drug law-enforcement is very poor. A US study found that for three different kinds of drug law enforcement, the return on investment was between 15 and 52¢ per dollar and the return on investment for $1.00 in drug treatment was $7.46. Yet, despite that, 93 per cent of US Government expenditure in response to cocaine that was allocated to drug law enforcement was only 7 per cent to drug treatment.

Similarly, for needle syringe programs—and I remind you only 1 per cent of Commonwealth, State and Territory governments' allocated funding expenditure went to needle syringe programs—the return on investment is a health saving of about $4.00 per dollar and an overall saving of $27.00 per dollar. Yet we have to fight tooth and nail to defend the needle syringe program. This inquiry is taking particular note of naltrexone implants, and there is a recommendation that compulsory treatment with naltrexone implants be considered for heroin dependence. I think that is a very good example of why we struggle with alcohol and drugs generally in the community. No other field of health care has to contend with such a degree of politicisation. Cardiologists are not told to do more coronary artery stents and fewer coronary artery bypass grafts; endocrinologists are not told that insulin treatment is going to be limited to two years. But here we are where a treatment of unproven effectiveness is being considered for compulsory treatment. I will leave it at that and I hope that we will be able to answer all of your questions.

The Hon. JENNIFER GARDINER: I would like to ask you to expand on some recommendations made in your submission. Firstly, you say that placing alcohol and drug treatment services under mental health was a serious error and should be reversed. Could you expand on why that policy or that configuration should be reversed?

Dr WODAK: It should be reversed because it should never have been there in the first place. It was under the mistaken view that alcohol and drugs were some kind of mental health disorder, and in some cases, of course, they are, but in many cases people with alcohol and drug problems are people without mental health problems; they have just developed a problem with alcohol and drugs and now they are burdened with all the stigma that attaches to not only having a serious drug and alcohol problem but also having a mental health problem. It makes a difficult field even more difficult.

I would say that 90 per cent of senior clinicians around this State and around this country share the view that I expressed in the submission. I know that many of my international colleagues have a similar view that this international trend to put alcohol and drugs under mental health has been very negative. My colleagues and I are very happy to work with our mental health colleagues, and that is not the issue; it is working under mental health colleagues that is the problem. In some cases, funding which is already very scarce in the alcohol and drug field has found its way to be moved under mental health. Mental health is a difficult field and I do not want my response, written or verbal, to be misinterpreted as anything but respectful of the difficulties and importance of mental health; it has been a field that has also suffered from gross underfunding for a long time, and I applaud the fact that New South Wales was the leader in trying to redress that. There is still a way to go in improving the funding of mental health, but the issue that I wanted to direct this Committee to is the fact that placing mental health over alcohol and drugs has been a big mistake.

The Hon. JENNIFER GARDINER: Is it possible to have a guesstimate as to what proportion of people who are being dealt with for drug and alcohol issues are without mental health issues?

Dr WODAK: I think there are estimates of that kind and I think it is fair to say that the proportion of people with severe alcohol and drug problems who also have a severe mental health problem is roughly the same as the proportion who have a severe physical health problem, and, of course, some people have both. People with liver disease, for example, due to alcohol—liver disease due to alcohol is found in people who drink generally in an unrelenting fashion six or seven days a week; they tend to rarely have severe mental health problems but they obviously have severe physical health problems. People who drink episodically are more likely to have severe mental health problems. So different styles of drinking are associated with different likelihoods of getting physical health problems or mental health problems.

The Hon. JENNIFER GARDINER: Do you have any examples of where you say that funding for drug and alcohol treatment services has been diverted to mental health services where they really should have been kept specifically for drug and alcohol services?

Dr WODAK: A colleague working in the St George area has told me that this had affected her unit. I do not have the details. I could contact that person and provide that information to you if you wish.

The Hon. JENNIFER GARDINER: That would be great. In respect of your recommendation number 10, that New South Wales should support national endeavours to reduce consumption of prescription opioids, are you suggesting that New South Wales is not supporting national endeavours or is there something that we should be doing in New South Wales to be more supportive?

Dr WODAK: This is a very important issue—a growing issue—and Australia unfortunately is following the trends of the United States where there are 16,000 deaths from prescription opioid overdose a year. To put that in perspective: the United States has 20,000 deaths a year from gunshot suicides and 10,000 deaths a year from gunshot homicides. So this is a huge issue, and I regret to say that Australia is following the same trends as the United States, and Canada and the United Kingdom are also following down this area. My colleague Dr Osborn has done a lot of work on this issue with the College of Physicians, where she was responsible for drawing together separate policy papers on alcohol, illicit drugs, tobacco and prescription drugs.

To answer your question, overall we should be limiting the use of prescription opioids—difficult to do—but guidelines and so on could bring the profession back. I think we have been too generous in how many people we provided them for, the doses that were provided and the duration, and this should all be pulled back. Opioids should not be the default option when any person enters the doctor's waiting room. The difficulty is that

the areas that needed to be developed that do not involve prescribing do not have a payment system attached to them. What I mean here is that we need to make much more use of nurses, occupational therapists and other allied health professionals providing non-pharmaceutical treatment for people with chronic pain, but we do not have a training system for this yet, we do not have any diplomas for this yet and we do not have a system yet for paying these people. This all needs to be developed.

The Hon. DAVID CLARKE: You said that you oppose calls for compulsory treatment of addicts with naltrexone implants. What recognised bodies or authorities have been calling for compulsory treatment with naltrexone implants of addicts?

Dr WODAK: Well, I understood that the bill that was being considered as part of this inquiry is calling for compulsory treatment with naltrexone implants for heroin-dependent people.

The Hon. DAVID CLARKE: I am not sure of that; I do not know.

The Hon. HELEN WESTWOOD: Yes it is. It is in the bill.

The Hon. DAVID CLARKE: Does it call for compulsory treatment, or does it call for a trial?

Dr OSBORN: No, it does not.

The Hon. HELEN WESTWOOD: It is compulsory; it is in the bill.

The Hon. DAVID CLARKE: Right. Well, most organisations would certainly oppose compulsory treatment with naltrexone, as I understand it. Would you support a properly supervised trial here in New South Wales of naltrexone implants?

Dr WODAK: Let me answer the first part of your question first and then the second part. Dr Osborn is just directing me to the term of reference—the delivery and effectiveness of treatment services for those addicted to drugs and/or alcohol, including naltrexone treatment. To answer the first part of your question regarding compulsory treatment, outside the mental health field I do not support compulsory treatment in the alcohol and drug field or in medicine generally and last night I read a statement coming from the United Nations where 12 United Nations agencies combined to oppose compulsory treatment for alcohol and drug problems, so I have grave reservations about that on several grounds.

In terms of your second question: do I support a trial? Yes, I do support a trial provided the trial is conducted scientifically and ethically. That means that it is a trial which has been submitted and approved by a research ethics committee which is conducted according to the guidelines of the National Health and Medical Research Council and if such a trial is conducted, of course I would support that— always have, always will.

The Hon. DAVID CLARKE: Do you think on what you have observed with naltrexone that there could be fruitful possibilities coming from it?

Dr WODAK: The emphasis is on the words "could be", but there are lots of potential treatments that look attractive theoretically that turn out empirically not to be effective or not to be safe and conversely there are some treatments that have very little going for them theoretically that turn out to be very effective when carefully evaluated. What really matters is not how strong the theoretical grounds are for a treatment but how strong the empirical evidence is for effectiveness, safety and these days also for cost effectiveness.

The Hon. DAVID CLARKE: So a properly controlled trial within the proper framework could be worthwhile?

Dr WODAK: Would be worthwhile.

The Hon. DAVID CLARKE: I think that the National Health and Medical Research Council say that they would not oppose it in those circumstances?

Dr WODAK: And I agree with them on that but I should point out that this subject has been under discussion for 20 years or so and no well-conducted study has yet been published. All the studies that have been published so far have been very deficient.

The Hon. SHAOQUETT MOSELMANE: I refer to some questions asked by the Hon. David Clarke, in particular with reference to the bill introduced by Reverend the Hon. Fred Nile, the Drug and Alcohol Treatment Amendment (Rehabilitation of Persons with Severe Substance Dependence) Bill 2012, which seeks to broaden the scope of persons eligible to request that a person with suspected severe substance dependence undergo a medical assessment. At present only a medical practitioner can request an assessment. It is proposed that the eligibility be extended to include social workers, police officers, psychologists and other persons involved in delivering the service. Can you tell us your view on this and whether this is something that the New South Wales Government should support?

Dr WODAK: We are talking about a treatment that is not registered in Australia by the Therapeutic Goods Administration. It is only registered in two countries in the world—Russia, which has a medical regulatory system that does not inspire confidence outside Russia, and the Food and Drug Administration of the United States of America where the decision to register extended-release naltrexone—not naltrexone implants as we have them in Australia but long-acting injections—in the United States was very controversial and there was a lot of criticism that it was improper. Bear in mind, though, that only two countries have registered extended-release naltrexone, so we are talking about that.

We are talking about a treatment that the National Health and Medical Research Council in 2011, after a careful review of the international evidence, decided that the evidence for effectiveness and safety was very limited and that the use should be restricted, as the Hon. David Clarke pointed out, to scientifically well-conducted trials. We are talking about a treatment which was heavily criticised in a 2012 coronial inquiry into three deaths in New South Wales which resulted in the reference of a clinician to a professional tribunal and his subsequent deregistration as a psychologist.

I think all the alarm bells should be ringing for us to tell us to be very cautious about this. I have looked after several patients who had attended the clinic Psyche N Soul and who ended up at St Vincent's Hospital with life-threatening conditions and I have to say this did not endear me to this treatment either. I do not have a problem with well-conducted trials. I do have a great problem with any other approach outside carefully conducted scientific trials.

I should also point out that the manner in which this routine treatment has been provided around Australia has used category A of the Special Access Scheme and I do not see how anybody could reasonably argue that this was in conformity with the Special Access Scheme and I am at a loss to understand why the authorities in this country have not launched an inquiry into the apparently inappropriate use of the Special Access Scheme to allow these treatments to be conducted.

