EDUCATION AND HEALTH STANDING COMMITTEE

REVIEW OF WA'S CURRENT AND FUTURE HOSPITAL AND COMMUNITY HEALTH CARE SERVICES

INQUIRY INTO THE ADEQUACY AND APPROPRIATENESS OF PREVENTION AND TREATMENT SERVICES FOR ALCOHOL AND ILLICIT DRUG PROBLEMS IN WESTERN AUSTRALIA

BRIEFING HELD AT SYDNEY
WEDNESDAY, 30 SEPTEMBER 2009

SESSION ONE

Members

Dr J.M. Woollard (Chairman)
Ms L.L. Baker (Deputy Chairman)
Mr P.B. Watson
Mr I.C. Blayney
Mr P. Abetz

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Briefing commenced at 8.30 am

LINTZERIS, ASSOCIATE PROFESSOR NICHOLAS
Policy Committee, Chapter for Addiction Medicine at the Royal Australasian College of Physicians,
c/- RPAH, SSWAHS, Missenden Road,
Camperdown 2050:

WODAK, DR ALEX
Doctor, St Vincent's Hospital, Victoria Street,
Darlinghurst 2010:

The CHAIRMAN: On behalf of the Education and Health Standing Committee I thank you for your interest and your appearance before us today. This is a private briefing for the committee's information. The committee may paraphrase the information you give us, but will generally not directly quote from it.

This committee is a committee of the Legislative Assembly of the Western Australian Parliament. This hearing is a formal procedure of Parliament and therefore commands the same respect given to proceedings in the house. Before we proceed to the questions we have for you today, I need to ask you a series of questions. Have you completed the "Details of Witness" form?

The Witnesses: Yes.

The CHAIRMAN: Do you understand the notes at the bottom of the form about giving evidence to a parliamentary committee?

The Witnesses: Yes.

The CHAIRMAN: Did you receive and read an information for witnesses briefing sheet provided with the "Details of Witness" form today?

The Witnesses: Yes.

The CHAIRMAN: Do you have any questions in relation to being a witness at today's hearing?

The Witnesses: No.

The CHAIRMAN: In that case, Professor, would you please state your full name and the capacity in which you appear before the committee today.

Prof. Lintzeris: My name is Nicholas Lintzeris. I attend as the chair of the Policy and Advocacy Committee, Chapter for Addiction Medicine at the Royal Australasian College of Physicians and also I am employed as a senior staff specialist at Sydney South West Area Health Service and hold a conjoint associate professor post at the University of Sydney.

The CHAIRMAN: Thank you.

Dr Wodak: My full name is Alexander David Wodak. I am a doctor and I am the director of the Alcohol and Drug Service at St Vincent's Hospital and I also chair the committee that wrote the policy on alcohol and illicit drugs for the Royal Australasian College of Physicians. I also submitted a document to this inquiry largely in relation to naltrexone implants.

The CHAIRMAN: We will start with Professor Lintzeris. I understand that you have seen this committee's term of reference. It is wanting to look at needs and gaps in terms of alcohol and illicit drugs. Thank you very much for supplying the committee with your alcohol policy. I notice that at

the back of the policy under "Where to Now?" reference is made to the availability of alcohol—in short, community interest is equal to the alcohol beverage industry influence and decisions, but a number of conditions, outlets and law enforcement are considered a more effective way of increasing liquor licensing strategies and responsible service of alcohol effectiveness by law enforcement agencies. Alcohol is not a problem just in WA. We actually attended the conference yesterday that was put on by NDYA at which alcohol was identified as the key problem in all states. While we are here to look at alcohol and illicit drugs, we are particularly interested in you, as you give your presentation, expanding on those two points.

Prof. Lintzeris: In deference to Alex, I think he is probably in a better position to actually talk about the alcohol policy initiatives. We can both touch upon those. In many respects the key responses to alcohol are largely evidence based. We know what works to address alcohol problems in the community, and that has pretty much been shown in evidence, not only here in Australia but also internationally. What works in Europe works in Australia as well. So it is a combination of factors. There are issues around levers that will impact upon accessibility and availability and cost. They are the biggest levers that we have available to us.

