**REPORT OF PROCEEDINGS BEFORE**

# GENERAL PURPOSE STANDING COMMITTEE No. 2

## INQUIRY INTO DRUG AND ALCOHOL TREATMENT

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**At Sydney on Thursday 4 April 2013**

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**The Committee met at 9.30 a.m.**

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**PRESENT**

The Hon. M. A. Ficarra (Chair)

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

**CHAIR:** Welcome to the General Purpose Standing Committee No. 2 Inquiry into Drug and Alcohol Treatment. The inquiry is examining and reporting on the effectiveness of current drug and alcohol policies with respect to deterrence, treatment and rehabilitation. Before I commence with questions I acknowledge the Gadigal people, the traditional custodians of this land, pay respect to the elders, past and present, of the Eora nation and extend that respect to any Indigenous people who are present. Today is the second of four hearings that we plan to hold for this inquiry. Today we will hear from representatives from the Sydney Medically Supervised Injecting Centre, UnitingCare, the South Eastern Sydney Local Health District, the Australian Medical Association (NSW), The Lyndon Community, Drug Free Australia, the NSW Users & AIDS Association, the Australian College of General Practitioners and St Vincent's Hospital, Inner City Health Program, Alcohol and Drug Service. It will be a busy day.

Before we commence, 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 as such comments will not be protected by parliamentary privilege if another person decided to take action for defamation.

Regarding adverse mention, committee hearings are not intended to provide a forum for people to make adverse reflections about others. The protection afforded to committee witnesses under parliamentary privilege should not be abused during these hearings. I therefore request that witnesses focus on the issues raised by the inquiry's terms of reference and avoid naming individuals unnecessarily. For delivery of messages and documents tendered to the Committee, witnesses are advised that any messages should be delivered to Committee members through the Committee staff. Finally, for the sake of Hansard, could everybody turn off their mobile phones or put them on silent and take them away from the microphones.

**HOWARD SCOTT PACKER**, Deputy Chair, UnitingCare NSW/ACT, sworn and examined:

**MARIANNE JAUNCEY**, Medical Director, Sydney Medically Supervised Injecting Centre, affirmed and examined:

**CHAIR:** I welcome our first witnesses from the Sydney Medically Supervised Injecting Centre and UnitingCare, Dr Howard Packer and Dr Marianne Jauncey. Thank you for coming along to give us your expertise. You have the opportunity to make a short introductory comment, if you wish. We have your submission in front of us, so it is not mandatory.

**Mr PACKER:** I have a short statement, which is accompanied by a picture that I would like to table. I have copies for each of you.

**CHAIR:** Thank you.

**Document tabled.**

**Mr PACKER:** I think it is always nice to start with a picture. I have given each of you a copy of William Hogarth's eighteenth century engraving Gin Lane. I used this picture when I led the Uniting Church in its theological reflections as it came to the decision to seek to become the licensee of what is now known as the Medically Supervised Injecting Centre. In the picture you will see people fighting, a man pawning his winter coat and tools of trade for money to buy liquor and a woman pawning her cooking pots for the same purpose; children fighting a dog for a meatless bone outside a gin house; a breastfeeding mother in a narcotic stupor dropping her suckling child; meanwhile, a man takes his own life in a noisome tenement. The picture resonates through the centuries because it depicts so much of the reality today for people who work in the area of addiction, or who are addicted, or who live with somebody who has an addiction.

The picture is important for two reasons. The first is that it reminds us that people with addictions are not first and foremost drug addicts but, rather, parents, children, work colleagues and neighbours. The addictions faced by people take place in the context of all of the common daily activities that people without addictions do. The second reason that the picture is important is that it reminds us that the Uniting Church, in taking up this role, was not doing anything radically new. The engravings remind us of the role that the churches took in the temperance movement, a movement that tackled addiction to alcohol and poverty that is graphically displayed in the picture. The temperance movement tackled these issues in a multifaceted, whole-of-person way, including teaching people to read and write, seeking reform of labour and housing conditions, care of children, and provision of basic levels of nutrition.

We, in the twenty-first century church, like those who had gone before us, were facing up to the new issues and, importantly, drawing on the new resources available to us in the twenty-first century. We were doing nothing more than restating in action the gospel message our forebears had stated in their day and age. That gospel message, and indeed the message of all mainstream faiths, is essentially this: First, every person needs to be assisted and empowered to become the best person that they can be. Secondly, such assistance and empowerment are to be given first to the least, the weakest, and those who face the greatest obstacles to becoming the best person that they can be. It is a message very consistent with many of the aims and objectives of government in Australia. Therefore, the opportunities for future collaboration between organisations such as UnitingCare and the Government of New South Wales are huge. Thank you.

**CHAIR:** Thank you. I am interested in the safe environment you provide but also, turning to page 5 of your submission, the rehabilitation services. You express a concern that some persons who have a dependency problem who visit your centre and use your facilities are not being able to access residential rehabilitation services. Will you expand on what you feel is needed in ongoing rehabilitation services for these clients?

**Dr JAUNCEY:** We see a broad range of people, but obviously in the spectrum of drug use we see the severe end of things. We see people who are homeless who have been using for many, many years, and often started using as a young teenager and have suffered generational cycles of not only drug use but also abuse and neglect. Mental illness is very common. It is the pointy end of things. We often get asked how many people we directly refer to residential rehabilitation, which is a service we would support, but because by nature you have to be detoxified to go into rehab—and by the very nature of our service we are not likely to see people who are

detoxified from drugs—our process is to refer someone for detoxification services, if that is what they are requesting and it is appropriate, and we would support them to do that.

They would go into either an inpatient or outpatient—it is more likely to be an outpatient—detoxification program. What we know from experience from those people we see down the track is that after they have finished their detoxification—for example, a drug like heroin may take seven to 10 days—it is not always possible for them to go directly into an inpatient resi-rehab position, because they are not there. There is a bit of a disconnect between lining up when somebody goes to rehab or successfully finishes the detox to get into rehabilitation. Certainly we know of people who have had a period of waiting, or they have had to make repeated phone calls, or they have needed to pay an up-front fee that they could not afford and they fall through the cracks at the point that they finish the detoxification.

**CHAIR:** You indicate that there is a We Help Ourselves program that is showing some flexibility. It is accepting some of your clients before they are off drugs and it stabilises them on methadone?

**Dr JAUNCEY:** What is new and great about the We Help Ourselves program is that now they are able to accept people into the residential rehab capacity but who are already on methadone. Methadone is one of the opiate substitution therapies or opiate pharmacotherapies. It is a very good and effective treatment for opiate dependence. But if you had people who were on methadone but were chaotic in other aspects of their life, potentially in other aspects of their drug use and other classes of drug, they could never get into any residential rehabilitation. What is now possible through the We Help Ourselves service is that they can dose the methadone in that service. We would support services like that and we would support there being more of them.

**CHAIR:** Do you know who operates the We Help Ourselves program? It is one of the programs that allows flexibility in respect of the clients that it accepts and it helps them in their rehabilitation by helping them stabilise on methadone. Are all the other residential programs rehab programs?

**Dr JAUNCEY:** For all residential rehabs you have to be drug free.

**CHAIR:** Who sets that policy? Is it NSW Health?

**Dr JAUNCEY:** It would be the individual services, many of which are the private programs that run. The basic tenet is that they are drug-free services. You have to be drug free in order to be eligible to enter and then you have to maintain your drug-free state during the period you are in there.

**CHAIR:** Is your call for greater flexibility in the entry points for these residential rehabilitation programs shared by other public health physicians or addiction medical specialists?

**Dr JAUNCEY:** Yes, I believe so. Currently there are no residential services available for people that are either stabilising on methadone, potentially if they want to come off methadone, and also buprenorphine on the basis that even though it is a prescribed medication that is listed as being an essential medicine by the World Health Organisation, and is taken in the manner in which it was prescribed, they would not be eligible for residential services.

**CHAIR:** It sounds overly restrictive. Perhaps the Committee will ascertain whether or not it has any influence over that policy. I acknowledge that research is not your primary goal but what statistics are collected? Are any outcomes measured? If so, are those statistics collected? For how many years has the centre been operating?

**Dr JAUNCEY:** Twelve years.

**CHAIR:** Has any research been published in the years of operation of the centre?

**Dr JAUNCEY:** Yes, is the simple answer to that. The service was independently evaluated in the first 10 years of its operation—11 reports were produced by five different organisations. It began with the National Drug and Alcohol Research Centre; it then went to the National Centre in HIV Epidemiology and Clinical Research, and, more recently, KPMG. They all produced independent research reports, some were governmental reports and some were published in the scientific literature. There has also been Saha-International and NSW Bureau of Crime Statistics and Research [BOCSAR]—the group headed up by Don Wetherburn—which produced independent reports about the processes, operations and outcomes of the centre.

I guess the key outcomes that we have had for our centre—which are also assisted by research that has come out of a large injecting centre in Vancouver that opened a couple of years after we did—are predominantly the outcomes that have been found, and accepted broadly by the medical establishment within this country and internationally, are that medically supervised injecting centres do save lives. They prevent injury associated with drug overdose, they take public injecting off the streets—there is very clear evidence that is one of the reasons why they are very well accepted and supported by the local Kings Cross community, both the residents and the businesses—and they are an effective conduit into other services. It is well described as a fixed-site outreach service—people do not come to the service necessarily acknowledging that they are coming to a health service and that they need assistance.

Obviously as a health service we provide assistance but we can also provide that conduit for them in making contact with other areas of the health service. There has been no increase in crime—none of the alleged honey pot effect. There has been no impact on community rates of drug treatment; if anything there has actually been more referrals—and it was very nicely shown by the Vancouver people that there are more referrals to treatments services. They have also been shown to be cost effective. There have been a number of different studies both for our service and others, which have shown the cost-effectiveness of the centres.

**CHAIR:** The report of the Vancouver Drug Injecting Centre that the Committee has talks about the Vancouver, British Columbia four-pillar approach to drug treatment, which has been quite successful, and that some interesting things are being done in Montréal. The report comments also on increases in HIV. Recently it was stated that for the first time in five years our HIV rates are on the increase. As a public health physician what do you think we are not doing correctly for HIV in this country?

**Dr JAUNCEY:** In terms of HIV amongst people who inject drugs we have been incredibly successful. We have been successful because before an epidemic was allowed to become established we intervened with a pragmatic approach that said: Whether we like it or not, let's allow people to do something safely in order to prevent an epidemic of HIV. And we have very effectively done that through the provision of needles and clinical injecting equipment to drug users—that was introduced in the late 1980s. Certainly when I attend conferences internationally and people ask where I am from and I say Australia they say, "Wow, you guys did it well from a HIV point of view in preventing an epidemic amongst people who inject drugs." In Australia the predominant mode of transmission continues to be amongst men who have sex with men.

I think with the advent of highly effective antiretrovirals there has been a sense that this is no longer necessarily a death sentence but something that can be managed as a chronic disease. There are obviously a lot of positives with that but one of the issues is that the men who are having sex with men and young gay men in Sydney do not know people who died from the disease, like people did some time ago. Certainly there are some issues in the use of condoms in high-risk populations. In terms of the injecting drug use population, obviously hepatitis C is of much greater concern, greater morbidity, greater mortality, but we have been trying to expand and make sure that our needle and syringe program [NSP] services are available not only in the city but also in rural and remote areas. We also need to make sure that they are available at appropriate services where people can access them without necessarily having to out themselves as a drug user.

We need a range of approaches, not just a one size fits all. For example, the availability of other service providers, NSPs and providing the availability of automatic dispensing machines. We need a range of options so that whenever people need it they are able to access injecting equipment. One thing that is potentially being considered is the availability of other people to pass on injecting equipment. For example, if somebody works at NSW Users and Aids Association and has clean injecting equipment and then they are somewhere else where they see other people using drugs, they are not able to provide that equipment because they are not a licensed NSP worker. Anything that would allow for the broader distribution of clean injecting equipment is always going to be beneficial from a blood-borne virus transmission prevention point of view.

**CHAIR:** Anecdotally, I am alarmed that a large number of the gay population I know as personal friends put a lot of confidence in the medications: "We are not going to die because the meds are so good." People looking back and seeing how much money has been invested into keeping them HIV safe are now alarmed that the HIV rates are on the increase. We all have to life out game because it is very sad.

**The Hon. SHAOQUETT MOSELMANE:** I begin by commenting that I loved the strong sentiments expressed in the UnitingCare NSW/ACT submission. It was short and, importantly, it contains a vision for a just, fair and compassionate society advancing "principles of access, equity, participation and human rights". It

wants to help marginalise and give a voice to the disadvantaged. Mr Packer, can you paint a picture for the Committee of how the injecting facility works and about its future impact? I ask that because some members of this Parliament hold the view that injecting rooms should not be allowed to continue.

**Mr PACKER:** I will let Dr Jauncey comment on this as well. I think the first thing to say is that all members of this Committee, and indeed any other members of Parliament, at any time would be most welcome to arrange to come and have a personal visit—that is probably the best way to get an understanding of what happens at the centre. The facility itself is very nicely appointed. You come into the reception area where you have to be registered—a lot of the statistical information that is gathered comes about because of registrations. We now know a lot more about the type of people who inject heroin, when they do it, how frequently they do it, their age group, whether they have a profession or other work environment, and those sorts of things—that information over the 12 years has come out. I find it very useful in my work in the criminal justice system quite often in dealing with people with addictions to be able to refer to those statistics if I have somebody who falls within one of those categories. Once people come in they then have the booths where they can inject what they have brought in. I will let Dr Jauncey talk about the rest of it—she has the more firsthand experience. You keep them there for quite some time after injection, do you not?

**Dr JAUNCEY:** It depends. I was going to say that all members of the Committee either by themselves, altogether or whatever would be more than welcome to come. We would be very pleased to host a visit whenever was convenient when the service was not operating, so you can physically go through and see it while the clients are not there. We would be very happy to arrange that. As Howard has said, after they have been assessed at the front reception area they go into stage two—the actual supervised injecting room itself—where there are eight stainless steel booths. Up to two people can sit in a booth; the maximum number in stage two at any one time is 16. They collect equipment from a desk—which is a bit the same as NSPs where people can collect the injecting equipment but we provide additional equipment there that is not available at other services. People are encouraged to wash their hands, which seems pretty simple but if you are homeless and you do not have access to running water even that can have a major impact on risk of spread of other diseases down the track. People will then sit at a booth and instead of that injection of drugs occurring somewhere outside in a lane, in a back alley somewhere; it is occurring off the streets in a facility where there are councillors and nurses available to talk to them before, during and after.

They will dispose of the equipment in safe and secure bins, instead of that equipment potentially going into a gutter or on a street somewhere. They will then move through to stage three of the service, which is the aftercare area or chill out room. Again there will be nurses and councillors available on hand to talk to them. They can sit, they can have a cup of coffee, they can read the paper and there is a lot of health-promotion work done in that area of the service. We rotate through a series of topics and there will be a lot of activities—basically anything in my view that can start a conversation with them, even if it is not necessarily, "Let me talk to you about your drug use today." Anything that starts a conversation is a good thing because it can lead down the track to all sorts of other things. Then they exit out Kellett Street.

**The Hon. SHAOQUETT MOSELMANE:** On page 6 of your submission you note that you oppose compulsory drug treatment. Why is that?

**Dr JAUNCEY:** There are good position statements from the World Health Organisation—I think I quoted one in that submission—and at the end of the day people have human rights first and foremost. Anything that violates someone's human rights in the name of treatment should not be accepted. I guess an easy analogy for people to understand is there is a lot of talk about obese Australians and indeed many in first world countries becoming obese. I do not think there is likely to be a push or an acceptance that somebody who has a body mass index [BMI] of more than 30 and who is overweight should be force to only eat particular foods and should be supervised in the eating of that food or should be forced to undergo surgery to staple his or her stomach, for example, in order that he or she was not able to physically cope with the degree of food.

**The Hon. SHAOQUETT MOSELMANE:** What do you say to the argument that for extreme cases there may be a need for compulsory treatment?

**Dr JAUNCEY:** Partly sometimes it comes down to definition, so something like the Magistrates Early Referral Into Treatment [MERIT] system and drug courts are a wonderful thing. Anything that can divert people from the criminal justice system and get them into treatment is worthwhile. There have been some good outcomes from that but still at some level that is a voluntary thing. They have been arrested and charged with an offence, clearly a drug-related offence, and we know that our prisons are full of people who are there for drug-

related offences. If at that stage they can choose to go into treatment rather than incarceration then that has to be a step in the right direction. But plucking someone off the street and saying, "You're a heroin addict. I am forcing you into treatment", apart from potential human rights violations, there is also no evidence to show that it actually works.

**The Hon. SHAOQUETT MOSELMANE:** I will ask one more question before I have to share the time with my colleague. On page eight you note that the rate of HIV infection among people who inject drugs in Australia has remained around 1 per cent compared to other countries where prevalence rates can exceed 50 per cent. Is that because of the ease of access to needles and the injecting rooms? What other reasons do you see?

**Dr JAUNCEY:** Among people who inject drugs, the basic only reason that we have done so well is that we introduced needle syringe programs early before the epidemic took hold. In other countries, for example, in the United States in places in New York, there are rates of HIV infection among people who inject drugs in excess of 50 per cent and 60 per cent, including at other places in Europe, because they do not have a universal access to clean injecting equipment. That is it.

**Mr PACKER:** Chair, I just have a couple of quick comments on the Hon. Shaoquett Moselmane's questions. Firstly, the choice by a person to go to the injecting centre and inject there is, I think, a very powerful statement by them of how they regard the worth of their life, rather than being in an alley, and by doing it in a safe environment or an environment in which, if something goes wrong, there are medically trained people who can do something about it. That is a very important, if you like, first step on the continuum that we would like to see leading all the way to full recovery. The opportunity, the facility, is there. People are using it. People come from all over Sydney; it is not just local residents because it is around the corner. People come from all over the place to use it. I think that is a very important statement.

The second aspect about compulsory treatment follows Dr Jauncey's comments about the Magistrates Early Referral Into Treatment [MERIT] program. People have crises in their lives. It can be an arrest for a criminal charge. It can be the fact that the Department of Family and Community Services have taken away their children because of their drug addiction. Those crises are opportunities for them to look at their life and deal with their addiction. I have had a lot of experience with WHO, which is the We Help Ourselves organisation, and we have talked about that. That, very successfully— having mothers with addictions who have lost their children and whose children will be out of their hands in foster care for 18 months or sometimes two years— gives the mothers the opportunity to go into residential facilities.

The We Help Ourselves program is a staged program. They do not just go in. They go in in different houses and different buildings, and as they progress through the We Help Ourselves regime onto no drug usage, they are moved about. I see that crises in people's lives can either be real problems or they can be opportunities. The more that we are able to offer people who have those crises the opportunities, that is the time, and that is far more effective, in my experience, than force, or forcing them to do it at a time that may not be opportune for them.

**The Hon. HELEN WESTWOOD:** I will ask either of you, but perhaps Dr Jauncey may be in a better position to answer my question. However, please feel free, Mr Packer. The Chair referred to this issue a little earlier. Yesterday we had a witness who claimed that the needle exchange program has led to an increase in the infection and spread of hepatitis C. He claimed he had a research paper, which we have just received this morning, so maybe you could take this question on notice. It is called "High Rates of HIV Infection among Injection Drug Users Participating in a Needle Exchange Program in Montreal: Results of a Cohort Study". It was published in the American Journal of Epidemiology.

**CHAIR:** I will give you a copy of it.

**The Hon. HELEN WESTWOOD:** I would like your view about that because it concerns me greatly that that is now on the record. It would be good to hear from those who are working in the field of drugs and alcohol in Australia and in infectious diseases to perhaps offer us a counterview to that, or perhaps it is correct. It would be very worthwhile for us to have some evidence on that. Now my time has run out, so I do not get to ask the other questions I had in mind. Thank you.

**The Hon. JAN BARHAM:** Put them on notice.

**Dr JAUNCEY:** You know, there are all sorts of national research institutions in this country and in other areas that would categorically and emphatically state that needle syringe services reduce the incidence of blood borne virus transmission. When you look at hepatitis C and the epidemic that we do have in Australia, in a way it is an example of what could have happened with HIV, had we not done what we did. There is a large amount of hepatitis C virus among people who inject drugs. Why were we not effective with hepatitis C when we were so effective with HIV? The reason is that hepatitis C was already there and already spreading among people who inject drugs before we even knew that it was hepatitis C. It was just that it was called non-A and non-B hepatitis. It was not until about 1990 that we isolated the virus and got an antibody test in 1991 for hepatitis C.

But if you go back to stored serum samples from the 1970s, you can now do tests on them with the technology that we have and say, "That outbreak of non-A and non-B hepatitis among people who injected drugs—actually, that was hepatitis C". What we know is that before there was available clean injecting equipment, where people were reusing injecting equipment routinely, that virus was able to very quickly spread and almost universally affect people who injected drugs. So now there are very good mathematical calculations that you can do based on the likelihood of somebody being positive with whom you share and the likelihood of that sharing event resulting in transmission. We know with mathematical modelling that once a virus has taken hold in a population—and you need to share only once—the chances are that the person you share with has got probably hepatitis C and there is a reasonable chance that you are going to get it if you share a needle, it is very difficult then to get that epidemic under control.

That is why I think there needs to be a push, and there is a push, to increase the numbers of treatment for people who have hepatitis C. You can in fact cure it. It is not an easy thing to cure and it is not taken with a drug overnight but, you know, within three, six and 12 months of treatment, you can effectively cure more than 50 per cent of people. There needs to be more focus on that. I am happy to read that paper but, you know, I have worked at the National Centre for HIV Epidemiology and Clinical Research, and I know data from that centre as well as international data, and it is absolutely clear that needle syringe services prevent the transmission of blood borne viruses.

**Reverend the Hon. FRED NILE:** Thank you very much for coming in. Dr Jauncey, I note that you state in your submission that there is only one injecting room in Australia. Why do you think there is only one when you claim it is such a successful operation? Why do the other States, particularly Labor Government States, not introduce them?

**Dr JAUNCEY:** Certainly under a Labor Government here, we got the legislation in New South Wales that states that there will only be one in New South Wales. I think it is, you know, not a surprise to anyone that this service was politically sensitive. I am pleased to say that I think it is probably, hopefully, less politically sensitive now than perhaps it was when we first opened.

**Reverend the Hon. FRED NILE:** Other States particularly, I was referring to.

**Dr JAUNCEY:** In relation to other States, I think there has been for some time, a number of years, a push in Melbourne. I think probably if you looked around Australia that would probably be the next city where it would be sensible to put an injecting facility. They are not services that need to be on every street corner—and I do not think anybody sensible is suggesting that—but where there is a concentration of drug injecting that is occurring in public and a large number of overdoses and ambulances roaring down the streets on a daily basis, which is what used to happen in Kings Cross, a supervising injecting facility can be a reasonable public health response to that. I think there are a number of people, including the Australian Medical Association and the College of Physicians and health and medical workers in Melbourne, who are very keen to see that established. It has not been, and I think it has not been for predominantly political reasons.

**Reverend the Hon. FRED NILE:** I know you have heard the criticism over the years about the honey pot situation. Where do your clients get the heroin from?

**Dr JAUNCEY:** They get the heroin from Kings Cross. We ask, at registration, what is the primary reason for somebody being in Kings Cross that day, and the primary reason—and I think off the top of my head it is more than 85 per cent of people—for being in Kings Cross is that that is where they came to buy the drugs. That has not changed, so you cannot put an injecting centre somewhere the drug use is not happening because people will not tend to go there. I know how we were saying that people tend to come from all over Sydney. I would not mind if that was true, but actually the reality is that people, if they are coming from elsewhere, they

come to Kings Cross to buy their drugs. We do not see people from Blacktown, who bought their drugs in Blacktown, come to use our health service. They use their drugs where they bought their drugs, and that is true around Sydney, it is true in Melbourne, and it is true the world over.

That is because, first, if people are hanging out, they want to use; and, secondly, they do not want to be at risk of prosecution and losing the substance that they have just paid their money to get. So they will tend to use it as quickly as they can. If somebody is homeless, they are going to do it in the public domain somewhere—in the street, in the back alleyway, or behind a parked car.

**Reverend the Hon. FRED NILE:** I understand it is virtually a no-go zone for the police around the injecting centre, and they are not arrest people with heroin, or who are even selling heroin, near the Kings Cross railway station.

**Dr JAUNCEY:** Yes, I have certainly heard that said, and that is one of the questions we hear. We run public tours every three weeks and I have certainly had that question before. I can honestly tell you it is just not true. We operate well with the police. Obviously the police support the service of the medically supervised injecting centre. The Commissioner of Police is one of our licence holders, so it is the Commissioner of Police and Director General of Health who grant the licence to UnitingCare in order for us to operate. I talk to the police—I have a good relationship with the local area commander—and when we need the police, we call the police. They have a very pragmatic approach in much the same way I think a lot of the health professionals did. They were the ones who were finding the bodies and they were the ones who were calling the next of kin, and that does not happen as much as it did, so they support the service.

Trust me, they can, and do, arrest people all up and down Darlinghurst Road. I go to regular community meetings with the police, and they show at those meetings where people are getting arrested, and people are getting arrested where the drug dealing is occurring. That is up and down Darlinghurst Road. That is because that is where it has always been occurring—up and down Darlinghurst Road. Certainly Don Wetherburn's staff from the Bureau of Crime Statistics and Research has specifically got three documented reports that have looked at the operation of the injecting centre specifically to crime, and drug-related crime, and acquisitive drug-related crime, and there has been no impact. He has access to all police data and he has shown that there has been no change. That is because I think that we located the service where it needs to be, which is in the thick of it.

So there is not—there truly is not—a no-go zone. There have been times, in all honesty, when we have had police with somebody out the front of our service. We will at least go out and say, "Can you just move down the road because people can't get in our front door", so there is a no-go zone; but the police will not generally charge or go up to somebody with no reason, who appears to be walking, you know, towards our front door and who is doing nothing else. They will not, and they have no cause, to legally go up and search them and then arrest them on possession, purely for possession's sake. But if anybody is exhibiting antisocial behaviour or they are dealing or they are doing anything else, they can, and will, be subject to police intervention in Kings Cross.

**The Hon. JAN BARHAM:** Thank you for coming in. How would you refer to the type of people who inject? After 12 years, do you have an insight into the type of people who are addicts, or the type of people who inject? Can you give us some background on any of that?

