REPORT OF PROCEEDINGS BEFORE

GENERAL PURPOSE STANDING COMMITTEE No. 2

INQUIRY INTO DRUG AND ALCOHOL TREATMENT

At Sydney on Wednesday 10 April 2013

The Committee met at 9.30 a.m.

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: Welcome to the third 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 polices in respect of deterrence, treatment and rehabilitation. I acknowledge the Gadigal people, who are the traditional custodians of this great land, pay our respects to the elders, past and present, of the Eora nation and extend that respect to other Aboriginals who may be present in the course of the hearing. Today is the third of four hearings that the Committee plans to hold for this inquiry. We will hear today from representatives of Salvation Army Recovery Services, the Australasian Professional Society on Alcohol and Other Drugs, the Drug and Alcohol Nurses of Australasia Inc., the Australian College of Emergency Medicine, the Wesley Hospital, Kogarah, the Department of Education and Communities and the Australian Medical Association (NSW) Limited.

Before we commence the taking of evidence I will make some comments about the procedures for today's hearing. Copies of the Committee's broadcasting guidelines are available from the 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 they must take responsibility for what they publish about the Committee's proceedings. It is important to remember that parliamentary privilege does not apply to what witnesses may say outside of their evidence at the hearing. I urge witnesses to be careful about any comments that they make to the media or to others after they complete their evidence, because such comments will not be protected by parliamentary privilege if another person decided to take action for defamation.

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's terms of reference and avoid naming individuals unnecessarily. Witnesses are advised that any messages should be delivered to Committee members through the Committee staff. Mobile phones should be turned off or put on silent for the duration of the hearing. I welcome our first witnesses, from Salvation Army Recovery Services.

GERARD BYRNE, Clinical Director, Recovery Services, The Salvation Army, and

DAVID PULLEN, Director, Recovery Services, The Salvation Army, sworn and examined:

CHAIR: There is an opportunity to make an opening statement if you wish to do so. We have your submission before us.

Mr PULLEN: No, we will take questions.

CHAIR: The introductory paragraph of your submission states that you provide approximately 260 residential treatment places at four locations and a range of out-client and day programs in multiple locations across the State. Where are those services provided and how long it has taken you to establish them? Are they sufficient to respond to the need in the community? Please tell the Committee anything we need to know to support you in your work because we admire The Salvation Army globally not only nationally.

Mr BYRNE: Thank you for that. Those figures concentrate on New South Wales. We provide services across Queensland, New South Wales and the Australian Capital Territory with 550 treatment places at eight residential treatment services and four inpatient detoxification services. We also provide a number of out-client and day programs. Within New South Wales that comprises a newly established service, the Dooralong Transformation Centre, to which we relocated our combined Morisset and central coast services. We have been there now for about a fortnight. We moved into the Dooralong resort. In Sydney we have William Booth House in Albion Street, Surry Hills. We have two specific detoxification services there, one targeting homeless people and the other targeting people undergoing residential alcohol and drug treatment. There are two streams of treatment and two separate services. We have about 80 residential rehabilitation beds within that service. We are also at Leura in the Blue Mountains, where we have a 21-bed service. We have been there for about eight or nine years. We also have a service in Canberra. There is a lot of trans-border service provision from that service, particularly into Queanbeyan and the southern part of New South Wales and the South Coast.

CHAIR: How long have you been providing these services?

Mr BYRNE: The Salvation Army began a program for homeless alcoholic men at Collaroy Plateau in about 1900. It was a farm setting in those days and it stemmed from the work that The Salvation Army was doing with the skid row people at what we now know as Darling Harbour. The army was involved in that work at Collaroy and in hostels it ran in the inner city for some decades. In about the early 1960s it began to be formalised into a drug and alcohol program. That is the origin of what we have today; that is, the Bridge Program, which is the army's model of treatment.

CHAIR: I am not saying that the drug issue is not huge, but is alcohol abuse still the predominant issue?

Mr PULLEN: Yes. The Salvation Army has expanded its services through its own funding, although there is a new cessation-based methadone treatment program at Penrith. We are working to have that program commence on 1 July. We have a number of day programs and community-based programs at a range of centres across New South Wales, including Nowra, Wollongong, Coffs Harbour-Tamworth, Gunnedah and some of the other outreach areas. They are funded largely from Salvation Army resources.

The Hon. DAVID CLARKE: Do you see drug minimisation as a final objective in itself or as one possible means of getting addicts drug free? We have heard evidence that people have been treated with methadone for 20 years. What is your attitude to that?

Mr BYRNE: We see various harm minimisation strategies as being a way to keep people safe on their way towards more robust treatment, and hopefully that does not involve them being addicted for decades. We see it as part of a continuum of approaches in the community. However, it is not a means to an end in and of itself.

The Hon. DAVID CLARKE: Do you think someone being treated on methadone for 20 years is what you call a robust treatment?

Mr BYRNE: No.

The Hon. DAVID CLARKE: Do you support properly conducted trials of naltrexone in New South Wales?

Mr BYRNE: Yes.

The Hon. DAVID CLARKE: In your submission you hold the position that mandatory treatment is an effective way to provide entry to treatment. You say this is based on years of practical experience. Could you elaborate on that?

Mr PULLEN: I think with naltrexone in particular Salvation Army would say that it needs to be evidence based. All treatment must be evidence based.

The Hon. DAVID CLARKE: That would be the basis of clinical trials?

Mr PULLEN: Yes. I think that would be in all things, even with your first question related to people on methadone. It is one of the reasons the Salvation Army tendered for a methadone-to-abstinence program, because we believe there must be options for people. From a Salvation Army point of view, nothing is all evil and nothing is all good. We feel there must be a process of helping people to escape from those things in which they get entrapped. It is a whole social justice issue for the Salvation Army. It is about allowing people to live justly in this world.

The Hon. DAVID CLARKE: But you would find being treated with methadone for 20 years not a satisfactory situation?

Mr PULLEN: It is not acceptable unless there is a regime of case managing and helping people to get out of those traps. I think that is the basis of what Gerard was saying.

The Hon. DAVID CLARKE: Mandatory treatment?

Mr BYRNE: We are supporters of mandatory treatment in that it provides people with a pathway into treatment. It assists them to make decisions that they would not normally have made around accessing treatment. It provides people with an option that is opposite to straight incarceration, if that is the case in terms of the crime they have committed. The Salvation Army has been involved in court and prison work through its chaplaincy department since its origins in 1860 in London with what was known in those days as a prison gate ministry. We have a high prominence at the moment in relation to court chaplains and prison chaplains in New South Wales. For decades the Salvation Army has been involved in people coming out of the prison system into its treatment programs as a means of parole or bail or under the old Griffith remand systems as well, when they were charged with indictable offences. Sometimes coming into contact with the criminal justice system is the motivating factor that assists people to make the decision that something more drastic than simply doing some more time has to happen in their lives.

Mr PULLEN: There are enough studies to prove that being mandated into treatment is not a prohibitor to change. The studies I have read on that indicate the opposite: the capacity to change is exactly the same. It is all about the whole process of a person's capacity to change. If you are putting them into treatment the treatment has to be valued and validated. It cannot be just an alternative. There has to be a value in that treatment.

The Hon. JENNIFER GARDINER: You say in relation to the adequacy of funding for drug and alcohol services there has been a dramatic increase in the type, complexity and number of complex and concurrent issues that are being dealt with. Can you give the Committee a picture of how dramatic it is and how that manifests itself and what is the proportion of the dramatic increase for alcohol compared to other drugs?

Mr BYRNE: The demographic of the client has shifted, particularly over the last decade. There has been a push from funding bodies in relation to the capacity of, in particular, non-government organisation drug and alcohol providers and us as well to identify and treat comorbid presentations as part of that. The needs of the client have increased and the types of services that we have to provide have increased. There is a lot of evidence around the provision of robust after-care systems for people when they leave treatment that indicates they are precursors to getting a better treatment outcome. The traditional historical funding models really focused on financial support for organisations to treat people in their services—in the bed, so to speak—and did not look at the whole range of issues that the person brought with them nor in a sense what would occur for the person after

they left treatment. Over the past 10 years we have moved to provide that. We provide after-care housing, we provide counselling services, and we link to the various church-based and community-based programs that the Salvation Army has, but that has all been within our own resources and that resource has a finite limit to it.

The fact is that the treatment population is becoming younger. Twenty years ago our average client was a 45-year-old alcoholic male. Today they are still male because males predominantly are the largest users of drug and alcohol services across the country, and there are a whole lot of reasons why that occurs, but they are now in their mid-30s and come with poly-drug use as opposed to straight alcohol and marijuana, for argument's sake. They use a whole range of drugs. That brings with it psychiatric and general health complications. In a sense what we are dealing with is an individual that is much more adversely impacted by their drug and alcohol use than what we had some years before.

Mr PULLEN: The gaps in adequate funding are around whole-of-family treatment and youth. I really believe there is not enough variety of service access for young people. It is not just New South Wales; I think it is Australia wide. You really are limited, if you are a young person, as to what choice you can make. It is the same with whole-of-family. I believe it is a whole-of-family issue. The victims in families need treatment too and we really ought to be caring in that sense.

The Hon. SHAOQUETT MOSELMANE: It is clear you support mandatory treatment. What about involuntary treatment? Where does the Salvation Army stand in that regard?

Mr PULLEN: I could give an illustrative story and then ask Gerard to speak from a clinical background. We had a young guy who graduated from our program on the Central Coast recently who was put into one of our programs involuntarily. He was nine weeks in involuntary treatment and he stayed 10 months in the program. He recently wrote a letter expressing the value of that treatment. We could tell many stories where that has happened. I guess in turn there would be stories where it has not happened, but I think it does work because it is not a precursor to people not changing. People do make changes. Gerard can speak from a clinical perspective.

Mr BYRNE: Within mandatory treatment there is still always that option for people to say, "No thanks" and take their chances in the criminal justice system, so to speak. As far as involuntary treatment is concerned, we support that given certain parameters. We were the after-care service provider to the involuntary care treatment trial that happened at Nepean where dependency certificates were issued for people to go into Nepean Hospital to be detoxified. Once that dependency certificate expired we picked them up. It worked quite well; we had a 90 per cent retention rate on our after-care service, and where people fell over we had direct entry back into health care services for them. The parameters for that were around people who were in imminent danger of serious illness or indeed death. We had a couple of people on the doorstep of end-stage liver disease who were still drinking. In that situation it was a good thing and it worked.

The Hon. SHAOQUETT MOSELMANE: The impacts of involuntary treatment are long-term evidence based, it is not just short-term, 10 months, and you have a result.

Mr PULLEN: It is long term.

The Hon. SHAOQUETT MOSELMANE: Going back to your comment, you support evidence-based research rather than it being based on stories and situations. What would you say to that?

Mr BYRNE: Evidence-based services have their begin point somewhere. They have to start; it has to be new and it has to be innovative and then you build up some evidence around it. If we do not embark on providing flexible, innovative services we will all just keep doing the same thing we have done over and over again because the evidence base was developed for it 20, 30 or 40 years ago. I am not saying we need to be cowboys about things. Certainly when we implement a new service or it is an innovative service there does need to be some evidence around the efficacy of some of the structures that we put in place, but in terms of involuntary care and in particular the type of involuntary care trial that was implemented at Nepean, the services that were provided under the guise of that involuntary care service were evidence based. Involuntary care in and of itself needs to have its origins somewhere so that it can build its evidence base.

The Hon. SHAOQUETT MOSELMANE: You say in point 5 that drug and alcohol education is too generic. Can you elaborate? What do you mean by too generic?

Mr BYRNE: That was in relation to the fact that over the years there has been an evolution in drug and alcohol education around providing a one-size-fits-all approach. There are different age groups where drugs are more relevant than others. For younger people and primary school children we know that things such as second-hand cigarette smoke are a serious health hazard. For older children, particularly in the early high school years, it is the advent of alcohol. When children hit their late teens, particularly years 10, 11 and 12, when they start to get a little bit of work at food shops and supermarkets and things like that, they get some disposable income and that opens the door to another range of drugs they can then access because they then have their own income to do that. So we need to be specifically targeting the age groups with the type of education that we provide. Also, education ought to include information about the addictive qualities of the drugs that they are using, not just what they do to your liver and how they make you intoxicated.

The Hon. HELEN WESTWOOD: Mr Byrne, do you have a number of staff who have medical- or health-related qualifications?

Mr BYRNE: Yes.

The Hon. HELEN WESTWOOD: In what categories are those staff?

Mr BYRNE: We have registered nurses, psychologists, social workers and drug and alcohol workers who are qualified at diploma or certificate 4 level.

Mr PULLEN: We also have Dr Winston Kardell, who is a consultant to the outreach program, and he is at the Nepean detox unit.

The Hon. HELEN WESTWOOD: Does he specialise in addiction medicine?

Mr BYRNE: He is an addiction medicine specialist, yes.

The Hon. HELEN WESTWOOD: I wanted to follow the line of questioning on involuntary treatment. The Committee has heard evidence from clinicians that with addiction you often have this pattern of behaviour where people will become clean, will not be taking drugs or alcohol, and then maybe months or years later relapse into drug and alcohol use. In relation to involuntary treatments, do you have any evidence, or do you feel confident, that the same pattern of relapse would not continue with involuntary treatment?

Mr BYRNE: As far as the outcomes of the involuntary treatment trials are concerned—and I know it is being implemented at the moment at the North Sydney hospital and at one other country location, I think Orange—the evidence is out long-term as to what the outcomes will be. But that draws me back to the question asked by the member about after-care and how we provide for people that post-treatment support, because that is absolutely critical to whatever happens in the residential treatment service, whether it is a detox or a rehabilitation service. The World Health Organisation classifies addiction as a chronically relapsing illness. One of the prime examples of that at the moment is the Commonwealth quit smoking advertisement on television: the more tries you have at quitting, the better you get at quitting, and eventually one day it will stick. I am not being flippant when I say that; there is a strong element of truth in it. If we are going to put people into involuntary treatment, mandated treatment or even voluntary treatment, there needs to be a robust support service in place for those people. That will be what delivers the outcomes longer term. I just want to say that if someone is in imminent danger of serious illness or death, I think that is where involuntary treatment may have a place.

Mr PULLEN: Why would we punish a person who acts in a way that their condition would normally send them? If a person has a heart attack and is treated, and then has another one, we do not withdraw treatment; we actually increase treatment. So often we look at withdrawal of treatment because someone has relapsed, when in reality we believe that is the time we should be increasing treatment, not withdrawing it.

The Hon. HELEN WESTWOOD: What could we recommend in terms of having that after-care available throughout New South Wales? The scenario we are talking about is the relapse of someone who perhaps has been clean for a few years. What do we need in the community to assist those people?

Mr BYRNE: It would be services that provide for the people the counselling, drug and alcohol support, access to housing, employment services—all of the things that indicate that there is a quality of life out there for a person. So it is a service that can either provide that range of services or bring them in by brokerage

or linkages with other providers, because the minute a person starts to feel that their life is unfulfilling then whatever the cravings are will take over. So an after-care service is not necessarily about extending treatment per se; it is more about targeting all of those indicators of social success, for want of a better description, that people who are not in that position have, such as adequate and appropriate housing, adequate accommodation, access to counselling services if they need those, and drug and alcohol support. So it is a range of services. Most of the services exist; it is just that they exist in pockets and silos within separate departments that have specific target groups. Those are, in a sense, the walls that need to be broken down.

Mr PULLEN: Gerard and I presented in Oxford on some of our work, and that clearly was the determining outcome of that conference in Oxford: that, really, for people to have sustainable recovery those very basic needs of housing and employment must be addressed.

The Hon. HELEN WESTWOOD: Is there any other jurisdiction, not just in Australia but overseas, that is doing that well?

Mr BYRNE: Various organisations are; but there is not, in a sense, a concerted or coordinated approach. For argument's sake, in Queensland, where we have some of our services, they are under a grants review process as well, so they have extended grants for another 12 months while they sort out the situation up there. Within the addendum came through, "We will provide after-care." I contacted them and said, "You have put in there that we need to do after-care. I just want to let you know we are already doing that, but it is not actually funded by you, we fund it ourselves." What happened was that they had a consultant who told them, "If you are providing a good, solid residential rehabilitation program then part of that should include after-care." So they said, "Okay, let us put it in." In a sense, we do not have an issue with that. But the point needs to be made that if we are going to do it let us not try to bolt it onto something that already exists; let us make sure it is adequately resourced and put in place in a concerted and coordinated manner so that it does achieve its outcomes.

The Hon. JAN BARHAM: How could we assess the level of funding that would be needed to do an integrated, whole-of-family service? Do you know what sort of additional cost would be involved?

Mr PULLEN: No. But there is experience around that. I hope this is not taken as a flippant answer, but I think the issue is the cost if we do not do it.

The Hon. JAN BARHAM: Any papers or further information about integration of services from the Oxford experience would be really helpful. The other thing I am interested in is the whole-of-family and youth-based approach. Do you provide any youth residential programs?

Mr PULLEN: We do through the Salvation Army Oasis programs. There is a funded program called Choices. I think most of the work we do with youth is done out of community centres; it is community church-based work. We need places where young people who run into trouble are able to have clear and concise treatment that works; where they are not just taken aside and left, but are intentionally treated and worked with and provided with clear forms of access and pathways.

The Hon. JAN BARHAM: You mentioned poly-drug use. Is that an increasing issue, and is it more so within one demographic?

Mr BYRNE: Very much so, particularly around amphetamine-type substances, marijuana and alcohol. Those are the main ones.

The Hon. JAN BARHAM: What about prescription abuse?

Mr BYRNE: It can be too, with what they colloquially call on the streets hillbilly heroin, such as OxyContin. So it is those sorts of pharmaceutical drugs, but it is also around things like methamphetamines, ice or speed. People are coming in with very complex physical health and mental health issues because of the way in which they have combined and used drugs, and the amount of drug use that is occurring; and people are coming into treatment earlier because of that.

The Hon. JAN BARHAM: Are you able to provide services that deal with the psychological issues around that sort of substance abuse?

Mr BYRNE: Yes.

The Hon. JAN BARHAM: Is that sufficient question

Mr BYRNE: No. We do what we can; and then, at some point, we need to access the mental health services that are available through the hospital system or the health department, and that is when it becomes very difficult; there is no integrated approach to it. Despite all of the moves to try to integrate those two services and the initiatives that have been put in place, there still is this gap between the provision of mental health and drug and alcohol services, particularly in residential settings. If you live in Liverpool and you come into our service on the Central Coast, for argument's sake, and two days later because you have stopped your drug use you have some sort of episode and we try to access mental health services, we get back responses like, "This person was in Liverpool two days ago; now they are up here and they are a drain on our services. Shouldn't you have got this sorted out before you brought them in?" Each local health district has its own finite budget for the work that they do.

The Hon. JAN BARHAM: Do you have a solution? Does there need to be transferrable funding?

Mr BYRNE: Absolutely. Possibly one of the answers to that may be the clinical care packages where funding for treatment follows the person, as opposed to being sequestered to a geographical region.

CHAIR: Personalised and individualised treatment, such as we are talking about with the National Disability Insurance Scheme?

Mr BYRNE: Exactly.

The Hon. JAN BARHAM: Are you still involved with the continuation of the involuntary care trial program?

Mr BYRNE: No. That was not continued when there was a change in government. It was implemented again at Royal North Shore and at Orange. But the one at Nepean was not, no. It was very successful; KPMG reviewed that.

Reverend the Hon. FRED NILE: I note you say in your submission that "the use of Naltrexone implants be subject to rigorous research and trial". So you are not against the trial, if one could be approved by the State medical health department?

Mr BYRNE: Given proper research and trial parameters, yes, because anything that assists people—and again it would be by choice if people want to go down that road for treatment, if it was implemented—to deal with their drug use, if it is properly evaluated, if it is put in place with rigour around it and it is clinically sound, should be available for people.

Reverend the Hon. FRED NILE: If the State Government funded the trial, would the Salvation Army be able to participate in the trial? Do you have any facilities that would enable you to take part in the trial?

Mr BYRNE: We do have facilities that would enable us to take part. Whether the Army decides to be involved in them or not, is not determined.

Reverend the Hon. FRED NILE: You would have to make a policy decision.

Mr BYRNE: Yes.

Mr PULLEN: We would have to take that to the Salvation Army Policy Council for that decision to be made. Would we recommend it? Possibly, depending on the nature of the rigour around the trial, I would suggest.

Reverend the Hon. FRED NILE: You mentioned how successful the Nepean program was. Has there been any attempt to try to recommence it? Have you lobbied to have it recommenced?

Mr BYRNE: We certainly did at the time. But it seemed that the decision was finalised to end that trial. So it did not go ahead. Then around about a year later, or maybe a bit more, the current Government

implemented involuntary care in the Royal North Shore Herbert Street Clinic, and I believe in Orange at the Bloomfield hospital.

Reverend the Hon. FRED NILE: In your submission you said that campaigns had highlighted the addictive potential of alcohol and drugs, and this is in regard to education programs. We have had a few witnesses who have been a bit cynical about the value of education. Do you feel there is some value in educating the community about the dangers of drugs?

Mr BYRNE: Information gives people options. If people have information they have a better capacity to exercise their options around it. Currently one of the things that we think is missing, particularly within school-based education, is the information on the addictive qualities of the drugs, and for us it is a key hole that has not been filled within school-based education; also, as I said before, targeting that education at the various age groups.

Reverend the Hon. FRED NILE: There is a lot of material on the dangers of cigarette smoking, and I support education programs on that, but there is almost silence on the dangers of cannabis or marijuana smoking. Do you feel there should be more education programs in that area?

Mr BYRNE: Absolutely, yes, and also in particular around the mental health impacts of marijuana, particularly on younger people: we are talking about maybe the 12 or 13 year olds to the 14 or 15 year olds when demographically that is when the onset of that use generally occurs in the main—some are earlier, some are older, naturally enough, but in the main if you are a teenager and you are going to smoke marijuana or use cannabis that is generally the age at which it occurs. Definitely I think education around the dangers in relation to that, its addictive qualities and its impact on mental health wellbeing.

Mr PULLEN: I think education without treatment—I think education per se is hollow; I think it has got to be holistic. I think that is what we would agree to.

Reverend the Hon. FRED NILE: What would be an example of that education message then—on TV or radio?

Mr PULLEN: For an example, to educate young people without giving them an option for help may be hollow in itself. I feel there is a gap there for young people and whole of family. I think that if we are only resourcing education and not treatment then we may still have that being hollow. It is not decrying the value of education, because I agree with my colleague totally on that, but I think treatment needs to be valued. I hope that answers the question.

CHAIR: On behalf of the Committee I thank you both for coming in and representing the Salvation Army. We really respect the hands-on work that you have done over decades, for more than a century. There are some internal Committee secretariat questions for you before you leave, but thank you so much for the evidence that you have given.

(The witnesses withdrew)

ADRIAN DUNLOP, Professor, Australasian Professional Society on Alcohol and other Drugs, affirmed and examined:

CHAIR: Welcome to the inquiry. We have your submission in front of us but do you want to make an opening statement before we start questions?

