General Purpose Standing Committee No. 2

Drug and alcohol treatment

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Terms of reference

On 21 November 2012, General Purpose Standing Committee No. 2 self-referred an Inquiry into the effectiveness of current alcohol and drug policies with respect to deterrence, treatment and rehabilitation, and in particular:

1. The delivery and effectiveness of treatment services for those addicted to drugs and/or alcohol, including naltrexone treatment, with reference to the welfare and health of individuals dependent on illicit drugs and the impact on their families, carers and the community having regard for:

    (a) The need for appropriate human research, ethics and Therapeutic Goods Administration approval for use of new treatments in clinical trials

    (b) The current body of evidence and recommendations of the National Health and Medical Research Council

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

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

4. The adequacy of integrated services to treat co-morbid conditions for those with drug and/or alcohol addiction, including mental health, chronic pain and other health problems

5. The funding and effectiveness of drug and alcohol education programs, including student and family access to information regarding the legal deterrents, adverse health and social impacts and the addictive potential of drugs and/or alcohol

6. The strategies and models for responding to drug and/or alcohol addiction in other jurisdictions in Australia and overseas, including Sweden and the United Kingdom

7. The proposed reforms identified in the *Drug and Alcohol Treatment Amendment (Rehabilitation of Persons with Severe Substance Dependence) Bill 2012*

That the Committee report by Thursday, 29 August 2013.

Committee membership

The Hon Marie Ficarra MLC	Liberal Party	*Chair*
Revd. the Hon Fred Nile MLC*	Christian Democratic Party	*Deputy Chair*
The Hon Jan Barham MLC	The Greens	
The Hon David Clarke MLC	Liberal Party	
The Hon Jenny Gardiner MLC	The Nationals	
The Hon Shaoquett Moselmane MLC	Australian Labor Party	
The Hon Helen Westwood MLC	Australian Labor Party	

*** Substituting for Hon Paul Green MLC**

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Chair's foreword

I am pleased to present the report of General Purpose Standing Committee No. 2 on drug and alcohol treatment, which contains seven recommendations.

The evidence received by the Inquiry highlights the many and widespread negative effects of drug and alcohol abuse. The costs to the community include family and relationship breakdown, poor individual health, and public disorder. It goes without saying that substance abuse is one of our most pressing social issues. It is important that as a community we continue to think about how we can respond to the scourge of drug and alcohol abuse more effectively. Alcohol-related harm in particular, is a nationally significant issue, and all levels of Government as well as industry and non-government organisations, need to work together if we are to develop a comprehensive approach to alcohol.

The evidence made it clear that in the field of drug and alcohol treatment there are no easy solutions. However, it was also apparent that there is a consensus among addiction practitioners that they would welcome more treatment options. In addition, the evidence showed the value of using the criminal justice system to effect positive change for offenders with substance abuse issues, the important role of education in preventing substance abuse issues from developing, and the need for funding levels to keep pace with the increasing demand for drug and alcohol treatment services.

The key issue for this Inquiry was the use of naltrexone implants in treating opioid dependence. I agree with the view that while naltrexone implants show promise as part of a treatment program, I note that they have not yet been approved for use in Australia. I am keen for the evidence base regarding naltrexone implants to continue to develop. I am hopeful that in the future it will be practicable to conduct a randomised control trial comparing naltrexone implants with other licensed treatments used to treat opioid dependence, and thus expand the treatment options available.

On behalf of the Committee, I would like to acknowledge the time and considerable effort that Inquiry participants invested in this Inquiry, through submissions, hearings and additional information. I would also like to thank the drug and alcohol treatment providers that kindly hosted visits by the Committee.

I express my thanks to my colleagues for their thoughtful and engaged contributions to this Inquiry. Our work has benefited greatly from both our individual perspectives and our cooperative approach.

Hon Marie Ficarra MLC
Committee Chair

Summary of key issues

In November 2012, General Purpose Standing Committee No. 2 initiated an inquiry into drug and alcohol treatment. The Inquiry's most prominent theme was the use of naltrexone implants in treating opioid dependence. This is highlighted by the volume of evidence received regarding the current availability and manufacture of naltrexone implants, as well as the evidence base for their use. The Committee heard diverging views in relation to the efficacy of naltrexone implants; however, most addiction experts did agree about the need to expand the suite of treatment options available to treat to opioid dependence

A number of other important matters were raised during the Inquiry and the evidence presented highlighted the many negative effects of drug and alcohol abuse. It became clear that the way the community deals with substance abuse matters greatly.

The key issues considered during the Inquiry and this report, and the Committee's recommendations, are summarised hereunder.

Alcohol abuse

We received evidence from numerous Inquiry participants that alcohol is the substance presenting the greatest challenge to public health, and that the negative social and economic effects of alcohol abuse are more significant than those caused by other substances. Alcohol is a unique challenge for policy makers because, unlike other substances, it can be used safely and it can also be used recklessly.

Because the attention of this Inquiry was primarily given to naltrexone implants, it is difficult for the Committee to draft detailed recommendations in response to alcohol misuse. However, we acknowledge the many negative effects of alcohol abuse and welcome all initiatives to address this important social issue. After we completed our hearings, the NSW Auditor-General published a report, entitled, *Cost of alcohol abuse to the NSW Government*, which indicated that the NSW Government could better respond to alcohol abuse if it had more information on the associated costs. No one actor can solve the problem of alcohol abuse: we believe that alcohol abuse is a nationally significant issue requiring the involvement of all levels of Government, as well as the alcohol industry and non-government organisations. Consequently, we think that New South Wales can play an important role in instigating and supporting national efforts to deal with this issue by recommending that the NSW Government approach the Commonwealth Government to request that a national summit on alcohol abuse be convened in a timely manner.

Recommendation 1

That the NSW Government, noting the report of the NSW Auditor-General, entitled, *Cost of alcohol abuse to the NSW Government,* and the evidence submitted to the General Purpose Standing Committee No. 2 Inquiry into drug and alcohol treatment, approach the Commonwealth Government to highlight the need for a national response to the problem of alcohol abuse, and to request that a national summit on alcohol abuse be convened in 2014-2015.

Treating opioid dependence through naltrexone implants

Naltrexone is a form of opioid antagonist treatment; namely, a pharmacotherapy that aims to induce an opioid-free state in opioid dependent individuals. A naltrexone implant is a surgically implanted device that provides a slow release of naltrexone over a period of time, effective for three to six months.

Naltrexone implants are not currently registered for licensed use in Australia; the primary reason being that the Therapeutic Goods Administration (TGA) – the national regulatory body for therapeutic goods – has not been presented with sufficient evidence demonstrating their safety and efficacy. However, naltrexone implants have been used throughout Australia because clinicians have been able to administer them under the TGA Special Access Scheme, which allows the use of unapproved therapeutic goods for individuals whom death is likely.

The most prominent clinician administering naltrexone implants through the Special Access Scheme is Dr George O'Neil of the Fresh Start Recovery Programme, Subiaco, Western Australia. Through his company Go Medical Industries Pty Ltd, Dr O'Neil has developed a naltrexone implant which he is hoping to register with the TGA. Currently, Dr O'Neil only uses his naltrexone implants to treat Fresh Start patients.

A number of Inquiry participants addressed the question of whether there is an evidence base for the use of naltrexone implants. While commenting on the same literature, published both internationally and in Australia, it became clear that they held divergent views on the conclusions of the work. Some argued that the research supporting the effectiveness of sustained-release naltrexone was well established, while others contended that the evidence presented was not yet sufficient.

Of particular importance to establishing the evidence base for naltrexone implants was a literature review prepared by the National Health and Medical Research Council (NHMRC) – Australia's peak body for supporting health and medical research. The NHMRC found that although naltrexone implants may show some efficacy as part of a treatment program, more research was needed.

A consistent view of the researchers, epidemiologists and addiction medicine practitioners that gave evidence to the Inquiry was that there needs to be an expansion in the treatment options available to treat opioid dependence. Another commonly made point was that not only is there is a need for more treatment options, but there is also a need for what is currently available to be used more effectively.

The Committee agrees that it would be beneficial to expand the treatment options available to treat opioid dependence and supports the NHMRC's position that further research on naltrexone implants is required. As such, we recommend that if Dr O'Neil's naltrexone implants are approved by the TGA, that a randomised control trial be undertaken comparing naltrexone implants with other licensed treatments used to treat opioid dependence. The Committee was advised that the funding of clinical research is primarily a Commonwealth responsibility. However in the event that funding for research into naltrexone implants is not forthcoming from the NHMRC, we recommend that the funding instead be provided by the NSW Government and that other Australian States and international jurisdictions be encouraged to participate in the trial.

Recommendation 4

That if naltrexone implants are approved for use by the Therapeutic Goods Administration, that the NSW Government fund a randomised control trial comparing naltrexone implants with other licensed treatments used to treat opioid dependence, if such a trial is not successful in securing funding from the National Health and Medical Research Council.

The trial must be conducted to the highest standards and be developed in consultation with experts from the fields of addiction and public health medicine, and that participation in such a trial by other Australian States and international jurisdictions be encouraged.

Funding

The evidence indicated that it is difficult to assess the adequacy of funding for drug and alcohol treatment services. Funding for treatment in New South Wales comes from a variety of sources, namely the State and Commonwealth Governments as well as the private sector, and it is not always easy to firstly determine where the funding for a service comes from and secondly who is responsible for funding what service. In addition, some Inquiry participants expressed concern that too little was being spent on treatment compared to law enforcement for illicit drugs, while others were concerned that funding was not commensurate with the increasingly complex needs of those seeking treatment.

We are pleased to note that the NSW Ministry for Health is leading the development of the Drug and Alcohol-Clinical Care and Prevention (DA-CCP) Planning Model. It is hoped that the Model will assist with assessing the adequacy of funding for drug and alcohol treatment services. The DA-CCP Planning Model, when implemented, will per 100,000 people, show the likely number of people with substance addictions and then demonstrate the level of services required to effectively meet treatment demand.

The Committee accepts and supports the argument that funding for drug and alcohol treatment services must be commensurate with the demand for such services. We are hopeful that the DA-CCP Planning Model will be a beneficial reform regarding the allocation of resources for drug and alcohol treatment. As such, we recommend that following the implementation of the Drug and Alcohol-Clinical Care and Prevention Planning Model, the NSW Government ensure that funding levels keep pace with the increasing demand for drug and alcohol treatment services.

Recommendation 6

That following the implementation of the Drug and Alcohol-Clinical Care and Prevention Planning Model, the NSW Government ensure that funding levels keep pace with the increasing demand for drug and alcohol treatment services.

Education

Drug and alcohol education aims to reduce the prevalence of drug and alcohol use and in doing so prevent substance abuse issues from developing. In effect, it is about prevention rather than treatment of established problems.

The evidence to the Inquiry regarding drug and alcohol education was primarily relevant to school students. Some Inquiry participants said that drug and alcohol education could be more effective. In response to such concerns, the relevant Government agencies, responsible for delivering drug and alcohol education in New South Wales, advised the Committee that they use evidence based approaches in developing education initiatives. The Committee believes that this practice should continue.

The Committee also considered the provision of drug education programs and in particular the work of Life Education NSW, a non-profit provider of preventative drug and health education programs to children and young people. We heard that a student's attendance at Life Education NSW programs is paid for by a mix of direct payments by parents, State Government funding, and fundraising by Life Education NSW. However, some students miss out as their parents cannot afford the $10 fee required by Life Education NSW.

The Committee supports the work of Life Education and other providers and believes that all students should be given the opportunity to be involved in their programs. Therefore, we recommend that the NSW Government provide additional funding to Life Education NSW and other providers to ensure that all students can participate in their programs.

Recommendation 7

That the NSW Government provide additional funding to Life Education NSW and other providers to ensure that all students are given the opportunity to participate in their programs.

Involuntary treatment

This Inquiry considered the Involuntary Drug and Alcohol Treatment (IDAT) Program, the State's system for involuntarily treating individuals with severe substance dependence. The IDAT Program is provided for by the *Drug and Alcohol Treatment Act 2007* (the principal Act). On 25 October 2012, Revd. the Hon Fred Nile introduced the *Drug and Alcohol Treatment (Rehabilitation of Persons with Severe Substance Dependence) Bill 2012* to reform the principal Act.

The Committee was informed that it took eight years to develop the IDAT Program, it has been permanently operating since September 2012, and that treatment is only delivered to a small cohort of the most at risk individuals. That is, individuals who are at immediate risk of serious harm due to their drug and alcohol use, have lost the ability to make rational decisions regarding their wellbeing, and for whom the likely outcome is death or severe impairment.

In addition, the Committee received evidence regarding some of the arguments for and against involuntary treatment. This included high costs, human rights and ethical concerns, and the circumstances in which involuntary treatment may be appropriate.

The Committee found that the evidence base supporting involuntary treatment is still developing, and it is for this reason that we support an evaluation of the efficacy of the IDAT program, once it has been operating for a reasonable period of time. The evidence also indicated that at this stage it is too early to make any significant changes to the operation of the IDAT Program.

Summary of recommendations

Recommendation 1 **xi**

That the NSW Government, noting the report of the NSW Auditor-General, entitled, *Cost of alcohol abuse to the NSW Government,* and the evidence submitted to the General Purpose Standing Committee No. 2 Inquiry into drug and alcohol treatment, approach the Commonwealth Government to highlight the need for a national response to the problem of alcohol abuse, and to request that a national summit on alcohol abuse be convened in 2014-2015.

Recommendation 2 **32**

That the NSW Government review the recommendations of the 2003 New South Wales Alcohol Summit and provide an update regarding its response to those recommendations.

Recommendation 3 **53**

That the NSW Government consider expanding the availability of naloxone and the provision of training to relevant healthcare professionals to prevent opioid overdose fatalities.

Recommendation 4 **xiii**

That if naltrexone implants are approved for use by the Therapeutic Goods Administration, that the NSW Government fund a randomised control trial comparing naltrexone implants with other licensed treatments used to treat opioid dependence, if such a trial is not successful in securing funding from the National Health and Medical Research Council.

The trial must be conducted to the highest standards and be developed in consultation with experts from the fields of addiction and public health medicine, and that participation in such a trial by other Australian States and international jurisdictions be encouraged.

Recommendation 5 **70**

That the NSW Government consider a further expansion of the Drug Court program to other regional centres outside of Sydney and the Hunter.

Recommendation 6 **xiii**

That following the implementation of the Drug and Alcohol-Clinical Care and Prevention Planning Model, the NSW Government ensure that funding levels keep pace with the increasing demand for drug and alcohol treatment services.

Recommendation 7 **xiv**

That the NSW Government provide additional funding to Life Education NSW and other providers to ensure that all students are given the opportunity to participate in their programs.

Chapter 1 Introduction

This Chapter provides an overview of the Inquiry process, including the methods the Committee used to facilitate participation by members of the public, Government agencies, experts from the field of addiction medicine, and relevant organisations. It also includes a brief outline of the report structure.

Establishment of the Inquiry

1.1 On 21 November 2012, General Purpose Standing Committee No. 2 (GPSC 2) self-referred an Inquiry into the effectiveness of current alcohol and drug policies with respect to deterrence, treatment and rehabilitation.

1.2 The Inquiry was also required to examine the *Drug and Alcohol Treatment Amendment (Rehabilitation of Persons with Severe Dependence) Bill 2012* (the Bill) which was introduced into the NSW Parliament by Revd. the Hon Fred Nile on 25 October 2012. The bill seeks to amend the *Drug and Alcohol Treatment Act 2007* to further provide for the involuntary rehabilitative care of persons with severe substance dependence.

1.3 During his second reading speech, Revd. Nile advised that he would support the Bill being considered by GPSC 2. At the conclusion of the second reading speech debate on the Bill was adjourned.[1]

Terms of reference

1.4 The Inquiry terms of reference required the Committee to inquire and report on the following matters relevant to drug and alcohol treatment: the delivery and effectiveness of treatment services, and in particular naltrexone implants; the effectiveness of involuntary treatment; the proposed reforms identified in Revd. Nile's bill; adequacy of funding; the effectiveness of education programs; strategies and models in other jurisdictions; and the adequacy of integrated services to treat people with co-morbid conditions.

1.5 The full terms of reference can be found at page iv.

Submissions

1.6 The Committee invited submissions by advertising in the *Sydney Morning Herald* and the *Daily Telegraph* on 28 November 2012. A media release announcing the Inquiry was sent to all media outlets around the State.

1.7 The Committee also sought submissions by writing directly to individuals or organisations with a likely interest in the Inquiry, including government agencies, community organisations and experts from the field of addiction medicine and public health. The closing date for submissions was 1 March 2013.

1 *LC Debates* (25/10/2012) 16480.

1.8 The Committee received a total of 54 submissions and one supplementary submission from a range of stakeholders.

1.9 A list of submissions is available at Appendix 1.

Hearings

1.10 The Committee held four hearings at Parliament House on 3, 4 and 10 April 2013 and 27 May 2013.

1.11 A list of witnesses who appeared at the hearings is reproduced in Appendix 2. The list of documents tabled during the hearing is available at Appendix 4, and the list of witnesses who provided answers to questions taken on notice during hearings can be found at Appendix 5.

1.12 Transcripts of the hearings are available on the Committee's website www.parliament.nsw.gov.au/gpsc2 and the minutes of the proceedings of all Committee meetings relating to the inquiry are included in Appendix 6.

Site visits

1.13 The Committee undertook site visits on 14-16 May 2013 and 12 June 2013. In sequential order the Committee visited the:

- Lyndon Community, Orange, New South Wales
- Involuntary Drug and Alcohol Treatment Centre, Bloomfield Hospital, Orange, New South Wales
- Fresh Start Recovery Programme, Subiaco, Western Australia
- Drug and Alcohol Office, WA Health, Mt Lawley, Western Australia
- Sydney Medically Supervised Injecting Centre, Darlinghurst, New South Wales
- St Vincent's Emergency Department, and Drug & Alcohol Service, Darlinghurst, New South Wales.

1.14 The Committee would like to thank all those who participated in the Inquiry, whether by making a submission, giving evidence or attending the public hearings, or hosting a site visit.

1.15 For further information regarding the site visits please refer to Appendix 3.

Report structure

1.16 Chapter 2 sets the context for the Inquiry by providing background information on three key issues: evidence received by the Inquiry concerning the nature and prevalence of substance abuse; the policy and program frameworks underpinning the delivery of drug and alcohol treatment in New South Wales; and some of the models for responding to drug and/or alcohol addiction used in other jurisdictions.

1.17 Chapter 3 considers the evidence presented to the Inquiry regarding treatment responses to drug and alcohol abuse. It identifies the different phases of treatment and considers the need for customised treatment. It also looks at issues identified by Inquiry participants as impacting upon treatment services.

1.18 Chapter 4 concerns the most prominent issue addressed during this Inquiry: the treatment of illicit opioid abuse through naltrexone and, in particular, naltrexone implants. It looks at the rationale for naltrexone implants, their availability and manufacture, and the evidence base for their use. In addition, the provisions relevant to naltrexone implants in the Drug *and Alcohol Treatment (Rehabilitation of Persons with Severe Substance Dependence) Bill 2012* are examined. The Chapter concludes by considering the value of further research into naltrexone implants and other pharmacotherapies in treating opioid dependence.

1.19 Chapter 5 looks at the system of involuntary drug and alcohol treatment for individuals with severe substance dependence by detailing the operation of *Drug and Alcohol Treatment Act 2007* and considering the reforms proposed in the *Drug and Alcohol Treatment (Rehabilitation of Persons with Severe Substance Dependence) Bill 2012*. The Chapter also examines some of the arguments for and against involuntary treatment and outlines some of the drug and alcohol treatment interventions provided through the criminal justice system.

1.20 Chapter 6 considers funding for drug and alcohol treatment services in New South Wales. It notes that there are multiple sources of funding for treatment and discusses the impact this has on the ability to assess the adequacy of funding levels. It also looks at the development of the National Drug and Alcohol-Clinical Care and Prevention Planning Model. The Chapter concludes by noting specific treatment services requiring additional funding as identified by Inquiry participants.

1.21 Chapter 7 explores matters relevant to the delivery of drug and alcohol education in New South Wales. In particular, it focuses on drug and alcohol education for school students.

Chapter 2 Background

This Chapter sets out the context for the Inquiry by providing background information on three key issues. The first section details some of the data and comment received by the Inquiry concerning the nature and prevalence of substance abuse. The second section outlines the policy and program frameworks underpinning the delivery of drug and alcohol treatment in New South Wales. The third section considers some of the models for responding to drug and/or alcohol addiction used in other jurisdictions.

Nature and prevalence of drug and alcohol abuse

2.1 This section begins by noting key health, economic, social and legal effects of substance abuse. Next, some of the evidence received by the Inquiry regarding substance abuse patterns is detailed.

A far-reaching and widespread problem

2.2 According to the NSW Ministry for Health problematic substance abuse causes many types of harm within the community. The effects of drug and alcohol abuse are many and widespread: they impact upon individual health and wellbeing, families and relationships, and public health and safety; can result in crime, imprisonment and legal problems; and can cause severe economic hardship.[2]

2.3 In its submission, the Australasian Professional Society on Alcohol & other Drugs (APSAD), a multidisciplinary body for professionals involved in the alcohol and other drug field, advised the Committee that while drug and alcohol abuse occurs across all socioeconomic classes, people with severe substance dependence issues are likely to have low socioeconomic status and demonstrate poor health literacy.[3]

2.4 APSAD also advised the Committee that substance dependence is a chronic condition and those experiencing problems often require a wide range of interventions over a long period of time.[4]

2.5 In addition, several Inquiry participants argued that substance dependence is primarily a health matter rather than a legal issue. For instance, in its submission Family Drug Support, a support line which receives 28,000 telephone calls a year from families affected by alcohol and other drugs, argued 'we believe that drug dependence is best dealt with as a health issue rather than a legal one'.[5]

2.6 From the perspective of an addiction specialist, Professor John Saunders, Drug and Alcohol Program Director, Wesley Hospital Kogarah, advised the Committee that the medical profession's understanding of substance dependence and addiction has changed over the past

2 Submission 51, NSW Ministry for Health, p 3.

3 Submission 10, Australasian Professional Society on Alcohol & other Drugs, p 6.

4 Submission 10, p 6.

5 Submission 25, Family Drug Support, p 4.

two decades. Professor Saunders noted that while substance abuse, at least initially, might be within a user's control, dependency resets the brain's neurochemical pathways meaning it progressively becomes more difficult for an individual to control their use. Professor Saunders then argued that more needs to be done to increase the community's understanding of the issue:

> …I draw the attention of the Committee to developments in our understanding of the nature of substance dependence and addiction over the past 20 years. Many people regard these conditions as self-inflicted disorders and no more than that. That is quite wrong. What we see in people who have dependencies and addictions is a profound resetting of neurochemical pathways in the brain that result in what I describe as a driving force that directs their use of the substance. It is certainly true that when someone starts using a particular substance, be it alcohol or a drug, it is under their voluntary control initially. However, things change. I urge the Committee in its deliberations to be mindful that the neurobiology of dependence is now well recognised and well established and that a lot of the important modern treatments are based on that. It is also important that family members and the community understand the nature of substance dependence more than they do at the moment.[6]

2.7 Mr Kelvin Chambers, CEO, Drug and Alcohol Multicultural Education Centre, an organisation working specifically with culturally and linguistically diverse communities from both a project research and a counselling perspective, highlighted the human element of addiction, stating:

> We are dealing with people who are pretty broken…We have got to be realistic about that…Most communities see drug and alcohol abuse as a failure of spirit rather than a health issue.[7]

2.8 A number of Inquiry participants provided the Committee with statistics to illustrate the seriousness of substance abuse in terms of health outcomes, economic and social costs, and crime. A selection of these statistics is detailed below:

- The St Vincent's Hospital, Inner City Health Program, Alcohol & Drug Service, estimates that the burden of disease caused by drug and alcohol abuse accounts for 12 per cent of the total burden of disease.[8] The burden of disease is a measure used to assess and compare the relative impact of different diseases and injuries on a population.[9]
- According to the Australian Institute of Health and Welfare, Australia's national agency for health and welfare statistics, nationally, there is approximately one drug overdose death per day.[10]

6 Professor John Saunders, Drug and Alcohol Program Director, Wesley Hospital Kogarah, Evidence, 4 April 2013, p 39.

7 Mr Kelvin Chambers, CEO, Drug and Alcohol Multicultural Education Centre, Evidence, 27 May 2013, p 2.

8 Submission 28, St Vincent's Hospital, Inner City Health Program, Alcohol & Drug Service, p 3.

9 Australian Institute of Health and Welfare, 'Burden of disease', accessed 15 July 2013, http://www.aihw.gov.au/burden-of-disease/.

10 Submission 51, p 4.

- In its submission, the Australian Medical Association (NSW) Limited, advised the Committee that in 2011, of those adults that consumed alcohol in New South Wales almost one-third were doing so at levels posing lifetime risks to their health.[11]
- Evidence presented by the South Eastern Sydney Local Health District, indicated that nationally, for the financial year 2004/05, the social cost attributed to alcohol, tobacco and illicit drug misuse was estimated at $55.2 billion.[12]
- The Aboriginal Health and Medical Research Council of NSW (AH&MRC) advised the Committee that in 2008 in New South Wales, Aboriginal people were less likely to drink alcohol, with 33 per cent abstaining compared to 15 per cent of non-Aboriginal people. However, the AH&MRC also noted that for those Aboriginal people who did drink alcohol they were more likely to do so at more harmful levels as opposed to non-Aboriginal people.[13]
- Of relevance to the criminal justice system, in 2010 nationally, 66 per cent of the prison population had admitted to using illicit drugs in the twelve months prior to incarceration.[14] Additionally, during 2008, 65 per cent of a national sample of Australian police detainees tested positive for at least one illicit drug.[15]

Substance abuse patterns

2.9 In the evidence received by the Committee it became clear that a wide range of substances, both licit and illicit, are being abused within New South Wales. Some of the data and commentary, presented to the Inquiry, regarding substance abuse patterns are detailed below.

2.10 According to the New South Wales Population Health Survey, cannabis is the most widely used drug in the State. For the period 2007 to 2010, the percentage of the population aged 12 years and over that reported recent cannabis use grew from 8 per cent to 9.3 per cent.[16]

2.11 Data obtained in the 2010 National Drug Strategy Survey shows that as a percentage of the population nationally:

- Tobacco use has declined from 29 per cent in 1993 to 18 per cent in 2010.
- The abuse of prescription drugs for non-medical purposes has risen from 3.7 per cent in 2007 to 4.2 per cent in 2010. The most commonly abused prescription drugs are opioid analgesics (painkillers) and benzodiazepines (sedatives).
- Cocaine abuse grew from 1.6 per cent in 2007 to 2.1 per cent in 2010.[17]

2.12 In evidence, the Director of Mental Health and Drug and Alcohol Programs within the NSW Ministry of Health, Mr David McGrath, advised the Committee that according to

11 Submission 8, Australian Medical Association (NSW) Limited, p 4.

12 Submission 42, South Eastern Sydney Local Health District, p 5.

13 Submission 53, Aboriginal Health and Medical Research Council of NSW, p 5.

14 Submission 51, p 5.

15 Submission 52, Department of Attorney General and Justice, p 119.

16 Submission 51, p 5.

17 Submission 10, pp 9-10.

Ministry estimates there are approximately 35,000 people in the State currently dependent on heroin.[18]

2.13 In its submission, the Australian Institute for Health and Welfare informed the Committee that in 2010-2011, of the 35,365 people that sought closed treatment[19] for substance abuse in New South Wales, the top five principal drugs of concern were:

1. Alcohol 17,904 (50.6 per cent)
2. Cannabis 6,993 (19.6 per cent)
3. Heroin 3,157 (8.9 per cent)
4. Amphetamines 2,945 (8.3 per cent)
5. Benzodiazepines 76 (2.2 per cent).[20]

2.14 The Committee also received evidence alerting members to the fact that poly drug usage (the use of multiple substances simultaneously) is increasing in prevalence. Professor Nadine Ezard, Clinical Director, St Vincent's Hospital, Inner City Health Program, Alcohol & Drug Service advised the Committee that:

> Some time ago, say, in the mid-1990s, people would come along. They would be stimulant dependent, opiate dependent or alcohol dependent. We are increasingly seeing poly drug 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.[21]

2.15 Professor Alison Ritter, Director of the Drug Policy Modelling Program (DPMP), a drug and alcohol policy research and practice program at the University of New South Wales, in response to questioning concerning the issue of growing poly drug use, stated:

> The research community has let down policy-makers in this regard. Everybody is a poly drug user. I have not met anyone using heroin that is not using everything else at the same time and yet as researchers we persist in categorising people as single drug events…What is really clear is that people use multiple drugs and often that is completely pragmatic choice—price and availability—all they want to do is get out of it. Our treatments need to be broad to address multiple substances simultaneously.[22]

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18 Mr David McGrath, Director, Mental Health and Drug and Alcohol Programs, NSW Ministry of Health, Evidence, 27 May 2013, p 28.

19 Closed treatment is a counting measure used by the Australian Institute of Health and Welfare. It refers to a period of contact, with defined dates of commencement and cessation, between a client and a treatment agency. Australian Institute of Health and Welfare, 'Alcohol and other drugs (AODT-NMDS) data cubes, accessed 15 July 2013, http://www.aihw.gov.au/alcohol-and-other-drug-treatment-services-data-cubes/.

20 Submission 14, Australian Institute of Health and Welfare, p 6.

21 Professor Nadine Ezard, Clinical Director, St Vincent's Hospital, Inner City Health Program, Alcohol & Drug Service, Evidence, 4 April 2013, p 67.

22 Professor Alison Ritter, Director, Drug Policy Modelling Program, National Drug and Alcohol Research Centre, Evidence 3 April 2013, p 23.

Policy and program settings

2.16 Drug and alcohol treatment in New South Wales, indeed nationally, is underpinned by the concept of harm minimisation. This section details the key objectives of the harm minimisation approach and describes how this approach is reflected in the drug and alcohol treatment services in New South Wales.

Harm minimisation

2.17 Nationally, drug and alcohol policy is guided by the *National Drug Strategy 2010-2015* (the Strategy). The Strategy is based upon partnerships between Australian, State and Territory Governments (namely the health, law enforcement and education portfolios) via the Ministerial Council on Drug Strategy, and the non-government sector. The Strategy aims to improve health, social and economic outcomes by preventing harmful drug use and reducing the negative effects of licit and illicit drugs in society.[23]

2.18 The central component of the Strategy is the concept of harm minimisation, which encompasses reduction in demand, supply and harm:

- Demand reduction seeks to prevent and/or delay the uptake of alcohol, tobacco and drug use; reduce drug and alcohol abuse; and support people recovering from substance dependence.
- Supply reduction aims to prevent, disrupt or reduce the production and supply of illegal drugs; and effectively manage the supply of legal drugs.
- Harm reduction concerns interventions designed to reduce the adverse consequences of substance abuse.[24]

2.19 In its submission, the NSW Ministry for Health advised the Committee that, in addition to the Strategy, New South Wales has its own drug and alcohol objectives. These objectives are set out in the *NSW State Plan 2021: A Plan to make NSW Number One* and they focus on: health promotion and minimising hospital admissions; reducing smoking and at risk drinking rates; preventing and reducing re-offending rates for people with substance abuse issues; and better supporting the most vulnerable members of the community to help them break the cycle of disadvantage.[25]

2.20 Advocates for harm minimisation take the position that there are some within society that will inevitably abuse drugs and that response efforts should seek to minimise the harmful consequences associated with such abuse.[26] Further, some proponents of harm minimisation argue that while achieving a drug free society is the ultimate goal of any response to the issue of drug abuse, strict adherence to such a goal would jeopardise public health as it would preclude the implementation of successful harm reduction strategies.[27]

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23 Submission 51, p 6.

24 Submission 51, p 6.

25 Submission 51, p 6.

26 Submission 46, Alcohol and other Drugs Council of Australia, p 2.

27 Submission 46, p 10.

2.21 In contrast to harm minimisation proponents, drug free advocates argue that policy should focus predominately on preventing harm to individuals from illicit drug use rather than working to reduce or minimise its impacts. The argument is predicated on a belief that harm minimisation sends a message that the illegal and dangerous abuse of drugs is acceptable.[28] The strategy encourages the redirection of resources that treat the outcomes of drug and alcohol abuse to stronger prevention measures and to treatment options that enable users to be drug free.[29] The drug free approach favours medical treatments which seeks to achieve abstinence from drugs as opposed to drug substitution treatments such as methadone or buprenorphine – these and other treatments will be considered in detail in Chapters 3 and 4.

2.22 In order to inform itself about harm minimisation the Committee on 12 June 2013, undertook a visit of inspection to one of the at times controversial harm minimisation services in New South Wales, the Sydney Medically Supervised Injecting Centre (SMSIC). Committee members met with some of the staff operating the SMSIC and were advised about the Centre's work in seeking to reduce death and injury associated with injecting drug use. The SMSIC staff informed the Committee that, as well as providing the injecting service, the Centre also worked with clients to improve their general health and wellbeing.

Program frameworks

2.23 According to the NSW Ministry for Health, responding to the impacts of substance abuse requires close collaboration across government, given the widespread nature of the problem:

> Harms associated with drug and alcohol use arise from and impact on the socioeconomic, community, family and individual environments. Whilst responsibility for providing treatment interventions to reduce harm from use to individuals and families predominantly falls with health, responsibility for reducing broader community impacts falls across government. In order to prevent or break the cycle of harm, including homelessness, crime, disruption to public amenity and domestic violence, it is necessary for collaboration between government agencies including: NSW Police Force, Attorney General and Justice, the Office of Liquor Gaming and Racing, Family and Community Services (Housing, Community, Ageing Disability and Home Care), Education and Communities and Corrective Services.[30]

2.24 In its submission, the NSW Ministry for Health advised the Committee that a six stream service continuum, delivered by Government, non-government organisations and the private sector, has been developed to achieve the State's drug and alcohol policy objectives. The six continuum streams are:

1. *Prevention, health promotion, and early and brief intervention*: this acknowledges the benefits of preventing substance abuse rather than treating established problems. Interventions include education programs, information awareness campaigns, and promoting healthy living.
2. *Evidence based treatment and extended care services*: this requires that all treatment services be evidence based and subject to review to ensure they are meeting stated objectives. Further, treatment services should be tailored to the specific needs of individuals.

28 Submission 30, Drug Free Australia, p 31.

29 Submission 5, FamilyVoice Australia, p 2.

30 Submission 51, p 6.

3. *Specialist services*: are based on the dual argument that standalone substance-specific services can attract users into treatment who might not identify with mainstream treatment services, and that user profiles differ between drugs and there are clinicians with specialties in helping treat patients with specific drug issues.
4. *Involuntary and criminal justice diversion programs*: involuntary treatment refers to the State taking responsibility for a person's consent to drug and alcohol treatment; and diversion refers to the use of the criminal justice system to divert defendants into treatment.
5. *Co-morbid conditions*: this recognises that a high prevalence of those presenting with substance abuse problems do so with more than one disorder and that responsibility for their treatment lies with both specialist drug and alcohol services and other medical and psychosocial interventions.
6. *Treating specific population groups*: this refers to a commitment to ensure that drug and alcohol treatment is appropriate to the individual's age, gender, ethnicity, and culture. [31]

Approaches in other jurisdictions

2.25 This section outlines the strategies and models for responding to drug and/or addiction used by Sweden, the United Kingdom, and Western Australia. Although the Inquiry did not receive detailed evidence on these models, it is important to consider some of the key models used by other jurisdictions because they provide a context for some of the possible strategies available to New South Wales in responding to drug and/or alcohol addiction.