**Dr JAUNCEY:** I think what we have got a much better insight into is the type of people who inject in Kings Cross, which is not representative of all people who inject drugs in Australia by any means. But as I think I mentioned before, we very much see the pointy end of harm. We see people on the severe end of the continuum of drug use and drug addiction. We know and we have good data on the people that we see. There have been 13,500 individuals who have registered with the service. At the moment, we supervise about 205 visits a day. It is usually more during the week and slightly less on the weekends, but we are open seven days a week. We know that about 75 per cent of them are male and that is consistent with other data collected around the country. We know that it is gradually an ageing cohort, so the average age of our group has gone up over the years and we know, again, that is consistent with other data from around New South Wales and around Australia.

Fewer young people are taking up injecting; that is fabulous. The group that we are left with is now gradually getting older. We have a referral coordinator, who is sitting in the room, and one of the things we asked him to do was to look at the people we see frequently. So we did a snapshot over a month of all of the top

most frequent attendees or clients who were attending, and then we had a bit of a look at exactly these people were. The majority of them were homeless. The majority of them had significant mental health issues, often not formally diagnosed and often not in treatment. They had an average length of injecting career of—overall of all our registrations—more than 13 years, on average, when we first see them, so we do not see young new users. Amongst this group it was even longer. So it was an extremely marginalised, extremely vulnerable, extremely at risk, extremely disenfranchised and poorly connected group of individuals who were not connected with mental health services, who were not connected with other health services, who by and large were very much your archetypal intergenerational cycles of neglect and abuse and had been using for long periods of time.

**The Hon. JAN BARHAM:** In your submission you refer to access to narcan.

**Dr JAUNCEY:** Naloxone or narcan, yes.

**The Hon. JAN BARHAM:** And you say that it should be expanded. How and where should it be expanded to and what difference would it make?

**Dr JAUNCEY:** There are a number of other countries where—naloxone is a bit like naltrexone in that if you have a heroin receptor heroin comes along, presses a button and turns it on. Naltrexone comes along, bumps heroin off and binds that receptor and turns it off. Naloxone, same as naltrexone, comes along to the heroin receptor, binds it, turns it off but only does it for a short time, whereas naltrexone is a much longer acting drug. But naltrexone and naloxone are similar drugs. Naloxone is the drug we give for heroin overdose. We are able to give it at the injecting centre. We are basically able to do what the ambulances did, which is why the ambulance callouts have gone down. But given that the legislation does not allow for any more injecting centres in New South Wales and, as has been pointed out, there are no other ones in Australian States, and yet opiate deaths are significantly on the increase, this is a drug which is ridiculously safe, which could be given to you or me and have no side effects but given to somebody who was suffering from an opiate overdose it can wake them up and save their life.

**The Hon. JAN BARHAM:** Who should have access to use that?

**Dr JAUNCEY:** Pretty much anyone. At the moment it is only available to doctors and paramedics and nurses under special protocols. It is available over the counter in Italy and has been since I think 1993. You can have expanded access so that, for example, people working in methadone clinics, in residential rehabilitation services and accommodation services that are seeing at-risk people who are using drugs, if they are the first on the scene they should have access to the drug. Sure, they should also call an ambulance but if they can get in and, for example, spray something up a nose, which is the trial that we are doing to see if the spray works as well as the injection, why would you not do it? Family members—

**The Hon. JAN BARHAM:** That is a trial you are currently doing?

**Dr JAUNCEY:** Yes.

**The Hon. JAN BARHAM:** Are you the only ones doing that trial?

**Dr JAUNCEY:** Yes, I guess because it is the perfect site for that kind of research to be done. We are conducting a randomised double blind control trial, which means it is sort of the best level of evidence that you can get, which basically compares two routes of administration of the drug naloxone. Normally at our centre and all around Australia if somebody has an opiate overdose they can get this drug either via an intramuscular injection or into a vein in an infusion in a hospital. We are trialling the spray and determining whether the spray up the nose is as effective as an intramuscular injection. I guess that is probably a lot more appealing to some people like family members.

**The Hon. JAN BARHAM:** Is the spray restricted by the legislation in the same way as an injection? Is the drug restricted? Is that the problem?

**Dr JAUNCEY:** Yes. You could look at changing the scheduling of the drug.

**CHAIR:** If there was an NHMRC-approved level one trial on naltrexone implants, what would be your opinion on that?

**Dr JAUNCEY:** If it was to be conducted?

**CHAIR:** Yes.

**Dr JAUNCEY:** I think that would be a great thing. It is obviously—

**CHAIR:** Scientifically sound, NHMRC approved.

**Dr JAUNCEY:** Yes. It is needed.

**CHAIR:** We appreciate you coming in with your expertise in the centre, which is unique in Australia. We thank you for giving us your time and your professional opinion.

**(The witnesses withdrew)**

**NICHOLAS LINTZERIS**, Director, South Eastern Sydney Local Health District, sworn and examined:

**CHAIR:** Thank you for coming and giving us your expertise. In what capacity are you appearing before the Committee today?

**Professor LINTZERIS:** I am appearing before the Committee as the director of drug and alcohol services for South Eastern Sydney Local Health District.

**CHAIR:** There is an opportunity for you to make an opening statement. It is not mandatory but if you wish to.

**Professor LINTZERIS:** Just to note that I also currently hold the position of chief addiction medicine specialist for the Ministry of Health, the mental health drug and alcohol office, and I also hold a position at the University of Sydney. Today I will be representing South Eastern Sydney Local Health District and indeed the submission to the inquiry was done under my SESLHD capacity but happy to obviously comment from broader experience. I have worked in the drug and alcohol area now for over 20, 25 years in various clinical research policy and training roles. I also welcomed the inquiry's interest in the drug and alcohol treatment sector. It is a largely underfunded, under-resourced area. It affects diverse areas of the community and our responses, likewise, need to have breadth and diversity to them.

**CHAIR:** I was impressed by not only your five years in the United Kingdom and the work that you did there but you have worked across Europe and Asia and for the World Health Organisation. We are fortunate to have your expertise. I note in your submission that at one stage you were very interested in doing a trial with vivitrol, the injectable format of naltrexone, the intramuscular injectable format, but that unfortunately never came around because of problems with supply from the manufacturing company. I put this to you: in terms of what data exists now with the oral intramuscular injectable format and now the subcutaneous implant preparation of naltrexone, if there was to be an NHMRC-approved trial of naltrexone in whichever format—let us say that would depend again on supply, just as you discovered—would this be something that you would feel to be of benefit from a medical and scientific point of view, given again level one research and NHMRC approved?

**Professor LINTZERIS:** Yes, it would be a good step forward for an NHMRC-funded trial. I would actually state though that it is not necessary to have an NHMRC-funded trial for us to be able to get level one evidence in high quantum research. What we need is the ability to conduct research within the TGA framework for investigations of new medications. Whether or not the NHMRC supported that, it would great if we could get that funding. As you can see in my submission, we have applied several times to try to get vivitrol research up. That is in the context also that I have been involved in naltrexone research since the late 1990s, oral in the first place. Oral naltrexone was the first format introduced in Australia. We have been very keen to look at the role of naltrexone, not just for opiate dependence. It is widely used in Australia for alcohol dependence and there are some promising result internationally about the role of naltrexone in some other substance use disorders as well—early stages though.

**CHAIR:** Given the pharmacokinetics often of injectable versus implant, subcutaneous implants, and patient compliance with taking the medication, longevity of treatment, do you see any advantages of the implant over the injectable format in terms of that compliance?

**Professor LINTZERIS:** Ultimately it depends on the formulations at the end of the day. The current licensed product available in the United States is the vivitrol product, which is a one-month preparation. The kinetic studies suggest you can get up to about six weeks out of it but it is licensed for a four-week readministration period. When it comes to the implants, it depends on the manufacture of the formulation. You could manufacture an implant that lasted one month, three months, I think up to—I am unaware of anyone being able to demonstrate reliable plasma levels of naltrexone beyond about six months. But again much of this research is done by pharmaceutical companies and it is commercial in confidence so there is not wide published literature available to independent researchers with regards to products in development. Biotech companies have their own confidentiality and commercial interests.

**CHAIR:** But if those pharmacokinetics could show long acting, three months, that would be an advantage from the patient point of view?

**Professor LINTZERIS:** I would suggest you would find different patients being attracted to and responding to different kinds of formulations. Indeed, the treatment system would also have differential uptake. What I mean by that is that a depo injection is a relatively simple medication to administer. We do this in health care all the time—things like depo injections of mental health medications. That is something we are quite comfortable in the health system in delivering injectable products. Implants obviously have a higher front-end engagement in terms of the service system. Often it will require some degree of surgical procedure and some degree of professional training.

Some patients will be attracted to that and some service providers will be capable of delivering that. Again, it is not which is the winner; it would be a case of in an ideal world we would have a range of formulations, licenced, proven, demonstrated to be effective, cost effective and publicly available, because they are expensive medications. One the significant barriers to the uptake of these preparations internationally has been the expense of the medication. It is being able to have a variety of options on how we might use opiate antagonists and we would find almost certainly, like most areas of medicine, that different patients would respond differentially to different formulations.

**The Hon. DAVID CLARKE:** Do you have a view of the Western Australia experience with naltrexone implants? Are you aware of what is happening there?

**Professor LINTZERIS:** I am familiar I guess historically with what has happened in Western Australia. Obviously I have had discussions, communications, with some of the key figures there, such as Professor Gary Hulse and Dr George O'Neil, and also the treatment system in Western Australia. So I have some familiarity. Also, I am abreast of the published literature.

**The Hon. DAVID CLARKE:** Do you have a favourable impression of what has been happening there?

**Professor LINTZERIS:** Elements of what has occurred in Western Australia have been positive in terms of being able to progress the science. I must say I am not in favour in the widespread use of the unlicensed naltrexone implants that is occurring in Western Australia, not because I am against naltrexone implants, but largely because we just do not have a licensed product. I have concerns in the area of addiction treatment that somehow the relevant regulatory and protective mechanisms that the Therapeutic Goods Administration applies for medications to be used for any health disorder for any patient seem to have been bypassed in the instance of the widespread use of naltrexone implants in Western Australia.

My understanding is that thousands of implants have been administered. It is hard to know because there is no official registry. There is no way of being able to go and search how many implants have been administered. You are reliant on individual practitioners and on somehow contacting them. There is no need to register naltrexone implants used by practitioners if they are going to be operating outside the special access scheme. So it is hard to know how many have been provided. My understanding is it is in the thousands. I think that is outside the scope of the special access scheme. I understand how that has initially been used. Small numbers of clinical trials were conducted but I am glad there were some clinical trials.

**The Hon. DAVID CLARKE:** Would you be favourable to a trial here in New South Wales?

**Professor LINTZERIS:** I have been involved in clinical research in drug and alcohol and special opiates treatments for more than 15 or 20 years. I did my PhD in this area, published widely. I am in favour of all research that looks to develop new medication products that will widen the appeal of treatment and also the effectiveness of treatment. I genuinely believe there is a role for long-acting opiate antagonist treatment. It is not the magic bullet—few things are in drug and alcohol treatment. But there would almost certainly be a role for a population of patients. Any research that would be able to further us being in a position to use such medications, licensed medications, would be a step in the right direction.

**The Hon. JENNIFER GARDINER:** Professor, you started by saying that drug and alcohol services are underfunded and underresourced. Yesterday we had some discussions with some non-government organisations about the view that they felt they had more to offer. You are with a local health district. Is there a potential for non-government organisations to be a better indicator and to provide more services in this area?

**Professor LINTZERIS:** I think there is greater scope and greater need for all parts of the health system to be more engaged in this area and to be better resourced. I would not like to see us in a position of

fighting as to which part of the service system should get the scraps that we currently receive in resources. Again, it is not a case of where the limited resources should go; it really is a case of how do we build upon the strengths of the different parts of the service system, as we do in all areas of health. In other areas of health we would identify that there are broader population approaches to responding to health problems, so there is a role for addressing drug and alcohol problems in primary health care. General practitioners and other primary health care providers—it can be pharmacists or a whole range of services—have a greater role to play and they are our new partners in that. The Medicare role in the system is to coordinate services there.

We need greater engagement by the specialist health system. By that I mean hospitals, emergency departments, gastroenterology, mental health and pain services. A whole range of specialist services need to look at how they identify and respond to drug and alcohol problems. If you look at mental health, pain services, it is clear there is a high prevalence of drug and alcohol problems in those populations. We also then need to look at how the specialist drug and alcohol treatment system does its business. Then we need to make sure that we have the right players working in concert in delivering appropriate services. The non-government organisation sector is particularly good at providing certain kinds of services, better than the local health districts. If we are looking at being able to provide for issues such as a lot of social welfare support systems, being able to provide things such as supported accommodation—these are not peripheral to the treatment of drugs and alcohol; these are often patients with severe drug and alcohol problems—these are quite central to addressing drug and alcohol problems in that hardcore, extreme end of the problem.

We also should not be sacrificing a professional sector. I have worked in settings such as Victoria. I worked through that process in the 1990s where we saw pretty much the closure of the government sector and it was transferred over to the non-government organisation system. Similar things are occurring in places such as the United Kingdom now. There are some advantages but there is also the risk that you end up losing the whole professional sector. For example, if you compare Victoria and New South Wales, there are very few specialised drug and alcohol nurses working in Victoria; we have hundreds in New South Wales. There are very few addiction medicine specialists in Victoria, fewer than 10—we have counted them—working in public sector positions; New South Wales has, we estimate, over 50, and we are developing more. We have a training system, so we are training, on average, four or five new addiction medicine specialists a year. Victoria is struggling to train one.

It is not a case of which part of the service system should be responding to drug and alcohol problems; we should be recognising that different parts of the health system are particularly good at doing certain things. We would be foolish to turn our backs on what the local health district and government sector and professional services can provide. We should not forget that drug and alcohol services are at a disadvantage compared to other areas of health care in that we largely do not have a strong private professional sector. Whereas in mental health there is a whole community of private psychiatrists, so that even if the government mental health services were to be diminished, you could still access specialist psychiatric services through Medicare-funded private systems.

Drug and alcohol does not have that established private sector. So if we were to reduce the involvement of government sector services we would largely be turning our backs on a professional sector. This means having the skilled clinical psychologists, doctors, nurses and the kinds of services they can provide that for less qualified staff; it is just not their strength. Also, when we are thinking about how to engage the remainder of the health system, how do we get gastroenterologists, psychiatrists, emergency department specialists and primary care to take on drug and alcohol services, to engage with the treatment system? That is hard to do if you are not part of the same health system. It is very difficult to get non-government organisations to influence practices in an emergency department. It is much easier to change the way an emergency department operates if you have drug and alcohol services in that hospital.

Again we should recognise there needs to be a diversity of service responses and different players are involved. The non-government organisation sector is a really important component of the system. Anything we can do to work more collaboratively with non-government organisations and specialists in the government sector drug and alcohol services and, importantly, the Medicare locals, which is where primary care is now being coordinated, is certainly a step in the right direction.

**The Hon. HELEN WESTWOOD:** Thank you for being with us today. I have already found your expertise invaluable. The Hon. David Clarke asked you about this earlier but I am interested to know about research that would look at the efficacy of naltrexone implants. Could the same study look at intramuscular naltrexone or do they need to be two separate studies?

**Professor LINTZERIS:** The design of clinical trials ultimately depends on what research question you want to address and also, realistically, the logistics of setting up a study. The more arms you want to compare, the more different interventions you want to compare and contrast, in general, that increases the size of the study, the number of patients that need to be enrolled, and increases the expense of conducting the study. They are just logistical, pragmatic issues. If there was a bottomless pit of resources, of course, you could do anything.

The other aspect of that, though, is having the necessary conditions to proceed with a proper Therapeutic Goods Administration framework for a clinical trial. One of the significant barriers to us being able to proceed with long-acting naltrexone products has been difficulties in being able to get the necessary investigator's brochure to be able to proceed with a clinical trial notification or a clinical trial exemption study. Where a medication is not licensed, to proceed through an ethics process you need to be able to comply with both the clinical trial notification and clinical trial exemption systems. You need to be able to provide what they call an investigator's brochure, which really highlights the fundamental properties of the medication being used. It will review animal studies, human safety data, biological analyses, shelf life studies, pharmacokinetics, a range of studies. That is necessary for the ethics committee or, if you are going to go with a clinical trial exemption, for the Therapeutic Goods Administration to be able to say yes, this product looks at least safe enough to proceed with a clinical trial. That has been our stumbling block.

It has been difficult, for example, to go and get Vivitrol, just to buy it. There is nothing stopping us from buying it from the manufacturer but if the manufacturer is not going to support us through a clinical trial, it will not give us the investigator's brochure, so it is difficult to proceed, which is a difficulty we had about four five years ago when we had some funding to do some pilot Vivitrol research. Likewise, the barrier in proceeding with naltrexone implants is having a manufacturer who can provide us with a necessary investigator's brochure to do that research. So, that has been the stumbling block to date, as well as no-one has given us the money to do it. It is twofold: You need the resources to do research and you also need to be able to have the pharmaceutical industry behind you to allow you to do appropriate research.

One other aspect, in the design of any clinical trial you should never only compare one investigational method to another investigational method. It is difficult to then compare that to what would be the control or the existing treatment. You usually need some control group, be that a placebo group, be that standard care, and the question is what would be the appropriate placebo group, control group, and so forth. Some have suggested it should be in comparison with methadone or buprenorphine; others have highlighted that that is difficult to set up for a range of reasons and probably an inappropriate comparison group. Indeed, in our submissions to the National Health and Medical Research Council we went through all three different variations of control groups, and each time someone found a fault with each of them. Nevertheless, it is possible to design these. No single study ever addresses all research questions. That is an important point. It is not as though we can set up the one study that is going to answer everything. If only medical science was that easy. But at least having one large multisite, properly conducted, independent study in Australia would at least pave the way for subsequent research.

**The Hon. HELEN WESTWOOD:** Are the barriers to acquiring the investigator's brochure beyond a government? What would it take for a researcher to be able to get the investigator's brochure?

**Professor LINTZERIS:** Normally it is the pharmaceutical manufacturer, the industry partners are the ones who provide the investigatory brochure. There are examples in other countries. I am not familiar with this having happened in Australia, I am not sure about the way the CSIRO developed its vaccine program, to the extent there was government support there. I am not familiar with that. I know, for example, in the addiction field in the United States, the National Institute for Drug Abuse has invested heavily in pharmaceutical development for the very reason that it realises that drug companies invest in products where they see there is a profit to be made. To date, other than the relatively new medication of buprenorphine, there is not a long history or legacy of profitable medications in the addiction sector. So, on the whole, we have not had pharmaceutical companies beating a heavy path to our door asking us, please help us research the next drug.

Whereas in other areas of health, mental health, mainstream health services, because industry identifies there is a profit to be made they will invest in research. I know some of the barriers are that Australia is a small market. It may not be profitable for industry to develop up a product solely for an Australian market. The United States is obviously larger, but even the United States realised that in order to develop up medications in the addictions field they had to invest very heavily over a 10 to 20 year period to basically take the place of industry because industry was not investing

**The Hon. HELEN WESTWOOD:** Are there other treatments that we have not talked about that you think could be an area—

**Professor LINTZERIS:** For?

**The Hon. HELEN WESTWOOD:** Our terms of reference are very broad, it is drug and alcohol. We have tended to concentrate around naltrexone, because that was mentioned in the original terms of reference. I am just wondering whether you think there are other areas of treatment that we should be considering for further research or further investment by government?

**Professor LINTZERIS:** There could be significant improvement in the way that we respond to people with drug and alcohol problems not necessarily by trying to find the new cure. We could improve our response to this issue by application of what we already know. Let us get on and do what we know works. Why are we not doing that? A lot of that has to do with the place of drug and alcohol both in society, the stigma for patients to present for services and the marginalisation of drug and alcohol services from mainstream health systems. Our trainee doctors and our trainee nurses on the whole are not being introduced to drug and alcohol as though that is a legitimate area of health care. Most GPs do not want to be involved in the treatment of people with drug and alcohol problems even though most GPs already have practice rooms full of patients with drug and alcohol problems. Indeed many of those GPs are actually contributing to the dependence of many of those patients in the area of pharmaceutical drugs, which I will come back to.

The main problems we have in drug and alcohol is alcohol first and foremost. The second biggest problem is alcohol and the third biggest problem is alcohol. Let us be clear about this: in terms of the impact upon our health systems, upon mortality and economic and social factors, alcohol outstrips everything else. It is night and day. Then traditionally we would talk about cannabis and heroin but in many respects the growing phenomenon is actual pharmaceutical drug problems. For some time it has been benzodiazepines and more recently pharmaceutical opiate analgesics. We now have more opiate overdoses presenting to hospitals through prescription opioids than we have heroin. The field has changed. It is not 1999 anymore; it is almost 15 years since then. In many parts of Australia they do not see heroin users. They have not seen a heroin user. In Tasmania, for example, they do not see heroin users. It is people misusing morphine, oxycodone preparations.

This is an emerging phenomenon. We have to think our way through this. Part of this is then do we need the new miracle cure to identify how to address Xanax problems? I would argue no, we already know a lot of what we could do and what we should be doing. There is currently a pharmaceutical drug misuse framework, it is not a strategy, that is currently being considered by all jurisdictions through the Intergovernmental Committee on Drugs [IGCD]. That has developed a whole range of really important strategies, things such as setting up what gets called electronic real-time prescription monitoring systems. If a doctor can actually see live on their computer and say, "No, I am not going to prescribe you another box of 200 OxyContin tablets because it says here you went to another doctor yesterday and got that." These are important things that we can proceed with through just better coordination and better resourcing.

There is always the attraction of finding that miracle cure because that will solve all our problems. I would hasten to add that even if we identified a new medication that worked better than anything we had before we would struggle to actually implement it in our current service systems largely because again you need a lot of resourcing and a lot of development time to introduce new treatment modality to get the actual implementation. This is the translation of research to practice. Just because it is hard, just because it is difficult does not mean we should not be doing it. Indeed, if we were to identify the most pressing problems with opioids again if someone came to me in my various roles I would be arguing that we need to be thinking about better responses to pharmaceutical opioid problems at the moment rather than, dare I say, the two more popular extremes. We still hear people calling for heroin trials or injectable heroin trials and we also have people arguing that we need more naltrexone implant research or injectable research. I do not dispute either of those; I think we do need both injectable and antagonist research but I would not say it is the priority area for us at this point in time. Pharmaceutical opioids are what are filling up our hospitals at the moment.

**The Hon. SHAOQUETT MOSELMANE:** Following on from the Hon. David Clarke's question about you supporting a New South Wales trial for naltrexone treatment, who do you think could best conduct this trial in New South Wales?

**Professor LINTZERIS:** New South Wales is the place to do it anywhere in Australia, to lead the trial at least anyway. I think that to do this kind of research you need multisite research first and foremost. It cannot just be done in one spot. You need to be able to engage a range of service providers. We have some very prestigious clinical researchers and research teams in New South Wales. Clearly, we have the researchers at the National Drug and Alcohol Research Centre. We also have a range of services that have been heavily involved.

We at Langton Centre have been involved in doing investigational trials in this area for over 20 years. We have colleagues across New South Wales in local health district [LHD] sectors. To do investigational trials you need the setting up of institutions that have done these kinds of trials before. You need trial pharmacies. You need a whole clinical research infrastructure around it. That exists in New South Wales, so it is not impossible to do. It is expensive to do this kind of research. Off the top of my head, without submitting you a research application, anything less than half a million to a million dollars to support the research components and you are not going to be able to do it. That is to support the research components. That does not include—

**The Hon. SHAOQUETT MOSELMANE:** I want you to ask for $5 million so that we can get it.

**Professor LINTZERIS:** That is actually a really important point. If you look at what would be the investment of clinical services to provide, when I say half a million to a million dollars, that is just to get the independent researchers in to be doing the independent research. If we then also look at the costs associated with services—the doctors, the nurses, the patient consumer advocates and so forth—that usually, in my experience of running trials, is somewhere between three to 10 times more the cost of the research. That ballpark of around five million bucks, you are probably not wrong there in terms of the total commitment that would be required.

**CHAIR:** I think when you were talking about the cervical cancer vaccine you said CSIRO. I think you meant CSL, did you?

**Professor LINTZERIS:** CSL, yes.

**CHAIR:** I declare I had an interest there because I worked for Merck Sharpe and Dohme that developed the product and put them money in. You are right, it is up to the pharmaceutical companies.

**The Hon. JAN BARHAM:** Thank you for raising the issue of prescription drugs. I want to focus on that and what I see as an emerging problem that is not getting enough attention. That is young people with polydrug use, particularly with alcohol, Xanax, and a range of antidepressants. This problem is there and I do not think it is being addressed. Can you advise how you see it, what can be done about it, and how we can address that?

**Professor LINTZERIS:** There are two populations. There are two age populations that we need to consider. One is the youth. We have been interested now for 10 or 15 years about youth. Then we have the elderly—the aging population. I should not refer to them as elderly—the aging Australians. If we look at issues of youth, a lot of people get worked up about where are the drug and alcohol services for youth? In many respects drug and alcohol services for youth really need to be invisible in the sense that they really need to be integrated into services for youth. That is not to say there should not be some specialist youth services but that should not be the main approach to how we respond to drug and alcohol issues in young people.

Most young people with drug and alcohol problems will also be experiencing a range of other significant health and often social problems. There will often be disruptions in education, in employment, in vocation. There will often be mental health problems, a range of sexual health risk factors. There are often family issues as well. These are multidomain problems and I think one of the errors of the 1990s was the idea of let us go and set up standalone youth drug and alcohol services. This gets back to where should drug and alcohol services be? They should be everywhere. But when we are thinking about particular populations that we know are not going to come to traditional drug and alcohol clinics we need to be thinking how do we actually take the services to where the people are rather than trying to get them to come to us? That is where we really need to be thinking about integration of drug and alcohol services into youth services. Things such as the Headspace model is a good model. It is a useful model, but it addresses those with mental health issues and we need to be thinking along the lines that drug and alcohol really should be seen as everyone's issue.

The same thing is occurring with our aging populations. The baby boomers have now reached that age, their history of substance use is very different to earlier generations and research that we have been doing at South Eastern Sydney both with my colleague Professor Draper, who works in aged mental health and also in

drug and alcohol service, we have been looking at substance use in aging populations and there is a lot of concern there. It looks as though we can predict that we are going to have a new population to be worried about and that again is going to ask the question: how do we respond to that? Again we have got to be thinking about how we integrate drug and alcohol responses interventions into existing service systems.

**The Hon. JAN BARHAM:** This leads to your point about underfunding and the population-based funding of the Drug and Alcohol Clinical Care and Prevention model [DA-CCP]. Is that going to change the way funding happens and the allocation of services and the integration? Is the lack of integration a big part of the problem?