Professor DUNLOP: I might say a few things about myself and then about the society. I am a medical practitioner. I have 20 years of experience as a clinician and as a teacher and a researcher in the field of addictions. I am a professor with the Faculty of Health at the University of Newcastle and area director for drug and alcohol in Hunter New England Health. I am a foundation fellow of the Chapter of Addiction Medicine in the College of Physicians, the clinical adviser for drug and alcohol in the Ministry of Health in New South Wales and a previous Churchill Fellowship recipient studying addictions in pregnancy in North America and in Europe, but I am presenting today in the role of being the immediate past president of the Australasian Professional Society on Alcohol and other Drugs [APSAD].

The society is a multidisciplinary society including addiction specialists, psychiatrists, nurses, public health doctors, psychologists, counsellors, researchers and policy makers. It runs an annual conference and has done so for over two decades now. It also runs the seventh most highly ranked academic channel in the world on drugs and alcohol, and the goals for the society are to improve the standards of research and treatment using evidence-based treatment and to promote public awareness of drug and alcohol issues and problems in our society.

CHAIR: Given that drug and alcohol abuse is such a big social issue, would you say, looking at it holistically, the problem still centres, in terms of the human cost, social cost and physical cost, on alcohol issues and problems? We seem to focus a lot on the drugs area because it can be so devastating and intensely acute, but how would you proportion the problem and the overlap often between alcohol and drug abuse?

Professor DUNLOP: There is no doubt, and there are good Australian studies showing this, that alcohol and tobacco by far cause the most morbidity and mortality and costs to our society—medical costs but also public and social and other costs, and illicit drugs is an important and significant issue and we need not to ignore that. But yes, alcohol and tobacco are by far the biggest contributors of harm in our society.

CHAIR: Why do you think we have been so successful in tobacco but have not really tackled alcohol well?

Professor DUNLOP: I think one of the important differences is that alcohol, of course, can be used recreationally and can be used safely—and many members of our society do use alcohol safely and recreationally—but it can also be abused. I think as a country, and it probably goes back to our origins a couple of hundred years ago and how we were founded as a country, we have a high degree of tolerance to alcohol and public drunkenness, and that has changed certainly in the two decades I have worked in the field: there is far less tolerance of alcohol-related harm, but it still exists. It is interesting when you go to other countries that do not have that strong history in consuming alcohol—certainly at high levels—you notice that difference and how people think differently about why alcohol is a problem.

CHAIR: We have had submissions looking at the multicultural aspect of getting good information on drug and alcohol treatment across. Do you find that there are any cultural differences? Have you looked into any research done within various community groups within Australia, since we have been the recipient of so much migration? I know anecdotally from my background within the Italian and Mediterranean community that there often is a different approach from childhood up to adulthood in terms of how you treat the usage of alcohol. Would you like to comment on that?

Professor DUNLOP: There certainly are cultural differences. I did a PhD looking at heroin dependence in ethnic Vietnamese in Australia, focusing both in Melbourne and also a little bit in Sydney, and certainly there are important cultural differences in cultural sub-populations in how they understand addiction, how they understand access to Western health services and how they respond to treatment, and that is something we need to be aware of. Mentoring culture—it is very important of course to mentor our Aboriginal population. They are very overrepresented in all alcohol and drug treatment statistics. It is a very sad fact and we have great work to do to try to redress those imbalances.

CHAIR: Do you think we have got enough training and education in those issues amongst our workers within drug and alcohol treatment services? Do you think that that issue of cultural sensitivities and background history to explain behavioural patterns is understood by people treating?

Professor DUNLOP: I think we do relatively well as a multicultural society, but of course we could always do a lot better.

CHAIR: You heard the previous witnesses from the Salvation Army talk about a better linkage to be achieved between education services and treatment. Some of the submissions have been quite negative about how well we are doing with education at the various levels of our youth. I note your own submission here before us. What do you think the value is of education for the various ages of youth and the stages they are going through before they get into adulthood? Do you think it serves a purpose if we could do it better and what do you think about linking it to treatment?

Professor DUNLOP: We always could improve our practices; there is no doubt about that. The evidence base for the effectiveness of education is limited. In theory, educating young people about the harms of alcohol and drug problems should prevent their use, but it is not that straightforward, unfortunately. In a worst-case scenario you might be telling people about things that they are better not to know about. It is complex and we need to be very careful with education programs that we roll out that we know that they have a benefit and they are evidence-based and they support the growth and development of that young person, and I say that not only from an academic perspective but also from being a father myself and seeing kids grow up. So it is very important that we do it well, but our knowledge of what works and what is safe in the short term is limited and in the longer term is even more limited.

CHAIR: You make mention that some models in Europe deserve consideration; in particular, the Portuguese approach to drug and alcohol you say is worthy of a review. Could you just expand upon that? We have not heard very much about the Portuguese approach.

Professor DUNLOP: The Portuguese model is somewhat unique in the world in that approximately 12 years ago they made a decision—and the history to the decision is a very long one and I could provide documents if that was useful in the longer term, but it is a long story and I should not try to over summarise it. But, in summary, in a very short period of time, Portugal had been a dictatorship and essentially isolated from the rest of the Western world and very quickly had a problem with cannabis, heroin and cocaine and other drugs and it became an issue that was very commonly known. Frequently, members of a family would know someone who had a son or daughter or would know somebody who had a substance abuse problem, and that had changed very rapidly.

So the interest from the community and the interest across Parliament, across the various political parties, was very high. A number of options were explored and they decided to not decriminalise drugs but to move the treatment of drugs from a system of going through courts and having a court-based system that would work out appropriate sentences for persons who had used illicit drugs, to target people who were not selling drugs but who were clearly addicted to drugs and had drug problems and move that from a criminal justice system to a health-based system. There is not another equivalent country, but the resources that in our society, and in most other societies, go into processing people through courts for typically minor drug offences, go into a health-based system and then people sit in front of a committee, a course of treatment is recommended and that is then what the person is requested to attend.

It is a very different system. The evidence from that country is that it is no worse in terms of the outcomes or use of drugs; drug honeymooning is not going on there and, in fact, it is less bad than surrounding and neighbouring countries that have our traditional, or most countries', approaches of keeping illicit drugs illicit. It is a complex story and I do not want to try to oversummarise it, and it is the only country that has gone down that path, but there are two important things to note: there has been a very significant decrease in HIV-related deaths and, of course, there has been a significant decrease in the number of people in custody from drug-related crime, and that has some savings to their community.

CHAIR: We have recently seen a spike in HIV rates in Australia, which has shocked public health—or perhaps it has not shocked them if they are involved in it. What do you think we are doing wrong? Where do you think we can improve?

Professor DUNLOP: We need to remember what we are doing right. Our early adoption of the needle exchange program is extremely notable. Every time I go to any other country and talk to clinicians who work in the alcohol and drug field I do not have to talk about our stories of managing HIV and drug dependence. That is so striking and it has such an effect on the health of the population. It is very notable. We need to continue to do that. The concern, in my understanding, is within gay men and we need to continue to try to work out why there is not an adequate practice of safe sex amongst gay men, and also in the heterosexual population.

The Hon. DAVID CLARKE: In your report you make clear that you see a place for mandatory treatment. To those who say this is very restrictive you would say it is certainly less restrictive than going to jail.

Professor DUNLOP: Yes.

The Hon. DAVID CLARKE: You see it as an alternative to going to going to jail.

Professor DUNLOP: Absolutely, yes.

The Hon. DAVID CLARKE: You are not aware of any situation where it is mandatory and the alternative is going to jail, are you?

Professor DUNLOP: Currently we have a number of programs where people can choose to do a court mandated program that has quite strict conditions and they can elect to do that as an alternative to going to jail.

The Hon. DAVID CLARKE: But all of those mandatory programs are giving a choice; the other choice being that you go to jail.

Professor DUNLOP: Correct.

The Hon. DAVID CLARKE: That is the only situation where mandatory programs are being used; as an alternative to jail. That is putting it in perspective.

Professor DUNLOP: Correct. Voluntary to mandatory, yes.

The Hon. DAVID CLARKE: You spoke about the Portuguese experience. What about the Swedish experience? Do they not have some pretty impressive statistics to show that their programs of being tough have produced fruitful results?

Professor DUNLOP: Can I just clarify, are you asking me about their public health approach to alcohol?

The Hon. DAVID CLARKE: No, illicit drugs.

Professor DUNLOP: They have both agonist treatment and antagonist treatment and they have expanded agonist treatment quite significantly over the last decade or so. Having a choice of options is of course very important. The concept of them being tougher on drugs concerns me because I think it elicits a sense that if we are not adopting that approach we are not serious about drugs or we do not think drug problems are significant. I think as a field we think drugs are very significant, that is why we work in this field, and a range of options need to be provided. There are some benefits of having the Swedish approach, but we need to have a range of options.

The Hon. DAVID CLARKE: What do the statistics show? Is there any support for their approach in those statistics?

Professor DUNLOP: You might have to remind me of exactly which statistics we are talking about. I am sorry, I am not sure.

The Hon. DAVID CLARKE: Getting addicts drug free.

Professor DUNLOP: Again I am concerned with the concept of getting addicts drug free. The last presentation I heard gave a very good description of the issues with trying to assist people to remain away from alcohol or other drugs in the long term. Unfortunately it is not that simple—people relapse. Yes, there should be

a goal of trying to get people to their optimal level of functioning, including being in the workforce and including being effective members of our society, and I would absolutely support that.

The Hon. DAVID CLARKE: But on illicit drugs you had the statistics relating to HIV levels in Portugal, but are you aware also of the statistics in Sweden that they have an overall lower rate of illicit drug abuse than most other countries in Europe?

Professor DUNLOP: Yes, and there are a number of other things about Sweden's geography that mean that might be the case as well. Every country has an individual situation for a whole number of reasons.

The Hon. JENNIFER GARDINER: This inquiry has very wide terms of reference. If you had your druthers what one or two things would you like to see the Committee recommend in terms of drug and alcohol services overall in New South Wales?

Professor DUNLOP: I imagine others have already discussed with the Committee that there is a very useful program that has been developed. It is a joint partnership between NSW Health and the Federal Government in trying to work out exactly what level of services should we provide adjusted for the size of our population. That is the drug and alcohol clinical packages program. It is close to being finalised. I have seen early drafts of it. It is the first time we have had a good evidence-based model which looks at what we know about problems of drug use in our community and estimates what level of services we should have. It is a very useful model and to see it implemented would be a wonderful thing. Of course there is going to be a gap between what we understand to be our current level of services and what we think we should have in an ideal world.

I think I make some reference in the submission to the level of funding for drug and alcohol problems and the significance of drug and alcohol problems and the level of funding that we have for mental health problems and that even though the burden of disease is similar the level of funding is far less. The single biggest thing would be reflection on the level of funding for drug and alcohol services and particularly for evidence-based services. The second thing is some careful concern about recommending specific treatments when there are many things that need to be considered in terms of trying to advance the evidence base for drug and alcohol treatment. If there was extra funding available the priority in my mind would be to fund services that we know are effective and to have more of them so that we do not have gaps in treatment as we do currently.

The Hon. SHAOQUETT MOSELMANE: We have had a number of submissions from witnesses who support the idea of mandatory treatment. We also have received submissions from witnesses here who see the effectiveness of involuntary treatment remaining very much unclear. What is your view in terms of involuntary treatment?

Professor DUNLOP: Involuntary treatment essentially should be always reserved for situations when it would appear that the person's continued use of a substance is going to result in their death. That is, I think, the only situation.

The Hon. SHAOQUETT MOSELMANE: It is a very narrow situation?

Professor DUNLOP: It is a very narrow situation. There is not a robust evidence base suggesting that it is effective beyond those situations. I have used involuntary treatment with patients. I have a good understanding of its role. I have a good understanding of the effect of taking away somebody's liberty to essentially dry them out and to get them to think about and reflect about their use of substances. It has a limited role. It has got a very important role, but it has a limited role.

The Hon. SHAOQUETT MOSELMANE: If we do apply involuntary treatment we would generally be in breach of international guidelines. For example, I note that in one of the points that you raise you say that the World Health Organization guidelines recommend that treatment should not be compulsory. We would be in breach of those guidelines if we did it.

Professor DUNLOP: That is the case. There are a number of countries in South-East Asia where treatment is not voluntary and there are serious human rights concerns in those countries.

The Hon. HELEN WESTWOOD: I want to go back to the important point that we have been talking about and that you refer to in your submission; that is, the level of funding. We have heard from a number of

witnesses, and it has been contained in a number of the submissions we have received, about the cost of the burden of disease related to addiction and the proportion of the health budget on that. Do you have a view as to why governments have continued to do that?

Professor DUNLOP: I do not know that there are examples of many countries in the world that do a lot better than we do as a country. I think there are a number of things that governments must choose in terms of their responsibility for making choices about how budgets are spent. I am sure the Committee is well aware of the increasing pressure on health budgets that goes on year after year and the concern regarding that. I imagine that it is a very competitive agenda to have alcohol and drug issues prioritised.

Having said that, I think we can learn from mental health over the last couple of decades. Once mental health was heavily stigmatised and now it is far better recognised and the need for treatment is recognised. Indeed, we have got a Mental Health Commission in New South Wales now and a Federal commission. In my mind, drug and alcohol issues in the last two decades are starting to change like that. Once upon a time I think people only felt lots of stigma if a family member had a drug and alcohol problem. I do not think that is the case now. I think people have a better sense of the fact that people need treatment, but there still is a great need for education in our community. I guess to some degree our community needs to be more vocal in saying that we need treatment for our members of society that have problems.

I reflect back to being in Portugal the year before last and talking about illicit drugs. It was striking to me how the average person—and I met a number of persons in the week I was there—seemed to have a different perspective. Their perspective was that these people need help. Interestingly, of the people who had gone through their program 55 per cent were employed. Our level in our patients of employment is around about 5 per cent at best. The biggest reason they thought for that was that the stigma is less.

The Hon. HELEN WESTWOOD: We heard from one of our witnesses about the low status and indeed the hostility towards addiction specialists and from other practitioners about the approach to addiction, which is very different to other health conditions. I guess I am coming to my own conclusion about that, but one of the issues raised earlier which I think relates to it is the question of treatments. I will use the methadone program as an example. Our earlier witnesses said that is a bad thing, we should not have people on methadone for extended periods of time. In your experience, do you agree with that? If you have diabetes you have insulin and it is for a lifetime. I have high blood pressure, I take medication every day and no-one is suggesting that I am weak and I need to go off it. It that a fair comparison, or should people not be on methadone for long periods of time?

Professor DUNLOP: It is a good comparison. There are a number of good academic papers in very notable journals making exactly that comparison and thinking about the prognosis and the course of treatment over a period of time. My father has diabetes. If I was to say to him, "No, five years on insulin and that's it. Sorry, you've got to lose weight. If you don't lose weight you are not eligible for treatment"—clearly people with addiction problems need a range of sorts of supports from a range of different agencies. They need a range of medications, a range of good psychosocial interventions, good clinicians well able to treat them, and they need that over a long period of time.

It would be great if that were not the case. It would be great if one day somebody could come along with a simple cure, like we hope for cures for cancer. It is not the case, and we need to be particularly sceptical of anyone who is suggesting that they have a quick and easy answer for addiction. It is very seductive to family members. Look in parents' eyes when they have said, "Somebody told me this would be a cure and it's not", and see how devastated they are. We need to be very cautious with what we can suggest our treatments can do.

To suggest methadone and buprenorphine treatment is ineffective is saying that we do not believe in science. It is a hard argument to counter. Are there problems with methadone and buprenorphine? Of course. Any medication, any doctor will tell you, has problems. There are risks and benefits of any medication in the short term and in the long term and I do not minimise the problems that people experience on methadone and buprenorphine. I treat them. I treat them every day and I would never minimise those problems, but to suggest that it is not effective or it should be removed from the treatment platform is a little bit like saying that you can only have insulin for a period of time. It is a very strange statement.

The Hon. HELEN WESTWOOD: The other area I am interested in is the workforce in drug and alcohol treatment and whether it is your view that we have enough health professionals with the range of

qualifications and expertise that is needed. Also, back to my other question about status, is the stigma associated with addiction medicine a barrier to people pursuing this as a career?

Professor DUNLOP: It is for some but not for all. Certainly I think our more junior staff—we have lots of different programs. NSW Health has been very good at trying to develop training programs for nurses, psychologists and doctors. Generally our junior staff have fewer of those ideological barriers or problems with it. There are some people who should not work in the addiction field. They have had traumatic experiences themselves or family members and they find it too challenging. That of course has to be understood. There are many things we could do to improve undergraduate and postgraduate education and I could talk to you for a long time about them. But, yes, we certainly should invest more in that as a society.

The Hon. HELEN WESTWOOD: Is that something that the Federal or State governments have looked at in any recent work looking at workforce capacity and whether it is meeting the demand?

Professor DUNLOP: There have been suggestions but there has not been a robust body of work done, no.

The Hon. HELEN WESTWOOD: In our discussion so far the emphasis has been on involuntary treatment for illicit drug use but are there experiences of involuntary treatment or alcohol addiction in other jurisdictions?

Professor DUNLOP: We do involuntary treatment as part of the revised Act and that includes people with alcohol dependence. Yes, it is used for alcohol dependence and other drug dependence. It tends to be more used for alcohol dependence than other drug dependence but over the last decade or so there has been more use of non-alcohol as reasons for people undergoing involuntary treatment.

The Hon. HELEN WESTWOOD: Does involuntary treatment for alcohol addiction include pharmacological treatments or is its basis counselling and support?

Professor DUNLOP: Typically it is a combination of both and if somebody is severely alcohol dependent then they need to undergo withdrawal and that needs medicated support. They may need help after that and there is lots of counselling that is immediately required in the short and medium time and medications may play a role in the longer term.

The Hon. HELEN WESTWOOD: What is the pharmacological treatment for alcohol addiction, is it naltrexone or are there other drugs?

Professor DUNLOP: For long term addiction naltrexone and disulfiram are the medications that have the strongest evidence base. Unfortunately it is not available through the Pharmaceutical Benefits Scheme [PBS]. There has been action over a couple of years to try to make it available through the Pharmaceutical Benefits Scheme. It should be available through the Pharmaceutical Benefits Scheme but it requires a significant body of work from a pharmaceutical company to do so and there is not a significant market advantage in doing that at the moment so it is unlikely to happen in the short term.

The Hon. HELEN WESTWOOD: Is it quite expensive?

Professor DUNLOP: It is more expensive for patients, yes. It is not an incredibly expensive drug but it is more expensive and given that a high proportion of people are impoverished in that population it is difficult.

The Hon. HELEN WESTWOOD: Does that mean that some of the services would be subsidising that?

Professor DUNLOP: Typically the patient subsidises it.

The Hon. HELEN WESTWOOD: In what sort of setting would that treatment happen? Does it have to be a residential setting or out-patient?

Professor DUNLOP: Out-patient or day program would occur most of the time.

The Hon. HELEN WESTWOOD: I am interested in the issue of a randomised trial of naltrexone implants or intramuscular treatment. We have had evidence about the need for a trial. Most people who have appeared before us are supportive of that but all say it has to be done within an ethical framework and done by an appropriate body or research organisation. One of the things we have heard is that it would be so costly that it is unlikely to happen. Do you have a view on that?

Professor DUNLOP: I guess it relates to what the outcome is and which preparation or product and for what use. Probably the closest medication that could be used in that sort of setting is the Vivitrol, the naltrexone depo injection, which is registered by the Food and Drug Administration in the United States. The NSW Health has funded a trial of that for National Drug and Alcohol Research Centre [NDARC]. NDARC was unable to obtain the product from the pharmaceutical company Alkermes. There has been an attempt to have a trial of naltrexone depo injections in New South Wales. If we are talking about naltrexone implants a single study is unlikely to resolve the issue. The National Institute on Drug Abuse approached Dr O'Neil from Go Medical over a number of years and Dr O'Neil was unable to prepare a product for their investigation of new drug status that had been passed through a good manufacturing practice [GMP] process that could be used for research. They were keen for a number of years to study naltrexone implants, unfortunately that could not happen. Dr O'Neil was unable to produce a product they could use and that was because there was inadequate animal, toxicological and safety data as well as having GMP. There would be a significant body work, if it was that particular product, to have a trial and it would not be a trial it would be several trials.

If NSW Health had unlimited coffers and was able to fund a program of research we then would need to argue is that the next most important thing to do and there are many examples of good evidence-based treatments to support young families who have drug addiction with young children where we already know there is waiting lists. We are poor at treating alcohol dependence in our society. There are many examples of people turning up at hospital emergency departments and being admitted where alcohol is not even recognised as being a problem. There are many examples of where we know treatment could be expanded and there would be an immediate benefit.

As an academic question I am fascinated by the role of naltrexone. I was a prescriber in 1997-98 in the first randomised control trial of naltrexone in Australia conducted at Turning Point Alcohol and Drug Centre. It has been published. It was uninspiring to use as a medication but I was fascinated to be part of that trial. I would be fascinated and keen to participate in a trial that was used here. I am not anti-science on any medication. There is, of course, a role for it. It needs some careful consideration of what are the next most important questions for us to answer clinically or in our research work.

Reverend the Hon. FRED NILE: I have seen some recent reports that the government of Portugal is modifying the program in Portugal. Are you aware of that? They are bringing in low penalties and so on.

Professor DUNLOP: I should add two things, one is that they have brought in alcohol dependence treatment in the last five years and that has been important. the pool of people they have sent through their system—it is not a court system but a hearing system—has expanded so it is not just addicts, it is also young people experimenting with drugs and they have worked hard to work out appropriate penalties to show to young people who are caught experimenting with drugs that there are harms and dangers from drugs. I understand that has been effective. However, at the same time, as I am sure you are aware, Europe has undergone a significant financial crisis and there are severe limitations on their capacity to fund that program. There are other problems that have occurred at the same time.

Reverend the Hon. FRED NILE: It is not a total decriminalisation?

Professor DUNLOP: No, it should not be called a decriminalisation. Depenalisation is probably a better word.

Reverend the Hon. FRED NILE: You mentioned you were involved with naltrexone, was that injections or implants?

Professor DUNLOP: That was the tablets when they were first introduced on a trial basis in the late 90s. I have not used implants, no.

Reverend the Hon. FRED NILE: You have not had any trial experience with naltrexone implants?

Professor DUNLOP: No. I have had patients with implants and I have seen patients with implants but I have not been responsible for putting in the implants.

Reverend the Hon. FRED NILE: You mentioned Dr O'Neil's Fresh Start program in Western Australia. That is one clinic, it is not a commercial pharmaceutical company that produces drugs. You said he could not supply them but that would not be a surprise, would it?

Professor DUNLOP: No. Dr O'Neil is a passionate clinician who is working incredibly hard and is devoted to his patients but there are significant issues with developing a medicine that is safe and effective and can be approved by the Therapeutic Goods Administration, it is a large undertaking.

Reverend the Hon. FRED NILE: You are not aware of naltrexone implants being produced anywhere else overseas such as the United Kingdom or the United States?

Professor DUNLOP: They were being produced in China but I do not know the details of production. I am aware that some Australians are using naltrexone implants produced in China and I think that was in New South Wales but I am not absolutely sure.

Reverend the Hon. FRED NILE: If they were approved in China by their health department would that be sufficient to use them in a trial?

Professor DUNLOP: We would want to carefully review the process because I do not think we could assume that the Chinese regulatory process would be sufficient for our own regulatory process including safety issues.