Sweden

2.26 According to the NSW Ministry for Health, Sweden seeks to achieve a drug free society through three primary ways: reducing recruitment to drug use; inducing individuals with substance abuse problems to give up their use; and reducing the supply of drugs.[32]

2.27 The Swedish model includes widespread drug testing, significant investment in prevention and treatment, and strict law enforcement. Treatment focuses upon attaining complete abstention from substance and abuse, and individuals can be forced into treatment via mandatory means.[33]

2.28 The Swedish model has been praised by zero-tolerance drug advocates when arguing that drug abuse can be effectively addressed through restrictive laws and policies. In evidence, Mr Gary Christian, Secretary, Drug Free Australia (NSW), stated that 'through mandatory treatment [Sweden] has reduced its drug use from the highest levels in Europe to the lowest in the developed world'.[34]

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31 Submission 51, p 7.

32 Answers to questions taken on notice 27 May 2013, Mr David McGrath, Director, Mental Health and Drug and Programs, NSW Ministry for Health, Question 5, p 4.

33 Answers to questions taken on notice 27 May 2013, Mr McGrath, Question 5, p 4.

34 Mr Gary Christian, Secretary, Drug Free Australia (NSW), Evidence, 4 April 2013, p 20.

2.29 In its submission, Drug Free Australia drew the Committee's attention to the United Nations *World Drug Report 2000* which they said showed that the annual prevalence of illicit drug abuse was lower in Sweden than other countries including the United Kingdom and Australia.[35] Data from the *World Drug Report 2000* comparing the annual prevalence of illicit drug abuse in Sweden, the United Kingdom and Australia is reproduced in the table below:

Table 1 Annual prevalence of abuse of illicit drugs

Country	Cannabis % and year	Opioids % and year	Cocaine % and year	Amphetamines % and year	Ecstasy % and year
Sweden	0.1% 1998	0.1% 1997	0.2% 1998	0.2% 1997	0.1% 1998
United Kingdom	9.0% 1998	0.5% [aa]	1.0% 1998	1.3% [aa]	1.0% 1998
Australia	17.9% 1998	0.7% 1998	1.4% 1998	3.6% 1998	N/A

United Nations 2000 World Drug Report, p 165, retrieved 9 August 2013, http://www.unodc.org/unodc/en/data-and-analysis/WDR-2000.html.

aa – Tentative estimate for the late 1990s.

2.30 Other Inquiry participants, however, questioned the success of the Swedish approach. In its submission, the National Drug and Alcohol Research Centre, a research centre at the University of New South Wales, argued that the research regarding the Swedish model had not been conducted in any great depth: 'Sweden has a long history of compulsory treatment. This approach has been subject to simple descriptive evaluations but not to any rigorous experimental evaluation'.[36]

2.31 Regarding alcohol abuse, the submission from the Australia Drug Law Reform Foundation (ADLRF) notes that Sweden imposes high levels of alcohol taxation. The ADLRF submission also notes that alcohol consumption and binge drinking rates are smaller in Sweden by comparison to other European countries with lower levels of alcohol taxation. The ADLRF contends that this is a result of Sweden's policy of higher alcohol taxation.[37]

2.32 In addition, the ADLRF submission informed the Committee that in 1990, Sweden lowered its legal driving blood alcohol content (BAC) threshold from 0.05 to 0.02, and that studies on the effect of lowering the BAC threshold 'have reported a 10 per cent reduction in fatal crashes related to drink driving after the change'.[38]

United Kingdom

2.33 The United Kingdom's approach to drug and/or alcohol addiction is underpinned by the *Drug Strategy 2010: Reducing demand, restricting supply, building recovery* (the Strategy), which aims to reduce illicit and other harmful drug use and increase the number of substance dependent individuals that are in recovery.

35 Submission 30, p 34.

36 Submission 34, National Drug and Alcohol Research Centre, p 4.

37 Submission 37, Australia Drug Law Reform Foundation, pp 16-17.

38 Submission 37, p 17.

2.34 According to the DPMP the Strategy has prioritised recovery from substance dependence:

> Although a focus on prevention and demand and supply reduction remains, there is now an increased emphasis placed upon improving 'recovery' outcomes for those identified as drug and alcohol dependent.[39]

2.35 In evidence, Professor Ritter from the DPMP observed that the emphasis on recovery was controversial because the agencies involved in treating people with drug and/or alcohol addiction will only be paid by the Government if their clients become abstentious. Professor Ritter indicated that such an approach was incongruent with the argument that addiction is a chronic relapsing condition:

> …a movement towards recovery as the treatment outcome and agencies only being paid if they have successfully enabled their clients to be abstentious, which is extremely controversial when you are dealing with a chronic relapsing condition.[40]

2.36 In its submission the Australasian Therapeutic Communities Association (ATCA), a peak body representing therapeutic communities in Australia and New Zealand, argued that the policy of only making payments for those clients that become abstentious could create a perverse incentive whereby treatment providers will only accept individuals with mild to moderate substance abuse issues because they are more likely to respond to treatment. The concern for ATCA is that individuals with severe substance dependence issues may be ignored by treatment providers:

> This is a potentially dangerous policy which cuts across human rights legislation. Potentially, it will result in only those clients who are in the mild to moderate range of drug use being accepted into treatment. Those who are chaotic and with complex substance use problems, and for whom substance use is an entrenched behaviour, are less likely to be accepted into treatment, as they are less likely to show positive results six months after treatment completion. For therapeutic communities, this is the prime population group. Therefore, the payment model will create uncertainty for services and will run the risk that services will only take accept clients who are likely to respond to treatment. Services will potentially refuse those who are more complex and more vulnerable. In essence, it works against what the government is trying to achieve and means that those who need treatment most will be the ones least likely to receive it.[41]

2.37 In contrast, in its submission, Drug Free Australia emphasised the potential benefits of focusing upon recovery from substance dependence. Drug Free Australia cited a British Government report showing that since the implementation of the Strategy in 2010, drug treatment outcomes have improved, with an 18 per cent increase in the number of individuals leaving treatment free of dependence for the reporting period 2010-11.[42]

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39 Submission 23, Drug Policy Modelling Program, p 9.

40 Professor Ritter, Evidence, 3 April 2013, p 13.

41 Submission 50, Australasian Therapeutic Communities Association, p 13.

42 Submission 30, p 36.

Western Australia

2.38 As part of its evidence gathering activities, the Committee, on 16 May 2013, met staff from the Drug and Alcohol Office (DAO), WA Health. DAO is the lead agency within the Western Australian Government responsible for alcohol and drug strategy, policy and service provision. DAO works to coordinate and support the activity of other relevant agencies, non-government organisations, and community groups.[43]

2.39 The Committee was advised that Western Australia's approach to drug and alcohol issues is underpinned by the *Drug and Alcohol Interagency Strategic Framework for Western Australia 2011-2015*. The framework's primary focus is prevention, namely preventing drug use and harmful alcohol consumption; preventing drug supply; and preventing harm to individuals, families and communities. The Western Australian model is consistent with the national framework of supply, demand and harm reduction.[44]

2.40 The Western Australian Government's involvement with the Fresh Start Recovery Programme is detailed in Chapter 4.

Committee comment

2.41 The Committee notes the data highlighting the negative effects of drug and alcohol abuse. We believe that the manner in which the community responds to the scourge of dependence matters greatly. The remainder of this report examines issues affecting the State's response to this widespread problem.

43 Tabled document, Government of Western Australia, Drug and Alcohol Office, *Drug and Alcohol Office Overview,* p i.

44 Tabled document, *Drug and Alcohol Office Overview,* p 25.

Chapter 3 Treatment responses

This Chapter considers the evidence presented to the Inquiry regarding treatment responses to drug and alcohol abuse. It begins by identifying the different phases of drug and alcohol treatment and by considering the need for customised treatment. Next, it looks at issues identified by Inquiry participants as impacting upon treatment services. These include workforce challenges; the growing problem of prescription opioid abuse; drug and alcohol related presentations to hospital emergency departments; the efficacy of needle syringe programs; and the extent of alcohol abuse.

Treatment phases and customised treatment

3.1 This section starts by identifying the phases under which drug and alcohol treatment services are delivered. It then considers the need for customised treatment by looking at two examples of where drug and alcohol treatment providers have developed strategies to better engage different social cohorts in the treatment system.

Treatment phases

3.2 Drug and alcohol treatment involves a broad range of services designed to assist individuals addicted to drugs and/or alcohol. According to the NSW Ministry for Health, underpinning each service is the objective of reducing the health, social and economic harm to individuals and the community arising from substance abuse.[45]

3.3 In evidence, Mr David McGrath, Director, Mental Health and Drug and Programs, NSW Ministry for Health, advised the Committee that drug and alcohol treatment services fall within one of three broad phases:

> I basically construct the drug and alcohol program into three boxes and within those three boxes there is [an] oversimplification, but you have got the assessment and treatment planning component, the actual provision of treatment and then the psychosocial support that comes with it.[46]

3.4 The first phase, assessment and planning, involves identifying and then initiating appropriate treatment interventions to individuals presenting with substance abuse issues.

3.5 The second phase refers to the direct delivery of treatment for drug and/or alcohol addiction. This includes supervised withdrawal, pharmacotherapy treatment programs, outpatient care and residential rehabilitation.

3.6 The third phase comprises psychosocial supports such as counselling services, education and training, housing support, family support and strategies to minimise relapse post treatment.

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45 Submission 51, NSW Ministry for Health, p 3.

46 Mr David McGrath, Director, Mental Health and Drug and Programs, NSW Ministry for Health, Evidence, 27 May 2013, p 25.

3.7 In its submission, the Australasian Therapeutic Communities Association, a peak body representing therapeutic communities across Australia and New Zealand, commented that the complexity of responses to substance abuse reflects the complex nature of the problem:

> What is important to understand, is that a complex issue such as substance use requires a number of strategies and interventions to address the range of community concerns in relation to prevention, early intervention and treatment.[47]

3.8 The phases outlined above provide only a snapshot of the services developed to address drug and/or alcohol addiction. Most evidence and attention during the Inquiry focused on the direct delivery of treatment, in particular, pharmacological treatments for opioid dependence, including naltrexone implants. Naltrexone in considered in Chapter 4.

Customised treatment

3.9 A commonly made point in evidence was that drug and/or alcohol users are not a homogenous cohort. Inquiry participants noted that there are varying degrees of addiction, the range of substances to which people are addicted are growing, as are the means by which substances are being abused, and the individuals presenting for treatment are doing so with complex needs.

3.10 For instance, in its submission, the Salvation Army Recovery Services, a treatment provider, remarked that client presentations are becoming more complex and require a broad range of issues to be addressed. These include a variety of co-morbid conditions, such as mental illness or other health and social issues:

> There has been a dramatic in increase in the type, complexity and number of complex and concurrent issues that are now being dealt with within the context of drug and alcohol treatment, these issues include; mental illness, chronic health problems, poor dental health, homelessness, unemployment, social exclusion and isolation and family and relationship breakdown.[48]

3.11 The NSW Ministry for Health similarly commented on the challenges to drug and alcohol treatment providers (and policymakers) posed by this diverse cohort, stating:

> The delivery of effective treatment services is continuously challenged due to the fact that drug and/or alcohol users are not homogenous as a cohort. There is a diversity of substance users and a diversity of markets. This coupled with changing demographics and patterns of use such as the emergence of synthetic substances and increased misuse of pharmaceuticals presents challenges for policymakers and service providers to ensure that treatment programs are effective.[49]

3.12 In evidence, Mr McGrath advised the Committee that the NSW Ministry for Health worked 'hard on targeting the different niches of the cohort and providing a particular response to each niche to get [an] outcome'.[50]

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47 Submission 50, Australasian Therapeutic Communities Association, p 4.

48 Submission 26, the Salvation Army Recovery Services, p 3.

49 Submission 51, p 3.

50 Mr McGrath, Evidence, 27 May 2013, p 22.

3.13 The following two case studies from the Drug and Alcohol Multicultural Education Centre and the Lyndon Community detail the work of two organisations in seeking to deliver culturally appropriate services to cohorts that have experienced poor engagement outcomes with drug and alcohol treatment.

Case study: the Drug and Alcohol Multicultural Education Centre

The Drug and Alcohol Multicultural Education Centre (DAMEC) is an organisation working specifically with culturally and linguistically diverse (CALD) communities from both a project research and a counselling perspective. In its submission, DAMEC detailed its work in educating CALD communities about the concept of drug and alcohol treatment through its counselling service (Submission 32, Drug and Alcohol Multicultural Advisory Education Centre, p 3).

DAMEC advised the Committee that not all people from CALD communities understand the concept of treatment, as applied in the Australian context. Consequently, some CALD individuals are not accessing or have difficulty accessing the drug and alcohol treatment services available to them (Submission 32, p 3).

Mr Kelvin Chambers, CEO, DAMEC, detailed the work of his organisation, namely the use of educational approaches to get more CALD people into drug and alcohol treatment:

> We work from an assumption that people know when they walk through the door what drug and alcohol treatment is. Within culturally and linguistically communities that cannot be a given; they come from cultures different from our Western system of health care—they come from backgrounds where the response to drug and alcohol use is to be locked in prison. So we spend a lot of time just doing simple psychoeducational approaches in trying to get them to understand concepts of treatment, and then we work through a series of models—it can be cognitive based, we use a brief solution therapy model, we use a narrative model—in terms of working these clients through [the treatment system] (Mr Kelvin Chambers, CEO, Drug and Alcohol Multicultural Advisory Education Centre, Evidence, 27 May 2013, p 3).

Mr Chambers informed the Committee that DAMEC had observed positive outcomes from its drug and alcohol counselling work with CALD communities:

> We find through our datasets we are keeping at the moment, which includes the MDS dataset—the minimum dataset—that we keep for NSW Health and recently an outcome measure that we have put on, which is a client outcome measure system, that we are getting very good results (Mr Chambers, Evidence, 27 May 2013, p 3).

One such outcome is that for the period April 2009 to November 2011, 80 per cent of DAMEC's clients, whose first language was not English, were able to access drug and alcohol counselling at DAMEC in their native tongue. DAMEC is the only provider of targeted drug and alcohol counselling for CALD clients in New South Wales. Without such a service it is reasonable to argue that these clients would have otherwise not accessed counselling.

* Answers to questions on notice taken during evidence 27 May 2013, Mr Kelvin Chambers, CEO, Drug and Alcohol Multicultural Advisory Education Centre, Evidence, Question 1, enclosing *DAMEC Counselling Service Evaluation Report 2011*.

Case study: the Lyndon Community's 'soft entry' approach for Aboriginal clients

The Lyndon Community is a non-government organisation providing drug and alcohol treatment services in rural and regional central west New South Wales.

On 14 May 2013, the Committee met with the staff operating and managing the Lyndon Community and spoke with them about their experiences in delivering drug and alcohol treatment services in rural and regional settings.

The Lyndon Community informed the Committee about its work in seeking to better engage Aboriginal people in drug and alcohol treatment through its 'soft entry' approach. Aboriginal people are a cohort that has faced barriers to effectively accessing and engaging drug and alcohol treatment (Dr Juliane Allan, Deputy Chief Executive Officer, the Lyndon Community, Evidence, 4 April 2013,p 38).

The Lyndon Community noted that the 'soft entry' approach has been developed in response to research, published in the journal *Social Work in Health Care*, which suggested that it has been difficult for Aboriginal people in engage in drug and alcohol treatment because treatment providers apply standard western practices rather than approaches more compatible for Aboriginal people:

> ...organisations have tended to adopt the Western medical model by referring to alcoholism or substance abuse as an illness or disease. It has been suggested that the disease model is inappropriate, because there is no Aboriginal concept equivalent to the Western notion of dependence or addiction as a disease-like condition.

The 'soft entry' approach aims to give control over when and how drug and alcohol interventions are delivered to the community and individuals within it. It is applied by drug and alcohol workers visiting Aboriginal communities, participating in activities and providing individuals with the chance to talk about drug and alcohol treatment when the appropriate moment arises. Drug and alcohol treatment workers make connections in the community by being available to those who want to discuss treatment options in an informal setting rather than waiting for people to come directly to the provider in an environment that can be intimidating (Dr Allan, Evidence, 4 April 2013, p 38)

The Lyndon Community advised the Committee that an evaluation of the 'soft entry' approach found that it had increased the frequency of Aboriginal people accessing drug and alcohol advice, support, and information in the areas in which it had been delivered. In the 18 months prior to the implementation of the 'soft entry' approach drug and alcohol advice, support, and information was provided to Aboriginal people 26 times; while in the 18 months following it was provided 157 times.

The 'soft entry' approach is consistent with one of the Aboriginal Health and Medical Research Council of NSW's key principles for effective Aboriginal drug and alcohol treatment; namely that drug and alcohol treatment for Aboriginal people must be culturally appropriate (Submission 53, Aboriginal Health and Medical Research Council of NSW, p 7).

* Answers to question on notice taken during evidence 4 April 2103, Dr Juliane Allan, Deputy Chief Executive Officer, the Lyndon Community, Question 3, enclosing Allan and Campbell, 'Improving Access to Hard-to-Reach Services: A Soft Entry Approach to Drug and Alcohol Services for Rural Australian Aboriginal Communities', *Social Work in Health Care,* vol. 50, 2011, pp 443-453.

Committee comment

3.14 The Committee acknowledges that addiction is a complex issue requiring a number of treatment strategies and interventions. Directly treating addiction through medical intervention is just one part of the ongoing support needed to address substance abuse.

3.15 The Committee supports the concept of customised treatment. We believe that both the Drug and Alcohol Multicultural Education Centre and the Lyndon Community, provided positive examples of tailoring responses to drug and alcohol abuse to the specific needs of particular cohorts.

Issues impacting on treatment services

3.16 This section looks at a number of issues raised by Inquiry participants impacting upon drug and alcohol treatment. The discussion commences by looking at some of the challenges facing the drug and alcohol sector workforce. The growing issue of prescription opioid abuse and the pressures being placed on hospital emergency departments caused by drug and alcohol misuse are then considered. The section concludes by looking at the efficacy of needle syringe programs and strategies to minimise alcohol abuse.

Workforce challenges

3.17 Some Inquiry participants noted that the drug and alcohol workforce faced a number of challenges. The challenges identified in evidence included:

- The drug and alcohol workforce lacks appropriate skills.[51]
- The field of addiction medicine is only relatively new.[52]
- There is a perceived lack of investment in addiction medicine training.[53]
- There are social barriers to working in the addiction area and it is subject to politicisation.[54]
- The non-government sector finds it hard to retain staff due to funding and contract uncertainty, and because it cannot compete with the wages provided by the public sector.[55]

3.18 In evidence, Professor Alison Ritter, Director of the Drug Policy Modelling Program (DPMP), a drug and alcohol policy research and practice program at the University of New South Wales, remarked that the drug and alcohol workforce lacks appropriate skills and that the field was also disliked by the medical community. Professor Ritter also advised the

51 Professor Alison Ritter, Director, Drug Policy Modelling Program, Evidence, 3 April 2013, p14.

52 Professor Ritter, Evidence, 3 April 2013, p14.

53 Professor Adrian Dunlop, Professor Adrian Dunlop, Immediate Past President, Australasian Professional Society on Alcohol & other Drugs, Evidence, 10 April 2013, p 14.

54 Dr Alex Wodak, President, Australia Drug Law Reform Foundation, Evidence, 3 April 2013, p 33.

55 Ms Tanya Merinda, Director of Planning and Strategy, Network of Alcohol and Drug Agencies, Evidence, 3 April 2013, p 43.

Committee that addiction had only recently become an established medical specialty and there was a tension between different elements of the drug and alcohol sector as a consequences of its evolution from a social issue to a medical matter:

> The workforce is terrible. New South Wales is probably better than other jurisdictions in terms of the professionalisation of the workforce. The alcohol and drug clinical training is poor; it is not a specialty. It has not been a specialty within medicine until the recently established addiction medicine specialty so they were people who did not have a specialty. It is disliked by the medical community. It has also been taken up, if you go back in history, to the temperance movement. It has been taken up by welfare organisations as part of their brief so it has not been treated as a medical or a mental health problem; it has been treated through the welfare system and the welfare system is also a deprofessionalised area and there is enormous internal tension in our sector between the medicalisation of alcohol and drug use and disorders and the social science sort of welfare notion about alcohol and drug use and that tension is sometimes quite palpable between professional groups, which also then adds to a problem with our identity to government or within the broader community.[56]

3.19 Professor Adrian Dunlop, Immediate Past President, the Australasian Professional Society on Alcohol & other Drugs (APSAD), a multidisciplinary body for professionals involved in the alcohol and other drug field, observed that the attitude of the medical community toward addiction was improving, especially amongst younger medical professionals. Professor Dunlop also argued that more investment should be made in formal addiction medicine training:

> Generally our junior staff have fewer of those ideological barriers or problems with it...There are many things we could do to improve undergraduate and postgraduate education and I could talk to you for a long time about them. But, yes, we certainly should invest more in [addiction medicine training] as a society.[57]

3.20 In addition, Ms Tanya Merinda, Director of Planning and Strategy, Network of Alcohol and Drug Agencies, a peak organisation for the non-government drug and alcohol sector in New South Wales, remarked that it is difficult for the sector to maintain and develop its staff. Ms Merinda observed that non-government drug and alcohol organisations received contract based funding, meaning that security of employment was an issue for many workers, and that the sector also found it hard to retain staff because it could not compete with the wages provided by the public sector. When questioned on staff retention, Ms Merinda responded:

> It is difficult and it is certainly more difficult in the non-government sector. An example is that the majority of non-government organisations that are funded by the Ministry of Health today have contracts to 30 June. So staff are leaving and moving to the public sector because it pays better, there is security in their positions. That has been ongoing—it is always going on but normally the cycles are three or four years. In the last couple of years it has been six-month to 12-month extensions. So it is difficult to retain staff. In attracting staff, the competition is that the salaries provided to the non-government sector are a lot less than the government sector. There is also difficulty in the professional development and opportunities for staff in the non-government sector.[58]

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56 Professor Ritter, Evidence, 3 April 2013, p14.

57 Professor Dunlop, Evidence, 10 April 2013, p 14.

58 Ms Merinda, Evidence, 3 April 2013, p 43.

3.21 In response to a question about the challenges facing the drug and alcohol workforce, Mr McGrath of the NSW Ministry for Health, remarked that addiction medicine was a new speciality and stated it would take the workforce time to develop the competencies needed to carry out its functions. Mr McGrath also stated that the establishment of addiction as a medical specialty was a positive thing:

> If you look at it across the board, clearly addiction medicine specialty is a nascent specialty. It has not been around for very long and, as a result, it is on a steep curve in terms of the exercise of additional competencies and the exercise of additional interventions that are available to that particular workforce. The fact that there is finally a particular specialty in drug and alcohol has generally been positive for the drug and alcohol workforce overall. That has created a degree of stature within the health system, which is helpful.[59]

Prescription opioid abuse

3.22 Another matter considered by the Inquiry was the issue of prescription opioid abuse. It was brought to the Committee's attention by a number of Inquiry participants who indicated that the abuse of prescription opioid analgesics (painkillers) was an emerging problem.[60]

3.23 Professor Nicholas Lintzeris, Director, Drug and Alcohol Services, South Eastern Sydney Local Health District, advised the Committee that prescription opioid abuse was becoming arguably more significant than heroin and cannabis use:

> …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.[61]

3.24 Speaking from her perspective as a regional drug and alcohol treatment provider, Dr Allan of the Lyndon Community similarly advised the Committee that treatment for prescription medication 'is much more common these days than heroin'.[62]

3.25 Dr Allan contended that the growth in prescription opioid abuse may be due to heroin being in short supply. She also informed the Committee about some of the strategies medical practitioners were using to minimise prescribing pharmaceutical opioids to individuals that may abuse them and to prevent so called 'doctor shopping' – the process through which individuals move between doctors and pharmacies to have multiple prescriptions filled. When making her statement, Dr Allen also noted that education for general practitioners was an important way to respond to the issue:

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59 Mr McGrath, Evidence, 27 May 2013, p 25.

60 Submission 42, South Eastern Sydney Local Health District, p 5.

61 Professor Nicholas Lintzeris, Director, Drug and Alcohol Services, South Eastern Sydney Local Health District, Evidence, 4 April 2013, p 15.

62 Dr Allan, Evidence, 4 April 2013, p 34.

> 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...I think GP education is an important part of helping doctors to resist prescribing those drugs.[63]

3.26 In evidence, Dr Alex Wodak, President, Australia Drug Law Reform Foundation argued that another reason for the emergence of prescription opioid abuse was that medical practitioners have too readily prescribed opioids to patients with chronic pain. Dr Wodak argued that more should be done to broaden the range of treatment options available to the medical profession to treat chronic pain:

> …we should be limiting the use of prescription opioids—difficult to do—but guidelines and so on could bring the profession back. I think we have been too generous in how many people we provided them for, the doses that were provided and the duration, and this should all be pulled back. Opioids should not be the default option when any person enters the doctor's waiting room…we need to make much more use of nurses, occupational therapists and other allied health professionals providing non-pharmaceutical treatment for people with chronic pain, but we do not have a training system for this yet, we do not have any diplomas for this yet and we do not have a system yet for paying these people. This all needs to be developed.[64]

3.27 Regarding other ways of addressing prescription opioid abuse, Professor Lintzeris advised the Committee that a pharmaceutical drug misuse framework was currently being considered by the Intergovernmental Committee on Drugs (IGCD). Professor Lintzeris also noted that the IGCD had established an electronic real-time prescription monitoring system for pharmaceutical opioids:

> We have to think our way through this…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. 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.[65]

3.28 The electronic real-time prescription monitoring system referred to by Professor Lintzeris was trialled in Tasmania. It monitors the prescription of schedule 8 medications (medicines which have a high potential for abuse and addiction, such as prescription opioid analgesics) in real-time and allows medical practitioners to refer to a database before filling prescriptions. In its submission, the Addiction Medicine Network (NSW membership) of the Royal

63 Dr Allan, Evidence, 4 April 2013, p 34.

64 Dr Wodak, Evidence, 3 April 2013, pp 34-35.

65 Professor Lintzeris, Evidence, 4 April 2013, p 15.

Australian College of General Practitioners (RACGP) stated that its purpose is 'to prevent misuse and save lives while facilitating proper analgesic care to others'.[66]

3.29 The RACGP submission also noted a proposal to implement the electronic real-time prescription monitoring system nationally but argued this had not happened because of disagreements between Federal, State and Territory Governments.[67]

3.30 A number of Inquiry participants expressed support for the national implementation of the electronic real-time prescription monitoring system. For instance, Ms Fiona Davies, Chief Executive Officer, Australian Medical Association (NSW) Limited (AMA), stated that:

> We are very supportive of the Tasmanian model and think that more needs to be done by governments to support doctors in the prescribing that they are offering about schedule 8 medications. So, yes, we would be very supportive of the Tasmanian model being implemented nationally.[68]

3.31 Professor Adrian Dunlop of APSAD advised that his organisation also supported the Tasmanian model, noting:

> I think the example of Tasmania is a good one and shows that it can be done, and we have wanted it elsewhere in the country for a long period of time. We continue to think that would be a much better solution to try to minimise the problems at the prescribing end.[69]

Pressures on emergency departments

3.32 Another issue brought to the Committee's attention was the pressures drug and alcohol abuse were placing on hospital emergency departments.

3.33 In its submission, the Australasian College for Emergency Medicine (ACEM), a not-for-profit organisation responsible for the training of emergency physicians and for advancing professional standards in emergency medicine in Australia and New Zealand, identified a number of concerns regarding drug and alcohol related presentations to hospital emergency departments. The ACEM's concerns included:

- the pressures placed on emergency department staff;
- the effect on other emergency department patients;
- the allocation of resources that may otherwise be deployed elsewhere;
- the impact on emergency department waiting times;

66 Submission 36, Addiction Medicine Network (NSW membership) of the Royal Australian College of General Practitioners (RACGP), p 9.

67 Submission 36, p 9.

68 Ms Fiona Davies, Chief Executive Officer, Australian Medical Association (NSW) Limited, Evidence, 10 April 2013, p 61.

69 Professor Dunlop, Evidence, 10 April 2013, p 18.

- violent drug and alcohol related presentations; and
- using emergency departments as a method of removing intoxicated individuals from public areas, when they otherwise have no medical issues.[70]

3.34 In evidence, Associate Professor Richard Paoloni, Chair, NSW Faculty, ACEM, emphasised that while the impact of substance abuse, particularly alcohol, on emergency departments was significant it was also difficult to quantify. Associate Professor Paoloni stated that intoxicated individuals could present with a number of needs requiring treatment, and it was these needs being recorded in diagnoses, rather than the contributing factor, namely substance abuse, that led to them arriving at hospital emergency departments:

> The impact of alcohol on emergency departments in particular is enormous. It is very difficult to quantify because as we are health facilities our databases are around diagnoses: people who present with alcohol can present with a huge number of diagnoses and it is very difficult to tease out….the difficulty we face is that we are primarily a clinical service and so our databases are designed around clinical presentation, around diagnoses, rather than contributing factors.[71]

3.35 Associate Professor Paoloni also noted the ACEM did know that 30 per cent of trauma patients at the Royal Prince Alfred Hospital had been found to have been above the legal driving limit, and that many emergency department patients were not intoxicated but rather the victims of abuse or assault at the hands of intoxicated individuals.[72]

3.36 The ACEM also advised the Committee that it was working on a research project, seeking to quantify the burden of alcohol related presentations and admissions to hospital emergency departments, so that the knowledge base regarding this issue could be increased.[73]

3.37 In addition to receiving evidence from the ACEM, the Committee, on 12 June 2013, undertook a visit of inspection to the St Vincent's Hospital Emergency Department, and Drug & Alcohol Service, and met with representatives from both sections. The St Vincent's staff informed the Committee about their work in servicing the needs of emergency department patients, many of whom suffer from co-morbid conditions such as mental illness or the effects of substance abuse.[74] By way of response to these challenges, the St Vincent's Hospital has developed the Psychiatric, Alcohol, & Non-prescription Drug Assessment ward which is considered in the case study below.

70 Submission 40, Australasian College for Emergency Medicine, p 2.

71 Associate Professor Richard Paoloni, Chair, NSW Faculty, Australasian College of Emergency Medicine, Evidence, 10 April 2013, p 30.

72 Associate Professor Paoloni, Evidence, 10 April 2013, p 30.

73 Submission 40, p 2.

74 Correspondence from Dr Paul Preisz, Deputy Director, Emergency Department, St Vincent's Hospital to Committee, enclosing 'The Psychiatric, Alcohol, & Non-prescription Drug Assessment Area Project', p 1, 14 June 2013.

Case study: the 'Psychiatric, Alcohol, & Non-prescription Drug Assessment' ward

St Vincent's Hospital is located in Sydney's inner city and the population demographic it oversees has high rates of mental health illness, and drug and alcohol abuse. Additionally, by virtue of its location the Hospital also manages a high number of intoxicated patients. 15 per cent of the presentations to the St Vincent's Hospital Emergency Department involve mental illness and/or the effects of drug use. The Hospital has experienced challenges in treating such patients.

St Vincent's Hospital treats many emergency department patients suffering mental illness and/or the effects of substance abuse, under the Mental Health Act 2007 which requires that they must be reviewed by a psychiatrist before they can move beyond the emergency department. For the review to be performed the patient must be free from the influence of any drugs or illness. Depending on the influencing substance or illness, it may take hours or even days before a patient may be deemed fit for review. Consequently, these patients are resource intensive, taking up bed space in an environment where beds are limited.

In response to the above issues, the St Vincent's Hospital has established the Psychiatric, Alcohol, & Non-prescription Drug Assessment (PANDA) ward. The PANDA ward is a six bed, seven day a week, 24 hour a day service. It is managed by St Vincent's Clinical Pharmacology and Drug and Alcohol teams, in close collaboration with the Emergency Department and the Mental Health Service.

The PANDA receives patients who are considered medically unfit for immediate psychiatric assessment under the Mental Health Act 2007. It also takes referrals from the Drug and Alcohol or Clinical Pharmacology units as well as the Intensive Care unit.

The PANDA's main functions are to issue medical assessments and diagnoses; provide a safe environment for mental health assessment, social work, drug and alcohol and other consultations as needed; and facilitate access to community drug and alcohol interventions appropriate to patient needs. Its objectives include:

- providing safe facilities to assess, observe, and treat patients outside the emergency department;
- alleviating bed access blockages in the emergency department;
- providing a specialised service targeting one patient group, to best serve their needs; and
- providing specific patients with a more suitable environment than the busy emergency department.

* Correspondence from Dr Preisz to Committee, enclosing 'The Psychiatric, Alcohol, & Non-prescription Drug Assessment Area Project', 14 June 2013

The efficacy of needle syringe programs

3.38 A concern for some Inquiry participants was the efficacy of needle syringe programs (NSPs) and their role in minimising harms to injecting drug users. The Committee received evidence from some Inquiry participants supporting NSPs and it also received evidence from others who were critical of NSPs.

3.39 According to a paper published by the Commonwealth Department of Health and Ageing, entitled, *Needle and Syringe Programs: a review of the evidence,* which was provided to the Committee in response to a question on notice by Dr Marianne Jauncey, Medical Director, Sydney Medically Supervised Injecting Centre, NSPs seek to reduce the spread of infections such as HIV and Hepatitis C among injecting drug users by providing access to sterile injecting equipment and educating users on a number of health matters. The paper states:

> Needle and Syringe Programs are a public health measure, consistent with the National Drug Strategy's harm minimisation framework, to reduce the spread of infections such as HIV and hepatitis C among injecting drug users. They provide a range of services that include provision of sterile injecting equipment, education on reducing drug use, health information, and referral to drug treatment, medical care and legal and social services. The injecting equipment provided includes needles and syringes, swabs, vials of sterile water and 'sharps bins' for the safe disposal of used needles and syringes. Needle and Syringe Programs do not supply drugs or allow people to inject drugs on the premises. Governments provide sterile injecting equipment to prevent people sharing needles and syringes which can lead to the spread of HIV and hepatitis C. Needle and Syringe Program workers also address the transmission of HIV via sexual contact by providing condoms and safe sex education.[75]

3.40 The Commonwealth Department of Health and Ageing paper also notes that Australia was one of the first countries to implement NSPs and that they were adopted in response to concerns about a HIV epidemic among injecting drug users. Australia's first NSP was delivered as trial project in 1985 in Darlinghurst, Sydney. The broad implementation of NSPs became NSW Government policy the next year and they have been since adopted by all Australian Governments. Nationally, there are now over 3,000 NSPs in Australia.[76]

3.41 According to the Commonwealth Department of Health and Ageing paper, Australia's early adoption of NSPs has been recognised by the Joint United Nations Programme on HIV/AIDS as best practice:

> [Australia's], early and vigorous HIV prevention programmes aimed at injecting drug users resulted in stable and low rates of HIV prevalence among drug users and related population groups. It is generally agreed that this prompt - and sustained – action fundamentally altered the course of the country's epidemic.[77]

3.42 In its submission, the Australian Medical Association (NSW) citing research published in the *Journal of Acquired and Immune Deficiency Syndromes*, noted that NSPs had achieved positive public health and economic outcomes in New South Wales:

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75 Answers to questions taken on notice 4 April 2013, Dr Marianne Jauncey, Medical Director, Sydney Medically Supervised Injecting Centre, Question 1, enclosing Dolan et al, 'Needle and Syringe Programs: a review of the evidence', *Commonwealth Department of Health and Ageing,* 2005, p 9.

76 Answers to questions taken on notice 4 April 2013, Dr Jauncey, Question 1, enclosing 'Needle and Syringe Programs: a review of the evidence', pp 6-10.

77 Answers to questions taken on notice 4 April 2013, Dr Jauncey, Question 1, enclosing 'Needle and Syringe Programs: a review of the evidence', p 8.