A key issue is taxation and, importantly, moving, if possible, towards a volumetric taxation system. Do committee members understand what we mean by volumetric taxation system?

The CHAIRMAN: Yes.

Prof. Lintzeris: It is one of the key policy arguments with regards to what works and to avoid the situation that we had in Australia, for example, most recently, with alcopops. There are forms of alcohol available in Australia that are not taxed to the same degree as other forms and that basically means that there are cost drivers. Taxation is one key issue.

I ask Alex to step in when he thinks that I have not made the point adequately.

Advertising is another key area. In Australia there are restrictions on advertising, but there have been some very clever ways in which industry has been able to get around those limitations and, in particular, the way the industry has been able to get advertising through sponsoring sport. Cricket is brought to us by various brewers and so forth. The whole idea about the restrictions around advertising is to limit advertising to particular vulnerable groups, particularly youth.

Mr P.B. WATSON: Do you think that the government should be taking over the responsibility of funding sport instead of the alcohol industry? Would they be concerned about the taxes they are not getting off the alcohol?

Prof. Lintzeris: No, at the end of the day sport is a big enough industry in its own right. It has a product that lots of people would be very keen to market. The same argument was made that if, 20 years ago, tobacco advertising had been pulled out of cricket and football, sport in this country would have collapsed. That did not happen. The Grand Prix is a more recent example. Bans on tobacco advertising in sport did not result in the collapse of sport. Sport is big enough and successful enough that it does not need government sponsorship.

Mr P.B. WATSON: I am from a regional area and I am not a great fan of sponsoring sport, but in regional areas the local hotel might sponsor the sport in the town, because it is the only one in the town that can do it. Coles and Woolies do not want to have anything to do with it. That is where we have to look at whether government should step in and maybe assist in some way in regional areas; not so much for the major sports, because they can look after themselves.

Prof. Lintzeris: You raise a very good point. A lot of that is about developing a framework for responsible involvement of groups such as the alcohol industry. The local pub in a country town is quite a different issue to Carlton and United Breweries having every second advert in the cricket. There is an outcry when one of the cricketers gets caught drunk. There are different standards going on here. That really does send a confusing message to people like us, let alone what it sends to the

average layperson who is trying to interpret what is going on. It would be possible to develop. Already local community involvement has been included in the development of some frameworks. I am not saying that we want to kick out the local pub from being involved. At the same time, there is a need to look at some of the practices that happen. For example, things like happy hour and those kinds of practices that are designed largely to attract custom and drink. Those kinds of things are areas in which the government should have a role.

The CHAIRMAN: Did you say that there are guidelines for those areas?

Prof. Lintzeris: A framework—we do not have good guidelines anywhere yet. There are lots of groups across the country. I know, for example, that there is good work happening in Newcastle, Geelong and other parts of Australia. I am not sure, but I expect there would be work happening in Western Australia, given some of the people working in Western Australia, into how to get community groups working with sporting clubs and so forth.

Unfortunately there has been the muddying of the water with the whole issue of DrinkWise. It has become a very big player in a lot of the community action partnerships. I am not sure whether you are familiar with some of the concerns around the independence of DrinkWise from the alcohol industry. DrinkWise was set up and it should never have had the majority of its board of directors coming from the alcohol industry. At the moment we have a situation in which, because of vacancies on the board, at least a percentage of the membership comes from the alcohol industry. At the moment it is about a 50-50 split.

The CHAIRMAN: What is DrinkWise?

Prof. Lintzeris: DrinkWise was not a government group; it was set up by Howard —

Mr P.B. WATSON: It is like RoadWise in WA. It is an independent group.

Prof. Lintzeris: Independent from government. I know that the federal government put money into establishing it. It was a John Howard government initiative. It received money from industry as well. It is largely run—I am not 100 per cent sure of its charter—along the lines of how to minimise the harm of alcohol on the community.

The CHAIRMAN: Like the hotel industry here.

Prof. Lintzeris: This is one of the difficulties when you have got industry involved. Of course, we want industry involved in partnerships.