Reverend the Hon. FRED NILE: You do not think it is as strong as the Australian system?

Professor DUNLOP: It is significantly different enough, this is from people I know in business, that their business systems are different and we could not assume and I do not have the expertise to say that we could assume that it would be an adequate system.

Reverend the Hon. FRED NILE: You have stated in your submission similar comments—that a trial has to be carried out under expert medical conditions and so on—you are not against a trial if one could be organised but you are questioning the priority of the finance issue?

Professor DUNLOP: That's correct. Any trial of any new medication for addiction I am in favour of but there is a list of things we need to consider as priorities.

Reverend the Hon. FRED NILE: I note in your submission you refer to the dramatic decline in the levels of smoking, 29 per cent in 1993 down to 18 per cent in 2010, what do you think are the reasons for that?

Professor DUNLOP: I think it is a range of public health measures: We stopped tobacco advertising, we have raised the price of cigarettes, we have made cigarettes harder to buy, we have made it difficult for minors to buy cigarettes and most recently introduced plain packaging. There are a range of public health measures and, in effect, it is seen as less acceptable for people to be smokers. Public perception that it is acceptable to be a smoker has changed and that is part of why people do not smoke as much now. The story around alcohol is more complex.

Reverend the Hon. FRED NILE: You make the comment that the number of smokers has remained stable from 2007 to 2010 at 3.3 million. There is now a group that are not responding to all the campaigns. What more can be done to reduce that figure, especially with young women as one of the large categories?

Professor DUNLOP: It will be interesting to see the effect of plain packaging because we do not know yet what that effect will be. There are more public health measures: we can consider the taxation on tobacco, decrease its supply and social measures are important for particular populations such as young women. We need to be careful because in some populations such as Aboriginal people it is not clear that the increase in price is having the effect that it is having in the broad population.

Reverend the Hon. FRED NILE: You made a reference to what seems to be an inconsistency with the Pharmaceutical Benefits Scheme only being available for treatment of alcohol dependence, why not for drug dependence and what can we do to expand it to include drug dependence because of the cost of the treatment?

Professor DUNLOP: There are two or three issues: In relation to naltrexone dependence my understanding is that naltrexone tablets are not authorised because the low effectiveness of naltrexone tablets and that is probably an appropriate decision but it can be reviewed. In relation to methadone and buprenorphine treatment there is a significant financial cost and we do not have equivalent medication in our society where we ask patients on long-term treatment to pay that amount of costs. That results in people remaining impoverished.

Reverend the Hon. FRED NILE: That is the argument why it should not be on the list, because it is expensive?

Professor DUNLOP: Yes.

Reverend the Hon. FRED NILE: It is not very good for the addicts?

Professor DUNLOP: It is appalling.

The Hon. JAN BARHAM: I will ask questions about the issues around addiction and treatment and the longitudinal studies about how long does it take to determine whether someone is cured, do we have much on that?

Professor DUNLOP: There are long term follow-up studies of heroin dependence, less so with amphetamine dependence and pretty good studies with alcohol dependence that go over many decades. The story is overall, I am summarising a lot here, that, yes, people do stop using drugs. They stop using drugs or drinking alcohol when their life changes. It is hard to effect a life change, a single intervention rarely does it, and relapse is common and does occur and can occur at any stage. Unfortunately a high proportion of people die and if they do not die from their drug dependence they die from tobacco dependence.

The Hon. JAN BARHAM: They are related. Is multiple drug use an increasing problem in that cohort?

Professor DUNLOP: There are more and more drugs available and it is different from 20 years ago and I am sure it will continue to evolve.

The Hon. JAN BARHAM: With young people, I am particularly interested in frightening information about young people using multiple drugs and the abuse of prescription drugs, such as Xanax and OxyContin and those types of drugs, as recreational use mixed with alcohol. Is there recognition of emerging trends, ability to deal with those and provide services for those sorts of people who are undertaking that risky behaviour?

Professor DUNLOP: With young people, I think we are still quite early in the piece. The research and treatment services have developed around adults and have been implemented around adults, and there are a few specific services for young people. I worked in one in Victoria about a decade ago. That is part of the remit of the Headspace programs. But it is still pretty early in the piece and hard to say that we know what is better for young people. We do understand, or understand more and more, about prescription drug misuse both of benzodiazepines and of opiates, and we need to commit more resources to understanding those problems and working out how to minimise them.

The Hon. JAN BARHAM: Would that include better services in terms of monitoring and work on monitoring programs?

Professor DUNLOP: Yes.

The Hon. JAN BARHAM: There seems to be confusion about what level of information and data sharing is available with that. Is that a major problem for New South Wales and something that could be remedied by having a better system in place?

Professor DUNLOP: I think the example of Tasmania is a good one and shows that it can be done, and we have wanted it elsewhere in the country for a long period of time. We continue to think that would be a much better solution to try to minimise the problems at the prescribing end.

The Hon. JAN BARHAM: And it is relatively simple, is it not?

Professor DUNLOP: It should be.

The Hon. JAN BARHAM: In relation to the Drug and Alcohol Clinical Care and Prevention [DACCP] model, when that is resolved, do you know how long it will be until we have got that as a model? You said you had been working on that.

Professor DUNLOP: We should have that as a model in the next few months.

The Hon. JAN BARHAM: Should that provide the information about the level of harm and risk and where the funding should go in terms of whether the focus is on illicit drugs and/or alcohol?

Professor DUNLOP: Yes. It is based on alcohol, cannabis, heroin and other opiates and amphetamines, so it gives us some guidance over four of the main drugs that cause harm in our society and it is useful. It gives guidance for what we think for young people, such as the different sorts of services, different types of treatments—for example, general practitioners compared to specialist treatment—but there is still some capacity to work out each individual geography. There might be different mixes of services that exist under this model.

The Hon. JAN BARHAM: I am interested in the rural and regional aspect and whether or not it takes into account the availability of after-care services and the primary health care that is needed.

Professor DUNLOP: The plan is that it tries to plan the sorts of service you would expect a person would need from admission or initial assessment across a period of time, and that range of services available, yes. There is not a specific loading for virality, though. There is a separate project that I understand less about for Aboriginal people. I understand there are some differences for them. That is earlier in the stages of development, and I cannot really comment much more other than to say that I am aware of it.

The Hon. JAN BARHAM: I might ask you, if you can, to provide more information on that. In relation to the workplace situation, a lot of submissions have talked about the need for more specific training to provide for professionals that work across the primary health care system to understand how they deal with drugs and alcohol issues.

Professor DUNLOP: The number of general practitioners who actively practise drug and alcohol medicine is low. It is probably less than 5 per cent. We do not have really good data on it. There are a whole number of reasons that that is the case. There are a number of good programs that have looked at trying to enlist more general practitioners in managing these issues. Some of it is around confidence. Some of it is around some general practitioners having had personal histories, or their families have or something like that, and so that is why they do not want to be involved. There are some good programs. There are some good programs that even NSW Health has sponsored to try to get more exposure for younger doctors to addiction treatment, but there is more that we could do. Certainly there is a lot more that we could do.

The Hon. JAN BARHAM: We have a submission from nurses saying that there is a lot more they could be doing, if they were appropriately trained in early intervention support systems. Is that something that you would support?

Professor DUNLOP: Absolutely. Probably the biggest gap in our treatment is that we know there are lots of brief interventions that work, but they just do not happen. They could occur in primary care and they could occur in hospital settings, and they just do not.

The Hon. JAN BARHAM: And they would not need a doctor?

Professor DUNLOP: You do not need a specialist with three or five years of training to carry them out, no.

CHAIR: Thank you, Professor Dunlop, for providing your expertise and your time to the Committee. We really value it.

Professor DUNLOP: Thank you very much.

The Hon. JAN BARHAM: All the witnesses know that we might ask them for additional information.

CHAIR: Members of the Committee could be cruel and ask you for additional information.

Professor DUNLOP: That is fine.

Reverend the Hon. FRED NILE: Questions that are taken on notice.

The Hon. JAN BARHAM: They will be sent to you.

(The witness withdrew)

(Short adjournment)

STEPHEN LING, Member, Drug and Alcohol Nurses of Australasia Incorporated, affirmed and examined:

CHAIR: Welcome and thank you for appearing before the Committee. Would you like to make an opening statement?

Mr LING: I thank the Committee for the opportunity to appear at this hearing on behalf Drug and Alcohol Nurses of Australasia Inc. Since our initial submission to the inquiry we have had an opportunity to examine the proposed amendments to the Drug and Alcohol Treatment Act 2007. It is of some concern to us as a professional body that a program about which safety and effectiveness has not been clearly established—that is, implantable naltrexone—has been singled out as a treatment of choice. That is particularly given that widely used agents with proven efficacy, such as methadone and buprenorphine maintenance for opiate dependence, have been ignored. The involuntary use of implantable naltrexone raises several issues, particularly with regard to the evidence base for the approach being considered.

The Cochrane review, which was published in 2008—and I have the reference here—states that "There is insufficient evidence to evaluate the effectiveness of sustained-release naltrexone for treatment of opioid dependence." A recent review of the issue in 2012, while concluding that sustained-release formulations of naltrexone are feasible, safe and effective, acknowledges that more research is required to confirm these findings and to compare this treatment with current standard treatments.

The second issue is the evidence base for involuntary treatment. To our knowledge, there is little to support this approach. Involuntary treatment is not to be confused with evidence-based approaches such as the Magistrates Early Referral into Treatment Program or the drug court programs, which have been studied and proven to be efficacious and both of which retain a measure of choice on the part of the individual involved—that is, they can choose to undergo treatment or to be incarcerated. As I understand the legislation, involuntary treatment would involve no choice for the patient. We have serious ethical concerns for persons treated in this manner.

Thirdly, while there is insufficient evidence to support either implantable naltrexone or involuntary treatment in this context, there is certainly no evidence to support the combined approach of both together—that is, no-one has ever studied involuntary treatment with implantable naltrexone. We have concerns about that. It is our view that proven and efficacious treatment should be made widely available and that efforts should be made at all levels of government and in all jurisdictions to provide appropriately funded drug and alcohol programs for the care of individuals with substance use disorders in a professional and compassionate manner. It is our understanding that staff shortages and extended waiting lists for treatment exist within some jurisdictions, not only in New South Wales but throughout Australia generally. It is difficult to imagine how appropriate treatment can be offered to persons served with a dependency certificate requiring more comprehensive and intensive treatment when issues continue to persist even with standard treatments.

The New South Wales Parliament has been extremely proactive in the past 10 to 15 years in amending a number of Acts to allow nurse practitioners to function within the New South Wales healthcare jurisdiction. Unfortunately, much more needs to be done if nurse practitioners are to be able to support the healthcare system in any real way. To date there are only two nurse practitioners in drug and alcohol positions in New South Wales and a third is in a transitional position. I have provided copies of a scholarly paper which I wrote and which was published several years ago that outlines some of the pros and cons associated with nurse practitioners in the drug and alcohol field.

CHAIR: Your submission states that no treatment modality should exist in isolation and you support evidence-based approaches and methodologies. The Committee does not want to give the impression that it is opposed to any of the currently available treatments. Do you to believe that we should always try to expand our evidence-based armoury as physicians or nurses?

Mr LING: Absolutely. I have been saying to a number of people are over a number of years that we know what works well but not what works better. Any research into what works better is vital within any system.

CHAIR: The Committee has heard a great deal of evidence from researchers and epidemiologists that they would be keen to participate in a clinical trial if it involved a Therapeutic Goods Administration-approved substance and a National Health and Medical Research Council level one randomised control trial. Regardless

of the treatment modality, would you support a multi-centre trial involving a number of public health physicians or addiction medicine specialists and a treatment that could give some relief to drug addicts?

Mr LING: Absolutely, as long as it went through the usual approval processes and that funding arrangements were arrived at through a competitive process in the same way that any other trial would compete for funds.

CHAIR: What about if it were a decision made by the New South Wales Government?

Mr LING: It would be up to the government to make that decision.

CHAIR: You stated in your submission and in your introductory remarks that we have a limited number of nurse practitioners involved in drug and alcohol treatment. What is their role and how does one become a nurse practitioner? How can they assist in drug and alcohol treatment?

Mr LING: Nurse practitioners are expert nurses with advanced clinical practice skills. They have generally had many years of experience—I have had 18 years of experience in the addictions field. Until two or three years ago there were two pathways to endorsement for a nurse practitioner. One was through a master's degree program with endorsement through the Nursing and Midwifery Board of Australia. However, that has now changed with the Australian Health Practitioner Regulation Agency taking over the board's role. There are now two pathways, but there is no clinical pathway for a nurse practitioner. The only way to become a nurse practitioner now is through a master's level degree either as a nurse practitioner or through a master's degree in the field of expertise of the nurse that is then approved by the agency.

The role of a nurse practitioner is a little different from the role of a generalist nurse. Nurse practitioners are able to prescribe medication within a scope of practice in their field of expertise. I can prescribe medications for drug and alcohol dependence although I cannot prescribe antibiotics or cardio-vascular drugs. I can prescribe medication only for use in the drug and alcohol field. We are also able to order and interpret diagnostic tests.

CHAIR: What recommendations should the Committee make about increased funding for nurse practitioner programs? Is there a place for big general practitioner clinics to have specialised nurse practitioners?

Mr LING: Absolutely. General practitioners often treat people with drug and alcohol problems but they may not know about those problems. Having a drug and alcohol specialist in the form of a nurse practitioner can be very useful in offering the sort of support that a general practitioner may find helpful in treating an existing patient. We have found in the public health system that nurse practitioners can be very useful in training junior medical staff and nursing staff. Of course, the junior medical staff must have medical training; we are not doctors and we cannot provide that sort of training. However, we can train them with regard to some of the psychosocial issues involved in addiction and the impact that may have on the individual.

CHAIR: Has there been enough encouragement from the medical professional groups with regard to dialogue with Drug and Alcohol Nurses of Australasia? Have they encouraged the use of nurse practitioners? Have they also encouraged more people to become nurse practitioners? Of course, it could be very expensive. Is there enough encouragement or are you still seen as being on the periphery and not really involved?

Mr LING: It is still largely on the periphery. In a small survey that we did, which is in press at the moment, where we examined senior nurses in drug and alcohol services throughout New South Wales and the reasons for their not pursuing becoming a nurse practitioner we found there were a range of barriers to them. Certainly one of those was the financial cost of going back to university. Many nurses felt they did not want to do that. Many felt there was no end point in terms of a position for them once they had achieved endorsement, so even though they were endorsed as a nurse practitioner they might be left in limbo from an employment point of view because they would still be employed only as a registered nurse and not as a nurse practitioner.

CHAIR: You may or may not wish to answer this question: How do you think the medical colleges see the role of nurse practitioner?

Mr LING: I think it is safe for me to say that the Australian Medical Association has been quite vocal with some inflammatory rhetoric around nurse practitioners and it may or may not have deliberately confused nurse practitioners with practice nurses at times in some of the information. It has not been very helpful.

CHAIR: So there could be a role for the Government to improve the cooperation between different practitioners, nursing and medical?

Mr LING: Absolutely, and I think cooperation is a very useful word because nurse practitioners are not meant to be working in an isolated unit; they are meant to be working collaboratively with their medical colleagues. None of us is working in a vacuum and we need to take advantage of each other's knowledge and experience if we are going to manage these situations in an appropriate way.

The Hon. JENNIFER GARDINER: Do you work in the Hunter New England Local Health District in the Hunter Valley?

Mr LING: I do.

The Hon. JENNIFER GARDINER: Where does the other nurse practitioner you referred to work?

Mr LING: North Sydney. The Hunter has been very good in obtaining some funding to employ a transitional nurse practitioner as well. We have a nurse in a transitional role; she is not endorsed as a nurse practitioner as such but she is looking at postgraduate study which will allow her to transition to that role.

The Hon. JENNIFER GARDINER: As well as nurse practitioners Drug and Alcohol Nurses of Australasia has a nurse credentialling process. Could you expand on that? Is this a popular line of work that nurses wish to get into or is it one they steer away from? Roughly how many per annum would be credentialled in New South Wales?

Mr LING: The credentialling process is not current; it is still in the process of being developed and it has not been pushed through as yet. As to whether nurses want to do drug and alcohol work, it is difficult to say. Anecdotally I suggest there is a lot of fear among even generalist nurses in managing drug and alcohol problems. The third part of your question related to numbers, but because the credentialling process has not been pushed through it is difficult to say what the numbers might be.

The Hon. JENNIFER GARDINER: Is the fear that nurses have of entering this field a reflection of a general stigma in society or is it because of the violence they may encounter in the workplace?

Mr LING: It is probably the result of a number of issues. Training would have to be one issue, certainly undergraduate training. It is very difficult to have drug and alcohol issues put on the agenda for undergraduate training of nurses. Another question is whether there are sufficient support networks for those nurses to transition from one role into a drug and alcohol role, and that is one I cannot answer.

The Hon. JENNIFER GARDINER: When you say training, do you mean getting enough places?

Mr LING: There are probably two issues: It is very difficult to have drug and alcohol issues put on the agenda for university undergraduate nursing programs. The second issue is that as things stand, any nurse can transition from whatever role they are currently working in to a drug and alcohol role. The question is whether they receive any training in order to do that. To my knowledge, there are no nurse educators specifically for drug and alcohol training in New South Wales to support those people in making that transition.

The Hon. JENNIFER GARDINER: Should there be such positions?

Mr LING: I think I probably need to leave that to the Committee to decide.

The Hon. JENNIFER GARDINER: I guess that is fairly obvious. Are there any other recommendations the Committee could make to enhance the number of nurses in this field?

Mr LING: I heard some of Professor Dunlop's presentation and I think that using some of the computerised modelling systems that are available now to look at what level of staffing is required to run an appropriate drug and alcohol service for a particular population, but also looking at the acuity of staffing—not only the number of registered nurses you require to support those people but also medical staff, pharmacy staff and administrative staff to support those people in performing their duties. They are the sorts of things we need to be considering at the moment.

The Hon. DAVID CLARKE: Our terms of reference refer to models in other countries including Sweden and the United Kingdom. Do you have a view on the Swedish model? The idea is out there that they take an approach of a drug-free society—I am talking about illicit drugs—and statistics are quoted which show that Sweden has a lower level of illicit drug abuse than most other countries in Europe. There could be a whole host of reasons for that but there could be other reasons why Portugal has a lower HIV rate that may have something to do with things other than its program.

Mr LING: Absolutely. It is an extremely complex question. There is no panacea for drug and alcohol problems generally. They are complex and they require a range of strategies not only in relation to treatment but in what the Committee is trying to achieve in looking at what needs to be done generally for people with drug and alcohol dependency. You need to be mindful of the differences in each jurisdiction. Sweden is a very different place from Australia and indeed New South Wales. We need to consider what those differences are and how they are likely to impact on the results that the Swedish clinicians and government are showing us. We also need to ask whether the various systems in Sweden have a philosophical interest in presenting something which may or may not be true. We just do not know at the end of the day.

The Hon. DAVID CLARKE: Is there any suggestion that they are?

Mr LING: No, I am not suggesting that but at times people become invested quite philosophically in what they are trying to present and it would be good to look at the base data to see what is really going on.

The Hon. SHAOQUETT MOSELMANE: You heard Professor Dunlop say basically that priority number one would be to recommend increased funding for drug and alcohol services. He notes in his submission that mental health funding is eight times greater than drug and alcohol funding according to the 2009-10 figures. In your submission you say there is definitely a need for alternative funding. What alternative funding are you looking at apart from increased taxes on alcohol?

Mr LING: Increased taxes on alcohol are certainly one way of providing some degree of funding for drug and alcohol services. To my knowledge revenue raised from alcohol is disproportionate to the spending required for alcohol problems. As a lone solution it will not be sufficient without raising those taxes further. We also need to think about nicotine and tobacco. We have been successful to some degree by raising taxes on tobacco and reducing the demand for tobacco.

The Hon. SHAOQUETT MOSELMANE: What other strategies are there to raise funds? You indicated that one strategy would be to increase taxes on alcohol.

Mr LING: It is probably not a question I can answer fully for you. It is not my particular area of expertise.

The Hon. SHAOQUETT MOSELMANE: The reason I ask that is we have had submissions and witnesses have said that alcohol is the biggest cause of problems in society yet when you compare the money that is going to treat mental health, illicit drugs and alcohol problems, alcohol is receiving the least. That is why I was asking what other strategies there are to address the problem.

Mr LING: As I said, I am probably not the best person to ask.

The Hon. SHAOQUETT MOSELMANE: You have indicated that you support a trial of naltrexone implants in New South Wales. Is that correct?

Mr LING: No, that is not quite what I was saying.

The Hon. SHAOQUETT MOSELMANE: Do you support a trial of naltrexone implants in New South Wales?

Mr LING: It depends on what you mean by that—implantable or injectable?

The Hon. SHAOQUETT MOSELMANE: Implantable.

Mr LING: Only if that trial was robust and had appropriate ethics approval. There are a number of issues that need to be considered. We certainly would support any sort of research around what is going to work better for us, even if it is an add-on—an additional treatment for people if it is an option available to them. I think there are other issues around the safety of the implantables, which is not proven, and that does need to be proved before we would support any research, and the efficacy of those implants.

The Hon. SHAOQUETT MOSELMANE: In your submission you see the need to define mandatory treatment and you raise a number of questions in relation to that, for example, mandates from family members or treatment settings and community settings and so forth. Can you elaborate on that, and what do you see as a possible definition of mandatory treatment?

Mr LING: Having read the proposed amendments to the Act now I have a better understanding of what is meant by that. As I said in my opening statement, programs such as the Merit program and the drug court system still retain a degree of choice for the patient in that they can choose not to have treatment, which means they are looking at incarceration as a result. Mandatory treatment where the patient has no other option is not something we would consider as being an ethical alternative.

The Hon. SHAOQUETT MOSELMANE: In relation to mandatory treatment you say in your submission that another important consideration is what happens at the end of the treatment. What happens now and what should happen?

Mr LING: That is a good question. It has not been stated in the amendments what happens beyond the period of treatment. We would see a multifactorial, multidisciplinary approach to managing people as the best option. Generally, people require long periods of treatment. Their drug and alcohol dependence did not occur overnight—it has taken many years—and their recovery will not necessarily happen overnight either. It will take many years of struggle for that person to recover from their drug and alcohol dependence. A number of people are required to help manage that. It is very difficult to manage that by yourself as a clinician. We need a range of options in terms of medication and psychosocial assistance for such things as housing, accommodation and employment and training.

The Hon. HELEN WESTWOOD: Can you provide us with the referral for the article you cite in your submission by Carter, Hall and Iles in relation to mandatory treatment? Can we have some more detail about that?

Mr LING: I do not have access to that particular paper but I am certainly happy to forward it to the Committee.

The Hon. HELEN WESTWOOD: Would you take that on notice?

Mr LING: Yes.

The Hon. HELEN WESTWOOD: Just continuing with that issue of involuntary treatment: one of the issues that have been raised with me by nurses is the principle of informed consent. Are nurses or nurse practitioners concerned about the issue of involuntary treatment versus informed consent?

Mr LING: Absolutely. I suppose it was what I was saying previously about having some ethical concerns around enforcing treatment for people who quite often, beyond the withdrawal period, are unable to provide informed consent. If they have been served with a notice that lasts for up to 90 days, we would have concerns that beyond a certain period they would be able to provide informed consent but would be legally mandated not to be able to do that. I think there are concerns around that.