> In 2009 it was estimated that in NSW alone, needle syringe programs had prevented over 50,000 cases of HIV/AIDS and/or Hepatitis C infection, resulting in a saving of $513 million in healthcare costs.[78]

3.43 The Sydney Medically Supervised Injecting Centre (SMSIC), also presented evidence in support of NSPs. The SMSIC's submission noted that NSPs had minimised the transmission of Hepatitis B, Hepatitis C and HIV/AIDS; and that the rate of HIV infection among people who inject drugs in Australia was approximately one per cent compared to other countries where prevalence rates can exceed 50 per cent.[79]

3.44 In evidence, Professor Dunlop from APSAD, similarly stated that Australia's early adoption of NSPs had produced positive results:

> We need to remember what we are doing right. Our early adoption of the needle exchange program is extremely notable. Every time I go to any other country and talk to clinicians who work in the alcohol and drug field I do not have to talk about our stories of managing HIV and drug dependence. That is so striking and it has such an effect on the health of the population. It is very notable.[80]

3.45 In contrast, Mr Gary Christian, Secretary, Drug Free Australia (NSW), challenged the evidence regarding the success of NSPs in Australia. He argued that it was inconsistent with an international review which had indicated the link between NSPs and HIV transmission was inconclusive and that NSPs were ineffective in reducing Hepatitis C:

> 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.[81]

3.46 Dr David Phillips, National President, Family Voice Australia, also questioned the efficacy of NSPs. Referring to a study undertaken in Montréal, Canada, which compared the health outcomes of two different drug injecting groups, one which had used NSPs and the other that had not, Dr Phillips indicated that NSP participants were more likely to demonstrate poor health outcomes.[82]

3.47 In response to a question on notice about the Montréal study, Dr Jauncey argued that the findings were subject to selection bias. Dr Jauncey noted that the individuals in the study that had used the NSP were younger, poorer, injected drugs more frequently and were more likely to engage in risky activities such as sex work when compared to those who obtained their injecting equipment via other means. Dr Jauncey stated:

78 Submission 8, Australian Medical Association (NSW), p 8.

79 Submission 17, Sydney Medically Supervised Injecting Centre, p 8.

80 Professor Dunlop, Evidence, 10 April 2013, p 11.

81 Mr Gary Christian, Secretary, Drug Free Australia (NSW), Evidence, 4 April 2013, p 20.

82 Dr David Phillips, National President, Family Voice Australia, Evidence, 3 April 2013, p 52.

> …the accepted scientific finding [of the Montréal study] is that the results were from selection bias. i.e. that NSPs tend to attract higher risk people compared to those who obtain their syringes from other sources. Similar findings have tended to be observed when you compare those who legally buy syringes from pharmacies to NSP attenders - pharmacies tend to attract those with higher socioeconomic status and lower HIV risk.[83]

3.48 Regarding the position of the NSW Ministry for Health on NSPs, in a response to a question on notice, the Ministry advised the Committee that the evidence indicates that the number of HIV and Hepatitis C infections, attributable to injecting drug use, can continue to be reduced through increasing the coverage of NSPs across New South Wales.[84]

The challenge posed by alcohol abuse

3.49 Although the Inquiry's principal focus was on matters concerning the treatment of opioid dependence, numerous Inquiry participants stressed that alcohol is the substance that presented the greatest threat to public health.

3.50 The evidence to the Committee regarding alcohol abuse was not limited to matters relating to its treatment. A number of Inquiry participants explained why alcohol is a challenging issue for policymakers, while others presented ideas on how to minimise alcohol abuse. A discussion of some of these issues is presented below.

3.51 Commenting on the challenges posed by drug and alcohol abuse, Professor Lintzeris of the South Eastern Sydney Local Health District, argued that alcohol was undoubtedly the biggest issue in terms of health, social and economic outcomes:

> 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.[85]

3.52 Dr Wodak from the Australia Drug Law Reform Foundation also argued that alcohol abuse posed a greater challenge to the community than the use of illicit drugs:

> …I think alcohol is by far a much bigger problem than illicit drugs and I think we make an even bigger mess of alcohol as a community in policy terms than we do with illicit drugs.[86]

3.53 The submission from the Australasian Therapeutic Communities Association, a peak-body representing therapeutic communities across Australia and New Zealand, informed the Committee about the risks posed by alcohol abuse in health, economic and social terms:

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83 Answers to questions taken on notice 4 April 2013, Dr Marianne Jauncey, Question 1, p 2.

84 Answers to questions taken on notice 27 May 2013, Mr David McGrath, Director, Mental Health and Drug and Alcohol Programs, NSW Ministry of Health, Question 7, p 7.

85 Professor Lintzeris, Evidence, 4 April 2013, p 15.

86 Dr Wodak, Evidence, 3 April 2013, p 38.

> The excessive use of alcohol provides a considerable risk factor, contributing 3.2 per cent to the total burden of disease and injury in Australia and representing significant social cost, estimated at $36 billion. Most importantly, it needs to be acknowledged that much of this cost is borne by children, families and the community, where results of personal consumption often result in violence and injury.[87]

3.54 After the Committee had completed its hearings, the NSW Auditor-General published a report, entitled, *Cost of alcohol abuse to the NSW Government.* In a media release the Auditor-General, Mr Peter Achterstraat indicated that the NSW Government could better respond to alcohol abuse if it had more information on the associated costs:

> If social costs are included, the total cost of alcohol abuse in New South Wales is around $3.87 billion per annum, or about $1,565 from each household.
>
> It is important for Government to have good information on the costs of alcohol abuse so it can respond effectively to the problem…If costs were increasing, this could be a trigger for a different approach.
>
> The NSW Government should estimate the cost of alcohol abuse (every 3 years) and publically report the cost – so the Government and the public know whether the problem is getting better or worse…The community also has a right to know this information so it can inform public debate on alcohol abuse and the best ways to combat it.[88]

3.55 In response to questioning regarding the social cost of alcohol, Professor Dunlop from APSAD stated that it and tobacco causes more harm societal harm than other substances:

> There is no doubt, and there are good Australian studies showing this, that alcohol and tobacco by far cause the most morbidity and mortality and costs to our society—medical costs but also public and social and other costs, and illicit drugs is an important and significant issue and we need not to ignore that. But yes, alcohol and tobacco are by far the biggest contributors of harm in our society.[89]

3.56 Professor Dunlop also advised the Committee that alcohol was a more difficult issue to respond to than to tobacco or other drugs because alcohol can be used safely and it can also be used recklessly:

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

87 Submission 50, the Australasian Therapeutic Communities Association, p 3.

88 *Auditor-General's Report – Counting the cost of alcohol abuse,* accessed 8 August 2013, https://www.audit.nsw.gov.au/ArticleDocuments/200/Media_Release_Cost_of_alcohol_abuse_to_the_NSW_Government_6_August_2013.pdf.aspx?Embed=Y.

89 Professor Dunlop, Evidence, 10 April 2013, p 9.

> consuming alcohol—certainly at high levels—you notice that difference and how people think differently about why alcohol is a problem.[90]

3.57 Dr Lai Heng Foong, Public Health Committee, Australasian College for Emergency Medicine, similarly remarked that many people in the community do not comprehend the dangers posed by alcohol because there is a fine line between responsible and irresponsible drinking:

> …alcohol is second only to tobacco in terms of a preventable cause for drug related death and hospitalisation, not heroin, cocaine or marijuana but alcohol. I think a lot of people just do not get it and I think there is a fine line between drinking socially and drinking in an out of control fashion. Most people who are drinking out of alcohol do not realise it. It just does not get to them.[91]

3.58 In its submission, the St Vincent's Hospital, Inner City Health Program, Alcohol & Drug Service argued that more needs to be done if risky drinking levels are to be reduced in accordance with the goal set out in the *NSW State Plan 2021*:

> Alcohol use is of particular concern – more investment in treatment and early intervention, as well as efforts for health promotion and prevention of high risk drinking [are needed] – if New South Wales is to reach its goal outlined of reducing total risk drinking to less than 25 per cent.[92]

3.59 In evidence, Professor Nadine Ezard, Clinical Director, St Vincent's Hospital, Inner City Health Program, Alcohol & Drug Service, noted the problems arising due to a growing culture of heavy episodic drinking:

> 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.[93]

3.60 Regarding strategies on how to minimise alcohol abuse, Ms Davies from the AMA called for greater controls on the supply of alcohol. Referring to an initiative in Newcastle which had reduced pub and club trading hours, Ms Davies argued that the evidence from Newcastle showed that reducing access to alcohol could minimise alcohol related community harms:

> It is absolutely critical that governments look at the issue of supply of alcohol and particularly the evidence that has come from the Newcastle model in association with reducing the opening hours of licensed facilities. At a personal level I cannot see any community justification for the need to open a pub in this State until 6.00 a.m. I simply cannot understand how anybody benefits from that. If you are making your employment dollars by being open from 3.00 a.m. to 6.00 a.m. you maybe need a business model that is a little bit better than that. Again, it comes back to the evidence. The Newcastle model does not make everything perfect and does not prevent all forms of alcohol harm but it has produced evidence that has shown that cutting back and reducing access to alcohol, pricing models on alcohol and alcohol advertising are

90 Professor Dunlop, Evidence, 10 April 2013, p 9.

91 Dr Lai Heng Foong, Public Health Committee, Australasian College for Emergency Medicine, Evidence, 10 April 2013, p 34.

92 Submission 28, St Vincent's Hospital, Inner City Health Program, Alcohol & Drug Service, p 3.

93 Professor Nadine Ezard, Clinical Director, St Vincent's Hospital, Inner City Health Program, Alcohol & Drug Service, Evidence, 4 April 2013, p 62.

> really important steps the Government needs to be taking to keep our community safer.[94]

3.61 Similarly to Ms Davies, Dr Foong informed the Committee that she supported the restriction of venue opening hours. Dr Foong also identified pricing controls as another measure to address alcohol abuse.[95]

3.62 In addition, Ms Davies indicated that the AMA supported warning labels being placed on alcohol products to educate users about the harmful effects of irresponsible consumption:

> …we are very supportive of warning notices and clear alcohol labelling. People should have a very clear understanding and an easy understanding of the risks associated with alcohol and alcohol harm. So, yes, the Australian Medical Association at a State and Federal level is supportive of better labelling for alcohol.[96]

3.63 In evidence, Professor Ezard of St Vincent's Hospital's Alcohol & Drug Service argued that not enough was being done to address alcohol abuse. Professor Ezard then expressed her support for bringing together all relevant stakeholders to develop an approach to alcohol that incorporates health promotion, provides adequate treatment to those in need, and promotes early intervention:

> I think we are investing inadequately in the whole alcohol problem…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…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.[97]

3.64 In addition to this Inquiry, the New South Wales Parliament, at the time this report was written, was conducting two other alcohol related Inquiries. The Legislative Council's Social Issues Committee is considering *Strategies to reduce alcohol abuse among young people* while the Legislative Assemblies' Social Policy Committee is examining the *Provision of Alcohol to Minors*.

3.65 The Committee also notes that it is ten years since the 2003 New South Wales Summit was held and that a number of important recommendations were made at the Summit.

Committee comment

3.66 The Committee notes the evidence that addiction is a new medical speciality. As a result the drug and alcohol sector will take time to develop the structures needed to lead to improvements both in treatment services and workforce capacity. In addition, more investment in formal addiction medicine training is required. The Committee further notes

94 Ms Davies, Evidence, 10 April 2013, p 58.

95 Dr Foong, Evidence, 10 April 2013, p 34.

96 Ms Davies, Evidence, 10 April 2013, p 62.

97 Professor Ezard, Evidence, 4 April 2013, p 62.

that workforce capacity in non-government drug and alcohol organisations faces difficulty due to contract based funding.

3.67 The Committee recognises the emerging challenge of prescription opioid abuse. We therefore strongly support the development of the electronic real-time prescription monitoring system for pharmaceutical opioids and are hopeful that it will be implemented nationally in an expeditious manner.

3.68 The Committee supports the efforts of the Australian College for Emergency Medicine in seeking to better understand and quantify the significant impacts of drug and alcohol abuse on hospital emergency departments. We were impressed by the St Vincent's Hospital, Psychiatric, Alcohol, & Non-prescription Drug Assessment ward, developed in response to the high proportion of individuals presenting for treatment with mental illness and/or the effects of substance abuse. Such innovative responses to the challenges confronting hospital emergency departments are to be commended. The Committee encourages the consideration of uniform data collection in relation to substance abuse for emergency department presentations.

3.69 We note the evidence regarding the benefits of needle syringe programs within a harm minimisation framework, although in an ideal world, our communities would be free of drug abuse, and there would be no need for such programs.

3.70 The Committee acknowledges that alcohol is the substance posing the most significant challenge to public health. We draw attention to the concerns of Inquiry participants that more could be done to address alcohol abuse and welcome all efforts to address this important social issue. We believe that developing a response to the harmful consequences of alcohol abuse is a nationally significant issue requiring the involvement of all levels of Government, as well as the alcohol industry and non-government organisations. The NSW Government cannot solve the problem on its own without the cooperation, input and expertise of all relevant stakeholders.

3.71 We believe that New South Wales can play an important role in instigating and supporting national efforts to deal with alcohol-related harm.

3.72 The Committee's Recommendation 1 is therefore that 'the NSW Government, noting the report of the NSW Auditor-General, entitled, *Cost of alcohol abuse to the NSW Government,* and the evidence submitted to the General Purpose Standing Committee No. 2 Inquiry into drug and alcohol treatment, approach the Commonwealth Government to highlight the need for a national response to the problem of alcohol abuse, and to request that a national summit on alcohol abuse be convened in 2014-2015'.

3.73 The Committee notes that it is ten years since the 2003 New South Wales Alcohol Summit was held and that a number of important recommendations were made at the Summit.

Recommendation 2

That the NSW Government review the recommendations of the 2003 New South Wales Alcohol Summit and provide an update regarding its response to those recommendations.

Chapter 4 Naltrexone and other opioid treatments

This Chapter concerns the most prominent issue addressed during this Inquiry: the treatment of illicit opioid abuse through naltrexone and, in particular, naltrexone implants. To understand the rationale for naltrexone implants, this Chapter begins by outlining the two treatment types currently used to treat opioid dependence; opioid substitution treatment (for example, methadone) and opioid antagonist treatment (such as naltrexone).

Next, matters of specific relevance to naltrexone implants are considered, including their current availability and use, their manufacture, and the evidence base for their use. The Chapter concludes by considering the value of further research into naltrexone implants and other pharmacotherapies in treating opioid dependence.

Treatment types for opioid dependence

4.1 Opioids are a class of drug that relieves pain and can create a sense of wellbeing. Opioids are depressants that slow the functions of the brain and body. Heroin is the most well-known opioid while other opioids include methadone, buprenorphine, opium, oxycodone, codeine and morphine.[98]

4.2 There are two treatment types for illicit opioid abuse. The first, opioid substitution treatment refers to methadone and buprenorphine; pharmacotherapies that act as a substitute for an illicit opioid. The second, opioid antagonist treatment incorporates naloxone, oral naltrexone, intramuscular naltrexone injections and naltrexone implants; pharmacotherapies which induce an opioid-free state in opioid dependent individuals.

4.3 Opioid dependence, as with other substance dependencies is a chronic condition and those experiencing problems often require a range of interventions over a long period.[99]

4.4 As defined by the *New South Wales Opioid Treatment Program: Clinical guidelines for methadone and buprenorphine treatment of opioid dependence* opioid dependence is:

> A cluster of behavioural, cognitive, and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activity and obligations, increased tolerance, and sometimes a physical withdrawal state.[100]

4.5 According to the NSW Ministry for Health the health, social and economic costs of opioid dependence are significant and disproportionate to the prevalence of use – less than one per cent of the Australian population aged 14 years and over will have used heroin or another

98 *New South Wales Opioid Treatment Program: Clinical guidelines for methadone and buprenorphine treatment of opioid dependence*, accessed 8 July 2013, http://www0.health.nsw.gov.au/policies/gl/2006/GL2006_019.html.

99 Submission 10, Australasian Professional Society on Alcohol & other Drugs, p 6.

100 *New South Wales Opioid Treatment Program: Clinical guidelines for methadone and buprenorphine treatment of opioid dependence*, accessed 8 July 2013, http://www0.health.nsw.gov.au/policies/gl/2006/GL2006_019.html.

opioid for non-medical purposes in the previous 12 months. However, the costs attributable to opioid dependence include overdose deaths, the spread of infectious diseases such as Human Immunodeficiency Virus (HIV) and Hepatitis C, psychological complications, social and family disruption, violence and drug related crime.[101]

4.6 Any discussion regarding naltrexone implants needs to be contextualised with regard to the other forms of treatment used to address opioid dependence, namely opioid substitution. To begin, the Chapter therefore describes the role of opioid substitution treatment, the primary method through which opioid dependence is treated in New South Wales, and notes some issues regarding its effectiveness as highlighted by Inquiry participants. The emerging field of opioid antagonist treatment is then discussed. Here, the rationale for the use of naltrexone, and in particular naltrexone implants, is first considered. Matters regarding the manufacture, use and research into the efficacy of naltrexone implants are then examined.

Opioid substitution treatment

4.7 Opioid substitution treatment refers to the substitution of an illicit, short-acting opioid with a legal, longer lasting opioid taken orally.[102] Opioid substitution treatment can also be referred to as opioid substitution therapy or opioid maintenance treatment. It incorporates the use of methadone and buprenorphine.[103]

4.8 The primary purpose of opioid substitution treatment is to enable individuals to better manage their lives and reduce the risks associated with their substance abuse without having to deal with the various problems associated with withdrawal.[104]

4.9 Methadone is a long acting liquid or syrup opioid usually taken on a daily basis that works to treat heroin addiction. Methadone reduces the use of heroin through cross tolerance, which reduces withdrawal symptoms, desire to use heroin, and the euphoric effect when heroin is used. Methadone has a low incidence of side effects, however there is a risk of overdose.[105]

4.10 Methadone was introduced into Australia in 1969 and since 1985 it has been endorsed by State, Territory and Commonwealth Governments as an appropriate treatment for opioid dependence.[106]

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101 Submission 51, NSW Ministry for Health, p 15.

102 *New South Wales Opioid Treatment Program: Clinical guidelines for methadone and buprenorphine treatment of opioid dependence*, accessed 8 July 2013, http://www0.health.nsw.gov.au/policies/gl/2006/GL2006_019.html.

103 Submission 51, p 15.

104 Answers to supplementary questions 7 May 2013, Australasian Professional Society on Alcohol & other Drugs, question 8, enclosing Mattick, Ali and Lintzeris (eds), *Pharmacotherapies for the treatment of opioid dependence: Efficacy, Cost-Effectiveness and Implementation Guidelines*, New York, Informa Healthcare, 2009 p 6.

105 Tabled document, Government of Western Australia, Drug and Alcohol Office, *Opioid Pharmacotherapy,* p 9.

106 Answers to supplementary questions 7 May 2013, Australasian Professional Society on Alcohol & other Drugs, Question 8, enclosing Mattick, Ali and Lintzeris (eds) p 108.

4.11 Buprenorphine, like methadone, is a long acting opioid that works to block the effects of heroin. Its effects are milder than those of methadone with a reduced risk of overdose. Buprenorphine can be taken via a tablet or a film placed on the tongue known as Suboxone. Suboxone has been developed to minimise the risk of diversion of buprenorphine to illicit drug users outside treatment, because once placed on the tongue it is absorbed very quickly.[107]

4.12 Buprenorphine was approved for use in Australia as an alternative to methadone in 2001.[108]

4.13 In its submission, the NSW Ministry for Health advised the Committee that methadone and buprenorphine are the chief pharmacotherapies prescribed to opioid dependent individuals through the New South Wales Opioid Treatment Program.[109] The Ministry's submission also indicated that positive outcomes are achieved when opioid dependent individuals are treated with methadone and buprenorphine:

> Those in opioid substitution treatment significantly reduce illicit opioid use and criminal behaviour - the rate of each approximately halves with each year that a patient remains in treatment…participation in an opioid treatment program results in major improvements in a patient's social, personal and physical functioning. This is reflected in stabilisation of social relationships, work and other activities.[110]

4.14 In the discussion concerning opioid substitution treatment, many Inquiry participants advised that methadone and buprenorphine are supported by a robust evidence base.[111] These Inquiry participants claimed that at this point in time, methadone and buprenorphine represent the most effective form of treatment for opioid dependence. For instance, Dr Alex Wodak, President, Australia Drug Law Reform Foundation, stated that:

> The gold standard treatment is methadone or buprenorphine. These are well tried and true treatments endorsed by the World Health Organization, the United Nations Office on Drugs and Crime and the Joint United Nations Programme on HIV/AIDS and other medical and scientific bodies.[112]

4.15 Dr Hester Wilson, General Practitioner and Addiction Specialist, member of the National Faculty of Specific Interests in Addiction Medicine through the Royal Australian College of General Practitioners, similarly observed that methadone and buprenorphine are endorsed by

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107 Tabled document, *Opioid Pharmacotherapy,* p iv.

108 *New South Wales Opioid Treatment Program: Clinical guidelines for methadone and buprenorphine treatment of opioid dependence*, accessed 8 July 2013, http://www0.health.nsw.gov.au/policies/gl/2006/GL2006_019.html.

109 Submission 51, p 15.

110 Submission 51, p 16.

111 Dr Alex Wodak, President, Australian Drug Law Reform Foundation, Evidence, 3 April 2013, p 37; Dr Hester Wilson, General Practitioner and Addiction Specialist, member of the National Faculty of Specific Interests in Addiction Medicine through the Royal Australian College of General Practitioners, Evidence, 4 April 2013, p 49; Professor Nadine Ezard, Clinical Director, St Vincent's Hospital, Inner City Health Program, Alcohol & Drug Service, Evidence, 4 April 2013, p 64; Professor Adrian Dunlop, Professor Adrian Dunlop, Immediate Past President, Australasian Professional Society on Alcohol & other Drugs, Evidence, 10 April 2013, p 13; and Submission 33, NSW Users & Aids Association, p 6.

112 Dr Wodak, Evidence, 3 April 2013, p 37.

the World Health Organisation, and noted that they have been subject to numerous trials and are cost effective:

> 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.[113]

4.16 However, the Inquiry also received evidence critical of opioid substitution treatment. One criticism was that it prolongs opioid dependence by maintaining people on methadone or buprenorphine when they would otherwise be opioid free. For instance, Drug Free Australia cited research published in the *British Medical Journal* indicating that individuals used methadone for longer periods than they used heroin: 'we note that with heroin alone the average length of injecting was 5 years, yet with methadone the average length of injecting was over 20 years'.[114]

4.17 A related criticism was that opioid substitution treatment was replacing one drug of dependence with another and was failing to promote any abstinence goal. This argument was made by FamilyVoice Australia, which in its submission recommended the cessation of government funded methadone substitution programs 'unless they have as their goal a proven pathway to abstinence'.[115]

4.18 Major Brian Watters, member, Drug Free Australia, offered another critique of methadone arguing that in his experience many individuals being treated with it had found it too restrictive in their efforts to become opioid free:

> 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.[116]

4.19 Major Watters also stated his belief that any questioning of methadone was restricted by economic interests:

> 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?[117]

113 Dr Wilson, Evidence, 4 April 2013, p 49.

114 Submission 30, Drug Free Australia, p 8.

115 Submission 5, FamilyVoice Australia, p 5.

116 Major Brian Watters, member, Drug Free Australia, Evidence, 4 April 2013, p 24.

117 Major Watters, Evidence, 4 April 2013, p 24.

4.20 In response to such criticism, some Inquiry participants argued that keeping an individual in opioid substitution treatment for an extended period of time was an objective in itself given it was improving their quality of life and leading to other positive outcomes. Professor Nadine Ezard, Clinical Director, St Vincent's Hospital, Inner City Health Program, Alcohol & Drug Service, for example, argued:

> …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.[118]

4.21 Professor Adrian Dunlop, Immediate Past President, Australasian Professional Society on Alcohol & other Drugs (APSAD), a multidisciplinary body for professionals involved in the alcohol and other drug field, also responded to the criticism of opioid substitution treatment. Professor Dunlop noted that while there are benefits and risks associated with methadone and buprenorphine use, there are risks associated with any medication, and they remain an effective way to treat individuals with opioid dependence:

> To suggest methadone and buprenorphine treatment is ineffective is saying that we do not believe in science. It is a hard argument to counter. Are there problems with methadone and buprenorphine? Of course. Any medication, any doctor will tell you, has problems. There are risks and benefits of any medication in the short term and in the long term and I do not minimise the problems that people experience on methadone and buprenorphine. I treat them. I treat them every day and I would never minimise those problems, but to suggest that it is not effective or it should be removed from the treatment platform is a little bit like saying that you can only have insulin for a period of time. It is a very strange statement.[119]

Opioid antagonist treatment

4.22 As noted earlier, naltrexone implants are the key pharmacotherapy considered by this Inquiry in treating opioid dependence. Naltrexone is classified as an opioid antagonist pharmacotherapy.

4.23 Opioid antagonist treatment refers to the use of opioid antagonist medication to bring about an opioid-free state in opioid users. Opioid antagonist medication acts by inhibiting the opioid receptors in the brain, thereby blocking the effects of opioids. The medication can either be short acting or long acting. The short acting version naloxone is used to treat opioid overdose, while the long-acting version naltrexone is used to prevent individuals from taking illicit opioids.[120]

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118 Professor Ezard, Evidence, 4 April 2013, p 64.

119 Professor Dunlop, Evidence, 10 April 2013, p 13.

120 Professor Alison Ritter, Director, Drug Policy Modelling Program, Evidence, 3 April 2013, p 18.

4.24 Professor Alison Ritter, Director of the Drug Policy Modelling Program (DPMP), a drug and alcohol policy research and practice program at the University of New South Wales advised the Committee about how opioid antagonist medication works in response to heroin:

> Heroin is an opiate that sticks really strongly to your opiate receptors and you become dependent because—I will use common language—you sort of silt up all of your opiate receptors. Then you need to use more in order to get the same effect because your opiate receptors are all full up. The administration of naltrexone or naloxone, or Narcan as it is registered, is short-acting naltrexone. If you have got your opioid receptors full of an opiate, whether it is heroin or morphine or pethidine, whatever it might be, and you administer either naloxone or naltrexone it is stickier than the heroin and it immediately throws the heroin off one's opiate receptors.[121]

4.25 In its submission, the Australian National Council on Drugs (ANCD), the principle advisory body to the Commonwealth Government on drug policy, informed the Committee that in 2012 it had issued a position statement calling for the expansion of naloxone availability.[122]

4.26 The ANCD's statement noted that: naloxone can quickly reverse the effects of opioid overdose; evidence shows that expanding its availability and training potential overdose witnesses to administer naloxone is a safe and effective intervention for preventing opioid overdose fatalities; and there is no evidence suggesting that expanding its availability would encourage riskier drug use or have other adverse consequences.[123]

4.27 The ANCD's position on naloxone was supported by positive statements made by other Inquiry participants regarding its efficacy. This included the Sydney Supervised Medically Injecting Centre, Professor Ritter of the DPMP and Family Drug Support.[124]

4.28 Regarding naltrexone, this pharmacotherapy is used in programs to assist people with opioid dependence to become opioid-free. It can be taken orally in tablet form, via implants or through an intramuscular injectible format known as Vivitrol.

4.29 Naltrexone tablets were approved for prescription use to address opioid dependence in Australia in 1998. A fact sheet on naltrexone tablets, provided to the Committee by the ANCD, notes that:

- The effectiveness of naltrexone tablets can be significantly reduced by non-compliance, if people stop taking their tablets to regain the effects of any opioid use.
- Studies on oral naltrexone have reported increases in the risk of overdose post treatment due to a decreased tolerance for opioids.[125]

4.30 The issue of compliance with oral or tablet-form naltrexone was also addressed by Professor John Saunders, Drug and Alcohol Program Director, Wesley Hospital Kogarah. Professor

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121 Professor Ritter, Evidence, 3 April 2013, p 18.

122 Submission 3, Australian National Council on Drugs, attachment 7, 'ANCD Position Statement: Expanding Naloxone Availability', September 2012.

123 Submission 3, Australian National Council on Drugs, attachment 7.

124 Submission 17, Sydney Supervised Medically Injecting Centre, p 9; Professor Ritter, Evidence, 3 April 2013, p 18; and Submission 25, Family Drug Support, p 9.

125 Submission 3, attachment 7.

Saunders advised the Committee that he had conducted a randomised control trial comparing oral naltrexone with methadone. Randomised control trials refer to the random allocation of research subjects into separate groups, namely the medical intervention group and the control/placebo group. The outcomes of each group are then compared.

4.31 Professor Saunders found that those on methadone were more likely to stay in treatment and with that their chances of achieving positive outcomes increased:

> I can give you a little bit of background because just over 10 years ago I established a randomised controlled trial comparing naltrexone in tablet form, not the implant form, with methadone. This has been reported and it has been presented at professional societies. The results of that trial—please remember that it was with naltrexone tablets—were that most people who were taking the tablets ceased treatment. They entered treatment with considerable enthusiasm but they found it hard. People who were assigned to methadone were far more likely to be retained in treatment and with retention in treatment comes a reduction in morbidity and mortality of approximately 75 per cent, a reduction in injecting drug use of 90 per cent if people are on methadone, morbidity and mortality down 75 per cent and criminal activities down 75 per cent.[126]

4.32 To address the issue of non-compliance in the taking of naltrexone tablets, naltrexone implants and injectible intramuscular sustained-release naltrexone were developed. A naltrexone implant is a surgically implanted device that provides a slow release of naltrexone over a period of time, effective for three to six months.[127] The injectible format, known as Vivitrol, provides sustained-release naltrexone effective for four weeks.[128]

4.33 In its submission, the ANCD indicated that the research concerning whether naltrexone implants can lead to the same risk of post treatment overdose (as with tablets) is unclear and noted that despite there being a strong theoretical case for naltrexone implants, evidence for their safety and efficacy sufficient for registration in Australia has not been presented.[129] The evidence to the Committee regarding the evidence base for the use of naltrexone implants is considered in detail in the next section.

4.34 To date, the Therapeutic Goods Administration, the national regulatory body for therapeutic goods, has not evaluated and approved naltrexone implants for registered use in Australia.[130] Naltrexone implants can, however, be administered under certain exemptions within the Commonwealth *Therapeutic Goods Act 1989* applying to clinical trials and to the provision of unapproved products through the Special Access Scheme.[131] The use of naltrexone implants through the Special Access Scheme was of concern for several Inquiry participants and this issue is also considered in the detail in the next section.

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126 Professor John Saunders, Drug and Alcohol Program Director, Wesley Hospital Kogarah, Evidence, 10 April 2013, p 40.

127 Submission 3, attachment 7.

128 Professor Ritter, Evidence, 3 April 2013, p 15.

129 Submission 3, attachment 7.

130 Submission 3, attachment 7.

131 Correspondence from Dr John Skerritt, National Manager, Therapeutic Goods Administration, to Chair, 4 June 2013.

4.35 In relation to injectible naltrexone, Vivitrol was approved for use in the United States for the treatment of opioid dependence in 2010. It is currently not licensed for use in Australia,[132] although the Committee was advised of efforts to conduct trials on its effectiveness in New South Wales.[133]

4.36 The submission from the South Eastern Sydney Local Health District advised the Committee that its Director of Drug and Alcohol Services, Professor Nicholas Lintzeris, had unsuccessfully sought funding on three occasions from the National Health and Medical Research Council (NMHRC) – Australia's peak body for supporting health and medical research[134] – to undertake randomised control trials examining Vivitrol in conjunction with the National Drug and Alcohol Research Centre at the University of New South Wales. Professor Lintzeris was, however, successful in obtaining funding from the NSW Ministry for Health, to conduct trial research using Vivitrol for opioid dependence, but was unable to secure supplies of the medication from the manufacturing company in the United States and consequently the trial did not proceed.[135]

4.37 In evidence, Professor Ritter of the DPMP stated that the research conducted overseas into Vivitrol showed promise:

> All of the research from overseas, the randomised control trials, have been done on the injection. The drug is called Vivitrol; that is its trade name…In 2010 it was registered for the treatment of heroin dependence, so there is a sustained-release naltrexone approved by the FDA in America and is in widespread use and those clinical trials are exceptionally promising.[136]

Naltrexone implants

4.38 This section builds on some of the matters detailed above relevant to naltrexone implants. Issues considered include the availability and use of naltrexone implants, their manufacture, and the conflicting views of Inquiry participants concerning whether there is an evidence base to support their use. The section concludes by discussing the provisions in the *Drug and Alcohol Treatment (Rehabilitation of Persons with Severe Substance Dependence) Bill 2012* regarding involuntary treatment with naltrexone implants.

Dr George O'Neil and the Fresh Start Recovery Programme

4.39 The focus for the Inquiry was primarily on matters relevant to a naltrexone implant used by the Fresh Start Recovery Programme, Subiaco, Western Australia, a clinic administering naltrexone implants to individuals with opioid dependence. This naltrexone implant has been

132 Professor Ritter, Evidence, 3 April 2013, p 15.

133 Submission 42, South Eastern Sydney Local Health District, p 4.

134 The NHMRC is Australia's peak body for supporting health and medical research; for developing health advice for the Australian community, health professionals and governments; and for providing advice on ethical behaviour in health care and in the conduct of health and medical research.

135 Submission 42, p 4.

136 Professor Ritter, Evidence, 3 April 2013, p 15.

developed by Go Medical Industries Pty Ltd whose founder Dr George O'Neil is also the Medical Director of the Fresh Start Recovery Programme.[137]

4.40 The submission by the Fresh Start Recovery Programme indicated that Go Medical Industries Pty Ltd has been working to manufacture naltrexone implants for broader use in Australia for 13 years. It is an initiative led by Dr O'Neil and has involved a number of Western Australian universities including the University of Western Australia, Curtin University, Edith Cowan University and Murdoch University.[138]

4.41 In evidence, Dr O'Neil informed the Committee that he began developing naltrexone implants following his involvement with a program for mothers on methadone. Dr O'Neil indicated that he was unhappy with the treatment provided for mothers on methadone and that this instilled in him an interest and commitment to the field of opioid treatment:

> If I go back 25 years ago I started working with the drug and alcohol authority in Perth to look after the methadone mothers because methadone mothers coming through King Edward Memorial Hospital were not being well looked after. I took them down to my surgery and looked after them. It gave me a strong commitment to this area of medicine.
>
> …17 years ago Professor Sunderland and I started talking about bringing buprenorphine in, which is a partial agonist, thereby moving from an agonist to a partial agonist. Then we got excited by naltrexone. Together we took a young graduate, Yandi Liu, who was just finishing his PhD—I was working with him and Professor Sunderland—and we set up a project and worked for three years at Curtin University. That allowed us to develop microspheres, develop formulations and put the formulations in mice and rats, but most specifically rats. We proved that if we made an injection with microspheres we could achieve good naltrexone levels for a month.[139]

4.42 As part of its evidence gathering activities, the Committee travelled to the Fresh Start Recovery Programme on 15 May 2013. The Committee met with Dr O'Neil and the staff operating and managing the Fresh Start Recovery Programme and also with some patients being treated with naltrexone implants. The site visit provided the Committee with the opportunity to gauge firsthand the use of naltrexone implants in treating opioid dependence.

4.43 The Committee also met with representatives from the Drug and Alcohol Office, WA Health on 16 May 2013. The Drug and Alcohol Office staff advised the Committee on a number of matters including the relationship between the Western Australian Government and the Fresh Start Recovery Programme.

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137 Dr George O'Neil, Medical Director, Fresh Start Recovery Programme Western Australia, Evidence, 3 April 2013, p 2.