Mr P.B. WATSON: You have to have a small amount.

Prof. Lintzeris: Yes. They need to be at the table. It is not as though we can do this without industry being involved. When they end up having either the majority or, at least, an equal say basically means that there will always be a conflict of interest in the extent to which industry will promote strategies, policies and interventions, which, at the end of the day, will reduce alcohol sales, particularly alcohol sales, that are profitable. We know that the alcohol industry is very vocal in trying to prevent some of the alcopop taxes that went through, as you would expect. This is their industry. It is not a benevolent society that is there for the wellbeing of the public; it is an industry group. A lot has been written about the independence of DrinkWise and a lot of leading public health groups in Australia have publicly announced that they will not receive funding from DrinkWise; they refuse to accept funding from DrinkWise because it is essentially industry controlled money at this point in time.
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Ms L.L. BAKER: I will turn to our terms of reference. There are three key issues. One is on the interventions around school-aged children and how effective they are. The second is about the gaps in services that are provided to deal with illicit drugs and alcohol. The third is about the level and scope of training that we give professionals. I would really like to hear what the Australian College

of Physicians' view is on each of those three points. The submission was understandably about naltrexone—that is fine, we can talk about that later—but I am really keen to hear what your comments are about school-aged children, the gaps in services and the training available, because we are looking to learn from you.

Prof. Lintzeris: In that order?

Ms L.L. BAKER: I do not mind, but that would work for me.

Prof. Lintzeris: I suggest maybe we do the treatment system because if we provide that as a framework then that allows us to then look at how it impacts upon youth and what it means for training. I think one of the key messages is that there is and there will always continue to be a significant component of the population who drink or use drugs to a harmful level and will always need some form of intervention and support. We need treatment services and we also need a range of access to treatment or interventions at different levels, so we need widely available, early interventions targeting those individuals who are not necessarily at the pointy tip of the —

Ms L.L. BAKER: Community or government-led—what is you preference?

Prof. Lintzeris: A combination of both, ultimately. When we are talking health interventions, ultimately health interventions are largely delivered in the health system. The quality of a drug and alcohol treatment system largely depends upon the quality of the health system and how good the public health system is. This population is by definition usually the marginalised, the ones who cannot afford access to private services necessarily, so we need to make sure that our services are accessible, available and embedded within a public health system. That will necessarily mean that they need to be public government services, as well as recognising that a large part of the Australian health system is based in private care. General practitioners are largely private practitioners; they are government-funded private practitioners but they are still private practitioners.

At this point in Australia—I am not sure exactly on where Western Australia is up to—our state-funded community health service system, the old community health centres that used to exist in many parts of Australia, have largely been wound back. Now in most parts of Australia we have state systems that focus on hospitals and sometimes in areas such as drug and alcohol specialist services. Primary care is largely funded through the commonwealth, so we will need systems that can be rolled out in primary care. We also need to recognise what is achievable in primary care settings. Primary care settings are where we roll out the early interventions, the brief interventions. Therefore, that is for the problem drinkers who may not be alcohol-dependent yet, or it might be for those individuals, for example, with pharmaceutical opioid problems or who are developing problems and we need to make sure that there are ways we can sort of prevent the development of people with early stage difficulties moving into the latter stage. Once you start talking about the delivery of services though to dependent individuals, the alcohol-dependent, the illicit drug users, the regular heroin users and the amphetamine users, then generally we largely are talking about a specialist service sector.

Ms L.L. BAKER: If you were to give a balance to early intervention or primary care versus tertiary and secondary care in this area, my assumption would be that we would probably have to spend more money on secondary and tertiary at the moment. Would you like to see more money eventually spent on prevention than on what is happening at the moment in treating people when they are addicted or are having problems?

Prof. Lintzeris: The key there is not so much about whether we take money away from the specialist sector to put into prevention, it is whether we take the money away from where we are spending most of our money, which is in law enforcement, and turning that back into more effective strategies. At the moment, most of our money in drug and alcohol goes on law enforcement. Therefore, we should be looking at taking money away from what we know works, such as sort of treatment of the dependent population; we know that works and is necessary. If we do not spend

money on these individuals in terms of treating them, they cost us more. They cost us in terms of criminal justice, public health, hospital admissions and Medicare expenses so we either pay upfront or we are going to pay later.