The Hon. HELEN WESTWOOD: Are there any comparisons with other circumstances where there would be involuntary treatment? I am thinking, for example, about the case of a patient with a serious mental illness that leads to psychosis.

Mr LING: So you are thinking of community treatment orders and those sorts of things?

The Hon. HELEN WESTWOOD: Yes.

Mr LING: Again, to my knowledge, they have not been systematically studied. There is certainly some anecdotal evidence to be able to say: yes, these are grave, and morally do we have a responsibility to provide care for this person whether or not they agree to it? Those are probably questions for another day. But we would certainly hold some concerns for mandated involuntary treatment for people who, in some situations, after a certain period would be able to provide informed consent in one way or another; they would be competent to be able to do that.

The Hon. HELEN WESTWOOD: Back to the question of the credentialing process for nurse practitioners in the drug and alcohol field: Is there anything that this Committee could recommend that could expedite that process? Has it been halted, or is going along as it should in a timely manner?

Mr LING: There are probably two things there, and they are a little different. There is the credentialing of drug and alcohol nurses generally, which is largely a Drug and Alcohol Nurses of Australasia led process; so Drug and Alcohol Nurses of Australasia will be facilitating that. I suppose it is important to keep in mind that anything done by Drug and Alcohol Nurses of Australasia is done on a voluntary basis; nobody is paid for their involvement with Drug and Alcohol Nurses of Australasia. So any credentialing process which does take place will be done on a voluntary basis; and they are getting pretty close to rolling out credentialing nationally, basically.

In terms of endorsement of nurse practitioners, it is really an individual process for an individual nurse to follow. So that nurse would need to decide whether or not to undertake the endorsement process and then apply to university and go through that process. In terms of reducing the barriers to nurses undertaking that process however, I think it would be extremely useful to have some positions available generally throughout New South Wales for people to enter once they are endorsed, because that seems to be one of the biggest barriers for nurses in undertaking the endorsement process to begin with; if they cannot see that they will have a job at the end of the day, they are not going to go through two years of university training in the hope that they just might get a position at the end of that training.

The Hon. HELEN WESTWOOD: The training for a nurse practitioner does not necessarily specialise in drug and alcohol; that would be a nurse practitioner generalist. Or are there specific streams that you want to take the training in?

Mr LING: There are specific streams which you must acknowledge when undertaking the endorsement process. So the training tends to be quite generalist in terms of the post-graduate masters programs; but, when seeking endorsement, you need to have a scope of practice within your field of expertise, and a limited formulary of medications which you prescribe within that scope of practice.

The Hon. HELEN WESTWOOD: Is it your experience of the experience of Drug and Alcohol Nurses of Australasia that there are sufficient nurses pursuing drug and alcohol as a field of expertise? I am just thinking generally about that issue of workforce capacity and meeting the demand.

Mr LING: I think generally Drug and Alcohol Nurses of Australasia would recommend that there probably are not enough nurses now, and certainly not enough nurses entering the field. I would think that anything we can do to help address that would be useful. Certainly, as I mentioned before, targeting the undergraduate programs throughout the State, and trying to inspire an interest in treating people for drug and alcohol dependence very early on in a nurse's career, is vital in trying to instil in them a longer-term interest in the field.

The Hon. HELEN WESTWOOD: Has Drug and Alcohol Nurses of Australasia had an opportunity to be involved in the development of curricula? As I understand it, from time to time universities review their curricula. I also think that the Nurses and Midwives Board has some input to that. Have you had an opportunity to be involved in that?

Mr LING: As an individual, yes, I have. Again, I cannot speak for Drug and Alcohol Nurses of Australasia specifically on that issue. But certainly, as an individual I have. It is extremely difficult to have drug and alcohol placed on an undergraduate program. There just seem to be too many competing priorities for those programs.

The Hon. JAN BARHAM: I would like to follow up the addendum to your submission, which refers to four years of funding of $9.7 million. In what year was that introduced, and when is it rolling out?

Mr LING: I would need to look at the paper. I hope I have a copy here. No; I think I have given them all out.

The Hon. JAN BARHAM: I will pass you this copy. That is the amount of money you were referring to.

Mr LING: Yes. Whilst I was writing this article the Federal Government had released some moneys to allow nurse practitioners access to both the pharmaceutical benefits scheme and the Medicare benefits schedule.

The Hon. JAN BARHAM: That was in 2007?

Mr LING: Exactly.

The Hon. JAN BARHAM: So is that funding finalised now?

Mr LING: As far as I know, that is recurrent funding. However, there has been a report for the Western Australian Government, which had KPMG look into nurse practitioners and the various models of practice for a nurse practitioner, and they identified that a nurse practitioner, in order to function as a sole practitioner and be financially viable, would be required to see 48 patients in a day under the current Medicare arrangements that are in place. So that is just not viable.

The Hon. JAN BARHAM: It is not possible, is it?

Mr LING: No. It is just not a viable situation. So we are unlikely to see full value for nurse practitioners until the Federal Government widens the Medicare rebates available for nurse practitioners.

The Hon. JAN BARHAM: That is the point you are making in your conclusion. You wrote this in 2007. Since then, has there been any movement?

Mr LING: Very little, from what I understand.

The Hon. JAN BARHAM: I really do not understand what the barriers would be with something like this.

Mr LING: I suppose it comes down to the funding bucket not being bottomless and the need for a line to be drawn in the sand; and the Federal Government has decided that this is how much it is going to fund that arrangement, and is not prepared to fund it any more than it already has.

The Hon. JAN BARHAM: We have heard from pretty much everyone involved in dealing with this issue about the need for integration, aftercare, whole-of-life services, accommodation, housing, employment and so on. Is it not the case that, if this is looked at more holistically, the value would be there for investing in these sorts of programs?

Mr LING: Absolutely.

The Hon. JAN BARHAM: Is there a light that suggests we might see that awareness?

Mr LING: I suppose at the end of the day you get what you pay for; and if governments generally are not prepared to pay for enhanced services then they are not going to exist.

The Hon. JAN BARHAM: But you only get what you pay for if you know the value of what you are getting in the long term.

Mr LING: Absolutely. I suppose that was one of the points I was making earlier when I was suggesting that there are already effective treatments for drug and alcohol which already are not being utilised to their full capacity because the funding just does not exist for that to happen. Certainly, we would suggest that money should be made available where there is known safety and efficacy around medications, treatments and psychosocial treatments, rather than looking at something which to date really has not been appropriately investigated.

The Hon. JAN BARHAM: You referred to fear before.

Mr LING: That is just one of many issues.

The Hon. JAN BARHAM: But the violence issue in association with alcohol, and the broader social impact.

Mr LING: Again, it is something that I am not sure has been studied. I am not sure that anyone has ever looked at undergraduate nurses and studied, "Are you interested in drug and alcohol work? And if not, why not?" Maybe that is something that should be attempted. But, to my knowledge, it has never been done.

The Hon. JAN BARHAM: On the aftercare issue, is there anything more broadly on which you can advise the Committee, and specifically how we could implement a more effective system of working with patients, and the importance of the role of aftercare in achieving outcomes?

Mr LING: I think I have pretty much covered the importance of having appropriate aftercare, in the sense that it is very rare for there to be just a drug and alcohol problem. More often than not, there are multiple issues; it is not just the drug and alcohol problem. I heard earlier some talk around the treatment of young people. From our perspective, the drug and alcohol issue for a young person is a symptom of other stuff going on. What else is happening, in the family in particular? What are mum and dad doing? What are their siblings doing? What is their peer network engaged in? Unless you start to address some of these issues, you are unlikely to change anything for that young person.

The Hon. JAN BARHAM: This morning we heard from the Salvation Army about their whole-of-family programming. Is Drug and Alcohol Nurses of Australasia supportive of that approach?

Mr LING: Any approach that is going to address that, because drug and alcohol use has a rippling effect; it is not just the person involved, it is everyone around them, and it ripples out from there. To address that, you really do need to be looking at what is happening generally for that person, and that does involve the family and peer network.

Reverend the Hon. FRED NILE: I would like to follow up on some of the questions already asked. You seem to be negative in considering involuntary or mandatory treatment. I assume you have nurses who belong to your association who previously worked at the Nepean on that program. Have you had any feedback from them?

Mr LING: We may well have such nurse members, but we have not had any feedback from them.

Reverend the Hon. FRED NILE: That was under the Labor Government. Now the Coalition Government has a similar program at the Royal North Shore Hospital. Have you had any contact with your members working in that program?

Mr LING: No, not around that program in particular. We have certainly experienced some issues with that program, particularly in terms of transport. There are no transport arrangements to get somebody to and from that program. So, again, that program as it currently exists is not being used to its full capacity, as we would see it.

Reverend the Hon. FRED NILE: I am trying to ascertain whether your members are happy with the program that they are working in, either originally at Nepean or now at Royal North Shore Hospital.

Mr LING: We have not heard from anybody other than on what we have already sent through in the submission.

Reverend the Hon. FRED NILE: Do you think if they were unhappy you would have heard something?

Mr LING: We would have heard something.

Reverend the Hon. FRED NILE: I had the opportunity to visit the Swedish drug rehabilitation program and they have very impressive nurses working in the mandatory program in the sanatoriums there. Have you had any contact with the Swedish nursing association?

Mr LING: No, not at all.

Reverend the Hon. FRED NILE: You have had no feedback from them as to whether they are happy with the program? They appeared to be from my conversations, but I am not an authority to that extent.

Mr LING: Certainly, again, I think they are things worth pursuing—getting a sense of how effective staff feel their program is. I think there is some value to that. But, again, that needs to be systematic and not some people coming to you and others standing back and not saying anything.

Reverend the Hon. FRED NILE: The ones I met seemed very happy. The male nurses said they would sometimes sit up all night with patients going through withdrawal and so on, rubbing their back and massaging them. I was very impressed with their level of care. I note in your submission you make a reference to not being supportive of mandatory treatment and in your last sentence you compare it to the health conditions of hypertension, diabetes and so on—that we do not give mandatory treatment to those people. I would have thought that the main difference with the issue we are debating is drugs are addictive and people with diabetes or hypertension did not suddenly choose to have those conditions.

Mr LING: Perhaps a better example may be nicotine. I certainly see significant numbers of people in hospital every day dying from nicotine-related conditions, and yet would we mandate those people to treatment?

Reverend the Hon. FRED NILE: For people addicted to nicotine?

Mr LING: Yes.

Reverend the Hon. FRED NILE: That could be looked at. I do not know whether it is simply a straight-out negative.

Mr LING: But it is an addictive drug and it is probably, in terms of mortality, associated with more deaths every year in Australia than any other addictive drug, and yet nobody is considering mandated treatment for nicotine dependence.

Reverend the Hon. FRED NILE: Maybe we should. Are you suggesting it should be considered?

Mr LING: Absolutely not.

Reverend the Hon. FRED NILE: In a previous inquiry we visited people dying in the hospital from the effect of nicotine. We spoke with them one day and were told the next day that they were deceased.

Mr LING: It is an awful death, and what you have described is not the norm: it is a very drawn-out, prolonged process. Death from many nicotine-related conditions, particularly chronic airways diseases, can take several years.

Reverend the Hon. FRED NILE: I notice that DANA has set up this credentialing process. Is that something that is within your organisation or was it approved by the AMA or by the health department?

Mr LING: It would be approved by DANA, so DANA as an organisation itself is rolling that out for drug and alcohol nurses. We need to be very clear that DANA is not associated with the AMA as such; it is a separate organisation, and it is a process whereby we are looking at attempting to standardise the level at which a drug and alcohol nurse should be functioning to appropriately care for patients they are treating.

Reverend the Hon. FRED NILE: I think that is good. I am just concerned as to whether it should have some higher status—not just an internal organisation setting up a system; it should be approved by the health department or some other body.

Mr LING: There is certainly some interest from the ministry in New South Wales around this very process.

Reverend the Hon. FRED NILE: To give it greater strength, greater support?

Mr LING: Yes. There is certainly some interest.

Reverend the Hon. FRED NILE: I notice in your submission you are also complimentary of the harm minimisation program and state how effective it is in reducing the HIV infection rate. Do you think that is the only criterion for success of that program?

Mr LING: No, I think success can be measured along a continuum. How you define harm minimisation is another question altogether and people will define harm minimisation differently depending on who you ask. But treatment itself needs to be along a continuum. I suppose whenever we are seeing anybody we are all hoping this person is going to stop doing what they are doing—that is our hope for everyone. The reality, however, is that many of the people that we see cannot, and often it is best just to contain that behaviour to a certain degree by providing measures which are going to reduce the harm associated with whatever behaviour they have in the knowledge that this person is just not ready for that end point at this time. They may be in the future, and that is where we would be keen to engage them in longer-term treatment, in the hope that when that point comes we can help them with that, but we need to acknowledge that not everyone is ready to stop today.

Reverend the Hon. FRED NILE: We have run out of time, but that is one of the reasons I am supportive of naltrexone, because it takes away that issue you are talking about, that they cannot stop.

Mr LING: We cannot be sure of that. It really has not been studied fully to be able to say that.

CHAIR: Thank you, Mr Ling, for giving your time and your expertise to this inquiry. Please convey our thanks to your associate members in DANA.

(The witness withdrew)

RICHARD PAOLONI, Chair, NSW Faculty, Australasian College for Emergency Medicine, sworn and examined:

LAI HENG FOONG, Public Health Committee, Australasian College for Emergency Medicine, affirmed and examined:

CHAIR: Welcome to our inquiry. We thank you for your submission and the time you have taken to appear before the Committee to answer some of our questions based on your submission. There is an opportunity to make an opening statement if you wish to do so.

Associate Professor PAOLONI: We would just like to clarify that we are representing a health body and so we will confine our comments largely to that, unless the Committee wishes us to make broader comments. The impact of alcohol on emergency departments in particular is enormous. It is very difficult to quantify because as we are health facilities our databases are around diagnoses: people who present with alcohol can present with a huge number of diagnoses and it is very difficult to tease out. We do know that as well as the primary effects of alcohol on the individual—those who present with intoxication or withdrawal—there is a much bigger pool of people who present with secondary effects of alcohol. Some studies from Royal Prince Alfred Hospital show that about 30 per cent of trauma patients were alcohol-affected above the legal driving limit at the time. We obviously also see people who are not intoxicated who come to emergency but who are the victims of abuse or assault at the hands of people who are alcohol intoxicated. So it is a significant problem taking up significant resources and posing a great threat to the community as a whole.

CHAIR: Your association represents the physicians of emergency medicine throughout our hospital system within Australasia, is that correct?

Associate Professor PAOLONI: That is correct.

CHAIR: So you would have approximately how many members?

Associate Professor PAOLONI: We have just under 2,000 consultant-level specialist emergency physicians—that is across Australia and New Zealand because we represent both. We also have some role in representing non-specialist emergency doctors. So we do have a role in supporting other doctors who work in emergency departments but do not have a specialist qualification.

CHAIR: Just for the benefit of Committee members, what sort of proportion would there be of those doctors that may not be specialised in emergency medicine but are working within emergency departments?

Associate Professor PAOLONI: They are quite a large proportion. The emergency positions are a smaller group of specifically trained people. You then have usually people who are called career medical officers, who are working in emergency generally full-time but not pursuing a specialist training program. There are also general practitioners, particularly in rural areas, working in emergency departments. And in all emergency departments there are then a range of more junior doctors who often have not yet chosen whether they are or are not specialising.

CHAIR: When reading your submission it is frustrating that we do not have high-level research telling us what the statistics are of alcohol- and drug-related dependent patients presenting to emergency departments in our hospital system. Is it surprising that we really have not had comprehensive research to know what is really going on, the level, and see how that has changed over, say, the last 10 years. Anecdotally, there is a feeling that you are really copping a lot of the acute situations there and that the demands on your services are growing enormously, but how do we know? We have not got an evidence base and so how can we appropriately fund? I am getting that sense of frustration in reading your submission and other submissions that we have had.

Associate Professor PAOLONI: Obviously, we can only collect data on those people who present to emergency departments. The community prevalence and those sorts of issues are not things that we could cover. As I was saying before, the difficulty we face is that we are primarily a clinical service and so our databases are designed around clinical presentation, around diagnoses, rather than contributing factors. We certainly are interested in this area. We are part of the alliance in New South Wales together with a whole range of other groups, and we are looking nationally at ways that we could potentially amend our databases to provide us with the sort of information you are seeking.

CHAIR: So is there a recommendation that we could bring from this inquiry to help that data that is being assembled for an improved service delivery for every State, including New South Wales?

Associate Professor PAOLONI: I think the sorts of studies that would need to be done would certainly require research support; they are not studies that could be done solely by clinicians working clinical shifts. They are also not the sort of thing that could be extracted easily from a database because there is a lot of subjectivity around those sorts of decisions. So I think there is a role for a research group to partner with somebody like ourselves to do such research; I do not think we could do it solely on our own. Yes, I think there is a tremendous need for it.

CHAIR: And it would involve all of the State health jurisdictions coming together and cooperating perhaps through your body as an Australasian-based body to enable that research and data collection to be effected?

Dr FOONG: I would like to inform the Committee that the college has deemed the issue so important that they have funded a project called the Reducing Harm from Alcohol Project, and that is going to be rolled out within the next year. That will basically involve collecting prospective data on patients presenting to emergency departments with alcohol-related illnesses. The Public Health Committee has quite a few representatives from various States and so what we are going to do, the plan is to come up with sort of a 24-hour collection of patients who present with alcohol-related problems.

As Professor Paoloni has mentioned, different States have different data systems in emergency. A lot of diagnoses are not clear. Furthermore, a lot of trauma patients get assigned a diagnosis based on their trauma but if they are intoxicated they do not get—if that is put as a second diagnosis they do not count, or it is harder for us to actually draw out the figure. The study that Professor Paoloni mentioned at Royal Prince Alfred Hospital is there because the trauma team actually makes a concerted effort to do alcohol testing on all patients coming in with trauma, so then we have a more reliable data set.

First of all, we do not have a standardised emergency data collection system. Secondly, the diagnoses are variable. They are like alcohol-related liver disease or there is trauma, there is domestic violence but it not attached to intoxication so you can already see how problematic collecting data would be. But what we do know is that patients presenting to emergency have a high rate—it is about 1.5 to 3 times that of primary care, so GPs—of alcohol-related injuries and conditions. We see a disproportionately higher representation of patients who have problems related to their alcohol consumption.

CHAIR: Do you think there should be a standardised data collection methodology for all public hospitals?

Dr FOONG: In an ideal situation, yes. But I think it is limited by some hospitals already having their own data system, it costs a lot of money to change it. But I guess with better collaboration and perhaps communication we could try to identify all the alcohol-related diagnoses in different data systems and try to come to more evidence based, as you call it, data.

CHAIR: Do you want this project to be Australia-wide? If we had a standardised data collection system would it not be advantageous to have it throughout the country?

Dr FOONG: For sure, yes. The Government is already planning to come out with an e-system for collecting patient information. That would be one way to link it, but basically we have to train triage nursing and medical staff to actually put down the diagnosis when alcohol-related conditions are found. That is the difficult one, because in a busy department the tendency is to click on the first kind of reasonable diagnosis and leave it at that, whereas having a more robust data set would involve everyone clicking on the same diagnosis to find out about alcohol-related problems.

CHAIR: But it is certainly something that your college would like to be consulted about if the New South Wales system tried to move with the college and involve other States in getting a standardised data collection system so that we would get better effectiveness of our public health dollars to help you in your treatment modalities.

Dr FOONG: That would certainly help. And I guess following on with that would be a data set of services provided to people with alcohol dependence to make sure that they are linked, because there is lot of frequent attendants in emergency with alcohol problems. There are a lot of people who frequently access alcohol withdrawal programs, they relapse, they go through the same. There is also a lot of housing and a lot of linked social organisations that provide support for alcohol-dependent patients but they are not linked either and so you do not know how effective the services are or how much a few people in a group keep on accessing them.

CHAIR: You would see reoccurring patients present and possibly have a sense of frustration about what happens to those people after they leave your department; how they access the services and what sort of integration there is. We need to have a system of coordination of services so it minimises the number of times they have to represent at emergency departments.

Dr FOONG: Yes.

Associate Professor PAOLONI: There are people who frequently re-attend. I think if you had any emergency physician sitting here we could name five without even thinking at our various sites; they are that well known to us. Some of those people are intractable alcoholics and would not seek treatment even if it was offered to them, but there is another group who really do want treatment but the difficulty of accessing treatment in an appropriate time frame, particularly with the 24-hour nature of emergency departments, can often be very frustrating for us. We can deal with the acute issue, we can make a referral, but then we have to send the patient home knowing full well that the chance that they are going to get a spot in a detox place is extremely low.

CHAIR: I suppose in rural and regional areas it becomes an even greater challenge.

Associate Professor PAOLONI: Yes, exactly.

The Hon. JENNIFER GARDINER: On that point, you say that the college would like to see an increase in funding targeted to improve referral pathways for drug and alcohol related presentations to emergency departments. Would you see that that would be targeted towards a one-off project to get the pathways working better, or is that something that needs to be funded on a continuous basis?

Associate Professor PAOLONI: I think that the primary cost would be the up-front cost. There would obviously be some continuation cost. As Dr Foong was saying, there is a huge range of services providing alcohol detoxification and alcohol rehabilitation but the current system very much relies on the patient doing lot of the work, which is fair enough because they want to know that the patient is committed to stopping alcohol otherwise they know that there is a high chance that it is going to be ineffective. However, the coordination in terms of having a patient who is alcohol affected and often disorganised, maybe homeless, et cetera, accessing multiple phone numbers on a regular basis until they find somewhere is a very poor way to organise it. I think there needs to be some coordination that assists them to find a detox position if they want to detox.

The Hon. SHAOQUETT MOSELMANE: You spoke about the disproportionate rate of patients presenting with alcohol problems. In your submission you say that in New South Wales alcohol has been reported as the most common principal drug of concern since 2000-01. What action do you suggest we recommend in our final report?

Dr FOONG: There are quite a few suggestions.

The Hon. SHAOQUETT MOSELMANE: The key ones.

Dr FOONG: This being the Legislative Council, I think there are a few components that already have been legislated or could be legislated such as restricting opening hours of bars and controlling pricing. From my reading control pricing is quite difficult. Basically all the studies, if you read them, the main two things that they say—this is for alcohol, probably it can be extended to drugs as well—that could restrict the supply is pricing and availability. Availability is through liquor licences and opening hours. And pricing, I am not sure whether the Legislative Council can control the pricing, but those are the two main things.

The Hon. SHAOQUETT MOSELMANE: We can make recommendations.

Dr FOONG: Yes. In terms of other things more related to emergency, as I mentioned in my submission, there are a lot of evidence-based treatments for alcohol dependence. That is for sure. But we in

emergency find that we are kind of facing the consequences of alcohol problems. We can recommend that they get treated for their alcohol dependence but it depends on whether they can access those services. As Professor Paoloni mentioned, it is the access that is the problem.