The Hon. SHAOQUETT MOSELMANE: You have been pretty scathing of Dr O'Neil's procedures, particularly when it comes to potential conflict of interest and you ask a lot of question in relation to that. Dr O'Neil was asked that question this morning and he basically—I do not want to misquote him—said that all doctors effectively have a conflict of interest so he effectively dismissed your criticism. What is your response to that?

Dr WODAK: The issue is not whether people have a conflict of interest or not; the issue is whether they declare a conflict of interest. We just saw in this very room 20 minutes ago that two members of this Committee declared a possible conflict of interest, quite properly in my view, and that is all that is required in medicine; that people then leave it up to the reader to judge whether or not that conflict of interest may or may not have interfered with the research that they have conducted and whether or not Dr O'Neil likes it or not, it is a requirement of the college of which he is a member to declare a conflict of interest on all occasions where this could be potentially important and a failure to do so is, in my view, serious.

The Hon. SHAOQUETT MOSELMANE: You are pretty critical of the naltrexone implant, particularly when there are deaths associated with the application of it. Dr O'Neil this morning gave an example of a patient who received the implant and he recited the situation of him using it for the last nine years, I think. That was an example of the implant being a successful medication, yet you do not recite examples contrary to your strong belief that it is basically one that is associated with death?

Dr WODAK: Over the last 50 years medicine has dramatically improved the way in which evidence is considered and built up over a period and this whole approach is referred to as evidence-based medicine and it is something like the legal system of amassing evidence and considering evidence. That system does not really

take into account anecdotes. Medicine in previous centuries did take into account anecdotes; it does not any more. It is a very serious and very technical business of amassing quantities and qualities of evidence to such a degree that there can be a high degree of confidence that we have a treatment that is effective, safe and these days also cost effective and so far that evidence has not been presented by Dr O'Neil or anybody else around the world to the satisfaction of the National Health and Medical Research Council or the Cochrane Collaboration, which is an international group that does work like the NHMRC does on a major scale and is very highly regarded. The Cochrane Collaboration also does not rate the evidence for naltrexone implants or injections highly on the basis of the evidence so far presented. Anecdotes do not count. They make good media, they may impress laypeople, with all due respect, but scientifically they do not count.

The Hon. HELEN WESTWOOD: We heard evidence this morning from Professor Ritter about naltrexone in other forms, obviously oral, but also intramuscular. She informed the Committee that that treatment is the favoured one in the United States where naltrexone is used. Do you think a trial should look at both intramuscular and implants or any other forms of administration of naltrexone?

Dr WODAK: I will give a brief answer and then I will ask Dr Osborn to add to that. I think these are important questions and they are very technical questions. With respect, I think it is very difficult in a setting like this to really ask that question and to answer it is even more difficult. Can I go back a step and sort of bridge to the answer I gave to the Hon. David Clarke, and that is that heroin is a serious problem in this and other countries. The treatments that we have in Australia and around the world are very limited. We need more choices. In medicine, as in other areas of life, choice is good and where choice is restricted we struggle. We have some good treatments for heroin dependence but we do not have enough of them and we do not deploy maximally the ones that we do have. They are constrained by, among other things, funding and also by the severe politicisation of the alcohol and drug field, which makes life for clinicians such as me even more difficult.

When we come to decide about implants or injections there are advantages and disadvantages of both. Ultimately it is a technical question but, more importantly, really the comparison should be made to gold standard treatment. One of the changes that has taken place in medical research in recent years is that there is growing concern about comparisons with so-called placebo and an increasing emphasis on comparisons with the gold standard treatment. The gold standard treatment is methadone or buprenorphine. These are well tried and true treatments endorsed by the World Health Organization, the United Nations Office on Drugs and Crime [UNODC] and the Joint United Nations Programme on HIV/AIDS [UNAIDS] and other medical and scientific bodies. That is where the comparison should be made. I am more interested in what is the comparator than I am in whether it is the injection or the implant. But Dr Osborn has done a lot of research and a PhD, in fact, on questions like this. I will ask her to correct my errors.

Dr OSBORN: The issue of choice is very important in this case, particularly because often people who have an addiction lead very chaotic lives. If they can be given the choice of, for example, a naltrexone implant where they do not actually have to attend a doctor's surgery or a clinic every day or three or four times a week, that is preferable. But I think the trials need to be done on individual treatments and then looking at the safety and harm for the patients and their ability to continue their activities of daily life just like a normal person, as if they were a diabetic person.

Reverend the Hon. FRED NILE: Thank you for coming in. Obviously, Dr Wodak, you are very critical of any use of naltrexone implants or injections. Have you actually studied what is happening at the Fresh Start Programme with Dr O'Neil and the results he has achieved over 15 years?

Dr WODAK: A number of members of the Committee have prefaced their remarks by suggesting that I am critical of naltrexone implants. I would say that my views are representative of 90 per cent of senior clinicians and researchers in Australia and around the world. Many others share the views that I have on this issue that this is a treatment of unproven effectiveness and that the way a lot of the research has been done is very disquieting. Have I studied Fresh Start? I have not visited the program but I have had many discussions with Dr O'Neil over the years. I have read the papers, I have studied the literature, and I am familiar with what has been happening in New South Wales as well.

Reverend the Hon. FRED NILE: You would admit though for a program to be going for 15 years and receiving both Labor Government and Liberal Government funding it must have some merit?

Dr WODAK: The funding that was provided by Liberal and Labor Governments has not been in open competition except in the case of the National Health and Medical Research Council [NHMRC] funded study. Most of the grants that Dr O'Neil and his team have received have followed personal appeals, one-to-one appeals to politicians, and they really, to be blunt, do not count for very much in the world of science. They may count for a lot in the media but they count for very little scientifically. The studies that have been done have been poor quality studies. Not only has Dr O'Neil and his team used naltrexone implants for treating heroin dependence, which is concerning enough, but they have also used this for gambling, for amphetamine dependence and in at least one case for tobacco cessation as well, smoking cessation as well. I must say I am alarmed at what has happened not only in Western Australia but around the country.

Reverend the Hon. FRED NILE: You acknowledge though you keep being critical that it is not through the Therapeutic Goods Administration [TGA], but as it is a private operation I understand it would cost many thousands of dollars that only big drug companies have to go through all the TGA approval processes. It is not a matter of not wanting it, he wants it, but how to achieve it financially?

Dr WODAK: It is true that I am critical of Dr O'Neil and Fresh Start. So too I think you will find, if you look at Commonwealth *Hansard*, the secretary of the Department of Health and Aging, Ms Jane Halton, is also on record in a Senate inquiry also being very critical of naltrexone implants. She was joined on that occasion by Dr Rohan Hammett, who was then the director of the TGA and is now working in the New South Wales Ministry of Health. He also joined in her criticisms.

Reverend the Hon. FRED NILE: I think you have even stated or implied that naltrexone has sometimes caused fatalities. Do you agree that naltrexone itself does not cause fatalities; it is a result of the detox program and other things associated with the use of naltrexone? The actual drug itself has not killed anyone.

Dr WODAK: I think we are splitting hairs. When we are dealing with a person who has permanently stopped breathing and has a tag around their big toe and they are lying on a marble slab really it does not matter to me all that much what the details are. If the treatment as a whole has caused death it should be, I would submit, of concern to all of us. This morning I was rung just before I came here by a woman whose boyfriend, partner, died of a heroin overdose in February last year. She rang me and she said that a day does not pass when she does not think about her loss. She obviously loved her partner, heroin user or not, and that is the way I approach it. These are human beings and their death is a tragedy for them and their families and for the community. Of course medically and scientifically the question you ask is an inappropriate one, what caused the death, so that we can try to prevent that from happening in the future.

Reverend the Hon. FRED NILE: I am only concerned that it gives the impression that the drug itself is dangerous. The actual drug is innocent. It depends on the conditions of treatment and other factors that have caused those deaths.

Dr WODAK: The drug can be used safely under certain conditions but when oral naltrexone was used—you may be unaware in Australia there has been a longer use of oral naltrexone before the implant came in—the death rate was something like six to eight times higher than expected. Those are studies conducted by the National Drug and Alcohol Research Centre.

Reverend the Hon. FRED NILE: That is why I am supporting the implants and not the oral use of naltrexone, for those reasons you just quoted.

Dr WODAK: The oral drug itself is associated with an increased risk. I have prescribed oral naltrexone myself with considerable reservations, but nevertheless on occasions when there were no alternatives I have prescribed it.

Reverend the Hon. FRED NILE: Just on the positive side, I support many of your recommendations dealing with alcohol.

Dr WODAK: Thank you. Can I say in response to that, Reverend Nile, that I think alcohol is by far a much bigger problem than illicit drugs and I think we make an even bigger mess of alcohol as a community in policy terms than we do with illicit drugs. Last week I took part in a meeting with the father of an 18-year-old boy whose death received a lot of publicity. His death in Kings Cross last July received a lot of publicity, and that death occurred very close to where I live. The matter has not come before the courts yet so I will limit what

I say but I am very moved by that experience, by what that family is going through, and I am trying to help that family deal with that matter. Let us hope that we can work together to prevent other tragedies of this kind.

The Hon. JAN BARHAM: We have heard a bit today from other people about the problems with methadone and that it is unsatisfactory as a recovery treatment. Can you talk about the primary objective for harm minimisation and where methadone fits into that?

Dr WODAK: Let me begin by going back to 1926, if I may, when Sir Humphry Rolleston., the then president of the Royal College of Physicians in England, a baronet and a member of the House of Lords, a pillar of the English establishment, was asked by the then Ministry of Health to comment about the use of mood altering drugs in dealing with people with problems due to mood altering drugs. He chaired a committee which was very influential in the United Kingdom for several decades. The crux of what Sir Humphry Rolleston said at that time in 1926 was that the overall objective was to help people to lead a normal and useful life. I would submit today in 2013 that is really what we should be directing ourselves to. If someone can lead a normal and useful life, as Sir Humphry Rolleston himself recognised, but can only do that when they take a mood altering drug, preferably as small a dose as possible for as short a period as possible—if that is what has to happen then that should be considered acceptable. That is the framework that I operate in.