**Professor LINTZERIS:** Poor coordination of services, poor integration, yes, that is a significant issue. With the DA-CCP, it would be great to think that a modelling project is going to change the world. What it does allow us at least to identify is, as you will note in the response—I think you have asked us to estimate are we adequately resourced. We all know we are not, but by how much? It is hard to actually place a figure on it. So the DA-CCP at least gives us a modelling approach, our best guesstimate based according to what we know.

**The Hon. JAN BARHAM:** Better than not knowing.

**Professor LINTZERIS:** Better than not knowing how short we are of the mark. What DA-CCP does not necessarily tell us is who should provide those services. The DA-CCP will provide, for example, that we need 100 counselling episodes for that town. It does not actually say that should be delivered by a GP, by an NGO, or by a government sector or by a psychologist on Medicare; it just says we need 100 counselling episodes.

**The Hon. JAN BARHAM:** Who is looking at how that can be provided and where the shortcomings are or whether there should be a new integrated model devised?

**Professor LINTZERIS:** The Commonwealth has initiated a review. Whilst it is supposed to be a whole of all government approach, the terms of reference clearly are more oriented and targeted towards the Commonwealth-funded NGO sector. It is not to say that other parts of the system will not be looked at, but the focus is on the Commonwealth-funded NGOs. We have the problem of coordination of health care in Australia. We could be talking any part of health and we would be having the same discussion. Commonwealth funds services through NGOs directly. It does not necessarily talk or coordinate particularly well with State-funded NGOs. There may be examples where Commonwealth and State are funding the same NGO to deliver the same service. There is no way of checking.

Then we have LHD-based services. It is easier to map those because the New South Wales Government knows the funding that has been given out, as it is easier for New South Wales to map what State-funded NGOs are doing. Then we have the big black box of what is occurring out in Medicare land. How many home-based alcohol withdrawal episodes are being delivered by general practitioners at the moment? We have no way to estimate that; none. How many psychologists are providing drug and alcohol counselling? We have no way of estimating that. Those Medicare items do not differentiate or tell us what the focus of the intervention was. We can make guesses from big epidemiology studies such as the Beach study but they are unsatisfactory. We have a problem of coordination of the delivery of services and that is challenging for Commonwealth-State relations. I think I best leave it at that when I start talking about Commonwealth-State relations.

**Reverend the Hon. FRED NILE:** Thank you for coming in, professor. I will follow up on previous questions. You made a comment a moment ago about the seriousness of alcohol abuse and I agree with that. If we had a trial into the use of naltrexone implants could the trial include both alcohol dependent persons and drug dependent persons, would that be feasible?

**Professor LINTZERIS:** I would argue you would set up separate trials. You could not really set up one study with one protocol that enrolled either alcohol or opiate dependent people. You could set up a study that focused on alcohol and opiate dependent people but there is not many of them. It would be a hard study to fill and that is not the main problem. Let us be clear, the future of long-acting naltrexone products, whether or not implants or depo injections, or however we do it, the real commercial viability is in the management of alcohol. Vivitrol was licensed initially for alcohol, not for opioids, and the real market is in alcohol. What we try to do in our applications at the National Health and Medical Research Council [NHMRC] and the studies we tried to set up were for alcohol dependence. Not that there wasn't a role for opioid dependence but there is a game that needs to be played about how you get industry involved. Part of that game is demonstrating, first, that

it is feasible and we can do it but, secondly, there is a market there. When you do the sums the market is most certainly for alcohol dependence in Australia and that is based on volume of people not because it necessarily works better or worse: that is, do your sums and how you present that to industry.

The other reason we were keen to look at Vivitrol for alcohol dependence or would consider any naltrexone product for alcohol dependence is that naltrexone is already subsidised by the Pharmaceutical Benefits Advisory Committee [PBAC] for alcohol dependence—you can get it on a free script. It costs $5 or $6 a month. It is not on the free script for opioid dependence. That was a determination by the PBAC based on evidence that did not support naltrexone as cost effective. This was a Pharmaceutical Benefits Advisory Committee decision made 10 years ago when naltrexone was licensed. The PBAC deemed that there was not sufficient evidence to demonstrate that naltrexone is cost-effective for opioid dependence and did not support it being on the free list for opioids but did support it for alcohol.

Our strategy, in focusing on alcohol, was that at the end of the day uptake and the market for this medication would be very much reliant on it being able to be on the free list of medications. If patients had to pay for the existing Vivitrol from the United States, depending on the exchange rate of the Australian dollar, estimates are somewhere from $600 to $1,000 per injection. Different manufacturers charge differently but the implants cost from $2,000 to $5,000 for a course of naltrexone implant treatment over six months or so. Being able to afford the treatment is a significant barrier for most patients.

**Reverend the Hon. FRED NILE:** How do we change that?

**Professor LINTZERIS:** Cost-effectiveness. There needs to be a rational framework for what medicines governments do subsidize. There is a framework and the Pharmaceutical Benefits Advisory Committee has its systems: you have to demonstrate cost effectiveness and any study of naltrexone implants or depo would have to have a cost effectiveness arm. To proceed without a cost effectiveness arm would be a huge error. That is why in many respects if alcohol was always the target because there is more alcohol dependent people—many more, over 10 to 20 times more—so the market is bigger and we would stand a chance if we could demonstrate it is as cost effective as oral naltrexone if not more cost effective. If that occurred we would have a leg to stand on to ask the Pharmaceutical Benefits Advisory Committee [PBAC] to put it on the subsidised list and make the treatment available.

**CHAIR:** The Pharmaceutical Benefits Advisory Committee?

**Professor LINTZERIS:** Yes.

**CHAIR:** They judge on three arms: safety, efficacy and cost effectiveness?

**Professor LINTZERIS:** Yes.

**Reverend the Hon. FRED NILE:** You are aware that Dr O'Neil has a set-up in Perth manufacturing naltrexone implants?

**Professor LINTZERIS:** I am aware there are several manufacturers in Australia.

**Reverend the Hon. FRED NILE:** Of the implants?

**Professor LINTZERIS:** Of implants.

**Reverend the Hon. FRED NILE:** But they have trouble getting Therapeutic Goods Administration approval, is that correct?

**Professor LINTZERIS:** You would have to ask them if they have lodged an application. I am not sure if they have ever lodged as that is usually commercial in confidence information. I am not sure they have ever lodged. I am aware, because it is public knowledge, that there have been research grants to support the development of that medication through United States and Australian research grants. That was to support the development of that medication. Anyone who has been involved in developing medications knows it is a long arduous process and if you have not done it before the chances are you are not going to do it. There is a reason why biotech companies operate the way they do. You need a lot of expertise to get the product to a point where a big pharmacology company, who really has the resources to push it through, will do so.

There is a method that this usually rolls out with and it is fair to say that has not yet occurred in this country with naltrexone implants. To my understanding we have not seen the normal engagement of the pharmaceutical industry in picking up the naltrexone products. I am aware of a company somewhere in Melbourne, other groups in Queensland and George O'Neil's group, Go Medical, that have looked into developing implants. They have all been engaged in the process but I would have to say I am not aware of and cannot give testimony as to whether or not anyone has applied to the Therapeutic Goods Administration and without applying to the Therapeutic Goods Administration you will not get licensed: that is the way it goes.

**Reverend the Hon. FRED NILE:** You have applied for other research grants, if we got the State Government to agree to a trial of naltrexone implants would you be interested in being involved with the trial?

**Professor LINTZERIS:** Certainly. The South Eastern Sydney Local Health District has been heavily involved in leading a range of clinical trials over the years for opiate medications, including oral naltrexone, methadone, buprenorphine, slow release oral morphine and long-acting naltrexone research. We have been involved in doing research with these populations. I also have my own expertise as a researcher in this area. You need to make sure that you have the appropriate governance over any study: You need the right mix of independent researchers, clinicians, consumers and industry all working together to make an effective study.

**CHAIR:** Thank you Professor Lintzeris, your expertise is valued by the Committee. If members of the Committee have any questions in writing would they be able to forward them to you?

**Professor LINTZERIS:** Yes, the secretariat has my contact details.

**(The witness withdrew)**

**(Short adjournment)**

**ROSS COLQUHOUN**, Member and Fellow, Drug Free Australia,

**GARY CHRISTIAN**, Secretary, Drug Free Australia NSW,

**BRIAN WATTERS**, Member, Drug Free Australia,

**SHARON CARR**, Member, Drug Free Australia NSW, sworn and examined:

**CHAIR:** Welcome everyone from Drug Free Australia. It is wonderful to have you here this afternoon contributing to the drug and alcohol inquiry. We have your submission in front of us, but if you wish to make an opening statement, you may do so.

**Mr CHRISTIAN:** Yes. Ninety-three per cent to 97 per cent of the Australian community do not approve of the regular use of heroin, cocaine, speed, ice, or ecstasy and 77 per cent do not approve of the regular use of cannabis. Clearly Australians do not want their legislature to entrench drug use in their society, yet up until the tough-on-drugs approach we were well ahead of the rest of the developed world for illicit drug use under the sole harm reduction strategies of previous years. Drug Free Australia's stance is based on research evidence from here and abroad and mirrors the desires of the Australian people rather than being ideologically driven. Unfortunately for years the legislature has been given incorrect information about most harm reduction initiatives. You have or will hear many incorrect claims for methadone during this inquiry. Compare them to this handout—the most authoritative review—that records that methadone shows no statistically significant benefit over non-treated users for reduced criminality or mortality, despite the claims made otherwise. You will hear all those claims.

Naltrexone, by contrast, shows demonstrable and significant decreases in mortality. Eight in every 1,000 methadone patients will die yearly compared with one in every 1,800 on naltrexone. That is 15 times lower. The National Health and Medical Research Council found naltrexone implants to be a valuable treatment for opiate dependence and they called for more trials, which need to be funded, and based on recent random control trials, also in the United States, declared implants safe and effective. Contrary to some claims, we at Drug Free Australia do not suggest that treatments other than naltrexone have no value or that naltrexone should be mandatory. It needs to be available to those who want to be drug-free and should be offered with good psychosocial supports or in conjunction with rehab. We emphasise that a Scottish study found that 57 per cent of methadone patients want to be drug-free, but methadone, which is often called chemical handcuffs, is more addictive than heroin, with only 3 per cent of patients becoming drug-free each year.

We want to highlight other harm reduction misinformation. Two Australian reviews claim that needle and syringe programs were preventing tens of thousands of cases of HIV and hep C with billions of dollars of savings to the community every decade, yet the most authoritative international review indicates that the connection between needle exchanges and HIV transmission is inconclusive and that it has no effectiveness in reducing hep C. Claims for the injecting room have been just as false. I refer you to handout number 2. It claims that 25 lives are saved per year from a facility that hosts, at best, 5 per cent of all Kings Cross injections, making the number of actual lives lost in Kings Cross double from the other 95 per cent of injections on the street. We can explore this later. No benefit has been shown in reducing HIV or hepatitis C at any time and only 11 per cent of clients are referred to treatment. Public amenity is only improved in line with the reductions in heroin use from the heroin drought and the Federal Government's tough on drugs strategy, which indeed worked. Overdose deaths went from 1,100 per year down to 300, but have since gone down to 700.

Mandatory treatment is marginally more successful than treatment by choice and so it is a real option for New South Wales. Sweden is an example. Through mandatory treatment it has reduced its drug use from the highest levels in Europe to the lowest in the developed world. Rehab works. The handout we have given you illustrates the results of another study in Australia from March 1999. The United Kingdom is prioritising an abstinence and recovery model. We commend their approach. We also recommend that more attention be given to linking services for mental health and alcohol and other drugs. In conclusion, a reduction in demand follows reduced accessibility and availability and the provision of effective treatment. Today we want to talk about effective treatment.

**CHAIR:** Thank you for those remarks. I will inform members of the Committee that we have handed out two Cochrane Collaboration articles. It goes to my one question that I was going to ask. In your submission in addressing the terms of reference—

**Mr CHRISTIAN:** I gave you the whole paper so we could at least say we had given real evidence.

**CHAIR:** We will get a copy for everybody.

**The Hon. DAVID CLARKE:** You referred to a report on needle distribution programs that you said was inconclusive.

**Mr CHRISTIAN:** Yes. That is the United States Institute of Medicine report from 2006. It is referenced in our paperwork.

**The Hon. JAN BARHAM:** The handout or the other one?

**Mr CHRISTIAN:** It is referenced in the full submission.

**The Hon. DAVID CLARKE:** Will you give the reference again?

**Mr CHRISTIAN:** The United States Institute of Medicine. The title is too long to remember, so that is why I am referencing our submission.

**CHAIR:** We will find it. Going to the materials that were handed out, would you spend some time highlighting the relevant points, because they are significant. It was a Cochrane review?

**Mr CHRISTIAN:** Yes.

**CHAIR:** I note on page 8 of your submission you state that the *British Medical Journal* 2010 indicated that the average length of injecting heroin is five years and the average length of injecting methadone is over 20 years. There seems to be a general community concern about the cost effectiveness of the amount of money that is being put into drug and alcohol treatment. No-one begrudges money spent on drug and alcohol treatment, but the community wants to see effective outcomes. This inquiry has heard of different approaches to be taken. Dr Colquhoun, will you take us through the salient features of the Cochrane report and perhaps indicate what the importance of the Cochrane review is from an epidemiological point of view.

**Dr COLQUHOUN:** The Cochrane review was published in 2009, authored by professors Mattick, Breen, Kimber and Davoli. As you know, the Cochrane review looks at the randomised control of trials for a specific intervention as part of the research literature.

**Mr CHRISTIAN:** It is a gold standard, by the way.

**Dr COLQUHOUN:** That literature is then analysed to come up with findings with respect to the effectiveness of particular treatment.

**CHAIR:** It is like a meta-analysis?

**Dr COLQUHOUN:** A meta-analysis, yes. It is quite unequivocal that there is a lack of evidence to support many of the claims made for methadone that it improves social outcomes and it reduces mortality, reduces criminality. In fact, the research shows that there is no support for that evidence whatsoever. I can quote directly from the Cochrane review. It says:

> Methadone is an effective maintenance therapy intervention for the treatment of heroin dependence as it retains patients in treatment

—not surprisingly given the addictive nature of the drug—

> and decreases heroin use better than treatments that do not utilise opioid replacement therapy. It does not show a statistically significant superior effect on criminal activity or mortality.

The other interesting finding is that there are no randomised control trials to link methadone use with HIV transmission. Therefore, there is no evidence whatsoever to indicate that methadone is effective in preventing HIV, which is often the main selling point for that particular medication or intervention. At the cost of $150 million a year to keep 46,000 people addicted to methadone, you wonder where the evidence comes from

for that program to be sustained. Moreover, methadone in itself tends to keep people in treatment much longer. The statistics, as quoted, indicate that the average career of a heroin addict is around 5.5 years whereas people on methadone stay on it for an average of 20 years–even though they might cycle in and out with that. Statistics from the United States now indicate that the largest group of people on methadone are those aged 45 or older, and that some 73 per cent of those people continue to inject drugs.

When you look at those factors put together—that mortality is no better than no treatment—that people on methadone tend to stay on it much longer than they would heroin and the fact that they continue to inject drugs, means that mortality in the long term is probably worse than heroin over the period of time that a person continues to use methadone. Moreover, something like 80 per cent of people do not want to be on methadone. The truth is that it is a highly addictive drug that has detrimental effects not only on lifestyle and freedom but also on people's health and, ultimately, on mortality rates and their capacity to live a decent life.

**CHAIR:** Various witnesses appearing before the inquiry have been canvassed about Therapeutic Goods Administration [TGA] approved trials and possibly National Health and Medical Research Council [NHMRC] approved trials on formulations of long-acting naltrexone, be it implants or depot intramuscular injections. What is the opinion of Drug Free Australia about NSW Health being involved in such a trial?

**Dr COLQUHOUN:** From looking at nearly all of those submissions, Australian National Council on Drugs [ANCD] et cetera, the NHMRC report is often referred to. That report says that there is very strong theoretical evidence and growing empirical evidence to show that naltrexone implants are effective in terms of treatment for opiate dependence. They all call for trials. In fact, back in 2004 there was a federal inquiry called the Roads to Recovery that called for trials of naltrexone implants as a matter of urgency. While there has been one trial funded in Australia by I think the University of Western Australia or Curtain University by Gary Hulse, there has been very little other funding of trials.

It is interesting too that the trials that were funded back in the late 1990s, conducted by John Currie at Westmead Hospital and another randomised controlled trial comparing methadone and naltrexone in Brisbane by John Saunders amongst others, have never been published; yet those results were quite clearly in favour of the use of oral naltrexone at that time. The methadone study showed that people who were on methadone benefited somewhat better going off the naltrexone and that it was an effective form of treatment. One wonders why those studies that were funded have never been published, even though they have been presented at different conferences at different times.

The NHMRC studies also indicate that as of 2010, despite quoting a number of studies, including randomised controlled trials in Norway and here in Australia, there was not sufficient evidence to support the use of naltrexone implants. Since then there have been a number of studies completed. Both Kunøe and Kapitzky in Norway and Russia respectively have completed studies. Since then the National Institute on Drug Abuse [NIDA] has come out to say that depot naltrexone has not only been shown to be effective but also a safe intervention for opiate treatment.

**CHAIR:** And the depot was the intramuscular injection?

**Dr COLQUHOUN:** That is right, which is a very similar concept to implants. There is very little difference—use the same lactates and so on to carry naltrexone—but are quite expensive, painful and obviously only last a month, whereas the implants that are made in Australia give protection for six months or more, so clearly a superior product. They also demonstrate superior outcomes in terms of mortality, not only of oral naltrexone but of other forms of treatment of opiate dependence. As well as those trials the clinic I was running also conducted a trial looking at naltrexone blood serum levels. That trial was approved by an ethics committee and registered with the TGA, and has now been approved for publication in an international peer review journal—I think I included a copy of that blood serum level paper. It is quite clear from the studies that we conducted, and we had other papers published in 2005 that looked at oral compared with implant naltrexone, which were quoted at length in the NHMRC study, as well as the Hulse study and the Kunøe study, it is clear from those that there are very few adverse outcomes.

Some years ago there was a paper written by Lintzeris and others who suggested that there were a number of poor outcomes or adverse events related to naltrexone implants. It is quite clear that none of them were specific to implants but were in fact the effect of opiate withdrawal. How they confused opiate withdrawal with specific adverse events related to an implant is beyond me. The latest studies that have now been

completed and approved for publication have been written by Kunøe, Lobmaier, Ngo and Hulse—I can table the report if the Committee wishes.

**CHAIR:** Thank you. This is the Western Australian group that trialled—

**Dr COLQUHOUN:** No, this is an international group of researchers from Norway and Western Australia—Kunøe and Lobmaier are from Norway.

**CHAIR:** So there was a collaboration between Norway and Western Australia?

**Dr COLQUHOUN:** That is correct, in reviewing the literature. This was published in 2013. The conclusion is that the sustained release naltrexone is a feasible, safe and effective option for assistance abstinence efforts and opiate addiction. That is the latest research that builds on the body of research that now is quite extensive and that has occurred over the last few years. But we would agree, as a group, that it is important to continue with those trials. We particularly need to look at longer-term outcomes. Anecdotally I have been treating people now for nearly 14 years. I know that naltrexone can be incredibly effective in turning people's lives around, freeing them from opiate dependence as well as methadone dependence, but we still need more research on longer-term outcomes.

The other thing we need to do is compare methadone to naltrexone, and that is research that was started back in the late 1990s and needs to be concluded with further funding. At this stage with respect to personal involvement in the outcomes, I wonder if we could ask Sharon if she might give some firsthand evidence to the Committee about her experience with some people who have been through the clinic.

**Ms CARR:** All members of the Committee, I would like you to understand that there are some individuals I have met over the last few years, who have been involved with the methadone program and who just did not want to be on that roundabout. They then had the implant and were able to build up their self-esteem and actually integrate back into the community. One young lass came to Government House to speak to an individual about her problem with addiction and she was able to represent herself. She is not here today—I wish she was—but she is a student now and is looking at coming back into the community, as is the case for most of the individuals who have been involved with naltrexone.

Naltrexone gives them individual opportunity to be drug-free, and I really hope you embrace this concept. The individuals I have spoken to, who are involved with the methadone program, have the challenges that they go in a collect their methadone. One young lass said to me that she blows her nose and the methadone is in her tissue. If she does not score within a short time after she has left the clinic—because the dealers know where the individuals are collecting their methadone—she then has to eat the tissue, if she does not end up scoring. This concept of being heroin-free or opiate-free when you are actually on the methadone program is a fallacy for a lot of the individuals who have an understanding of the methadone program. It is very challenging for those individuals then, if they are on the program, to integrate into the community because they are not able to conduct themselves in the normal day-to-day life of taxpayers and so forth in terms of working.

**CHAIR:** We have an extension of time, so each member will have an additional three minutes within which to ask questions.

**The Hon. JENNIFER GARDINER:** One of your recommendations is that the New South Wales Government should take up the United Kingdom approach, which of course recently was reviewed and implemented. Can you give us a snapshot on why we should do that in New South Wales, and whether there are any parts of the new United Kingdom regime which we should not adopt?

**Mr CHRISTIAN:** Okay. The United Kingdom has put its emphasis on recovery, which we believe concurs with the Australian consensus pretty much out there as to what they want with drug policy. We spell out at the beginning of our document what the surveys have shown about Australian attitudes. The United Kingdom, in taking that step in moving towards recovery, has actually put into place something that is a bit like the old Job Network that happened: they actually pay for outcomes. I think that is definitely worth a look. It will be worth somebody going to the United Kingdom and seeing how that is working, but their claims are actually recorded here. That was from their first report.

They say that they have an improvement with 18 per cent increase of people who are leaving treatment free of dependence. They are tracking what is happening and keeping the results. As far as anything that we

would not want to go with, I do not think that there is anything that we have discussed among ourselves that we would say was not worth going with. Sweden, of course, is the best example of what is working out there. The United Kingdom is trying to follow a little bit, but is not entirely in their tracks now.

**The Hon. SHAOQUETT MOSELMANE:** Thank you very much, gentlemen and Ms Carr, for being here this afternoon. You note in your opening statement that the majority of Australians want a drug-free Australia, and that politicians should follow the people rather than ideology.

**Mr CHRISTIAN:** Correct.

**The Hon. SHAOQUETT MOSELMANE:** I note that your submission is pretty much ideological, emotive and politically charged. What do you say to that comment?

**Mr CHRISTIAN:** With all respect, we would like to know where you see it as emotionally charged. We think we have given you evidence. We have footnoted where the evidence is coming from. If we are talking about needle exchange, it comes from the United States Institute of Medicine. If we are talking about the injecting room, it comes from our doctors, who are fellows of Drug Free Australia. It is all very, very evidenced, if you go and have a look at our stuff—very tightly evidenced. If there is anything emotive on top of that, that is because the evidence is for it. That is my best response.

**The Hon. SHAOQUETT MOSELMANE:** Can you tell the Committee what medical background you have?

**Mr CHRISTIAN:** Okay.

**The Hon. SHAOQUETT MOSELMANE:** Or any of the members?

**Mr CHRISTIAN:** I am the research coordinator, and we have 24 fellows who are dotted around the world but who are mostly within Australia. The majority of those are doctors mostly in addiction medicine, epidemiologists and those kinds of people, who contribute to our reports and who guide what we as Drug Free Australia publicly say. I do not have any medical qualification. I am just the bovver boy who just puts it all together for them, you know?

**The Hon. SHAOQUETT MOSELMANE:** Yes. Does anybody else?

**Mr WATTERS:** I think one of the problems we have had to face is the over-medicalisation of this problem. This is a psychosocial problem as much as it is a medical problem. I must say in respect to naltrexone and methadone that there is no magic bullet. Giving a person some sort of a chemical substitute, or even a chemical barrier, on its own is not going to solve the problem. We need to involve ourselves in the whole background of the person—the psychosocial factors that lead to addiction. If we do not deal with that—substance abuse in itself is a symptom of an underlying problem, and that is what we have to deal with. I frankly have dealt with literally thousands of people who come to the programs that I have managed to get off methadone. They found it was too restrictive in their life. They found to themselves going to places which were a honey pot for drug addicts and criminals, and which was leading them astray. They found they were too restricted in their ability to live a normal life, so they wanted to get off it.

The other thing that needs to be pointed out is that there is a huge amount of money invested in the methadone industry. As soon as any questions and doubts are being raised, I find that vested interests raise their head very quickly. We are talking about, in Australia, what—$150 million? I was in this building in 1986 when methadone was introduced in the Theatrette downstairs. I cannot remember if it was Mr Wran or Mr Carr. I think it was Mr Wran, was it?

**CHAIR:** It was Wran before. Nick Greiner came in in 1988.

**Mr WATTERS:** It was just before that. It was 1986. We were told that methadone was going to solve the problems for us. It was brought to Australia by Dr Stella Dalton, who had been working in the United Kingdom in a prescribed heroin clinic. She saw the people going down and down, and she felt she could no longer be part of that. She was returning to Australia and she heard about methadone being used in the United States. She inquired, and on that day in 1986, it was introduced as a six-week program, which would help people to come off heroin and it would be monitored. It would be given psychosocial support. There would be regular

urine tests to make sure they were not using other drugs. I can tell you I read an article not long ago by Dr Stella Dalton, who is breaking her heart about what has happened to it since. It is being presented as a magic bullet and expanded beyond all possible belief at that time. There is no cheap and easy way.

My qualifications, by the way: I am a trained addictions counsellor; I have managed the Salvation Army treatment centres for a number of years; I was also with the Federal Government, chairing the Drug Advisory Committee; and I had five years at the United Nationals International Narcotics Board. My other qualification is that I have a degree in sociological medicine.

**The Hon. SHAOQUETT MOSELMANE:** I will ask one more question before I pass on to my colleague. You argue that a naltrexone implant is proven and effective medication, but yesterday and today we have had witnesses who all argue that, to date, it has not been scientifically proven that it actually works. What is your response to that?

**Dr COLQUHOUN:** Can I answer this? There is a number of studies.

**Mr WATTERS:** I have visited the National Institute of Drug Abuse [NIDA] myself in the United States. It is by far the largest research organisation in the world. The national institute for drugs and addiction in Baltimore in the United States of America is a huge organisation. They have done research on this subject that we could never contemplate financially in Australia, and they have written a very comprehensive response to say that this is a very effective treatment.

**Dr COLQUHOUN:** Moreover, since the National Health and Medical Research Council did not dispute that it was a valuable treatment adjunct coupled with psychosocial support and readjustment to the community, particularly re-employment, there have been quite a number of studies published of randomised controlled trials, including our blood serum level study, that show quite clearly that it is highly effective. It is not only theoretically effective, but now the research is demonstrating that very clearly. But I will go back to your point about ideology, if I may. We have gone to a lot of trouble to find the research that not only supports the use of naltrexone—and that is presented before the Committee here and our references and also copies of that research—but we have looked at the research supposedly done to support the injecting room, needle exchange programs, and particularly methadone. We find that there have been a lot of claims made that are just not supported by the evidence.