We are probably the only 24-hour service for health that is available. Often we are on an evening shift and that is when they come in—evening, weekends—in crisis. There are many studies that have shown that when people are in crisis they are a lot more amenable to getting treatment for their drug or alcohol related problems, but when we try to refer them there is no-one to refer to so we sometimes have to keep some people in our extended emergency care units just so that we can have them talk to social services and talk to drug and alcohol services. That of course takes up a bed in an acute service. I would recommend that there is more funding for a 24-hour service for drug and alcohol support services in a form that I cannot define now.

Also in terms of limiting advertising, I think from the tobacco standpoint we can see how effective limiting advertising is in reducing the use of tobacco. But with alcohol, I think the public perceive it as less of an evil in a way because it is an evil that happens at home or sometimes in a bar and you go out and you are reminded that it is a problem. But it is very hard to stop advertising and it is very hard to try to target alcohol per se because the linkages are not as direct as tobacco. But certainly reducing advertising in big sporting events, sports events in schools and things like that could assist. Also in terms of the database, which we have already mentioned. Also in terms of funding for more screening and brief intervention for people in emergency, because I think emergency is a very busy place, it is under-resourced and a lot of doctors think that there is no place for screening and brief intervention to occur. But if we have, let us say, a drug and alcohol nurse—some departments have already started having a drug and alcohol nurse attached to emergency, but again it is 8 to 5 usually or 9 to 5. It is sometimes to midnight but not from midnight until 8. That is the problem.

The Hon. SHAOQUETT MOSELMANE: You recommend health warnings on packaging of alcohol and you note that they do that successfully overseas. Can you point out any State that does it in Australia and, if not, how do we recommend that such warnings be put on alcohol packaging?

Dr FOONG: From my knowledge there is no State in Australia that does it. I think there are some European countries that do it, but I do not know any State where there is such a thing.

The Hon. SHAOQUETT MOSELMANE: What sort of examples should we put on the alcohol packaging?

Dr FOONG: Just like again with cigarettes, before it became simple packaging they had a small warning saying that smoking can cause cancer. In terms of alcohol, it would be more difficult to make such a direct connection but you can certainly say that drinking alcohol can damage your liver and cause—you can sort of fill it in.

Associate Professor PAOLONI: Alcohol kills brain cells. Alcohol increases your risk of cancer.

Dr FOONG: Alcohol increases your risk of trauma and injuries.

Associate Professor PAOLONI: Certainly the evidence I am aware of is that it is much better to talk to consumers in terms of morbidity rather than mortality, because mortality is final and they often do not care about that. But the prospect of being disabled or having prolonged hospitalisation is far more effective, far more emotive.

The Hon. SHAOQUETT MOSELMANE: Apart from funding, is there anything specific that you recommend we highlight in our report or recommendations? Is there anything specific you would like us to take on board, even just one thing?

Associate Professor PAOLONI: I think the protean nature of how alcohol is affecting society, not just in terms of health, is an enormous message that needs to come across. Alluding to what was just said I think people have a tendency to minimise and dismiss the harms of alcohol because of the social aspect of alcohol that is ingrained in our culture and I think the first message is really to get people to understand that there is a problem and there is a problem that is much bigger than they think and it is a problem we need to address as a community.

Dr FOONG: If you could word it to say alcohol is second only to tobacco in terms of a preventable cause for drug related death and hospitalisation, not heroin, cocaine or marijuana but alcohol. I think a lot of people just do not get it and I think there is a fine line between drinking socially and drinking in an out of control fashion. Most people who are drinking out of alcohol do not realise it. It just does not get to them.

CHAIR: It becomes part of the norm for them.

The Hon. HELEN WESTWOOD: I have a couple of questions relating to your submission. The brief interventions that you refer to that can be effective tools in reducing risky alcohol consumption, what are they? Could you describe some of those brief interventions please?

Associate Professor PAOLONI: Yes. There are a number of them. They are all of reasonably similar format, which is that they are generally a short series of questions, sometimes four or five, that ask things about frequency of drinking, amount of drinking, whether the person has suffered any recent harm from drinking and it is partly an awareness raising in the person. Most of them have not been shown to immediately change people's mind but in the longer term studies the people who have had them applied do seem to either reduce their drinking of their own accord or more frequently present for assistance with alcohol related problems.

The Hon. HELEN WESTWOOD: The other area was the screening and you refer to two forms of screening here, the Screening, Brief Intervention, and Referral to Treatment [SBIRT] and the audit. I am wondering are they routinely used or is it when a patient presents with certain symptoms, injuries or disease?

Associate Professor PAOLONI: They are not routinely used at the moment. If people have suspicions that this person has a chronic problem with alcohol they may well use that. Again it comes down to time.

The Hon. HELEN WESTWOOD: Are they simple tests such as blood tests?

Associate Professor PAOLONI: They are question based.

Dr FOONG: It is a validated questionnaire to look at alcohol dependence. If you are to monitor alcohol dependence in a community this is the best way to do it. They usually have five to seven questions and following on that, if we do it and we find someone dependent on alcohol, what people could do is a brief intervention which is planting the idea in their heads to change their behaviour. There have been a lot of psychological studies that have been done saying that if you are not ready to change you will not follow on to change. It is more to highlight, as Professor Paoloni mentioned, the awareness of their dependence, what are they going to do about it and empowering them by giving them a card with a phone number saying, "Call this number tomorrow."

The Hon. HELEN WESTWOOD: I am wondering whether you have addiction specialists to refer patients to. If a patient presents with a heart attack they are referred to a cardiologist and I am wondering whether addiction specialists are available in the same way that other specialists are.

Associate Professor PAOLONI: They are not available in the same number. They are available at the major hospitals in Sydney but they are much fewer in number. To some extent the management of alcohol problems, both acute and chronic, is not as much a medical disease or medical intervention as something like a heart attack. It certainly could be argued you do not necessarily need as many addiction specialists as cardiologists, for example, but certainly the current numbers are very few.

Reverend the Hon. FRED NILE: I note in your submission you say your organisation supports current evidence-based practice and treatments including the use of naltrexone. Could you comment on whether you are referring to naltrexone implants, injections, or tablets?

Dr FOONG: Basically there has been a very good comprehensive document written by the Australian Department of Health and Aging 2009 which talks about guidelines for the treatment of alcohol problems and there is a lot of level one evidence, the top evidence, for treating patients with alcohol dependence. That includes acamprosate and naltrexone. It has been shown in various randomised control trials to be effective. There is no question about how effective this could be but all of those studies conclude that without other social and community support programs the patients will relapse. The drugs are a very good thing to address craving and dependence from a physiological point of view but the psychological part needs to be addressed as well.

That would be my only addition to a large body of evidence; I support the use in conjunction with other support services.

Reverend the Hon. FRED NILE: In your evidence you used the word "intractable" alcoholics. I am wondering if they are intractable would you consider mandatory treatment of those particular individuals who cannot help themselves?

Associate Professor PAOLONI: I think that is a difficult question to answer. I think there are very few situations in which I would even consider mandatory treatment. Although people can be intractable alcoholics, as I said, that does not mean that they do not have the capability to make their own decisions. Before any mandatory step is taken you need to be confident that the person does not have the capacity to decide for themselves and that the continuation of their current behaviour, in this case alcohol ingestion, is harmful. I think the second is not hard to prove but I think the first, judging their capacity, is a much more difficult problem. My own personal experience is that very few of those patients lack the capacity to understand they just choose not to do anything about it.

Reverend the Hon. FRED NILE: You would obviously be aware of the earlier involuntary program at Nepean hospital and the new one at Royal North Shore Hospital?

Associate Professor PAOLONI: Yes.

Reverend the Hon. FRED NILE: I assume that is for people with drug addiction and alcohol addiction?

Associate Professor PAOLONI: I believe so.

Reverend the Hon. FRED NILE: Do you have a view about that: they are involuntary programs?

Associate Professor PAOLONI: I do not know sufficient about it.

Dr FOONG: Are they people who have been charged with offences?

Reverend the Hon. FRED NILE: As far as I am aware there is another program for that.

Dr FOONG: I think a lot of the mandatory programs that have been run in Canada, and I think there is a program in Queensland, are quasi mandatory in the sense that it still requires the patient to give consent. A lot of the studies that have been done on mandatory treatment show that people who are in custody are more likely to take up the offer. It makes sense because the alternative is probably not very appealing for them. You attach conditions on to it. A lot of studies would say that to have someone wanting to do it would make a program more sustainable. Then there is the whole thing about rights of a patient.

Reverend the Hon. FRED NILE: In your submission you have a significant concern about the violent aspect of drugs and alcohol that is affecting the emergency departments. What is your recommendation? We want to help make the emergency department safe for the patients and staff, what can be done?

Associate Professor PAOLONI: I think again it comes back to the questions we had before around the access to alcohol through availability and pricing.

Reverend the Hon. FRED NILE: I was referring to the actual physical impact on the staff, do you have security or funding for that?

Associate Professor PAOLONI: Hospital security is generally quite helpful. These days they are often collocated with emergency departments because that generally tends to be where the most acute situations occur. There are certain issues with training and there are certain issues around maintaining that training because there is a very high turnover. There are also issues we find not just with drug health but with mental health around the distinction between what they are willing to do to assist in cases where there is a duty of care as opposed to where there is a schedule or some other higher level order in place. A lot of that comes down to the vagaries around what constitutes duty of care and what rights and responsibilities they and the patients have under that if they detain somebody.

Dr FOONG: Education and legal support is probably helpful. Just on that point about duty of care and mental health schedules: where I work at Liverpool Hospital we are awaiting ethics approval concerning the issue about patients who present violently or with altered behaviour and how do we distinguish people who need a mental health schedule and duty of care? We need to fund education programs hospital-wide, whether it is security, nursing or medical staff, because I think a lot of them do not understand that you do not need a mental health schedule to keep someone for treatment. At the same time I would support more police enforcement as well. Police can bring in patients or people who misbehave on the street to emergency and sometimes they are just drunk and misbehaving but they overwhelm our resources and a lot of them end up getting scheduled. Then they have to stay for a psychiatrist to review that, which adds to the burden.

The second thing is that some emergency departments have already introduced what they call a zero tolerance policy which is if a potential patient is in the waiting room and endangering the safety of other patients waiting or staff they get sent out. I guess sometimes the staff, nursing or medical, are a bit worried about what their legal protection is. To have that kind of policy supported in hospital is good for an emergency department. To be able to say we are not treating you, even if they are drunk or drugged, especially for repeat offenders and know that we are protected.

Associate Professor PAOLONI: The other thing I would say to that is that when there is a violent event in an emergency department that either damages property or injures somebody there is reluctance at multiple levels to prosecute that. I think that is a big mistake. There is a certain feeling that it is acceptable or permissible or in some way can be dismissed because it happened in an emergency department, whereas if it happened 10 metres outside the emergency department there would be an assault charge. I think that where we are getting actual instances of assault and damage, and we certainly have done this where I work, we involve the police and we bring charges. I think that is a very clear message to that person that their behaviour is unacceptable and that alcohol was a direct contributor to their behaviour.

The Hon. JAN BARHAM: I will follow on from that. It is of particular interest to me. I come from Byron Bay, which is a tourism area, where we do have a big problem with late night drinking issues and presentations to the emergency department. Do you have feedback on those related issues with tourist towns or tourist areas and the impact on emergency departments, and whether or not for rural areas it is a particular problem when you have a lack of resources?

Associate Professor PAOLONI: I think anecdotally there is a lot of evidence. Again, we lack the hard evidence. We do not necessarily need to go to a rural town to experience that in the sense that I work at the Concord Hospital. Every time there is a rave party at Homebush, you know there is going to be more people coming through the door.

The Hon. JAN BARHAM: Do you keep those statistics?

Associate Professor PAOLONI: We keep some statistics on that. It is a little bit difficult because each music festival draws a different audience, so you do find a lot of variability. But certainly there is an escalation in drug and alcohol presentations on those days, and we do get our triage nurses to document that they did come from the music event.

The Hon. JAN BARHAM: I have had experience with festivals and post-event assessment where the police and the hospital come together. You start collating those figures to see the presentations, then the charges, and the impact. Our hope has been to try and get more funds available to deal with what are commercial events that the public purse is paying for. Local people know to stay away from the hospital that night and they put their own lives or their children's lives at risk. Is there an idea that there should be some separate place that those people go to, rather than to an emergency department?

Associate Professor PAOLONI: Under the Inebriates Act as it exists at the moment, there are designated places where people who are alcohol affected but are not otherwise unwell can be taken basically to sober up. I think there is still a role for that. At the moment the emergency departments end up subserving that role because of the lack of other places for the police, usually, to take those people. I think there is a role for those places. I think they could certainly manage a significant number of people who currently come to emergency departments.

Dr FOONG: Often we find that the police actually bring the intoxicated people to emergency departments anyway, just to medically clear them, before they put them in jail. That adds to our workload. I

know from speaking to colleagues in the United Kingdom that actually there is a separate forensic doctor that has that role in the police system in the United Kingdom. I do not know whether it is applicable here, but basically I suggest planning ahead when there is an event. I do not have to go to Byron Bay to see that. I used to work at the Sydney Hospital where any event in the Domain I would see people there. During ours, they sometimes had first-aid tents that involve nurses and doctors, who get sent out there to kind of triage the drunks in a way. People who are really drug intoxicated or alcohol intoxicated, they get brought into hospital. But to have some sort of front triage system in these events would be very helpful.

The Hon. JAN BARHAM: Most of them do, I think. The impact is upon you and my other point of interest is for young people. Is it just anecdotal, or do you think this binge-drinking culture and the way that things are happening with young people is an increasing problem that is not being addressed?

Dr FOONG: Definitely.

The Hon. JAN BARHAM: Yes?

Dr FOONG: Yes. Again, from working in the Sydney Hospital, you see people who are 14 or 15 coming in on a bus, without their parents' knowledge or without their consent. They are coming in and they get drunk. I see younger people, especially women, who seem to get really intoxicated and either get their wallet stolen or something along those lines. It seems like they come out in a group but then, as soon as they get really drunk, their friends just put them in an ambulance and send to the hospital because it is too hard. They want to party on, or whatever it is. Again perhaps it reflects a larger social structure that is perhaps disintegrating. But I think people who go out in groups, they inevitably get just dumped in an ambulance and get brought to the emergency department, where again we need to let them sober up. We cannot assess the situation, the way it happens. If you do not have any history, you cannot just discharge someone in case they have a head injury or other things that complicate matters. So I do not what could be done about it, but it is definitely happening, especially on weekends and evenings.

Associate Professor PAOLONI: Relating to the age issue, I think we are seeing—and many people have commented on this—alcohol advertising targeting young people and the new products coming onto the market are specifically targeting young people. If that is where the commercial interest is, then that is the commercial population they are aiming at because that is where they see they are going to make their money. I think it is probably a good lead for us that there is an issue, a susceptibility, there.

The Hon. JAN BARHAM: Thank you. That is helpful.

The Hon. HELEN WESTWOOD: On the question of violence and its impact upon emergency departments, do you keep data on violence incidents either against healthcare professionals or other people in the waiting areas?

Associate Professor PAOLONI: There is data kept on those things mainly through our incident management systems. The issue is not so much around when actual incidents occurred, but the near miss incidents are probably not nearly as well recorded or the amount of time that people may take to de-escalate a situation and therefore avoid an incident. We do have information on actual incidents. We probably have under-reporting of near miss incidents, and we have no reporting of de-escalated incidents.

Dr FOONG: They usually reflect the more severe end of the spectrum where someone got hit, but lots of verbal abuse occurs, and threats. How do you quantify that? You cannot.

The Hon. JAN BARHAM: Is that publicly available? Is there somewhere where it is published?

Associate Professor PAOLONI: That incident monitoring system goes back to NSW Health.

CHAIR: And they will be appearing before us soon. Thank you, Dr Foong and Associate Professor Richard Paoloni. I admire you for working within your system of medicine—that is for sure. You are the first people we look at when someone happens to be at the other end. Hopefully, we will not need you in the near future or perhaps never, but we are happy to know that you are there. Thank you so much for appearing before the inquiry.

Dr FOONG: Thank you very much.

Associate Professor PAOLONI: Thank you.

(The witnesses withdrew)

(Luncheon adjournment)

JOHN SAUNDERS, Drug and Alcohol Program Director, Wesley Hospital Kogarah, sworn and examined:

CHAIR: Good afternoon. Welcome to this afternoon's session of the third day of public hearings for the General Purpose Standing Committee No. 2 inquiry into drug and alcohol treatment. I specifically welcome you, Professor Saunders, representing Wesley Hospital Kogarah. In what capacity are you appearing before the inquiry?

Professor SAUNDERS: I am a physician and an academic. I work at the Wesley Hospital Kogarah and I am representing Wesley Mission, and more specifically the Wesley hospitals.

CHAIR: Do you wish to make an opening statement?

Professor SAUNDERS: Thank you for the opportunity to do so. I draw the attention of members to a brief biography, which I have made available for distribution, and a two-page document containing notes for the inquiry, which expands on some of the brief points I will make.

CHAIR: Thank you.

Professor SAUNDERS: First, I draw the attention of the Committee to developments in our understanding of the nature of substance dependence and addiction over the past 20 years. Many people regard these conditions as self-inflicted disorders and no more than that. That is quite wrong. What we see in people who have dependencies and addictions is a profound resetting of neurochemical pathways in the brain that result in what I describe as a driving force that directs their use of the substance. It is certainly true that when someone starts using a particular substance, be it alcohol or a drug, it is under their voluntary control initially. However, things change. I urge the Committee in its deliberations to be mindful that the neurobiology of dependence is now well recognised and well established and that a lot of the important modern treatments are based on that. It is also important that family members and the community understand the nature of substance dependence more than they do at the moment.

Secondly, the understanding and the contract between a person with one of these disorders and the healthcare system is a little bit different. If you are a patient and you go to see a doctor, what do you want? You want a diagnosis and a quick fix—some treatment—and the doctor and the healthcare system want the same. However, a person with a substance dependence or an addiction may have considerable unstated or hidden agendas when going into the healthcare system because of the driving force of their addiction. Therefore, there can be aberrant behaviours and demand for drugs that are regarded as inappropriate. Also, because of the very powerful and essentially subconscious nature of this driving force of addiction often a person needs to be on a journey of recovery. It is not a case of going to a treatment service and accepting the treatment that is available, doing well and everything being fine. It is a journey because one of the effects of addiction from the neurobiological driving force point of view is that people are constantly shuttling back and forth in their minds in the early stages between wanting to do something about it themselves and recovering and having an almost magnetic attraction to the substance.

I turn to point three. Another important development in the past 20 years has been the concept and development of technologies for intervening at the early stage. These are well developed. I am talking about brief interventions that are now well established in helping people involved in hazardous substance use to turn away from a continuing pattern of hazardous use, developing a dependence and instead modifying their consumption at an early stage. I urge the Committee in its deliberations to be mindful of the range of evidence of brief interventions being effective in reducing hazardous alcohol consumption, amphetamine use and cannabis use, including the ability of some of these interventions to help people abstain from these substances.

Finally—and it may be not be appropriate for me to make such a comment—I ask in your work as parliamentarians and given your broader influence that whenever you consider a piece of legislation you think of it in terms of whether it is for the public good, for the public benefit and for the good of public health. As an example, I draw members' attention to European pro-competition legislation and legislation dealing with free trade agreements and harmonisation. Obviously such legislation has commercial benefits. However, in some countries harmonisation legislation in response to Europe-wide laws has resulted in their having to abandon controls on alcohol and other substances because they are no longer valid in the European Community. For example, Finland, which has traditionally had a relatively low rate of alcohol-related problems, has seen a four-fold increase in alcohol consumption and problems, including violence, since joining the European Union. Of

course, that is an example from the another part of the world, but I urge members to think of the public good and public health even when considering legislation that may not seem directly relevant.

CHAIR: Your biography indicates that you have qualifications in pharmacology and medicine from the University of Cambridge, you specialised in addiction medicine and other forms of medicine in the United Kingdom, you have worked for the World Health Organization, you have published four books, including a book on addiction medicine and one dealing with young people and alcohol, and you have been involved in more than 300 peer reviewed scientific papers, reviews and book chapters. You are obviously very highly qualified in this area. Many addiction medical practitioners refer to our having a gold-standard methadone treatment program. However, the community seems to be frustrated that people appear to be happy to be on that medication for up to 20 years or more. People feel that we need more in our armoury.

We have oral, intramuscular and now implantable naltrexone. Unfortunately because the pharmaceutical industry does not make a huge profit out of naltrexone not many level one studies have been done to provide the relevant epidemiological evidence. Would you support a multi-centre, level one trial of a Therapeutic Goods Administration approved form of longer acting naltrexone for improved patient compliance? Would you see that as a benefit in dealing with drug dependency? It could include alcohol dependency in the future. Would that increase the armoury of pharmacological treatments?

Professor SAUNDERS: The straightforward answer to that question is yes. I can give you a little bit of background because just over 10 years ago I established a randomised controlled trial comparing naltrexone in tablet form, not the implant form, with methadone. This has been reported and it has been presented at professional societies. The results of that trial—please remember that it was with naltrexone tablets—were that most people who were taking the tablets ceased treatment. They entered treatment with considerable enthusiasm but they found it hard. People who were assigned to methadone were far more likely to be retained in treatment and with retention in treatment comes a reduction in morbidity and mortality of approximately 75 per cent, a reduction in injecting drug use of 90 per cent if people are on methadone, morbidity and mortality down 75 per cent and criminal activities down 75 per cent.

For a group of patients with heroin dependence or other similar opiate dependence as a whole at any one time, my conclusion is that there is more to be gained by methadone or buprenorphine treatment than there is with naltrexone. However, the preparation of an implant takes naltrexone technology a step further, so I think that a multi-centre trial directly comparing a naltrexone implant with what would be regarded now as conventional treatments, which would be methadone or buprenorphine, is something I would strongly support. That would take our understanding and knowledge a considerable step forward. It would also hopefully give us information about for which types of patient a naltrexone implant would be best and be preferred and, correspondingly, for which types of patient methadone or a similar agonist treatment would be preferred. That would be an important study of international significance.

The Hon. JENNIFER GARDINER: Following up that question about a trial of that nature, you say in the Wesley Hospital submission that promising medications and also therapies should be evaluated by controlled studies and that funding should be made available for this option. Who do you think should provide funding?

Professor SAUNDERS: The most important of all funding bodies in Australia is the National Health and Medical Research Council [NH&MRC] and you will be familiar with the fact that they supported Professor Gary Hulse and his colleagues for a controlled trial of naltrexone implants versus naltrexone tablets, which showed a significantly better outcome in those people who were assigned implants. I think there is always a level of political correctness, if I may say so, among some of the funding bodies and there are some people who have certain views and who have very considerable influence. Personally I would prefer a kind of mixed funding arrangement whereby perhaps the State Government would announce a tender for conducting such a randomised controlled trial. Indeed, in another area of work, which is brief intervention, I received substantial funding which would be equivalent to about $300,000 to $400,000 a year for about 10 years from what was then the New South Wales Drug Offensive Council. That was of tremendous value particularly for the subsequent work on brief and electronic interventions. We would not have had that opportunity had we been reliant on NH&MRC funding only. So I would suggest some direct funding using the mechanism of a scientific advisory group to appraise the proposals and I think you could be rewarded by some world-leading research.