138 Submission 47, Fresh Start Recovery Programme, pp 1-2.

139 Dr O'Neil, Evidence, 3 April 2013, p 2

Availability

4.44 Most of the evidence on the use of naltrexone in Australia centred on the naltrexone implant manufactured by Go Medical Industries Pty Ltd for the treatment of Fresh Start Recovery Programme patients. Between 2001 and 2008, the Fresh Start Recovery Programme treated 2,211 opioid dependent individuals with naltrexone implants.[140]

4.45 There was also mention in evidence of other clinics in Australia that had used naltrexone implants in treating opioid dependent individuals. For instance, it is understood that naltrexone implants have been used by the First Step Clinic in Victoria and by two private medical practitioners in Queensland.[141]

4.46 In addition, perhaps the most high-profile and controversial use of naltrexone implants in Australia was the treatment of patients at the Psyche N Soul clinic in Ultimo, Sydney. The deaths of three patients treated with naltrexone implants by that particular clinic were subject to a 2012 Coronial Inquiry. The Inquiry resulted in a clinician being referred to a professional tribunal and subsequently being deregistered as a psychologist.[142] It is understood that the naltrexone implant used by the Psyche N Soul clinic was sourced from China and was not the one manufactured by Dr O'Neil and Go Medical Industries Pty Ltd.[143]

4.47 The Committee was advised that globally, there are currently several forms of naltrexone implant available for use. A naltrexone implant, known as Prodetoxon, has been developed in Russia and it is registered and approved for use by the Russian authorities.[144] Another naltrexone implant has been developed in China but the Committee did not receive detailed information regarding its use.[145]

4.48 As noted earlier naltrexone implants, have not been approved for registered use in Australia by the Therapeutic Goods Administration (TGA), however, while not an approved medicine they are used in Australia through an exemption provided for by the Special Access Scheme administered by the TGA. The Special Access Scheme refers to arrangements which provide for the supply of an unapproved therapeutic good for a single patient, on a case by case basis.[146]

4.49 To be treated by an unapproved medicine under the Special Access Scheme an individual has to be classified as a Category A patient. Category A applies to individuals classified by their medical practitioner as 'persons who are seriously ill with a condition from which death is reasonably likely to occur within a matter of months, or from which premature death is reasonably likely to occur in the absence of early treatment'.[147]

140 Tabled document, *Opioid Pharmacotherapy,* p 35.

141 Tabled document, *Opioid Pharmacotherapy,* p 35.

142 Dr Wodak, Evidence, 3 April 2013, p 36.

143 Professor Dunlop, Evidence, 10 April 2013, p 16.

144 Professor Ritter, Evidence, 3 April 2013, p 15

145 Professor Dunlop, Evidence, 10 April 2013, p 16.

146 Correspondence from Dr Skerritt to Chair, 4 June 2013.

147 Correspondence from Dr Skerritt to Chair, 4 June 2013.

4.50 The Committee wrote to the TGA requesting information regarding the Fresh Start Recovery Programme's use of the Special Access Scheme to administer naltrexone implants. In response, the TGA advised the Committee, that while it was unable to provide specific information about an individual doctor's use of the Special Access Scheme, in instances where a person has been treated as a Category A patient, via an unapproved medicine, the treating doctor is required to notify the TGA within 28 days.[148]

4.51 The TGA further advised the Committee that it has not been involved in approving naltrexone implants for registered use in Australia:

> In the case of naltrexone implants their use under the Special Access Scheme has always been through the SAS Category A pathway and hence has always been a notification of use and the TGA has not been involved in any approval of the use.[149]

4.52 A number of Inquiry participants raised concerns about the way in which patients were able to be treated with naltrexone implants under the Special Access Scheme. The Australia Drug Law Reform Foundation (ADLRF), for instance, argued that the Special Access Scheme was being misused given the mortality of heroin dependence was approximately one to two per cent and that this did not meet the threshold allowing the use of an unapproved medicine in the likely event of death or premature death. According to the ADLRF:

> Clinicians inserting naltrexone implants in Australia have generally used Category A of the Special Access Scheme because these devices have not been approved by the TGA and this scheme provides a mechanism for doctors to provide unapproved treatments for patients with a terminal illness and a short life expectancy. Category A patients are defined as 'persons who are seriously ill with a condition from which death is reasonably likely to occur within a matter of months, or from which premature death is reasonably likely to occur in the absence of early treatment'. As the mortality of heroin dependence is about 1-2% per annum, and as other recognised and effective treatments are available, this condition clearly does not satisfy the requirements of Category A of the Special Access Scheme. Why has nothing been done regarding this apparent misuse of a system designed for another and entirely legitimate purpose?[150]

4.53 Professor Nicholas Lintzeris, Director, Drug and Alcohol Services, the South Eastern Sydney Local Health District, voiced similar concerns regarding the use of an unapproved medical product through the Special Access Scheme. Professor Lintzeris stated that he was not against naltrexone implants; rather, he believed that the Special Access Scheme was being used for a purpose it was not intended for and that the scope of the program was too large to not have some form of official oversight:

> 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.

148 Correspondence from Dr Skerritt to Chair, 4 June 2013.

149 Correspondence from Dr Skerritt to Chair, 4 June 2013.

150 Submission 37, Australia Drug Law Reform Foundation, p 11.

> 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…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.[151]

4.54 However, Professor Lintzeris also acknowledged that 'elements of what has occurred in Western Australia have been positive in terms of being able to progress the science'.[152]

4.55 Other Inquiry participants to express concern regarding the use of naltrexone implants through the Special Access Scheme included Hepatitis NSW, the Australasian Therapeutic Communities Association and the Alcohol and other Drugs Council of Australia.[153]

4.56 In response to these concerns, Dr O'Neil stated that as he was currently using naltrexone implants to treat his patients only, he was within the requirements of the Special Access Scheme, but that if the product was registered for broader use he would be subject to the TGA regulatory system:

> So what we tell the TGA is that we have got this guy who wants to detox. Do you want us to use the registered product [oral naltrexone] or do you want us to use that which will give him 25 times less risk of dying? They say you had better just treat him. That is what the special access is all about. At present, when I have a fire in my factory, the TGA says please do not ask us questions, if you are only producing for your own patients, we are happy for you to produce for your own patients. But when you want to start to make the product Go Medical instead of making the product as Dr O'Neil, then I have an obligation to work inside the TGA system.[154]

Manufacture

4.57 One of the questions considered in evidence was when the naltrexone implants manufactured by Go Medical Industries Pty Ltd and Dr O'Neil may be ready to be brought to market for broader use in Australia, subject to TGA approval.

4.58 For a therapeutic good to meet TGA requirements for use in Australia, it must be manufactured to TGA standards in a TGA approved facility. Dr O'Neil advised the Committee that in 2005, Go Medical Industries Pty Ltd built manufacturing facilities to the standards required to achieve Good Manufacturing Practice. Good Manufacturing Practice refers to a set of principles and procedures developed and enforced by the TGA to ensure that manufactured therapeutic goods are of high quality.[155] In 2011, a fire destroyed Go Medical

151 Professor Nicholas Lintzeris, Director, Drug and Alcohol Services, the South Eastern Sydney Local Health District, Evidence, 4 April 2013, p 12.

152 Professor Lintzeris, Evidence, 4 April 2013, p 12.

153 Submission 44, Hepatitis NSW, p 6; submission 50, Australasian Therapeutic Communities Association, p 5; and submission 46, Alcohol and other Drugs Council of Australia, p 3.

154 Dr O'Neil, Evidence, 3 April 2013, p 7.

155 Dr O'Neil, Evidence, 3 April 2013, p 2 and Therapeutic Goods Administration 'Good manufacturing practice – an overview', accessed 10 July 2013, http://www.tga.gov.au/industry/manuf-gmp-tg.htm.

Industries Pty Ltd's premises and the organisation is currently working to develop new premises that meet Good Manufacturing Practice standards.

4.59 The submission from the Fresh Start Recovery Programme advised that at this point in time, Dr O'Neil is producing implants in temporary facilities based at the Fresh Start Recovery Programme clinic. These naltrexone implants are currently only being administered to Fresh Start patients.[156]

4.60 Dr O'Neil advised the Committee that the new Go Medical Industries Pty Ltd manufacturing facility is scheduled to be completed by the end of 2013. Go Medical Industries Pty Ltd will then reapply to the TGA for Good Manufacturing Practice status, which its submission indicated it expects to receive in May 2014.[157]

4.61 Along with seeking the attainment of Good Manufacturing Practice status, Go Medical Industries Pty Ltd plan to undertake a pharmacokinetic study of the naltrexone implant in June 2014 and a challenge study of their naltrexone implant at Bristol University, United Kingdom. Following these studies, and once it has achieved Good Manufacturing Practice status, the Fresh Start Recovery Programme submission indicated that Go Medical Industries Pty Ltd will seek to register its naltrexone implant with the TGA for broader use.[158]

4.62 To ascertain when it may be possible for Dr O'Neil's naltrexone implant to achieve TGA registration for use in Australia, the Committee wrote to the TGA seeking information regarding the process through which it would consider an application, once Dr O'Neil had achieved Good Manufacturing Practice status and once he had applied to the TGA for registration, to register the Go Medical Industries Pty Ltd naltrexone implant. The TGA advised that it would review the supporting data before sending it to an expert advisory committee for a detailed evaluation, and that the process would take approximately 11 months:

> To enable a medicine, such as naltrexone implants, to be marketed in Australia a sponsor is required to submit an application accompanied by scientific and clinical data to support the quality, safety and efficacy of the medicine for its intended use. The TGA reviews the data and will usually seek the advice of an independent expert advisory committee, the Advisory Committee on Prescription Medicines, before making a decision to approve or reject a new medicine. If an effective application is made to the TGA then a decision whether or not the medicine is approved will normally be made within 11 months.[159]

4.63 Commenting on Dr O'Neil's work in seeking to register his naltrexone implant with the TGA for broader use, Professor Adrian Dunlop of APSAD stressed that it was a large undertaking:

> Dr O'Neil is a passionate clinician who is working incredibly hard and is devoted to his patients but there are significant issues with developing a medicine that is safe, effective and can be approved by the Therapeutic Goods Administration, it is a large undertaking.[160]

156 Submission 47, p 2.

157 Submission 47, p 2.

158 Submission 47, p 2.

159 Correspondence from Dr Skerritt to Chair, 4 June 2013.

160 Professor Dunlop, Evidence, 10 April 2013, p 16.

Evidence base

4.64 Numerous Inquiry participants addressed the question of whether there is an evidence base for the use of naltrexone implants, and referred to a number of research articles that constitute the published literature on naltrexone implants. The three publications commonly referred to in evidence were a 2008 paper by the Cochrane Collaboration, a follow-up paper in 2012 by Kunøe et al, and a 2010 literature review by the NHMRC in Australia. While commenting on the same literature, Inquiry participants held divergent views on the conclusions of this work.

4.65 Mr Stephen Ling, Member, Drug and Alcohol Nurses of Australasia Incorporated, for example, referred in evidence to the research paper, published in 2008 by the Cochrane Collaboration,[161] on sustained-release naltrexone.[162]

4.66 The Cochrane paper, entitled, *Sustained-release naltrexone for opioid dependence,* evaluated the effectiveness of sustained-release naltrexone for opioid dependence and its adverse effects in different study populations. It did so by reviewing randomised control trial data taken from international medical databases and by examining identified studies and published reviews current as of November 2007. The paper was prepared by four researchers who independently evaluated the compiled data. Mr Ling drew the Committee's attention to the paper's conclusion, namely that:

> There is insufficient evidence to evaluate the effectiveness of sustained-release naltrexone for treatment of opioid dependence. For naltrexone injections, administration site-related adverse effects appear to be frequent, but of moderate intensity and time limited. For a harm-benefit evaluation of naltrexone implants, more data on side effects and adverse events are needed.[163]

4.67 Mr Ling, among other Inquiry participants including the Christian Democratic Party, Drug Free Australia and the Drug Policy Modelling Program, also informed the Committee about a 2012 paper published in the *British Journal of Clinical Pharmacology*, entitled, *Injectible and implantable sustained release naltrexone in the treatment of opioid addiction* (Kunøe et al).[164]

4.68 The Kunøe paper was prepared by some of the authors previously involved in reviewing the international evidence relating to sustained-release naltrexone for the Cochrane Collaboration in 2008.[165] It built on the 2008 work and also looked at more recent international research regarding sustained-release naltrexone.

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161 The Cochrane Collaboration is an independent international organisation formed to organise medical research information by reviewing randomised controlled trials of healthcare interventions.

162 Mr Stephen Ling, Member, Drug and Alcohol Nurses of Australasia Incorporated, Evidence, 10 April 2013, p 20.

163 Mr Ling, Evidence, 10 April 2013; and Lobmaier P, Kornor H, Kunøe N, Bjørndal, 'Sustained-Release Naltrexone For Opioid Dependence', *Cochrane Database of Systematic Reviews*, 2008, Issue 2. Art. No.: CD006140. DOI: 10.1002/14651858.CD006140.pub2.

164 Mr Ling, Evidence, 10 April 2013, p 20, submission 38; Christian Democratic Party, attachment 8; tabled document, Drug Free Australia; and Answers to question on notice taken during evidence 3 April 2013, Professor Ritter, Director, Drug Policy Modelling Program, Question 3, paper no 2.

165 Kunøe N, Lobmaier P, Ngo H, Hulse G, 'Injectible and implantable sustained release naltrexone in the treatment of opioid addiction', *British Journal of Clinical Pharmacology,* doi: 10.1111/bcp.12011.

4.69 The Kunøe paper noted that, since 2008, the evidence base for sustained-release naltrexone had accumulated to the point where more effective assessments could be made.[166] It concluded that the evidence indicated that sustained-release naltrexone could be effective in treating opioid dependence but further research was required to confirm such findings:

> The literature suggests that sustained-release naltrexone is a feasible, safe and effective option for assisting abstinence efforts in opioid addiction…The literature on sustained-release naltrexone for opioid addiction still requires more studies in order to confirm initial findings on effects.[167]

4.70 Speaking about the Kunøe paper, Dr O'Neil argued that it meant the research base in support of the effectiveness of sustained-release naltrexone was now well established:

> If you read the literature, the people who did the Cochrane review have now looked at the naltrexone work coming out of the United States, looked at the naltrexone work coming out of Russia, they have looked at the publications relating to our implants coming out of Oslo, they have looked at the publications coming out of Britain and they have looked at the work coming out of Perth and realise this whole business of sustained naltrexone work is now very well established.[168]

4.71 An alternate view was provided by Dr Alex Wodak of the Australia Drug Law Reform Foundation, who instead argued that the evidence base on the effectiveness of sustained-release naltrexone had not yet been established to the satisfaction of the Cochrane Collaboration or the NHMRC:

> It is a very serious and very technical business of amassing quantities and qualities of evidence to such a degree that there can be a high degree of confidence that we have a treatment that is effective, safe and these days also cost effective and so far that evidence has not been presented by Dr O'Neil or anybody else around the world to the satisfaction of the National Health and Medical Research Council or the Cochrane Collaboration, which is an international group that does work like the NHMRC does on a major scale and is very highly regarded. The Cochrane Collaboration also does not rate the evidence for naltrexone implants or injections highly on the basis of the evidence so far presented.[169]

4.72 Of direct relevance to the evidence base for naltrexone implants in Australia was a 2010 literature review, undertaken by the NHMRC, which found that although naltrexone implant treatments may show some efficacy as part of a treatment program, more research was needed.[170]

4.73 The NHMRC paper, entitled, *Naltrexone Implant Treatment for Opioid Dependence,* reviewed the available literature as of 2010 into the use of naltrexone implants for the treatment of opioid

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166 Kunøe N, Lobmaier P, Ngo H, Hulse G, 'Injectible and implantable sustained release naltrexone in the treatment of opioid addiction', *British Journal of Clinical Pharmacology,* doi: 10.1111/bcp.12011.

167 Kunøe N, Lobmaier P, Ngo H, Hulse G, 'Injectible and implantable sustained release naltrexone in the treatment of opioid addiction', *British Journal of Clinical Pharmacology,* doi: 10.1111/bcp.12011, p 3 and pp 16-17.

168 Dr O'Neil, Evidence, 3 April 2013, p 6.

169 Dr Wodak, Evidence, 3 April 2013, p 37.

170 Submission 43, National Health and Medical Research Council, p 1.

dependence in Australia. It concluded that naltrexone implants were 'an experimental product' and as such should only be used in the context of a well organised randomised control trials characterised by:

- sufficient sample size;
- appropriate duration of treatment and follow up;
- regular robust monitoring;
- provision of a comprehensive psychosocial treatment program; and
- comparison to current best practice.[171]

4.74 The NHMRC paper then stated that until a randomised control trial of naltrexone implants had been performed assessments regarding their efficacy could not be undertaken:

> …until these trials have occurred and the relevant data are available and validated, the efficacy of the treatment, alone or in comparison to conventional first line treatments, cannot be determined.[172]

4.75 Multiple Inquiry participants referred to the NHMRC paper to argue that the evidence base for the use of naltrexone implants has not been established. Inquiry participants to reference the NHMRC paper included the South Eastern Sydney Local Health District, the NSW Users & Aids Association Inc and the Australasian Therapeutic Communities Association.[173] The South Eastern Sydney Local Health District, for instance, stated:

> The recent NHMRC review of long-acting naltrexone products came to the conclusion that the safety and evidence base for naltrexone implants should only be used in properly conducted trials, within appropriate ethical and regulatory frameworks, and not as part of routine clinical practice. The available evidence indicates that there may well be an important role for long-acting naltrexone products, although there are concerns regarding its safety and by no means is it a panacea for opioid and other drug use...The NHMRC was conducted appropriately, and there is no reason to question the validity of its conclusions.[174]

4.76 Given the differing views of Inquiry participants regarding whether there is a robust evidence base on the efficacy of naltrexone implants, the Committee wrote to the NHMRC seeking information on whether it is considering providing funding for any future research projects on the efficacy of naltrexone implants. The NHMRC advised that future funding is dependent on medical investigators submitting high quality applications:

> In terms of future funding, the majority of NHMRC funds are allocated through investigator initiated applications which are subject to rigorous peer review. NHMRC funds for future research will largely depend on NHMRC receiving high quality applications in this important area.[175]

171 Submission 43, p 3.

172 Submission 43, p 3.

173 Submission 42, p 5, submission 33, NSW Users & Aids Association Inc., p 8, and submission 50, the Australasian Therapeutic Communities Association, p 15.

174 Submission 42, p 5.

175 Correspondence from Dr Clive Morris, Head, Research Policy Taskforce, National Health and Medical Research Council to Chair, 20 June 2013.

4.77 The NHMRC also advised the Committee that it had funded five research projects regarding naltrexone over the period December 2002 to December 2006.[176]

4.78 During the Inquiry it was suggested that one measure of confidence in the naltrexone implant manufactured by Go Medical Industries Pty Ltd and Dr O'Neil was the financial support provided to the Fresh Start Recovery Programme by the Western Australian Government.

4.79 Representatives from the Drug and Alcohol Office, WA Health advised the Committee that the Western Australian Government has provided financial support to Go Medical Industries Pty Ltd to assist the organisation in continuing to operate pending its development of a naltrexone implant suitable for presentation to the TGA. The Drug and Alcohol Office also advised that the Western Australian Government would not directly fund a medical treatment for use that had not been approved by the TGA.

4.80 In its submission to a 2009 Western Australian Parliamentary Inquiry into prevention and treatment services for alcohol and illicit drug problems in Western Australia, the Drug and Alcohol Office stated:

> The Drug and Alcohol Office provides funding to the [Fresh Start Recovery Programme/Go Medical Industries Pty Ltd] to support assessment, counselling and patient support services. The Drug and Alcohol Office does not provide funding for the purpose of providing pharmacotherapy services via naltrexone implants.[177]

4.81 From the perspective of the NSW Ministry Health, the Director of its Mental Health and Drug and Alcohol Office, Mr David McGrath indicated that the Ministry would not seek to fund the provision of naltrexone implants because they have not been approved by the TGA. Mr McGrath did, however, note if the TGA made a positive determination regarding naltrexone implants then the Ministry would be interested in potentially using them as a form of treatment:

> From our point of view it is difficult to implement something that the Therapeutic Goods Administration has not approved as a medication for that particular purpose. As far as I am aware the Commonwealth is looking at undertaking the appropriate research to allow the Therapeutic Goods Administration to make a determination. Once the Therapeutic Goods Administration makes that determination we would be interested in looking at how to turn that into a treatment program—if the Therapeutic Goods Administration has a positive affirmation, I should not presume that.[178]

Drug and Alcohol Treatment (Rehabilitation of Persons with Severe Substance Dependence) Bill 2012

4.82 The terms of reference for the Inquiry required the Committee to examine the provisions in the *Drug and Alcohol Treatment (Rehabilitation of Persons with Severe Substance Dependence) Bill 2012* (the Bill), which seek to allow involuntary treatment with naltrexone implants for individuals with severe substance dependence.

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176 Correspondence from Dr Morris to Chair, 20 June 2013.

177 Tabled document, *Opioid Pharmacotherapy,* p 38.

178 Mr David McGrath, Director, Health and Drug and Alcohol Office, NSW Ministry for Health, Evidence, 27 May 2013, p 22.

4.83 The Bill was introduced into the New South Wales Parliament by Revd. the Hon Fred Nile on 25 October 2012.[179] It seeks to amend the *Drug and Alcohol Treatment Act 2007* to further provide for the involuntary rehabilitative care of persons with severe substance dependence.[180] This section considers the provisions in the Bill relevant to naltrexone implants. The Bill's other provisions regarding the operation of the Involuntary Drug and Alcohol Treatment Program are dealt with in Chapter 5.

4.84 Some Inquiry participants raised concerns about the Bill in light of their questions on whether there is a robust evidence base for the use of naltrexone implants. For instance, Professor Nadine Ezard of the St Vincent's Hospital, Inner City Health Program, Alcohol & Drug Service expressed her concern that the Bill proposed involuntary treatment with an 'experimental' medical intervention:

> …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.[181]

4.85 Mr Ling from Drug and Alcohol Nurses of Australasia Incorporated, similarly argued that the effectiveness of naltrexone implants had not been established, and that the Bill should not preference naltrexone implants as a treatment of choice when there are other more efficacious treatment options available:

> …we have had an opportunity to examine the proposed amendments to the Drug and Alcohol Treatment Act 2007. It is of some concern to us as a professional body that a program about which safety and effectiveness has not been clearly established—that is, implantable naltrexone—has been singled out as a treatment of choice. That is particularly given that widely used agents with proven efficacy, such as methadone and buprenorphine maintenance for opiate dependence, have been ignored. The involuntary use of implantable naltrexone raises several issues, particularly with regard to the evidence base for the approach being considered.[182]

4.86 In its submission, the Western NSW Local Health District, Mental Health and Drug & Alcohol Services, which is for responsible for managing the Involuntary Drug and Alcohol Treatment centre at Bloomfield Hospital Orange, similarly expressed reservations about using an unapproved medical treatment and called for the Bill's provisions relating to naltrexone implants to be removed:

> The amendments proposed in relation to Naltrexone implants are not supported by evidence of effectiveness. In addition, Naltrexone implants are in fact not approved by the Australian TGA for use in this country except under very special and limited circumstances, and have not been shown at this time to be safe or effective treatment. It is unclear from the Amendment Bill 2012 if the proposed use of Naltrexone implants as part of outpatient involuntary treatment is intended for patients with

179 *LC Debates* (25/10/2012) 16480.

180 *Drug and Alcohol Treatment Amendment (Rehabilitation of Persons with Severe Substance Dependence) Bill 2012,* explanatory note.

181 Professor Ezard, Evidence, 4 April 2013, p 62.

182 Mr Ling Evidence, Evidence, 10 April 2013, p 20.

> opioid dependence or alcohol dependence, however, regardless of which, we would strongly urge this component of the Amendment Bill 2012 to be removed.[183]

Future research directions

4.87 The debate regarding naltrexone implants clearly showed that many of the researchers, epidemiologists and addiction medicine practitioners that gave evidence supported an expansion in the treatment options available to treat opioid dependence. Another commonly made point was that not only is there is a need for more treatment options, but there is also a need for what is currently available to be used more effectively.

4.88 For example, Dr Wodak of the ADLRF observed that the treatment options for opioid dependence were limited and while some of them were effective they were not being deployed optimally:

> …heroin is a serious problem in this and other countries. The treatments that we have in Australia and around the world are very limited. We need more choices. In medicine, as in other areas of life, choice is good and where choice is restricted we struggle. We have some good treatments for heroin dependence but we do not have enough of them and we do not deploy maximally the ones that we do have.[184]

4.89 Professor Lintzeris of the South Eastern Sydney Local Health District similarly stated that he supported efforts to expand the suite of treatment options available but he also stressed that within the addiction field there were no 'magic bullet' solutions:

> 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.[185]

4.90 In response to questioning regarding whether he would support an NHMRC-approved trial of naltrexone, Professor Lintzeris stated that

> 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.[186]

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183 Submission 54, the Western NSW Local Health District, Mental Health and Drug & Alcohol Services, p 2.

184 Dr Wodak, Evidence, 3 April 2013, p 37.

185 Professor Lintzeris, Evidence, 4 April 2013, p 12.

186 Professor Lintzeris, Evidence, 4 April 2013, p 11.

4.91 Professor John Saunders, from the Wesley Hospital Kogarah advised the Committee that he supported a trial comparing naltrexone implants with methadone or buprenorphine to determine what type of treatment best suits which patient:

> For a group of patients with heroin dependence or other similar opiate dependence as a whole at any one time, my conclusion is that there is more to be gained by methadone or buprenorphine treatment than there is with naltrexone. However, the preparation of an implant takes naltrexone technology a step further, so I think that a multi-centre trial directly comparing a naltrexone implant with what would be regarded now as conventional treatments, which would be methadone or buprenorphine, is something I would strongly support. That would take our understanding and knowledge a considerable step forward. It would also hopefully give us information about for which types of patient a naltrexone implant would be best and be preferred and, correspondingly, for which types of patient methadone or a similar agonist treatment would be preferred. That would be an important study of international significance.[187]

4.92 In regard to funding for such a trial, Mr McGrath of the NSW Ministry for Health advised the Committee that primary responsibility for funding clinical research lies with the Commonwealth Government:

> In New South Wales we fund very limited clinical trials. The majority of clinical trial funding goes through the Commonwealth. It would be rare for us, given the Commonwealth has constitutional responsibility for research, to invest money at that level given our focus is generally on service delivery.[188]

4.93 Professor Saunders advised the Committee that while the NHMRC is the principal funder for medical research in Australia, there was scope for the NSW Government to fund research projects if financial support from the NHMRC was not forthcoming and that in fact there are some advantages to non-NHMRC funding:

> The most important of all funding bodies in Australia is the National Health and Medical Research Council…Personally I would prefer a kind of mixed funding arrangement whereby perhaps the State Government would announce a tender for conducting such a randomised controlled trial. Indeed, in another area of work, which is brief intervention, I received substantial funding which would be equivalent to about $300,000 to $400,000 a year for about 10 years from what was then the New South Wales Drug Offensive Council. That was of tremendous value particularly for the subsequent work on brief and electronic interventions. We would not have had that opportunity had we been reliant on NHMRC funding only. So I would suggest some direct funding using the mechanism of a scientific advisory group to appraise the proposals and I think you could be rewarded by some world-leading research.[189]

Committee comment

4.94 The evidence presented to this Inquiry clearly demonstrates that opioid dependence is a significant health problem requiring effective pharmacological treatment. Effective treatment

187 Professor Saunders, Evidence, 10 April 2013, p 40.

188 Mr McGrath, Evidence, 27 May 2013, p 22.

189 Professor Saunders, Evidence, 10 April 2013, p 40.

matters because the lives of opioid dependent individuals can be improved, indeed lives can be saved, and positive public health outcomes can be achieved.

4.95 The Committee notes the broad support for the effectiveness of opioid substitution treatment including its positive outcomes in relation to improvements in patient's social, personal and physical functioning.

4.96 The Committee was advised by the Australian National Council on Drugs that naloxone is a safe and effective intervention for preventing opioid overdose and that it supports the expansion of naloxone availability and training to relevant healthcare professionals to treat opioid overdose.

Recommendation 3

That the NSW Government consider expanding the availability of naloxone and the provision of training to relevant healthcare professionals to prevent opioid overdose fatalities.

4.97 In regard to naltrexone implants, we note the findings of the NHMRC that at this stage in Australia they are an experimental product and require a randomised control trial before their efficacy can be assessed. We recognise that some of the more recent international literature, such as the 2012 Kunøe paper, shows that this form of treatment has promise. However, within the Australian context the requisite research and regulatory work to enable the broad distribution of naltrexone implants is yet to be undertaken, as demonstrated by the fact the TGA has not approved naltrexone implants for use.

4.98 Based on the evidence presented by Dr O'Neil we note that he intends for the TGA to review his naltrexone implants in mid-2014. We note the advice provided by the TGA stating that it normally takes 11 months to make a decision on whether or not a new medicine is approved. Therefore if Dr O'Neil is successful in registering his naltrexone implants, they would be available to the wider market in mid-2015 at the earliest.

4.99 Given that naltrexone implants are currently unlicensed for treatment in Australia, the Committee at this time cannot support the provisions in the *Drug and Alcohol Treatment Amendment (Rehabilitation of Persons with Severe Dependence) Bill 2012* that would legally provide for their use in New South Wales. If however Dr O'Neil is successful in registering his naltrexone implant it may be possible to revisit these provisions in the Bill.

4.100 We note the comments of Professor Lintzeris that there is no 'magic bullet' for treating opioid dependence, and the consensus among practitioners in this field that they would welcome more treatments options. The Committee agrees that it would be beneficial to expand the treatment options available to treat opioid dependence and supports the NHMRC position that a randomised control trial be undertaken before the efficacy of naltrexone implants can be assessed.

4.101 Therefore we recommend that if naltrexone implants are approved by the TGA that a randomised control trial be undertaken comparing naltrexone implants with other licensed treatments used to treat opioid dependence.

4.102 We note the evidence of Mr McGrath that the funding of clinical research is primarily a Commonwealth responsibility. We therefore believe that the NHMRC is best placed to fund comparative trial of naltrexone implants, provided of course that the application to conduct the trial meets the rigorous standards required by the NHMRC. We note the evidence of Professors Lintzeris and Saunders, and a number of the other researchers, epidemiologists and addiction medicine practitioners that the Committee consulted during the course of the Inquiry, that they would support such a trial in order to expand the number of treatment options available to treat opioid dependence.

4.103 The Committee also notes that in the 2011-2012 and 2012-2013 budgets, the NSW Ministry for Health did not allocate any funds for clinical trials.

4.104 In the event that an application to fund a comparative trial of naltrexone implants is not successful in securing funding from the NHMRC, we recommend that funding instead be provided by the NSW Government. Although we recognise that New South Wales funds very few clinical trials, we believe that the funding would be warranted given the substantial health, social and economic costs of opioid dependence which are disproportionate to the prevalence of use. We further note the evidence that the research findings would be internationally significant.

4.105 Therefore the Committee's Recommendation 4 is:

'That if naltrexone implants are approved for use by the Therapeutic Goods Administration, that the NSW Government fund a randomised control trial comparing naltrexone implants with other licensed treatments used to treat opioid dependence, if such a trial is not successful in securing funding from the National Health and Medical Research Council.

The trial must be conducted to the highest standards and be developed in consultation with experts from the fields of addiction and public health medicine, and that participation in such a trial by other Australian States and international jurisdictions be encouraged.'

Chapter 5 Involuntary treatment

This Chapter examines the operation of the State's system of involuntary drug and alcohol treatment for individuals with severe substance dependence. It does so by detailing the operation of *Drug and Alcohol Treatment Act 2007* and by considering the reforms proposed in the *Drug and Alcohol Treatment (Rehabilitation of Persons with Severe Substance Dependence) Bill 2012*.

The Chapter also considers some of the arguments for and against involuntary treatment, with reference to the applicability of involuntary treatment; the high costs of providing involuntary treatment; and human rights concerns. The Chapter concludes by detailing some of the coercive drug and alcohol treatment interventions provided through the criminal justice system.

The terms involuntary treatment and mandatory treatment are used interchangeably throughout the Chapter.

Changing approaches to treatment

5.1 The legislative approach to the State's system of involuntary drug and alcohol treatment has evolved over the past decade. This section details the relevant legislative and program developments impacting upon involuntary drug and alcohol treatment in New South Wales.

Inebriates Act 1912

5.2 There has been a legislative basis for the involuntary treatment of people with severe drug and alcohol dependence in New South Wales since 1900. The *Inebriates Act 1912* (originally passed in 1900, amended in 1909 and consolidated in 1912) was developed to provide for the care, control and treatment of 'an inebriate', namely 'a person who habitually uses intoxicating liquor or intoxicating narcotic drugs to excess'.[190]

5.3 For close to a century the *Inebriates Act 1912* was the primary mechanism through which individuals with severe forms of substance dependence could be made forcibly abstinent from alcohol and other drugs and compelled to undergo medical intervention. That intervention involved a presiding judicial officer referring the individual to a mental health facility for a significant period of time (sometimes up a year) to undergo treatment.[191]

5.4 The Committee heard that the *Inebriates Act 1912* was developed in an era when the medical and social understanding of and attitude to addiction differed to the present day. As time passed, numerous concerns regarding civil liberties, social responsibility, legal and treatment outcomes were raised relating to the effective operation of the *Inebriates Act 1912*. Despite these concerns the *Inebriates Act 1912* remained on the statute books with little amendment for over a century.

5.5 Mr David McGrath, Director, Mental Health and Drug and Programs, NSW Ministry for Health, informed the Committee of the limitations of the *Inebriates Act 1912* by stating:

190 *Inebriates Act 1912,* Part 1, Schedule 2.

191 Mr David McGrath, Director, Mental Health and Drug and Programs, NSW Ministry for Health, Evidence, 27 May 2013, p 27.

> ...the treatment [inebriates] received was limited because mental health facilities often were not the best place to treat somebody with a drug and alcohol problem. They were often there for much longer than was necessary to treat their problem and their treatment plan was actually prepared by the presiding judicial officer, generally the magistrate so it was not an effective regime for actually undertaking intervention with somebody with a drug and alcohol problem...[192]

5.6 In 2003, the New South Wales Summit on Alcohol Abuse recommended that the contemporary social, legal, medical and ethical implications of the *Inebriates Act 1912* be reviewed. This review was undertaken by the Legislative Council Standing Committee on Social Issues which concluded that the *Inebriates Act 1912* was fundamentally flawed and recommended its immediate repeal.[193]

5.7 In response to the Standing Committee on Social Issues' report, the Government committed to establishing a system of short-term involuntary care to protect the health and safety of people with severe substance dependence, who have experienced, or are at risk of serious harm and whose decision-making capacity is considered to be compromised due to their substance use.[194]

5.8 The response was formalised through the *Drug and Alcohol Treatment Act 2007*.

Drug and Alcohol Treatment Act 2007

5.9 The *Drug and Alcohol Treatment Act 2007* seeks to provide for the health and safety of persons with severe substance dependence through involuntary care, treatment and stabilisation.[195] The Act defines severe substance dependence as where a person has a tolerance to a substance; shows withdrawal symptoms when the person stops using, or reduces the level of use of, the substance; and has lost the capacity to make decisions about their substance use and personal welfare due primarily to their dependence on the substance.[196]

5.10 The principle reform of the *Drug and Alcohol Treatment Act 2007* was the establishment of the Involuntary Drug and Alcohol Treatment Program (IDAT) Program, a therapeutic framework for the involuntary treatment of severe substance dependence.[197]

5.11 Through the IDAT Program an individual, eligible for placement into involuntary care for severe substance dependence, receives inpatient treatment at a treatment centre, staffed by specialist medical and clinical professionals, for an initial period of up to 28 days.[198]

5.12 Treatment firstly involves the acute medical management of substance withdrawal and, if required, referrals to other specialist medical services are also made. Following the withdrawal

192 Mr McGrath, Evidence, 27 May 2013, p 26.

193 Submission 51, NSW Ministry for Health, p 17.

194 Submission 51, p 17.

195 *Drug and Alcohol Treatment Act 2007,* Part 1, Section 3.