If there is an ideological position taken, it is by those people who suggest that drug use is a matter of freedom of choice, a lifestyle choice, and a human right to use drugs, and who advocate decriminalisation of drugs, which we oppose. We think that would be a terribly sad and tragic experiment if we were to ever do that in this country. We know that as drugs become more accessible and more available, more people tend to use them. A lot of young people will start to use these highly dangerous drugs, including heroin, if they believe that somehow or another they are condoned. We very much oppose decriminalisation of drugs.

**The Hon. HELEN WESTWOOD:** There are a couple of areas that I just wanted to follow up with you. Dr Colquhoun, you have referred a number of times to the National Health and Medical Research Council studies.

**Dr COLQUHOUN:** Yes.

**The Hon. HELEN WESTWOOD:** Can you tell me when those studies actually occurred? Would you possibly be able to reference those, please?

**Dr COLQUHOUN:** Yes. The studies were released in March 2010. It depended on randomised controlled trials, which were available at the end of 2009 and which consisted of the Kunøe study in 2009 and the Gary Hulse study. They also referred to a number of other research studies, including the one that we did in our clinic comparing oral naltrexone to implant naltrexone, that were not randomised controlled trials. But, as I pointed out, in those three years since then, there have been quite a lot of randomised controlled studies and other studies that are now completed.

**The Hon. HELEN WESTWOOD:** Where is that evidence? Where could the Committee find the results of those trials?

**Dr COLQUHOUN:** I have a couple of those papers that I am happy to table for the Committee.

**The Hon. HELEN WESTWOOD:** That would be great, if you could do that.

**Dr COLQUHOUN:** This is the Kunøe-Lobmaier study. There is another by Krupitsky and another one in 2012 by Kunøe. I am happy to leave those with the Committee.

**Documents tabled.**

**Mr CHRISTIAN:** We also reference quite a few of the studies on page 13 and 14 of our submission, so you might refer to those.

**The Hon. HELEN WESTWOOD:** Thank you. Do you accept that addiction medicine is a legitimate stream of medical practice and research?

**Ms CARR:** Sure.

**Mr WATTERS:** Certainly.

**Mr CHRISTIAN:** Sure. I think we did make a statement, when we were talking about naltrexone, that we still recognise a legitimacy of other treatments, including methadone. We just want some reality about methadone. That is the important thing. We are not against it. We want some reality.

**Ms CARR:** And choice.

**The Hon. HELEN WESTWOOD:** Ms Carr, I will let you speak in a minute. I just want to add to that and you might wish to comment. Much of the evidence that we have received to date—even by people who in fact you refer to detrimentally in your submission—indicates that those people believe there should be a range of treatment options available.

**Mr WATTERS:** Yes.

**The Hon. HELEN WESTWOOD:** They see abstinence as certainly one of those options, but they do not think it is the only one because of the circumstances in which people live who have an addiction illness.

**Mr CHRISTIAN:** Sure.

**The Hon. HELEN WESTWOOD:** I am unclear. The other thing I struggle with is that you refer to the harm reduction movement. I would concur with my colleague who spoke about emotive terms. Who is the harm reduction movement? What is that?

**Mr CHRISTIAN:** People who push harm reduction ideologically, and I think there is plenty of evidence of that. There are people who say that harm reduction is the only thing that is really relevant. We have quotes in our submission, and there was one from Dr Richard Mattick, who said that abstinence is an unrealistic outcome. We see them as the apologists for a particular ideology, but that is a movement.

**The Hon. HELEN WESTWOOD:** I have to say that that is not the evidence that we have received here. We have actually heard those people. When each was asked about the trials for naltrexone, both implants and intramuscular, they all thought that that should happen. They also talked about some of the barriers to that in terms of cost and the difficulty in receiving funding for those studies. I wonder if you have a view on that, particularly Major Watters, who I know was an adviser to a previous Federal Government on this. Have you discussed trials with them and talked to the then Federal Government about what the barriers are to having those trials?

**Mr WATTERS:** Not specifically. What we did institute in those days was what was called the Tough on Drugs strategy. We took the approach that there had to be a wide-ranging multifaceted approach to the problem of drugs in Australia, which included law enforcement, customs and immigration controls, and availability of the wide range of treatment services. What we saw—and people do not seem to realise this—was a more than 80 per cent drop in drug deaths in Australia in that period. I get a bit frustrated when people say to me or tell me that nothing has worked. We knew that it did work, but it needed to be a multifaceted and comprehensive approach.

At that time, the only naltrexone provider that I knew was Dr George O'Neil in Perth. I visited him personally and I did make some approaches to the Commonwealth Department of Health to see if we could give him some financial support. At that time, the Howard Government did give him a one-off grant, but beyond that there was nothing specifically for naltrexone.

**Dr COLQUHOUN:** Can I make a comment, please, if I may?

**The Hon. HELEN WESTWOOD:** Yes.

**Dr COLQUHOUN:** Just with respect to the separate area of addiction medicine, my concern is that it is not just a medical problem but in fact psychologists, drug and alcohol counsellors, and therapeutic communities all have a very important role to play, as Mr Watters pointed out earlier. This is not simply a physical addiction. It has a lot of social and other implications that need to be dealt with at the time. The lifestyle of an addict is often aberrant and often preceded by abuse and other issues that really need to be addressed. The other issue is that there is a very close relationship or correlation between mental health issues and drug addiction. In the past we have had a separation in treatment between those two areas, with a lot of people falling between the cracks. My feeling is that we need to integrate services a lot more to include all those things.

The program that we ran involved psychosocial assessment. It involved families and it involved an after-care program as well as some medical practitioners putting implants in, and so on, to help people contain addiction. Those people who are most successful are those people who adjust to life during the period of time in which the implant is active and during which time they are blocked from using opiates; therefore there is no point in hanging around other addicts and those acquaintances. It gives an opportunity to reunite with families and community, and to get well. That potentially sets them up for a drug-free life. No guarantees of course, but it is certainly an improvement on what traditionally has been available. I just make that point about the integration of services.

**The Hon. JAN BARHAM:** Thank you for making those comments because they appear to be absent from your submission, a broader view of addiction and how it needs to be addressed. That is valuable. The other thing that does not appear to be here is your position on alcohol as an addictive substance and how you would see that being treated. Are you proposing that that be part—

**Mr CHRISTIAN:** We have not aimed to address alcohol in our submission. We are Drug Free Australia and we tend to limit ourselves more so to illicit drugs, less so to alcohol.

**The Hon. JAN BARHAM:** Are you aware of the cost to society of alcohol?

**Dr COLQUHOUN:** Of course.

**Mr CHRISTIAN:** We have no doubt about that but at the same time there is a comparison that needs to be done. When you talk about alcohol or nicotine—let us take nicotine. It kills one in every 300 people per year. It is a big killer, much bigger than alcohol in fact—19,000 deaths per year in Australia.

**Mr WATTERS:** Bigger than illicit drugs too.

**Mr CHRISTIAN:** If you are talking heroin, it is killing one in 100 every year from overdose alone. Our emphasis has been on—

**The Hon. JAN BARHAM:** I just wondered why you had not addressed it and I wondered about the scope of your Drug Free Australia. The other thing I am interested in is your position on methadone and the obvious point you are raising that you do not think it is a good method to use. Are you thinking that there would be funding to enable people to have that choice, those who are currently on methadone, to give them the opportunity to try naltrexone? Is that the idea? And that would be funded by government?

**Mr CHRISTIAN:** We would like to see more options on the table, including naltrexone, freely available to the community, just as much as methadone is. Methadone still has a place but we would like to see a few more constraints on methadone so that it achieves better outcomes.

**The Hon. JAN BARHAM:** Do you recognise that for some people being on methadone is a lesser problem for them than having a heroin or other addiction? What was not clear was that you were offering that they then have another choice with being drug free.

**Mr CHRISTIAN:** For sure.

**Ms CARR:** I have met individuals who are fortunate enough to come from families that can fund their implants. The difficulty is that not everybody has the choice in the community. I think that is what you are alluding to in that individuals can go on to the methadone program and it is funded, but other options are not funded. That seems to me to be an elitist position in that if you do not have adequate financial capabilities you are actually limited.

**The Hon. JAN BARHAM:** For me, that is what was missing. To condemn a method of treatment that is for some people a better option than keeping them out of the criminal system but then to say that they are not drug free, I think it lacks a bit of compassion.

**Mr CHRISTIAN:** I think you have heard our position that we do not condone methadone. We see a place for all of these. Our concern has been that there are people who strongly advocate for methadone who also very strongly seem to be saying things about naltrexone which are not true. That is our issue with them. You have heard their testimony. We would love to have heard their testimony. We will see it in *Hansard*.

**The Hon. JAN BARHAM:** It is all on the record so it is available to you.

**Mr WATTERS:** I do not believe methadone is treatment. I do not think naltrexone is treatment. It is an adjunct to treatment. Of itself, it will not solve the problem. Most of the people who I have worked with over many years who have come to us for residential type treatment have been on methadone and using other drugs at the same time. So in and of itself, it is not effective. I would not call it a treatment; it is a harm reduction strategy and an adjunct to treatment.

**The Hon. JAN BARHAM:** Do you accept that for some people it is a lifestyle option that gives them better quality of life?

**Mr WATTERS:** I will give you a quick anecdote. A young woman who did not succeed in our treatment program ended up prostituting herself up here and using every sort of drug. We tried and tried, and eventually I said to her, "Look, we've got to get you on a methadone program". We got her on methadone and supported it with psychosocial counselling. It helped her to redirect her life. She eventually graduated from university and is living a very healthy life. That is the way it should be used. If it helps people to overcome the immediate cravings and the need for that sort of—

**The Hon. JAN BARHAM:** Do you recognise that there are not enough support services for those people?

**Mr WATTERS:** Yes, absolutely.

**Mr CHRISTIAN:** Very clearly.

**The Hon. JAN BARHAM:** I might put something in writing to you to see if you could put that on the record because that would be valuable. What we are hearing is the need for more integrated, broader services.

**Mr WATTERS:** Absolutely.

**Dr COLQUHOUN:** I might add that naltrexone seems to be highly effective for alcohol dependence, particularly in conjunction with campral. I think the evidence is now overwhelming and it is pretty much standard in the United States for people with alcohol dependence. The other thing about naltrexone, which we did not mention, is the effect on other drug use, which is now becoming more and more documented that there is a decline. A lot of the people we see use other drugs—cannabis and amphetamines and so on—and our research and other research is showing that there is decline in that and there are claims to suggest that it affects gambling behaviour as well. So we are at the tip of the iceberg in terms of the potential for the use of naltrexone embedded in a proper psychosocial program that is comprehensive, well funded and available as a choice for people who want to be drug free. We are not talking about forcing people or coercing people.

**The Hon. JAN BARHAM:** You accept that it is prohibitive in terms of the cost of the service for a lot of people.

**Dr COLQUHOUN:** A naltrexone implant that lasts six months costs $1,800. That is fairly similar to what oral naltrexone costs. That is the implant that we were supplying to people. Compared to oral naltrexone, it is not a great deal dearer, particularly as oral naltrexone for opiate dependents is not on the PBS, costing about $160 per month. It offers a solution to people because it takes a lot of the psychological pressure away, having to take an oral tablet each day and back in those days we used to have to ensure that there was a relative who would give them the naltrexone each day and overdose rates were much higher than they are now, even though that has been exaggerated. Today the safety of naltrexone, because is allows that length of time as an implant for people to get their lives on track, is exceptional. We just have not reported any mortality compared to what used to be the case for years now.

**The Hon. JAN BARHAM:** On the cost, I think we were informed it was about $6,000.

**Dr COLQUHOUN:** That is in Western Australia, an implant there, they are charging $6,000. Mind you, a lot of people are not paying for it; they get it deducted from their dole money I think at the rate of $50 per week. The program over there, because they get $1 million or more from the Western Australian Government each year and a lot of donations they were able to subsidise that cashflow deficit and allow people to get their implant out of their dole money, which we were never able to do. We always had to charge. When they say $6,000, I think a lot of the time they do not get anywhere near that money because people suspend their payments when they get a job and so on. I think that program has been heavily subsidised by different organisations, including the foundation that was set up to get donations from the Western Australian Government for years. So it is a bit of a false price: $1,800 is the going price for a six-month implant.

**The Hon. HELEN WESTWOOD:** Is that available now?

**Dr COLQUHOUN:** Yes, if you can get them now.

**The Hon. HELEN WESTWOOD:** Can you get that in Sydney now at that price?

**Dr COLQUHOUN:** That is correct, yes.

**Mr WATTERS:** That is what you were providing.

**Dr COLQUHOUN:** That is what we were providing. The clinic is now closed. It means that people have had to go to Perth to get implants.

**The Hon. HELEN WESTWOOD:** So it is not available now in Sydney at that price?

**Dr COLQUHOUN:** No, correct.

**The Hon. DAVID CLARKE:** Why did it close?

**CHAIR:** I remind members that it is Reverend the Hon. Fred Nile's question time.

**Reverend the Hon. FRED NILE:** Thank you for appearing before the Committee. I notice that on page 11 of your submission you refer to an orchestrated campaign to discredit naltrexone. What is that orchestrated campaign?

**Mr CHRISTIAN:** We have expressed our concern within the submission about statements which are saying that it is not a legitimate substance according to the TGA when in fact it is; that it has not been manufactured correctly. All of these things are discouraging politicians, the public from seriously looking at this as an option. We have to ask the question: Why are these things being said when they are not true? What is going on? We have said that there is the possibility—we cannot prove it—that the methadone side of the drug policy sees this as a threat to their kingdom. That is a good enough word. So it is an anti-competitive issue that we may be seeing. We have great concerns about that. You have seen some of the statements and they are on the table.

**Reverend the Hon. FRED NILE:** Is there a financial factor involved in that, methadone versus naltrexone? Are people making money out of methadone?

**Mr CHRISTIAN:** Yes. I think there is an industry out there, and people have their livelihoods by providing methadone. The thing about methadone is that if you can keep people addicted then you keep making money. With naltrexone it is the opposite. You are getting people off the drug. Passing off your clients to abstinence, you are losing your clientele and the whole idea with naltrexone is to lose your clientele. Not so with methadone. Unfortunately that is the way it is practiced in this country.

**Dr COLQUHOUN:** Another thing is that if it was funded and more widely used, then the cost of naltrexone treatment would be somewhat lower—I am sure that would be the case—and much more accessible, and therefore affordable. The other thing too is that the pharmaceutical companies are very much looking at Asia with the fact that there are millions of addicts there and Australia and the harm reduction policy with methadone is an essential component. It is seen by them as an example of what could happen in Asia. I do not doubt for a moment that with that massive market there—there was a press release a couple of years ago saying that the first 100 people in Cambodia have been put on methadone at the cost of $US3,000 per person per year. To my mind that is an extremely expensive way to deal with the problem, given that those people would be dependent on methadone for years. In a place like Cambodia, to justify spending $US3,000 per year to keep someone addicted seems to be quite crazy.

There are a lot of ideological issues there. I think there is a fear by some people that naltrexone may be seen as coercive or mandatory, and I think one of the statement made by one of the groups, legal aid, saying that they disagree with naltrexone being a first line of treatment or mandatory. It has never been suggested that it should be mandatory, but I can understand the fears of those people who are dependent on drugs or support those people. Naltrexone might not necessarily be the best solution for those people and methadone might be a much better solution. People are not ready necessarily to come off—

**Mr WATTERS:** Not as a first line of treatment.

**Dr COLQUHOUN:** —not as a first line of treatment. That is probably a fear that is possibly unfounded but a real fear that may drive some of the issues. The other issue is the belief that people make a lot of money out of naltrexone, and there have been a number of submissions suggesting that. I can tell you first hand that there is no money in it and that is why the doctors who were supporting naltrexone for years—there were five programs in Sydney that do not exist any more because there is no money in it. It is extremely stressful and difficult work to deal with heroin addicts day in and day out with multiple problems, not just individually but with their families. It is not a job that you go to to make money out of, I can assure you, and I bitterly resent the implication that somehow or another I have profited as a result of offering this treatment.

**Reverend the Hon. FRED NILE:** I note that on page 14 of your submission you say there have also been attempts to discredit the GoMedical implants from Dr George O'Neil.

**Mr CHRISTIAN:** That is correct, and that is saying that they were not manufactured correctly, and the response of George I am sure you have heard. He has responded to that. He has a purpose-built facility, which meets all specifications of the Therapeutic Goods Administration. End of story.

**Dr COLQUHOUN:** The other thing too about the Therapeutic Goods Administration and the opposition to the use of naltrexone under the special access scheme, the truth is it has been allowing the use of naltrexone implants under that scheme for many years now. Moreover, it has been providing import permits for the importation of naltrexone implants by our clinic for at least six years. They are renewed very regularly, every three months or so. If the Therapeutic Goods Administration was opposed to the use of naltrexone implants and this special access scheme was seen as some backdoor method of using them, it could have quite easily stopped our import permits without any reason years ago, but it has up till recently, until the clinic closed, been providing those import permits.

Quite clearly, if the Therapeutic Goods Administration believes they are appropriately used under the special access scheme, as it told me on a number of occasions, and we also use them for alcohol under the special access scheme, something that I believe perhaps was not justifiable under its rules compared to heroin, but it assured me that under the special access scheme they would be allowed for alcohol dependence, and we have used them with remarkable success. It is quite extraordinary, the change in people's lives once they started on naltrexone for alcohol dependence.

**Mr CHRISTIAN:** Can I very quickly quote Dr John Curry, who is now in Melbourne. He said that naltrexone is a substance which has been okay within Australia, approved for a long, long time. Implants have been around for a long time. When you put the two together suddenly there is a wing of Australian drug policy to start making out there are some real problems. Both of these things, the substance and the technology, are well proven. If you put them together it does not make them any worse.

**CHAIR:** Associate Professor Lintzeris, who gave evidence this morning, was also complimentary about the efficacy of naltrexone to treat alcohol dependence.

**Dr COLQUHOUN:** Yes. I think it is well proven.

**CHAIR:** So there seems to be a shift in thinking, perhaps with the recent medical research that has been published and continues to be done internationally.

**Reverend the Hon. FRED NILE:** Obviously you would be in favour of a naltrexone implant trial if we recommended that the State Government finance it?

**Dr COLQUHOUN:** Absolutely. We have been calling for trials for years. The thing is, it is off patent. No large pharmaceutical companies—except for the Depot Corporation, and it has spent millions of dollars getting Food and Drug Administration approval for that product in the United States—who manufacture implants were interested in manufacturing, so trials will be dependent on government funding.

**(The witnesses withdrew)**

**EDWARD ZARNOW,** Chief Executive Officer, The Lyndon Community, and

**JULAINE ALLEN,** Deputy Chief Executive Officer, The Lyndon Community, sworn and examined:

**CHAIR:** I know you have presented us with a submission but do you wish to make an opening statement?

**Dr ALLAN:** I would just like to talk briefly about what we do and how we provide services. The Lyndon Community is a not-for-profit drug and alcohol treatment, training and research organisation. We work across western New South Wales and we operate a range of treatment types, including a medicated withdrawal unit, which we call the detox; a residential rehabilitation program and a number of community programs for Aboriginal people, for women and for families, and we do individual and group counselling. Our research program has a number of national research projects to do with delivering drugs and alcohol services in rural areas, and we train allied health and medical students from several universities, including the University of Newcastle and the University of Sydney. We provided around 1,500 treatment episodes last year across those different programs.

The key characteristics of the people we work with are that they are poor, they generally have chronic and complex problems, including mental illness and cognitive impairments, and mostly they seek treatment for alcohol problems. Around 60 per cent of our treatment episodes are for alcohol; about 15 per cent for cannabis; about 15 per cent for opiates, including prescription medication, which is much more common these days than heroin. The other 5 per cent is methamphetamines, benzodiazepine addiction, those sorts of things.

It is important to understand that our rule of thumb in treatment, and most treatment providers, is that you start with the least invasive option first. That would be screening and brief intervention, usually in settings like a general practitioner's surgery or community services other than drug and alcohol treatment providers. If that is ineffective, you would move into community-based programs, counselling, group therapy, those sorts of things, and then into the residential types of facilities. Really, you are putting your more intensive treatment types for people who have problems that they cannot overcome on their own or with limited support. Really that is the people where their substance use is entrenched, has been a problem for a number of years, they have tried different sorts of treatment but they are not working or experience mental illness, cognitive impairment, social isolation, those sorts of things.

The settings we work across include some of the poorest local government areas in New South Wales including, according to the recent Australian Bureau of Statistics, the Central Darling shire, which is Wilcannia, Menindee, Ivanhoe, Brewarrina, Walgett, as well as the central west of New South Wales—working west from Orange. Often in those towns, particularly towns of 1,000 or 1,500 people, there are really limited resources for services but there are also limited resources for employment, education and social activities. That is a challenge for people who are seeking to fill their lives with other things.

We talk in our submission about the costs we incur on a daily basis, particularly of our rehabilitation or residential services, but the challenges we face as a service provider are in three main areas. One is workforce. We compete with government departments for skilled and qualified staff, and the awards we pay people under our different to those awards they get in the Department of Health, for example. We need to train those, and these people work in an area that is quite emotionally demanding and stressful, as well as requiring a level of skills. The second area that is a challenge for us is infrastructure. No capital funding is available for us to maintain our facilities in a way that we consider respectful and appropriate for the people we work with. The third area is in the costs we incur that are really important to our quality of service delivery but are not part of direct services. For example, accreditation is quite expensive. In IT, we have spent $100,000 bringing in an electronic client management system, which is really important for the way we keep our records, communicate with each other and with our clients. Those sorts of things are challenges we face, those costs.

**The Hon. JENNIFER GARDINER:** Thank you for being here. You say on page 2 of your submission that New South Wales was the only State to record a statistically significant increase in illicit drug use. Would you say that that applies to non-metropolitan areas as well as to metropolitan areas? Have you observed an increase in illicit drug use in non-metropolitan New South Wales?

**Dr ALLAN:** Not so much, no. The drugs that people seek treatment for have remained stable over a number of years, and it is primarily alcohol. In reality, a lot of our service users are polydrug users and they will usually seek treatment for the thing that has got them into trouble this time. But most frequently that is alcohol.

**The Hon. JENNIFER GARDINER:** Your catchment area, so to speak, that western local health district area, has the largest cohort, I think, of clients. If you split that up is there an increase in the load for the smaller towns that you mentioned in the far west, for example, or is it just as much a problem, say, in the growing city of Orange, for example, those numbers seeking treatment for alcohol dependence?

**Dr ALLAN:** No, it is just as much a problem in the larger areas as the smaller ones.

**The Hon. JENNIFER GARDINER:** So the problem just keeps growing?

**Dr ALLAN:** Yes.

**The Hon. JENNIFER GARDINER:** The three challenges that you mentioned, workforce, infrastructure and the cost input you have to cope with to provide quality services, what do you think might be some recommendations this Committee could make to try to assist groups like you to best provide services for your clients?

**Dr ALLAN:** I think it is important to recognise the costs associated other than service delivery and that to provide services there are those additional things that need to be in place. There is definitely a move from government services to NGOs to provide services. I think that we can do it quicker and cheaper and potentially more effectively, but I would be concerned that we were seen as the cheap option because we do not pay people what they deserve because of their skills. I think an important recommendation would be around that workforce issue and that we need to be able to recruit people and pay them appropriately.

**The Hon. JENNIFER GARDINER:** Are there any other groups similar to yours working in non-metro areas that have the same kind of client base in terms of numbers?

**Dr ALLAN:** In drug and alcohol?

**The Hon. JENNIFER GARDINER:** Yes.

**Dr ALLAN:** In Wagga Wagga there is a drug and alcohol treatment agency called O'Connor House, which is part of Calvary hospital. Then when you go north there is Freeman House at Armidale, which is part of St Vincent's. There are some Aboriginal rehabilitation centres around the west of the State, two now, and there are some services in Canberra.

**The Hon. JENNIFER GARDINER:** Would you say that there needs to be more services available?

**Dr ALLAN:** We have no problem with demand. I think our service delivery since 2006 has doubled and partly that is because of our staffing levels. We have recruited more people and we provide more services via our community-based outreach services, we travel further and we go to more places. But we certainly are not scratching around for business.

**The Hon. JENNIFER GARDINER:** You talked about the foetal alcohol spectrum disorder. Is that a growing part of the problem?

**Dr ALLAN:** It is something that our clinicians recognise in the adults that they work with, which is perhaps something that they had not thought about in previous years. I think that is because of the publicity and the promotion of the problems associated with foetal alcohol spectrum for children and people in the sector are going, "Well, okay, the adults who we work with must have it." They are looking at people in a different way now. Instead of saying perhaps like the past approach to treatment would be that people who have a substance problem are weak or immoral or incapable, it is like perhaps actually they have a physical problem that affects their ability to control their drug use.

**The Hon. JENNIFER GARDINER:** One of the issues that has been mentioned over the past two days is the need for better integration between the NGO sector and government service providers. Do you see that as an issue, or how do you get on with the government services based in Orange and elsewhere?

**Dr ALLAN:** At a service delivery level we get on very well. People share resources, they refer between services. The people on the ground know who does what in different places and in different towns. I think that Health puts most of its effort and energy into hospitals and medical treatments, and that sometimes leaves their community services short. I think that we could do a better job than they do at providing those services. But, for example, our withdrawal unit is on the campus of Bloomfield Hospital. They give us that building for a peppercorn rent, NSW Health does. That is a very important resource for us, and they maintain it for us. Those relationships exist.

**The Hon. JENNIFER GARDINER:** Can you give us a bit of an insight into particular problems that you think people in rural areas have in terms of anonymity and so on when they are seeking treatment for particular issues compared to people in more populated areas?

**Dr ALLAN:** It is difficult to do anything in a rural area where people do not know. Our residential rehabilitation unit is in Canowindra, which is a town of 1,500 people. It is a large facility for that town. Everybody knows who the clients are there, who works there. People are just well known. I think that there is a lot of judgement in rural areas about people who have substance use problems. There is the town drunk but anybody else who might have a problem with drinking, for example, would want to be going out of town to seek help for that problem because of who would know. It could be their friend's wife who runs the community health centre, for example, so they are not going to pop in there and make an appointment to see the drug and alcohol counsellor. I think people are concerned about their reputations.

**The Hon. JENNIFER GARDINER:** You do not see that attitude changing; it is basically a stable cultural factor that does not really improve over time?