Mr P.B. WATSON: Nicholas, how early do you think we should be educating these people?

Prof. Lintzeris: This touches then on the issue of youth. The difficulty we have with interventions for youth is that we still really have an emerging evidence base. We do not really know—if someone were to say, "Here is a billion dollars, go and spend this on the education of youth to prevent alcohol and drug use", at this point in time we actually do not have great evidence available which tells us the effective strategies. The dilemma is that a lot of the politically saleable strategies—which is [*inaud*], Life Education, sort of in schools—unfortunately, there is not great evidence demonstrating that that works. What we do know works is often not politically easy to sell, so putting services into marginalised populations is essential. However, this is not necessarily just about treating 16-year-olds who are starting to binge drink and use some cannabis; these are broader issues about how we make sure that they have access to jobs, training, education, housing—the broader issues. Drug and alcohol prevention really goes hand in hand with those broader social and general health responses. It is not as though just going and making sure that every high school gets a one-hour lecture on "drugs are bad for you" is really the way forward, yet that has been historically the large focus on prevention. It is about mums and dads seeing that something is getting done for their sons and daughters, not necessarily putting the money where it is most needed.

Mr P.B. WATSON: Where is it most needed?

Prof. Lintzeris: We know who ends up having the greatest problems with drugs and alcohol. It is those people who are leaving school early, it is those people who are starting to get involved with crime at early ages, it is Aboriginal communities—so it is about making sure that the resources are going into those groups. All the warning signs are there at an early age, but historically that is not where we have necessarily focused a lot of our strategies.

The CHAIRMAN: We are going to move on to the naltrexone issue in a while, but while we are talking about prevention—those three areas—please join in on those three areas because you come from that treatment paradigm. I think Nicholas was saying to you before to join in and that way we will not again come back and ask you the same questions afterwards, so it will be useful when we are looking at the area, if we have the benefit of both of your comments.

Dr Wodak: On the first point, the education of school aged children, I think the evidence is in and I think the evidence is that the benefits of these efforts are fairly small and fairly transitory. There are numerous studies and I am quoting a specific meta-analysis that estimated the benefit was 3.7 per cent improvement, fairly small and did not last very long; a couple of months. I think that evidence is pretty consistent. Some interventions aimed at that population in fact had negative consequences. It is not the goldmine that people expect it to be. We have a real problem in the community and, if I may say so, amongst politicians that their expectations I believe are unrealistic and cannot be fulfilled. By all means young people need to be told the facts, I do not have a problem with that, but I do not think that we should expect that there is a bonanza in doing so.

The CHAIRMAN: I think what Nicholas was referring to was help those people who are falling out from school develop their sense of self-esteem and help them stay on at school, so that they do not move into that alcohol or drug-dependent knowledge.

Mr P.B. WATSON: The worst role models are the parents, really.

Dr Wodak: I think there is also emerging evidence, which I think is very persuasive, that inequality is a very significant issue. Australia is a remarkably unequal country when we look at the rich countries of the world in terms of the distribution of income and wealth. I am not an economist but I follow this because it is relevant to public health. In general, countries that are more unequal—the

United States, Australia, Portugal—have worse public health outcomes and this refers specifically to the prevalence of illicit drug use, obesity, mental health problems and incarceration rates, to give some examples; there are other outcomes that are also highly correlated with inequality. I think if we were serious about these issues, it is difficult to do but, I think particularly important at a time when our taxation system is under review and when one of the major mechanisms of redistribution perhaps could be changed, this is a time to have a debate about how much inequality we want to have. In a way, I suppose, the debate that we are now having about executive salaries and CEO salaries is part of that debate, so I think that is what I would say about —

Mr P. ABETZ: Are you familiar with what is happening in Sweden? I recently read an article on where the Swedes have taken quite a different approach to trying to minimise drug use. Whereas they have had a very liberal, for want of a better word, drug policy in the past, they have now moved to their prevention, as I understand it, of actually getting schools to identify the at-risk kids who are falling behind in education, who have trouble with learning, issues at home, and actually putting people alongside them to try to minimise that inequality, and they are working on that approach. I am just wondering what are your thoughts on that early intervention. They even have the kids at high school do urine tests and stuff to keep them on track?