I have looked after people with severe alcohol and drug problems for 30 years. Some of those people, not all of them but some of those people, are very damaged people. We would all like to believe that some miracle could occur tomorrow and that they would escape from generations of dysfunction and lack of education, lack of employment, lack of relationships, et cetera, but realistically the chances of that happening are very small. Sometimes this treatment has to be continued for long periods, perhaps indefinitely, but for most people treatment is a couple of years.

The Hon. JAN BARHAM: You are saying it is a much bigger problem. Do patients receiving methadone have access to other treatments to support them along that path? Is that process adequately funded and those services available as an alternative to a prolonged period on a less problematic drug?

Dr WODAK: Funding is limited and because funding is limited we have a choice of providing quality treatment to a very small number of people or basic treatment to a much larger number of people. Given that these days we have to keep the fear of HIV in our minds the treatments are pared back to what they were decades ago. This treatment is often vilified politically, for political advantage sometimes, resulting in funding being minimal and basic. We do the best we can but there are many people in New South Wales who would love to get into treatment today but know that they will not get into treatment this year and maybe not even next year. It is not the same in the whole of New South Wales but there are parts of New South Wales where it is certainly true.

The Hon. JAN BARHAM: It is difficult to find figures as to how many people want voluntarily to get treatment and whether it is available for them. Are you able to provide figures as to how many people would like to go into treatment but there are not the available services?

Dr WODAK: That is a very important question. Professor Alison Ritter did a study a few years ago, which I was involved in to some extent, and the answer she came up with to the question you have asked is that about 50 per cent of people who want treatment get into treatment. I should emphasise that that is a difficult question and answering it is even more difficult.

The Hon. JAN BARHAM: The other area is polydrug use. Is the layering of drug use such as alcohol and prescription drugs more prevalent than it has been in the past? Are we seeing a move by young people towards drinking alcohol and, due to street availability, the use of prescription drugs at the same time?

Dr WODAK: Thirty or 40 years ago people were dependent on one or two drugs but that is now very unusual and these days people generally use multiple drugs. The person who rang me today told me her boyfriend has been taking heroin, alcohol, benzodiazepines, cannabis and tobacco—and that is now the standard.

The Hon. JAN BARHAM: Is that recognised and is funding directed towards polydrug use or are we placing all the different drug users in silos? Is that part of problem?

Dr WODAK: You do what you can and in a clinic where funds are in short supply you can only do so much. We have, I would say, close to 100 per cent of people on methadone programs, meaning 95 per cent or 98 per cent of people on methadone programs smoke cigarettes very heavily. Fifty per cent of cigarette smokers die of tobacco related illness and we do nothing for that. Twenty to 30 per cent would have a severe alcohol problem and we do not have the funds to attend to that. We should attend to that but we do not. We should be attending to all of their health and social needs bearing in mind that this treatment will help a lot of people over a period of time get back to being productive members of the community. Even if they are not productive members of the community at least they will get some enjoyment from their life.

CHAIR: On that positive note we thank you both for coming in and contributing your expertise to the inquiry. If Committee members have any further questions on any of the evidence you have provided the secretariat will contact you in writing about that. It is unlikely but it can happen.

Dr WODAK: I will follow up the Hon. Jennifer Gardiner's question.

(The witnesses withdrew)

TANYA MERINDA, Director of Planning and Strategy, Network of Alcohol and Drug Agencies, and

LARRY PIERCE, Chief Executive Officer, Network of Alcohol and Drug Agencies, sworn and examined:

CHAIR: Do you wish to make an opening statement?

Mr PIERCE: We welcome the inquiry into drug and alcohol treatment in New South Wales. This is an opportunity for the Government to craft a new drug and alcohol strategy for the State. It has been over 13 years since the last comprehensive drug and alcohol strategy was formulated. We think that there have been many developments in that time and this is a good opportunity to review the entire way we are looking at drug and alcohol services across the State. In particular, the non-government organisation sector has grown in size, quality and clinical effectiveness since 1999. Major changes have been undertaken across our sector in relation to its breadth and depth of programs it can deliver, the complexity and sophistication of those programs and the skilled workforce it now has.

We are concerned that there are current deficits in the program. I note the previous speakers talking about demand. Our studies have indicated roughly the same figures: only 50 per cent of clients who want to access treatment actually get it. We are concerned that the public sector, due to cost pressures and budget pressures, have reduced their capacity to meet front line demand and we think that the specialist non-government drug and alcohol sector is in a good place to expand its activities across a range of program areas, as we outlined in our submission.

CHAIR: You say on page 3, in the summary of the Network of Alcohol and Drug Agencies submission, there is concern that there is poor community integration for Magistrates Early Referral Into Treatment [MERIT] clients. Could you expand on that statement? What improvements could government make to that program to get those better outcomes?

Mr PIERCE: We think the MERIT program has been overly locked in a fairly expensive public sector service delivery configuration with an increasingly smaller number of clients being managed and being managed within a small framework, that is, within a framework of services that the Government is providing. The assessment and referral of clients to a broader range of programs that exist, especially across the not-for-profit sector, has diminished and we think that the MERIT program is one of those programs that could use an overhaul. It is our view that it could be much more comprehensively managed achieving better integration across a range of social and other support services for clients on MERIT if it were managed through the not-for-profit sector.

CHAIR: Can you identify any non-government organisations that are doing a good job interstate with a different approach?

Mr PIERCE: In Victoria the entire diversion program is managed through the not-for-profit sector. In this State there are only a couple of non-government organisations that are managing MERIT courts and have contracts to do that. The rest of them simply provide either residential rehabilitation support beds or some counselling support services to MERIT clients who are referred from Government providers. The interaction between those programs is not very comprehensive. We think that an entirely non-government organisation MERIT system would produce a much greater diversity and range of services for clients travelling through that program. Most of the services that would achieve better results for clients mandated through the MERIT system, for example, are not just drug treatment they are educational, training, housing, family support and generally better social integration services and they are the sorts of things that non-government organisation programs are very good at supporting their clients through.

CHAIR: The integration holistically of all of their needs could be better managed by the non-government organisation sector?

Mr PIERCE: Yes.

The Hon. JENNIFER GARDINER: I have a general question. You say that the current drug and alcohol program within NSW Health has been operating in its current form since the drug summit. Is this the first significant opportunity that has occurred to review the programs that were put in place after the drug summit? Is this really the first time that the whole general topic has come up for re-examination?

Mr PIERCE: Yes, it is. We think this is an opportunity for that review. The drug summit program in its various iterations over the past 13 years has been down-graded as a program. Initially it was a program coordinated through Cabinet and there was a tight system of Cabinet oversight of various departmental agencies running initiatives from the drug summit. That wound down about halfway through its life. A lot of that program responsibility came back to the health department to manage and the health department does not have a good record of managing cross-agency programs. We think that the usefulness of the drug summit model has been dissipated by the reduction of the close inter-agency coordination that was a feature of its development.

The drug and alcohol program is now very much in the back blocks in New South Wales. Certainly it has faced the increasing budget pressures of most line agencies to provide efficiencies over the last number of years, including the current dividends and efficiencies the departments must provide, which means the Government dominated service delivery model we have in New South Wales has shrunk. We like to use the phrase "shrunk back into the hospitals" with the major budget items being soaked up in medical and nursing staffing components. The not-for-profit sector has had some growth over the last 10 or so years but not enough to pick up the slack where there is not the same access to those drug and alcohol services that were available 10 years ago if you are an ordinary punter out there. The drug and alcohol program in New South Wales is in the doldrums really. It has not had significant policy and planning focus. It has relied on a 13 year old model that is not even the model that it is actually delivered under now.

The Hon. JENNIFER GARDINER: Do you agree with the previous witness that putting drug and alcohol programs under the general heading of mental health and that part of the health budget has been a mistake?

Mr PIERCE: I think it would be if you did that, but I do not think that is what has happened in New South Wales. I think in New South Wales you see there is an amalgamation at a policy level in the Ministry of Health of mental health and drug and alcohol coming together. But the two service systems are still quite distinct service systems. So drug and alcohol is not under mental health in reality. They do share clients across the spectrum of co-morbidity but certainly the service structure and the model of engagement for drug and alcohol and mental health are still quite different and quite differently managed.

The Hon. JENNIFER GARDINER: You talk about one program, the drug and alcohol treatment program, IDATP, at John Morony and Dillwynia, which you say takes therapeutic jurisprudence and mandatory treatment to the next level. Does that program seem to be doing okay?

Ms MERINDA: It is very early days. I do not think anyone can make a call at this point.

The Hon. JENNIFER GARDINER: So it is not being reviewed. It is too early to say.

Ms MERINDA: There has been no evaluation as yet.

Mr PIERCE: And again we think it is a very expensive model.

The Hon. JENNIFER GARDINER: So you would have a better model?

Mr PIERCE: That is what I think we should be doing. We should be looking at what are cost effective and also better integrated ways or better ways of dealing with patient flows that give you an opportunity to have patients who are in a specific part of a drug and alcohol service system quickly and effectively located and supported to move across a range of social and health support programs that will ensure that the value of the treatment service will be reinforced by good case management and referral into other services.

The Hon. DAVID CLARKE: When you refer in your submission to naltrexone implants you talk about it in a way, I get this view, interpretation, anyway. You talk about the mandatory introduction of naltrexone implants. You talk about an intrusive mandatory component when you are referring to naltrexone. You would agree, would you not, that there is not a big call out there for it to be mandatory at all? Are there any professional bodies or prominent experts who are calling for the mandatory introduction of naltrexone implants?

Mr PIERCE: No, not that I am aware of.

The Hon. DAVID CLARKE: It confuses the situation when we speak of naltrexone, when you speak of naltrexone implants you refer to "mandatory introduction". Nobody is calling for mandatory introduction. That seems to be a superfluous thing. Would you agree that one could get the wrong impression when you refer to mandatory introduction and the intrusive mandatory component, obviously referring to naltrexone implants? There is no call out there for mandatory introduction of naltrexone at all, is there?

Mr PIERCE: It was our reading of the proposed bill that there be a mandatory component in it.