**Dr ALLAN:** They recently completed a two-year study on farming and fishing workers' use of drugs and alcohol. That was conducted across Victoria and New South Wales in a number of rural centres. There are very judgemental attitudes towards people who are considered drug users or drunks in those communities compared to people who might have a drink but are not seen to have a problem. So, no, I do not see that changing at all.

**The Hon. JENNIFER GARDINER:** One of your key points is about the need for flexible community-based rehabilitation options. How do you think that should be provided? You say it should include day rehabilitation with a training and employment component and a family inclusive practice which is needed, you say, in rural New South Wales.

**Dr ALLAN:** One of the problems that the drug and alcohol treatment sector has had over years is that they are very focused on the individual. The individual has the problem, the substance misuse problem, and they receive a treatment of some sort and then they go off and live their lives. With the people who come to our treatment services, they have multiple problems and they need more than managing their drug and alcohol treatment. They need support to access employment services. They need to repair relationships with their families and friends that they have damaged. I think that as a drug and alcohol treatment provider we need to assist them in making those connections and taking up training, education and employment; not just suggesting that they refuse the next drink and that is all the help that they need.

**CHAIR:** Prescription opioids are a growing problem in the metropolitan areas of Australia. I believe you stated it is a growing problem also in rural and regional New South Wales?

**Dr ALLAN:** Absolutely, yes.

**CHAIR:** Can you expand on that? Do you think we can do a better job with educating some of the doctors who are writing the prescriptions, or perhaps put in a real-time dispensing electronic system where doctors could see whether the patient sitting in their waiting room had just got a prescription yesterday morning from Dr Jones down the road? It is very hard for a lot of the GPs because they hear very convincing stories from the patients sitting in front of them. What should we do about that problem?

**Dr ALLAN:** I think that the way GPs approach it varies from place to place. I know that the practice that I go to in Orange has signs up in the waiting room and in all of the doctors' offices that say we will not prescribe these certain drugs and do not ask us for any Valium or those sorts of things on the first or second visit. They try to knock doctor shopping on the head right up-front. People who may in the past have used

heroin are much more likely to use prescription opiates these days. I believe there has been a heroin drought in Australia that has been referred to since the late 1990s or 2000s. We certainly see lot of people even in the far western towns of Bourke, Brewarrina and Walgett who have problems with prescription opiates.

The Aboriginal medical services that we work with will not prescribe those drugs anymore, but then that leaves a hole for people who really need pain-relieving drugs. There is a shortage of pain management specialists. Out at Maari Ma Aboriginal Health Service, where our addiction medicine specialist goes once every three months, they are setting up a joint consulting clinic with him and their pain specialist, who comes from Adelaide, so they can try to work out practical ways of dealing with those problems. For people who have genuine pain, they need good advice on how to manage that. I think GP education is an important part of helping doctors to resist prescribing those drugs.

**The Hon. SHAOQUETT MOSELMANE:** Just following up on that comment in relation to Aboriginal communities, how effective have the drug and alcohol policies been on Aboriginal communities in the country regions?

**Dr ALLAN:** Are there any policies in particular that you are thinking of?

**The Hon. SHAOQUETT MOSELMANE:** Just generally, because the terms of references of this Committee are wide and one is the effectiveness of current alcohol policies with respect to deterrents, treatment and rehabilitation. Have the current policies had any adverse or positive impact on the Aboriginal communities that you deal with, if any?

**Dr ALLAN:** We certainly deal with a lot and I think that what we have learnt in that experience is that there is no more significant drug or alcohol problems in Aboriginal communities than non-Aboriginal communities. What is different is the level of poverty and disadvantage that many of those people live in that make it more difficult for them to cope with those problems. I do not see Aboriginal people as having bigger problems than non-Indigenous people. I guess things that have tried—

**The Hon. SHAOQUETT MOSELMANE:** The issues about access to services, that would make it a little bit more difficult for them, would it not?

**Dr ALLAN:** There are problems with access to services and sometimes that is around who is providing the services in certain towns. Most of the towns will have Aboriginal medical services but they might be run by a family that some people do not want to associate with so they would prefer to go to the mainstream service. The biggest problem is perhaps visiting services, because they only come on a Wednesday and it is too bad if you need to see somebody on a Tuesday or a Friday. The Flying Doctor flies quite a lot of people into the towns of the north-west, including some of our staff, but that is for one day. Everybody turns up on one day and there is a huge flurry of activity and then they go away for two or three weeks.

**The Hon. SHAOQUETT MOSELMANE:** What do organisations like yours do in response to situations like this? If those situations are happening regularly what action do you take to address those sorts of problems?

**Dr ALLAN:** We look for more resources and the ability to have more people in those towns more often. But, for example, in Bourke we also work with the Bourke alcohol working group. They are a community group that pulls in people like us and our workers and the police and the council to work with liquor accords and look at supply issues and restricted trading hours and those sorts of things. That really varies from town to town and the capacity of the town and the people who are in it to take up those sorts of activities. Coonamble, for example, is working very hard at the moment on alcohol restrictions with the liquor accord and also ways that they can support people who have alcohol dependence differently, including naltrexone availability. That depends on their doctor's willingness to prescribe it.

**The Hon. SHAOQUETT MOSELMANE:** I looked at the pie charts in your submission and the significant and primary drug of concern is alcohol at 42.2 per cent. Does current funding address the significance of alcohol or is there a shortage of funding? What is your concern with regard to alcohol?

**Mr ZARNOW:** Alcohol, as we have indicated, is the drug of addiction most prevalent in the clients that we see. What we are trying to deal with to some degree are the two competing issues in the communities: There are issues with alcohol being available in pubs and clubs, those places being open until two or three in the

morning and issues of violence in relation to those, but that is different to the issues we deal with and the addiction issues of our clients. They do go hand in hand but it is quite a different problem to what we see. One of the biggest issues that we face, particularly in rural areas, is distance. For clients to be able to access our services we have to do a lot of travelling and we go out to the remote areas and various rural towns but it is very hard for clients to access our services whether that is a residential rehab service or withdrawal unit.

One of the issues we deal with quite frequently is the process of screening clients and making bookings for them to come to our services. At times we have a high fail-to-arrive rate. Clients, for whatever reason, do not arrive. It might be that they do not have the money to buy a train fare or a way of getting to the service or in the time between making their appointment, which might have been two weeks earlier, and their appointment they have either forgotten about it or it is not convenient at that particular time. The distance plus the availability of services is a problem for us. Although we do not have problems with demand overall it is being able to get access for clients to services sooner rather than later.

**The Hon. SHAOQUETT MOSELMANE:** In our report we will make recommendations and you are welcome to make recommendations to us that we can consider in the final report.

**The Hon. HELEN WESTWOOD:** It is wonderful to have a perspective from regional and remote New South Wales before the Committee today. There a couple of areas in which I have particular interest. In the submission you talk about the significant increases in female clients in two age brackets. You talked about illicit drugs. Is there a particular area of growth in their drug use that you can tell us about?

**Dr ALLAN:** Women are coming to treatment more frequently and usually for alcohol abuse. It used to be around about 25 per cent of the treatment population would be female and it is moving up to around the 35 per cent to 40 per cent mark.

**The Hon. HELEN WESTWOOD:** The other demographic I was interested in is age. One of the issues that has been raised with us by previous witnesses is youth specific services and the lack of detox beds for young people, in particular designated youth detox beds. Could you provide us with an age demographic for your client base but also if you have a particular view about young people and treatment options?

**Dr ALLAN:** We work mostly with people who are aged 18 and over. We do not have any youth specific programs although some of the community based councillors do have clients who are 16 and 17. We would not turn people away. Often family members will come to us concerned about their young people. We get asked all the time by schools, police and people in the community, "You must come and talk to the young people. You must do something. You have to stop them drinking or taking drugs." There is no effective way of doing that. Just turning up at a school and doing a talk, which is what people want so that they can feel that they have done something, has not been shown to be effective.

We were visited this week by a guy from Sweden who is conducting a large study about reducing cannabis use for young people and doing school-based interventions. He said they are working on their trial but as yet they do not have anything to report about what is effective. I think that sometimes people think if we work on the young people and forget about the older ones, not worry about the older ones, they can do whatever, then we will save the next generation. But I think if the older people stopped drinking and drug using then maybe their kids would as well.

**The Hon. HELEN WESTWOOD:** Is drug abuse or addiction not an issue amongst young people in the geographic area you service or is it that young people are not presenting for treatment? Do you know?

**Dr ALLAN:** I think it is less of an issue. Certainly alcohol use could start to become a problem and cannabis use would be a problem for some young people in our region but they are not presenting for treatment so we do not really know how much of a problem it is. If you look at where the problems in relation to alcohol related violence lie it is not with people under 18, it is with older people. We are looking at the 35 to 50 year olds who have had substance abuse problems for a significant period of time and are suffering quite severe problems because of that. That is a much bigger area of demand for us.

**Reverend the Hon. FRED NILE:** Thank you for coming to our inquiry. The shortage of detox beds has been raised by previous witnesses. How many beds do you have?

**Dr ALLAN:** Twelve to 15 in the detox with an average of an eight-day stay.

**Reverend the Hon. FRED NILE:** Do you get any government funding? I understand you are a non-government organisation.

**Mr ZARNOW:** Seventy-five per cent of the funding for our organisation comes from the Commonwealth. The detox unit is Commonwealth funded and our average program. Any State funding for our services is purely for our residential rehab program. That is the only funding we get from the State for our services.

**Reverend the Hon. FRED NILE:** Do you apply for any grants or do you think that you are not eligible?

**Mr ZARNOW:** Over the years we have applied for various funding rounds that have been available. Again, some of that is around our ability to deliver the type of services requested by Government but we have not been successful—in the last couple of years anyway.

**Reverend the Hon. FRED NILE:** You said in your submission that a lot of the people you deal with have alcohol problems. Do you have any treatment programs involving methadone?

**Dr ALLAN:** Our addiction medicine specialist prescribes methadone and he monitors the people he prescribes for. Some people do come into the detox seeking to reduce their methadone and we provide support for them to do that.

**Mr ZARNOW:** The big problem with the methadone program is our inability to service clients in more rural areas. We can certainly service clients in Orange because the specialist can monitor them locally but there is certainly demand in places like Bourke and out west further but we do not have the capacity to monitor and provide checks with those particular clients. We do not have the resources to send our specialist out there regularly enough.

**Reverend the Hon. FRED NILE:** You mentioned that some people want to get off methadone. How do you help them to get off methadone?

**Dr ALLAN:** They need to come in at a certain dosage level—which escapes me—and they are supported to reduce that over time.

**Reverend the Hon. FRED NILE:** You said you were dealing with a lot of folk with alcohol problems and a high Indigenous client base. Would the Aboriginal community be involved mainly with alcohol?

**Dr ALLAN:** Mostly alcohol but also prescription opioids.

**Reverend the Hon. FRED NILE:** You spoke of cognitive limitations in your submission. Are you referring to disabilities, people with poor sight or mental limitations?

**Dr ALLAN:** A range of cognitive problems ranging from an acquired brain injury, an adult with foetal alcohol syndrome or it could be an intellectual disability they were born with. We did a study that screened people in our residential units and found that around 40 per cent of people had some sort of cognitive impairment: forty per cent was mild to moderate and 12 per cent was moderate to severe. That is a problem in the type of psycho-educational treatment programs that are delivered because they do not have the capacity to take on the information and understand what they are being taught.

**Reverend the Hon. FRED NILE:** Your submission states that 27 per cent of your clients were of Indigenous background, which is very good in the sense that you are helping that needy group in our community which often does not get the help that it needs.

**Dr ALLAN:** We did an outcome study that found that our Aboriginal clients do just as well; they progress just as well in treatment and complete treatment at the same rate as non-Indigenous clients.

**Reverend the Hon. FRED NILE:** That is a high percentage of Aboriginal clients. Do you have Aboriginal staff?

**Mr ZARNOW:** Yes. We would probably have, I would not say a quarter, but we have a number of specific Aboriginal programs which are staffed by Aboriginals. Off the top of my head probably about 15 out of our 65 staff are Aboriginal.

**Reverend the Hon. FRED NILE:** Very good.

**Mr ZARNOW:** That extends through to the board. Our board has Aboriginal representation on it as well.

**The Hon. JAN BARHAM:** I will follow up on that question. Do you also provide culturally appropriate programs for those people? Is there a difference in the way in which they are dealt with by your staff or what is available to them?

**Dr ALLAN:** There is a little bit. We have an Aboriginal program in Bega on the South Coast that has a number of men's groups. That type of practice is led by a drug and alcohol councillors who are men, they have group meetings, they do cultural activities including painting and art work as well as fishing and those sorts of things.

**The Hon. JAN BARHAM:** Are they successful? Does it work well to provide that type of service?

**Dr ALLAN:** We are in the middle of evaluating that. One of the main things is that it gives people a purposeful engagement with their community, which I think is important, and while they are participating in those activities they are not allowed to drink or take drugs. It involves them in planning and working with younger people in the community such as activities they will do in father-son uncle-son type camps, those types of things. Before we had the Aboriginal program we identified that access to our mainstream programs was difficult for Aboriginal people: that perhaps people were reluctant to participate.

We spent a couple of years working on an approach called a "soft entry approach" and I believe Alex has sent around the video that describes how that works. You can click on the link and see it on your computer. One of the things that is different is instead of sitting in an office and waiting for someone to come and see them and talk about their problem it involves the drug and alcohol workers going out to the community to meet them in their activities, participate and talk about drug and alcohol abuse when the opportunity arises. They are making connections in the community and making themselves available rather than waiting for people to come to them.

**The Hon. JAN BARHAM:** Workers going out into the community to people on their turf.

**Mr ZARNOW:** That takes a lot more work and time because of the need to build up a relationship in those communities and it can take up to six months for a worker to become engaged with a community.

**The Hon. JAN BARHAM:** Longitudinal studies show what that delivers in the end is more whole of community.

**Dr ALLAN:** Yes.

**The Hon. JAN BARHAM:** Surely there has to be a better outcome. Was there a problem in Walgett with the removal of services? Are you aware of government funding being removed from some of those remote areas thus reducing service availability for Aboriginal people?

**Dr ALLAN:** We do go to Walgett regularly and we have a worker who works out of the Aboriginal Medical Service. Some of the Aboriginal medical services have had funding withdrawn because they were unable to fill positions and, once again, that is a workforce issue. As far as outcomes of that soft entry approach, our filmmaker was a finalist in Tropfest this year so it is worth a look.

**CHAIR:** That DVD is being circulated.

**Dr ALLAN:** We are involved in a study with the National Drug and Alcohol Research Centre on the outcomes of a particular type of intervention program with Aboriginal individuals but also family members. There is not any evidence about what works in drug and alcohol for Aboriginal people.

**The Hon. JAN BARHAM:** I am from the North Coast so the Buttery and its art-based programs are very much a part of the community and a lot of people get involved. It is the idea of art providing an entry point for people to talk about and deal with their stuff. I wonder how much that is utilised or considered as valuable without clear and hard research. It is anecdotal more than academic.

**Dr ALLAN:** It is time-consuming and it is demanding. You need a higher skill level as a worker to be able to engage with people in the community and to take up those opportunities to talk about their substance use while you are sewing or while you are painting, or whatever. It is a great idea, but it is challenging to do.

**The Hon. JAN BARHAM:** As Jenny was saying, things work differently in remote and rural areas where the community is more involved.

**CHAIR:** On behalf of the Committee, thank you. Would it be possible for you to provide us with a map of the areas that you cover? Obviously you cover a large part of New South Wales. There is no great hurry, but if you could give us some information that would be helpful.

**Dr ALLAN:** I have a map with dots on it that is easy to provide.

**The Hon. HELEN WESTWOOD:** There is one in the submission.

**Mr ZARNOW:** That one predominantly is where client numbers have come from, not necessarily the areas that we cover.

**Reverend the Hon. FRED NILE:** We thought you were based in Orange, but you mentioned Bega and other areas where you are operating, so you cover a lot of regional centres.

**Dr ALLAN:** I have a similar map with dots on it of the places that we go to.

**CHAIR:** That would be useful.

**The Hon. JAN BARHAM:** You mentioned the research that you have done. Are you able to provide that?

**Dr ALLAN:** I can provide a number of papers.

**CHAIR:** Thank you for your expertise and your time. It has been an interesting visit to Sydney for you. We value your input and the job you do around regional and rural New South Wales. Thank you so much for what you do.

**(The witnesses withdrew)**

**(Short adjournment)**

**SIONE CRAWFORD**, Director of Programs and Services, NSW Users and AIDS Association Inc., and

**JEFFREY WEGENER**, Policy and Advocacy Coordinator, NSW Users and AIDS Association Inc., affirmed and examined:

**CHAIR:** Welcome and thank you for appearing before us. We have your lengthy submission, but you can give us an opening statement if you wish.

**Mr CRAWFORD:** I have a couple of lines for clarification because of the organisation that we are. Thanks for your time. Today we will be speaking as representatives of the NSW Users and AIDS Association [NUAA], but we are an organisation that is not that well understood. We have 25 years of history working with drug issues. The thing that separates us from most of the organisations and representatives you will have heard from today is that, as a peer organisation, the people who work at and run NUAA are people with a history of drug use and of drug treatment experience. It is not always easy for us to stand up and talk about injecting drug use, HIV and hep C transmission, risks, drug treatment services and so on from a personal perspective. Most people will have an opinion about injecting drug use and it is not usually complimentary.

We both have the capacity to speak on behalf of the organisation but also as a person affected deeply and personally by issues of drug treatment. To be clear, today we will be speaking as NUAA representatives by default. If there are questions or reflections of a personal nature that you feel might be helpful to hear from us about, we would be happy to speak to and respond to most things. For clarity, we will preface personal statements by letting you know that they are personal and not necessarily as a representative of NUAA. In our submission we speak about the fact that we think that dependent drug use should be focused on as a health issue and that is the primary perspective we will be coming from today.

**CHAIR:** Thank you. Your submission is very thorough. I take you to page 8 of the submission. We have heard from many witnesses thus far in respect of two recurring issues and they believe that we need more resourcing of drug and alcohol treatment and they have outlined various aspects of what they believe the missing resources are. They have also touched upon a desire to have more clinical evidence, more medical research of various treatment options to help people who have a dependency on alcohol or drugs. We have heard that one of those options is long-acting naltrexone, whether it is an intramuscular injection or naltrexone implants. You touch upon the National Health and Medical Research Council literature review. It concluded in 2010 that there was not enough evidence to judge the efficacy of naltrexone implant therapy, but they recommended more research. If there was a multicentre Australian trial approved by the Therapeutic Goods Administration and the National Health and Medical Research Council for long-acting naltrexone to gain extra evidence, would that be the supportive view of your organisation?

**Mr CRAWFORD:** When you say "long-acting", I think you are talking about naltrexone implants?

**CHAIR:** Yes.

**Mr CRAWFORD:** As an organisation, we separate the idea of naltrexone itself and the implants. At the moment there is a problem with the implants, but we would not be supportive of implants in general, mainly because they take away any sense of choice after a certain period of time. Certainly you may choose to have them implanted, but personally we have seen situations where people have changed their mind down the track and they have done serious damage to themselves trying to get the implants out. That is the general position. Having said that, research is always really important. If any idea of using implants or long-acting naltrexone was to go ahead, we would recommend that it be studied and researched properly through a pilot and a trial, as you have laid out. Generally, we would be against it as a principle because of the idea that it takes away choice once you have had them implanted, and we have seen the effects.

**CHAIR:** When you say you have heard of instances where people have done damage to themselves by removing them, from what I understand it is a subcutaneous implant like many other drugs, including hormone therapies. Do you mean that they have tried to get the implant out themselves instead of getting it removed by a medical doctor?

**Mr CRAWFORD:** Yes.

**CHAIR:** Is that common? I had not heard that before.

**Mr CRAWFORD:** I do not know if it is common, but we have seen people who have done that. Sibling organisations of the NSW Users & AIDS Association, particularly in Western Australia and Queensland, have fed back to us that that is not common.

**Reverend the Hon. FRED NILE:** Will you repeat that?

**Mr CRAWFORD:** There are other drug user organisations around the country, including some in Queensland and one in Western Australia.

**Reverend the Hon. FRED NILE:** I thought you quoted a name of an organisation.

**Mr CRAWFORD:** No. I can give you the names of the other organisations, if necessary. I am not saying that is totally common, but it is quite an extreme path for someone to take. Our perception is always that our lives exist in a continuum, and sometimes for people who inject drugs things change day-to-day. People can be so eager and keen to please their families, to please themselves to try to stop using that they will undertake almost anything, only to regret it not that long afterwards. If you are talking about something like methadone or going into a detoxification service, that is something you can walk away from. An implant is not something that you can walk away from easily. The minimum we would want would be to know that they can be taken out relatively easily—perhaps not by the person—but without too many barriers if a person changes their mind.

**CHAIR:** Implants cost serious money. Are you saying that those people were probably encouraged by family members when they did not really want to do it and later on they tried to remove the implants themselves?

**Mr CRAWFORD:** Yes.

**CHAIR:** I cannot imagine someone paying up to $1,500 for something and then wanting to remove it?

**Mr CRAWFORD:** That is right. For this particular woman that is the circumstance I was thinking of—that is almost exactly the situation. Like I said, things change from day-to-day for some and sometimes from week-to-week for others. When you are talking about a period of weeks or months a lot can change in that time for people. In the media and in the movies people show drug dependence and some of the desperation that can occur for people, but it is hard to explain that drive unless you have experienced it—it can be a really strong drive for some people. If there is a possibility of actually being able to reverse something and a person thought they could do it, then they will try; for other people the reaction could instead be more uncertainty and depression and things like that.

**CHAIR:** Would you say that there has to be good information before any treatment is commenced?

**Mr WEGENER:** Absolutely.

**CHAIR:** And there has to be a good selection of patients with knowledge of what will happen to them so that they are more likely to be receptive?

**Mr CRAWFORD:** Absolutely.

**CHAIR:** Not any coercive or mandatory treatment for anything that is currently not approved to be given in a mandatory format?

**Mr CRAWFORD:** Yes.

**The Hon. DAVID CLARKE:** Mr Wegener, part of your submission comes from an organisation called the Australian Injecting and Illicit Drug Users League?

**Mr WEGENER:** Yes.

**The Hon. DAVID CLARKE:** What body is that?

**Mr WEGENER:** It is a national body. We are a State organisation, they are a national body. They are based in Canberra.

**The Hon. DAVID CLARKE:** Does your organisation support the decriminalisation of illicit drug use?

**Mr WEGENER:** Yes.

**The Hon. DAVID CLARKE:** It does?

**Mr WEGENER:** I have to be clear on a few things here. We actually are not involved with drug treatment per se and to really step into the area of politicising things like drug criminalisation and decriminalisation on a day-to-day basis is not really what we are about. However, we have seen daily with people we work with the problems caused by criminalisation of drug use and so on in that way.

**The Hon. DAVID CLARKE:** But one of your objectives is the decriminalisation of drugs?

**Mr CRAWFORD:** The decriminalisation of drugs is not in our strategic plan or an objective of ours per se; it is not something we strive towards. We have a funding performance agreement and everything we do is within that—and it is with two different branches of NSW Health.

**The Hon. DAVID CLARKE:** I am a little confused. When I asked you the question at the beginning you said yes.

**Mr WEGENER:** I suppose I was speaking personally. But as a professional organisation is it part of our working operations, no.

**The Hon. DAVID CLARKE:** Mr Crawford, what is your view? Do you support the decriminalisation of drugs?

**Mr CRAWFORD:** I think you were clear, Jeff. NUAA as an organisation has got a funded policy position and if asked for an opinion as representatives of an association with members—

**The Hon. DAVID CLARKE:** Did you say it is a funded organisation?

**Mr CRAWFORD:** Yes.

**The Hon. DAVID CLARKE:** Funded by whom?

**Mr CRAWFORD:** By a range of places but primarily NSW Health.

**The Hon. DAVID CLARKE:** Are you saying the view that you support the decriminalisation of drugs cannot be part of your official policy because you are in receipt of moneys from NSW Health? Is that basically what you are saying?

**Mr CRAWFORD:** What I am saying is as a non-government agency and as a separate organisation or association—absolutely as an organisation we can hold particular views and put out policy documents around them but the decriminalisation of drugs has never been something that we have focused on primarily. The main reason for that is that we are not funded primarily to work on those sorts of advocacy issues. However, if you asked NUAA and you asked me or Jeffrey whether or not NUAA would support decriminalisation we would but it would have a lot of caveats to it.

**The Hon. DAVID CLARKE:** Would most of your members be in the same category?

**Mr CRAWFORD:** There would be a wide range of opinions on that to be honest.

**The Hon. DAVID CLARKE:** It is interesting to note that. Turing to the question of naltrexone implants, are you opposed to a trial of naltrexone implants?

**Mr CRAWFORD:** If naltrexone implants are going to be utilised then obviously we need a trial but we believe that there are other options that work quite well; they are evidence-based so far and available for people to use right now.

**The Hon. DAVID CLARKE:** There can be a range of options, but would you favour a scientific trial being held in New South Wales to test naltrexone implants?

**Mr CRAWFORD:** Probably not.

**The Hon. DAVID CLARKE:** Even though you quote in your report Professor Lintzeris who earlier today said he was in favour—

**Mr CRAWFORD:** Of course he is.

**The Hon. DAVID CLARKE:** But you are opposed to it?

**Mr CRAWFORD:** We are opposed to it in principle, yes, but if there is an interest in using naltrexone implants further then obviously there should be a trial first.

**The Hon. DAVID CLARKE:** In your submission you are very critical of Sweden, which in your words "aims for a 'drug-free society'. A zero-tolerance foundation means that heavy enforcement against drug users is undertaken." Whilst you note that the United Nation's Office of Drug Control report on Sweden was "laudatory", you are very critical of what is going on in Sweden?

**Mr CRAWFORD:** Yes.

**The Hon. DAVID CLARKE:** You compare Sweden very unfavourably with what is going on in the Netherlands. Is that right?

**Mr CRAWFORD:** Yes.

**The Hon. DAVID CLARKE:** Would that have something to do with the fact that the Netherlands has a more open policy to the free use of drugs?

**Mr CRAWFORD:** Probably, yes. The main reason we are critical of Sweden is simply because—as I stated in the submission—there are other outcomes that you could just as easily causally attribute to their policies that are not just about there being a lesser prevalence of drug use but also, for instance, off the top of my head, there are not less overdoses.

**The Hon. SHAOQUETT MOSELMANE:** Why would you oppose a scientific trial of naltrexone implants?

**Mr CRAWFORD:** What I stated right at the start was that our belief and our perception of naltrexone implants is that primarily they take away choice. Once someone has an implant—like I said there is a day-to-day change sometimes in people who use drugs, and given that there is almost no way back from an implant—immediately anyway—our perspective is that they can be quite dangerous for some people. We do state in our submission that certainly oral naltrexone has got a place. It is used already as well, so we are not sure why you would need an implant when there is already a form of naltrexone that is useful.