Prof. Lintzeris: [*inaud*] highlights the importance of integrated thinking rather than this idea about there are things we do in schools, then there is a health system, taxation, and a self-regulating alcohol industry. What they have in Sweden, for example, is a higher level of taxation on alcohol than pretty much most countries in the world. Again, this gets us back to whether we put resources into school-based education programs that do not work and yet let the alcohol industry continue to advertise that Ricky Ponting drinks XXXX beer, for example—that is unintegrated thinking. That is actually quite short-sighted.

Sweden has a situation with a lot of the basic building blocks in place, such as a remarkable public health system in which they do not have this odd split between commonwealth and state-funded services where there are huge gaps. Who falls between the gaps? Often the marginalised. They have an integrated health system, they have a taxation policy and regulation of alcohol advertising that most of us would actually—the kinds of things that we call for, Sweden has in place. Once you have those basic building blocks in place how you respond to issues around cannabis use are really quite marginal issues in the big picture of the impact of drugs and alcohol in our society; how we respond to cannabis or to the one per cent of people who have used amphetamines recently, are almost side issues. Yes, the Swedes talk long and loud about how they are different from much of the rest of the world; there are huge similarities in what the Swedes are doing to what everyone else is doing. For example, Sweden has recognised in the last five years or so that their approach in responding to opioid dependence was not working. They more or less had a very restricted availability of methadone and buprenorphine treatment; almost no methadone treatments available. They were very proud of that other than the fact that it was not working for them. They have now gone and expanded access to things such as substitution and buprenorphine treatment, quite widespread expansion, but because of their own cultural and political reasons they will say that they are doing it differently from the way the rest of Europe is doing it. In many respects there is a lot to look at what Sweden is doing and is doing well, but it does not necessarily mean they have everything right. No one system gets everything right.

Dr Wodak: I will just add on that that Sweden, like the other Scandinavian countries—Norway, Finland, Denmark—is relatively much less unequal than Australia. What those Scandinavian countries have in common with Japan, another country that is relatively more equal than Australia, are low levels of prevalence of drug use. In the case of Sweden, I personally have some doubts about how accurate those estimates are because the climate, as Nick has indicated, is quite hostile to drug use. In a climate of hostility you have to be a little more questioning about how accurate any estimate could be because the risks that anybody takes by putting up their hand and admitting to drug use are so much greater than in a country like Australia, where it is not considered a good

thing to be a drug user but it is a little bit less unacceptable. However, the other Scandinavian countries have all come to accept harm reduction in the last few years. As Nick said, there is a ferocious debate going on about this in Sweden; they still have only two needle-syringe programs in the whole of the country and there is concern about whether they are managing to keep HIV under control among injecting drug users. But I think in general that I agree with Nick that we have a lot to learn from Sweden in terms of how they manage their problems with alcohol and for that matter tobacco. Sweden does very well with tobacco and oddly enough they embrace harm reduction for tobacco and get castigated by the European Union for allowing a product called snuus, which is a non-smokeable tobacco that is put in the mouth and dissolved. Sweden sees much lower levels of the rates of the tobacco-related problems that we see quite commonly in Australia and other wealthy countries, much lower levels than anywhere else in Europe and yet Europe is hostile to this particular form of tobacco product and wants Sweden to discontinue it. Sweden has been forced by the European Union to harmonise its alcohol taxation policies and has done so to some extent. The high taxing countries have been forced to lower their taxes; the low taxing countries of southern Europe have had to raise their taxes, but that process has come to a halt. Sweden has now started to see a lot more of the problems that the rest of Europe and the other wealthy countries in the world have in relation to illicit drugs as it has become more like the rest of the world.
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The CHAIRMAN: I was just thinking, again coming back to the terms of reference and looking at both alcohol and illicit drugs, that one of the terms of reference looks at allied health professionals and who is getting what.