The Hon. JENNIFER GARDINER: How do you think that fits into the priorities for the New South Wales Government in budgeting for alcohol and drug services in general?

Professor SAUNDERS: I would see it is an important and necessary percentage of the total budget that is allocated for drug and alcohol services which is for research and development. This is a very important question and it is very practically important because it could result in the translation into treatment relatively quickly, obviously depending on the findings. So in the spirit that organisations which provide services in the commercial world allocate a percentage for research and development, I personally would advocate for a percentage of the total drug and alcohol budget in New South Wales to be allocated likewise for research and development. I would not say that for most areas of research endeavour because I think there are opportunities through NH&MRC and some other funding bodies but because of the importance of this and because there was a lot of difficulty in having NH&MRC fund studies on naltrexone in the first instance I would prefer a kind of separate funding line, or at least that would be my recommendation.

The Hon. JENNIFER GARDINER: You have expertise in the area of brief intervention both in health-care settings and also through websites. Would you care to expand on that for the Committee?

Professor SAUNDERS: Brief intervention is, as described, a form of brief therapy which is structured, typically lasts for five or 10 minutes and is made available for somebody who has what we call risky or hazardous substance use. They have not yet developed a dependence but they are on their way potentially to developing a dependence. They may be experiencing some harm. Typically they tend to be at a younger age than some of the people who have an established dependence. It starts off with some simple questions or a screening instrument. I mentioned the AUDIT questionnaire, which is a simple 10-item screening instrument which can be given to people attending a general practice, a hospital outpatient clinic or in community screening in shopping centres. When the person is identified as having hazardous substance use, a brief intervention for alcohol has substantial benefits, cigarette smoking likewise, cannabis to some extent, and also amphetamines. It does not seem to work as a primary treatment for people who are using heroin in a hazardous way, but for the other substances there is evidence of benefit.

These days, with a lot of young people who are very electronically savvy, we have taken up what we anticipated was an opportunity and with a colleague of mine, Associate Professor Kypri, based at the University of Newcastle, have developed electronic brief interventions which are available in computer-presented form and on websites. For example, as a test of effectiveness, students in universities in Australia and separately in New Zealand have undergone screening, with a high response rate, and we have demonstrated that those students who get personalised feedback as a result of completing an electronic questionnaire do significantly better in terms of reduced alcohol consumption, reduced problems and better academic performance than those who are assigned to what we call the control group and who do not have any intervention. So, particularly in these electronic days when paper is regarded as rather passé by young people, there is considerable opportunity for scaling up the availability and delivery of these brief interventions particularly in electronic forms. I would be very happy to provide any further information including results of the studies and papers of those studies as the Committee wishes.

CHAIR: We would like you to provide that to the Committee so it can be circulated to members.

The Hon. JAN BARHAM: Does that include any website addresses?

Professor SAUNDERS: Yes. In terms of websites the materials that I developed a number of years ago are available on the University of Sydney website if you look at the section on "Drinkless".

The Hon. SHAOQUETT MOSELMANE: The third dot point in your submission's summary says that patients at Wesley Hospital are reporting a lack of access to post-hospitalisation rehabilitation services. What do you mean? Can you elaborate on that?

Professor SAUNDERS: The Wesley hospitals provide a detoxification and treatment program which typically lasts for about three weeks. Many people because of the extent of their dependence and I suppose the disintegration of many aspects of their life require more prolonged rehabilitation. There is a difficulty in ensuring rehabilitation for a number of reasons. One reason is that there is often a considerable gap between the patient expressing willingness to go into a rehabilitation program and that program or any program being able to accept them. Secondly, there is a philosophy or a policy on the part of some rehabilitation programs that they do not accept people on certain medications. They may not accept people on antidepressant medications or mood stabilisers, which are very important for the treatment of what we call comorbid mental health disorders.

The Hon. SHAOQUETT MOSELMANE: How do you overcome this?

Professor SAUNDERS: We find a rehabilitation program which will accept them. We often try to exercise choice and we also speak to the intake coordinators at the rehabilitation programs to see whether they have any particular concerns that a particular medication might be addictive. For example, many rehabilitation programs refuse to take people on naltrexone. I find that bizarre because naltrexone is absolutely not an addictive drug, it is the very opposite. Even having spoken to some of the rehabilitation programs I do not understand why they will not accept people on naltrexone. It may be that they do not have convenient access to a medical practitioner. I think in some cases that is the case. There are also difficulties with people who have been on methadone or buprenorphine maintenance and who wish to move on from that sort of treatment to a treatment which is abstinence orientated, including naltrexone. Most rehabilitation programs will not accept people who are on opioid agonist maintenance. There are some exceptions. We Help Ourselves has a methadone-to-abstinence program but most rehabilitation programs will not. Again, I can understand perhaps the concerns that maybe the program is not well suited to dispense methadone or buprenorphine; there may be diversion to other people within the program. But it is a real lack.

The third area that I would like to mention are people who have comorbid psychiatric disorders and who often are not accepted by rehabilitation programs. More people with substance dependence have comorbid psychiatric disorders these days than was the case 20 or 30 years ago. Indeed, having a psychiatric disorder 20 or 30 years ago almost provided some kind of protection against developing a substance dependence; but that is certainly not the case now. People with psychiatric disorders are between two and 10 times more susceptible to developing a substance dependence than a person in the general community.

So there are a number of blocks to ongoing rehabilitation. One would also say that some people express an interest in rehabilitation, but then have not readied themselves. So they express an interest and then tend to pull back. That of course reflects the shuttling back and forth in their mind between wanting to move forward and having this fatal attraction for a drug. So I am not saying it is purely a problem with the number of rehabilitation programs or their particular policies, although I think there should be an expansion in them; it is also an issue of people perhaps vacillating.

Could I mention one other problem, which is probably a little bit tangential? In my career, which extends back30 years in Australia, I have seen a considerable reduction in public hospital rehabilitation programs— programs which used to be able to have people in for two weeks, four weeks, six weeks, sometimes eight weeks, as compared with the non-government rehabilitation programs which are often three, six or 12 months. These public sector treatment and rehabilitation programs have essentially been closed down by area health services, largely on budgetary grounds. Whereas 20 years ago the Langton Clinic in South Dowling Street had 44 inpatient beds, as of about 12 years ago it had none.

Inpatient rehabilitation programs and detoxification programs also importantly act as a capture mechanism for people. People are shuttling backwards and forwards; they are vacillating; they do not know whether to go into a treatment program or not. A public sector detoxification unit is an excellent way not only of providing safe and effective detoxification but also of engaging people who may be thinking but are not yet fully committed. You can help nudge them on in their thinking to engage more fully in treatment through such a mechanism. That essentially is virtually inaccessible in New South Wales these days.

The Hon. SHAOQUETT MOSELMANE: Professor, given your background, I am sure you could give us a thesis on these issues, but I have one more question before I must pass on to my colleague. We are dealing with drug and alcohol treatment, and we have heard that a significant amount of money is going into mental health, and that there is a significant problem in terms of drugs and tobacco. But the biggest problem in New South Wales, and it is Australia wide, is alcohol.

Professor SAUNDERS: Yes.

The Hon. SHAOQUETT MOSELMANE: Yet we have been focusing very little on alcohol. What would you ask that this Committee recommend in its final report with regard to alcohol?

Professor SAUNDERS: The clearest evidence for benefit from policies and programs is to reduce overall alcohol consumption. Of course, that raises real problems because of the commercial value of alcohol in terms of commercial profits and tax income. So it is something that most governments have not, in the modern world, been willing to grapple with. I would suggest an approach whereby negotiations with alcohol producers

could assure them of a certain level of profit but that overall alcohol consumption would be reduced. This is what was achieved in Scandinavian countries. I note that one of the Committee's terms of reference is to examine what happens in other countries, and Sweden was noted. Many countries in Scandinavia and also Finland had a State alcohol monopoly. Now, I am not suggesting that we have that. But the principle was that it was relatively difficult to access alcohol, and strong alcohol in terms of wine and spirits was relatively expensive, beer less so. No advertising of alcoholic drinks was allowed. The alcohol companies that operated in those countries made considerable profits, and they and their shareholders were very happy.

It seems to me that there could be an exploration of making a disconnect between turnover and profit. If you look at utilities like water companies, they have a high profit margin, and water companies obviously have a public health responsibility in providing clean water. So I have come to the conclusion in recent years—and it may be a pipedream—that if we could make a disconnect between turnover and profit, and work with alcohol companies to guarantee them a certain level of profit, like water companies, then they may become part of the answer, as well as being part of the problem.

The Hon. JAN BARHAM: It is an interesting approach that we should support profitmaking but not responsibility for the public health problem.

Professor SAUNDERS: They certainly do have a responsibility. But the reality is that for every expression of responsibility there are probably 10 times as many commercially driven initiatives; and the sum total is that alcohol has become more readily available; and binge drinking, particularly in young people, has become almost the norm. Now, that is a real change in modern society. Advertising and alcohol companies do have some responsibility for that.

The Hon. JAN BARHAM: Forcing them to take that responsibility is the difficulty.

Professor SAUNDERS: Forcing them to take that responsibility indeed. But they have really clever ways, on the one hand, of accepting some level of responsibility, but on the other hand also promoting their products on the basis of freedom of choice, the commercial market and employing people in effect.

The Hon. JAN BARHAM: Yes, it is a big problem, and I appreciate your commenting on the young people issue. I have a real interest in that. I keep coming across problems with the lack of residential facilities being available in New South Wales specifically for young people. The assumption is that if the young are having difficulties and we deal with them by providing support for them, hopefully they will not carry those difficulties through life.

Professor SAUNDERS: Yes.

The Hon. JAN BARHAM: Can you give the Committee any specific information about access to services for young people?

Professor SAUNDERS: Yes. I mentioned earlier the preventive approach of brief interventions, including electronic brief interventions through website, mobile phones and the like. An advantage of that is that the word gets out into whole groups and populations of young people that this is something that they can properly be rather concerned about; it is information for them.

Young people's rehabilitation programs have difficulty, because the type of rehabilitation that is required tends to take a long period of time. Often you are looking at young people who have learning difficulties; some have dyslexia, some have attention deficit, hyperactivity disorder, or ADHD, or other comorbid mental health disorders. Often they are in trouble with the law, or they have very unsettled living arrangements or family arrangements.

For such a young person, who often has multiple problems, a relatively lengthy rehabilitation program is necessary. But to commit a year of your life at aged 17 or 18 years sounds an eternity for a young person. Yet the benefits can be huge. Earlier this week I saw a young woman who had got into some difficulties with alcohol recently. She had had a very difficult upbringing, but she went to a Christian rehabilitation program specifically for young people for a year, and said it had literally transformed her life. Having been in all sorts of trouble, she then proceeded to get a university degree, and is now in a significant job and married. So I would certainly endorse the availability of programs for young people. But they are not easy to establish and maintain. One of

the difficulties is that young people do not see so much the benefit; they are more concerned with what they are going to be doing in the next week or in the next month.

The Hon. JAN BARHAM: You also mentioned the ability to access these services, and you referred to the limitations as being the private nature of them and the lack of private health cover to be able to access services.

Professor SAUNDERS: Yes. Obviously we have a substantial number of young people who come into the two Wesley hospitals, and that reflects the fact that nearly 50 per cent of the population has private health insurance. However, the rehabilitation programs that tend to be of most benefit to young people tend to be ones which are provided by non-government organisations, and they tend to be ones which run for six to 12 months. There are quite a number of rehabilitation programs for young people. There needs to be some expansion in the number of rehabilitation programs for young people.

The difficulty is also post rehabilitation continuing care, to help people capitalise on what they have learnt and gained in the rehabilitation program. So, for some young people, it is not just a journey; it is almost an odyssey. Certainly an expansion of six to 12 months in non-government organisation rehabilitation programs would be very helpful. But I would also ask you to consider trying to help young people in a continuing way, maybe through having a range of social clubs which are not drug and alcohol involved, which are linked to some of the rehabilitation programs. Some rehabilitation programs have alumni or graduate organisations. I think that long-term involvement is particularly important.

Reverend the Hon. FRED NILE: At page 6 of your submission you comment about the controversy about the role of maintenance treatments, including methadone, versus treatments that have abstinence from all opioid drugs as their objective, and then you refer to naltrexone in the latter category. At page 7 of your submission you say that you would entirely agree that promising medications and also therapy should be evaluated by controlled studies, and that funding should be made available for this option; and you say that this would include not only naltrexone but other medications. So would you be supportive of a trial of naltrexone, particularly of naltrexone implants?

Professor SAUNDERS: I certainly would be supportive of a trial of naltrexone implants, particularly if the comparison group was on agonist maintenance with methadone or buprenorphine because then you would get what we call a head-to-head comparison. From the work that I did earlier on, the best results were seen in people who were taking naltrexone tablets and committed themselves to taking naltrexone tablets – in terms of total continuous abstinence from heroin and other opioid drugs. The problem was that they were in a minority because it was tough work taking naltrexone tablets and maintaining abstinence. Therefore, the implant gives us a technology which recognises more the journey that people have to go on, because the current implants will be effective for approximately six months.

So, yes, I certainly support that and it would certainly be very much in the principle of producing the evidence base and for practice to be evidence-based rather than not. So, yes, if that was a recommendation from the Committee, particularly with a comparison with methadone or buprenorphine, I would be very happy with that. I should also say that I do not have an interest in that my research now is really through other people rather than my being a primary researcher. I do not want you to think that in giving this advice there is any kind of potential conflict of interest on my part.

Reverend the Hon. FRED NILE: That was going to be my next question. Would your organisation be able to take part in the trial, because if we do recommend it the next question will be: Who will do it?

Professor SAUNDERS: There are in New South Wales some very good researchers in the drug and alcohol field, and I will certainly be able to suggest people who are primary researchers and also clinical researchers whom I know well—some are close colleagues of mine. I would therefore suggest that there is an availability of skill and expertise for conducting such a trial in New South Wales. I think that it would be important to have a scientific advisory committee reporting to, appropriately, this Committee with an appropriate reporting line to Parliament and that it is sent out for competitive tender and that the scientific review process is an open and transparent one and that the research group who have demonstrated the best capability of undertaking such a trial—which would be quite complex—would be awarded the funding.

Reverend the Hon. FRED NILE: Thank you. That is very positive. In your submission on page 8 you refer to one of our terms of reference of mandatory treatment and you comment on the two systems, one through

the criminal justice system, which we are aware of and that is working effectively. You say, "The real gap in knowledge is the effectiveness of mandatory treatment for those who have not committed any offence." Have you any thoughts about mandatory treatment for those in that category, such as happened at Nepean Hospital and now is happening at Royal North Shore Hospital?

Professor SAUNDERS: There was a trial under the Drug and Alcohol Treatment Act 2007 at Nepean Hospital, which was regarded as successful, although having spoken to some of the key staff at Nepean Hospital they expressed concern about the lack of uptake of continuing treatment or aftercare of the people who were in that trial program. As you say, it is no longer taking place at Nepean but at Royal North Shore Hospital and at Bloomfield Hospital, Orange. I have had one patient committed for compulsory treatment under the new system. He was released—perhaps I should not say any more than that for issues of medical confidentiality. In the years the Inebriates Act was operating—as you will appreciate, it has been suspended since last September—about 20 patients who I have seen would have been committed for compulsory treatment, either by me or on my recommendation.

My experience of the Inebriates Act was that it provided an opportunity for people with the most severe forms of substance dependence, often with comorbid medical disorders, psychiatric disorders and also comorbid brain damage or consequent brain damage, to have guaranteed abstinence from alcohol and other drugs for a prolonged period of time, which I saw in individual patients caused considerable improvements in their health and wellbeing. Some people, at the end of a year's treatment under the old Inebriates Act, were really quite transformed. The important thing though was continuation of treatment, and that was where the old Inebriates Act rather fell down, because there was no ready way of continued partly mandated or coerced treatment and so there was a significant relapse rate unless people went into a family situation or supported accommodation.

With regard to the current Act, it provides treatment initially for one month on a compulsory basis and it can be extended, as you will appreciate, for two more periods—so a maximum of three months. That does strike me as being a rather short period of time for many people because some forms of brain damage and the mental disorders require prolonged abstinence from the substance for people to experience significant recovery. It is not something that can be achieved in a month.

The old Inebriates Act was criticised because it was considered to be an affront to people's human rights because of its compulsory and coercive nature. My approach was that people in this situation—certainly that I saw—had virtually no human rights because of the desperate state of their addiction and their brain damage and mental and physical disorders. So to me the Inebriates Act provided benefit rather than being an affront to human rights. This is a very tricky issue and I am glad that I do not have to make any decisions—I can advise but am not in a decision-making capacity. But I would urge you to consider whether the present Act has a sufficient length of time for compulsory treatment and also whether some aspects of the Inebriates Act, like people self-committing or entering into a recognisance to abstain from psychoactive substances, might also be incorporated into the more modern Act. I think that it is helpful but I think the present Act could be much more helpful to a greater number of people for a greater length of time than it is at the moment.

CHAIR: Thank you, Professor Saunders, for your expertise. You have provided very valuable insight. We would appreciate the further information you made mention of being passed on to the Committee. Please convey our appreciation to Wesley Mission for the time you have taken.

(The witness withdrew)

CHRISTOPHER MILES, Principal Legal Officer, Legal Services Unit, Department of Education and Communities,

BRYAN SMYTH KING, Executive Director, Learning and Engagement, Department of Education and Communities, and

ROBYN BALE, Acting Director, Student Engagement and Interagency Partnership, Department of Education and Communities, sworn and examined:

ELIZABETH CALLISTER, Leader, Health and Wellbeing, Department of Education and Communities, affirmed and examined:

CHAIR: Welcome to the third day of public hearings of the inquiry into drug and alcohol treatment by General Purpose Standing Committee No. 2. Could you introduce yourselves and tell us in what capacity you are appearing in front of the inquiry?

Mr MILES: I will not be doing most of this presentation but I am here to advise the Committee in respect of particular legal aspects in relation to the matters at issue and advise the officers of the department on matters.

Mr SMYTH KING: I am the Executive Director of Learning and Engagement within the Department of Education and Communities. It is a new position. It was created at the end of last year and it has been substantively filled since probably mid-January onwards. It is an area of the department that embraces Aboriginal education, student wellbeing, student welfare and disability services. I am here today to represent the department in terms of leading the presentation.

Ms BALE: I have responsibility for a range of programs around student engagement and I work with other agencies, particularly in the area of health and wellbeing, child protection, school counselling services and social inclusion.

Ms CALLISTER: I am the leader of health and wellbeing and I report to Ms Bale as part of that area of responsibility. I look at a range of health and wellbeing issues within the department.

CHAIR: There is an opportunity for you to provide an introductory statement. We probably would find that useful because we have not got a submission in front of us. Perhaps, Mr Smyth King, would you be able to do that?

Mr SMYTH KING: Yes, I am very happy to do that. I would like to take the opportunity to thank you for the opportunity to speak with the Committee on behalf of the public schools portfolio within the New South Wales department. We will be really speaking from the aspect of public schools within New South Wales. The core business of the Department of Education and Communities is teaching and learning. This is regulated and facilitated through the New South Wales Board of Studies curriculum K-12. On any one day more than 60,000 teachers use the curriculum of New South Wales schools to provide learning opportunities for more than 740,000 students across more than 2,230 public schools. At some time in their schooling up to one in four students will require additional support during their educational provision. To this end, the department is strongly focused on the quality of the teaching and learning and the social outcomes of students in our public schools.

In 2012 the New South Wales Government initiated significant work in education to strengthen and focus teachers and schools to be better positioned to respond to the diverse and individual learning and support needs of students. This work is focusing on student learning outcomes, educational engagement for every student, and student completion of year 12 or its equivalent. This is being achieved through local decision-making and class teachers personalising learning and support for students who need it. You will appreciate that the nature of support needed for each student varies. For some students support will be related to wellbeing factors or health needs, for others it will be disability, or it will be generated by the diverse cultural or community experiences that they bring to school. These interrelated needs are most effectively addressed at the classroom and school level.

The teaching and learning programs that take place every day in schools directly engage learners in acquiring knowledge, information, lifelong capability and the foundations for informed decision-making, resilience and effective community engagement. Beyond the core learning of literacy and numeracy, the New South Wales curriculum K-12 provides a broad and comprehensive evidence base matrix of learning experiences for students. The New South Wales personal development, health and physical education curriculum provides young people with the opportunity to develop knowledge and understanding of a broad range of health issues that are likely to impact on the health and wellbeing of themselves and on others. This includes drug and alcohol education.

In primary schools, through the curriculum, students learn about different types of medications, their safe usage and storage. They also learn about the effects of alcohol and tobacco on the individual and in the community. In secondary schools students learn about the personal effects and social, legal and economic consequences of drug use, the prevalence patterns of influence of use, binge drinking and the marketing strategies and media influences associated with tobacco and alcohol. In years 11 and 12 public school students in New South Wales are involved in a mandatory 25-hour personal development and health education course known as Crossroads. In this course students explore contemporary drug and alcohol related issues in the community. They learn about the impact of these issues on the individual, the school, the local community and the wider community. Crossroads extends the personal development, health and physical education learning experiences that students access in years 7 to 10.

At a national level and State level a wealth of specific resources and programs have been developed over many years to support the professional learning of teachers and complement the curriculum and teaching and learning of drug education and alcohol education in our schools. I wish to tender to the members of the Committee samples of materials from the department's website. These are developed in collaboration with a wide range of experts from outside school education specifically. I will leave these here, which will give people an idea of the breadth and width of what we are providing.

In addition to the curriculum and the teaching and learning process, schools play an important role in implementing strategies to: promote a safe and a supportive school environment and a sense of belonging and achievement; support transition, for example for students moving from primary to secondary school; build positive social behaviours; and develop skills in communication, problem solving and dealing with conflict and stress. These interrelated elements of schooling are being strongly captured in the department's approach to personalising learning and support for students. We monitor closely the trends and patterns of school engagement and attendance. We also monitor closely school completion rates for year 12 or its equivalent. We know that school attendance is an important indicator for engagement in school completion.

Within schools there are a range of specialist positions to support the individual needs of students and the daily work of their teachers. These positions include over 1,900 learning and support teacher positions, 790 school counsellor positions, 135 home school liaison officer positions, and 50 student support officer positions working in high-needs schools. In addition to this range of resource and support in schools, we have an extensive range of support beyond the school. We have more than 244 specialist learning and engagement positions supporting the day-to-day work of schools across New South Wales and, in addition to that, their connections with other government and non-government specialist service providers.

In relation to drugs specifically, the information gathered through the triennial Australian School Students Alcohol and Drug Survey, known as ASSAD, assists government and non-government agencies including education jurisdictions to respond to the trends and patterns of school-aged people's drug use. The survey was last carried out in 2011 using a self-administered survey questionnaire involving a stratified sample of nearly 25,000 students aged 12 to 17 years of age who attended both government and non-government schools nationally. This was the tenth survey in a series that commenced in 1984. It includes questions on the use of tobacco and alcohol, over the counter and illicit substances. I am advised that this survey indicates that Australian second secondary school students do not use illicit drugs in the main. The survey also indicates that drug use rates among this group were either stable or decreasing for illicit drug use when compared to the 2008 survey.