**The Hon. SHAOQUETT MOSELMANE:** It seems to me that your objection is about the choice, not necessarily about whether the naltrexone will work. Is that right?

**Mr CRAWFORD:** Our perspective is that something that is not freely chosen by someone, even if they choose at this point—

**The Hon. SHAOQUETT MOSELMANE:** It would be a good thing, would it not, if, after trials by independent authorities, the scientific evidence showed that naltrexone implants with the consent of recipients can work?

**Mr CRAWFORD:** Because the consent would be given at the time, yes, and that is fine. If there was consent given, and the trial showed they worked for whoever, that is fine. We obviously could not argue against that, but our point would still be that any trial needs to be really rigorous and needs to involve consumers at all points so that the parameters are really clear as well. Like I said, the main thing is the fact that you are stuck with this thing that we have seen can have quite devastating effects for people.

**The Hon. SHAOQUETT MOSELMANE:** I note on page 3 of your submission you say that involuntary treatment waives the right of anyone to a fair trial, and we hear what you have just said now. But you refer to the bill that is considered in point 7 of the terms of reference. Can you point out to us what aspect of the bill you believe waives one's rights to a fair trial or to fair process?

**Mr CRAWFORD:** The reason we made that statement was because I think there is a quote in the bill around a medical officer making a judgement that for a person may be at risk of committing a crime in the next month or so, there may be an option to be given naltrexone implants. Our point is that if a person has not committed a crime yet, how can that be fair to punish them for it?

**The Hon. SHAOQUETT MOSELMANE:** I take your point. Thank you.

**The Hon. HELEN WESTWOOD:** Thanks, Mr Crawford and Mr Wegener, for being with us this afternoon. I just would be interested in your experience around and views on existing treatments and their adequacy. We have heard from a number of witnesses to date who have talked about the need for a range of services, but they have also spoken to us about the inadequacies, both in terms of funding and availability. I am just wondering, as people who may have used those services in the past, if you have a view on that?

**Mr WEGENER:** Absolutely. We believe that, yes, a treatment option should be a broad option. As people who use drugs are individuals, so should treatments options be individuals. As well as having a range of treatments, their availability should be there and present. At the moment there is not enough. There are shortfalls in treatment.

**Mr CRAWFORD:** From a personal perspective, I would say that, for me, methadone treatment has actually worked incredibly well. It has worked relatively well for me. I have a job. I can afford to pay the fees that they charge me, and I work in an organisation that understands that if I am late, because the doctor is running late or because there is a large queue at the clinic, that is not a problem. However, generally speaking, it is not a particularly responsive system. There are pretty strict guidelines and there is no way, for instance, for a person to get more—or it is very unusual for a person to get more—than a few unsupervised doses, so it can restrict a person's work quite seriously. But, generally speaking, although it can be improved, those options do work, and we have seen them work over and over for people.

But, as Jeffrey said, where we would see there being a shortfall is probably in not being a particularly broad spread and not a particularly equitable spread, either. We know that people in rural areas have a particularly difficult time in accessing treatment for almost whatever kind they want to access. Certainly pharmacotherapy treatment is particularly difficult. But, having said that, subutex and suboxone, as relatively new treatments, have really been quite successful in giving people a different option. I might add that suboxone, when it first came in, the reason we completely and utterly supported it was because there was an option there for people to be able to get 28 days of unsupervised dosing, after a certain period of time, obviously. We just note that that has not come to pass. But if some of those sorts of things were more available for people, I think that treatment could actually work better for a wide range of people.

I guess I will just finish by saying that people who use drugs are a wide range. There is a wide range of people who have got issues. There are people, for instance, in my methadone clinic that you would never ever pick as being a drug user, yet they have been on methadone for 20 years and still have to go in, still have to give urine tests and all that sort of thing, every couple of weeks. For them, they have had trouble moving on, and yet they are not ready to move on from methadone. They cannot move into a different phase, or it is a difficult thing for them to move into a different phase, because they have to go to clinic four times a week.

**The Hon. HELEN WESTWOOD:** Are there models of treatment that include methadone in any other jurisdictions where you think that it does not impose those limitations and it does allow drug users or patients of methadone clinics to then be able to have that flexibility? It allows them to work and do whatever else they need to in their life to get on with it?

**Mr CRAWFORD:** There are very few. I am sure Jeffrey would agree with this, but certainly we would consider a great start to be a wider range of private doctors, general practitioners and community pharmacies to be more involved, I suppose.

**Mr WEGENER:** Yes.

**Mr CRAWFORD:** There are 30 per cent or so of people who are on methadone and who dose through pharmacies. I think New South Wales is alone in the country in having these huge clinics where people sort of have to go every couple of days, or every day for most people. But Victoria has a relatively good community pharmacy system.

**The Hon. HELEN WESTWOOD:** The other evidence that we have heard from witnesses has been around whether the government sector or government agencies in that medical model or non-government organisations are better placed to deliver treatment services. Do you have a view on that?

**Mr CRAWFORD:** This has to be personal because the NSW Users and AIDS Association Inc. [NUAA] does not have a particular policy on who delivers the best treatment. The NSW Users and AIDS Association Inc. would say that services are like people almost: they are so different. There can be a government service that is, from our perspective, quite terrible and another government service that is run really well. I think that sometimes that is part of the problem. Across the board it does not feel like there is a lot of consistency. I have personally been at a range of different places and even within the same clinic, actually, my experience has been quite different over the course of a couple of years with new management and a new way of doing things. When I first started at the clinic I am at now, occasionally you would go in there and there would sort of a queue of 40 or 50 people. That is not actually an exaggeration. The queue would coil. Now there is never a queue. They have just brought in different systems.

Unless someone is really driven professionally to be in drug and alcohol, there is not a lot of money in it, and there is not a lot of kudos, I do not think, for a medical practitioner or even a service provider. I am sorry, that is the long way round of saying that sometimes services are really idiosyncratic. But certainly when we are talking about rehabilitations services and detoxification services, I think that community-based services would be my personal pick. That is simply because, if they are based in the community—by community-based, I mean probably non-government organisations and probably local or more localised services—generally speaking, they will know about the local situation. So whereas in somewhere like Coffs Harbour, there may be a lot of oxyContin use, for example, and there may be a different way of dealing with oxyContin use, in the centre of Sydney—although we hear that oxyContin use is big here as well—where heroin use is far, far more prevalent, or ice is used, whatever, we would say community based, primarily.

**Reverend the Hon. FRED NILE:** Thank you very much for coming in. I note in your submission on page 14 you refer to mandatory treatment, which is one of the proposals of the bill that I introduced to Parliament, but I note you are also critical of the existing programs, such as the Magistrates Early Referral Into Treatment Program [MERIT]. What is wrong with that program?

**Mr CRAWFORD:** It might have sounded highly critical. I suppose that once again for us it comes back to what I have come across personally and as an organisation that we have come across, which is plenty of Magistrates Early Referral Into Treatment Program workers, who are wonderful, and plenty of people who have been through the Magistrates Early Referral Into Treatment Program, for whom it has worked.

**Mr WEGENER:** Yes.

**Mr CRAWFORD:** So in the submission, it might have been more rhetorical than anything. But our main problem with any coerced treatment again comes back to the fact that people generally do not change until they want to. I think that with anything like the Magistrates Early Referral Into Treatment Program or the Drug Court, you are going to sweep up people who are ready for that, and that is wonderful, but there will always be people for whom it is a real struggle and for whom another approach might have been better. So, for us, coerced or mandatory treatment is not the first option. If that is the only option there is, then I guess, okay, you might be able, through netting 100 people, to get 20 people for whom it works really well for a period of time. That is the main thing—the fact that people do not have a choice and that, generally speaking, it has been shown that choice in treatment, or when a person is ready to take treatment, is when it succeeds best for them.

**Reverend the Hon. FRED NILE:** But they get a choice between the treatment or jail.

**Mr CRAWFORD:** Well, yes.

**The Hon. JAN BARHAM:** I think that is what coercive means.

**Reverend the Hon. FRED NILE:** Whereas they could probably still keep using drugs in jail.

**CHAIR:** I know which choice I would take.

**Mr CRAWFORD:** That is the main reason why we involve ourselves, in any way at all, in the decriminalisation debate. It has an impact in that respect in that people, who otherwise probably would not do crime, may well end up doing crime, just by using drugs. It is really complex and it is something that we would need to talk through.

**Reverend the Hon. FRED NILE:** You are critical of the Drug Court as well and the New South Wales Youth Drug Court. You do not see any positives coming from that?

**Mr CRAWFORD:** Yes. I am sorry if it comes across as being entirely critical. Like I said, it has worked for some people and if it keeps some people out of jail, that is great. But I go back to the idea that ideally people would not be having to go to jail for drug use in the first place, or for undertaking crime to get drugs. It would be great if there were other options well before that area, or before that thing happened.

**Reverend the Hon. FRED NILE:** But the reality is that that is where we are today, with laws prohibiting drug use and drug sale.

**Mr CRAWFORD:** Yes. That is one of the reasons why we do not—well, there are many reasons—

**Reverend the Hon. FRED NILE:** I would have thought it was good for addicts. It was helping addicts.

**Mr CRAWFORD:** It really depends on how you define that. I mean, like I said, it certainly has helped. I am sure it has helped some people. If you took 200 people off the street and forced them to do anything that we might think is a good thing for them, it may work for a percentage of them, but that does not mean it is the right thing to do.

**Reverend the Hon. FRED NILE:** You are also critical of the involuntary drug and alcohol treatment unit, obviously for the reasons you have said.

**Mr CRAWFORD:** I was not that critical of that. I said that that is something that already exists.

**Reverend the Hon. FRED NILE:** Yes.

**Mr CRAWFORD:** In that it is something that exists. It has changed the way that it is run recently. Like the Inebriates Act and whatnot has been changed and the evidence is still not in on that. That is what I am trying to say. I am saying that perhaps we should look at how that works first because that is the worst of the worst, so to speak—the people who really cannot make up their own minds about things.

**The Hon. JAN BARHAM:** Yes.

**Reverend the Hon. FRED NILE:** But it has had excellent results in the Nepean unit.

**Mr CRAWFORD:** And I am not naïve enough to think that there are not people out there with serious cognitive issues and serious emotional and mental health issues that are not in serious danger from alcohol—primarily alcohol, usually—or other drug use, and that that serves a function, no doubt.

**Reverend the Hon. FRED NILE:** I have just a quick comment on your response to an earlier question. You said about implants that someone might want to remove them. From what I understand—I have studied the implant system—no-one can get an implant unless there is a mentor or family support for that person. The people who conduct that program know it will fail, if they do not have that ongoing support for the six months.

**Mr CRAWFORD:** Yes.

**Reverend the Hon. FRED NILE:** That support would be there and they would not need to remove the implant; or, if they want to remove it, they can go back to the centre and I am sure they would remove it, at their request.

**Mr CRAWFORD:** I suppose I would go back to what I was saying before, which is that that is all well and good probably for many people, but some people choose to do something because it is the only option they have. If they do not do it, they are going to lose their family. They are going to lose contact with the family that they love because, for whatever reason and however they got to this point, it has become this critical moment. So, yes, of course you choose to try to do something that will be the right thing, but that does not mean that that mentor and that family support person has the training, capacity, the time, or even the real motivation to be what the client needs.

So I think that ideally you need family support and, if not that, then friends' support, for whatever treatment you are going through, no matter what it is. That would always be the case. I just think that when you are talking about something that is very hard to reverse, if there is any issue that occurs between you and that family support member, if there is anything that is not ideal in that relationship, it is also naïve to think that a person would then feel okay about asking to have it taken out. Even if that is only a score or 100 people out of 1,000 from our perspective that is a few too many.

**The Hon. JAN BARHAM:** What has become clear is that it is difficult for people to understand what addiction is, unless they have experienced it or been close to it. Perhaps if you are able to articulate—I suppose it is a personal perspective—why someone would change their mind when they are being offered freedom from addiction. The discussion around naltrexone is the idea that it might be offered to people so that they can choose it and the cost that is currently prohibitive is taken care of so it becomes a choice. If it was a choice, do you think that would make a difference? If not, the point you have made, if there is any way that you feel you can describe why it would not be what everyone is looking for.

**Mr CRAWFORD:** Do you want to talk about your friend in a minute?

**Mr WEGENER:** I guess the problem I have is a lot of these—I remember years ago, 10 years ago when the first Israel thing, fast detoxification, all of a sudden there was something out there and people thought this will happen immediately, you get on a plane to Israel and you will be cured. The reality was far from that. I am just concerned that with naltrexone, unless we have a system which runs on automatic which takes away people's own absolute motivation in what they are doing, this can be problematic. I have seen cases where people will stop using heroin but they will go mad on speed. It is very complex.

**Mr CRAWFORD:** I think we would love a magic bullet, but it takes a long time to get through dependence. I do not know if you can do it. I certainly cannot articulate the drive to continue using drugs when you know that you can sit back and say, "Okay, so I have $1,000. If I spend $800 or $900 of that on drugs and barely pay my rent and don't eat and my life won't be great", that is quite a good scenario in some respects because you are leaving some money to do other stuff. It is very hard to explain why you make those decisions, except I would say there is a little part of your mind that is always, "Well, tomorrow, a little bit later on it will be better." As Mr Wegener said, if there is an idea that there is something out there that can do that for you, it is very tempting to say, "Okay, let's do that."

The reality is that—although I am currently on methadone, I have also spent 10 years without using at all after having had opioid habits so I do know what it takes to get through that period of getting to a point where it is not actually an issue any more. How you get back into it is another thing altogether. The fact is that it can take a very long time to get through that sense of needing this other thing. If nothing else, it becomes a real part of your life and people do not acknowledge this but there is actually a community when you use drugs. There is a community. It is illicit, it is a bit dangerous, it is a bit underground. People bond over it as well. So there are a multitude of factors that go into it.

**The Hon. JAN BARHAM:** But is that not one of the points that is being made that if you were offered the chance to be rid of the physical dependence then you could more easily move away from those things and focus on some of the other supports that might let a person with an addiction move on? That is a point and I know it is difficult but it keeps coming up that there is this lack of understanding about why and how. There is a point here where your submission discusses the cost burden of methadone. I think it is great the way you have

made it clear that low-income people, whilst it is not expensive in most people's mindset, if you are low income it is and it becomes a choice about food or whatever. So the case for that option to be made more available cost-wise is an important position.

**Mr CRAWFORD:** I suppose that is what the thrust of our submission is and I guess it depends on how you read these things. There are other options that already exist but they are not being done optimally and our perspective is that we would like to see the things that have been trialled over 20, 30, 40 years—methadone in that instance—and other forms of detoxification funded properly and delivered in a more efficacious way first before we talk about invading people's bodies.

**Mr WEGENER:** I guess that is the crux of the situation. Idealistically, drug taking should be from abstinence and the whole spectrum through to methadone and that would include everything realistically. Of course, with funding issues, with cost issues, it is not as simple as that.

**Mr CRAWFORD:** If you can say that my activity is that I give people naltrexone implants and they walk out of my clinic free of opioid addiction, or I run a pharmacotherapy clinic and it will take a good five, six, seven, either, nine, 10 years, maybe less, maybe more, for someone to get through this, I think it is quite alluring to go with the fast option. I just think that through all my experience and knowledge of people who use drugs, stopping is not the problem. Well, it is a problem; physical dependence is difficult. I do not mean to underplay that. But that is overcomeable with opioids particularly. Ice is not particularly physically addictive, yet people have serious dependence issues with that. It is not about getting rid of the physical dependence only. There is something else—

**The Hon. JAN BARHAM:** And the other takes time for some people.

**Mr CRAWFORD:** Yes.

**CHAIR:** Thank you for giving us not only your insights as representatives of the New South Wales Users and AIDS Association but also your personal reflections. We value that and we thank you for doing that in the thorough submission you have given us.

**(The witnesses withdrew)**

**HESTER WILSON**, General Practitioner and Addiction Specialist, affirmed and examined, and

**SIMON HOLLIDAY**, General Practitioner and Addiction Specialist, sworn and examined:

**CHAIR:** I note that you are representing the Addiction Medicine Network, New South Wales membership, of the Royal Australian College of General Practitioners[ RACGP]. In what capacity are your appearing before the Committee today?

**Dr WILSON:** I am a GP and I am appearing before you today in my capacity as a member of the National Faculty of Specific Interests in Addiction Medicine through the Royal Australian College of General Practitioners.

**Dr HOLLIDAY:** I am a general practitioner and a member of the National Faculty of Specific Interests in Addiction Medicine as part of the Royal Australian College of General Practitioners.

**CHAIR:** There is an opportunity for you to make an opening statement if you wish to do so. We do have your submission in front of us.

**Dr HOLLIDAY:** Thank you for inviting us here today. General practitioners encounter drug and alcohol problems commonly in their practice though not usually as the presenting complaint. GPs have an important role in identifying and managing the range of such problems. However, only 1,444 of Australia's 92,503 registered medical practitioners are registered as opiate substitution therapy prescribers. Common barriers include stigmatising attitudes, workloads, and concerns about the accessibility of specialist support through the public or private system. Addiction in general, whether to licit or illicit drugs, as we heard from previous witnesses, tends to take a chronic course involving cycles of abstinence and relapse.

Therefore we need to be very careful when we hear evidence based on testimonials and case series reports because these can mislead us when we are making decisions about the usefulness of a treatment.
Creative ideas, and ideology, do have an important role in initiating change but these things require evaluation to see if they work or not. It is this evidence from that evaluation that both clinical practice and public policy should be based on. As Winston Churchill once said, "However beautiful the strategy, you should occasionally look at the results." We support more clinical research into the management of addictions within primary care.

**Dr WILSON:** One drug of addiction for which we can offer evidence-based management options is opioids. Opioid substitution therapy has now been endorsed by more than 30 randomised control trials and it is cost effective, saving $5 for every $1 spent in terms of criminal justice costs and health and welfare. Both methadone and buprenorphine have been included by the World Health Organisation [WHO] on their lists of essential medicines. The WHO defines health as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity". Opioid substitution therapy has a vital role in helping opioid consumers find recovery towards this state of health by the prevention, identification and management of opioid dependency. Finally, we have ethical and clinical concerns about the proposed amendment. We oppose conducting involuntary experimentation on the vulnerable subgroup of our population and we oppose any increase in the scope of mandated treatments on human rights grounds.

**CHAIR:** We have had various people appear before us from the medical field and the epidemiological field and we have seen recent NHMRC guidelines for further clinical trials involving long-acting naltrexone, whether it be intramuscular or implants. What is the view of the RACGP on gathering more information based on scientific evidence on long-acting naltrexone?

**Dr WILSON:** Long-acting injectable forms of naltrexone.

**CHAIR:** Yes, TGA approved and NHMRC approved trials.

**Dr WILSON:** We would absolutely support NHMRC and TGA approved trials of the medication. We need robust large randomised control trials but compare it to current best practice.

**Dr HOLLIDAY:** I think naltrexone is a very exciting drug. It has been around for many years. Unfortunately, we have not had the great outcomes that we would have liked to have had. There are some interesting suggestions that it might be able to be used in very small doses, like 12 micrograms, with a full

agonist opiate to decrease withdrawal or decrease the emergence of tolerance. It has a role with alcohol dependency. I have even seen a paper suggesting it had a role in cigarette smoking dependency and also in gambling. It is a drug that is neither black nor white. It is another pharmaceutical. We need to explore this fully. It might well be it has some very important roles and it might be that it has some very dangerous roles, depending on how we use it and who we use it in.

**CHAIR:** But we will never know that if we do not have level I clinical trials, will we?

**Dr HOLLIDAY:** Indeed. We do need good studies about these things. That does take resourcing, and we need to make sure the resourcing is not commercially based. We do not want to see people doing trials who have a vested interest or relying on pharmaceutical companies to be producing that sort of evidence.

**CHAIR:** Have not many trials relied on pharmaceutical industry input, including the cervical cancer vaccine?

**Dr HOLLIDAY:** There is no doubt that pharmaceutical-based research—I think it funds something like 60 per cent to 80 per cent—but we have to realise there is a cost to that. These companies do it for their commercial ends and not necessarily for the general welfare of everybody. A lot of evidence might be suppressed, it might not get published, and they carefully choose who is going to do it, how it is to be done and they might even interrogate the evidence and can the trial very early if it is in their best interests.

**CHAIR:** Dr Holliday, I have not seen too many pharmaceutical companies rushing in to manufacture or register or to be involved in any trials. I do not think there is a big rush on from the pharmaceutical industry. We would probably be proposing that it would be government subsidised, as a lot of the trials are in Western Australia—are you aware of that? The Western Australian Government subsidises a lot of the usage of naltrexone implants—both Labor and Liberal successive governments.

**Dr HOLLIDAY:** If someone had a pill that would cure drug addiction that would be a fabulous drug and a very profitable one. There has been quite a lot of interest from pharmaceutical companies about treatments. Reckitt Benckiser spends a lot of time trying to impress people that buprenorphine, for example, is far better than methadone.

**CHAIR:** You indicate on page 9 of your submission—just going to prescription drugs and particularly opioid prescriptions, and the addiction to a lot of prescription drugs has increased—that in Washington State there is a second opinion for opioid analgesic doses, and then you talk about what is happening in Tasmania with a system of online, real-time monitoring. Can you give us your opinions on what we can possibly recommend to reduce adherence to or dependency on prescription opioids and the abuse of these products?

**Dr HOLLIDAY:** How long have we got? It is very depressing. The number of guidelines that have been produced, the amount of expert consensus that has been had, and yet the completely remorseless worsening of the opiate abuse epidemic—as it is called by the White House in the United States and in Canada—and we are following in its footsteps in Australia. There have been some tiny little sparks of hope. I think one is in Washington State which has a wonderful group at the University of Washington that has produced some guidelines, which were not as well promulgated as they should have been but they were out there. They certainly had regulatory changes which involved, once you went over the dose of 120 morphine equivalents you had to get a second opinion. This single measure decreased the number of people who were on a high dose of opiates and dropped the rates of overdose deaths—a really remarkable turnaround from the normal worsening figures.

**Dr WILSON:** I would hasten to add that pharmaceutical opioids are very useful drugs, and in a group of people are very successful. They are most successful in the treatment of acute pain but there is a small group of people where they are useful in chronic pain. The big issue is that there is not great evidence to support that. The studies that have looked at managing chronic, non-malignant pain have been no longer than three months in duration. What we have is a treatment that sounds great. It is a great idea. I can write it on my script pad and it can fix your pain. But the problem is that chronic pain is not that simple. For some people opioids can be part of the solution but there needs to be a much larger solution in how that person manages their emotional state, how they manage their physical health and how they manage their interactions with the drug.

Also for us as doctors it is a tricky one. It is so much easier for us to write a prescription than it is for us to get someone to go to physiotherapy, which they have to pay a large amount of money for. There is a program

that is running over in Western Australia called the Step program, through one of the Medicare locals, where they took the waiting list of people who were waiting to get into specialist chronic pain clinics and worked with them on a non-pharmacological basis, and the majority of those people did not need to access the chronic pain clinic by the time they got to the end of the waiting list. Some really interesting things are happening to help people manage their chronic pain. I totally agree we do need to have greater controls around the use of prescribed opioids. I hasten to add they do have a place but it needs to be part of an overall plan as to how we assist people and how we assist doctors.

**CHAIR:** Do you think we will ever achieve real-time monitoring of S8 medications?

**Dr WILSON:** They did it in their trial in Tasmania. It was in hospitals and in selected pharmacies but they did do it.

**Dr HOLLIDAY:** It has been in British Columbia for quite some time.

**CHAIR:** Yes, it was in Vancouver. Do you think the Royal College of General Practitioners and the Australian Medical Association are doing enough to speak also with the Pharmacy Guild and get round table discussions so we can look at this seriously instead of just talking about it?

**Dr HOLLIDAY:** I have not heard any medical body speaking against this proposal, have you?

**CHAIR:** No, but nothing seems to happen, on a national basis.

**Dr HOLLIDAY:** No, I did not think it was due to lack of support from medical bodies because, as far as I have seen, they are all saying this is important, this is the public health equivalent of CPR.

**CHAIR:** So it could be something this inquiry recommends?

**Dr HOLLIDAY:** Absolutely. Please do.

**The Hon. DAVID CLARKE:** If we followed across the board your view that trials of naltrexone implants not involve any pharmaceutical financial involvement or even leadership, would not medical science have gone back 50 or 100 years? Have most of these lifesaving products that are out there on the market not all involved massive pharmaceutical financial research and financial investment?

**Dr HOLLIDAY:** There is no doubt that pharmaceuticals have been really important. But, on the other hand, if we just leave it to pharmaceutical companies we also will have harm from that. For example, disulfiram—which is also known as Antabuse—no pharmaceutical company is going to make a profit out of it so nobody is prepared to fund a very basic application to the Therapeutic Goods Administration, from memory to allow it to go on the Pharmaceutical Benefits Scheme. It is a simple, cheap, old, effective medication. Because we are so used to relying on corporate goodwill, it has not happened.

**The Hon. DAVID CLARKE:** I do not think anybody was suggesting that other bodies, apart from pharmaceutical companies, not be involved, but were you not suggesting that pharmaceutical companies not be involved? It was not a case of others should not be involved; were you not putting it to us that pharmaceutical companies should not be involved?

**Dr HOLLIDAY:** I think it is really important that we have independent funding of research. I think it is our responsibility, if we want to provide health services, to make sure that proper research and development is funded from non-commercial sources. However, of course, billions and billions of dollars are involved around the globe for pharmaceutical research and, of course, that could not be replicated by government.

**The Hon. DAVID CLARKE:** So where does the money come from?

**Dr HOLLIDAY:** We need to do both. If we rely on people who have a vested interest in producing the evidence that will make us make decisions about a medication, we are in danger of being sold a pup. If you look at councils who talk to financial planners with vested interests; they were sold this great dream of a cure for their financial problems, and what happened? They got the global financial crisis. We can have the same thing in the health system. It is not that hard for money to corrupt the health system. Pharmaceutical companies fund the research, fund the professional bodies, fund the guidelines and fund the literature reviews.

**The Hon. DAVID CLARKE:** But normally that does not happen, and that is evidenced by the fact that we have so many miracle cures out there that have been financed by pharmaceutical companies. You would agree with that, would you not?

**Dr HOLLIDAY:** Many miracle cures have bitten the dust as well.

**CHAIR:** We also have regulatory bodies but that is an issue for another day.

**The Hon. SHAOQUETT MOSELMANE:** Following on from what the Hon. David Clarke was asking in relation to trials, who do you believe then is best placed to conduct the trials in New South Wales?