The Hon. DAVID CLARKE: It did not refer to naltrexone. It spoke of involuntary treatment. There has been no specific call by anybody and not even in any suggested legislation for mandatory naltrexone implants. Would you accept that?

Mr PIERCE: Yes.

The Hon. DAVID CLARKE: Would you agree with the National Health and Medical Research Council that there could be a place for a properly conducted trial of naltrexone implants?

Mr PIERCE: Yes, we would agree with that.

The Hon. DAVID CLARKE: So this is a course that you think the New South Wales Government could rightly look at as a possibility, providing it was properly conducted, scientifically conducted?

Mr PIERCE: Yes.

CHAIR: In your opinion do we have enough properly trained addiction medicine physicians in Australia, in New South Wales?

Mr PIERCE: We are not in a position to make a statement about the numbers of trained medical addiction specialists because we do not operate in that area, although we would suggest that improving or increasing the number of trained addiction medicine specialists, while a good thing in and of itself, would not lead to a reform and an expansion of service delivery to clients in the same way that addressing the way in which drug and alcohol budgets are being allocated between public and not-profit sectors. Addiction medicine specialists are very expensive people. I think an addiction medicine specialist is about a $300,000 per annum investment. That is my memory of a discussion with one of the local health district drug and alcohol financial managers. So it is a very expensive option.

CHAIR: Do you think the alcohol and drug treatment sector has difficulty recruiting properly trained staff, either medical or health care workers within the sector? Is it difficult to recruit them and keep them?

Mr PIERCE: Yes.

Ms MERINDA: It is difficult and it is certainly more difficult in the non-government sector. An example is that the majority of non-government organisations that are funded by the Ministry of Health today have contracts to 30 June. So staff are leaving and moving to the public sector because it pays better, there is security in their positions. That has been ongoing—it is always going on but normally the cycles are three or four years. In the last couple of years it has been six-month to 12-month extensions. So it is difficult to retain staff. In attracting staff, the competition is that the salaries provided to the non-government sector are a lot less than the government sector. There is also difficulty in the professional development and opportunities for staff in the non-government sector. That has changed somewhat in more recent years, five to seven years, with the improved professionalism of the sector.

CHAIR: In talking about that restructuring that you address throughout the submission, you would also be looking at ultimately better outcomes in retaining proper staff, training them, their professional development, the whole thing, rather than this dichotomy that we have between the government sector, having the majority of the resources but outcomes not generally improving over time, and the NGOs being left on the periphery. We need to restructure the whole delivery of services to get better outcomes.

Mr PIERCE: That is our view.

Ms MERINDA: I think we need to look at the drug and alcohol sector as a whole and not have the non-government drug and alcohol sector and the government drug and alcohol sector. We certainly do not do that at the moment around planning or service delivery.

Mr PIERCE: It is our view that if you had a good connection and much more rigid and holistic connections between the not-profit sectors, drug and alcohol service delivery, and addiction specialists in the public health system, and better coordination between community-based treatment and addiction specialists in the public health system, that would be a much better model for looking at the utility and usefulness of very expensive addiction medicine specialists who would be providing a consultation-liaison service to treatment providers in community-based settings for a larger number of clients.

CHAIR: Is Victoria doing it better than us in that it is nearer to that model? Is there any State that is doing that?

Mr PIERCE: It is nearer to that model in Victoria largely because of the fairly significant shifts that occurred in the way that services were tendered out into the community in the Kennett years. The former governmental and State agencies developed partnerships with community-based agencies and a lot of community-based agencies developed consortia and a range of other organisational approaches to applying for that contracting so the whole budget was thrown out into the market and the market responded in that way. So you have ended up with a system in Victoria where the bulk of the service provision is through community-based agencies operating at a local level with good access by people in the community, clients and their families and so on and close relationships with a smaller number of addiction medicine specialists in the major hospitals.

The Hon. HELEN WESTWOOD: On a point of clarification, the Hon. David Clarke's questions to Mr Pierce suggested that there was a misunderstanding around the issue of involuntary treatment, including naltrexone implants. We need to be clear that the draft bill—in fact, Reverend the Hon. Fred Nile's second reading speech and the background paper all talk about involuntary treatment. The bill talks about it and it does talk about naltrexone implants as one of those options. It refers to the Fresh Start Program in Reverend the Hon. Fred Nile's speech. So I do not think that Mr Pierce or your organisation misunderstood or misinterpreted what we are looking at. It is very clear in all that is before us. I just want to make that very clear to all of us today.

Thank you for your attendance today and for your detailed submission. When you talk about a new approach that would expand the role of NGOs you mentioned particularly the MERIT program. Are there other programs as part of a drug and alcohol approach that you think we should also be looking at to include the NGO or expand the NGO's role in the delivery of those programs?

Mr PIERCE: Yes, certainly; detoxification or withdrawal management. The ability and the capacity of the public sector to provide particularly inpatient detoxification has been severely reduced due to budget pressures over the last five to seven years or so. Getting a detox bed is very difficult in this State at the moment. We have some excellent models of inpatient and ambulatory detox service provision being run by NGO specialists at the moment—the Salvation Army, Odyssey, the Lyndon community out at Orange and so on—which provide incredibly good and medically sound inpatient and ambulatory withdrawal services. We think the not-profit sector is probably better placed to provide the bulk or all of detoxification or ambulatory withdrawal management so that is another main area.

Ms MERINDA: There is also a program called the Community Engagement and Action program, and that is currently led by New South Wales Ministry of Health. It was with the Premier's department after the Drug Summit but a number of years ago transferred to the Ministry of Health. Because it is a community engagement program, we suggest that that would be better provided by community organisations. So that is another example where the NGO sector could be best placed to provide. Also at the moment the way the local health districts are structured, there is a drug and alcohol department or program within each LHD and generally they have counselling services. So there may be one or two counsellors providing our client counselling services. Unfortunately, because of the structure, they are very isolated and we would suggest that by having it with community organisations that perhaps a number of counsellors in an area that go out, it might be a better model to provide services from, rather than having one or two isolated counsellors across the State.

The Hon. HELEN WESTWOOD: On the issue of the lack of detox beds, you are not the only organisation or witnesses who have raised this issue with us during the inquiry. What do you do with a client or a patient who actually needs detoxification? If it does not happen in a detox bed, in what other environment can that person detox? What are the issues around that, such as safety and even success?

Mr PIERCE: I guess the short answer is either at home or on the streets.

Ms MERINDA: Or not.

Mr PIERCE: Or not and continued polydrug usage ensues usually. The difficulty with the government-run—we are not bagging government. I am just trying to say that there are some real resource and structural problems for government in being able to provide the support services post detox. Not-profit organisations generally locate their detoxification program right in the middle of their treatment program. People are not seen as different and they are not a different patient here until they move to there and become a different patient. It is a much more holistic way of approaching the problem and detox is really just seen as the initial phase of treatment. It is getting steady; getting your head a little clearer so people can engage with a treatment program. We manage to detox in the not-for-profit sector as an entry point into treatment, not as the treatment itself. It is simply a period for people to get a little bit well before they can actively engage in a more robust treatment setting.

Ms MERINDA: However, there are capacity limitations with that, and not all non-government organisations are able to do that, because they do not have the physical resources or the skilled staff—nursing, medical—to do that. Unfortunately, particularly with alcohol, clients leave it so late that they may end up in a hospital bed, which ends up costing more of course.

The Hon. HELEN WESTWOOD: Is there an alternative environment to detox other than hospitals?

Mr PIERCE: Absolutely.

The Hon. HELEN WESTWOOD: But their availability in New South Wales is still very limited?

Ms MERINDA: It is very limited.

Mr PIERCE: Very limited, yes.

Ms MERINDA: What has happened over the years, and I have been around about 20 years, is that the provision of withdrawal or detoxification services has greatly diminished and, in more recent years, the non-government sector has picked that up purely because there has been a need. Some of it is funded, some of it is not funded. Traditionally, to access a residential rehabilitation service, the client needed to be detoxed, and that was becoming impossible. Not only were they not getting detox treatment, they also were not getting residential treatment, the longer-term, life-changing treatment, because they could not get through the first door. That is when the non-government sector responded and started providing some detox services. It is still not adequate. There are whole parts of the State were you cannot get detox.

The Hon. HELEN WESTWOOD: On that issue of skilled staff, some of the submissions we have received talked about the way in which the drug and alcohol sector is perceived and politicised and often that makes it difficult to attract and retain staff. I wonder whether that is an experience your organisation has had or it is an observation you have made? If there is that gap in skilled staff what could we look at recommending to address that?

Mr PIERCE: Again getting back to our initial point, if we had a bit of a root and branch examination of the way in which you are running services out there and where all the budget ends up, we could certainly look at providing a more thorough response from the non-profit sector to increase its service delivery. We are the informal training ground for most government services, anyway. When people want to get into an area they generally get a position in a non-profit organisation, get skilled up and move on to a higher paying position in a government job. I do not think we would have much trouble in attracting and retaining a skilled workforce if we were the major provider of drug and alcohol services across the State, and we are not asking for another $100 million into the drug and alcohol program. We are simply saying that if you did a comprehensive review of where the money is at and where you are getting effectiveness for that spend, you would quickly see that reinvestment into the non-profit sector for it to grow would provide an answer to scale and to capacity to attract and maintain skilled staff.

The Hon. SHAOQUETT MOSELMANE: To follow up on that funding issue, I note on page 5 that you raise a number of services that require highly skilled, multidisciplinary approaches. You talk about the

whole of life treatment services. I am curious as to how government would be able to fund this whole of life treatment that you talk about?

Mr PIERCE: One of the characteristics of the non-profit sector in New South Wales in particular is that NSW Health is only one of the significant funders of treatment services. The Commonwealth is probably nearly providing the same level of contribution to the non-profit sector in this State as are the State Government health funds. There are also other departments that provide resources. Non-government organisations also provide a significant income stream through client contributions and fundraising. We believe that the growth of our sector can be quite effectively increased with relatively modest increases across the kind of funding provided by NSW Health so that in partnership as a funder with the non-profit organisations they can look at the development of a much larger range of service provision by leveraging, if you like, off the capacity of non-profit organisations to attract different sources of money.