196 *Drug and Alcohol Treatment Act 2007,* Part 1, Section 5.

197 Tabled document, Mental Health & Drug & Alcohol Services, Greater Western Area Health Service, *Information for the Non Government Sector on the Involuntary Drug and Alcohol Treatment Program.*

198 Submission 51, p 17.

phase inpatients are provided a range of supportive interventions, including counselling, nursing, psychology, social work, occupational and diversional therapy to address the causes of consequences of substance abuse.[199]

5.13 During an individual's inpatient stay a treatment plan for voluntary aftercare is developed to assist them to continue their recovery.[200] The objective of the voluntary treatment aftercare plan is to provide the support required to encourage continued abstinence and to manage the risks of relapse after the individual has been discharged. Unlike the involuntary inpatient withdrawal component, the aftercare phase is not compulsory, and individuals are not legislatively compelled to continue in treatment once they have left the inpatient treatment centre.[201]

5.14 Individuals may only be referred to the IDAT Program by medical practitioners – this is to ensure that involuntary treatment is primarily a clinical decision.[202] The referral process involves a medical practitioner asking an accredited medical practitioner to assess an individual for involuntary treatment. If an individual is deemed suitable for involuntary treatment they are issued a dependency certificate which is subject to the following criteria:

- the person has a severe substance dependence;
- care, treatment or control of the person is necessary to protect the person from serious harm;
- the person is likely to benefit from treatment for his or her substance dependence but has refused treatment; and
- no other appropriate and less restrictive means for dealing with the person are reasonably available.[203]

5.15 The Committee was informed that in effect, an individual would only meet the criteria for severe substance dependence in the most extreme cases.[204]

5.16 If an individual refuses to undergo an assessment, a referrer can apply to a magistrate for permission to conduct an involuntary assessment, which can include a NSW Police escort to an IDAT Program treatment centre.[205]

5.17 Once a dependent individual has been detained and a dependency certificate has been issued, the accredited medical practitioner must provide the individual an oral explanation and a written statement of their legal rights and other entitlements under the *Drug and Alcohol*

199 Tabled document, *Information for the Non Government Sector on the Involuntary Drug and Alcohol Treatment Program.*

200 Submission 51, NSW Ministry for Health, p 17.

201 Tabled document, *Information for the Non Government Sector on the Involuntary Drug and Alcohol Treatment Program.*

202 Tabled document, *Information for the Non Government Sector on the Involuntary Drug and Alcohol Treatment Program.*

203 *Drug and Alcohol Treatment Act 2007,* Part 2, Section 9.

204 Tabled document, Mental Health & Drug & Alcohol Services, Greater Western Area Health Service, *Involuntary Drug and Alcohol Treatment Program – Information for Medical Practitioners.*

205 Submission 51, pp 18.

Treatment Act 2007. Further, the accredited medical practitioner is also required to present the individual before a Magistrate to allow a review of the dependency certificate. [206]

5.18 The *Drug and Alcohol Treatment Act 2007* also allows a Magistrate to extend the initial detention period for up to three months on application by an accredited medical practitioner. Appeals regarding the issue and extension of dependency certificates can be made to the Administrative Decisions Tribunal.[207]

5.19 In evidence, Mr McGrath informed the Committee that he believed the *Drug and Alcohol Treatment Act 2007* was an improvement on the *Inebriates Act 1912*, because it provided a response better suited to the needs of individuals with severe substance dependence:

> The three benefits of that particular Act over the Inebriates Act are the corollaries of the three I mentioned a minute ago, which are the treatment of plans done by a medical officer so it is done by somebody who understands the addiction sphere...So instead of the magistrate making the treatment plan, the treatment plan is done by somebody who is actually trained for that purpose. The length of the order is generally from two to four weeks, which is appropriate for getting an inpatient intervention withdrawal underway and then followed up with appropriate community and psychosocial supports and the third benefit is the treatment is provided in a drug and alcohol unit with staff who are trained to provide drug and alcohol interventions rather than in an acute inpatient unit for mental health.[208]

5.20 In its submission, the NSW Ministry for Health advised the Committee that IDAT Program was initially introduced via a trial conducted over two years (2009-2011) at the Nepean Hospital, Centre for Addiction Medicine. The trial, which was subject to a KPMG evaluation, resulted in the following outcomes:

- Medical conditions and physical health were properly assessed and addressed.
- Extended periods of abstinence were achieved.
- Social relationships, in particular with family, improved during the period of involuntary treatment.
- Improved mental health through enforced abstinence, provision of drug and alcohol services and initiation to appropriate mental health care.
- 80 per cent of inpatients continued into voluntary aftercare at the end of their involuntary treatment period.
- The majority of inpatients that progressed into voluntary aftercare were observed to have better general, physical and mental health than in the six months prior to their period of involuntary treatment.[209]

5.21 In addition, the evaluation found that the *Drug and Alcohol Treatment Act 2007* provided effective safeguards to ensure that the rights and dignities of people with severe substance dependence were recognised and protected.[210]

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206 *Drug and Alcohol Treatment Act 2007*, sections 14, 16, 34, 35 and 36

207 *Drug and Alcohol Treatment Act 2007*, sections 14, 16, 34, 35 and 36.

208 Mr McGrath, Evidence, 27 May 2013, p 26.

209 Submission 51, pp 18-19.

5.22 In September 2012, the Government, subsequent to the positive findings of the KPMG evaluation of the Nepean trial, announced the establishment of two permanent IDAT Program treatment centres at the Royal North Shore Hospital, St Leonards, Sydney and Bloomfield Hospital, Orange.[211]

5.23 The establishment of the two permanent IDAT Program centres led to the repeal of the *Inebriates Act 2012* on 28 February 2013.[212]

5.24 As part of its evidence gathering activities, the Committee travelled to the IDAT Program centre Bloomfield Hospital, Orange on 14 May 2013 and held discussions with the staff operating and managing the centre. Committee members also met some of the inpatients undergoing involuntary inpatient withdrawal. The site visit provided the Committee the opportunity to gauge firsthand the operation of the IDAT Program.

Changes proposed in the Drug and Alcohol Treatment Amendment (Rehabilitation of Persons with Severe Substance Dependence) Bill 2012

5.25 The *Drug and Alcohol Treatment Amendment (Rehabilitation of Persons with Severe Substance Dependence) Bill 2012,* was introduced into the NSW Parliament by Revd. the Hon Fred Nile on 25 October 2012.[213] The bill seeks to amend the *Drug and Alcohol Treatment Act 2007* to further provide for the involuntary rehabilitative care of persons with severe substance dependence.[214]

5.26 The proposed reforms within the *Drug and Alcohol Treatment Amendment (Rehabilitation of Persons with Severe Substance Dependence) Bill 2012* that could impact on the operation of the IDAT Program include:

- Broadening the scope of persons eligible to request that a person with suspected severe substance dependence undergo medical assessment to include social workers, police officers, psychologists and other persons involved in delivering services to individuals with severe substance dependence.
- Providing for an alternative to involuntary treatment. Instead the dependent person would have the option of choosing an out-patient treatment program that includes having naltrexone implanted under their skin and undergoing counselling. Naltrexone implants are considered in Chapter 4.
- Increasing the maximum time for which a person may be detained for treatment from 28 days to 90 days and removing the ability to extend that time.
- Providing for the aftercare of persons who were formerly detained or treated, which may involve a second period of involuntary treatment if substance use continues.

210 Submission 51, p 19.

211 Submission 51, pp 19.

212 Schedule 1.13 to the *Courts and Other Legislation Further Amendment Act 2013 No 1.*

213 *LC Debates* (25/10/2012) 16480.

214 *Drug and Alcohol Treatment Amendment (Rehabilitation of Persons with Severe Substance Dependence) Bill 2012,* explanatory note.

- Applying the *Drug and Alcohol Treatment Act 2007* to any person 16 years or older. At present, the Act only applies to persons aged 18 and over.[215]

5.27 The Inquiry received limited evidence concerning the reforms proposed in the *Drug and Alcohol Treatment Amendment (Rehabilitation of Persons with Severe Substance Dependence) Bill 2012* relevant to involuntary treatment. Much of the evidence focused instead on some of the broader arguments for and against involuntary treatment – those arguments will be considered in greater detail later in the Chapter.

5.28 One argument made in response to the *Drug and Alcohol Treatment Amendment (Rehabilitation of Persons with Severe Substance Dependence) Bill 2012* was that any expansion of the parameters under which involuntary treatment is provided should be approached with caution due to there being a limited evidence base to support any changes. For example, the Australasian Professional Society on Alcohol and other Drugs, a multidisciplinary body for professionals involved in the alcohol and other drug field, argued:

> The evidence base for the long-term effectiveness of involuntary treatment is limited and has not been established by controlled clinical trials...Any widening of powers of people able to refer under this act therefore requires very cautious consideration to ensure adherence to an ethical process based in good medical treatment of addictions.[216]

5.29 The Hunter New England Local Health District, Drug and Alcohol Clinical Services submission similarly noted that the evidence base for involuntary treatment is limited, and also argued that if the scope of those who could refer individuals into involuntary treatment was broadened this may lead to a broadening of the scope of people being detained:

> The evidence base for the long-term effectiveness of involuntary treatment is limited…there is potential risk by broadening the scope of who can refer under this act. That is, the risk of involuntary detention of those with drug and alcohol problems may expand under the very small scope of who may be ethically detained – those who are at immediate risk of harm to themselves by drug and alcohol use and those for whom not enforcing sobriety or abstinence for prolonged periods of time will definitely result in loss of life in the short term.[217]

5.30 Another risk concerning the broadening of the referral process proposed in the *Drug and Alcohol Treatment Amendment (Rehabilitation of Persons with Severe Substance Dependence)*, was identified by the South Eastern Sydney Local Health District, who argued it may replicate a negative outcome the *Inebriates Act 1912* which saw homeless and Indigenous people disproportionality over-represented amongst those detained for involuntary drug and alcohol treatment.[218]

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215 *Drug and Alcohol Treatment Amendment (Rehabilitation of Persons with Severe Substance Dependence) Bill 2012,* explanatory note.

216 Submission 10, Australasian Professional Society on Alcohol and other Drugs, p 21.

217 Submission 29, the Hunter New England Local Health District, Drug and Alcohol Clinical Services, p 10.

218 Submission 42, South Eastern Sydney Local Health District, p 9.

5.31 The St Vincent's Hospital, Inner City Health Program, Alcohol & Drug Service expressed doubts regarding the proposed application of involuntary treatment for people aged 16 to 18 years, stating:

> It is unlikely that people under the age of 18 would meet the criteria for sustained and entrenched dependence. An integrated treatment approach tailored to young people is preferred.[219]

5.32 In its submission, the Western NSW Local Health District, Mental Health and Drug & Alcohol Services, the Health District for responsible for managing the IDAT Program centre at Bloomfield Hospital Orange, also intimated that applying the *Drug and Alcohol Treatment Act 2007* to individuals aged 18 and under would be inappropriate. Firstly, because it would potentially expose minors to inappropriate influences; and secondly, because the IDAT Program centres were not appropriately resourced. The submission stated:

- contact with older clients may place them at risk both of harm, by consorting with inappropriate influences at an age when they may be easily influenced,
- the staff in the Units will not have the appropriate skills or experience to adequately treat people under 18, as this is a specialist field,
- the programs in the Units will not be suitable for both older and under 18 age groups at the same time so will require more resources for separate programs.[220]

5.33 However, Wesley Mission argued in favour of the proposed reforms and, stated that strong interventions to assist people with severe substance dependence were a more palatable outcome than incarceration given:

> …the progressive nature of drug and alcohol dependencies often lead[s] to custodial sentences which can further entrench the degenerative, downward spiral of criminal activities in an attempt to maintain an addiction.[221]

5.34 Wesley Mission also supported of the proposal in the *Drug and Alcohol Treatment Amendment (Rehabilitation of Persons with Severe Substance Dependence) Bill 2012* to increase the maximum time for which a person may be detained for treatment with Professor John Saunders, Drug and Alcohol Program Director, Wesley Hospital Kogarah, stating:

> With regard to the current Act, it provides treatment initially for one month on a compulsory basis and it can be extended, as you will appreciate, for two more periods—so a maximum of three months. That does strike me as being a rather short period of time for many people because some forms of brain damage and the mental disorders require prolonged abstinence from the substance for people to experience significant recovery. It is not something that can be achieved in a month...I would urge you to consider whether the present Act has a sufficient length of time for compulsory treatment...I think the present Act could be much more helpful to a greater number of people for a greater length of time than it is at the moment.[222]

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219 Submission 28, St Vincent's Hospital, Inner City Health Program, Alcohol & Drug Service, p 6.

220 Submission 54, Western NSW Local Health District, Mental Health and Drug & Alcohol Services, p 2.

221 Submission 49, Wesley Mission, p 14.

222 Professor John Saunders, Drug and Alcohol Program Director, Wesley Hospital Kogarah, Evidence, 10 April 2013, p 45.

5.35 A number of other Inquiry participants also expressed their broad support for the reforms proposed in the *Drug and Alcohol Treatment Amendment (Rehabilitation of Persons with Severe Substance Dependence) Bill 2012*. This included FamilyVoice Australia, the Salvation Army Recovery Services and the Drug Advisory Council of Australia.[223]

5.36 The NSW Ministry for Health did not directly address the proposed reforms in the *Drug and Alcohol Treatment Amendment (Rehabilitation of Persons with Severe Substance Dependence) Bill 2012*. The Ministry did, however, note that the involuntary treatment program being delivered within its jurisdiction had only been made permanent the year previous and that the establishment of the two permanent IDAT Program centres was based upon the favourable outcomes of an evaluation undertaken into the initial trial conducted at the Nepean Hospital. The Ministry additionally indicated that it would also be closely monitoring future outcomes.[224]

5.37 The Western NSW Local Health District, Mental Health and Drug & Alcohol Services, similarly stressed the importance of monitoring outcomes, and further called for funding to be allocated to undertake a review of the IDAT Program: 'as the IDAT Program is a new initiative, funding to undertake an external evaluation of the IDAT Program to ensure informed future directions of the Program is imperative'.[225]

Committee comment

5.38 The Committee notes that it took a period of eight years to develop the State's current system of involuntary treatment for individuals with severe substance dependence. Consideration of a new approach was the focus of the 2003 Legislative Council Standing Committee on Social Issues Inquiry into the *Inebriates Act 1912*, and it was not until September 2012 that the two IDAT Program centres became permanent. On balance, the weight of evidence presented to the Committee, concerning the reforms proposed in the *Drug and Alcohol Treatment Amendment (Rehabilitation of Persons with Severe Substance Dependence) Bill 2012* advocated caution. In this context, the Committee believes that it is too early to make any significant changes to the operation of the IDAT Program, as proposed in the Bill.

5.39 The Committee supports the current approach to involuntary treatment for severe substance dependence, under which treatment is delivered to a small cohort of the most at risk individuals. That is individuals who are at immediate risk of serious harm due to their drug and alcohol use, have lost the ability to make rational decisions relating to their wellbeing and for whom the likely outcome is death or severe impairment. Accordingly, the Committee supports the current legislation under which only medical practitioners are eligible to make referrals.

223 Submission 5, Family Voice, p 10, Submission 26, the Salvation Army, p 5, and Submission 9, the Drug Advisory Council of Australia, p 3..

224 Mr McGrath, Evidence, 27 May 2013, pp 26-27.

225 Submission 54, p 1.

Arguments for and against involuntary treatment

5.40 The evidence presented to the Inquiry concerning involuntary treatment, namely the differences between it and coercive treatment; its applicability; cost issues; and human rights concerns are considered below.

Involuntary treatment as opposed to coercive treatment

5.41 In considering the arguments for and against involuntary treatment it is important to note the evidence highlighting the distinctions between involuntary treatment and coercive treatment.

5.42 Mr McGrath informed the Committee that involuntary treatment refers to the State taking responsibility for an individual's consent to undertake treatment; that is where the State compels an individual to undertake treatment. He indicated that involuntary treatment is best illustrated by the Involuntary Drug and Alcohol Treatment Program provided for by the *Drug and Alcohol Treatment Act 2007*.[226]

5.43 Coercive treatment applies where an individual consents to undertaking treatment but there is an implied negative consequence if they refuse to participate. Coercive treatment is typically delivered through the criminal justice system. An example of coercive treatment can be provided by the Magistrates Early Referral into Treatment Program, which is a 'pre-plea' drug diversion treatment program for defendants charged with offences linked to their substance abuse. While defendants are not required to enter the program, there is an implied contract that if they enter the program and they do well, their court proceedings might be more positive.[227]

5.44 Mr Steven Ling, member, Drug and Alcohol Nurses of Australasia Incorporated, highlighted the distinctions between involuntary treatment and coercive treatment and argued that the latter was supported by a more robust evidence base:

> Involuntary treatment is not to be confused with evidence-based approaches such as the Magistrates Early Referral into Treatment Program or the drug court programs, which have been studied and proven to be efficacious and both of which retain a measure of choice on the part of the individual involved—that is, they can choose to undergo treatment or to be incarcerated. As I understand...involuntary treatment would involve no choice for the patient.[228]

5.45 The evidence to the Inquiry focused on involuntary treatment rather than coercive treatment. However, some matters regarding coercive treatment are considered in the final section of this Chapter.

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226 Mr McGrath, Evidence, 27 May 2013, p 26.

227 Mr McGrath, Evidence, 27 May 2013, p 27.

228 Mr Steven Ling, Member, Drug and Alcohol Nurses of Australasia Incorporated, Evidence, 10 April 2013, p 10.

When is involuntary treatment appropriate?

5.46 Earlier in the Chapter the legislative provisions under which involuntary treatment may be delivered were identified and considered, including the stipulation in the *Drug and Alcohol Treatment Act 2007* that involuntary treatment for severe substance dependence can be only delivered in the most extreme cases.

5.47 In the evidence presented to the Committee, many of those a made case for involuntary treatment did so with the caveat that it only be used sparingly and in instances where there is a strong likelihood that an individual's severe substance dependence may result in death. For instance, Mr Gerald Byrne, Clinical Director, Recovery Services, The Salvation Army argued:

> As far as involuntary treatment is concerned, we support that given certain parameters. We were the after-care service provider to the involuntary care treatment trial that happened at Nepean where dependency certificates were issued for people to go into Nepean Hospital to be detoxified. Once that dependency certificate expired we picked them up. It worked quite well; we had a 90 per cent retention rate on our after-care service, and where people fell over we had direct entry back into health care services for them. The parameters for that were around people who were in imminent danger of serious illness or indeed death. We had a couple of people on the doorstep of end-stage liver disease who were still drinking. In that situation it was a good thing and it worked.[229]

5.48 In evidence, Professor Adrian Dunlop, Immediate Past President, Australasian Professional Society on Alcohol & other Drugs, a multidisciplinary body for professionals involved in the alcohol and other drug field, speaking to his experience in treating patients with severe substance dependence via involuntary means argued that it was useful but only in a very small number of situations:

> Involuntary treatment essentially should be always reserved for situations when it would appear that the person's continued use of a substance is going to result in their death. That is, I think, the only situation... It is a very narrow situation. There is not a robust evidence base suggesting that it is effective beyond those situations. I have used involuntary treatment with patients. I have a good understanding of its role. I have a good understanding of the effect of taking away somebody's liberty to essentially dry them out and to get them to think about and reflect about their use of substances. It has a limited role. It has got a very important role, but it has a limited role.[230]

5.49 The Alcohol and other Drugs Council of Australia (ADCA), a national non-government peak body representing the interests of the Australian alcohol and other drugs sector, similarly argued that involuntary treatment should only be used in instances of imminent and grave harm when an individual lacks the capacity to make reasoned decisions. ADCA added that as an individual's situation improves any application of involuntary treatment must be reviewed:

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229 Mr Gerald Byrne, Clinical Director, Recovery Services, The Salvation Army, Evidence, 10 April 2103, p 4.

230 Professor Adrian Dunlop, Immediate Past President, the Australasian Professional Society on Alcohol and other Drugs, Evidence, 10 April 2013, p 9.

> ADCA does not support the use of mandatory treatment except in extreme circumstances where a person's capacity to make decisions is diminished and they are at risk of injuring themselves or someone else. Note that diminished capacity to make decisions may change during treatment and should be reassessed over time. Further, involuntary treatment should continue only for the minimum time needed to reestablish capacity and safety for the individual.[231]

High cost of involuntary treatment

5.50 The Inquiry received evidence that highlighted the expensive nature of involuntary treatment and questioned whether it is an appropriate treatment option given limited resources. A question raised by some Inquiry participants, was that in the absence of an evidence base through which to assess its efficacy, should involuntary treatment be used when there are other treatment options available. For instance, ADCA argued that:

> Evidence based approaches are critical for success in dealing with the use of illicit drugs and the growing problem of pharmaceutical misuse. The money spent on establishing and running and involuntary detoxification and rehabilitation programs would be better spent on providing services to the community that are known to be effective and address fundamental issues that contribute to alcohol and drug related harm. Success in this area would lead to fewer people becoming severely dependent.[232]

5.51 In evidence, Professor Nadine Ezard, Clinical Director, St Vincent's Hospital, Inner City Health Program, Alcohol & Drug Service expressed a similar view and argued that involuntary treatment is an expensive treatment option without a robust evidence base:

> ..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...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.[233]

5.52 The Australia Drug Law Reform Foundation argued that involuntary treatment is expensive and likely to be delivered at the cost of not providing less expensive voluntary treatment options to a larger number of people:

> Compulsory treatment is not more effective than voluntary treatment but it is more expensive…Expensive and cost ineffective involuntary treatment for a small number of possibly intractable people is likely to be at the expense of less expensive, and more likely cost effective treatment for a larger number of people with less severe and more tractable problems.[234]

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231 Submission 46, the Alcohol and other Australian Drugs Council of Australia, p 9.

232 Submission 46, p 9.

233 Professor Nadine Ezard, Clinical Director, St Vincent's Hospital, Inner City Health Program, Alcohol & Drug Service, Evidence, 4 April 2013, p 63.

234 Submission 37, Australia Drug Law Reform Foundation, pp 13-14.

5.53 Another issue raised was the question of whether involuntary treatment diminishes the capacity for treatment to be delivered flexibly and in a manner that provides an individual, with severe substance dependence, a degree of ownership over their problem. In evidence, Ms Nichole Sullivan, Clinical Practice Leader, Youth AOD Services, Mission Australia stated:

> I agree [that] some people require involuntary treatment in order to preserve their life. We support that. Our thrust and philosophy is that people should have as much ability to have their voice heard in treatment as possible and that there is some flexibility within the system to allow them to have choice.[235]

5.54 Mr McGrath indicated that the NSW Ministry for Health holds a similar view. He informed the Committee that involuntary treatment should only apply in extreme circumstances, and stressed that a willingness to engage with treatment usually led to better outcomes:

> … there is generally a view that maintaining mandatory treatment just for the people at the tip of the pyramid who are clearly unable to consent to treatment in an appropriate way or who are clearly at risk of serious health consequences is probably the best place to limit it to.
>
> If you start to bring that down to those people who still have the capacity to make determinations about their decision-making and they are participating without any voluntary component to what they do within the program, you have a tendency not to get as positive an outcome, and that is seen in drug and alcohol treatment at all levels where people are coerced by family members, for instance, into programs; they tend to generally do poorer in treatment or if they are coerced by an employer they tend to do poorer in treatment than those people who voluntarily enter into the program.[236]

Human rights concerns

5.55 The Inquiry also received evidence highlighting some of the ethical and human rights concerns associated with involuntary treatment. For example, the Australasian Professional Society on Alcohol and other Drugs submission brought to the Committee's attention a United Nations Office of Drugs and Crime (UNODC) discussion paper considering the ethical framework for the application of involuntary treatment. The UNODC paper states:

> …drug dependence treatment without the consent of the patient should only be considered a short term option of last resort in some acute emergency situations and needs to follow the same ethical and scientific standards as voluntary treatment. Human rights violations carried out in the name of 'treatment' are not compliant with this approach.[237]

5.56 In evidence, Dr Marianne Jauncey, Medical Director, Sydney Medically Supervised Injecting Centre, equated involuntary treatment to a violation human rights:

> …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

235 Ms Nichole Sullivan, Clinical Practice Leader, Youth AOD Services, Mission Australia, Evidence, 3 April 2013, p 31.

236 Mr McGrath, Evidence, 27 May 2013, p 28.

237 Submission 10, p 21.

> 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 forced 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.[238]

5.57 The Australia Drug Law Reform Foundation submission expressed similar concerns for the rights of people with severe substance dependence, stating that involuntary treatment 'reduces the civil liberties of people with alcohol and drug problems and has a history of being often abused by authorities'.[239]

5.58 Conversely, Professor Saunders argued that people with severe addiction disorders have 'virtually no human rights' due to the impacts of their addiction and, that involuntary treatment therefore does not diminish their human rights:

> The old Inebriates Act was criticised because it was considered to be an affront to people's human rights because of its compulsory and coercive nature. My approach was that people in the situation—certainly that I saw—had virtually no human rights because of the desperate state of their addiction and their brain damage and mental and physical disorders. So to me the Inebriates Act provided benefit rather than being an affront to human rights.[240]

5.59 Professor Saunders also identified the difficulties in considering the ethical and human rights issues relevant to involuntary treatment for severe substance dependence, stating 'this is a very tricky issue and I am glad that I do not have to make any decisions…'[241]

Committee comment

5.60 Notwithstanding the difficult ethical questions regarding the use of involuntary treatment, the Committee notes the evidence presented to the Inquiry that involuntary treatment, supported by adequate safeguards, can be justified in limited circumstances. That is, where the likely outcome of an individual's substance dependence is severe impairment or death. It is for this reason that the Committee supports the involuntary treatment model provided for by the *Drug and Alcohol Treatment Act 2007*.

5.61 However, the Committee also acknowledges the concerns regarding the effectiveness of involuntary treatment for individuals with severe substance dependence, in light of there being a limited evidence base for this form of treatment. The Committee therefore supports timely evaluation of the efficacy of the involuntary treatment model once the IDAT program has been operating for a reasonable period of time, and ongoing evaluation thereafter.

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238 Dr Marianne Jauncey, Medical Director, Sydney Medically Supervised Injecting Centre, Evidence, 4 April 2013, p 5.

239 Submission 37, Australia Drug Law Reform Foundation, p 13.

240 Professor Saunders, Evidence, 10 April 2013, p 45.

241 Professor Saunders, Evidence, 10 April 2013, p 45.

Treatment through the criminal justice system

5.62 Evidence was presented to the Inquiry showing that many individuals who interact with the criminal justice system have substance abuse problems. In 2010 nationally, 66 per cent of the prison population had admitted to using illicit drugs in the twelve months prior to incarceration.[242] Additionally, during 2008, 65 per cent of a national sample of Australian police detainees tested positive for at least one illicit drug.[243] Given these statistics, a number of programs exist within the criminal justice system that seek to treatment those offenders with substance abuse issues.[244]

Objectives

5.63 Treatment of offenders who use illicit drugs occurs throughout the various stages of the criminal justice system via coercive means, namely implied negative consequences for refusing to participate in drug treatment programs. Defendants can be diverted into treatment prior to entering a plea, as part of bail conditions, after conviction, or whilst on parole. The Department and Attorney General and Justice is primarily responsible for delivering those interventions and a suite of policies and programs exist within the portfolio to assist those offenders whose substance abuse issues are intrinsically linked to their offending behavior.[245]

5.64 The principle aim of drug and alcohol treatment programs within the criminal justice system is to divert substance abusers from traditional forms of incarceration into treatment in order to improve health and social outcomes and to reduce reoffending.[246] To do this, Dr Anne Marie Martin, Assistant Commissioner, Offender Management and Policy, Corrective Services asserted that criminal justice treatment programs must embody three core principles, namely:

> Having the right intensity, targeting the right areas relating to risk of reoffending and also ensuring the programs address any response issues such as the people engaged in those programs can understand the program, that it works to their learning styles and it overcomes any barriers in that way.[247]

5.65 Regarding program evaluation, the Department of Attorney General and Justice advised the Committee that its key focus is to consider the impact of programs relative to offenders resuming the taking of illicit substances and recidivism.[248]

Treatment programs

5.66 The criminal justice system drug and alcohol treatment programs, most commonly referred to in the Inquiry, were the Magistrates Early Referral into Treatment Program (MERIT) and the

242 Submission 51, p 5.

243 Submission 52, Department of Attorney General and Justice, p 119.

244 Submission 52, p 119.

245 Submission 52, p 1.

246 Submission 51, p 3.

247 Dr Anne Marie Martin, Assistant Commissioner, Offender Management and Policy, Corrective Services, Evidence, 27 May 2013, p 46.

248 Dr Martin, Evidence, 27 May 2013, p 46.

Drug Court of NSW. The information received by the Committee regarding the delivery of these programs and the outcomes being achieved is detailed below.

The Magistrates Early Referral into Treatment Program

5.67 MERIT is a Local Court based pre-sentence diversionary program targeting defendants with illicit substance abuse problems who are motivated to participate in supervised drug treatment and rehabilitation as part of their bail conditions. To participate a defendant must meet certain criteria that will be reviewed by the Magistrate.[249]

5.68 If a defendant is eligible to participle in MERIT they are referred pre-plea. Treatment involves detoxification, pharmacotherapy programs, residential rehabilitation, individual and group counselling, case management, and welfare support and assistance. The defendant will return to court to answer their charges either upon completion or termination from the program. The Magistrate hearing the case is provided with a report detailing the defendant's participation and progress in MERIT. In sentencing, the Magistrate has discretion to consider a participant's compliance or non-compliance with MERIT.[250]

5.69 Concerning recidivism rates, the New South Wales Bureau of Crime Statistics and Research (BOCSAR) has found that those that complete MERIT reoffend at lower rates when compared to those that do not complete the program. For example, in 2008, within 12 months of exiting MERIT, 48 per cent of those that did not complete the program reappeared in court on fresh charges compared to 32.6 per cent of those that had completed the program.[251]

5.70 Regarding health outcomes, NSW Ministry for Health data indicates that in 2009, MERIT participants reported statistically significant reductions in substance dependence severity and substance usage frequency at program exit compared to program entry.[252]

The Drug Court of NSW

5.71 The Drug Court of NSW, provided for by the *Drug Court Act 1998,* is a specialist court that takes referrals from the Local and District Courts of drug offenders who are eligible and willing to participate in a Drug Court treatment program. A drug offender is a person charged with an offence to which their substance abuse has contributed. Many drug offenders have severe substance dependence issues that will likely lead to continued reoffending and imprisonment has often failed to deter them from committing crime.[253]

5.72 The Drug Court can impose compulsory drug treatment, that is, a form of custodial sentence that enables a drug offender to undertake legally coerced drug treatment provided as an alternative to incarceration.[254]

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249 Submission 52, p 88.

250 Submission 52, p 92.

251 Submission 51, p 19.

252 Submission 51, pp 19-20.

253 Submission 39, the Law Society of New South Wales, p 5.

254 Submission 52, p 9.

5.73 Each participant's Drug Court program is individually tailored with Justice Health undertaking an assessment to identify their specific needs. Treatment options including enforced abstinence, pharmacotherapy programs, case management and residential rehabilitation.[255]

5.74 Drug Court program participants receive close judicial supervision with regular progress reports given to the Court. A system of rewards and sanctions exist to encourage program participation and the achievement of success by participants. There are currently three Drug Courts located in Parramatta, Toronto and Sydney.[256] The Committee calls for consideration of a further expansion to other regional centres beyond Sydney and the Hunter.

5.75 In 2008, BOCSAR evaluated the Drug Court program and found that program participants when evaluated against non-participants were:

- 37 per cent less likely to be convicted of an offence
- 65 per cent less likely to be convicted of an offence against a person
- 35 per cent less likely to be convicted of a property offence
- 58 per cent less likely to be convicted of a drug offence.[257]

5.76 In addition, the Centre for Health Economics Research and Evaluation at the University of Technology Sydney examined the cost effectiveness of the Drug Court of NSW in 2001 and 2008. The evaluation indicated that the Drug Court program cost $16.376 million yearly and that the estimated cost of dealing with the same offenders via the conventional sanctions would be $18.134 million, resulting in the Drug Court program achieving a net saving of $1.758 million per annum.[258]

Committee comment

5.77 The Committee believes that the evidence received by this Inquiry, regarding drug and alcohol treatment for offenders, presents a case for using the criminal justice system to effect positive change for those offenders with substance abuse issues. The Committee also notes the evidence that identifies the cost savings achieved through the Drug Court program. The Committee supports all initiatives within the criminal justice system which seek to minimise offenders taking illicit substances and thereby contribute to reduced recidivism rates.

Recommendation 5

That the NSW Government consider a further expansion of the Drug Court program to other regional centres outside of Sydney and the Hunter.

255 Submission 52, pp 19-20.

256 Submission 52, p 15.

257 Submission 52, p 15.

258 Submission 52, p 15.

Chapter 6 Funding

This Chapter considers the level and adequacy of funding for drug and alcohol treatment services in New South Wales. In particular, the Chapter identifies that there are multiple sources of funding for drug and alcohol treatment and discusses the impact this has on the ability to assess the adequacy of funding levels. Also considered is the development of the National Drug and Alcohol-Clinical Care and Prevention Planning Model, developed to improve the planning and delivery of drug and alcohol treatment services. The Chapter concludes by noting examples of specific drug and alcohol treatment services requiring additional funding as identified by Inquiry participants.

Funding sources and adequacy

6.1 This section outlines the various sources through which drug and alcohol treatment services are funded in New South Wales and identifies some of the challenges regarding the evaluation of funding adequacy.

Sources

6.2 The funding for drug and alcohol treatment services in New South Wales comes from a variety of sources, namely the State and Commonwealth Governments as well as the private sector.[259]

6.3 The NSW Government funds treatment services through the State's Local Health Districts in addition to contracting out services to non-government providers. Commonwealth funding for treatment in New South Wales is administered primarily through the Substance Misuse Prevention and Service Improvement Grant Fund and the Non Government Organisation Treatment Grants Program. Private sector treatment services are delivered through a variety of means including private hospitals, private clinics and pharmacotherapy dispensaries.[260]

6.4 Professor Alison Ritter, Director of the Drug Policy Modelling Program (DPMP), a drug and alcohol policy research and practice program at the University of New South Wales, detailed the nature of this mixed funding model, highlighted its complexity and the impact on agencies navigating through the system:

> I think that analysing treatment funding is complicated because the funding is complicated. The really quick version is that the Federal Government funds agencies directly here in New South Wales through a grants program and through special purpose payments. The Federal Government also funds the New South Wales Government to provide funding to hospitals. So there is the hospital's stream of funding that the States determine the spread thereof; there are separate Federal grants; there is the State hospital funding; then there is the Pharmaceutical Benefits Scheme, and of course Medicare for medications and for primary care services; then there is direct funding by State Government to generally non-government organisations—therapeutic communities, residential rehabilitation—that bears no necessary relationship with the funding those agencies receive from the Federal Government

259 Submission 23, Drug Policy Modelling Program, p 2.

260 Submission 23, p 2.

> through the grants program; and then there is of course philanthropy and private health insurance and patient co-payment. In that quick simple map you have got about five, six or seven different funding sources and most agencies cannot distinguish what funds what. It is terrible.[261]

6.5 In their submission, the DPMP described the operational challenges for drug and alcohol treatment providers resulting from the current funding arrangements:

> …an NGO may receive some funds from the NSW government, some from the Commonwealth, income from patient co-payments and donations from the general public (and via fundraising). There is an atmosphere of funding uncertainty for [alcohol and drug] treatment services – palpable in relation to the short contract terms for funding. This often impacts negatively on retention of qualified staff.[262]

6.6 Professor Nicholas Lintzeris, Director, Drug and Alcohol Services, South Eastern Sydney Local Health District, argued that the uncoordinated funding system led to funding duplication and overlap, stating:

> 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.[263]

Adequacy

6.7 A commonly made point by Inquiry participants was that the multiple sources make it difficult to assess the adequacy of funding for drug and alcohol treatment. For instance, the National Drug and Alcohol Research Centre, a research organisation that conducts and disseminates research to increase the effectiveness of responses to alcohol and other drug related harm, argued that:

> The funding models for drug and alcohol treatment in New South Wales are less than transparent, due to multiple different funding bodies and funding arrangements. In this light, it is not possible to assess the adequacy of funding levels given the absence of accurate information about the current extent of funding.[264]

6.8 In the same way, the DPMP noted that:

> …the ability to assess whether the level of funding for [alcohol and drug] treatment is adequate resides in establishing the current extent of funding. Comparisons could then be made with funding available to other chronic, relapsing conditions (such as

261 Professor Alison Ritter, Director, Drug Policy Modelling Program, Evidence, 3 April 2013, p13.

262 Submission 23, p 2.

263 Professor Nicholas Lintzeris, Director, Drug and Alcohol Services, South Eastern Sydney Local Health District, Evidence, 4 April 2013, p 17.