When a school is concerned that a student may have a drug use problem, the principal, the teacher, the school counsellor and other staff such as the welfare coordinator or local service providers can facilitate for the student and their family access to a further range of specialist services. At the direction of the principal, the school counsellor can complement and extend drug education that take places in the classroom through the provision of counselling assistance to students, advice to teachers and the involvement of professional learning

activities for students, teachers and parents. Local police, including the school police liaison officer, may also support and advise. The department safety and security directorate is able to provide guidance and support to principals in working with the police. This complements a wide range of localised multi-agency interventions where local police often take the lead.

For a number of years now the department has worked in collaboration with a range of health and other experts to develop a broad range of specific resources for drug education. These have been welcomed and widely used by schools in educating young people about drug-related issues. The department's more recent focus on skilling teachers and schools in collaboration with students and their parents to personalise learning and support will see more students being engaged and retained in school education. Students will develop a broad range of skills, knowledge and attitudes and behaviours that will well place them to make effective life decisions and choices in regard to their personal health, wellbeing and contributions to the broader community.

CHAIR: Some of the organisations, mainly public health organisations and representatives from drug and alcohol treatment services, have more or less given us the impression in their submissions that they regard current educational services as being ineffective. It has been rather disturbing for us to read this position statement that comes up continually from these professional bodies. I am not saying all of them, but a great majority of them. Can I ask you, because you have outlined your educational programs relating to drug and alcohol usage that you impart to school students at various stages in their educational cycle, has there been any evidence-based evaluation of the success of the educational services in regards to drug and alcohol and smoking and other health issues? On what are you basing your successful outcomes?

Ms CALLISTER: There have been a number of analyses by quite significant researchers on the effectiveness of school-based drug education. The outcomes of those do vary. On the whole they would suggest that while some can have positive outcomes others are less effective. The literature reviews have come up with a number of areas where they would suggest if you are going to be effective in providing this sort of education there are certain things that need to be incorporated in that. For example, one of them might be you cannot just give information; you need a much more interactive approach, you need to be providing opportunity for students to have discussions.

That sort of background research was actually incorporated in some material published, which is on our website, by the National Drug Strategy by the Commonwealth where they pulled together a set of principles about what should be in place for effective drug education. I think all of the efforts that we have made as a department in terms of the nature of the resources that have been produced and the resources by the Commonwealth as well have focused on being consistent with those sets of principles that were research based and agreed to by a broad range of researchers in Australia and were based on a very broad review of the research.

CHAIR: Given that there is a lot social concern about young people and binge drinking, in terms of the K-12 curriculum and the research that you just outlined, do you believe that the message is being tailored to young Australians at various stages given what we currently know about their alcohol usage? During the late stages of high school and once they leave high school what they will encounter, what we know the social outcomes are at the moment with their amount of alcohol consumption, their exposure to illicit drugs and polydrug usage, do you think we are keeping up with how we need to prepare young people for the temptations that are going to be around them? Do you think we are doing it adequately? Are we keeping up to date with those changing social environments that they are going to encounter?

Mr SMYTH KING: I think very clearly that the reference I made earlier to personalised learning and support is probably very critical to the issues that you are raising now in terms of making sure that we bespoke the learning experiences for individuals within our schools to maximum effect so that they can leave school with a body of knowledge and understanding but also a resilience to make decisions and life choices that are going to be beneficial to them rather than being detrimental to them. I guess in the past we have spent a great deal of our resource developing materials and, as Ms Callister outlined, they are valuable but they are limited in terms of what you can engage a young person in. I think we have to focus as we move forward into building the capabilities of individuals and the decisions that they make for themselves and those around them that are going to stand them in better stead for when they leave school and move into the broader adult communities.

CHAIR: Student mentors, community mentors, past students, is there any research into the interaction of bringing mentors within their own circles and immediate past student leaders in to discuss with students what they are going to encounter and how they should build up their own resilience?

Mr SMYTH KING: It is beneficial to bring people in who have walked the path and learnt lessons through what they have done to share those experiences with other people. When you have peers that can share that experience with others it can be powerful. It is not on its own going to resolve all of the problems. What we need to look at is the individual and the development of the individual socially, emotionally and cognitively. That is going to be important for us. That can be one of the tools and strategies we draw on to enhance that learning experience but ultimately we need to be very much focused on the individual being able to make decisions for themselves that are going to be beneficial.

The Hon. DAVID CLARKE: What is the main message that you seek to give students in those drug education programs? What you are seeking to convey?

Ms CALLISTER: It depends on which age group we are talking about. If we are talking about illicit drugs then the message is that it is not appropriate behaviour, that we would not anticipate that use of that would be condoned or undertaken, that it is illegal and we would not expect them to be taking such drugs and if they were found in school to be doing so that would be taken as a serious issue because it is an illegal activity.

The Hon. DAVID CLARKE: You teach them that it is a harmful activity?

Ms CALLISTER: Indeed we do, very strongly. We are quite firm about that. If there are any issues around illegal drugs then we would be liaising closely with the New South Wales police on that matter.

The Hon. DAVID CLARKE: You teach abstinence?

Ms CALLISTER: For all drugs except for medications where they are appropriately taken. That is most appropriate for children of school age.

The Hon. DAVID CLARKE: You teach from kindergarten to year 10 and that is the message that you give from the beginning to the end?

Ms CALLISTER: Yes.

The Hon. JENNIFER GARDINER: Do you have any particular programs that target binge drinking amongst school children? How do you deal with that and how do you think the department is coping with that in terms of resources?

Ms CALLISTER: There are resources available. You will find them on the list of resources that we have provided. Like all alcohol education, it is part of gradually embedding the messages as children get older. There are, for example, pamphlets around drink spiking that are available for schools to use, there are safe celebrations activities and other materials. We work significantly, particularly around the time of the so-called schoolies week, with other agencies such as Health to get across very strong messages about alcohol use. I should just add that if you look at the broader research there are very strong messages around the harms related to alcohol in terms of the pricing policies that are put in place, the opening hours of local public houses and hotels and in terms of the number of alcohol outlets in areas. While we can work on those messages within school we have no control outside of the school context on those other aspects of it.

The Hon. JENNIFER GARDINER: You have mentioned the police and health. What sort of linkages are there with other agencies for a student who has really got problems?

Ms CALLISTER: I think, as Mr Smyth King has already mentioned, we have school police liaison officers who work extremely closely with schools. Police have youth liaison officers and the feedback we get from schools is that they work extremely well with schools and schools are positive about involving them. We have school counsellors who have had significant training over the last decade in motivational interviewing techniques, which is a technique that research has shown is a constructive approach and a positive way of dealing with drug issues. Our counsellors are not specialists so they, particularly through our school link program which is done jointly with NSW Health, so they establish good strong links in their local areas, they know the sorts of services available, they liaise with their colleagues in Health and with non-government organisations in the area that provide those sorts of services and they will work in the school and complement the work that the external treating services would undertake with any particular student.

The Hon. SHAOQUETT MOSELMANE: Following on from a question the chair asked, some of the comments the Committee has received in submissions are critical of the benefits of drug and alcohol education in schools. I will read a couple of paragraphs. The Wesley Mission states on page 12 of their submission:

> One of the unexpected findings in drug and alcohol education programs is that drug and alcohol education in schools do not produce the expected benefits. Indeed control trials of school education approaches in the USA have often shown higher levels of alcohol and drug use in school students receiving education compared with those who have received none.

The Sydney Medically Supervised Injecting Centre stated on page 7:

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

Can you comment on those statements?

Ms CALLISTER: There are programs, I think the Wesley Mission is correct, that have been run in the United States that have not been effective and in some cases have shown that there has been an increase in drug use. I do not particularly want to name them but we are aware of those. Fear incitement is also another area that has proven not to be effective and those are approaches that we do not take. You will find that they are not advised in, as I mentioned before, the principles for good drug education developed by the Commonwealth. They do not advise that we take those sorts of lines and we certainly do not. We take a much more constructive approach looking at the whole child and the issues for that child. We certainly do not pick up those sorts of programs

The Hon. SHAOQUETT MOSELMANE: What is the difference between our education procedures and that of the United States?

Ms CALLISTER: The ones that I have seen have tended to be more based on a fear approach, giving only information rather than developing skills or providing opportunities for discussion. Those are the ones we would not be adopting. We take much stronger interactive approaches to providing opportunities for students to have that sort of skill development approach. We also take a very strong approach to involving parents wherever possible into that program so that they are part of what is happening in school, they know what is happening in school and they can have some involvement in their children's education?

Mr SMYTH KING: It is important that we approach this particular issue as part of the holistic development of the child rather than a segmented development of one aspect of life that they may encounter. We need to prepare young people to be able to make good decisions for themselves and good decisions for those they have an impact on. From our point of view the evidence base that we use draws very much on us being able to do that in terms of the materials and the construction of the curriculum itself in terms of engaging young people to explore and understand the implications of these sorts of aspects of life that they may in some way be connected with.

The Hon. HELEN WESTWOOD: We have a submission from the Alcohol and Other Drugs Council of Australia addressing that term of reference around educational programs and expressing their concern at the closure of the drug education unit within the education department. Are they referring to the New South Wales education department?

Mr SMYTH KING: Yes.

The Hon. HELEN WESTWOOD: When did that unit close?

Mr SMYTH KING: The unit did not close; the department engaged in a reorganisation and the functions of the department were recalibrated, if you like, in the way in which they were put together. The area I am now working in assumes a broad area that was once very much segmented. Within that area we used to have a number of people, six people, who were responsible for developing teaching materials or classroom materials, teaching resources around drug education. That function has moved to sit within our curriculum area in secondary education and is now part of, and integrated fully into, the health and physical education curriculum area. It will be embraced within the standard provision of education. The services and things that we have out in the field and in the schools have not changed at all. They will be using the same resource base on which they have previously been working to not only provide the teaching and learning programs I made reference to at the

beginning but also to work with individual students where they need additional support in remaining engaged in education and completing education.

The Hon. HELEN WESTWOOD: How many people are now working on delivering those programs?

Mr SMYTH KING: I mentioned those before. Throughout the system we have hundreds of people focused on the delivery of drug education in schools. What they are drawing on is the curriculum that has been developed in New South Wales but increasingly we will be responding to the national curriculum, the Australian curriculum, as it is progressively implemented. What we will be drawing on nationally will be the resource base throughout Australia and 24 education jurisdictions and what they are producing. What we will be doing is strengthening the provision of support and specialist materials to schools through a broad range of strategies and aspects of our organisation nationally.

The Hon. HELEN WESTWOOD: In the area where you had six people developing your curriculums, is it still six now, or less, or more?

Mr SMYTH KING: No, they were not developing the curriculums. The curriculum is developed by the New South Wales Board of Studies and it is mandated by the Board of Studies. As we have done for some time, along with other education jurisdictions, we were supplementing the curriculum that is the mandatory requirement for our schools with teaching resources and some of the sort of things that you have seen on that list.

The Hon. HELEN WESTWOOD: Okay. Do you still have six people working on those, or is it more or less now?

Ms BALE: The development of curriculum resources took place in a number of different areas, as Brian mentioned. Through the work that was done at the end of last year, it has moved into the one area, the curriculum area. That will continue through that work area.

The Hon. HELEN WESTWOOD: In relation to the drug education unit that previously existed and the staff that were in that unit, do you still have the same number of staff carrying out the work that the other six did previously within the unit?

Mr SMYTH KING: It has transferred to the secondary area of curriculum education. Within that there is a large number of curriculum consultants who are being drawn on to provide this sort of input. The area that we work in, where Elizabeth works, will continue to provide input to the various sections of the department as they develop different materials.

The Hon. HELEN WESTWOOD: They are not dedicated staff anymore, the way they were with the drug education unit?

Mr SMYTH KING: There are no specifically dedicated staff within the department.

The Hon. HELEN WESTWOOD: There are no specifically drug education staff?

Mr SMYTH KING: That is correct.

The Hon. HELEN WESTWOOD: I want to ask you something that also relates to that same submission. They talk about the effectiveness of drug education programs and they say they have found that the most successful in schools tend to use a social influence approach, include wider community and parental involvement and address the whole school environment, promoting positive relationships and behaviours, reducing victimisation and bullying and increasing social connectedness. Are they the principles that you use in your drug education programs?

Mr SMYTH KING: Very much so. We use those in our entire welfare range of programs because it is about the individual and the resilience of the individual to be able to deal with the context in which they live. Yes, we embrace those fully. They are strong evidence-based approaches that work well.

Reverend the Hon. FRED NILE: I have just a general question. I am fully in support of drug education programs in schools, but has there been any survey of drug use by school students, particularly in the high school group? Do you have any information?

Ms CALLISTER: Bryan mentioned in his introduction that there is a survey. Its acronym is ASSAD, which is the Australian School Students Alcohol and Drug survey. It has been done now for quite a number of years. I think they first did it in 1984 and it is done every three years. Initially it was just about alcohol and tobacco, but in the mid-nineties or early nineties, I think they then added use of medications and illicit drugs. That is done, as I said, across Australia. I think the sample in New South Wales is just under 800 students.

Mr SMYTH KING: Eight thousand.

Ms CALLISTER: I am sorry, 8,000; you are right. It is 25,000 nationally and 8,000 in New South Wales. That is done across all education sectors. It is done as a randomised sample and stratified so that it is as representative as it can be of all three education sectors as well as all age groups, and ensuring that it is representing rural and city schools, et cetera. That survey is seen as, like any self-report survey, having certain parameters or limits around it in terms of confidence intervals, but it is generally regarded as good quality data. It is used by education jurisdictions and by Health, et cetera, for determining priority directions and for setting policy directions. We have been involved in the implementation of that survey almost since it began. It has proved very reliable and very constructive in allowing us to determine where we put our efforts.

Reverend the Hon. FRED NILE: Briefly, could you indicate what the surveys have shown? Is there an increase in drug use, or a decrease, or is it stable?

Ms CALLISTER: Generally speaking, over the last period of time there has been a decrease in cannabis use. Illicit drug use generally is extremely low. I think in the 2011 data across general illicit drug use, excepting cannabis—I am taking cannabis out of that—about 6.5 per cent of students in that 12 to 17-year-old age group had ever used an illicit substance, which is relatively low. The most frequently used drugs of any sort are analgesics. Obviously pain killers on the whole are used for legitimate purposes because people have a headache or something of that nature. Over the last couple of surveys, generally speaking, the use of alcohol among young people has been gradually decreasing, and the use of tobacco has also quite significantly decreased over the last decade. In that sense, the results are quite positive. But generally, going back to the focus of this group, illicit drug use is very low among school-age students. If you want to look at it from a positive point of view, over 85 per cent of secondary school students in New South Wales have never tried cannabis in their life.

Reverend the Hon. FRED NILE: What was the trend in regard to alcohol consumption and smoking?

Ms CALLISTER: The survey of ever having used smoking was about 21 per cent of students who had ever tried a cigarette. Obviously alcohol is higher. From memory, I think that is about 70 per cent who had ever tried an alcoholic drink, which is the 12 to 17-year-old students in total.

Reverend the Hon. FRED NILE: Thank you. That is very encouraging. You mentioned the national curriculum a couple of times. There is a strong opinion that the New South Wales curriculum is one of the best in Australia. Are you having an input into the national curriculum in regard to this drug education area? I am worried in case it is going to be a watered-down version.

Mr SMYTH KING: No, very much so. New South Wales is contributing very significantly to the development of the Australian curriculum. In any case, what is developed within that context, known as the Australian curriculum, the legislative frame here within New South Wales is that the Board of Studies will use that curriculum, those materials or that structure that have been developed nationally and develop it within the context of what is relevant for New South Wales schools. We are very much mindful of the same thing that you are: That the robustness and strength of the New South Wales curriculum can continue to be developed. We are very much engaged in being able to do that.

The Hon. JAN BARHAM: In relation to the information that is available on your website and your handout, could you just explain about these materials and resources that are available and where they are listed as a sale product and the number of them that seem to be addressing the same issues? There are numerous on cannabis. They seem to be information kits for teachers to teach.

Ms CALLISTER: This is on the public website. Most of these resources can be downloaded. They are available as downloads, or people can buy them as hard copy, but I think some of the for sale aspects are a bit of a hangover from the days when we did not have electronic versions available in the depth that we do have here. What we have tried to do is provide teaching materials, which are specifically for the classroom.

The Hon. JAN BARHAM: And that is what these are.

Ms CALLISTER: Some of them are, yes.

The Hon. JAN BARHAM: Because I cannot see in your professional development training course where the curriculum addresses specific stuff about drug education other than from a biological or physiological perspective, but not really from a social or cultural perspective. I am wondering whether that information is available.

Ms CALLISTER: What the curriculum specifically offers?

The Hon. JAN BARHAM: In terms of what is on the website. What you are talking about is very technical. It is not about the social realities or the cultural realities, and a lot of the materials seem to be written for teachers to teach. My understanding of the experience is that if you are trying to reach young people, then peer-developed resources are what work best.

Ms CALLISTER: For example, if you look at the one of school resources years 7 to 10, there is "Peer-led Alcohol Lessons for Students", which in fact we developed with the Peer Support Foundation. That is very much where more senior students in the school are working with junior students.

The Hon. JAN BARHAM: Which one is this?

Ms CALLISTER: It is called "Peer-led Alcohol Lessons for Students", known as PALS. It is on the page, and I am sorry they are not numbered—we tried to print them straight down from the website so you would see what people would see when they went in—but it is under the one called "School Resources years 7 to 12, secondary school". That is an example of where using peers as teachers, obviously supervised by the classroom teacher, would address alcohol issues. What classroom teachers would do is use teaching resources and the content of those resources to meet the outcomes in the syllabus. They would determine how best to use those within their classroom. For example, "Cannabis—Know the Risks", which is at the top of the same page to which I was referring, and if I maybe show you the page—

The Hon. JAN BARHAM: I have got the page. I am just trying to find it.

Ms CALLISTER: What we have also tried to do for teachers is provide them with material, which is the background research, so that not only have they got teaching resources but they have professional development materials that help them to understand what the issues are, what the statistics are, and what the research is saying, et cetera.

The Hon. JAN BARHAM: What hours are allocated to this part of the curriculum?

Ms CALLISTER: In high school, personal development, health and physical education [PDHPE] is 300 hours, years 7 to 10.

The Hon. JAN BARHAM: Three hundred over four years?

Ms CALLISTER: Three hundred hours over that period between—

The Hon. JAN BARHAM: And how much of that would be allocated to drug and alcohol? The course is much broader. I am trying to understand how it is placed within the system. I could not find that.

Ms CALLISTER: The teacher would determine how they would approach that, based on their scope and sequence for each year, and how they determined the needs of their particular students.

The Hon. JAN BARHAM: Do they pick and choose the resources they use? Some of these are very old.

Ms CALLISTER: Yes, but we were trying to give you an idea of the range of resources that have gone out to schools over the period of time when the teacher in the classroom would determine what was appropriate for use with his or her particular class.

The Hon. JAN BARHAM: What is the level of counselling available in schools to offer support for young people if they want to speak to someone about a problem?

Mr SMYTH KING: It depends on the student and the needs of the student. It is a matter that the individual needs of the student would be responded to by the specialist services that we have available, and that we have access to link them into. It is very difficult to give a quantum about what a specific allocation might be. The school gets an allocation of counsellor time, but where there is a high level of need within that school, there is flexibility to respond.

The Hon. JAN BARHAM: What is the allocation?

Mr SMYTH KING: I am happy to provide information on that.

CHAIR: The Deputy Chair would like some information about public education sector access to life education programs and any other non-government educational programs.

Mr SMYTH KING: What do you mean by "life education"?

CHAIR: The life education models—the mobile van. He would like information about any other non-government access and the extent of that access. He wants to know how they get access to the various schools and what level of access they have. Please provide that information on notice.

The Hon. JAN BARHAM: I would like that information in relation to the Expect Respect program that is run within schools.

CHAIR: Answers to questions on notice are generally expected within 21 days. Thank you for appearing before the Committee and providing a briefing. The Committee values input from the Department of Education and Communities.

(The witnesses withdrew)

FIONA DAVIES, Chief Executive Officer, Australian Medical Association (NSW) Limited, affirmed and examined:

CHAIR: Welcome and thank you for appearing today. Would you like to make an opening statement?

Ms DAVIES: The Australian Medical Association has made a submission, but I will make a brief statement to provide context. I apologise for the misunderstanding and particularly because we were hoping that our President, Brian Owler, would be able to appear. I apologise that our error made that impossible. I point out that I am not a doctor so I am not in a position to answer clinical questions. The Committee has received a large number of very good submissions from many clinical experts. However, if there are any clinical matters that members would like me to take on notice I am happy to do so. It is probably better that I do not make up the answers, so I am happy to get feedback.

The Australian Medical Association welcomes the Committee's inquiry into this very important issue. As noted in our submission, drug and alcohol issues are incredibly significant for individuals and also for the community and the health system given the impact that they have on the delivery of health services in New South Wales. Some of the harm caused by drugs and alcohol is very evident, and we are all too familiar with alcohol-related violence. However, many aspects of alcohol- and drug-related harm are much less obvious and much less frequently discussed. They are also often experienced by people who are not well able to advocate on their own behalf. That is why the association believes this inquiry is so important inquiry.

New South Wales has a proud history of harm minimisation and the Australian Medical Association fully supports the continuation of that approach. However, it has made strong submissions to this inquiry and others about the need for governments to take a more active and interventionist role in helping the community to better deal with the risks of and harm caused by alcohol and drugs and the impact they have on people's lives. I am happy to take questions.

CHAIR: Page 7 of your submission states that in 2009-10 "an estimated 29.7% of the GP-patient population in Australia were at risk drinkers". Does that mean that in 2009-10 alone general practitioners had access to more than 29.7 per cent of at-risk drinkers across the country? Is that interpretation correct or does it mean that about 30 per cent of general practitioners have a drinking problem because of stress or whatever?

Ms DAVIES: No.

CHAIR: I know that many general practitioners do have problems.

Ms DAVIES: They have occasional and very moderate alcohol consumption, particularly the general practitioners we mutually know. They are very responsible.

CHAIR: So it means the patient population.

Ms DAVIES: That is correct.

CHAIR: General practitioners are human like everybody else. They are very stressed and many of them do have problems.

Ms DAVIES: Thankfully we are referring to patients. One of the challenges with alcohol is that unlike drugs and smoking there is a variety of views about what is and is not a safe level of consumption. General practitioners are an incredibly important resource in addressing alcohol consumption that has health consequences. At-risk drinking covers a significant range of alcohol consumption. I clarify that it refers to the patients and not the general practitioners.

CHAIR: Given that general practitioners have limited time and that there is a shortage of practitioners, particularly in rural and regional areas, they are stressed just doing what they can. They would probably like to have long consultations and look at a person's overall issues. How can we give general practitioners the skills, time, support and incentives that they need to do these further interventions and screenings? I agree that general practitioners see a lot of this behaviour, but are they trained to pick it up? If they do pick it up, do they have time to do what they would like to do about it?

Ms DAVIES: We gave a lot of consideration to including that in our submission for exactly that reason. General practitioners are seen as the obvious answer in solving almost every public health problem. We would love the Committee to address the fact that general practitioners are not appropriately paid to provide the complex care that our communities need. We appreciate that that is somewhat beyond this Committee's remit. However, we included it because there are simple things that we believe general practitioners could be assisted to do for their patients, and there are a couple of different aspects to that. Public health messaging should encourage patients to feel comfortable talking to their general practitioner about drug and alcohol use. That is particularly relevant for young people. The Australian Medical Association launched its position statement this week encouraging young people to make better use of general practitioners and to feel comfortable talking to them about alcohol use.