They are much more entrepreneurial in the way they work than our government services because they have to be. We have found that model to be quite effective. What has been going on in New South Wales for the past decade or so, our sector has grown largely through the two major contributors, State health and Federal health and then a range of other departmental funders, client contributions and so on. We think we are a much more cost-effective model to invest in to get a larger expansion across the program through non-profit than through funnelling buckets of money into specific government services and saying do that.

Ms MERINDA: If I can just add, I think the way non-government organisations are funded as well could be improved, and it could be a cost saving measure, because at the moment the funding is very siloed. I know we keep referring to NSW Health, but that is the primary funder for our sector. There are individual programs you have to report on even though it is exactly the same money to do exactly the same thing from another program within the same department, within the same branch of the department. Some administrative review—which we have done many times with the department but not a lot of changes come from it—could save dollars.

The Hon. SHAOQUETT MOSELMANE: Would you be ready to tender if the Government tenders the services?

Ms MERINDA: The sector would be ready, absolutely.

Mr PIERCE: We are working closely with the sector on that issue at the moment and working quite closely with the Ministry of Health grants management and proven program review around that area, and the notion of outsourcing. We have had a number of forums with our members on that and fairly open dialogue; in fact invited Minister Humphries to our annual general meeting late last year, and he spoke to that issue because we had our annual general meeting that day around the notion of the growth of the non-profit sector and outsourcing. We are very engaged and ready to move.

The Hon. JAN BARHAM: To follow-up on the MERIT program, would there not be some difficulty for the non-government organisation sector in dealing with some of those programs where you have security issues and any risk of escape?

Ms MERINDA: The MERIT program is a voluntary program.

The Hon. JAN BARHAM: What is the other diversion program?

Ms MERINDA: The Drug Court, or do you mean the involuntary drug and alcohol program?

The Hon. JAN BARHAM: No, the Drug Court program.

Ms MERINDA: That is quite a different program to the MERIT program so perhaps that is not one of the programs that would be best tendered to the non-government sector because of the relationship that the Government providers have with the court system and the other players in the criminal justice system. Certainly there are drug and alcohol providers who provide residential treatment, for example, for clients on the MERIT program, but not as the overall case managers.

Mr PIERCE: But I would have to say that our sector has been working with the courts, Probation and Parole, magistrates as well as judges for the last 20 years. The MERIT program is a spectacularly funded and

Commonwealth, by and large, funded exercise in increasing diversionary programs across the nation, and we think the Commonwealth Government's program which is 10 or 13 years old now as well has been successful, but in New South Wales, unfortunately, the bulk of the funds have been tied up in expensive public infrastructure which do not give you the same reach as the model in Victoria. That is our main concern. Working with mandated clients or working directly with probation and parole and the courts has been our sector's stock in trade forever.

Ms MERINDA: There is no-one else.

The Hon. JAN BARHAM: Referring to the availability of those places, we have heard that there is a 50 per cent shortfall in availability. Do you think there is more than that? We do not seem to have any information that can tell us or any way of gathering information. I think the Department of Health is trying to establish a program that can assess that information?

Ms MERINDA: A number of things are going on at a Commonwealth level. The Department of Health and Ageing is doing a number of reviews of drug and alcohol services.

The Hon. JAN BARHAM: You referred to a Commonwealth program, a drug and alcohol program that the Commonwealth is doing?

Mr PIERCE: Yes, the Commonwealth has been a fairly significant funder of drug and alcohol programs through non-profit organisations nationwide since about 1998, I think.

The Hon. JAN BARHAM: I think there was some reference in your submission to a program or to some policy framework at the Federal level?

Ms MERINDA: A number of things are going on including the Drug and Alcohol Clinical Care and Prevention model [DA-CCP]. Is that what you are referring to?

Mr PIERCE: It is a population-based funding model that says per 100,000 of population, what is the likelihood within that 100,000 of certain people having these heightened addictions to licit and illicit substances and then what kind of treatment services would you need per 100,000 to meet the need? It is the same model they use in the mental health space.

The Hon. JAN BARHAM: This morning Dr Ritter talked about a modelling program that they are working on.

Ms MERINDA: Yes.

The Hon. JAN BARHAM: Is it about getting to a point where we do things differently with non-government organisations and government working together, understanding what the need is and providing for that need? What we are hearing is that there is a fundamental need to start being more efficient and getting a better bang for the buck by working differently.

Ms MERINDA: Not just a better bang for the buck, but understanding what the needs are and how we will respond.

The Hon. JAN BARHAM: I think that is what a better bang for the buck is; doing it well and making sure you are delivering the outcomes.

Ms MERINDA: I think a lot of the funding in New South Wales is historically based. We will give you X amount of dollars because we have given you that for the last 10 years. Nothing has changed, the amount has not changed necessarily and what we ask you to do with it has not changed. There is not really a lot of science behind it, and certainly funding has not kept up with costs. There is no real model of drug and alcohol service delivery as an overarching thing.

Reverend the Hon. FRED NILE: Just to follow up an earlier discussion about the use of mandatory or involuntary or coercive medical treatments, the bill that I introduced, the Drug and Alcohol Treatment Amendment Bill, will amend the Drug and Alcohol Treatment Act 2007—a Labor Government Act—which

already has in it mandatory or involuntary treatment. My bill simply builds on that. At page 19 your submission states:

> The current roll out of the Drug and Alcohol Treatment Act 2007 manifested in Involuntary Drug and Alcohol Treatment Programs which offers a 28 day stay in a purposefully developed hospital based unit in 2 sites across NSW.

Your submission goes on to state that it has been found to be very effective. My bill is building on that and is not laying down what the treatment will be; that is for the medical area. The term "involuntary" or "mandatory" is not such a shocking term; it already is in legislation introduced by the Labor Government in 2007.

Mr PIERCE: No, and we are not suggesting that it is shocking. It applies to a fairly small number of people who are out of control and at significant risk to themselves and others. They are not the normal drug and alcohol treatment population.

Reverend the Hon. FRED NILE: I think we call them people with severe dependence problems.

Mr PIERCE: Yes, severe; beyond severe.

Reverend the Hon. FRED NILE: In some ways the MERIT program is involuntary because you have a choice of jail or treatment.

Ms MERINDA: No, MERIT is not that type of program.

Reverend the Hon. FRED NILE: I am just saying that the encouragement to the person to take up the program is a choice between jail or the program. It is a diversionary program. I am not against it; I think it is great.

Ms MERINDA: If you opt not to go into the MERIT program you are not diverted to jail. That is more a Drug Court. You can opt in; it just means that you are sent—

Reverend the Hon. FRED NILE: The MERIT program is characterised as "a therapeutic jurisprudence diversion program" with "the option of entering into an intensive (up to 12 weeks) treatment program prior to sentencing".

Ms MERINDA: Sentencing is deferred for the three months that you are engaged in treatment. At the end of the treatment period, sentencing continues as it normally would. You would think—and it often happens—that the judge looks favourably on clients who have engaged well in treatment.

Reverend the Hon. FRED NILE: I am all for it. I am just saying that, in the individual's position, it is an incentive to take up the drug rehabilitation program, which I think is a good idea. On page 13 of your submission, you refer to the Drug and Alcohol Treatment program and you say that there are two units in New South Wales: the Royal North Shore Hospital and Orange Hospital.

Mr PIERCE: Yes.

Reverend the Hon. FRED NILE: Do you have much response to their programs? Are they being effective?

Mr PIERCE: No.

Ms MERINDA: They are the ones that the Hon. Jennifer Gardiner was referring to before, so it is still early days for those.

Mr PIERCE: Our main concern is that they are very expensive models.

Reverend the Hon. FRED NILE: What year did they commence then?

Mr PIERCE: In 2012. Some of our members are linked to those programs providing aftercare and support services to the clients who have come out of them. We are not aware of the success of those two initiatives, the North Sydney and the Bloomfield initiative. We do not have any detail, in terms of evaluation.

Reverend the Hon. FRED NILE: On page 21 of your submission you said that the naltrexone does not eliminate cravings. I thought that was the main purpose of it.

Ms MERINDA: It can and does but not necessarily. There is no guarantee of that.

Reverend the Hon. FRED NILE: That is the main purpose of it though, to cut off the part of the brain that wants the heroin.

Ms MERINDA: It is one of the purposes, yes. It does not work for everybody and cravings are very much environmentally cued.

Reverend the Hon. FRED NILE: I just thought it is a bit of a sweeping statement to say that it does not eliminate it when the purpose of it is to eliminate it. It may not work for everyone but it does work for the majority.

The Hon. JAN BARHAM: No, it is that it does not eliminate cravings.

Reverend the Hon. FRED NILE: It eliminates the cravings.

CHAIR: That is why we need a clinical trial to look at it. That is subjective.

Reverend the Hon. FRED NILE: It does eliminate the craving; that is the whole reason for it. That is what I understood as a lay person.

Mr PIERCE: We are in support of a clinical trial, absolutely.

Reverend the Hon. FRED NILE: A naltrexone trial would help to clarify all those things.

Mr PIERCE: Absolutely.

CHAIR: Thank you for coming in and sharing your expertise. You have given valuable insights to the Committee and given valuable input. If Committee members have any further questions we will put them to you in writing. It is unlikely but we may ask you to respond if you could.

Mr PIERCE: We would be happy to do so.

(The witnesses withdrew)

(Short adjournment)

DAVID MICHAEL PHILLIPS, National President, Family Voice Australia, and

GRAEME ALAN MITCHELL, State Officer, Family Voice Australia, sworn and examined:

CHAIR: Would you care to give any opening statements?

Dr PHILLIPS: I will say just a few things about Family Voice, about drug policy, about naltrexone and about compulsion. Firstly, Family Voice Australia is a Christian ministry. We receive support and have supporters from individuals and churches from all mainstream denominations. Secondly, we are politically neutral; we have no connections with any political party. We address public policy issues; we do not address political parties. In advancing and addressing public policy issues we do that on an evidence basis. We seek to bring forward evidence which would be for the benefit of the whole community. We address a limited range of policy issues, which we summarise as family, faith and freedom. This particular issue of drug policy we have addressed in many submissions and articles over many years. To us it is a matter of human dignity, it is a matter of undermining family relationships and it is a matter of doing harm in the general community. That is why we address those issues.