264 Submission 34, National Drug and Alcohol Research Centre, p 2.

> asthma, diabetes and so on). These data on current levels of funding in New South Wales are not available.[265]

6.9 As such, some Inquiry participants, including the South Eastern Sydney Local Health District, asserted that in the absence of readily accessible information assessments, it is not possible to accurately assess the adequacy of drug and alcohol treatment funding.[266]

6.10 The St Vincent's Hospital, Inner City Health Program, Alcohol & Drug Service suggested that one of the ways in which treatment funding levels could be estimated was by comparing the burden of disease caused by drug and alcohol abuse with government expenditure on drug and alcohol services as a proportion of the health budget. [267] The burden of disease is a measure used to assess and compare the relative impact of different diseases and injuries on a population.[268]

6.11 According to the St Vincent's Hospital, Inner City Health Program, Alcohol & Drug Service the burden of disease caused by drug and alcohol abuse is 12 per cent of the total burden of disease.[269] Professor Nadine Ezard, Clinical Director, St Vincent's Hospital, Inner City Health Program, Alcohol & Drug Service, used this figure and compared it with an estimate of one per cent of government expenditure on drug and alcohol services as a proportion of the health budget by stating:

> 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.[270]

6.12 Similarly, the South Eastern Sydney Local Health District drew attention to the gap, observing that 'there is a clear disparity between expenditure on services and the need for services'.[271]

6.13 Comparing the spending of the State and Commonwealth Governments on the police, health, education, welfare and social services portfolios, to deal specifically with illicit drug problems, the Drug Policy Modelling Program informed the Committee that recent estimates 'indicated that only 17 per cent of government expenditure was directed at treatment compared to 55 per cent on law enforcement and 23 per cent on prevention'.[272]

6.14 Professor Ritter of the DPMP contended that better outcomes would be achieved if more funding was given to drug and alcohol treatment rather than to law enforcement for illicit drugs:

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265 Submission 23, p 2.

266 Submission 42, South Eastern Sydney Local Health District, p 6.

267 Submission 28, St Vincent's Hospital, Inner City Health Program, Alcohol & Drug Service, p 3.

268 Australian Institute of Health and Welfare, 'Burden of disease', accessed 15 July 2013, http://www.aihw.gov.au/burden-of-disease/.

269 Submission 28, p 3.

270 Professor Nadine Ezard, Clinical Director, St Vincent's Hospital, Inner City Health Program, Alcohol & Drug Service, Evidence, 4 April 2013, p 59.

271 Submission 42, p 6.

272 Submission 23, p 2.

> The conclusions that I would draw, based on my experience, are that governments would have a better, more successful set of outcomes if they invested in treatment, whatever that treatment might be, than if they invested in law enforcement, and that the underfunding of treatment is a substantial problem across Australia—certainly not unique to New South Wales.[273]

6.15 Anex, a non-profit organisation working to improve responses to the problems arising from substance abuse, advised the Committee of the results of a survey it had undertaken to gauge public attitudes toward government spending on measures to deal with illicit drugs.[274] The Anex survey asked respondents how they thought the government (it did not specify state or commonwealth governments) should spend its budget to address problems associated with illicit drug use. The survey found that the majority of respondents believed more investment should be allocated to education programs to prevent illicit substance abuse use and to treatment services that work to reduce or stop people from using illicit drugs.[275]

6.16 Dr Alex Wodak, President, Australia Drug Law Reform Foundation (ADLRF), presented an economic case for the redistribution of drug and alcohol resources arguing that the return on investment for treatment was much higher than that of law enforcement:

> ...the return on investment for harm reduction and drug treatment is impressive; the return on investment for drug law-enforcement is very poor. A US study found that for three different kinds of drug law enforcement, the return on investment was between 15 and 52¢ per dollar and the return on investment for $1.00 in drug treatment was $7.46.[276]

6.17 In its submission, the Salvation Army claimed that funding for drug and alcohol treatment was not commensurate with the evolving needs of those seeking treatment and that there was a need for additional investment such as for aftercare services:

> …the level of funding for drug and alcohol treatment programs in New South Wales has not kept pace with the evolving needs of the treatment population nor with the range of services, including aftercare, that need to be provided to meet those needs.[277]

6.18 The Lyndon Community, a non-government organisation providing drug and alcohol treatment services in rural and regional central west New South Wales, similarly noted in its submission, that demand for treatment services has not been matched by commensurate 'growth in [service] funding and investment in infrastructure'.[278]

6.19 The Network of Alcohol and Drug Agencies, a peak organisation for the non-government drug and alcohol sector in New South Wales, in its submission, argued that rising operational costs for non-government service providers were not being met by requisite funding increases, meaning resources have been reallocated from direct client service delivery to cover administrative, compliance and monitoring functions.[279]

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273 Professor Ritter, Evidence, 3 April 2013, p 13.

274 Submission 35, Anex, p 6.

275 Submission 35, p 6.

276 Dr Alex Wodak, President, Australia Drug Law Reform Foundation, Evidence, 3 April 2013, p 33.

277 Submission 26, the Salvation Army Recovery Services, p 3.

278 Submission 11, the Lyndon Community, p 1.

279 Submission 20, NADA (Network of Alcohol and Drug Agencies), p 8.

Committee comment

6.20 The Committee notes the evidence of some Inquiry participants that they believed there is inadequate funding for drug and alcohol treatment services, including the unmet need for residential rehabilitation programs. We also acknowledge the need for funding of drug and alcohol treatment services to be commensurate with the demand for such services.

National Drug and Alcohol-Clinical Care and Prevention Planning Model

6.21 This section details the development of the National Drug and Alcohol-Clinical Care and Prevention (DA-CCP) Planning Model and considers the responses of Inquiry participants to its impending implementation.

Development of the National Drug and Alcohol-Clinical Care and Prevention Planning Model

6.22 A number of Inquiry participants referred to the DA-CCP Planning Model, recently developed to address some the issues regarding the assessment of funding adequacy.

6.23 In 2010, the national Ministerial Council on Drug Strategy commissioned the NSW Ministry for Health to develop the DA-CCP Planning Model.[280]

6.24 The DA-CCP Planning Model has been developed to provide a population based planning model that estimates the demand for drug and alcohol health services nationally and at the state and territory level.[281]

6.25 Mr David McGrath, Director, Mental Health and Drug and Programs, NSW Ministry for Health informed the Committee that the DA-CCP Planning Model's development has been undertaken in consultation with industry experts to identify the most applicable treatment required for different drug and alcohol cohorts:

> We have brought together people from across the drug and alcohol spectrum to get agreement on the right care packages to be provided to different people against their epidemiology. We took an arbitrary population of 100,000 people for the purposes of identifying the epidemiology and using all the available research stratified them into the market niches for each of the different groups and then looked at the suite of things that they should get in order to get the appropriate outcomes that we would like. That allowed us to aggregate across all those packages the resource inputs that would be necessary to achieve those outcomes. Clearly it is a tool that is a point-in-time tool and it needs to be reviewed probably every two to five years because there will be new treatment interventions that come up.[282]

280 Submission 51, NSW Ministry for Health, pp 29-30.

281 Submission 51, pp 29-30.

282 Mr David McGrath, Director, Mental Health and Drug and Programs, NSW Ministry for Health, Evidence, 27 May 2013, p 29 – note epidemiology is the branch of medicine that deals with the study of the causes, distribution and control of disease in human populations.

6.26 In effect, the DA-CCP Planning Model will, per 100,000 people, show the likely number of people with substance addictions and then demonstrate the level of services required to effectively meet treatment demand.

6.27 According to Mr McGrath, it is hoped that the creation of a model to estimate the demand for and supply of drug and alcohol health treatment services will provide a framework to make better decisions about resource allocation.[283]

6.28 The DA-CCP Planning Model was expected to be implemented by the end of June 2013, subject to endorsement of the Inter-Governmental Council on Drugs.[284]

Response to the National Drug and Alcohol-Clinical Care and Prevention Planning Model

6.29 A number of Inquiry participants expressed support for the development and implementation of the DA-CCP Planning Model and indicated that the model had the potential to achieve positive outcomes.

6.30 For example, the Hunter New England Local Health District, Drug and Alcohol Clinical Services submission stated that the DA-CCP Planning Model could improve planning and service delivery by estimating unmet need for drug and alcohol treatment and commented on how service planners would be better informed as to where resources should be allocated:

> The Drug and Alcohol Clinical Care and Prevention Model, developed as a NSW initiative and supported by the Federal Department of Health and Ageing, will provide a robust evidence based method to estimate unmet need for drug and alcohol treatment and inform resource allocation to the addictions field. This is an ideal model for improved planning and service development in identifying unmet needs.[285]

6.31 Professor Ritter of the DPMP suggested that the data generated by the DA-CCP Planning Model could show that State Government investment on drug and alcohol treatment in New South Wales will need to double in order to effectively meet demand:

> The Drug and Alcohol Clinical Care and Prevention Model estimates how much the New South Wales Government would have to spend if it offered treatment to those who need it and want it in a comprehensive fashion according to best practice. There will be available, when that model is complete, an estimate of what should be spent in an ideal world in New South Wales on drug and alcohol treatment. It is likely to be double what is currently spent, if I was hazarding a guess.[286]

6.32 The National Drug and Alcohol Research Centre also emphasised the potential benefits of the DA-CCP Planning Model regarding service planning and assessing funding level adequacy. However, it cautioned that the model would only work effectively provided funding levels were disclosed:

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283 Mr McGrath, Evidence, 27 May 2013, p 28.

284 Submission 51, p 30.

285 Submission 29, Hunter New England Local Health District, Drug and Alcohol Clinical Services, p 7.

286 Professor Ritter, Evidence, 3 April 2013, p 23.

> The DA-CPP model …will provide a nationally consistent approach to assessing the funding requirements for a sufficient level of alcohol and drug treatment. NSW government can use the model to develop projections about the extent of resources that would be required: including the numbers and types of staff, the numbers of outpatient/ambulatory treatment places; the number of beds and the costs for treatment associated consumables(medications, diagnostic tests and so on). This will be an invaluable tool to assess the level and adequacy of current NSW treatment funding – but requires that current levels of funding are known.[287]

Other funding concerns

6.33 In addition to drawing attention to a perceived inadequacy of current funding arrangements, a number of Inquiry participants drew the Committee's attention to specific examples of where they believed additional investment was necessary to improve treatment outcomes. Some Inquiry participants also expressed concern that, the co-location of drug and alcohol services with mental health services in the NSW Ministry for Health's Mental Health and Drug and Alcohol Office, could lead to the diversion of funds away from drug and alcohol treatment services.

Areas of unmet need

6.34 Inquiry participants identified a number of areas of unmet need for drug and alcohol treatment. One such area was youth detoxification beds. In evidence, Mission Australia, a youth drug and alcohol treatment provider, informed the Committee that it was their understanding that there were no publically available youth specific detoxification beds in New South Wales, meaning they were having to send clients interstate. Ms Nichole Sullivan, Clinical Practice Leader, Youth AOD Services, Mission Australia, stated that:

> There are no designated youth detox beds in the State. All of our three treatment centres utilise beds at Nepean youth drug and alcohol services at Nepean Hospital. They are adult beds in an adult ward that are supervised by the same medical staff who respond to adults in the process of detoxification. They are supported heavily by our youth drug and alcohol team but outside of that we are accessing beds in the Australian Capital Territory and Queensland.[288]

6.35 Another area of unmet need identified by Inquiry participants was residential rehabilitation places. The Sydney Medically Supervised Injecting Centre (SMSIC) remarked that it was their experience that clients were able to access a service for the management of their drug withdrawal but were then unable to access a residential rehabilitation service afterwards.[289] Dr Marianne Jauncey, Medical Director, SMSIC, advised the Committee that her organisation SMSIC was supporting clients to access detoxification services, but had found that once an individual had detoxed they were experiencing difficulties in transitioning to a residential rehabilitation position, due a lack of availability or cost impediments, and as a consequence they were falling through the system:

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287 Submission 34, p 2.

288 Ms Nichole Sullivan, Clinical Practice Leader, Youth AOD Services, Mission Australia, Evidence, 3 April 2013, pp 27.

289 Submission 17, Sydney Medically Supervised Injecting Centre, p 5.

> 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 residential 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.[290]

6.36 Another area of concern was ancillary services, including support for families of individuals affected by drug and alcohol use. In evidence, Mr Tony Trimingham, OAM, Founder and Chief Executive Officer, Family Drug Support voiced concern that his organisation, a support line which receives 28,000 telephone calls a year from families affected by alcohol and other drugs, had not received an increase in government funding to help deliver the service since 2000:

> We know that this is an inquiry about treatment, but we also believe that, in the broad range of treatment, ancillary services such as ours should be supported. We support the families who support the drug users. Whilst we are not directly involved in treatment ourselves, we think we provide a very important service to the community. We have been funded by New South Wales government since the year 2000, but we have never been funded adequately. Despite many attempts with both Governments since that time, we are still not funded adequately. [291]

6.37 In addition, the Committee heard that the needs of culturally and linguistically diverse (CALD) communities are not being adequately addressed. Mr Kelvin Chambers, Chief Executive Officer, Drug and Alcohol Multicultural Education Centre observed that information resources for the CALD community were not being developed in appropriate languages. Mr Chambers then recommended that more be done to disseminate information about drug and alcohol treatment services to the CALD community:

> I cannot remember the last time I saw a new translated resource coming out of the department or anywhere with drug and alcohol. It seems to have dried up as we have worked within budgetary constraints. Some recommendations from this Committee are maybe to look at that publication work and also look at it in terms of innovative styles. You do not need to now go to printers and print out 1,001 pamphlets that we produce stocks from. The web is a fabulous way to just get stuff up there, change it,

[290] Dr Marianne Jauncey, Medical Director, Sydney Medically Supervised Injecting Centre, Evidence, 4 April 2013, pp 2-3.

[291] Mr Tony Trimingham, OAM, Founder and Chief Executive Officer, Family Drug Support, Evidence, 27 May 2013, p 38.

> get it available in language and allow services across New South Wales to download them.[292]

6.38 In its submission, the NSW Ministry for Health advised that where possible through research and data collection, it was working to identify and address drug and alcohol treatment gaps. For example, the Ministry informed the Committee that an additional $3 million in funding had been recently allocated to the opioid treatment program in response to an observed increased in demand.[293]

Co-location of policy areas

6.39 Some Inquiry participants raised concerns regarding the co-location of the policy areas of drug and alcohol services with mental health services in the NSW Ministry for Health's Mental Health and Drug and Alcohol Office. Some argued that this coupling could lead to drug and alcohol funding cross-subsidising mental health initiatives. Dr Wodak of the ADLRF expressed this view:

> In some cases, funding which is already very scarce in the alcohol and drug field has found its way to be moved under mental health. Mental health is a difficult field and I do not want my response, written or verbal, to be misinterpreted as anything but respectful of the difficulties and importance of mental health; it has been a field that has also suffered from gross underfunding for a long time, and I applaud the fact that New South Wales was the leader in trying to redress that. There is still a way to go in improving the funding of mental health, but the issue that I wanted to direct this Committee to is the fact that placing mental health over alcohol and drugs has been a big mistake.[294]

6.40 Dr Hester Wilson, General Practitioner and Addiction Specialist, member of the National Faculty of Specific Interests in Addiction Medicine through the Royal Australian College of General Practitioners, echoed these concerns, highlighting how the co-location of both services had resulted in the erosion of drug and alcohol services:

> 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 power that drug and alcohol had to decide where their budget went was eroded.[295]

6.41 In response to these concerns, Mr McGrath of the NSW Ministry for Health informed the Committee that each program has a quarantined budget and that funding was not shifted from one program to pay for another:

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292 Mr Kelvin Chambers, Chief Executive Officer, Drug and Alcohol Multicultural Education Centre, Evidence, 27 May 2013, p 6.

293 Submission 51, p 30.

294 Dr Wodak, Evidence, 3 April 2013, p 34.

295 Dr Hester Wilson, General Practitioner and Addiction Specialist, member of the National Faculty of Specific Interests in Addiction Medicine through the Royal Australian College of General Practitioners, Evidence, 4 April 2013, p 53.

> …both programs are guaranteed for their specific purposes so there is no cross-subsidisation from one program to the other. They are both quarantined budgets for their own special program purposes and they are rolled out that way from the Ministry. They are rolled out under separate program codes and those program codes are monitored and reported on via our annual reporting processes.[296]

Committee comment

6.42 The Committee acknowledges the difficulty of assessing the adequacy of funding for drug and alcohol treatment services, as a result of which the Drug and Alcohol-Clinical Care and Prevention Planning Model has been developed. The Committee recognises that the Drug and Alcohol-Clinical Care and Prevention Planning Model is a significant reform regarding the allocation of resources for drug and alcohol treatment.

6.43 The Committee is pleased that the NSW Ministry for Health is leading the national initiative to develop the Drug and Alcohol-Clinical Care and Prevention Planning Model, a population based planning model that estimates the demand for drug and alcohol health services. We are hopeful that the Drug and Alcohol-Clinical Care and Prevention Planning Model will improve the way in which drug and alcohol treatment services are delivered, given service planners will have access to a framework enabling them to make better informed decisions about resource allocation. At the time of the Inquiry the Drug and Alcohol-Clinical Care and Prevention Planning Model had not been implemented.

6.44 As noted previously, some Inquiry participants suggested that drug and alcohol treatment services are not receiving adequate funding, in particular ancillary services. The Committee also notes the need for improved CALD services and the opportunity for web-based translated information. The Committee accepts that funding for drug and alcohol treatment services must be commensurate with the demand for such services. It is important that we get this right because not only are drug and alcohol treatment services delivered to some of the community's most vulnerable individuals, substance abuse also has a far-reaching impact upon society, and imposes significant costs borne by the entire community.

6.45 The Committee's Recommendation 6 is therefore 'that following the implementation of the Drug and Alcohol-Clinical Care and Prevention Planning Model, the NSW Government ensure that funding levels keep pace with the increasing demand for drug and alcohol treatment services'.

[296] Mr McGrath, Evidence, 27 May 2013, p 23.

Chapter 7 Education

This Chapter considers the delivery of drug and alcohol education in New South Wales, particularly to school students. It begins by identifying the objectives of drug and alcohol education and notes that its focus has evolved from information provision to personal development and strengthening social skills. Next, the Chapter considers the concerns of some Inquiry participants regarding the effectiveness of drug and alcohol education. In doing so, attention is also given to the principles underpinning drug and alcohol education initiatives. The Chapter concludes by looking at some practical matters pertaining to the delivery of drug and alcohol education in New South Wales schools.

Objectives and effectiveness of drug and alcohol education

7.1 This section comprises three parts. The first part identifies the objectives of drug and alcohol education. The second part considers the evidence presented to the Inquiry concerning the effectiveness of drug and alcohol education and the principles underpinning its delivery. The third part looks at targeted messages on drug and alcohol education.

Objectives

7.2 Drug and alcohol education is one of the primary methods through which information concerning the harmful effects of substance abuse is disseminated to the community. According to the NSW Ministry for Health, it aims to reduce the prevalence of drug and alcohol use and in doing so prevent substance abuse issues from developing. In effect, drug and alcohol education is about prevention rather than treatment of established problems.[297]

7.3 In its submission, the Alcohol and other drugs Council of Australia, a national non-government peak body representing the Australian alcohol and other drugs sector, highlighted the importance of the prevention of substance abuse, by stating:

> Preventing early use and delaying use is an important outcome because research indicates early use of alcohol, cannabis and other illicit drugs predicts subsequent risk of problematic use and dependent use.[298]

7.4 Drug and alcohol education can be delivered through a variety of means, namely school based programs; online and social media marketing campaigns; traditional forms of media including print, television and radio; peer education; and community engagement initiatives.[299] The evidence received by the Inquiry related more to the delivery of drug and alcohol education to young people and in schools than to broader awareness campaigns.

7.5 Drug and alcohol education is an important component of the harm minimisation approach, applicable to the three pillars of demand reduction, supply reduction and harm reduction. The NSW Ministry for Health submission advised the Committee that the majority of drug and alcohol education initiatives draw upon two or more of the harm minimisation pillars in their design:

297 Submission 51, NSW Ministry for Health, p 7.

298 Submission 46, Alcohol and other drugs Council of Australia, p 9.

299 Submission 51, p 8.

> Education activities in New South Wales can all be conceived under elements of the three pillars of the harm minimisation framework. A majority would draw on elements from two or more pillars in their design. For example, school education programs work at both the demand and harm reduction levels, whilst programs delivered to advise on the legal impacts of provision of alcohol to minors draw on supply and demand levels.[300]

7.6 In its submission, the Drug Policy Modelling Program, a drug and alcohol policy research and practice program at the University of New South Wales, observed that drug and alcohol education programs were previously concerned with information provision but have since evolved to focus more upon personal development and social skills training.[301]

7.7 In evidence, Mr Brian Smyth King, Executive Director, Learning and Engagement, Department of Education and Communities, similarly noted that within the State's public school system an increased emphasis is being given to initiatives that assist students to make better decisions rather than providing them with information resources:

> I guess in the past we have spent a great deal of our resources developing materials…they are valuable but they are limited in terms of what you can engage a young person in. I think we have to focus as we move forward into building the capabilities of individuals and the decisions that they make for themselves and those around them that are going to stand them in better stead for when they leave school and move into the broader adult communities.[302]

Effectiveness

7.8 It was generally accepted by Inquiry participants that the community should have access to resources and programs that enable individuals to make better informed choices about their health. Such agreement was not evident however in matters regarding the delivery of drug and alcohol education with the Inquiry receiving evidence from both public health organisations and treatment providers questioning its effectiveness.

7.9 For example, the Salvation Army Recovery Services, a drug and alcohol treatment provider, asserted that drug and alcohol education is too generic and does not deal with many of the issues faced by those seeking treatment. The Salvation Army also argued that, insufficient attention was given to the addictive qualities of drugs and alcohol, while too much focus was applied to the harms attributable to substance abuse, stating:

> There is little on the addictive potential of alcohol or drugs, the majority of education is focused on the harms that are caused by use or caused by using methods. Campaigns that highlight the addictive potential of alcohol and drugs are needed.[303]

7.10 Another drug and alcohol treatment provider, Wesley Mission, identified research indicating that drug and alcohol education may have unintended adverse impacts. Wesley Mission's

300 Submission 51, p 8.

301 Submission 23, Drug Policy Modelling Program, p 6.

302 Mr Brian Smyth King, Executive Director, Learning and Engagement, Department of Education and Communities, Evidence, 10 April 2013, p 48.

303 Submission 26, the Salvation Army, p 4.

submission noted that control trials undertaken to evaluate some drug and alcohol education programs delivered in the United States had found higher rates of substance abuse in those students that had received education as opposed to those that had not:

> One of the unexpected findings in drug and alcohol education programs is that drug and alcohol education in schools do not produce the expected benefits. Indeed control trials of school education approaches in the USA have often shown higher levels of alcohol and drug use in school students receiving education compared with those who have received none.[304]

7.11 In response to a question from a Committee member about the United States example, Ms Elizabeth Callister, Leader, Health and Wellbeing, Department of Education and Communities, stated that the Department's approach differed from that of the United States. Ms Callister explained that the programs in question were fear-based, providing only information, whereas the Department's initiatives looked to develop the skills of the student:

> There are programs, I think the Wesley Mission is correct, that have been run in the United States that have not been effective and in some cases have shown that there has been an increase in drug use…The ones that I have seen have tended to be more based on a fear approach, giving only information rather than developing skills or providing opportunities for discussion. Those are the ones we would not be adopting. We take much stronger interactive approaches to providing opportunities for students to have that sort of skill development approach. We also take a very strong approach to involving parents wherever.[305]

7.12 In evidence, Professor Adrian Dunlop, Immediate Past President, Australasian Professional Society on Alcohol & other Drugs, a multidisciplinary body for professionals involved in the alcohol and other drug field, advised that the evidence base to support the effectiveness of drug and alcohol education was limited. He argued that as a consequence all programs must be carefully implemented:

> The evidence base for the effectiveness of education is limited. In theory, educating young people about the harms of alcohol and drug problems should prevent their use, but it is not that straightforward, unfortunately. In a worst-case scenario you might be telling people about things that they are better not to know about. It is complex and we need to be very careful with education programs that we roll out that we know that they have a benefit and they are evidence-based and they support the growth and development of that young person.[306]

7.13 In response to another question from a Committee member, this time regarding the evidence base for drug and alcohol education, Ms Callister advised the Committee that its resources were based upon a set of evidence based education principles identified in the Commonwealth National Drug Strategy:

> There have been a number of analyses by quite significant researchers on the effectiveness of school-based drug education. The outcomes of those do vary. On the

304 Submission 49, Wesley Mission, p 12.

305 Ms Elizabeth Callister, Leader, Health and Wellbeing, Department of Education and Communities, Evidence, 10 April 2013, p 50.

306 Professor Adrian Dunlop, Professor Adrian Dunlop, Immediate Past President, Australasian Professional Society on Alcohol & other Drugs, Evidence, 10 April 2013, p 10.

> whole they would suggest that while some can have positive outcomes others are less effective…That sort of background research was actually incorporated in some material published, which is on our website, by the National Drug Strategy by the Commonwealth where they pulled together a set of principles about what should be in place for effective drug education. I think all of the efforts that we have made as a department in terms of the nature of the resources that have been produced and the resources by the Commonwealth as well have focused on being consistent with those sets of principles that were research based and agreed to by a broad range of researchers in Australia and were based on a very broad review of the research.[307]

7.14 In an answer to a question on notice, Mr Jay Bacik, CEO, Life Education NSW, informed the Committee that the principles, referred to by Ms Callister, were developed by the Commonwealth Department of Employment, Education and Workplace Relations through the commissioning of research into what constitutes best practice for the delivery of drug and alcohol education. The research included literature reviews and approximately 100 case studies conducted in schools.[308]

7.15 The principles aim to convey the essence of what is currently understood to be best practice, without prescribing a specific set of procedures within a school. The principles are organised around four interconnected themes, namely that drug and alcohol education must:

- be based on comprehensive and evidence-based practice;
- promote positive school climates and relationships;
- be appropriately targeted to meet specific needs; and
- apply effective pedagogical practices.[309]

Targeted messages

7.16 In evidence, Mr David McGrath, Director, Mental Health and Drug and Alcohol Programs, NSW Ministry of Health, highlighted the need for all drug and alcohol education programs to be suitable to their target market.[310]

7.17 Mr McGrath's advice drew upon research undertaken by Blue Moon Planning and Research, a market research company, that had found within any group there will be a variety of responses to a drug and alcohol education initiative and that to effectively reach an individual (or a particular group with similar beliefs) the message must reflect their orientation regarding drug use.[311]

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307 Ms Callister, Evidence, 10 April 2013, p 48.

308 Answers to questions on notice taken during evidence, 27 May 2013, Mr Jay Bacik, CEO, Life Education NSW, Question 1, *Report to Life Education Australia, Commissioned by the Australian Government of Health and Ageing, Best Practice Education As applied to Life Education Australia*, p 8.

309 Answers to questions on notice taken during evidence, 27 May 2013, Mr Jay Bacik, Question 1, pp 9-12.

310 Mr David McGrath, Director, Mental Health and Drug and Alcohol Programs, NSW Ministry of Health, Evidence, 27 May 2013, p 20.

311 Mr McGrath, Evidence, 27 May 2013, p 20.

7.18 The Blue Moon Planning and Research identified a set of groups in which the attitude of students to drug use could be classified. The groups include:

- those who, irrespective of the offer of drugs and alcohol, would be unlikely to ever abuse substances;
- those who may contemplate or consider use, most likely on an experimental basis, but who would be unlikely to engage in any future problematic use;
- thrill seekers with a positive orientation towards drugs, that is those individuals looking for experiences outside the norm and at the edge of societal norms; and
- reality swappers, namely individuals who had experienced difficult childhoods and were using drugs as a way of overcoming their problems.[312]

7.19 Based upon the different classifications it was found that depending on which group you were targeting, the message needs to be different. A theoretical example of how this would apply to the thrill seeking group was provided by Mr McGrath:

> For instance, if you make a significant reference to the dangers of, say, party drugs—amphetamines, Ecstasy, those sorts of drugs—you may, in fact, be encouraging the thrill seekers to use drugs, if you target the message towards that particular group. You need to be careful about understanding the orientation of the group you want to target the message towards, ensure that the distribution channels are targeted towards those groups and that the message matches those distribution channels for young people.[313]

7.20 In its submission, the Alcohol and other Drugs Council of Australia, a national non-government peak body representing the interests of the Australian alcohol and other drugs sector, identified research contained in a literature review undertaken by the National Centre for Education and Training (NCETA), pertaining to the delivery of effective drug and alcohol education. NCETA's review found that within schools the most successful programs:

- applied a social influence approach that aimed to teach young people to avoid taking drugs by resisting peer pressure to do so and by increasing coping skills, rather than a competence enhancement approach;
- included wider community and parental involvement; and
- addressed the whole school environment, by promoting positive relationships and behaviours, reducing victimisation and bullying and increasing social connectedness.[314]

7.21 In response to the NCETA findings, Mr Smyth King advised the Committee that the Department of Education and Communities was applying these components in its programs:

> We use those in our entire welfare range of programs because it is about the individual and the resilience of the individual to be able to deal with the context in which they live. Yes, we embrace those fully. They are strong evidence-based approaches that work well.[315]

312 Mr McGrath, Evidence, 27 May 2013, p 20.

313 Mr McGrath, Evidence, 27 May 2013, pp 20-21.

314 Submission 46, Alcohol and other drugs Council of Australia, p 9.

315 Mr Smyth King Evidence, 10 April 2013, p 51.

Delivery of drug and alcohol education in schools

7.22 Having already identified the objectives and effectiveness of drug and alcohol education, this section considers some practical matters regarding its delivery in New South Wales schools. It considers the reported closure of the Drug Education Unit within the Department of Education and Communities; looks at drug and alcohol support services offered to students; and details the work of Life Education NSW, a non-profit provider of health education to children and young people.

The reported closure of the Drug Education Unit

7.23 Some Inquiry participants raised concerns regarding the reported closure of the Drug Education Unit within the Department of Education and Communities. For instance, the Australia Drug Law Reform Foundation submission expressed reservations as to whether the Unit's role had been effectively replaced:

> The highly regarded NSW Alcohol and Drug Education Programme (in the Education Department) has recently been closed. The work on alcohol previously undertaken by this department is now being undertaken by *Drinkwise*, an organization which is, in effect, a branch of the alcohol beverage industry.[316]

7.24 The Alcohol and other Drugs Council of Australia, echoed these concerns and stressed the need for students to receive information about drugs:

> ADCA would like to express its concern at the closure of the drug education unit within the Education Department. Young people need to be informed about drug issues because they live in a world in which drug use is ubiquitous.[317]

7.25 In response to these concerns, the Department of Education and Communities advised the Committee that the Drug Education Unit had not closed rather it had been restructured. Mr Smyth King stated that the Drug Education Unit had been restructured to better integrate it with the area of the Department responsible for managing curricula, and added that the restructure had not impacted upon the delivery and services:

> The unit did not close; the department engaged in a reorganisation and the functions of the department were recalibrated, if you like, in the way in which they were put together. The area I am now working in assumes a broad area that was once very much segmented. Within that area we used to have a number of people, six people, who were responsible for developing teaching materials or classroom materials, teaching resources around drug education. That function has moved to sit within our curriculum area in secondary education and is now part of, and integrated fully into, the health and physical education curriculum area. It will be embraced within the standard provision of education. The services and things that we have out in the field and in the schools have not changed at all.[318]

316 Submission 37, Australia Drug Law Reform Foundation, p 15

317 Submission 46, p 9.

318 Mr Smyth King, Evidence, 10 April 2013, p 50.

School based initiatives

7.26 The Committee was advised by the Department of Education and Communities that all students within the New South Wales public school system receive support to help them respond to drug and alcohol issues.[319]

7.27 The primary method of supporting students is through the mandatory Personal Development, Health and Physical Education (PDHPE) curriculum. Over years 7 – 10 students undertake the PDHPE program for a period of 300 hours, while in years 11 and 12 students participate in the Crossroads personal development health education program for 25 hours.[320]

7.28 The Department of Education and Communities advised the Committee that teachers are primarily responsible for deciding how much drug and alcohol education is taught during the hours allocated for PDHPE and that each school is able to tailor what is taught so that local issues are addressed:

> Teachers are best placed to deliver drug and health education to their students. Teachers know the curriculum, the needs and abilities of their students, and the way they learn. They are also aware of the peer groups and the community in which the students live. Schools work with their communities to identify localised issues and plan and implement teaching and learning programs to reflect student learning and support needs within the context of the PDHPE key learning areas.[321]

7.29 The Department also informed the Committee that drug and alcohol education is taught within the individual and community health strand of the PDHPE curriculum. This particular strand addresses significant health issues and students learn about risk by examining what constitutes risky behaviour:

> Drug education is mainly included in the Individual and Community Health strand. This strand focuses on health issues of significance and also includes mental health, sexual health and road safety. In this strand, students have opportunities to consider the concept of risk and analyse the factors that influence risk behaviours. They appreciate that different circumstances can mean individuals have varying degrees of control over these influencing factors. They describe strategies to minimise harm in a range of relevant contexts and develop an understanding of the interrelationship of factors that can increase the potential for harm.[322]

319 Answers to supplementary questions 10 May 2013, Department of Education and Communities, Question 3, p 4.

320 Answers to supplementary questions 10 May 2013, Department of Education and Communities, Question 3, p 4.

321 Answers to supplementary questions 10 May 2013, Department of Education and Communities, Question 8, p 14.

322 Answers to supplementary questions 10 May 2013, Department of Education and Communities, Question 2, p 2.

7.30 In response to a question from a Committee member regarding what is the key message of the teaching students receive on illicit substances, Ms Callister replied that the emphasis was on abstinence:

> If we are talking about illicit drugs then the message is that it is not appropriate behaviour, that we would not anticipate that use or that it would be condoned or undertaken, that it is illegal and we would not expect them to be taking such drugs and if they were found in school to be doing so that would be taken as a serious issue because it is an illegal activity.[323]

7.31 Further, the Committee heard that the New South Wales public school system also supports students suspected of possible or potential drug use. In instances where a student may be at risk, decisions about the response that will best suit the student and their circumstances are made by the relevant principal and teachers. [324]

7.32 In regard to the support provided to classroom teachers, the Department of Education and Communities advised that external resources and advice are provided to teachers to help them better respond to students at risk. An example of this is the SchoolLink program, an initiative established by the NSW Ministry of Health. Through SchoolLink, school counsellors have close contact with mental health professionals so that schools are aware of the services available to help address the needs of individual students.[325]

Life Education NSW

7.33 As well as receiving drug and alcohol education through the PDHPE curriculum, many students in New South Wales are also taught about making healthy lifestyle choices by Life Education NSW. Life Education NSW is a non-profit provider of health education to children and young people. The organisation's purpose is to deliver preventative drug and health educations programs 'which motivate, encourage and empower young people to make smart life choices for a healthy future, free from the harms associated with drug misuse'.[326]

7.34 Life Education NSW advised the Committee that it uses a direct delivery method whereby mobile learning centres travel to schools, by invitation, once a year. The mobile learning centres are equipped with interactive technology to engage students in the delivery of drug and alcohol education. The people employed by Life Education NSW to deliver its program must have degrees and typically have physical education and health science backgrounds.[327]

7.35 Life Education NSW seeks to develop healthy lifestyles by demonstrating the uniqueness of each individual person rather than simply focusing on issues relating to the implications of

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323 Ms Callister, Evidence, 10 April 2013, p 49.