The other thing that general practitioners desperately need—and this comes across in the submission from the Australian College of Emergency Medicine—is better access to services and particularly public services to refer people. General practitioners certainly do not have the time and many do not have the expertise to take on the longer-term treatment or interventions that people with drug and alcohol problems need. However, they are well placed to have that trusting relationship and to start the conversation about the need to look at the way people are using drugs and alcohol and the health impacts. We must encourage those two simple outcomes. The worst thing that happens is not that a person raises a problem—that is not a lengthy conversation—but when a patient does that and the general practitioner cannot refer them on. That is a particular issue for people who cannot access public services. That is the real problem for general practitioners; that is, when the issue is raised but they cannot help their patient to access the help they need.

CHAIR: Some large general practice clinics have nurse practitioners, and I acknowledge that that is very costly. Does the Australian Medical Association see that as being of assistance to general practitioners because the nurse practitioners can do the screening and provide the ongoing counselling or interventions that the general practitioners do not have the time to do?

Ms DAVIES: In many instances they are practice nurses and it becomes an issue of terminology. Incorporating broad-based allied health services as a comprehensive part of a clinical team is part and parcel of good general practice. The association strongly supports those models within general practice. In rural and regional areas there are some fantastic examples of general practices that incorporate psychologists, nurses and a range of other treatment providers who can help people to access the services they need. General practices that choose to specialise in drug and alcohol will be making use of that approach. I do not have evidence, but it will probably never be a large part of the service of most general practices. That is where we need a mix of general practitioners who have decided to specialise in this area and then easy and immediate access for them to provide the services they need from community or private providers.

CHAIR: I know that a majority of the members of the Australian Medical Association are general practitioners. However, it also includes other medical practitioners. What is the broad profile of the membership?

Ms DAVIES: The Australian Medical Association is the only organisation that represents everybody from medical students to senior specialists. We cover a wide spectrum of practitioners and are therefore well placed to see the impact of drug and alcohol use in our hospital system and in the community. Each of our different membership groups has a very important role to play in the delivery of drug and alcohol services and the support that people need. That can range from medical students and their interactions and potential roles in educational processes right through to the most senior hospital specialist and general practices.

The Hon. DAVID CLARKE: Your submission states that there should be strategies directed at reducing harm from the use of such drugs. Do you also support strategies directed at the reducing the use of drugs themselves?

Ms DAVIES: Yes, we do. We support a harm-minimisation approach and that is why we have supported strategies such as the Sydney injecting room. The evidence has comprehensively supported that on a harm-minimisation basis. We believe overall that drug abuse is a bad thing.

The Hon. DAVID CLARKE: Are you saying that the injecting room reduces the harm caused by continuing use of drugs or that the injecting room is directed at reducing the use of drugs themselves?

Ms DAVIES: We believe that the evidence suggests both. It was a very lengthy conversation for our council to determine that it would support the trial and more recently its continuation. That was not a decision that any of the medical groups made lightly. In reaching that decision they considered the very significant evidence both about the benefits to the community, which is a very important factor in disease prevention, and also the outcomes the centre has achieved in reducing people's dependence on or usage of drugs.

The Hon. DAVID CLARKE: So in addition to strategies which, as you have said, are reducing harms from the use of such drugs, although you do not mention it you equally support strategies aimed at reducing the use of such drugs?

Ms DAVIES: Yes we would.

The Hon. DAVID CLARKE: Talking about programs and media and public education campaigns and so forth, which I certainly agree with you about, what programs does the AMA itself conduct among its members and in relation to material to be put in the waiting rooms of its members?

Ms DAVIES: At a Federal level we produce a number of publications that are aimed at assisting communities and doctors to understand the harm-related impacts of drugs. At a State level I have to say it is not something we have particularly focused on but we would be willing to consider it. Federally, there is a lot of information available. We have recently updated our position statements on cannabis and we have position statements and health information on a range of other drug material.

The Hon. DAVID CLARKE: Does any material at all go out from the State AMA?

Ms DAVIES: Not that we have produced recently but we would certainly be happy to look at that.

The Hon. DAVID CLARKE: Is that something you would like to take on board?

Ms DAVIES: Yes. I heard the question previously about the absolute importance of ensuring that public health and community messages are done very well and are relevant and appropriate to the target audience.

The Hon. DAVID CLARKE: It would be very useful to have some programs coming from doctors themselves through the AMA.

Ms DAVIES: That is certainly something we would be happy to look at. Our colleagues in Western Australia run a program that we have certainly considered and will review further. It is called the "Doctor Yes" program, which uses medical students to go out schools to teach a range of different health-related messages, obviously not only drugs and alcohol, and that has had some success in providing a more immediate peer-based education message that is sometimes seen as more relevant to younger people than perhaps simply receiving information from doctors that they may not necessarily relate to. We would certainly be happy to look at what sort of role we could take in that.

The Hon. JENNIFER GARDINER: You have recommended that the needle syringe program be extended, that the public opiate substitution program should be expanded and more readily available particularly where there is a long waiting list, and that the medically supervised injecting facilities also be made more readily available throughout the State. Can you indicate where you think those expanded services might be extended to? Would they be places like Newcastle or beyond that to rural areas, for example?

Ms DAVIES: We do not have a position on where would be appropriate locations for the medically supervised injecting centre beyond saying that we believe the benefits could be obtained in other places that they may have considered in New South Wales. We do not have a view on where they would be appropriate and we do not have access to the evidence. It would need to be a very detailed evidence-based process to determine that. We would like to see opiate substitution programs extended, particularly for rural and regional areas. We get some feedback from our GPs across New South Wales that those programs are difficult to access and that there are not enough places to access those services. Again, I could not give you specific locations but the issues about accessing opiate substitution programs outside the Sydney metropolitan area are significant and are having health impacts on communities.

The Hon. SHAOQUETT MOSELMANE: Following up those questions from the Hon. Jenny Gardiner in relation to needle injecting facilities, I note that you say on page 8 of your submission that in 2009 it was estimated that in New South Wales alone needle syringe programs had prevented over 50,000 cases of HIV/AIDS and/or hepatitis C infection, resulting in a saving of $513 million in health care costs. We have received submissions and heard witness statements calling for immediate cessation or abandonment of the needle exchange program and immediate cessation of funding to harm minimisation services. What is your response to those sorts of calls?

Ms DAVIES: The AMA would be very concerned to see New South Wales lose its leadership role in harm minimisation. We recognise that these are very difficult issues. I do not think anybody underestimates that. We think that what the Government and communities need to do is consider the evidence. The evidence for New South Wales and for the trial supports the fact that it improves the health of our community. We would all absolutely prefer that we did not need that facility because we did not have drugs in our community. International evidence and the evidence from New South Wales indicate that sadly that is a difficult goal to achieve and we therefore want to ensure that we continue to support a harm minimisation model both for the users of drugs and for our community, and that is a position we will be continuing to hold.

The Hon. SHAOQUETT MOSELMANE: You suggest that a sustained campaign be conducted through the mass media on the harms of alcohol and that there be a levy on alcohol products. What sort of levy and what sort of funding are you talking about?

Ms DAVIES: We certainly would not be able to indicate what sort of funding but we recognise that government expenditure is always under a lot of pressure to determine where that should come from and that the alcohol industry should be starting to take a much more significant role in impacting on the harms it is causing. Whether that would be a campaign on the level of the road safety campaign or something more moderate we still believe there is a very important role to be played in educating the community, particularly young people, to understand that alcohol has very significant harm relationships. It is hard to know how much that would be and how it would be funded because as we have said before, the challenge with alcohol is that the message is sophisticated. It is not as simple as smoking. There is a very simple message for smoking: any level of smoking is harmful. Alcohol is a much more complex message and will need much more complex ways of dealing with it. We have put this in because we think if you use the parallels to the motor vehicle campaigns there is a community benefit in highlighting to young people the harms that can come to them from alcohol. We would like to see that as part of the alcohol industry's responsibility to the health of the people of New South Wales.

The Hon. SHAOQUETT MOSELMANE: Is there a comparable levy in other States that you could point us to?

Ms DAVIES: Not that I am aware of. I am happy to take that on notice.

The Hon. HELEN WESTWOOD: Picking up on the issue of the voluntary codes in the alcohol and advertising industries, you have made recommendations in your submission around those advertising codes and I accept that. The other area you have not addressed and which has been raised by a number of witnesses is the availability of alcohol. Are you familiar with or does the AMA have a view on the Newcastle experience that closed alcohol outlets at certain times and limited the number of drinks people could have?

Ms DAVIES: I apologise that we did not include it in the submission but we were not entirely certain about the direction. The AMA is now part of the New South Wales and Australian Capital Territory Alliance for Alcohol Prevention. We have also been very involved in the Last Drinks Coalition. It is absolutely critical that governments look at the issue of supply of alcohol and particularly the evidence that has come from the Newcastle model in association with reducing the opening hours of licensed facilities. At a personal level I cannot see any community justification for the need to open a pub in this State until 6.00 a.m. I simply cannot understand how anybody benefits from that. If you are making your employment dollars by being open from 3.00 a.m. to 6.00 a.m. you maybe need a business model that is a little bit better than that. Again, it comes back to the evidence. The Newcastle model does not make everything perfect and does not prevent all forms of alcohol harm but it has produced evidence that has shown that cutting back and reducing access to alcohol, pricing models on alcohol and alcohol advertising are really important steps the Government needs to be taking to keep our community safer.

The Hon. HELEN WESTWOOD: Another area that is not touched on in your submission goes to one of our terms of reference relating to mandatory or involuntary treatment. Does the AMA have a view on that?

Ms DAVIES: We recognise that the issue of involuntary treatment is very complex. Largely we support the submissions that have been put forward by the College of General Practitioners and we have reservations about mandating treatment where that treatment is still seen as somewhat experimental. We think the best health outcomes come in most circumstances from voluntary access to treatment and that mandating treatment should be limited wherever possible, particularly where there are questions about the efficacy of the treatment. We would much prefer to see the recommendations of this Committee emphasise the need for further research and review rather than changing the legislative framework.

The Hon. HELEN WESTWOOD: On the question of research and review, another area in our terms of reference that has been raised a number of times is trialling research that looks at the efficacy of naltrexone implants as a form of treatment. Does the AMA have a position on that?

Ms DAVIES: No. As a medico-political body we have limited our submission to leave some of those more detailed clinical questions to the colleges because they have that day-to-day expertise. We are not necessarily seeking to take a position on some of those issues. Our general position is that we are very supportive of all avenues of increased research and evidence to create a greater body of knowledge but we are very conscious of the complexities of those issues.

The Hon. HELEN WESTWOOD: Going back to an earlier question about expansion of the opiate substitution treatment program, you refer in your submission to public treatment. Some of the evidence we have received from general practitioners is about the cost of opiate substitution treatment and they have referred to its unaffordability. Is that the reason you refer in your submission to public treatment or is there another reason for it?

Ms DAVIES: No, the AMA is very supportive of the public or private models for the delivery of drug and alcohol treatment services. We recognise the non-government sector has a very important role to play. Our policy emphasis though does tend to be around the levers that can be pulled with public services. We fully support the submission from the College of General Practitioners and we have very similar feedback that the affordability of and access to services is absolutely critical. We are not particularly concerned about how that is delivered but we recognise that the public system, because of its ability to provide a comprehensive array of services, is really important and is probably going to be the most significant element in the delivery of those services. For people who are marginalised and having difficulty holding down a job and who may also have mental health and other chronic illnesses the cost of accessing care and services is one of the significant deterrents to continuing with a treatment program.

The Hon. HELEN WESTWOOD: Your recommendation 3.1 is: That there should be greater capacity for doctors to use medical practice staff resources more efficiently and flexibly to provide preventive interventions for those at risk. Could you be more specific about that? This morning we had evidence from nurse practitioners. I wonder whether the Australian Medical Association has a view on the role of nurse practitioners in drug and alcohol treatment.

Ms DAVIES: We recognise that there are within the public hospital system nurse practitioners who provide very valuable drug and alcohol treatment services. Our recommendation, and any recommendation about nurse practitioners or practice nurses, is that it is critical that it is incorporated as part of the clinical team. Establishing yet another silo system that may be an independent stand-alone clinic, or something outside of an non-government organisation clinic or a practice or a hospital clinic will just further fragment care, and that is something that we would like to see avoided. But accessing expertise and resources from a range of different health providers is something we would like to see, but within existing clinical teams and in the context of a very comprehensive array of health services. We fully recognise that nurse practitioners are providing drug and alcohol services in public hospitals, and are doing so very effectively. But it should not be a stand-alone service.

The Hon. HELEN WESTWOOD: You recommendations on education programs says, in 2.1.2: That classroom-based programs that develop teenagers' decision-making skills and resistance to risk-taking are implemented in NSW schools …You might take this on notice, but I am wondering whether the Australian Medical Association has examples of the types of programs it has in mind in that recommendation, and whether they are in existence in New South Wales schools currently, or whether they are available in other jurisdictions.

Ms DAVIES: We did not have specific examples in mind. We put it in a general context. But I am very happy to take that question on notice, and also provide some further information on the Dr YES program.

The Hon. HELEN WESTWOOD: Thank you very much.

The Hon. JAN BARHAM: I am interested in the point about the use of medical practice staff resources more efficiently. How can government make that possible? Are you talking about some sort of incentive for doctors to expand or enhance the way they provide services?

Ms DAVIES: It is very difficult for this Committee to make recommendations, because some of it would come down to funding. There are some models at a State government level, such as the Health One program at Mount Druitt, that provide public sector based hub and spoke allied health staff who can then go and work out in general practices or other forms of clinics; and it would be within the remit of this Committee to look at recommendations such as that.

The Hon. JAN BARHAM: Health One?

Ms DAVIES: It is called Health One. It is a State government funded service through Mount Druitt, continued and enhanced by the current Government, and—

The Hon. JAN BARHAM: So that is a drug—

Ms DAVIES: No. It is actually a comprehensive primary care hub and spoke network. Recognising that this Committee does not have the capacity to recommend on Medicare fees, this Committee could make recommendations about access to allied health staff through the public hospital system, and whether there could be more flexibility in the way in which those staff are used in private and non-government clinics.

The Hon. JAN BARHAM: But in relation to Medicare fees—and we certainly have the capacity to make a recommendation if something is brought to our attention—what specific areas are you alluding to that might, should or could benefit from Medicare fee changes?

Ms DAVIES: The difficulty for general practitioners across all ranges of chronic and complex diseases is that we have a Medicare benefits schedule that rewards short consultations with limited complexity. Drug and alcohol consultations are by their very nature complex. They may often involve only the one particular issue, but it is a lengthy issue. Also, there are different funding models for how allied health services are able to be funded and accessed within the system.

The Hon. JAN BARHAM: So could that be like a mental health check, where you have a one-off opportunity to try to develop a plan or a referral?

Ms DAVIES: That is right.

The Hon. JAN BARHAM: And that would be a bulk-billing type of arrangement?

Ms DAVIES: Yes.

The Hon. JAN BARHAM: That is great.

Ms DAVIES: Another specific example is that one of the policy changes of the Federal Government that we were very concerned about was the reductions in the Better Access to Mental Health Care plan, and the implications that that has had for people seeking psychology services and the role of general practice in being able to access those sorts of services.

The Hon. JAN BARHAM: On the ability to refer, if you were able to do that with people who are coming in and being trusting enough to talk about their problems, do you have any indication of waiting times that people are experiencing, particularly in rural and regional areas, if people voluntarily come in and want help?

Ms DAVIES: My understanding is that it is significant. It would not be difficult for me to clarify the access to that. So I am very happy to take that question on notice. But for access to public clinics, my anecdotal understanding is that there are significant ways for people to be able to access those services.

The Hon. JAN BARHAM: And your points about the opportunity or ability for government to do something about closing times and everything, unfortunately the problem is that they have got an approval and it is going to cost money.

Ms DAVIES: Yes.

The Hon. JAN BARHAM: The more people that speak out really helps to convince government that there is value in paying them out.

Ms DAVIES: We do not underestimate the difficulties of dealing with the alcohol lobby, but we see our role as being to remind the community and government that what we are talking about is not wowserish, it is not prohibition, shutting pubs at 3.00 a.m.

The Hon. JAN BARHAM: So did you join with Last Drinks?

Ms DAVIES: Yes.

The Hon. JAN BARHAM: Have you done any separate distinct media work or advertising that identifies your organisation's concerns?

Ms DAVIES: Our President, Brian Owler, appeared in the *Four Corners* program recently. We have been very active in the public forum, and it will continue to be one of our public policy priorities. Our focus will remain on alcohol-related violence and harm, because while there are many other aspects to alcohol, almost all of us, any parent irrespective of how old your children are, are frightened about the prospects of those children going out in Sydney at night.

The Hon. JAN BARHAM: And you are aware of the other inquiry looking at young people issues specifically?

Ms DAVIES: Yes. We will certainly be making submissions there. We get constant feedback from our members who work in the public hospital system that on Friday and Saturday nights in Sydney our emergency departments are being consumed with the victims of consequences of alcohol-related violence.

The Hon. JAN BARHAM: And poly-drug use, particularly involving young people and the mixing of drugs with alcohol, is that an emerging problem?

Ms DAVIES: I do not have evidence on that one way or the other. One of the other elements that have become apparent to us is that there is the need for a lot more research. I know the Australian Hotels Association made submissions in the *Four Corners* program to suggest that alcohol was not the issue; that it was drug usage. The feedback we have received from our members is that that is a simplification of the problem, and that alcohol is a very significant factor in the presentations to our emergency departments in the harm that is befalling our young people.

The Hon. JAN BARHAM: On real-time monitoring, we have had a few submissions that have referred to the need to follow the Tasmanian example.

Ms DAVIES: On schedule 8s?

The Hon. JAN BARHAM: Yes.

Ms DAVIES: We are very supportive of the Tasmanian model and think that more needs to be done by governments to support doctors in the prescribing that they are offering about schedule 8 medications. So, yes, we would be very supportive of the Tasmanian model being implemented nationally.

Reverend the Hon. FRED NILE: You have some very good recommendations on page 6 dealing with alcohol advertising and so on. You seemed as if you were trying to just pick various aspects of advertising. Do you see some value in following the same procedure as proposed by the bill I introduced, the Tobacco Adverting Prohibition Bill, which covered all those sorts of areas but was more comprehensive?

Ms DAVIES: We are mindful of how difficult it is for governments to follow the same approach to alcohol as it has been for tobacco. We would like to see at least a scaling back of alcohol advertising. Alcohol will be difficult because, unlike tobacco, there is a level of alcohol consumption that is not harmful. So our submissions have, up until now, focused on those areas of most inappropriate behaviour and greatest harm, because we feel that, from a community standpoint and where community attitudes are, that is hopefully most likely to succeed. I think the community are very concerned about the suggestion that we are on our march to treating alcohol the same way as we treat tobacco, and I think that increases their resistance to sensible community intervention. So we think we really need to focus on particularly the social media advertising to young people, which is absolutely terrible, unregulated and targeted the links between alcohol and sport. If we can get community support and government support for those key areas, we think that is probably a better approach with alcohol advertising.

Reverend the Hon. FRED NILE: Do you have a policy in regard to warning notices about alcohol, especially for pregnant women?

Ms DAVIES: Yes, we are very supportive of warning notices and clear alcohol labelling. People should have a very clear understanding and an easy understanding of the risks associated with alcohol and alcohol harm. So, yes, the Australian Medical Association at a State and Federal level is supportive of better labelling for alcohol.

Reverend the Hon. FRED NILE: As you know, there is a problem of binge drinking. Would the Australian Medical Association give consideration to whether we should review the legal age for drinking alcohol, to restore the original legal age of 21 years, which New South Wales used to have?

Ms DAVIES: Our Federal President, Dr Steve Hambleton, is on record as saying this is a conversation that the community should have. It has not been something that the Australian Medical Association has determined policy on, and we think that there are probably a range of interventions for government that will be more palatable to the community before that. But we certainly recognise that alcohol is having a very significant impact on young people and their long-term health, and it is a conversation we need to have. But at that stage we do not have a formal policy supporting a reduction in the drinking age.

Reverend the Hon. FRED NILE: Could you clarify how you make a formal policy—

Ms DAVIES: It is a very long and detailed process.

Reverend the Hon. FRED NILE: —such as the one supporting the needle-injecting centre, not only in Kings Cross but apparently across New South Wales? Was that put to a vote of Australian Medical Association members?

Ms DAVIES: Yes, it was.

Reverend the Hon. FRED NILE: Members, not council members.

Ms DAVIES: Both State and Federal Australian Medical Associations operate on an elected council structure; so we consult with our members about various policy issues; and then the councils, who are our elected representatives, much like a Parliament, make the decisions on these issues. We do not ever promise to have recognised or represented the individual views, but we seek to gain a consensus in the development of our policy statement.

Reverend the Hon. FRED NILE: Do you think, in some controversial matters, you should survey Australian Medical Association members?

Ms DAVIES: On this one we certainly did consult with them. But the final policy decision, much like Parliament, comes down to the representatives who are elected from the membership. Trust me, when we get it wrong our members let us know.

CHAIR: I have to declare a conflict of interest through my husband. They often let you know if they think you have got it wrong.

Ms DAVIES: They do.

CHAIR: I have got a cousin who was a former president, too.

Ms DAVIES: Yes. Doctors are never backward in coming forward. But, as I say, this was a decision that we took very seriously. We take all of our decisions from the premise that we should consider evidence. Evidence should be the basis of all health decision-making, and that is the most important factor to take into account. People obviously have individual views, or a level of comfort or discomfort, but in the end we consider the evidence.

Reverend the Hon. FRED NILE: Are you as enthusiastic for needle-vending machines then to be put round New South Wales, machines that operate automatically without any supervision?

Ms DAVIES: Where there is evidence that that is in the health interests of the community, we absolutely are supportive of that; and there have been some instances where, for particular community groups or in particular locations, we do believe there are circumstances in which this should be considered. But, again, it should be about saying, "What does the evidence suggest will be in the best health interests of our community?" As I have said, none of these are conversations that we are comfortable with; it is about what does the evidence say the community will be protected by, and that is what we look to.

Reverend the Hon. FRED NILE: Should the community's views also be considered?

Ms DAVIES: Absolutely. Drug and alcohol issues are challenging for the community and obviously that needs to be weighed up as part of the conversation. Lots of communities will, quite rightly, have reservations about things like access to drug and alcohol treatment services in their community. The job of government, of health experts and of everybody is to have the conversation with the community about evidence and about the health needs of our community.

Reverend the Hon. FRED NILE: I understand the Aboriginal community at Redfern is strongly opposed to a vending machine being established in their community against their wishes.

Ms DAVIES: I am not aware of the specifics of individual places. I would assume that where there are strong community views that is weighed up in the process of determining where services are located.

CHAIR: Thank you, Ms Davies, for coming in and representing the views of the AMA, NSW Division. We thank you for making the submission. Please convey our thanks also to Professor Owler.

(The witnesses withdrew)

The Committee adjourned at 4.16 p.m.