On drug policy, in 1985 Australia adopted a harm minimisation approach to drug policy. We believe that was a mistake and it is time to review that and abandon it. I think it is arguably a failure and it should be replaced by a goal of a drug-free society. There was an inquiry in 2003, which recommended a change from harm minimisation to the goal of a drug-free society. There was another inquiry in 2007 that recommended the same change, but that change has never been made. I think there is an opportunity in New South Wales to lead the nation by being the first State in Australia to adopt as a matter of bipartisan policy a change of goal of drug policy, and we would support that—really learning from the success in Sweden of making that change in 1969.

A few comments on naltrexone. Because naltrexone works chemically by addressing the opiate receptors in the brain, in my understanding it removes the craving and allows people to get past the chemical dependence on opiates and other drugs so that they can come off their psycho-modified mental state and actually address the issues. Most people end up on drugs for other reasons. There has not been much talk about comorbidity in the hearing today. I think that is a vitally important issue. Most people on drugs are on drugs because they have other problems in their life that they have not been able to get on top of, but you cannot address the other problems until you have got people drug-free. The huge advantage, as I see, of naltrexone is that it enables people to become drug-free and then to work through the other issues, which may be very hard.

That needs to be fully tested. One of the lamentable things in Australia with the WA program running for some 15 years, in my understanding the only significant clinical trial is a comparison between oral naltrexone and implants. More is needed in terms of a clinical trial. The implants were clearly better than the oral. The need for a clinical trial is to compare implant naltrexone—or slow-release naltrexone—with alternative approaches to treatment. If this Government can fund such a trial with a properly neutral body doing it, the problem is, if Dr Wodak's evidence is right that something like 90 per cent of Australians in the medical profession are already hostile to naltrexone, then it may be difficult to find a researcher who is truly impartial when it comes to a trial. Impartiality would be essential if the trial was to be given a fair hearing.

The final question is of consent. I noticed there was some discussion earlier in the day about that. I thought a helpful distinction emerged. What is my understanding of the current Act and this bill is that there is involuntary detention—that if someone is living a drug-dependent lifestyle, dependent on welfare, unable to contribute to society, then the involuntary detention is to say, "That cannot continue. You are going to be taken out of society". What happens after that is there may be a number of options and the person can then have a voluntary choice as to whether they want to enter into a naltrexone program or other programs. We can explore that further, but I think it is a useful distinction to say involuntary detention but voluntary treatment regime.

CHAIR: Without putting words into Reverend the Hon. Fred Nile's mouth, I think what he means by the naltrexone implants as one of the choices for involuntary treatment is only when it has been approved by a properly conducted level one NHMRC-approved clinical trial as acceptable therapy that it would be one of the options that would be offered.

The Hon. DAVID CLARKE: Dr Phillips, you started by saying that Family Voice is a Christian ministry. You would be aware of other Christian ministries that specifically conduct drug rehabilitation

programs, like the Salvation Army. Is it your experience that the Salvation Army operates quite successful programs and that the Salvation Army has as its final object a drug-free society?

Dr PHILLIPS: I am not familiar with the New South Wales Salvation Army. Perhaps my colleague is.

Mr MITCHELL: I am not particularly familiar with their progress but I believe that is the case, yes.

Dr PHILLIPS: The program I am familiar with is DrugBeat in South Australia, run by Ann Bressington, who is now a member of the Legislative Council in South Australia. One of the questions I wanted to raise with this Committee is: Are you calling Ann Bressington to give evidence?

CHAIR: No, we are not at this stage.

Dr PHILLIPS: Could I make a recommendation that you invite Ann Bressington to give evidence to this Committee? She has run the DrugBeat Program, which has the goal of being drug-free. She started this program because her daughter died of a heroin overdose. She said her daughter was put into a harm minimisation program and she was maintained on methadone and ultimately died of an overdose. Ann said—she was just an ordinary mum—something has got to be better than that. Her daughter died as a result of the harm minimisation approach and she established a program which seeks to get people drug-free. Three months I think is the typical program where she gets people detoxed and then addresses all the other problems in their life. Sorry—a long answer to a short question.

CHAIR: We will definitely follow that up, thank you, Dr Phillips.

The Hon. DAVID CLARKE: You have a section in your report "Abandoning Harm Minimisation". Would it be true to say that the position of your organisation is that you believe that drug minimisation should be seen as but one interim step to getting drug users as a final goal to being drug-free rather than seeing drug minimisation being seen, especially by young people, as a final goal in itself?

Dr PHILLIPS: Absolutely. This is part of saying we want to abandon the harm minimisation approach. We are recommending that be done in favour of a drug-free society.

The Hon. DAVID CLARKE: As a final goal?

Dr PHILLIPS: As a final goal. That is the goal we are aiming for. With any patient or client who comes in for assistance with their problems in life, the final goal of the program is for them to be drug-free, but the first step towards that is to get them off drugs altogether, not to maintain them on methadone—get them off drugs so that their head is clear and they can think straight, and then address the comorbidities. What are their social problems and their medical problems? They may have mental illness, schizophrenia or they may have relationship problems—a whole string of problems and that is what takes the time but you cannot address them when their heads are scrambled by drugs.

Mr MITCHELL: And might I just add that it is surely the role of the Parliament to take the leadership in this and this is why we have this Committee, which will make some very valuable recommendations to the Parliament. The uppermost policy setting needs to be a drug-free society and the Parliament needs to say that this is our objective as a Parliament and as a society in New South Wales and then the subsidiary policies can flow from that—the actual practical policies. But it is important to get the policy setting right at the highest level to begin with.

CHAIR: You would not necessarily want to reject certain programs along the pathway to becoming drug-free that have been shown, say, to keep hepatitis C at bay; in other words, the production of fresh, clean syringes rather than sharing dirty syringes because we know that hepatitis C is causing a lot of liver damage, liver cancer and death from liver failure. You are not saying that all of the programs under the harm minimisation regime are bad rather a fresh evaluation in terms of the overall objectives and then ticking off all the programs that help you get to that objective, because there would be many public health physicians who may have a concern if you, for instance, took away the provision of clean needles. As abhorrent as we find injecting illicit drugs, if they are going to do it, we want them to do it at least with clean apparatus. What are your feelings on that?

Dr PHILLIPS: Are you leading the witness, Madam Chair?

CHAIR: I do not want it to be misconstrued that you would throw out a lot of public health policies.

The Hon. JAN BARHAM: Page 2 of your submission is quite clear on that.

Dr PHILLIPS: Let me answer the question. We heard Dr Wodak say earlier that naltrexone must be compared with the "gold standard treatment", which I thought was a bit over the top.

CHAIR: It was very sad actually.

Dr PHILLIPS: And his emphasis on "anecdotes are not good enough; you must have proper scientific studies". I am sorry but he has been making those statements without adequate evidence to back them up. There has never been, in the literature search that I have done, a proper controlled study to determine whether the release of needles, syringes, into the community or the Kings Cross injecting room and the methadone program actually achieve the objective claimed. There are some studies to which Wodak has his name that are what I would call snapshot studies—I think it was 1995, 1996 and 1997 where they just asked a bundle of clients, "Have you got hepatitis C?" Those studies say, Well the latest studies had a lower rate of hepatitis C than the earlier studies.

Snapshot studies do not prove a thing. Let me try to give you an example. If you take one study with 1,000 patients and 50 per cent of them have hepatitis C. Twelve months later it becomes so popular that you have 2,000 patients—another 1,000 and the 1,000 that come in are clean of hepatitis C. You do the assessment asking, "Have you got hepatitis C?" 12 months later and you only have 500 with hepatitis C out of 2,000 so the hepatitis C rate is now 25 per cent and those who do the study say, "Hepatitis C has gone down because of our program". No, it has not. Hepatitis C has gone down because the new people who have entered the program were clean.

I cannot emphasise strongly enough the supposed evidence on which Dr Wodak relies are snapshot programs which do not prove his case. It is a flawed scientific study. What is needed is a cohort longitudinal study where you take a certain cohort of people and trace what happens to them over a period of time. This was done in Canada, a study in Montréal—I can provide the reference for that—where they talk to groups of patients or people, one where they use needle exchange programs and one that never went near a needle exchange program. They trace them over a period of time to see what happened to their hepatitis C status. Those involved in the needle exchange programs ended up with somewhere between twice and 10 times the hepatitis C rate as those who did not use the needle exchange program. Not many studies have been done but the Montréal study is probably the prime one that I am aware of and it shows the exact opposite. The evidence is that the harm minimisation approach actually aggravates and increases the rate of hepatitis C with all the adverse consequences you say.

I make a little comment on needle exchange programs. It is a complete misnomer, as I am sure everybody in this room knows. My daughter was a pharmacist and worked in a local pharmacy. The last thing the local pharmacy wanted was for people to come into the pharmacy with a syringe full of blood and say, "I want to exchange this." The pharmacist did not want anyone bringing potentially a weapon into the pharmacy. There is no exchange. It is just free handouts and the thing that irked my daughter was that one customer comes into the pharmacy and says, "I am a heroin addict. Can I have a free needle?" "Yes, here you are." The next patient comes into the pharmacy and says, "I am a diabetic, I need daily insulin. Can I have a free needle?" But no, I cannot. I have to pay for one. The gross injustice of that is just intensely irksome.

CHAIR: Why do you think the Swedes have been so successful in being drug free and moving towards abstinence over a number of years whereas Australia, the United Kingdom, most of Europe and everywhere else has gone down the harm minimisation route?