324 Answers to supplementary questions 10 May 2013, Department of Education and Communities, Question 4, p 5.

325 Answers to supplementary questions 10 May 2013, Department of Education and Communities, question 4, p 5.

326 Answers to questions on notice taken during evidence, 27 May 2013, Mr Jay Bacik, Question 1, p 1.

327 Answers to questions on notice taken during evidence, 27 May 2013, Mr Jay Bacik, Question 1, p 1.

substance abuse. Like the Department of Communities, Life Education NSW also applies the education principles identified in the Commonwealth National Drug Strategy in its program.[328]

7.36 Life Education NSW's key aims are to assist young people to:

- acquire age appropriate knowledge to support informed health choices;
- develop and practice skills and strategies to act upon individual decisions; and
- recognise the values and attitudes that may influence lifestyle choices and behaviours.[329]

7.37 In its submission, the Drug Policy Modelling Program cites Life Education NSW as an example of the drug and alcohol education approach that has evolved to focus more upon personal development and social skills training rather than information provision.[330]

7.38 In evidence, Mr Bacik informed the Committee that each year Life Education NSW delivers its program to 300,000 across 1,400 schools both public and private.[331] In addition, an evaluation of Life Education undertaken in 2006 estimated that the program, since its establishment in 1979, has been delivered to approximately five and half million students nationally.[332] The evaluation also found that between 93 to 95 per cent of the schools that had invited Life Education to deliver its program had asked the organisation to return.[333]

7.39 Mr Bacik advised the Committee that it costs Life Education NSW approximately $20 per student to deliver its program. The program receives $1.8 million in NSW Government funding which equates to approximately $6 per child while parents are asked to pay $10. Life Education NSW meets the remaining $4 through fundraising and other initiatives.[334]

7.40 Mr Bacik argued that the shared funding arrangements were a positive thing as it meant his organisation operated in partnership with government and the wider community, stating:

> …I think partnerships are very important. I am concerned as a general person that too many charities act as if they are a division of the Government and expect the Government to pick up the whole tab.[335]

7.41 Further, Mr Bacik went on to call for increased Government support for those students unable to afford the $10 fee to attend a Life Education NSW program:

> If a kid turns up at school—and this is an increasing issue for us. The cost to the parents at $10 is too high in many places. If I could get your help on that, that would

328 Answers to questions on notice taken during evidence, 27 May 2013, Mr Jay Bacik, Question 1, p 8.

329 Answers to questions on notice taken during evidence, 27 May 2013, Mr Jay Bacik, Question 1, p 8.

330 Submission 23, p 6.

331 Mr Jay Bacik, Chief Executive Officer, Life Education NSW, Evidence, 27 May 2013, p 11.

332 Answers to questions on notice taken during evidence, 27 May 2013, Mr Jay Bacik, Question 1, p 5.

333 Mr Bacik, Evidence, 27 May 2013, p 13.

334 Mr Bacik, Evidence, 27 May 2013, p 12.

335 Mr Bacik, Evidence, 27 May 2013, p 12.

> be terrific. If a kid turns up at school and he does not have $10 to spend on this program, I am not going to shut the door on him.[336]

7.42 Mr Bacik also remarked that he believed Life Education NSW's relationship with the Department of Education and Communities could be improved. To support his point Mr Bacik cited an example of where the Department had developed a program to have consultants deliver drug and alcohol education, in addition to the PDHPE subject, across the State at a cost of $2.6 million. Mr Bacik contended that the program was a failure and that the resources required to set it up could have been better deployed:

> The Government put $2.6 million into that but they could not tell you how many children were seen in the program. I thought it was inept and it was not measurable. At least I can tell you that we see physically more than 300,000 children.[337]

7.43 Mr Bacik commented that Life Education NSW had the capacity to assist the Department of Education and Communities in developing its program but had not been consulted. He then made an argument for greater interaction between his organisation and the Government:

> …Departments should not be working in silos. We see more children, 50 per cent of children in New South Wales are involved in this program… Why would you want to crank up a new program on bullying or some other aspect to do with drugs and alcohol when you have an organisation that has the infrastructure, the training, the people, the compliance with curricula throughout every State in Australia? That is there to go. I am saying to the department, "Why don't you use someone like us to help that?"

Committee comment

7.44 The Committee strongly supports the objective of drug and alcohol education, namely to reduce the prevalence of drug and alcohol use and by doing so prevent substance abuse issues from developing.

7.45 The Committee notes the concerns of some Inquiry participants that drug and alcohol education could be more effective. To that end, the Committee encourages relevant Government agencies to continue to use evidence based approaches in developing education initiatives tailored to the needs of target groups.

7.46 Regarding the reported closure of the Department of Education and Communities' Drug Education Unit, the Committee accepts that agencies may need to be reorganised for operational reasons. The Committee, however, stresses that the resources dedicated to supporting teachers and schools in delivering drug and alcohol education must not be diminished as a consequence.

336 Mr Bacik, Evidence, 27 May 2013, p 14.

337 Mr Bacik, Evidence, 27 May 2013, p 14.

7.47 The Committee commends Life Education NSW and other providers on their work in teaching students about making healthy lifestyle choices, and the Committee believes that given their expertise in this area, the Government should consult Life Education NSW and other providers on drug and alcohol education initiatives. In addition, we believe that Life Education NSW and other providers should be provided with additional funding, by the NSW Government, to address any deficiencies that could prevent students from attending their important programs.

7.48 Therefore the Committee's Recommendation 7 is that 'the NSW Government provide additional funding to Life Education NSW and other providers to ensure that all students are given the opportunity to participate in their programs'.

Appendix 1 Submissions

No	Author
1	Mr Adam Strahan
2	Murrumbidgee Local Health District - Drug and Alcohol Services
3	Australian National Council on Drugs
4	Name suppressed
5	FamilyVoice Australia
6	The Redfern Society
7	Legal Aid NSW
8	Australian Medical Association (NSW)
9	The Drug Advisory Council of Australia Inc
10	Australasian Professional Society on Alcohol and other Drugs (APSAD)
11	The Lyndon Community
12	Name suppressed
13	Dr Ross Colquhoun
14	Australian Institute of Health and Welfare
15	The Addiction Treatment Foundation Inc (Partially confidential)
16	Dr Ian Douglas
17	Sydney Medically Supervised Injecting Centre
18	Manly Drug Education and Counselling Centre
19	Dr Penny Brabin
20	NADA (network of alcohol and drug agencies)
21	UnitingCare NSW.ACT
22	Drug and Alcohol Nurses of Australasia Inc (DANA)
23	Drug Policy Modelling Program
24	Mr Phil O'Grady
25	Family Drug Support
26	The Salvation Army
27	Mission Australia
28	St Vincent's Hospital, Inner City Health Program, Alcohol & Drug Service
29	The Hunter New England Local Health District, Drug and Alcohol Clinical Services
30	Drug Free Australia
31	Psychologist in private practice (Partially confidential)
32	Drug and Alcohol Multicultural Education Centre (DAMEC)

No	Author
33	NSW Users & AIDS Association Inc
34	National Drug and Alcohol Research Centre
35	Anex
36	Addiction Medicine Network (NSW membership) of the Royal Australian College of General Practitioners (RACGP)
37	Australia Drug Law Reform Foundation
38	Christian Democratic Party
39	The Law Society of New South Wales
40	Australasian College for Emergency Medicine (ACEM)
41	South Pacific Private Hospital
42	South Eastern Sydney Local Health District
43	National Health & Medical Research Council
44	Hepatitis NSW
45	NSW Young Lawyers Criminal Law Committee
46	Alcohol and other Drugs Council of Australia
47	Fresh Start Recovery Programme
48	The Royal Australasian College of Physicians
49	Wesley Mission
50	Australasian Therapeutic Communities Association (ATCA)
51	NSW Ministry of Health
52	Department of Justice and Attorney General
53	Aboriginal Health and Medical Research Council of NSW
54	Western NSW Local Health District

Appendix 2 Witnesses at hearings

Date	Name	Position and Organisation
Wednesday, 3 April 2013 **Macquarie Room, Parliament House, Sydney**	Dr George O'Neil	Medical Director, Fresh Start Recovery Programme
	Mr Jeff Claughton	Chief Executive Officer, Fresh Start Recovery Programme
	Mr Terry Beauchamp	NSW Representative, Fresh Start Recovery Programme
	Mr Charlie Popov	Fresh Start Recovery Programme
	Professor Alison Ritter	Director, Drug Policy Modelling Program, National Drug and Alcohol Research Centre, University of New South Wales
	Mr Martin Thomas	General Manager, Social Advocacy and Public Affairs, Mission Australia
	Ms Nichole Sullivan	Clinical Practice Leader, Youth AOD Services, Mission Australia
	Dr Alex Wodak	President, Australian Drug Law Reform Foundation
	Dr Mary Osborn, PhD	Member, Australian Drug Law Reform Foundation
	Mr Larry Pierce	Chief Executive Officer, Network of Alcohol and Drug Agencies (NADA)
	Ms Tanya Merinda	Director of Planning and Strategy, Network of Alcohol and Drug Agencies
	Dr David Phillips	National President, FamilyVoice Australia
	Mr Graeme Mitchell	State Officer, FamilyVoice Australia
Thursday, 4 April 2013 **Macquarie Room, Parliament House, Sydney**	Dr Marianne Jauncey	Medical Director, Sydney Medically Supervised Injecting Centre
	Mr Howard Packer	Deputy Chair, UnitingCare NSW/ACT Board
	Associate Professor Nicholas Lintzeris	Director, South Eastern Sydney Local Health District,
	Dr Ross Colquhoun	Member and Fellow, Drug Free Australia
	Mr Gary Christian	Secretary, Drug Free Australia
	Mr Brian Watters	Member, Drug Free Australia

Date	Name	Position and Organisation
	Ms Sharon Carr	Member, Drug Free Australia
	Mr Edward Zarnow	Chief Executive Officer, The Lyndon Community
	Dr Julaine Allan	Deputy Chief Executive, The Lyndon Community
	Mr Sione Crawford	Director of Programs and Services, NSW Users and AIDS Association Inc.
	Mr Jeffrey Wegener	Policy and Advocacy Coordinator, NSW Users and AIDS Association Inc.
	Dr Hester Wilson	General Practitioner Addiction Specialist, Member of the National Faculty of Specific Interests in Addiction Medicine, Royal Australian College of General Practitioners
	Dr Simon Holliday	General Practitioner and Addiction Specialist, Member of the National Faculty of Specific Interests in Addiction Medicine, Royal Australian College of General Practitioners
	Associate Professor Nadine Ezard	Clinical Director, St Vincent's Hospital, Inner City Health Program, Alcohol & Drug Service
Wednesday, 10 April 2013 Macquarie Room, Parliament House, Sydney	Mr Gerard Byrne	Clinical Director, Recovery Services, The Salvation Army
	Mr David Pullen	Director, Recovery Services, The Salvation Army
	Professor Adrian Dunlop	Immediate Past President, Australasian Professional Society on Alcohol and other Drugs (APSAD)
	Mr Stephen Ling	Member and Nurse Practitioner in Drug and Alcohol, Drug and Alcohol Nurses of Australasia Inc. (DANA)
	Associate Professor Richard Paoloni	Chair, NSW Faculty, Australasian College of Emergency Medicine (ACEM)
	Dr Lai Heng Foong	Public Health Committee, Australasian College of Emergency Medicine (ACEM)
	Professor John Saunders	Drug and Alcohol Program Director, Wesley Hospital, Kogarah

Date	Name	Position and Organisation
	Mr Brian Smyth King	Executive Director, Learning and Engagement, Department of Education and Communities
	Ms Robyn Bale	Acting Director, Student Engagement and Interagency Partnership, Department of Education and Communities
	Ms Elizabeth Callister	Leader, Health and Wellbeing, Department of Education and Communities
	Mr Christopher Miles	Principal Legal Officer, Legal Services Unit, Department of Education and Communities
	Ms Fiona Davies	Chief Executive Officer, Australian Medical Association (NSW) Limited
Monday, 27 May 2013 **Macquarie Room, Parliament House, Sydney**	Mr Kelvin Chambers	Chief Executive Officer, Drug and Alcohol Multicultural Education Centre
	Ms Rachel Rowe	Senior Research Officer, Drug and Alcohol Multicultural Education Centre
	Mr Jay Bacik	Chief Executive Officer, Life Education
	Mr David McGrath	Director, Mental Health and Drug & Alcohol Programs, NSW Ministry of Health
	Mr Tony Trimingham, OAM	Chief Executive Officer, Family Drug Support
	Ms Carla Unicomb	Member, Volunteer, Family Drug Support
	Ms Judy Smith	Volunteer, Family Drug Support
	Mr Brendan Thomas	Assistant Director General, Crime Prevention and Community Programs, Department of Attorney General and Justice
	Dr Anne Marie Martin	Assistant Commissioner, Offender Management and Policy, Department of Attorney General and Justice

Appendix 3 Site visits

Tuesday, 14 May 2013
Orange, New South Wales

The Committee travelled to Orange, New South Wales where they met with the staff operating and managing the Lyndon Community and spoke to them about their experiences in delivering drug and alcohol treatment services in rural and regional settings. The Committee also received a briefing from the staff operating and managing the Involuntary Drug and Alcohol Treatment Centre, Bloomfield Hospital, Orange, New South Wales.

Wednesday, 15 May 2013
Perth, Western Australia

The Committee travelled to the Fresh Start Recovery Programme, Subiaco, Western Australia, and met with its Medical Director, Dr George O'Neil, some of the other staff operating and managing the clinic, and some patients being treated with naltrexone implants. The site visit provided the Committee with the opportunity to gauge firsthand the use of naltrexone implants in treating opioid dependence.

Thursday, 16 May 2013
Perth, Western Australia

The Committee travelled to the Drug and Alcohol Office, WA Health, Mt Lawley, Western Australia, and was briefed on a number of matters including the relationship between the Western Australian Government and the Fresh Start Recovery Programme.

Wednesday, 12 June 2013
Sydney, New South Wales

The Committee travelled to the Sydney Medically Supervised Injecting Centre, Darlinghurst, New South Wales and was advised about the Centre's work in seeking to reduce death and injury associated with injecting drug use. The Committee also visited the St Vincent's Emergency Department, and Drug & Alcohol Service, Darlinghurst, New South Wales and learnt about the Hospital's innovative responses to substance abuse.

Appendix 4 Tabled documents

Wednesday, 3 April 2013
Public hearing, Macquarie Room, Parliament House

1 Document entitled 'High rates of HIV infection among injection drugs users participating in needle exchange programs in Montreal: results of a cohort study.', tendered by Dr David Phillips, National President, Family Voice Australia

Thursday, 4 April 2013
Public hearing, Macquarie Room, Parliament House

2 Copy of William Hogarth, eighteenth century engraving entitled *Gin Lane* tendered by Mr Howard Packer, Deputy Chair, UnitingCare NSW/ACT Board

3 Mattick RP, Breen C, Kimber J, and Davoli M, (2009), 'Methadone maintenance therapy versus no opioid replacement therapy for opioid dependence (Review), *The Cochrane Collaboration,* Issue 3 tendered by Mr Gary Christian, Secretary, Drug Free Australia NSW

4 *The Cochrane Collaboration,* review of methadone maintenance therapy, tendered by Mr Gary Christian, Secretary, Drug Free Australia NSW

5 Krupitsky et al, (2012), 'Randomized Trial of Long-Acting Sustained-Release Naltrexone Implant vs. Oral Naltrexone or Placebo for Preventing Relapse to Opioid Dependence', *Archives General Psychiatry,* tendered by Dr Ross Colquhoun, Member, Drug Free Australia NSW

6 Lobmaier et al, (2012), 'Injectable and implantable sustained release naltrexone in the treatment of opioid addiction', *British Journal of Clinical Pharmacology,* tendered by Dr Ross Colquhoun, Member, Drug Free Australia NSW

Wednesday, 10 April 2013
Public hearing, Macquarie Room, Parliament House

7 Article 'Nurse practitioners in drug and alcohol: where are they?', *Australian Journal of Advanced Nursing*, Vol 26, No 4, tendered by Mr Stephen Ling, Member and Nurse Practitioner in Drug and Alcohol, Drug and Alcohol Nurses of Australasia Inc

8 NSW Public Schools Learning and Teaching – Frequently asked questions – extracted from www.schools.nsw.edu.au, .tendered by Mr Brian Smyth King, Executive Director, Learning and Engagement, Department of Education and Communities

Tuesday, 14 May 2013
Site Visit – Involuntary Drug and Alcohol Treatment (IDAT) Centre, Orange NSW

9 Medical admission pack for the Involuntary Drug and Alcohol Treatment Centre, tendered by Dr Barbara Sinclair, Clinical Director, IDAT Unit

10 Forms relating the operation of the *Drug and Alcohol Treatment Act 2007,* tendered by Dr Barbara Sinclair, Clinical Director, IDAT Unit

11 Information papers on the Involuntary Drug and Alcohol Treatment Program, tendered by Dr Barbara Sinclair, Clinical Director, IDAT Unit

Wednesday, 15 May 2013

Site Visit – Fresh Start Recovery Programme, Subiaco, Perth, Western Australia

12 Information package – Fresh Start Recovery Programme, tendered by Mr Jeff Claughton, CEO, Fresh Start Recovery Programme

Thursday, 16 May 2013

Site Visit – Drug and Alcohol Office, WA Health, Mt Lawley, Perth, Western Australia

13 Drug and Alcohol Office, *Submission to the Education and Health Standing Committee,* Inquiry into the Adequacy and Appropriateness of Prevention and Treatment Services for Alcohol and Illicit Drug Problems in Western Australia, tendered by Mr James Hunter, Director, Client Services and Development, WA Health

Monday, 27 May 2013

Public hearing, Macquarie Room, Parliament House

14 Family Drug Support promotional materials, tendered by Mr Tony Trimingham, OAM, Chief Executive Officer, Family Drug Support

15 2012 Family Drug Support annual report, tendered by Mr Tony Trimingham, OAM, Chief Executive Officer, Family Drug Support

16 April-May 2013 Family Drug Support newsletter, tendered by Mr Tony Trimingham, OAM, Chief Executive Officer, Family Drug Support

Appendix 5 Answers to questions on notice

The Committee received answers to questions on notice from:

- Drug Policy Modelling Program, National Drug and Alcohol Research Centre, University of New South Wales
- Mission Australia
- FamilyVoice Australia
- Sydney Medically Supervised Injecting Centre
- The Lyndon Community
- The Salvation Army
- Australasian Professional Society on Alcohol and other Drugs (APSAD)
- Drug and Alcohol Nurses of Australasia (DANA)
- Australasian College for Emergency Medicine (ACEM)
- Wesley Hospital Kogarah
- NSW Department of Education and Communities
- Australian Medical Association (NSW) Limited
- NSW Ministry for Health
- NSW Department for Attorney General and Justice
- Life Education NSW
- Drug and Alcohol Multicultural Education Centre (DAMEC)

Appendix 6 Minutes

Minutes No. 24
Wednesday 21 November 2012
General Purpose Standing Committee No. 2
Members' Lounge, Parliament House, Sydney, at 1.00 pm

1. Members present
Ms Ficarra, *Chair*
Ms Barham
Mr Brown (*Mr Green*)
Mr Clarke
Ms Gardiner
Mr Moselmane
Ms Westwood

2. Substitutions
The Chair advised of the following substitution:

- Mr Brown for Mr Green.

3. Previous minutes
Resolved, on the motion of Mr Clarke: That Draft Minutes No. 23 be confirmed.

4. Correspondence
The Committee noted the following item of correspondence:

Received

- 13 November 2012 – From the Hon Marie Ficarra MLC, the Hon Jenny Gardiner MLC and the Hon Paul Green MLC to Ms Madeleine Foley, Director, Committees, requesting a meeting to consider proposed terms of reference for an inquiry into policies and services for drug and alcohol addiction.

5. Consideration of proposed terms of reference for an inquiry into drug and alcohol treatment

Resolved, on the motion of Ms Barham: That the terms of reference be adopted, as drafted.

The Committee considered a number of matters relating to initiation of the Inquiry.

Resolved, on the motion of Mr Clarke: That the following timeline be adopted for the management and administration of the inquiry:

- 28 November 2012 – Advertisements to be placed in major newspapers
- 1 March 2013 – Closing date for submissions
- April/May 2013 – Hearings and site visits to be undertaken
- 29 August 2013 – Report to the House

Resolved, on the motion of Mr Moselmane: That advertisements calling for submissions be placed in the *Sydney Morning Herald, Daily Telegraph*, and *The Land*, with a media release announcing the Inquiry to be distributed state-wide.

Resolved, on the motion of Ms Gardiner: That the closing date for submissions be Friday 1 March 2013.

Resolved, on the motion of Mr Clarke: That the Secretariat email members with a list of stakeholders to be invited to make written submissions, and that members have until 5pm, Wednesday 28 November 2012 to nominate additional stakeholders.

Resolved, on the motion of Ms Westwood: That the Committee potentially hold three Sydney hearings and at least one site visit, and set aside a fourth reserve hearing date, on dates to be determined by the Chair after consultation with members regarding their availability.

Resolved, on the motion of Ms Gardiner: That the short name for the Inquiry be:
'Inquiry into drug and alcohol treatment'.

Resolved, on the motion Ms Westwood: That the Committee authorise the publication of all submissions to the Inquiry into alcohol and drug policies, subject to the Committee Clerk checking for confidentiality, adverse mention and other issues.

6. Budget Estimates 2012-13: Chair's draft report

The Committee considered the Chair's draft report on the Budget Estimates 2012-13.

Resolved, on the motion of Mr Clarke: That the Committee present the report to the House, together with transcripts of evidence, tabled documents, answers to questions on notice, minutes of proceedings and correspondence relating to the Inquiry.

7. Adjournment

The Committee adjourned at 1.10 pm, *sine die*.

Madeleine Foley
Clerk to the Committee

Minutes No. 25

Wednesday, 3 April 2013
General Purpose Standing Committee No. 2
Macquarie Room, Parliament House, Sydney at 10.45 am

1. Members present

Ms Ficarra, *Chair*
Revd Nile, *Deputy Chair*
Ms Barham
Mr Clarke
Ms Gardiner
Mr Moselmane
Ms Westwood

2. Substitutions

The Chair advised that she had received written advice that Revd Nile would substitute for Mr Green for the purposes of the Inquiry into drug and alcohol treatment.

3. Election of Deputy Chair

The Chair called for nominations for the Deputy Chair for the purposes of the Inquiry into drug and alcohol treatment, as a result of the vacancy created by the substitution of Revd Nile for Mr Green.

Mr Clarke moved: That Revd Nile be elected Deputy Chair of the Committee.

There being no further nominations, the Chair declared Revd Nile elected Deputy Chair.

4. Previous minutes

Resolved, on the motion of Ms Westwood: That Draft Minutes No 24 be confirmed.

5. Correspondence

The Committee noted the following items of correspondence received:

- 15 January 2013 – From Mr Ben Harris, Chief of Staff to the Hon Mary Wooldridge Minister for Mental Health, Minister for Women's Affairs and Minister for Community Services, Parliament of Victoria – providing information in response to an invitation from the Committee to make a submission to the inquiry into drug and alcohol treatment.
- ****.
- 28 March 2013 – From Ms Deborah Hyland, Director, Strategic Relations and Communications, NSW Ministry of Health – declining the invitation to give evidence at the public hearing on Wednesday, 3 April 2013.
- 2 April 2013 – From Mr Tony Wood – correspondence concerning drug policy.
- 2 April 2013 – From Dr David Phillips, National President, Family Voice Australia – request to have photo taken at the witness table with Committee Members in the background.
- 2 April 2013 – From Ms Sandra Crawford, Assistant Director, Criminal Justice Interventions, Department of Attorney General and Justice – response to request for a witness to attend a public hearing to give evidence regarding the Magistrates Early Referral Into Treatment program.

Resolved, on the motion of Miss Gardiner: That the Committee write to both the Ministry of Health and Department of Attorney General and Justice seeking written briefings, within 21 days, that detail the following information, respective to the drug and alcohol treatment programs delivered by each agency, including:

- policy and program guidelines;
- funding;
- eligibility criteria;
- waiting list periods;
- service locations; and
- outcomes achieved and corresponding statistical data.

Further, that both agencies be requested to appear at the public hearing for the Inquiry into drug and alcohol treatment on 27 May 2013.

The Chair indicated that she would make herself available at the conclusion of the hearing to have a photo taken with the witnesses from Family Voice Australia.

6. Inquiry into drug and alcohol treatment

6.1 Submissions

Public

Resolved, on the motion of Revd Nile: That the Committee note that submission nos 1-3, 5-11, 13-14, 16-30, 31, 33-47 were published by the Committee Clerk, subject to checking for confidentiality, adverse mention and other issues, in accordance with the Committee's resolution of 21 November 2012.

Resolved, on the motion of Revd Nile: That the Committee note that submission no 29 from the Hunter New England Health District was retracted and replaced with a new version, at the request of the submission's author, subject to the Committee Clerk seeking the Committee's agreement to this request by email on 27 March 2013.

Name suppressed
Resolved, on the motion of Mr Clarke: That the Committee note that submission nos 4 and 12 were published by the Committee Clerk in accordance with the Committee's resolution of 21 November 2012, with the exception of the authors' names. Further, that the Committee keep confidential the authors' names at the request of the submissions' authors.

Partially confidential
Resolved, on the motion of Ms Gardiner: That the Committee note that submission nos 15 and 31 were published by the Committee Clerk in accordance with the Committee's resolution of 21 November 2012, with the exception of any identifying information. Further, that the Committee keep the submissions partially confidential as per the authors' request.

Confidential
Resolved, on the motion of Ms Westwood: That the Committee that submission no 32 remain confidential.

Change to: Resolved, on the motion of Revd Nile: That submission no 32, which was kept confidential at the request of the submission's author, be made public at the request of the submission's author.

Confidential attachments
Resolved, on the motion of Revd Nile That the personal information included in the curriculum vitaes in the attachment to submission 38 that contains potentially identifying information remain confidential.

6.2 Witnesses
Resolved, on the motion of Mr Clarke: That the Committee note the list of witnesses to be invited to the hearings on 3, 4 and 10 April 2013, circulated by the Committee Clerk. Further, that the Committee invite Life Education and Family Drug Support to appear as witnesses to a public hearing.

The Committee Clerk advised that Hepatitis NSW and Legal Aid NSW declined the invitation to give evidence at a public hearing, and that Anglicare and Catholic Care were yet to confirm their attendance.

6.3 Allocation of time for questions during hearings
Resolved, on the motion of Revd Nile: That the time allocated for questions during hearings be divided equally among Government, Opposition and cross bench members.

6.4 Return of answers to questions on notice
Resolved, on the motion of Ms Westwood: That for all hearings, answers to questions on notice and supplementary and supplementary questions are due within 21 days, and members have three days after a hearing to provide supplementary questions.

6.5 Macquarie room audio system
The Chair informed the Committee about the microphone upgrade in the Macquarie Room and advised members that the microphones allow improved pick-up of sound, including private conversations between members while at the table.

6.6 Public hearing
Witnesses, the public and the media were admitted.

The Chair made an opening statement regarding the broadcasting of proceedings and other matters.

The following witnesses were sworn and examined:

- Dr George O'Neil, Medical Director, Fresh Start Recovery Programme
- Mr Jeff Claughton, Chief Executive Officer, Fresh Start Recovery Programme
- Mr Terry Beauchamp, NSW Representative, Fresh Start Recovery Programme
- Mr Charlie Popov, Fresh Start Recovery Programme.

The evidence concluded and the witnesses withdrew.

The following witness was sworn and examined:

- Professor Alison Ritter, Director, Drug Policy Modelling Program, National Drug and Alcohol Research Centre, University of New South Wales.

The evidence concluded and the witness withdrew.

The following witnesses were sworn and examined:

- Mr Martin Thomas, General Manager, Social Advocacy and Public Affairs, Mission Australia
- Ms Nichole Sullivan, Clinical Practice Leader, Youth AOD Services, Mission Australia.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Dr Alex Wodak, President, Australian Drug Law Reform Foundation
- Dr Mary Osborn, PhD, Member, Australian Drug Law Reform Foundation.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Mr Larry Pierce, Chief Executive Officer, Network of Alcohol and Drug Agencies (NADA)
- Ms Tanya Merinda, Director, Planning and Strategy, Network of Alcohol and Drug Agencies.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Dr David Phillips, National President, Family Voice Australia
- Mr Graeme Mitchell, National President, Family Voice Australia.

Dr Phillips tendered the following document, entitled, 'High rates of HIV infection among injection drugs users participating in needle exchange programs in Montreal: results of a cohort study.'

The evidence concluded and the witnesses withdrew.

7. Adjournment

The Committee adjourned at 5.09 pm until Thursday, 4 April 2013 at 9.30 am, Macquarie Room.

Alex Stedman
Committee Clerk

Minutes No. 26
Thursday, 4 April 2013
General Purpose Standing Committee No. 2
Macquarie Room, Parliament House, Sydney at 9.30 am

1. Members present
Ms Ficarra, *Chair*
Revd Nile, *Deputy Chair*
Ms Barham
Mr Clarke
Ms Gardiner
Mr Moselmane (until 4.45 pm)
Ms Westwood.

2. Inquiry into drug and alcohol treatment

2.1 Public hearing
Witnesses, the public and the media were admitted.

The Chair made an opening statement regarding the broadcasting of proceedings and other matters.

The following witnesses were sworn and examined:

- Dr Marianne Jauncey, Medical Director, Sydney Medically Supervised Injecting Centre
- Mr Howard Packer, Deputy Chair, UnitingCare NSW/ACT Board.

Mr Packer tendered the following document:

- William Hogarth, eighteenth century engraving, entitled, *Gin Lane.*

The evidence concluded and the witnesses withdrew.

The following witness was sworn and examined:

- Associate Professor Nicholas Lintzeris, South Eastern Sydney Local Health District.

The evidence concluded and the witness withdrew.

The following witnesses were sworn and examined:

- Mr Gary Christian, Secretary, Drug Free Australia NSW
- Ms Sharon Carr, Member, Drug Free Australia NSW
- Dr Ross Colquhoun, Member, Drug Free Australia NSW
- Major Brian Watters, Member, Drug Free Australia NSW.

Mr Christian tendered the following documents:

- Mattick RP, Breen C, Kimber J, and Davoli M, (2009), 'Methadone maintenance therapy versus no opioid replacement therapy for opioid dependence (Review), *The Cochrane Collaboration,* Issue 3.
- *The Cochrane Collaboration,* review of methadone maintenance therapy.

Dr Colquhoun tendered the following documents:

- Krupitsky et al, (2012), 'Randomized Trial of Long-Acting Sustained-Release Naltrexone Implant vs. Oral Naltrexone or Placebo for Preventing Relapse to Opioid Dependence', *Archives General Psychiatry.*
- Lobmaier et al, (2012), 'Injectable and implantable sustained release naltrexone in the treatment of opioid addiction', *British Journal of Clinical Pharmacology.*

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Mr Edward Zarnow, Chief Executive Officer, The Lyndon Community
- Dr Juliane Allan, Deputy Chief Executive Officer, The Lyndon Community.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Mr Sione Crawford, Director of Programmes & Services, NSW Users & AIDS Association Inc
- Mr Jeffrey Wegner, Policy and Advocacy Coordinator, NSW Users & AIDS Association Inc.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Dr Hester Wilson, General Practitioner & Addiction Specialist, Australian College of General Practitioners (RACGP)
- Dr Simon Holliday, General Practitioner & Addiction Specialist, Australian College of General Practitioners (RACGP).

The evidence concluded and the witnesses withdrew.

The following witness was sworn and examined:

- Associate Professor Nadine Ezard, Clinical Director, St Vincent's Hospital, Inner City Health Program, Alcohol & Drug Service.

Mr Moselmane left the meeting.

The evidence concluded and the witness withdrew.

2.2 Deliberative meeting

The Committee Clerk informed the Committee that Anglicare had declined the invitation to attend a public hearing.

Resolved, on the motion of Revd Nile: That the Committee write to Ms Ann Bressington MLC, to invite her to make a submission to the Inquiry.

Resolved, on the motion of Revd Nile: That the Chair seek the authorisation of the House, with the approval of the President, for the Committee to travel interstate for the purpose of inspecting the naltrexone treatment program at the Fresh Start Clinic in Perth, Western Australia.

Resolved, on the motion of Revd Nile: That the Committee undertake a site visit to the Sydney Medically Supervised Injecting Centre; and investigate the possibility of visiting St Vincent's Hospital Emergency Department, and St Vincent's Hospital, Inner City Health Program, Alcohol & Drug Service.

3. Adjournment

The Committee adjourned at 5.16 pm until Wednesday 10 April 2013 at 9.15 am, Macquarie Room.

Alex Stedman
Committee Clerk

Minutes No. 27
Wednesday, 10 April 2013
General Purpose Standing Committee No. 2
Macquarie Room, Parliament House, Sydney at 9:21 am

1. Members present
Ms Ficarra, *Chair*
Revd Nile, *Deputy Chair*
Ms Barham
Mr Clarke
Miss Gardiner
Mr Moselmane
Ms Westwood

2. Previous minutes
Resolved, on the motion of Mr Clarke: That Draft Minutes Nos 25 and 26 be confirmed.

3. Correspondence
The Committee noted the following items of correspondence:

Received:

- 3 April 2013 – Email from Dr George O'Neil – providing a copy of a document, entitled, *Sustained Release Naltrexone in the treatment of heroin addiction.*
- 4 April 2013 – Email from Mr John Carroll, Professional Practice Coordinator, Counselling and Relationship Services, Anglicare – declining invitation to give evidence at the public hearings for the inquiry drug and alcohol treatment.
- 4 April 2013 – Letter from Ms Fiona Davies, CEO, Australian Medical Association (NSW) – apologising for her error which led to her non-attendance at the public hearing for the inquiry drug and alcohol treatment on Thursday, 4 April 2013.

Sent:

- 5 April 2013 – Letter to Dr Michelle Bruniges, Director General, Department of Education and Communities – advising that a Departmental officer is scheduled to attend a public hearing for the inquiry into drug and alcohol treatment on Wednesday, 10 April 2013.
- 5 April 2013 – Letter to the Hon Ann Bressington MLC – inviting her to make a submission to the inquiry into drug and alcohol treatment.
- 8 April 2013 – Letter to Dr Mary Foley, Director General, NSW Ministry of Health – requesting a background briefing and inviting the agency to attend a public hearing for the inquiry into drug and alcohol treatment on Monday, 27 May 2013.
- 8 April 2013 – Letter to Mr Laurie Glanfield, Director General, Department of Attorney General and Justice – requesting a background briefing and inviting the agency to attend a public hearing for the inquiry into drug and alcohol treatment on Monday, 27 May 2013.

Resolved on the motion of Ms Ficarra: That the secretariat contact Dr O'Neil to confirm if the document, entitled, *Sustained Release Naltrexone in the treatment of heroin addiction* has or will be published and if so in what journal.