**Dr WILSON:** I think, rather than in New South Wales, it would be a national approach. I do want to come back to what the Hon. David Clarke said. Absolutely, pharmaceutical companies are very important in research and development. You are absolutely right, there are many drugs that we would not have without them. But there needs to be both. We need to have independent evaluation. There needs to be a level of independence. It might well be that there is some drug company funding but the people who investigate and evaluate are independent.

**The Hon. DAVID CLARKE:** Regulatory?

**Dr WILSON:** Well, regulatory, but they are also researchers. I would think that the National Health and Medical Research Council is the perfect body. Let us get some funding. It will come from various places. I do not mind where you get the money from, and from there we look at who are the independent researchers who can do that research.

**The Hon. SHAOQUETT MOSELMANE:** I am interested in the summary you have on page 2, particularly recommendations 1 and 3. In recommendation 1 you suggest, "that the Committee investigate the role of taxation and regulation in deterring and preventing harms from tobacco and alcohol". Can you expand a little on that?

**Dr HOLLIDAY:** Sure. I think we have a funny sort of approach towards drugs. Some drugs are culturally taboo and other drugs are okay. After a motor racing session we get champagne out, although we do not want to associate alcohol with driving. I remember reading about the women's temperance movement in the United States, after crusading against alcohol retiring for a glass of laudanum, which is an opiate containing the product. We have all sorts of changes from time to time. At the moment we think heroin is a terrible drug. When it was first marketed in 1898 by Bayer, it was marketed as a way of helping people with morphine addiction to come off the morphine.

I think we need to move away from opiates as the sole focus of our concern about drug and alcohol issues in New South Wales. We have to think about what kills the most people. The drug that kills the most people in New South Wales is tobacco. We have very simple things that can help people with tobacco. The first thing is pricing. We know that as you increase pricing of legal and regulatory drugs you decrease the use, especially at the top end, and also decrease the entry into the use of the drug by young people. The equivalent for alcohol is volumetric taxation.

**The Hon. SHAOQUETT MOSELMANE:** Just on that point, I heard somebody the other day say that because tobacco is now so expensive people who deal in drugs now deal in selling tobacco because it is so expensive and it is more profitable for them to do so.

**Dr HOLLIDAY:** There is an enormous illegal tobacco industry, and I am wondering about the zero tolerance on tax-free tobacco. Clearly this is the very dangerous drug that we have and it kills far more people than opiates do.

**The Hon. SHAOQUETT MOSELMANE:** In relation to recommendation 3 where you refer to the Committee quarantining the budget for drug and alcohol, do you mean quarantining it from the mental health budget?

**Dr WILSON:** That is a concern for drug and alcohol services—we are talking public drug and alcohol services that are funded by New South Wales—that drug and alcohol services are very small in comparison to

mental health services. What we have seen is that there was a time when they were separate and then they came together. What happened during that time when drug and alcohol came underneath the auspices of mental health was that services were eroded and the powers that be in that drug and alcohol had to decide where their budget went was eroded. One of the things for drug and alcohol is that it is a small part of the health system. We would say that it is a very important part, but it is small. It is very easy for someone who is running a health budget to go, "Should we take this money from consultation liaison drug and alcohol to heart transplants, that is much more important?" From our point of view it is very important that those budgets are maintained, particularly in a time when money is very short as it is now.

**The Hon. HELEN WESTWOOD:** Your recommendation 2 is about the cost of opioid substitution therapy. You have already talked about the cost of it and I understand that, but you might want to expand on that and also your recommendation around regulations for the dilution of takeaway doses and what that would mean. You also talk about buprenorphine treatment. Could you tell me a little bit more about that and what the difference is between that as a—

**Dr WILSON:** The cost?

**The Hon. HELEN WESTWOOD:** Yes and I am actually not familiar with how it is administered and how it differs from the methadone program. Is it exactly the same or are there differences?

**Dr WILSON:** I will just reiterate the cost issue. If people are being dosed in a public system it is free. If they are commenced on treatment in a public system the treatment is free and the cost of dosing, the cost of preparing dispensing doses, is free. For many people it is very important that they are started in a hospital basis or a public clinic basis. We are very lucky in New South Wales to have public clinics—they do not have them in Victoria—where people can actually be stabilised. What we find is that people find it tricky to move from the public service where they have been stabilised out into the community setting because suddenly they are hit with a bill of at least $35 to $40. Is it the same up in Taree?

**Dr HOLLIDAY:** Yes.

**Dr WILSON:** It can be up to $70 depending if they are in a private clinic for the cost of dosing. As was pointed out by the gentleman before us, that is a huge amount if you are on a low wage, which the majority of people are. That is a real barrier in terms of people moving on. One of the issues that I have is that if you are staying in a public clinic setting you are kind of stuck. One of the things that we work very hard at at the clinic I work in is to kind of shift people's thinking around to you are actually really well, you are graduating from our program, let us move you out to pharmacy so that you can get on with a normal life. It would be so much easier for us to do that if it did not cost them $35 to $40 a week for that.

Just to talk about the dilution issues, in other States, including Victoria, all takeaways are diluted. In New South Wales that is not the case. You can request as a prescriber that your takeaways be diluted, but the containers that we have in New South Wales are only 30 to 40 millilitres. You can only take it up depending on how much they are on by half or one quarter or whatever, because depending on what they are on they will be on 10, 20 or 30 millilitres. There is an issue of how much you can dilute the small containers that we use in New South Wales. The main reason and concern that we have around the dilution is that you want it as dilute as possible so that if a child actually unfortunately accesses it they are less likely to die, because a child will die from a small dose of methadone. Methadone is a liquid. That is the particular risk there.

**The Hon. HELEN WESTWOOD:** The risk is not so much to the person on the methadone program; the risk is to others?

**Dr WILSON:** The risk of child poisoning is very important. The other part of it of course is that we know that takeaway doses are diverted and sold on and injected. Diluted methadone is safer to inject. There are two types of methadone. There is one that is mixed in a syrup and that is quite abrasive to blood vessels and causes harm. The Biodone, which is a water-based one, is safer that they are perhaps less likely to inject or safe to inject if they are diluted. But the main reason for the dilution is around the issues around child poisoning. The problem that we have at the moment is that our pharmacies and our private clinics are set up for those small jars and they would find it quite difficult to swap across to 200 millilitres jars. Just because of storage, that would be an issue for them.

Coming onto the difference between methadone and buprenorphine, the basic difference between methadone and buprenorphine is that methadone is a liquid or a syrup and buprenorphine is now mostly in the form of Suboxone, which is a combination of buprenorphine and naloxone. Naloxone is like a short-acting naltrexone. It is in a little film tab and people put it under their tongue. It is absorbed from being taken under the tongue. It is actually a really effective and very quick way of getting people dosed. Compared to methadone where you swallow it and you drink some fluid and have a chat afterwards to make sure that you are not holding it in your mouth for diversion, it works within 15 to 20 seconds. I have tried the placebo and it sticks and you cannot get it off and it dissolves within a minute.

The very good thing about the Suboxone is that it is very long acting, so some people can go to second or third daily dosing. It is also a much safer form of treatment in terms of overdose. One of the good things about that is that with methadone the maximum amount of takeaways that a person can have in any one week is four and usually they are in lots of two. You have an observed dose every third day. The person will go to the chemist, have an observed dose, get two takeaways for the two following days and then go back on day four, have another observed dose, another two takeaways. That is for people who are very stable. I have people in my general practice who have been on that for years. They are working full-time, they are accessing their medicine through a private clinic because they can actually do that early in the day, it costs them $70 a week to do that, and they cannot get any more stable than that. They cannot get any more freedom from interactions with a pharmacy than that. With buprenorphine, because it is a much safer drug and because it is long acting, people can move to second or third daily dosing as I said, weekly dosing, second weekly dosing and monthly dosing.

One of the things that we are looking at at the moment is a proposal around the buprenorphine being taken on to the Pharmaceutical Benefits Scheme [PBS] so that people can actually, when they are stable, get a month's takeaway at a cost of $5.70 or $30 depending on your status. One of the ongoing conversations that I have with pharmacies is to point out to them that if they are only seeing a person once a week that does not take $35 worth of work. There are some pharmacies that are charging people who are on monthly takeaways $160 a month. I will argue with pharmacies and move people to other pharmacies who are open to saying that I am only seeing them once a month so I will charge them $30 for the month.

**Dr HOLLIDAY:** I agree with all that Dr Wilson said. If somebody is in a public clinic it costs a lot to the State, but one of the barriers is that they have got to come up with the $35 every week or in some places, as Dr Wilson said, considerably more. Clearly, if we could convince the Federal Government to find a place for methadone and buprenorphine—which are very efficacious and well-proven substances—under the PBS in some way that would be a good thing. Unfortunately drug treatments come under a funny sort of State-Federal system which is quite different to a lot of other treatments. I believe that State and Territory governments have to administer and are responsible for how prescribers and dispensers are regulated and paid.

One of the problems that we have with dilution then is that there are so many different steps that have to be taken, so many particular ingredients that chemists have to put in that it makes it prohibitive. I have had chemists say to me that you say you want all your takeaways diluted but I am not going to do it because I am going to have to pay a pharmacist some hours every week and it makes it uneconomical for me to run a program if you say you want it diluted. I say that I want it diluted because what if it gets diverted to a toddler? Someone could die, it could corrupt the program, cause outrage, et cetera. This Committee perhaps by such a simple step by looking at how pharmacists do the dilutions could perhaps create a good outcome.

**The Hon. HELEN WESTWOOD:** I have a lot more questions but my time has expired.

**Dr WILSON:** We are happy to talk to you at another time, if you wish.

**The Hon. JAN BARHAM:** In your submission on page 7 you refer to every hospital having dedicated beds for detox. I am from a rural area so I understand why it is difficult in rural areas. Have you got any understanding or insight into what level of need is out there and what is not being met?

**Dr HOLLIDAY:** The vast amount of serious alcohol problems flies right under the radar of the health system until some catastrophic event occurs—motor vehicle accidents, assaults, death with polydrugs. But there is a lot more out there than meets the eye. If we had better services rurally we could help a lot more people detox. At the moment we try to struggle along doing home detox. It is very hard to do home detox in the country. You have to say that these are the features you have got to look out for. We have to talk to family or friends and say that these are the features you have got to look out for. It is really complex. Or you have to say

to them to come back and see us every day five days a week, or go to your pharmacist and ask them to do a withdrawal scale. It does not work. It is really hard to do drug and alcohol withdrawals in the community.

Alcohol withdrawal is an important step for some people. As with opiates, detoxification and withdrawal is a significant part of the natural history of dependency. It is also associated with relapse of course, but for some people withdrawal and detoxification is an important step in their rehabilitation. If we had more access to these sorts of things in rural areas, particularly as I am a rural doctor, it would be a wonderful thing.

**The Hon. JAN BARHAM:** I am glad you mentioned polydrug use. I am really interested in that seeing that a lot of younger people are mixing alcohol with prescription drugs. You mentioned Xanax. Some of the things that are going on seem to be a little bit under the radar and are not being addressed. Do you have any advice or insight as to what is going on there? We have heard from other people that people used to have two or three drugs that they were using; now there are five or seven. We have heard that the rate of mixed drug use has increased over the past 20 years.

**Dr WILSON:** Absolutely. I can remember the old days when people just used heroin. That is a thing of the past now. It is very common in established drug users that they are using a variety of different drugs, different sedatives like opioids, benzodiazepines, alcohol, as well as stimulants like cocaine and ecstasy and methamphetamine. Are you more interested in the recreational user?

**The Hon. JAN BARHAM:** In young people I am worried about recreational use and the message or the way of treatment in terms of particularly alcohol with some of the prescription drugs. I am wondering if there is a new way of dealing with that sort of polydrug use that is currently not available or if that is being misunderstood or misread.

**Dr WILSON:** There are specific issues for young people and how you access young people, how you support young people into treatment. You need youth-specific services. It is not appropriate quite often to have young people in an adult service. I think of a young person coming into the Langton Centre amongst a group of people in their forties and fifties who are very experienced injectors. You do not want a young non-injecting person who is experimenting to actually have interactions with that group of people for the most part. The other thing is that young people may not consider this as a problem. We are doing this for fun. One of the real dangers that you have around the education awareness campaigns, and the ice one is a good one where it presents this terrible outcome from ice use when the majority of young people who use ice actually do not see that.

That does not happen. That is not me. That is someone else. This is not my reality. You need to be cleverer around the awareness campaigns that you run to make sure that they are not shocking, to make sure that they have currency with the young person. You need to have youth-specific services. The other thing is that as health professionals you need to be able to keep up to date with what is out there and how you approach it, but without being alarmist. Without being alarmist, the interesting thing when you look at ecstasy is the amount of media reports regarding ecstasy is far more than any other drug. It has a reputation for being extremely dangerous and it can be harmful in some situations but it is much less harmful than tobacco and alcohol.

**The Hon. JAN BARHAM:** Concerning youth specialist services, do you agree that residential services need to be isolated for the young?

**Dr WILSON:** I do.

**The Hon. JAN BARHAM:** Recognising that in some regional areas there are no public services how do you deal with the takeaway doses issue and the time and cost involved?

**Dr WILSON:** Can I just say that each public hospital in New South Wales is supposed to be able to dispense pharmacotherapy but they do not. That would be an easy thing for the Committee to recommend, that all public hospital pharmacies should actually be prepared to dispense and that would make a huge difference for rural and regional people with dependency.

**The Hon. JAN BARHAM:** Does that mean that people transferring and moving on to a pharmacy should not incur a cost for that?

**Dr WILSON:** That would be wonderful but that is not the case at the moment.

**The Hon. JAN BARHAM:** That would make a big difference.

**Dr WILSON:** We know if you get someone established in treatment that the longer people stay in pharmacotherapy treatment, whether it is methadone or buprenorphine, the better their outcomes.

**The Hon. JAN BARHAM:** You spoke of people stabilising with methadone. The Committee is having trouble understanding why someone would choose to stabilise rather than being clean when naltrexone enables you to be clean?

**Dr WILSON:** I was interested in a question asked of the previous witness about freedom from addiction. I don't actually think that naltrexone gives you that, it gives you freedom from tolerance.

**The Hon. JAN BARHAM:** That is the way it is being presented to us.

**Dr WILSON:** The issue is that addiction is a chronic relapsing medical condition. When I talk to people about it I compare it to asthma: Some people have asthma occasionally and might only have it as a child and they are fine for the rest of their lives; other people need ongoing medication and they might only need it occasionally; and other people have severe asthma that puts them in hospital and they need ongoing care and medication for the rest of their lives. It is a chronic relapsing condition. Diabetes is the same. Drug and alcohol dependency is the same. It would be a wonderful to have a miracle quick fix but the problem is that it is a much more complex issue than that. It needs to be dealt with and strongly engaged through a psychosocial model which takes into account the reasons people started using: what precipitated it, what perpetuated it, what have the outcomes been from it and how can you support that person to go through what is for most people a long period of supportive recovery.

I have had a number of people in my general practice that I have assisted to come off treatment, who are drug free and it is not part of their lives at all. There are others that need to be maintained on methadone or they may cut down. I have a couple of people slowly cutting down who have been on methadone for quite a few years but there may be some who need to be on treatment. They are having good lives, they are working, they have family and they have lives of meaning while they are still on treatment. For me that is the goal. It may be for some of them they can complete treatment. I do not mean jump off and start using again but actually complete and move on.

**The Hon. JAN BARHAM:** That is the complexity that is not understood unless people have had experience with the issue. Thank you for making those comments. I may ask you for more information in writing.

**Dr WILSON:** Yes.

**Dr HOLLIDAY:** Could I add a couple of things: Education for poly drug use with children and young people is possibly good and possibly not, it depends how you do it and you need to evaluate it. There are some education programs such as the Drug Abuse Resistance Education [D.A.R.E.] in the United States which was shown to increase problematic behaviours because risk-taking adolescents who thought they were immortal thought the authorities say do not do this so we are going to do it.

Pharmacies in a rural community may refuse to provide methadone because they do not like drug addicts and it might mean that people have to travel an hour or more to get a daily dose. I have had people drive three hours to find a prescriber to get access to substitution therapy. Freedom from addiction sounds great; wouldn't that be wonderful; magic; we love this sort of thing; but pain and addiction are both really complex. It is not as simple as if you have pain we will give you opiates and you will feel better or if you have addictions we will give you naltrexone and you will feel better. They are complex issues. It is to do with genetics, upbringing, peers, environment, poverty and the way the brain starts to get rewired as well.

One of the ways that the brain is rewired with addiction is that people develop a problem with cognitive function. They have a trigger and straight away they find they might be using a drug but they do not know why, they did not think about it, it just happened. They may think "life's terrible so I am going to have one" "… or a party" or "I want a quick fix for my personal problems". That is what they have been learning while they have been substance using for a long time—a quick fix is the solution. If we tempt people with a "cure from addiction" that is a quick fix through an implant that might be intrinsically appealing to someone who has that type of cognitive impairment. I think we need to be careful not to exploit people in that way.

**Reverend the Hon. FRED NILE:** I gather those people who do support naltrexone understand what you have just said, that they need to do a lot of other things with the individual, not just give them an implant and send them home?

**Dr HOLLIDAY:** I have heard reports of people getting an implant and a taxi cab charge and being sent on their way. There might be ethical people who give long-term multidisciplinary care and there might be other people who do not.

**Reverend the Hon. FRED NILE:** Have you ever recommended naltrexone?

**Dr WILSON:** I use naltrexone as an oral treatment for alcohol dependence. I do not currently recommend naltrexone implants because it is still experimental and it is not an established treatment. We do not yet have evidence from good randomised controlled studies done by independent researchers to tell us if it is beneficial.

**Reverend the Hon. FRED NILE:** You are aware they have been using it in Perth for 15 years?

**Dr WILSON:** I am. Unfortunately the quality of the research undertaken over there is not of a good standard and has not been done by independent researchers.

**Dr HOLLIDAY:** I have treated a number of people with alcohol dependency with naltrexone. I had one patient where I thought this is finally the patient where I am going to offer somebody oral naltrexone. This guy had cycled from alcohol dependency to heroin dependency. He was a postman. His marital relations were better when he was using heroin but he would either be using one or the other. He had done this for quite some time and I thought he would be a perfect candidate for oral naltrexone. We thought about it and discussed it but unfortunately it did not work out, he became a lot more chaotic. I am really glad that I did not use it in that case and that was probably the clearest case where I could have offered it to somebody.

**Reverend the Hon. FRED NILE:** Would you support a recommendation for a proper scientific trial of naltrexone implants in New South Wales?

**Dr HOLLIDAY:** Would you be comparing it to placebo or therapies we know are evidence based?

**Reverend the Hon. FRED NILE:** That will be up to the people running the trial.

**Dr HOLLIDAY:** If it was compared to a placebo I would say it would be unethical. What you would be doing is knowingly delaying people getting proven effective treatment for some theoretical idea of having "freedom from addiction".

**Dr WILSON:** It would be need to be a head-to-head study against the current best evidence-based treatments.

**The Hon. SHAOQUETT MOSELMANE:** If you are giving them a placebo you are not giving them anything?

**Dr WILSON:** That is right.

**Dr HOLLIDAY:** I believe there was a study such as that in Russia that the Americans used to get a permit for naltrexone over there. The reason the pharmaceutical company did it in Russia is because you can get away with doing placebo trials there when you have effective treatments.

**Dr WILSON:** You cannot have a group of people that are not able to access treatment when you know good treatments exist, that is unethical.

**Reverend the Hon. FRED NILE:** I am assuming we would have university professors running the trial and they would use the correct procedures.

**Dr WILSON:** I would support a large randomised controlled head to head trial against the established treatments and done by independent researchers. It would be fantastic if naltrexone implants had a place in the

management of dependency. When you look at, for example, hypertension we have something like 40 different drugs to manage people's high blood pressure because not one drug always works. It is wonderful to have different options. At the moment we have two pharmacotherapy options for opioid dependency. We do have non-pharmacological methods. It would be great if there were more and I would absolutely support that but it has to be a large-scale randomised controlled head to head trial against established treatments done by independent researchers.

**Dr HOLLIDAY:** It would have to involve something like a double dummy where everybody gets an implant, one might be a placebo implant and one might be a naltrexone implant, and everybody has to take syrup or a tablet so they do not know if they are on methadone or something else. You could do something like that. There has been some evidence from the United States that I have seen regarding opiate dependent physicians that says naltrexone has a role with opioids that could be interesting. In this particular highly motivated group, whose jobs were on the line if they did not stay in treatment, there were reasonable outcomes. United States physicians are not the same as the opiate dependency we are seeing in Australia, although we do see it in that client group as well.

It would be interesting to explore a range of options, as Hester has said, and it may be that naltrexone implants have an important role which we are yet to discover in a certain group at a certain time and there may be other treatment options. We heard a presentation recently where in Britain they used heroin assisted treatments. Again, you find a more chaotic clientele that can access treatments as against methadone and these people have to be highly motivated to stay in treatment and come along twice a day to get treatment. It might well be that if we had a range of treatment we could pick people at various stages of opiate dependency and find a treatment that helped them get better outcomes: less likely to die or go to jail or wreck their social lives.

**Reverend the Hon. FRED NILE:** Tailor-made treatments.

**Dr WILSON:** One of the big problems with naltrexone is the fact that it destroys your tolerance and what happens when people stop taking naltrexone is they die of an overdose. The issue is that they have lost their tolerance, they go back to injecting the same amount they always have and they overdose and die.

**Reverend the Hon. FRED NILE:** They can be told that when they are doing the treatment?

**Dr WILSON:** Absolutely, but the problem is that when you have a dependency, when you have an addiction, your brain does not always work and take into account all your risks. There are probably a small group people who would benefit from oral naltrexone for opioid dependency but they tend to be people that are highly intelligent, highly motivated, with incredibly good social supports and United States doctors fit into that category—maybe not all of them.

**CHAIR:** Thank you for coming along and giving evidence on behalf of the Australian College of General Practitioners.

**(The witnesses withdrew)**

**NADINE EZARD**, Clinical Director, St Vincent's Hospital, Inner City Health Program, Alcohol & Drug Service, affirmed and examined:

**CHAIR:** We have your submission in front of us, but you can make an opening statement to the inquiry, if you wish.

**Professor EZARD:** I would, because it is the end of the day, and I know you have been here all day and I know you are here often. People who know me know that I have been working for many years outside Australia in settings of fragile States, in settings of weak governance. It is an honour for me to be here and to participate in a process that we probably take for granted—a process of democracy and a process that recognises the human rights of the population of Australia and that believes that we should be providing evidence-based healthcare to the population on the basis of need. This inquiry is testimony to that fundamental belief.

However, having said that, I am surprised that the State and national budgets pay so little attention to effective drug and alcohol treatment. We know that although 12 per cent of the burden of disease in this country is due to drug and alcohol problems, maybe less than 1 per cent of our health budgets is spent on drug and alcohol treatments. I am taking this inquiry as a positive step forward in the way that we, as a population, as a community—despite our differences on some points of view—take drug and alcohol seriously.

**CHAIR:** In your submission you state there is a long waiting list, particularly for the growing range of psychostimulant and other emerging psychoactive substance use disorders. What would you like from this Committee in respect of addressing that need?

**Professor EZARD:** One of the problems with our treatment services is the lag time in respect of emerging problems and drug use trends, and the matching of those trends with our services is quite large. We, at St Vincent's Hospital, as you know from my submission, run a stimulant treatment program, one of only two in the State, and at the moment we have a waiting list of 50 people for that program. We can suggest that perhaps the service provision for stimulants is not adequate. At the same time, we do not have a lot of evidence-based intervention.

In respect of research to address that population need, not enough effort is put into that area either. On the other hand, we know that one of the growing problems in Australia is prescription opioid misuse. This is a fast-increasing problem and we are not addressing that adequately at a State level. The drug modelling problem that the National Drug and Alcohol Research Centre in New South Wales is leading for the whole of the country will be useful in respect of looking at the way we collectively are distributing our interventions versus population need.

**CHAIR:** You mention that NSW Health runs the Drug and Alcohol Specialist Advisory Service through St Vincent's Hospital and there is the round-the-clock statewide telephone advice service for professionals. It sounds as though this service is under threat because there is not enough funding.

**Professor EZARD:** It is interesting that you bring that up. The Drug and Alcohol Specialist Advisory Service is a 24-hour on-call telephone advice service for health professionals. We ask staff specialists that are employees of the State around New South Wales to volunteer to be on that on-call roster 24 hours a day. I do not know of any other specialist area where senior doctors are asked to volunteer their time for the good of the public health of the population. We recognise this as an area where staff are not trained adequately in their undergraduate years. People do not have enough education on what services and what interventions work. As a collective of professionals we would like to assist other professionals in delivering good quality care, but it is testimony to the inadequate resourcing of that service.

**CHAIR:** What can we do to help?

**Professor EZARD:** There are two things. One is adequate funding for a 24-hour on-call service and adequate dissemination of the existence of that service. I have met doctors and nurses, particularly from rural areas, who do not realise there is this 24-hour service. It has to be matched with training of doctors and nurses in their undergraduate and postgraduate years. Representatives from the College of General Practitioners were here. In the same way that mental health was not seen as part of general practice 20 years ago, drug and alcohol is not yet seen as part of general practice. A lot of general practitioners will either not want to see someone with an obvious drug and alcohol problem or not know how to assess or refer or deal with a drug and alcohol

problem. It needs to be part of the core business in primary care in dealing with common drug and alcohol problems. We know that drug and alcohol problems are hugely prevalent in our society. At the moment, our efforts are placed mainly in meeting the needs of severely dependent people. We are not looking at a population approach where there are many people who are using drugs and alcohol perhaps in a risky manner or harmfully, and they are not getting the early intervention before they develop dependence. At a population level, it is those people who are causing more harm than the small proportion of people who use substances who are severely dependent. We need to get those treatments and interventions into the general primary care setting.

**CHAIR:** We have heard from a number of different witnesses that there are limited opioid treatments. You have got methadone, the gold standard, that has been in place for many years. There is a need to expand our clinical research bases. We have heard from lots of people about the need to have high level clinical trials that are approved by the Therapeutic Goods Administration and the National Health and Medical Research Council on long-acting naltrexone as one of the arms of treatment. We have had oral naltrexone for a long time, but not enough research has been done into it. In America there is an intramuscular naltraxone formulation and, in Australia, we have naltrexone implants, but everybody has reiterated that there have not been enough clinical trials. What would be your opinion if there is a multicentre high level clinical trial that is approved by the National Health and Medical Research Council for long-acting naltrexone implants in Australia?