Dr PHILLIPS: Sweden is a strange country. My wife and I visited it a few years ago and spoke to a couple of members of Parliament. I cannot answer this authoritatively but in the 1960s those of us who were around then know what cultural revolution there was during the 1960s and how drugs took over the world. Sweden went down that route at that time and drugs were sloshing around Sweden at that time and I think the Swedes said, "This is doing damage to our society. We will do something about it." Whether you agree with them or not when the Swedes decide they going to do something, they do it properly and if they say, "We are going to get rid of drugs from our society", their Parliament passed a series of legislation, "We will crack down on imports and production. We will crack down on demand and users. We will introduce education programs so

that we try to educate our schoolkids so that they do not get involved with taking drugs". They had rehabilitation programs for drug addicts. It was a multifaceted approach and they said, "We are going to aim at a drug-free society" and they have done it. The rates of drug usage in Sweden are far below most other European countries.

CHAIR: And they also tax alcohol in a volumetric fashion, which is interesting?

Dr PHILLIPS: Yes.

Mr MITCHELL: Might I just add very quickly that even though we might struggle to understand why different countries have taken different policy routes, I think demonstrably the Swedes have been successful. I think it should impress us all that they set out to achieve this goal and they largely seem to have achieved it.

CHAIR: There are some in the harm minimisation industry who say that they have high rates of overdosage but I have not been able to find that in my internet research on Sweden.

Dr PHILLIPS: Let me make a comment on that. In Sweden they are very careful about identifying the cause of death. In the Netherlands, for example, the cause of death will be put down as asphyxiation, heart attack and so on. The only time in the Netherlands when they will actually say that the cause of death was a drug overdose is if they find a syringe sticking into the arm of the victim as he lies there dead. That is probably a loose paraphrase but the Netherlands and many of the other countries are very reluctant to record as a cause of death that it was a drug overdose. Sweden is much more honest and that is why they have higher rates. The problem with that is that it is an subjective measure.

Someone looks at a dead person and makes a subjective judgement as to what the cause of death is. It would be better to take something such as: Do they have opiates in their body at the time of death? You need to do a post-mortem to get an objective assessment. I think the claim that Sweden has higher rates of drug overdose is due to the manner in which the statistics are held.

The Hon. HELEN WESTWOOD: Dr Phillips, can I clarify a point that the Hon. Marie Ficarra raised with you earlier and is in your submission to us. Did I understand you correctly that you are of the strong view that needle exchange programs have led to an increase in the incidence of hepatitis C?

Dr PHILLIPS: Yes, that is the result of the Montréal program that I quoted.

The Hon. HELEN WESTWOOD: Your background is science research?

Dr PHILLIPS: I am a physicist by training.

The Hon. HELEN WESTWOOD: What experience does FamilyVoice have in providing services to people who are addicted to drugs and/or alcohol?

Dr PHILLIPS: We do not provide services. That is not our reason for being. We talk to people such as Ann Bressington and we really seek to represent the concerns of parents who have drug-addicted children and spouses who have drug-addicted spouses. For example, one of the people we quote in our submission on page 3 is Ryan Hidden. Ryan as a young man became involved in drugs and he went along to the standard government clinic and said, "My life is in a mess. I am addicted to drugs. I want to get off them. How can you help me?" Basically the agency said, "Well, don't think of that as a problem. If you want to be maintained on drugs we can handle that. We can put you on a methadone program."

Ryan Hidden's story is that he was given no suggestion that there was a way of getting drug free. The only options put to him were that he could be maintained on methadone and it was not until he came into contact with Ann Bressington and Ann Bressington said, "Ah, but you can become drug free. We will help you become drug free" and helped him and he became a drug free and now he is an enthusiastic supporter of the Drug Beat program that enabled him to become drug free. We are representing people, not directly, like Ryan Hidden and others in this world who want to become drug free and we are faced with a drug policy culture that is not helpful.

The Hon. HELEN WESTWOOD: Do you refer any of your members or clients to drug and alcohol counselling?

Dr PHILLIPS: We are not formally a counselling agency either but we do get inquiries from people from time to time and we will suggest they contact a counsellor. We do not do counselling. We may advise people on suitable places where they can receive counselling or treatment.

The Hon. HELEN WESTWOOD: Do you have a list of services and organisations which you think are appropriate to refer such people to from your organisation?

Dr PHILLIPS: No.

The Hon. HELEN WESTWOOD: I am talking about within New South Wales, because that is what we are looking at, but perhaps there are other jurisdictions in Australia. You mentioned Ms Bressington. Are there any other services?

Dr PHILLIPS: I will take that as a suggestion that my colleague and I might look at. I do not think we have that at the present time, but it is worthy of development as part of our organisation.

The Hon. HELEN WESTWOOD: Are you familiar with the work of Mission Australia in the area of drug and alcohol services?

Dr PHILLIPS: We were both here for the submission earlier today.

The Hon. HELEN WESTWOOD: Do you disagree with any of the evidence that they presented to us this morning?

Dr PHILLIPS: One of the things that I noticed was the term "client opinion" or "customer opinion", I forget?

The Hon. HELEN WESTWOOD: "Client led".

Dr PHILLIPS: "Client led". That I think conveys an unhelpful message that if a person is unable to contribute to society through working, earning an income, supporting themselves and becoming a fully functioning and productive member of society—if they are unable to operate as a productive member of society because of their drug addiction then to say that they are entitled to choose that as a lifestyle without challenge I think is an unsatisfactory starting point. I think society needs to say there is an obligation on members of this society to contribute to the point of at least supporting themselves if they are able to do so.

The options presented to a drug addict should not include indefinite maintenance on drugs. I am not sure whether Mission Australia was saying that, but we would want to say if someone is assessed as a drug-dependent person in need of intervention they should have patient choice but the options presented to them should not include indefinite maintenance on drugs. The options presented should be that the end goal would be a drug-free and productive member of society.

The Hon. HELEN WESTWOOD: You argue that our aim should be to be a drug-free society and that should be our policy approach in lieu of harm minimisation. Can you define what you mean by drug free?

Dr PHILLIPS: There are a number of illicit drugs and drug-free means people do not use illicit drugs.

The Hon. HELEN WESTWOOD: What about prescription drugs? You would be aware that there are some problems with abuse and overuse of prescription drugs. How would that fit into your regime of a drug-free society?

Dr PHILLIPS: We recognise there is a problem. I guess it is a question of guidelines to the medical profession on indicators for prescribing drugs. Exactly how that is addressed, I am not sure that we have developed a position on that.

The Hon. HELEN WESTWOOD: Do you want to add anything, Mr Mitchell?

Mr MITCHELL: Not really. If I understood your question though, perhaps you can correct me if I have not, I understood you to be asking whether we are looking for a totally drug-free society including pharmaceutical drugs.

The Hon. HELEN WESTWOOD: I just wanted to be clear. You are saying that we should replace the policy approach of harm minimisation with a policy approach of a goal of a drug-free society. I am not clear how you would define that. That is why I am asking you about the specifics.

Dr PHILLIPS: Free from illicit drugs.

Mr MITCHELL: I would put the word "illicit" in. I would say pharmaceuticals bring a lot of benefit to society and help with medical conditions. "Illicit" is the key word, yes.

The Hon. HELEN WESTWOOD: You would be aware that the other area we are looking at is alcohol. You also may be aware that much of the evidence this morning talked about drugs of addiction and that new genre of medicine, addiction medicine, also talks about tobacco. Do you have any views on that that you want to share with the Committee?

Dr PHILLIPS: We support the current Federal Government's moves to seek to restrict and discourage people from using tobacco products, because it contributes to huge personal loss. My father was a heavy smoker, died of emphysema and lung cancer. My mother also suffered, she was also a heavy smoker. I have personal sadness over what tobacco has done within my own family and there is a lot of tragedy over tobacco. I think the Federal Government is doing the right thing in trying to discourage people in a variety of ways.

Mr MITCHELL: It is probably worth just clarifying also that there is a difference between mood-altering and mind-altering drugs and drugs like tobacco. Drugs like tobacco are undesirable; they are not in the same category perhaps as the stronger narcotics and so on.

The Hon. HELEN WESTWOOD: How about alcohol?

Mr MITCHELL: Alcohol is tricky, I suppose, in the sense that it is already legal and somewhat heavily regulated, but personally I do not have a problem with the use of alcohol in moderation.

Dr PHILLIPS: I think it is the binge drinking that people are generally agreed needs to be addressed. How, I am not sure.

The Hon. SHAOQUETT MOSELMANE: I support the idea of New South Wales or any State leading the charge in changing the current drug policy culture. I think everyone would agree that achieving a drug-free society is the ultimate objective, but the realities come in. Obviously we have to be reasonable in terms of the realities and how we deal with policies. I am intrigued by one recommendation which you make at page 5 of your submission where you call on this Committee to immediately cease all financial and other support for harm minimisation programs. Do you not think it is a bit too extreme to call on the Committee to cease all funding given that there is a society out there that is built on attending to the needs of people who unfortunately for one reason or another have got themselves into drugs and need to be assisted? By ceasing all funding you are then causing significant harm to those other human beings that need your assistance right now.

Dr PHILLIPS: I accept your point. Proceeding immediately to that is probably precipitate and it would need to be addressed more carefully over a period of time. My comments made earlier, I think the current syringe releasing program, the evidence is that it is actually counterproductive. It is increasing HIV, it is increasing hepatitis C. I think if a proper study were conducted in Australia, a longitudinal cohort study comparing those who are using the needle exchange program with those out in the community, that could be done. Also a study of naltrexone to see how it compares with methadone maintenance.

In doing properly controlled studies I think it is very important to look at the criteria that are used to assess it. The criteria should be assessed firstly against the goal of being drug free. Does the naltrexone program or does the methadone maintenance program lead to the person being drug free in two years, five years? It should be assessed on that basis. Hepatitis C, does it result in a lower number of hepatitis C incidences with naltrexone versus methadone? It needs to be against objective criteria and the right criteria. If you get the wrong criteria you will get the wrong outcome. That needs to be looked at very carefully.

Mr MITCHELL: It is important to understand the recommendation. We are not suggesting that we remove harm minimisation programs and replace them with nothing. We are suggesting they should be replaced

with harm prevention programs. There is help needed to be given; we are just suggesting that the harm minimisation programs are of doubtful value.

The Hon. SHAOQUETT MOSELMANE: My understanding is there are harm prevention programs already in existence as well as harm minimisation.

Mr MITCHELL: Yes.

The Hon. SHAOQUETT MOSELMANE: They are working hand in hand, but I take your point.