4. Tabled papers
Resolved, on the motion of Ms Barham: That the Committee accept the documents tendered during the hearings on 3 April 2013 and 4 April 2013 and publish the document entitled *The Cochrane Collaboration, review of methadone maintenance therapy and accompanying documents.*

5. Inquiry into drug and alcohol treatment

5.1 Submissions

Resolved, on the motion of Ms Barham: That the Committee note that submissions 32 and 49 were published by the Committee Clerk, subject to checking for confidentiality, adverse mention and other issues, in accordance with the Committee's resolution of 21 November 2012.

Resolved, on the motion of Ms Barham: That the Committee invite the author of submission 32 to appear at a public hearing on 27 May 2013.

5.2 Site visits

The Committee discussed site visit options following the resolutions of 4 April 2013 to visit the Fresh Start Clinic in Perth, Western Australia, the Sydney Medically Supervised Injecting Centre, and to investigate other potential site visits.

Resolved on the motion of Revd Nile: That the Committee investigate the possibility of visiting the Fresh Start Clinic on Thursday, 16 May 2013.

Resolved on the motion of Mr Moselmane: That the Committee undertake a site visit to Orange to inspect the Lyndon Community and the Involuntary Drug and Alcohol Treatment Centre, Bloomfield Hospital; and investigate the possibility of visiting drug and alcohol treatment services in the Far North Coast, New South Wales.

The Chair advised the Committee that if members were unable to attend all proposed site visits that the quorum of a committee is three members.

5.3 Public hearing

Witnesses, the public and the media were admitted.

The Chair made an opening statement regarding the broadcasting of proceedings and other matters.

The following witnesses were sworn and examined:

- Mr Gerard Byrne, Clinical Director, Recovery Services, The Salvation Army
- Major David Pullen, Director, Recovery Services, The Salvation Army.

The evidence concluded and the witnesses withdrew.

The following witness was sworn and examined:

- Professor Adrian Dunlop, Member, Australasian Professional Society on Alcohol and other Drugs (APSAD).

The evidence concluded and the witness withdrew.

The following witness was sworn and examined:

- Mr Stephen Ling, Member and Nurse Practitioner in Drug and Alcohol, Drug and Alcohol Nurses of Australasia Inc (DANA).

Mr Ling tendered the following document:

- Ling S, 2007, 'Nurse practitioners in drug and alcohol: where are they?', *Australian Journal of Advanced Nursing*, Vol 26, No 4.

The evidence concluded and the witness withdrew.

The following witnesses were sworn and examined:

- Associate Professor Richard Paoloni, Chair, NSW Faculty, Australasian College of Emergency Medicine (ACEM)
- Dr Lai Heng Foong, Public Health Committee, Australasian College of Emergency Medicine (ACEM).

The evidence concluded and the witnesses withdrew.

The following witness was sworn and examined:

- Professor John Saunders, Drug and Alcohol Program Director, Wesley Hospital Kogarah**.**

Professor Saunders tendered the following documents:

- Brief biography for Professor John B Saunders
- "Notes for NSW Parliamentary Inquiry".

The evidence concluded and the witness withdrew.

The following witnesses were sworn and examined:

- Mr Brian Smyth King, Executive Director, Learning and Engagement, Department of Education and Communities
- Ms Robyn Bale, Acting Director, Student Engagement and Interagency Partnership, Department of Education and Communities
- Ms Elizabeth Callister, Leader, Health and Wellbeing, Department of Education and Communities
- Mr Christopher Miles, Principal Legal Officer, Legal Services Unit, Department of Education and Communities**.**

Mr Smyth King tendered the following document:

- NSW Public Schools Learning and Teaching – Frequently asked questions – extracted from www.schools.nsw.edu.au.

The evidence concluded and the witnesses withdrew.

The following witness was sworn and examined:

- Ms Fiona Davies, Chief Executive Officer, Australian Medical Association (NSW) Limited.

The evidence concluded and the witness withdrew.

6. Deliberative meeting

Resolved, on the motion of Ms Westwood: That the Committee contact the NSW Aboriginal Drug and Alcohol Network to invite them to make a submission to the Inquiry and appear at a public hearing on 27 May 2013.

7. Adjournment

The Committee adjourned at 4:15 pm *sine die.*

Alex Stedman
Clerk to the Committee

Minutes No. 28
Tuesday, 14 May 2013
General Purpose Standing Committee No. 2
Terminal 2, Sydney Domestic Airport at 7.30 am

1. Members present
Ms Ficarra, *Chair*
Revd Nile, *Deputy Chair (Mr Green)* (until 12.30 pm)
Ms Barham
Mr Clarke
Mr Moselmane
Ms Westwood

2. Apologies
Miss Gardiner

3. Inquiry into drug and alcohol treatment
Committee members travelled to Bloomfield Hospital, Orange to the Lyndon Community, and Involuntary Drug and Alcohol Treatment Centre.

Committee members met with representatives from the Lyndon Community, including:

- Mr Ed Zarnow, CEO
- Ms Michelle Campbell, Manager Withdrawal Unit
- Ms Erin Stanley, Aboriginal Outreach
- Ms Cathy Wilson, Manager, Residential Rehabilitation
- Ms Ali Whytes
- Ms Jess Stanley.

Committee members undertook a tour of inspection of the Lyndon Community facilities.

Revd Nile left the meeting.

Committee members met with representatives from the Involuntary Drug and Alcohol Treatment Centre, including:

- Dr Russell Roberts, Director, MHDA
- Bruce Middleton, Manager MHDA Service Delivery
- Robyn Murray, Manager MHDA Service Development & Performance
- Walter Zyla, Senior Nurse Manager MHDA
- Dr Scott Clark, Clinical Director, MHDA Services
- Adrian Fahy, MHDA Manager, Orange and Regions
- Helen Gotch, Acting Senior Team Leader Drug & Alcohol, Orange & Regions
- Michael Thompson NUM, IDAT Unit
- Dr Barbara Sinclair, Clinical Director, IDAT Unit
- Helen McFarlane, MHDA Senior Nurse Manager, Bloomfield Campus
- Mr Deryk Slater, Clinical Leader Drug & Alcohol, Orange & Regions
- Dr Tony Gill, VMO, Addiction Medicine.

Dr Sinclair tendered the following documents:

- Medical admission pack for the Involuntary Drug and Alcohol Treatment Centre
- Forms relating the operation of the *Drug and Alcohol Treatment Act 2007*

- Information papers on the Involuntary Drug and Alcohol Treatment Program.

Committee members undertook a tour of inspection of the Involuntary Drug and Alcohol Treatment Centre.

4. Adjournment
The Committee adjourned at 6.25 pm until Wednesday, 15 May 2013 at 7.25 am, Terminal 3, Sydney Domestic Airport.

Alex Stedman
Clerk to the Committee

Minutes No. 29
Wednesday, 15 May 2013
General Purpose Standing Committee No. 2
Terminal 3, Sydney Domestic Airport at 7.25 am

1. Members present
Ms Ficarra, *Chair*
Revd Nile, *Deputy Chair (Mr Green)*
Ms Barham
Mr Clarke (from 12 pm)
Mr Moselmane
Ms Westwood

2. Apologies
Miss Gardiner

3. Inquiry into drug and alcohol treatment
Committee members travelled to the Fresh Start Recovery Programme, Subiaco, Perth, Western Australia.

Mr Clarke joined the meeting.

Committee members met with the representatives from the Fresh Start Recovery Programme, including:

- Mr Jeff Claughton, CEO
- Dr George O'Neil, Addiction and O&G Specialist, Medical & Research Director
- Dr Zravko Cerjan, Psychotherapist
- Ms Erin Kelty, Research Coordinator
- Mr Gary Anderson, Mental Health Nurse.

Mr Jeff Claughton tendered following document:

- Fresh Start Recovery Programme information package.

Committee members undertook a tour of inspection of the Fresh Start Recovery Programme facilities.

4. Adjournment
The Committee adjourned at 5.00 pm until Thursday, 16 May 2013 at 8.40 am, Hyatt Regency foyer, Perth.

Alex Stedman
Clerk to the Committee

Minutes No. 30

Thursday, 16 May 2013
General Purpose Standing Committee No. 2
Hyatt Regency foyer, Perth at 8.40 am

1. Members present

Ms Ficarra, *Chair*
Revd Nile, *Deputy Chair (Mr Green)*
Ms Barham
Mr Clarke
Mr Moselmane
Ms Westwood

2. Apologies

Miss Gardiner

3. Inquiry into drug and alcohol treatment

Committee members travelled to the Drug and Alcohol Office, WA Health, Mt Lawley.

Committee members met with the following representatives from the Drug and Alcohol Office, WA Health:

- Mr Neil Guard, Executive Director
- Mr James Hunter, Director, Client Services and Development.

Mr Hunter tendered the following document:

- Drug and Alcohol Office, *Submission to the Education and Health Standing Committee,* Inquiry into the Adequacy and Appropriateness of Prevention and Treatment Services for Alcohol and Illicit Drug Problems in Western Australia.

4. Adjournment

The Committee adjourned at 12.30 pm until Monday, 27 May 2013 at 9.15 am, Macquarie Room, Parliament House (public hearing).

Alex Stedman
Clerk to the Committee

Draft Minutes No. 31

Monday 27 May 2013
General Purpose Standing Committee No. 2
Macquarie Room, Parliament House, 10.05 am

1. Members present

Ms Ficarra, *Chair*
Revd Nile, *Deputy Chair*
Ms Barham
Mr Clarke
Miss Gardiner
Mr Moselmane
Ms Westwood

2. Previous minutes

Resolved, on the motion of Ms Barham: That draft Minutes No. 27, 28, 29 and 30 be confirmed.

3. Correspondence

The Committee noted the following items of correspondence:

Received

- 11 April 2013 – From Mr Jeff Claughton, CEO, Fresh Start Recovery Programme – responding to the Chair's request for the reference details for an article, entitled, *Sustained Release Naltrexone in the treatment of heroin addiction.*
- 2 May 2013 – From the Hon Don Harwin MLC, President of the Legislative Council – approving the Committee's request to travel to Perth, Western Australia for site visits to the Fresh Start Recovery Programme and the Drug and Alcohol Office, WA Health.
- 13 May 2013 – From Mr Brendan Thomas, Assistant Director General, Department of Attorney General and Justice – response to the Committee's request for the Department to prepare an information briefing and to appear as a witness at a public hearing on Monday, 27 May 2013.
- 16 May 2013 – From Ms Erin Kelty, Research Coordinator, Fresh Start Recovery Programme – providing the Committee with research publications on opioid use during pregnancy.
- 22 May 2013 – From Ms Sallie Cairnduff, Manager, Public Health Unit, Aboriginal Health & Medical Research Council – declining invitation to attend public hearing on Monday, 27 May 2013.

Sent

- 11 April 2013 – Email to Ms Sandra Bailey, CEO, Aboriginal Mental Health & Medical Research Council – inviting the NSW Aboriginal Drug and Alcohol Network to make a submission to the Inquiry into drug and alcohol treatment and to appear as a witness at a public hearing on Monday, 27 May 2013.
- 24 April 2013 – Letter to Dr Russel Roberts, Director, Mental Health and Drug and Alcohol Services – requesting that the Committee undertake a site visit to the Involuntary Drug and Alcohol Treatment Centre, Bloomfield Hospital, Orange.
- 2 May 2013 – Memorandum to the Hon Don Harwin MLC, President of the Legislative Council – requesting approval for the Committee to travel to Perth, Western Australia for site visits to the Fresh Start Recovery Programme and the Drug and Alcohol Office, WA Health.
- 3 May 2013 – Letter to Mr Neil Guard, Executive Director, Drug and Alcohol Office, WA Health – requesting that the Committee undertake a site visit to the Drug and Alcohol Office, WA Health.
- 3 May 2013 – Letter to the Hon Helen Morton MLC, Western Australia Minister for Mental Health; Disability Services – advising her of the Committee's site visits to the Fresh Start Recovery Programme on 15 May 2013 and the Drug and Alcohol Office, WA Health on 16 May 2013.
- 7 May 2013 – Letter to Mr Andrew Gee MP – advising him of the Committee's site visits to the Lyndon Community and Involuntary Drug and Alcohol Treatment Centre both located at the Bloomfield Hospital, Orange on 14 May 2013.

4. Inquiry into drug and alcohol treatment in NSW

4.1 Submissions

Resolved, on the motion of Ms Westwood: That the Committee note that submissions nos 48, 50, 51, 52 and 53 were published by the Committee Clerk, subject to checking for confidentiality, adverse mention and other issues, in accordance with the Committee's resolution of 21 November 2012.

4.2 Responses to questions on notice and supplementary questions

Resolved, on the motion of Miss Gardiner: That the Committee, in accordance with its resolution of 30 May 2011, note the publication by the Committee Clerk, of the answers to questions on notice and supplementary questions provided by the witnesses listed above.

4.3 Correspondence seeking further information

Resolved, on the motion of Revd Nile: That the Committee write to the Therapeutic Goods Administration to seek further information on:

- the procedure by which Dr O'Neil currently obtains approval to use the naltrexone implant he has developed for treatment under the Special Access Scheme
- the approval process that Dr O'Neil would need to comply with in order to obtain approval to supply and market the naltrexone implant he has developed; that is, for treatment on patients other than those under Dr O'Neil's care at the Fresh Start Recovery Programme, and any indicative timeframes associated with this process.

Resolved, on the motion of Revd Nile: That the Committee write to the National Health and Medical Research Council to seek advice on whether the Council is considering providing funding for any future research projects on the efficacy of naltrexone implants.

4.4 Public hearing

Witnesses, the public and the media were admitted.

The Chair made an opening statement regarding the broadcasting of proceedings and other matters.

The following witnesses from Drug and Alcohol Multicultural Education Centre were sworn and examined:

- Mr Kelvin Chambers, Chief Executive Officer
- Ms Rachel Rowe, Senior Research Officer.

The evidence concluded and the witnesses withdrew.

The following witness from Life Education was sworn and examined:

- Mr Jay Bacik, Chief Executive Officer.

The evidence concluded and the witness withdrew.

The following witness from the NSW Ministry of Health was sworn and examined:

- Mr David McGrath, Director, Mental Health and Drug & Alcohol Programs.

The evidence concluded and the witness withdrew.

The following witnesses from Family Drug Support were sworn and examined:

- Mr Tony Trimingham OAM, Chief Executive Officer
- Ms Carla Unicomb, Member, Volunteer
- Ms Judy Smith, Volunteer.

Mr Trimingham tendered the following documents:

- Family Drug Support promotional materials
- 2012 Family Drug Support annual report
- April-May 2013 Family Drug Support newsletter.

The evidence concluded and the witnesses withdrew.

The following witnesses from the Department of Attorney General and Justice were sworn and examined:

- Mr Brendan Thomas, Assistant Director General, Crime Prevention and Community Programs
- Dr Anne Marie Martin, Assistant Commissioner, Offender Management and Policy

The evidence concluded and the witnesses withdrew.

The public hearing concluded at 3.31 pm. The public and the media withdrew.

5. Adjournment

The Committee adjourned at 3.31 pm until Wednesday 12 June 2013 at 8.00 am, Parliament House (site visit).

Alex Stedman
Clerk to the Committee

Minutes No. 32

Wednesday, 12 June 2013
General Purpose Standing Committee No. 2
Security Gatehouse, Macquarie Street, NSW Parliament at 8.00 am

1. Members present

Ms Ficarra, *Chair*
Revd Nile, *Deputy Chair (Mr Green)*
Ms Barham
Mr Clarke
Mr Moselmane
Ms Westwood
Miss Gardiner

2. Inquiry into drug and alcohol treatment – site visit to the Sydney Medically Supervised Injecting Centre

Committee members attended the Sydney Medically Supervised Injecting Centre and were met by the following representatives:

- Ms Jennifer Holmes, Clinical Services Manager, SMSIC
- Mr Steve Teulan, Director, Uniting Care, Ageing
- Mr William Wood, CNC – Referral Coordinator, SMSIC
- Mr Mark Goodhew, CNC – Mental Health Nurse Coordinator, SMSIC.

Committee members undertook a tour of inspection of the Sydney Medically Supervised Injecting Centre facilities.

3. Inquiry into drug and alcohol treatment – site visit to the St Vincent's Emergency Department, and Drug & Alcohol Service

Committee members attended the St Vincent's Emergency Department, and Drug & Alcohol Service and were met by the following representatives:

- Professor Gordian Fulde, Director, Emergency Department
- Dr Peter McGeorge, Director, Mental Health
- Dr Robert Graham, former Director of the Alcohol & Drug Service
- Ms Catherine Andrews, Rankin Court Nurse Unit Manager
- Mr Brian Francis, Manager, Stimulant Treatment Program

- Dr Paul Preisz, Deputy Director Emergency Department
- Sianne Hodge, Project Officer, Alcohol & Drug Service.

Committee members undertook a tour of inspection of the St Vincent's Emergency Department, and Drug & Alcohol Service facilities.

4. Adjournment
The Committee adjourned at 12.15 pm *sine die.*

Alex Stedman
Clerk to the Committee

Minutes No. 33
Thursday 20 June 2013
General Purpose Standing Committee No. 2
Member's Lounge, Parliament House, 12.50pm

1. Members present
Ms Ficarra, *Chair*
Mr Green, *Deputy Chair* (from 12.55 pm)
Ms Barham
Mr Clarke (from 12.55 pm)
Miss Gardiner
Mr Moselmane
Ms Westwood

2. Previous minutes
Resolved, on the motion of Ms Westwood: That draft Minutes No. 32 be confirmed.

3. Correspondence
The Committee noted the following items of correspondence:

Received

- 4 June 2013 – From Dr John Skeritt, National Manager, Therapeutic Goods Administration (TGA) to Committee regarding procedures by which Dr O'Neil gets TGA approval to use naltrexone implants under the Special Access Scheme; and the approval process that Dr O'Neil would need to comply with in order to obtain approval to supply and market naltrexone implants.
- 14 June 2013 – From Professor Paul Preisz to Director providing a copy of St Vincent's drug and alcohol model of care, 'Psychiatric, Alcohol, Non-prescription Drug Assessment' Area Project (PANDA), June 2012.

4. Inquiry into Drug and Alcohol Treatment – Responses to questions on notice and supplementary questions

Resolved, on the motion of Miss Gardiner: That the Committee, in accordance with its resolution of 30 May 2011, note the publication by the Committee Clerk, of the answers to questions on notice and supplementary questions provided by the following witnesses:

- Dr Marianne Jauncey, Medical Director, Sydney Medically Supervised Injecting Centre
- Professor John Saunders, Drug and Alcohol Program Director, Wesley Hospital Kogarah.

5. ***

6. ***

7. Adjournment
The Committee adjourned at 12:57pm until 9:30am, Thursday 8 August 2013, Room 1153, Drug and Alcohol Treatment Report deliberative.

Stewart Smith
Clerk to the Committee

Draft Minutes No. 34

Thursday, 8 August 2013
General Purpose Standing Committee No. 2
Room 1153, Parliament House at 9.30 am

1. Members present
Ms Ficarra, *Chair*
Revd Nile, *Deputy Chair* (Mr Green)
Ms Barham
Mr Clarke
Miss Gardiner
Mr Moselmane
Ms Westwood

2. Previous minutes
Resolved, on the motion of Ms Barham: That Draft Minutes No. 33 be confirmed.

3. Inquiry into drug and alcohol treatment

3.1 Correspondence
The Committee noted the following items of correspondence:

Received

- 20 June 2013 – From Dr Clive Morris, Head, Research Policy Taskforce, National Health and Medical Research Council (NHMRC) – response to the Committee's correspondence on whether the NHMRC is considering providing funding for any future research projects on the efficacy of naltrexone implants.

Sent

- 29 May 2013 – Correspondence to the NHMRC – seeking information on whether the NHMRC is considering providing funding for any future research projects on the efficacy of naltrexone implants.
- 29 May 2013 – Correspondence to the Therapeutic Goods Administration – seeking information on the procedure by which Dr O'Neil currently obtains approval to use the naltrexone implant he has developed for treatment under the Special Access Scheme; and the approval process that Dr O'Neil would need to comply with in order to obtain approval to supply and market the naltrexone implant he has developed.
- 21 June 2013 – Correspondence to Ms Sianne Hodge, Project Officer – Alcohol and Drug Service, St Vincent's Health Network – thanking Ms Hodge and her colleagues for coordinating the Committee's site visit to St Vincent's Hospital on 12 June 2013.

- 21 June 2013 – Correspondence to Mr Rohan Glasgow, Office Manager, Sydney Medically Supervised Injecting Centre (SMSIC) – thanking Mr Glasgow and his colleagues for coordinating the Committee's site visit to the SMSIC on 12 June 2013.

Resolved, on the motion of Revd Nile: That the Committee publish the correspondence received from the NHMRC and the Therapeutic Goods Administration.

3.2 Submissions

Resolved, on the motion of Mr Clarke: That the Committee note that submission No. 54 was published by the Committee Clerk, subject to checking for confidentiality, adverse mention and other issues, in accordance with the Committee's resolution of 21 November 2012.

3.3 Answers to questions on notice and supplementary questions

Resolved, on the motion of Ms Westwood: That the Committee, in accordance with its resolution of 30 May 2011, note the publication by the Committee Clerk, of answers to questions on notice and supplementary questions provided by the following witnesses:

- 20 June 2013 – Department of Attorney General and Justice
- 25 June 2013 – Australian Medical Association (NSW) Limited
- 27 June 2013 – NSW Ministry for Health
- 4 July 2013 – Life Education NSW, enclosing a hard copy of Report to Life Education Australia, Commissioned by the Australian Government of Health and Ageing, Best Practice Education As applied to Life Education Australia
- 22 July 2013 – Drug and Alcohol Multicultural Education Centre.

3.4 Consideration of the Chair's draft report on drug and alcohol treatment

The Chair submitted her draft report entitled 'Drug and alcohol treatment' which, having been previously circulated, was taken as being read.

Chapter 1 read.

Resolved, on the motion of Revd Nile: That paragraph 1.7 be amended by inserting the words 'and public health' after the words 'addiction medicine' at the end of the first sentence.

Chapter 2 read.

Resolved, on the motion of Revd Nile: That the title 'A ubiquitous problem' be amended by omitting the word 'ubiquitous' and inserting instead the words 'far-reaching and widespread'.

Resolved, on the motion of Revd Nile: That, where appropriate, instances of the word 'ubiquitous' be replaced with the words 'many and widespread' throughout the report.

Resolved, on the motion of Revd Nile: That paragraph 2.17 be amended by inserting the words 'via the Ministerial Council on Drug Strategy' after the words 'education portfolios),' in the second sentence.

Resolved, on the motion of Revd Nile: That paragraph 2.22 be amended by omitting the words 'high profile' and inserting instead the words 'at times controversial' after the word 'more' and before the words 'harm minimisation' in the first sentence.

Resolved, on the motion of Revd Nile: That a new paragraph and table be inserted after paragraph 2.28 to read 'In its submission, Drug Free Australia drew the Committee's attention to the United Nations *World Drug Report 2000* which they said showed that the annual prevalence of illicit drug abuse was lower in Sweden than other countries including the United Kingdom and Australia. Data from the *World Drug Report 2000* comparing the annual prevalence of illicit drug abuse in Sweden, the United Kingdom and Australia is reproduced in the table below':

Table 1 Annual prevalence of abuse of illicit drugs

Country	Cannabis % and year	Opioids % and year	Cocaine % and year	Amphetamines % and year	Ecstasy % and year
Sweden	0.1% 1998	0.1% 1997	0.2% 1998	0.2% 1997	0.1% 1998
United Kingdom	9.0% 1998	0.5% [aa]	1.0% 1998	1.3% [aa]	1.0% 1998
Australia	17.9% 1998	0.7% 1998	1.4% 1998	3.6% 1998	N/A

Chapter 3 read.

Resolved, on the motion of Miss Gardiner: That a new paragraph be inserted after paragraph 3.53 to read:

'After the Committee had completed its hearings, the NSW Auditor-General published a report, entitled, *Cost of alcohol abuse to the NSW Government.* In a media release the Auditor-General, Mr Peter Achterstraat indicated that the NSW Government could better respond to alcohol abuse if it had more information on the associated costs:

- If social costs are included, the total cost of alcohol abuse in New South Wales is around $3.87 billion per annum, or about $1,565 from each household.
- It is important for Government to have good information on the costs of alcohol abuse so it can respond effectively to the problem…If costs were increasing, this could be a trigger for a different approach.
- The NSW Government should estimate the cost of alcohol abuse (every 3 years) and publically report the cost – so the Government and the public know whether the problem is getting better or worse…The community also has a right to know this information so it can inform public debate on alcohol abuse and the best ways to combat it'.

Resolved, on the motion of Ms Barham: That a new paragraph be inserted after paragraph 3.63 to read 'The Committee also notes that it is ten years since the 2003 New South Wales Alcohol Summit was held and that a number of important recommendations were made at the Summit'.

Resolved, on the motion of Ms Barham: That paragraph 3.64 be amended by inserting new sentences to read 'In addition, more investment in formal addiction medicine training is required. The Committee further notes that workforce capacity in non-government drug and alcohol organisations faces difficulty due to contract based funding' at the end of the paragraph.

Resolved, on the motion of Ms Barham: That paragraph 3.65 be amended by inserting the word 'strongly' after the word 'therefore' and before the word 'support' in the second sentence.

Resolved, on the motion of Ms Barham: That paragraph 3.66 be amended by inserting the word 'significant' after the words 'quantify the' and before the word 'impacts' in the first sentence.

Resolved, on the motion of Ms Barham: That a new sentence be inserted to paragraph 3.66 at the end of the paragraph to read: 'The Committee encourages the consideration of uniform data collection in relation to substance abuse for emergency department presentations'.

Resolved, on the motion of Ms Westwood: That paragraph 3.67 be amended by omitting the words 'drug free' and instead inserting the words 'free of drug abuse'.

Resolved, on the motion of Ms Barham: That a new paragraph be inserted after 3.68 to read 'The Committee notes that it is ten years since the 2003 New South Wales Alcohol Summit was held and that a number of important recommendations were made at the Summit'.

Resolved, on the motion of Miss Gardiner: That Recommendation 1 be amended by inserting the words 'noting the report of the NSW Auditor-General, entitled, *Cost of alcohol abuse to the NSW Government,* and

the evidence submitted to the General Purpose Standing Committee No. 2 Inquiry into drug and alcohol treatment', after the words 'that the NSW Government' and before the word 'approach'.

Resolved, on the motion of Mr Moselmane: That Recommendation 1 be amended by omitting the words 'a timely manner' and inserting instead '2014-2015' after the words 'convened in' at the end of the sentence.

Resolved, on the motion of Ms Barham: That a new Recommendation be inserted after Recommendation 1 to read: 'That the NSW Government review the recommendations of the 2003 New South Wales Alcohol Summit and provide an update regarding its response to those recommendations.'

Chapter 4 read.

Resolved, on the motion of Ms Barham: That the words 'and other opioid treatments' be inserted after the word 'Naltrexone' in the title of Chapter 4.

Resolved, on the motion of Ms Barham: That a new paragraph be inserted after paragraph 4.94 to read: 'The Committee notes the broad support for the effectiveness of opioid substitution treatment including its positive outcomes in relation to improvements in a patient's social, personal and physical functioning'.

Resolved, on the motion of Ms Barham: That a new paragraph be inserted after paragraph 4.94 to read: 'The Committee was advised by the Australian National Council on Drugs that naloxone is a safe and effective intervention for preventing opioid overdose and that it supports the expansion of naloxone availability and training to relevant healthcare professionals to treat opioid overdose'.

Resolved, on the motion of Ms Barham: That a new Recommendation be inserted to read: 'That the NSW Government consider expanding the availability of naloxone and the provision of training to relevant healthcare professionals to prevent opioid overdose fatalities'.

Resolved, on the motion of Ms Westwood: That paragraph 4.99 be amended by omitting the words 'Dr O'Neil's' from the first sentence.

Resolved, on the motion of Miss Gardiner: That a new paragraph be inserted after paragraph 4.100 to read: 'The Committee also notes that in the 2011-2012 and 2012-2013 budgets, the NSW Ministry for Health did not allocate any funds for clinical trials'.

Revd Nile moved: That Recommendation 2 be amended by:

- Inserting the words ', if naltrexone implants are approved for use by the Therapeutic Goods Administration' after the word 'That' at the beginning of the first sentence
- omitting the second sentence which reads 'The conduct of this trial would be conditional on naltrexone implants being approved for use by the Therapeutic Goods Administration'
- inserting the words 'and public health' after the words 'addiction medicine' in the final sentence
- inserting the words 'and that participation in such a trial by other Australian States and international jurisdictions be encouraged'.

Question put.

The Committee divided.

Ayes: Mr Clarke, Ms Ficarra, Miss Gardiner, Revd Nile

Noes: Ms Barham, Mr Moselmane, Ms Westwood

Question resolved in the affirmative.

Chapter 5 read.

Resolved, on the motion of Ms Westwood: That paragraph 5.60 be amended by omitting the words 'agrees with' and instead inserting the word 'notes' in the first sentence.

Resolved, on the motion of Revd Nile: That paragraph 5.74 be amended by inserting the words 'The Committee calls for consideration of a further expansion to other regional centres beyond Sydney and the Hunter' at the end of the paragraph.

Resolved, on the motion of Ms Barham: That paragraph 5.77 be amended by inserting a new sentence to read 'The Committee also notes the evidence that identifies the cost savings achieved through the operation of the Drug Court program, and calls for consideration of a further expansion to other regional centres beyond Sydney and the Hunter' after the first sentence.

Resolved, on the motion of Ms Barham: That a new Recommendation be inserted to read 'That the NSW Government consider a further expansion of the Drug Court program to other regional centres outside of Sydney and the Hunter'.

Chapter 6 read.

Resolved, on the motion of Ms Barham: That paragraph 6.20 be amended by inserting the words 'including the unmet need for residential rehabilitation programs' after the word 'services,' in the first sentence and by omitting the paragraph's last sentence.

Resolved, on the motion of Ms Barham: That paragraph 6.44 be amended by inserting the words ', in particular ancillary services,' after the word 'funding in the first sentence and by inserting a new second sentence to read 'The Committee also notes the need for improved CALD services and the opportunity for web-based translated information'.

Chapter 7 read.

Resolved, on the motion of Ms Westwood: That paragraph 7.46 be amended by inserting the words 'resources dedicated to supporting' after the words 'stresses that' and by omitting the word 'support' in the second sentence.

Resolved, on the motion of Ms Westwood: That paragraph 7.47 be amended by:

- Omitting the words 'on its work' and inserting instead the words 'and other providers on their work' after the words 'commends Life Education NSW' in the first sentence
- Omitting the word 'its' after the word 'given' and inserting instead the word 'their' in the first sentence
- Inserting the words 'and other providers' after the words 'should consult Life Education NSW' in the first sentence
- Inserting the words 'and other providers' after the words 'Life Education NSW' in the second sentence
- Omitting the words 'its' after the word 'attending' and inserting instead 'their' in the second sentence.

Resolved, on the motion of Ms Westwood: That paragraph 7.48 be amended by inserting the words 'and other providers' after the words 'Life Education NSW' and by omitting the word 'its' after the words 'participate in' and inserting instead the word 'their'.

Resolved, on the motion of Ms Westwood: That Recommendation 4 be amended by inserting the words 'and other providers' after the words 'Life Education NSW' and by omitting the word 'its' after the words 'participate in' and inserting instead 'their'.

Resolved, on the motion of Revd Nile: That the draft report, as amended, be the report of the Committee and that the Committee present the report to the House;

That the transcripts of evidence, submissions, tabled documents, answers to questions on notice, answers to supplementary questions, minutes of proceedings and correspondence relating to the inquiry be tabled in the House with the report; and

That upon tabling, all transcripts of evidence, submissions, tabled documents, answers to questions on notice, answers to supplementary questions, minutes of proceedings and correspondence relating to the Inquiry not already made public, be made public by the Committee, except for those documents kept confidential by resolution of the Committee.

Resolved, on the motion of Revd Nile: That any dissenting statements be provided to the Secretariat by 9 am, Tuesday 13 August 2013.

Resolved, on the motion of Ms Barham: That the final report on drug and alcohol treatment be tabled on Thursday, 15 August 2013.

The Chair advised that a revised Summary of Key Issues and the Chair's foreword would be circulated to members.

4. Adjournment

The Committee adjourned at 12.39 pm until Monday, 12 August 2013 at 8.45 am, Jubilee Room, Parliament House (Budget Estimates).

Madeleine Foley
Clerk to the Committee

Appendix 7 Dissenting Statement

DISSENTING STATEMENT BY
THE HON HELEN WESTWOOD AM MLC AND THE HON SHAOQUETT MOSELMANE MLC

On 25 October 2012 Revd. the Hon Fred Nile introduced into the NSW Parliament the Drug and Alcohol Treatment Amendment (Rehabilitation of Persons with Severe Dependence) Bill 2012. The Bill seeks to amend the Drug and Alcohol Treatment Act 2007 to further provide for the involuntary rehabilitative treatment of persons with severe substance dependence.

On 21 November 2012, General Purpose Standing Committee No.2 (GPSC 2) self-referred an Inquiry into the effectiveness of current alcohol and drug policies with respect to deterrence, treatment and rehabilitation.

The Inquiry received evidence from experts in the field of addiction medicine (both clinicians and researchers), police and government and non government drug and alcohol services.

We are in general agreement with the comments and recommendations of the report, however we are not in agreement with Recommendation 4 and argue that the evidence before the Inquiry does not support such a recommendation being made.

We agree with the expert clinicians and researchers who gave evidence that NSW government funds are best directed towards funding the proven treatment options currently available at a level that meets the need in the NSW community. Further, the Inquiry received evidence that the current level of funding is inadequate to meet existing demands and accordingly recommended the NSW Government ensure funding levels keep pace with increasing demand as per Recommendation 6.

Specifically, we agree with the expert witnesses who gave evidence that

1. Naltrexone implants are experimental products that are proposed as a possible intervention for the treatment of opioid dependence.

2. Existing treatments, such as methadone and buprenorphine are effective.

3. The treatment gap in New South Wales between available interventions and those who need them is enormous. A significant number of people requiring treatment are not able to access proven cost effective treatments.

4. 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 significant funds, resources and time there is

no evidence to support the investment of State government funds into research into naltrexone implants as a higher priority for research funding than other interventions or other areas of research that is important for our State.

5. In respect of a new product that is experimental, research should progress and find interventions for many illnesses that face the human population, but these need to be on the basis of population need. We do not agree that research as proposed in Recommendation 4 is the best use of NSW Government funding in the area of drug and alcohol treatment.

6. There is a process nationally through the National Health and Medical Research Council with competitive rounds that are subjected to peer review where funding could be sought to conduct the random trials as recommended in Recommendation 4.

In conclusion we are of the strong view that:

1. The development, testing and approval of new drugs is not a NSW Government responsibility.

2. Expense of such a trial would inevitably divert NSW Health funds away from front line services.

3. Concerns about the safety of these implants would make ethics approval and informed patient consent for such a trial problematic, most likely impossible.

4. Involuntary treatment (which would need a court order) with a drug would most likely present a risk to patient safety, and would make the NSW Government liable for any adverse events. The Insurance company (NSW TMF) would most likely recommend against such a trial.

5. There is no significant support worldwide among the Drug and Alcohol specialists for the use of such a trial in any patient, even less so for involuntary patients.

6. A trial such as recommended in recommendation 4 would (most likely) be unable to be blinded (ie have a placebo arm, or be compared to usual treatment). Added to the small numbers of persons to be treated, such a study would have limited scientific merit.

7. Naltrexone implants is a drug that has had very significant concerns raised about its safety to recommend involuntary treatment with such a drug is unethical and dangerous.