**Professor EZARD:** For the treatment of opioid dependence?

**CHAIR:** Yes.

**Professor EZARD:** At the moment we know that naltrexone implants are experimental products that are proposed as a possible intervention for the treatment of opioid dependence. We also know that some treatments, such as methadone and buprenorphine, work—the gold standard, as you mentioned. We also know that the treatment gap in this country is enormous. A number of people requiring treatment are not getting it. We have those available interventions, and we are not providing them to everyone who needs them. The question in respect of a new product that is experimental, yes, by all means, research should progress and find interventions for many, many illnesses that face the human population, but these need to be on the basis of population need as well.

If a substance such as naltrexone implants is proposed for research, we need to look at the opportunity costs of researching that as opposed to something else. Research is expensive. Researching naltrexone implants will require a lot of money, a lot of resources, a lot of time from many people. The question is—as a population do we want to put our effort into that as an intervention versus other interventions or other research that is important for our population? By way of an example, alcohol is a huge problem in our population. What do we have for treating alcohol dependence and alcohol misuse?

**CHAIR:** We have been told today by many witnesses, including Associate Professor Nicholas Lintzeris, that there is increasing evidence of naltrexone implants being effective for alcohol dependency.

**Professor EZARD:** Yes.

**CHAIR:** But you dismiss clinical trials?

**Professor EZARD:** I am not dismissing a clinical trial for anything that is being discussed here. It is about how we, collectively as a population, make a decision about what is more important to research than something else. There are a number of other substances that people bring up many times as a drug that should be trialled. We have a process nationally through the National Health and Medical Research Council with competitive rounds that are subjected to peer review on the basis of does this study make scientific sense? Is it feasible? The question is why are we focusing on this one particular substance rather than another intervention? What is it that we want to know and what is it that we need from a population perspective?

We are talking about a very small proportion of the population that is afflicted by severe opioid dependence. We already have gold standard treatments that we are not getting out at scale to the population. We are not intervening earlier by providing interventions at the hazardous and harmful level, and we are doing very little in terms of health promotion and prevention. We know that the majority of our illicit drugs budget goes to law enforcement. The question is given those opportunity costs, is it worth pursuing research into naltrexone implants for the purposes of opioid dependence? I am not giving an answer, I am proposing the question.

**The Hon. DAVID CLARKE:** If it has apparent success it might be.

**CHAIR:** Have you been over to Western Australia to observe what Dr George O'Neill has done and other researchers who have been publishing ongoing—

**Professor EZARD:** I am abreast of the current research and, as Dr Wilson mentioned earlier, the research that has come out of that experience—which is now, as you say, several years of experience—is not of a scientific quality that would convince the medical community and should not convince the general population that we have enough evidence as yet to know whether this is effective or not.

**CHAIR:** My question to you was: If it was an NHMRC approved multicentre clinical trial here in Australia would you think that would be worthwhile?

**Professor EZARD:** Approved you mean as in—

**CHAIR:** I mean approved.

**Professor EZARD:** —funded through the NHMRC or?

**CHAIR:** And probably part funded by government.

**Professor EZARD:** If a study meets accepted scientific standards, which in Australia is according to NHMRC guidance, there is no reason not to conduct a study on one substance or another. We certainly cannot proceed in using a substance such as naltrexone implants unless they have Therapeutic Goods Administration approval in this country. We cannot use it only in an experimental setting and that setting should be in accordance with scientific standards such as the NHMRC guidance documents suggest. Only then will we have an answer. Any study that is conducted would have to be, as I think Dr Wilson outlined—I did listen to her statement—

**CHAIR:** The Committee is proposing: level one NHMRC approved. That is my question to you.

**Professor EZARD:** But the question is what? Would I support that as opposed to?

**CHAIR:** Do you not think that it would be a good thing for physicians treating alcohol and drug dependency around the world if we could get a multicentre Australian clinical trial, an NHMRC approved level one study?

**Professor EZARD:** The study would need to be for a certain population. So for a start it would have to be decided if it was for opiates or for alcohol—

**CHAIR:** Let us start with opiates.

**Professor EZARD:** We cannot use that product until it has met adequate scientific standards. So if we are suggesting using that, it would need to be subject to research protocol. It is not my place to say whether naltrexone implants should be studied ahead of any other treatment. Why are we proposing this rather than heroin-assisted treatment, which we have seen experience of and actually some research evidence from other settings? Why are we not suggesting that that should also be trialled? We are talking about a small population of opiate dependent people.

**CHAIR:** That is why the Committee is taking evidence from a range of witnesses, including you.

**The Hon. JENNIFER GARDINER:** Will you please outline to the Committee what is involved in the Stimulant Treatment Program at St Vincent's?

**Professor EZARD:** The Stimulant Treatment Program is a pilot program funded by NSW Health. It has two sites in New South Wales—our site and a second site at Hunter-New England, Newcastle. It is a stepped care program. People engage in intensive counselling up to four times a month for as long as is necessary for them. Some people who have very severe dependence, who met certain very strict eligibility criteria, are provided with dexamphetamine substitution therapy under strict supervision. They do not get takeaway doses at our clinic; they have to come in every day to pick up their dose, which helps engage people in treatment and in

their counselling. It is a small program. In terms of dexamphetamine substitution, we have only eight people on that program at the moment.

**The Hon. JENNIFER GARDINER:** And you have a waiting list of 50 people?

**Professor EZARD:** For the whole Stimulant Treatment Program. Just to reiterate, the bulk of the treatment is counselling—it is person-to-person talking therapy. There are about 50 people on the list and we keep in contact with the people waiting for treatment by SMS or email.

**The Hon. JENNIFER GARDINER:** How long do they have to wait?

**Professor EZARD:** It depends.

**The Hon. SHAOQUETT MOSELMANE:** On page three of your submission you say "drug and alcohol treatment services should be funded on a transparent basis". What do you mean by that?

**Professor EZARD:** At the moment it is quite difficult to work out how much money goes to drug and alcohol treatment. What we would like is to actually have available in the public domain evidence of how much money goes towards drug and alcohol treatment, particularly for us as a proportion of the NSW Health budget, for example.

**Reverend the Hon. FRED NILE:** A separate budget.

**Professor EZARD:** Transparent so at the public level the public knows how much is spent on drug and alcohol treatment and how this compares with the need for drug and alcohol treatment.

**The Hon. SHAOQUETT MOSELMANE:** On page three of your submission you also say "alcohol use is of particular concern". Everyone has expressed that view but we seem to be focusing on naltrexone and other drug-related issues rather than alcohol. From your perspective is the current alcohol policy in relation to deterrence, treatment and rehabilitation effective? If not, how can it be made better?

**Professor EZARD:** I think we are investing inadequately in the whole alcohol problem in this State and we need to have multi-sectorial approaches to that. We need to be bringing in industry and private sector, as well as the Health sector, to find comprehensive approaches to alcohol. There are a lot of evidence-based interventions that have strong evidence from around the world, including taxation and limitation of marketing and sponsorship, for example, of sporting events, and limiting promotion of alcohol. Governments around the world struggle with the perceived tax benefits of taxing legal alcohol supply versus the lack of health benefits or health costs.

We need to get everybody at that table to actually develop a policy that looks at prevention and health promotion as well as providing adequate treatment not just for the most dependent but early intervention. We know that screening and brief intervention of high-risk alcohol use is an effective intervention—there is very good research evidence from around the world. We are not doing that at scale here yet. We also know that we are not actually accessing early enough in terms of people's alcohol use. We also know that we are having a binge drinking culture, if you like. We are seeing these very rapid cultural shifts towards promoting of intense alcohol use and consequent health impacts as a result of that.

**The Hon. SHAOQUETT MOSELMANE:** At page 5.7 of your submission in relation to the proposed reforms identified in the Drug and Alcohol Treatment Amendment (Rehabilitation of Persons with Severe Substance Dependence) Bill 2012 you say "The proposed reforms to the bill cannot be supported." Will you elaborate on that?

**Professor EZARD:** This is very complex but the crux of my concerns with the proposed reforms is this heavy reliance on an intervention that we have already discussed as requiring further research and being an experimental intervention. I do not think that the State can prescribe something that is still a research-based intervention. The other thing is that we have no experience of outpatient involuntary treatment in this State—not in drug and alcohol, there is in mental health—and that is also another research question I think in terms of the place of involuntary treatment altogether. We have some experience with the new Drug and Alcohol Treatment Act. I personally have had a number of patients who have gone through under that new Act and there are some problems.

I would agree with the short duration of the intervention in terms of not having adequate time to deliver more long lasting change. But to me there are fundamental problems with the whole idea of involuntary treatment, given how expensive it is, given that there is no evidence at all for its effectiveness, and given that we know that evidence-based interventions are not being delivered at scale in this State and people cannot act—evidence-based non-compulsory interventions. The question again is the opportunity costs at a population level of putting so many resources into something that is perhaps of questionable human rights value and also is not evidence-based. The question again is putting resources to areas where we know they are going to work and to where we know they will have a much bigger population impact.

**The Hon. HELEN WESTWOOD:** You have worked in other jurisdictions outside of Australia. Do you mind mentioning where were those jurisdictions were?

**Professor EZARD:** I have worked in many, many settings but I can list them: Honduras, East Timor, Liberia, Sierra Leone, Afghanistan, and Congo.

**The Hon. HELEN WESTWOOD:** I am wondering whether other jurisdictions have the same polarised, political approach that we have in Australia. This has been evident in the submissions that the Committee has received and from the evidence of the witnesses who have appeared before us about a terrible conspiracy to prevent naltrexone being delivered by all those who only support one type of drug treatment. I do not think that is what is before us but if you look at the submissions and from hearing the line of questioning that appears to be the argument. Has that been your experience in other jurisdictions? Do other parts of the world have this same political problem in effectively dealing with addiction or dependence amongst their populations?

**Professor EZARD:** There are very few other areas of medicine that bring so much ideological and moral bearing to people's thinking around this problem, which is why in my statements I am trying to bring it back to a population health approach. I have very much a public health approach—what is the best for the population as a whole. It is true that alcohol and drug use brings up an incredible amount of ideological and moral thinking with it. It is hard for all of us. I think probably all of us at the table have our own personal views around the place of drug and alcohol in our lives and in the lives of other people in the community. It is true that many, many populations struggle with this. I think Iran might be a good example where, as you know, people with a certain amount of opiate offences actually receive capital punishment.

At the same time, the Iranian Government instituted needle syringe programs in prison. That was an enormously difficult and political process that took some time for people to come around the table and make that kind of decision. And it is something that we struggle with here, even among us here. I am sure we all have very different opinions about what should be done. We all are starting from the same point—that we want the best for the population. I think we have commonalities in that area. We do not agree, probably, on the best way to get there.

Particularly in this, we very quickly descend into a debate about drug-free versus pro-drug. I think that obscures many of the health issues. I am about to have some coffee here. I mean, coffee is a psychoactive substance. It has a whole global economy associated with it. We can talk about that: there are good and bad things and there probably is some merit to the argument of eradicating coffee from the world. Does it have any benefits? I do not know. Yes, maybe it does. We go out for a coffee with friends. There is social benefit and not too many harms.

**Reverend the Hon. FRED NILE:** We do not supply alcohol to the witnesses.

**CHAIR:** Nor illicit drugs.

**Professor EZARD:** Australia has been remarkably forward thinking in a lot of ways. We are leading the pack in terms of tobacco control. We are seeing a rapid decline in the tobacco use epidemic here, and that took a lot of negotiating among all the interested parties. As part of that, nicotine replacement therapy has become an accepted norm. Nicotine replacement therapy is not curing anyone of their nicotine addiction, but it is certainly limiting the population impact of second-hand smoke and it is certainly having an impact on the culture of smoking so that young people are less likely to take up smoking. Those individual people, when they are ready, can give up their nicotine replacement, but we are not suggesting that the primary goal of nicotine replacement therapy is not to get everyone off nicotine straightaway. It is to have all those other benefits as well.

Yes, eventually we would like people to help people, if that is what they choose, to get towards being nicotine-free, but in the interim that is an accepted intervention. However, it has taken us a long time to get to that point. The debates around illicit drug use and around alcohol use are similar in that way.

**The Hon. HELEN WESTWOOD:** The other term that you used, which has been used in the past as well—again, I have heard criticism of that and dismissal of it—is the term "gold standard treatment". Some people seem to be saying that there exists at the moment some really effective combinations of treatments. They are there, but because of the lack of funding they are not put to the use to which they should be put and for that reason we are looking for something else. I have heard others refer to the gold standard treatment. Could you describe what that term means, as you understand it?

**Professor EZARD:** You are absolutely correct: we should not be using that term. Gold standard implies it is some degree of perfection, if you like.

**The Hon. HELEN WESTWOOD:** Yes.

**Professor EZARD:** We should be using the term "evidence-based intervention". Particularly when we talk about opioid substitution therapy with methadone or with buprenorphine, we are talking about not just reduction or cessation in other drug or other opiate use; we are talking about improvements in quality of life, we are talking about decreased criminality, and we are talking about engagement in employment, vocational training opportunities, community engagement and looking after family—those kind of outcomes—and most importantly, decreasing mortality and morbidity. We know that being on methadone or buprenorphine decreases your chances of overdosing and dying. We are very keen on stopping people from dying, particularly people, for example, coming out of prison. We know that that first week or two out of prison, the risk of opioid death is very high and that is well documented by Dr Dolan and others from the National Drug and Alcohol Research Centre. Substitution therapy will save lives.

We know that those interventions work for some people. We also know, as we have heard before, that we do not have a full range of interventions. I am by no means suggesting that maintenance therapy suits everybody. Some people say they do not want maintenance therapy; they do want to stop using and be drug-free, if you like, or free from their opiate dependence, and that we should have ways to help people to achieve that as well. But the interventions that we have, we do know that they work and we do know that they are not available to everyone that wants them. It is not just inadequate funding. It is also to do with our model of treatment. In this State we have had very clinic-based treatment for delivering opioid substitution therapy. We know that there is a group, or a whole population, that is not actually accessing treatment because that kind of clinic model will not suit them. They may actually be quite functional but are struggling with their dependence.

If we can get more opioid treatment out into general practice and into primary care, we will be attracting in a whole new cohort of people and also allowing better integration into the community. We need to be changing our model for delivery of these evidence-based interventions as well. We need more experience with that. So in terms of bang for your buck, in terms of deciding where you could get most population impact for expenditure from the State, I personally would be pursuing ways of expanding the interventions that we have got and that we know work. I am certainly not opposed to any research that increases the range of treatment options that we have available to us as doctors, but in terms of policymakers at the moment, expanding the range of treatment options and access to existing treatments is a good way to go.

**Reverend the Hon. FRED NILE:** I am just following up on the use of naltrexone implants. Do you see some advantage, if you had a patient who is a drug addict and has the implant and has no desire for drugs for six months? What would you do with that person?

**Professor EZARD:** It is an interesting question. The theory behind naltrexone implants is not that it cuts your desire. It is that if you then use opioids on top of that, you do not experience any intoxication effect from the opioids. It blocks the effect of the opioid. Therefore, the theory—I say it is "theory" because we still need the research to prove it—is that that will then break your behavioural pattern. It will break that link that you make between stress, or whatever it is that makes you want to use, and the association with relief from that by using the substance. One of the problems we see now increasingly is this phenomenon of poly-substance use. I have some people on our methadone program who are on quite high doses of methadone, but they still need, for whatever reason, to seek psychoactive substance release for their difficult lives or whatever the trigger is for that individual person. So they are often going to another class of drugs.

We see now very much a combined use of opiates and methamphetamines, or ice as it is commonly called. My concern—and again this is just in theory and this is why it needs to be tested—is that that person who is then on an opioid-blocking agent will then be seeking that release, if we are not actually dealing with some of the underlying issues, from other substances.

**Reverend the Hon. FRED NILE:** That is the point of my question. How would you do that? I am saying that addict is in a state of mind to cooperate with methods to find out what is the trigger and what causes the original addiction.

**Professor EZARD:** But we have good engagement already with people who come and voluntarily treatment with us. They are very much looking for treatment and looking for assistance to stabilise their lives and make improvements in their lives. It depends very much on their social, physical and mental health contexts as to what they are able to do. Cognitive impairment for long-term opioid users is a very important factor limiting treatment options. But we already have good engagement with people. We are already offering what we can to people. Just being on an opioid blocker will not, I do not think—and again this is a research question—theoretically, make any difference in terms of engagement in counselling or in making changes to life. We already do that with the methadone program on buprenorphine.

My other concern with the naltrexone implant is, as Dr Wilson brought up, is any research that is done would need to follow out post-treatment because of the risk of opioid overdose with the decreasing tolerance while people are on the naltrexone implant. But, again, they are research questions. They are good questions to ask of the research, and any comprehensive research program could think about adding in adjuvant psychotherapy to the program. But another good research question is: What can the implant offer versus what can the implant plus counselling offer? Again we need to be using existing evidence-based interventions as well and asking what additional advantage this treatment can offer that population.

**Reverend the Hon. FRED NILE:** I would have thought it would have been easier at the counselling-advice stage if that person had that blocking agent.

**Professor EZARD:** Why would you think that?

**Reverend the Hon. FRED NILE:** Because they no longer have a desire for drugs.

**Professor EZARD:** I do not quite understand the link between an implant that blocks the affective opioids and a desire for psychoactive substances. I do not think that is a demonstrated link there.

**CHAIR:** You are talking about counselling, are you not—receptiveness to counselling.

**Reverend the Hon. FRED NILE:** Yes.

**Professor EZARD:** But we already have people—

**Reverend the Hon. FRED NILE:** But they are still using drugs. This person would have stopped using drugs.

**Professor EZARD:** Not everybody who is on the methadone and buprenorphine program is using. Most people smoke, actually, but apart from that, not everybody is using other psychoactive substances.

**Reverend the Hon. FRED NILE:** No, on methadone, they are on a drug. They are still on drugs. Methadone is a drug.

**Professor EZARD:** So are antihypertensive agents, so is salbutamol, and so are many of the antipsychotics and people with major mental health problems, and we still try to engage those people in treatment and interventions as well.

**CHAIR:** Antihypertensives are not mind-altering drugs. It is not a fair comparison.

**Professor EZARD:** Except that somebody who is on methadone or buprenorphine, we provide that to prevent the withdrawal effects. So people who are dependent, whose body is entirely used to opiates, when they stop the opiates go through a withdrawal syndrome, which is a very predictable physical syndrome and

psychological syndrome of sweats and shakes. People know the syndrome. The reason for providing the replacement therapy is that it stops that withdrawal. One of the theories behind why this works is that the withdrawal itself is a trigger to using. So people are stabilised on a substance, which is legal, which is oral, which is once a day or, in the case of buprenorphine, can be only three times a week. That then allows them to engage in the kind of things that I think you are hinting at—in terms of re-establishing their lives. It is not given for its intoxicating purposes. In fact, someone who is dependent will not experience any intoxication from those substances. It is not the same as someone who is opiate naïve taking a dose of methadone or buprenorphine.

**Reverend the Hon. FRED NILE:** You seem to be resisting replying that it would be easier to deal with a person who has a naltrexone implant to assist them during that six-month period.

**Professor EZARD:** I do not see the logic. It is certainly not our experience that we have a difficulty in engaging people because of their methadone or their buprenorphine. I do not see that it would be easier, as you say, to engage with someone who is on the naltrexone implant. I do not know because I have never worked with anyone on a naltrexone implant.

**Reverend the Hon. FRED NILE:** I gather that it is. That is why I am raising that it is easier.

**Professor EZARD:** It is a research question. I think it is a question for research.

**Reverend the Hon. FRED NILE:** That is what has been happening in Perth for 15 years.

**Professor EZARD:** Reverend Fred Nile, I would invite you to come to our clinic and speak to some of our patients and see perhaps some of the other treatments that are available that we know work.

**Reverend the Hon. FRED NILE:** I am not against the other treatments. I accept that.

**The Hon. JAN BARHAM:** I will follow on a bit. Why not? We are into an interesting area late in the afternoon about what the purpose is.

**Professor EZARD:** Yes.

**The Hon. JAN BARHAM:** Are we looking at trying to find a range of choices for people? If people have choice, I think the voluntary situation of people having choice about what might suit them and the idea that it might be more attractive to some people to say, "Okay, can I rid myself of the addiction so then I can get on with life?" might be psychologically an easy way for them and their families to deal with it. I think that is part of what is going on. I do not think there is very much understanding available about what addiction is and how it works, and that it is not just about that physical thing. If you are able to provide any comment now or any further information around that, I think that would be really helpful and if there something you can say about how it works.

**Professor EZARD:** Thank you for that. I think people who have been involved professionally with other people who are addicted to anything—it can be a psychoactive substance or it can be other things; gambling is a very good example for us here in New South Wales. If you have family members you know the suffering of that person who is addicted and also of the family and the immediate community. The addiction becomes overriding. There are clear definitions, clear criteria, for dependence—we prefer to use the term "dependence"—that set out some of those characteristics which include pursuing the use of that substance even though you know it is causing you and other people harm; feeling out of control with the substance use; requiring increasing amounts of the substance to have the same effect; using the substance to prevent what you know will be a withdrawal syndrome; and a reduction in your activities of daily life so that it becomes much, much more focussed on procuring, using and recovering from the effect of that psychoactive substance.

If you have been close to someone like that you know that they will jeopardise everything that is important to them. We have seen parents lose contact with their children, who are probably the most important people in their lives, because they cannot stop themselves from using substances. The same with gambling. Most of us have had contact with somebody who has gambled the family home and put the whole family on the streets because they cannot stop themselves from using that substance or doing that activity. It is that compulsion and that lack of control, despite damaging everything that is important to you. I have patients who have in effect killed themselves. They have subjected themselves to so many of the harms associated with their drug use that in the end they die from using that. Even though they know that that is going to happen to them,

they cannot stop themselves. It is this chronic ongoing condition that takes quite a long time to develop, and once you have developed it it is very hard to recover from it. It is a chronic relapsing condition—I think Dr Wilson explained that to you before—like any other chronic relapsing condition. If we genuinely want to help people who have problems with dependence, we need to be in it for the long term, have a long-term perspective and not encourage people to think there is a quick fix out there.

**The Hon. JAN BARHAM:** If a trial is done how long would it need to take to be able to test and understand?

**Professor EZARD:** It is a very good question. I think if there is a trial the duration of outcome and the outcome measures need to be very carefully defined. The duration of outcomes should be some time after the cessation of the intervention. Trials are very expensive and very hard. The longer you conduct your follow-ups post intervention, the more chance you have of lots to follow up. It is very expensive to catch those people who have stopped having the intervention. But if the aim of this intervention is to enable people to cease that particular substance use for a long time, then we need to follow them up for a long time and look at their substance use.

**The Hon. JAN BARHAM:** I think the problem with Western Australia is that we do not have that information to know what has happened to the 8,000 or so who have gone through over time.

**Professor EZARD:** Scientific standards at the moment require a comparison group. We do not have a comparison group for that population. The comparison group needs to be matched on all sorts of criteria, say, age, socioeconomic status and all those kinds of things to see what would have happened if they had not had that treatment and they had a gold standard, sorry, an evidence-based treatment to compare that with and followed out for a long enough period, if that is the aim. If the aim is eventual abstinence from that substance and an improvement in quality of life and not increasing mortality, which is a huge concern with any trial, they need to be followed up to look at other adverse events during and post the intervention. So it would require some prolonged period of follow-up. It is very expensive and that is my concern. I am not at all opposed to investigating any alternative treatment for my patient population. I have very little to offer them at the moment in terms of range of choices if they have tried things and it did not work for them. Because of the expense of this kind of intervention, if the primary outcome is long-term abstinence from opiates, then we will need to follow them up long term and it will be very expensive.

**The Hon. JAN BARHAM:** Can I ask you about polydrug use? Do you see much of it? Currently I am hearing and seeing a lot of young people mixing alcohol and Xanax.

**Professor EZARD:** I am glad you brought up alprazolam. Alprazolam is one of our biggest bug-bears. It is a legal substance. It has an enormous range of harms and I am surprised that we are still allowing it to be prescribed, to be honest. The harms we see are far greater than the benefits.

**The Hon. JAN BARHAM:** And the harm of mixing it with alcohol?

**Professor EZARD:** Polydrug use is increasingly the norm. Some time ago, say, in the mid-1990s, people would come along. They would be either stimulant dependent, opiate dependent or alcohol dependent. We are increasingly seeing polydrug use and increased harms as a result of that poly drug use. When people overdose, when we have overdose deaths, it is usually a combination of opiates plus benzodiazepines plus alcohol. A treatment that addressed only one substance is not going to address the range of poly substance problems that we are seeing and the harm at a community level from those substances.

**The Hon. JAN BARHAM:** Another concern is that when people do front, if they go to their doctor once a year or whenever, if it is misuse of prescription drugs or illicit drugs, they are not informing their medical practitioner who cannot then manage their health if they do not know the full range. Is there some way around that so that people can front up and be honest about what they are doing without fear of reaction? I hear that from young people; they are saying, "I'm not going to tell anyone what I am doing because I'll get in trouble." So they are going along and not being honest and therefore not getting treatment that addresses the real issues.

**Professor EZARD:** That is a very good question and a difficult question. I work hard in my practice to present a non-judgemental attitude. Certainly by the time people come to us as a specialist service they want to address their substance use issues and most people, unless there is a reason for not telling the truth and not disclosing their substance use, for example, they might suspect that there is some Community Services

involvement or there is some legal involvement but if they are there and they know it is just for their health, most people will tell you what is going on because they want help and they want me to help them help themselves, which is the approach we take. So there is no disincentive to disclosure. One of the problems in general practice is, as we have mentioned with the increasing problems with prescription drug use, so opioids and benzodiazepines, is that in effect the doctor is the drug dealer.

So you are engaged in a relationship where if you are doctor shopping the aim of your visit to the doctor is quite different to what the doctor perceives that interaction to be. There are two things that we can done. First, we can skill up general practitioners and other health care providers in the assessment and management of substance use problems. There are increasingly standardised tools for conducting assessments that do not take too long. General practitioners are not aware of them. We just need to skill them up in terms of that. Another thing that has been on the table for some time in terms of the drug misuse strategy is real-time prescription data. If I have somebody who I see in hospital with severe problems and I ring up the doctor shopping line, they can give me details that are more than three months old and require voluntary reporting from a doctor or pharmacist who suspects that person and who will then take the time to go through the reporting process. It is not working as we have got it now. And the way we can have it is this real-time reporting that we can access immediately as doctors. That will help us enormously.

**The Hon. JAN BARHAM:** I have heard that. I think everyone thinks that is logical.

**CHAIR:** Thank you for your expertise and the time taken in putting in the submission.

**(The witness withdrew)**

**(The Committee adjourned at 5.09 p.m.)**