Dr PHILLIPS: Probably "phase out" rather than "immediately".

Reverend the Hon. FRED NILE: Thank you for attending our inquiry as witnesses. I note on your submission at page 4 you have "The Swedish model" and a chart. I could not see the year when that chart was formulated. Is it 2006?

Dr PHILLIPS: Reference 12 says 2012.

Mr MITCHELL: It is in the footnotes.

Dr PHILLIPS: Reference 13 is 2007. So it is 2012 and 2007.

Reverend the Hon. FRED NILE: But the figures are from 2007?

Mr MITCHELL: I believe the text is for 2007 and the table is 2012.

Reverend the Hon. FRED NILE: The interesting thing with the table on page 4 of course is the comparison with Australia, with its harm minimisation policy, compared to the drug-free policy in Sweden. It states that we have a 1,478 per cent higher use of opiates, a 420 per cent higher use of cocaine, a 368 per cent higher use of cannabis and a 3,000 per cent higher use of ecstasy. That is interesting when there are people wanting to legalise cannabis and ecstasy and so on in Australia. You fully support the Swedish model? You feel that is the result of the drug-free policy of Sweden?

Dr PHILLIPS: Yes. We would support using the Swedish model as a guide.

Reverend the Hon. FRED NILE: Did you have any reaction to Sweden using the involuntary or mandatory drug program they have for drug addicts, for people with severe drug dependence?

Dr PHILLIPS: I am not actually familiar with the involuntary elements of that. My earlier comment was I think the saying "involuntary detention" and then, within the framework of that, "client choice" as to which of a number of restricted options with the objective of becoming drug free is a good model.

Reverend the Hon. FRED NILE: In your submission on page 1 you quote the National Drug Strategy 2010-2015, which states that the policy of harm minimisation will continue. Have you investigated as to who originated the drug strategy? Was it ever passed by a Federal or State Parliament, or is it a creation of drug bureaucrats? I am only asking that because I do not remember debating that in our State Parliament.

Mr MITCHELL: I suspect you are right. I suspect it is the Federal bureaucrats who have developed the policy, yes.

Reverend the Hon. FRED NILE: Do you agree it was important that the policy in Sweden was intensively debated with all political parties from the Green, Communist, Liberal, Democrat and all the others and they all agreed to adopt the drug-free policy. It would not have worked if society was split. They were able to get a united policy. Do you believe that our drug policy should be debated in our Parliaments and passed by Federal and State Parliaments?

Dr PHILLIPS: Yes, that would be desirable. That is reference 1, which was the Ministerial Council on Drug Strategy. I am not sure of the composition of the ministerial council.

Mr MITCHELL: That would be the health Ministers from each of the States, would it not?

Reverend the Hon. FRED NILE: It could be health Ministers or Attorneys General.

Mr MITCHELL: That is what the councils usually are.

Reverend the Hon. FRED NILE: That still is not the Parliaments debating it.

Dr PHILLIPS: No. Any legislation would have to be passed by Parliament, so it would mean Parliament adopting a strategy proposed by the ministerial council, I presume.

Reverend the Hon. FRED NILE: Was that ever done?

Dr PHILLIPS: That is a good question.

Reverend the Hon. FRED NILE: Was harm minimisation debated in the Parliament?

Dr PHILLIPS: I cannot answer the question. I can take that question on notice.

Reverend the Hon. FRED NILE: If you could take it on notice and see whether any Parliament, Federal or State, debated and adopted it. I note on page 1 you quote the Federal Standing Committee on Family and Community Affairs as recommending, "the Commonwealth, State and Territory governments replace the current focus on the National Drug Strategy on harm minimisation with a new focus on harm prevention and treatment of substance dependent people". You obviously agree with that?

Mr MITCHELL: Yes. Dr Phillips referred to that 2003 standing committee in his opening statement. The 2007 standing committee had similar recommendations and yet there is no action as a result of either of them, which is a puzzle.

Reverend the Hon. FRED NILE: Why would you say there was no action?

Dr PHILLIPS: Again I cannot answer the question. I can endeavour to find out and take the question on notice.

Mr MITCHELL: One may imagine that the harm minimisation philosophy had become so well entrenched it was beyond questioning; perhaps people were not willing to suggest other alternatives for a way forward or consider them seriously.

Reverend the Hon. FRED NILE: But Federal standing committees did?

Mr MITCHELL: Yes.

Dr PHILLIPS: I suspect—this is only a suspicion—that the culture in Australia of supporting harm minimisation is so strong that any Government seeking to move away from that or any Parliament seeking to move away from that would create considerable controversy and there is a lot of vested interest in the whole harm minimisation. One can almost call it a drug maintenance industry. Lots of people are providing ongoing counselling and drugs so there is a lot of money supporting that industry and any move away from that would undermine people's positions and careers. I do not envy the politics of making the change. I think the politics of it needs to be handled very carefully which probably means there first needs to be a carefully controlled study to produce evidence that would enable governments to act on the basis of evidence from that controlled study.

Mr MITCHELL: Could I remind the committee of Dr Wodak's evidence earlier today. If he is correct about the figure of 90 per cent of clinicians supporting the harm minimisation point of view that is a lot of inertia to overcome. You would have to say that is a deeply entrenched position.

Reverend the Hon. FRED NILE: If that percentage is correct.

Mr MITCHELL: Yes, if it is correct. I qualify that.

Reverend the Hon. FRED NILE: I know a lot of doctors who do not agree with it.

Mr MITCHELL: If it is correct it is a lot.

CHAIR: There are a lot of public health physicians that would disagree. I am married to one of them.

The Hon. JAN BARHAM: I am having terrible trouble finding the needle exchange report—the Montreal report from the Children's AIDS Fund.

Dr PHILLIPS: I can give you the title.

The Hon. JAN BARHAM: I have the title.

Dr PHILLIPS: "High rates of HIV infection among drug users participating"—

The Hon. JAN BARHAM: —The title is here. It says it is an evidence-based review of needle exchange programs.

Dr PHILLIPS: No. Let me read onto the transcript the title of the paper to which I am referring. This is a paper referred to by the paper that is given in the footnote.

The Hon. JAN BARHAM: That is tricky.

Dr PHILLIPS: I am sorry about that.

The Hon. JAN BARHAM: Some of us check all the references.

Dr PHILLIPS: I am pleased you do.

CHAIR: Do you want that as a question on notice?

Reverend the Hon. FRED NILE: You can quote the title of the paper now.

Mr MITCHELL: Dr Phillips can give the paper to the Committee today. It is a clean copy.

Reverend the Hon. FRED NILE: Just quote the title will you?

Dr PHILLIPS: I will give you the reference. The author is Julie Bruneau et al, "High rates of HIV infection among injection drug users participating in needle exchange programs in Montreal: Results of a cohort study", published in the *American Journal of Epidemiology*, Vol. 146, No. 12, 1997. I will give you a copy of this afterwards.

CHAIR: If that could be tabled.

Document tabled.

The Hon. JAN BARHAM: Could I follow up on the zero tolerance position of Family Voice Australia and refer also to its reference to a drug free society? It seems that position in part is based on an assessment of whether or not something is legal and not whether it is doing harm through the volume of people affected or the cost to society, which is what a lot of the other submissions the Committee has received refer to. Other submissions refer to the level of harm and damage caused to society by alcohol and tobacco but Family Voice Australia is basing its position on whether or not it is legal, is that correct?

Dr PHILLIPS: The question that needs to be asked prior to that is why are illicit drugs illicit? The answer is because of the recognised severe consequences from the use of those drugs. I was driven to the airport by a man from mainland China who told me about the opium wars in China and the difficulties that were encountered when a large proportion of the population became addicted to opium. He said that in the army, in 1948-49 or thereabouts, about the time of the revolution, they discovered that 50 per cent of army personnel were addicted to opium and they could not get any sense out of them.

The Hon. JAN BARHAM: That is not really my question.

Dr PHILLIPS: I am saying that illicit drugs are illicit because they are psychotropic; they mess with your mind. People who have dysfunctional minds are unable to be productive members of society.

The Hon. JAN BARHAM: You do not believe that alcohol plays that role?

Dr PHILLIPS: Alcohol abuse does.

The Hon. JAN BARHAM: Are you aware of alcohol abuse and the amount that it costs society?

Dr PHILLIPS: It is a serious problem but a lot of people use alcohol in a way that does not lead to abuse. The purpose of taking psychotropic drugs is to change your mental state.

The Hon. JAN BARHAM: Does your organisation have a position about the point before that drug abuse? Does it have an understanding of what might have led those people into psychologically damaging incidents and the despair and pain that they experienced?

Dr PHILLIPS: I am not sure whether we have a paper or position statement on that but we are aware of co-morbidity issues. There was a drug summit in South Australia some years ago. One of the difficulties identified at that summit was that the mental health care, the psychiatric care, of patients and drug treatment services were seen as separate issues and in a large number of cases the two are merged together. People who take cannabis, for example, it is now established that it is a trigger in some people for schizophrenia and the two are linked together. Very often there are mental health problems and there are social problems. Ann Bressington would be the person to ask.

The Hon. JAN BARHAM: I met Ann when she visited the North Coast campaigning against fluoride, which she has done vocally and widely. I am sure many professionals agree with that position as well.

CHAIR: I would not say that. It is a sweeping statement. I am a firm believer in fluoride.

The Hon. JAN BARHAM: That is a big campaign for her.

Dr PHILLIPS: Ann Bressington would be able to answer that question.

The Hon. JAN BARHAM: In relation to what?

Dr PHILLIPS: The co-morbidity issues.

The Hon. JAN BARHAM: I was asking whether your organisation had a position about the factors in society that influence people to that point of mental illness or drug abuse. I am more interested in the core issues and whether you have looked at them.

CHAIR: Important though that issue is, it is a topic for another inquiry. I thank you both for coming in and representing Family Voice Australia. Thank you for imparting your expertise, for being present since lunchtime and for listening to all the other witnesses.

Dr PHILLIPS: Thank you for the opportunity.

(The witnesses withdrew)

(The Committee adjourned at 5.10 p.m.)