Prof. Lintzeris: It is hugely important, because the nature of primary care in Australia over the last 10 or 20 years has become so heavily driven by medical practice. The states have largely stepped back from the provision of primary care services—not entirely, but largely—to the point at which now primary care largely means going and seeing your general practitioner, who will give you Medicare in a bottle. This has had a huge impact in Australia, for example, in the area of methadone and buprenorphine treatment, where if we go back 15 years ago the vast majority of Australian methadone treatment was delivered in specialist multidisciplinary state-funded services, such as Next Step.

The CHAIRMAN: Yes, Next Step.

Prof. Lintzeris: Exactly. Other parts of Australia have got very similar models. What we have seen over the last 10 years—I am not necessarily being critical of this general direction—is that there has been a moving of a lot of that treatment into community-based settings. What we mean by that is the general practitioner-community pharmacist. For many individuals, that is an appropriate treatment setting for them, but what is missing out there is: how do these individuals then get access to a broader range of services beyond what a general practitioner can do in a 10-minute consultation? How do these methadone patients and buprenorphine patients then access counselling, nurse practitioners, social workers, psychologists and so forth? There is some provision through the new mental health items that came out through Medicare. Unfortunately, in most of the greatest areas of need where drug use is prevalent, there has been a huge shortage in the availability of clinical psychologists who can provide their 12 sessions of CBT. Many of those eligible workers are not necessarily trained in drug and alcohol work. Psychologists get no specific training in drug and alcohol, unless that has been an elective that they have decided to go and focus on. It is not part of the generic training for psychologists. So that has meant that increasingly we have been shifting a lot of drug and alcohol treatment into primary care settings—where much of it belongs—but what we really need to see is an expansion of what primary care treatment means in Australia. Some of the discussion that is coming out in the NDARC reports is about how can we broaden the flavour of primary care as to who is funded to do this kind of work. The reason I have talked about methadone and buprenorphine is because they are a significant part of the treatment that is delivered out there. To a certain degree, we have got good data on what is happening with methadone and

buprenorphine. That is probably a reflection of what is going on in other parts of the health system. The responses as to how we are dealing with amphetamines, alcohol and cannabis in primary care settings are probably going to be very similar to the responses about what is going on with methadone and buprenorphine.

Dr Wodak: If I can just come in there and say that I accept what Nick is saying, but we have to be conscious of the gaps that we are providing in Australia. The drug policy modelling program, which is part of the National Drug and Alcohol Research Centre, has estimated that only about 50 per cent of the people who should be in methadone and buprenorphine treatment and who would want to be in that treatment are actually getting treatment in Australia today. This is a national estimate, not specific to our state.

The CHAIRMAN: Fifty per cent. That is quite high.

Prof. Lintzeris: That is not necessarily 50 per cent of opiate-dependant people, but 50 per cent of those people who probably should be in treatment, recognising that it is only a proportion of those people who would be in treatment.

Dr Wodak: And there are many reasons why we have such a shortfall. Having large unmet demand is a bigger problem than it actually seems, because not only are we not providing treatment for people who could improve, but also it corrupts the system when a large number of people who really would like to get into treatment cannot get into treatment.

Mr P. ABETZ: What are the barriers for people getting onto methadone treatment? In Western Australia just about anyone can rock up and —

Dr Wodak: We have a shortage of practitioners who want to do this work. We have trouble recruiting people to do this work. We do not have enough funding to pay people, even if all the people we wanted to come forward would come forward.

Mr P.B. WATSON: We used to have a problem in regional areas where the pharmacists just did not want to do it, because some of the people who came in on the methadone thing upset the staff and so they said they cannot come back, but there is nowhere else for them to go.

Dr Wodak: There are a number of issues there. Another major problem is also that the co-payment for opiate substitution treatment in Australia is the highest co-payment for any medical condition bar none. The drug users pay about 30 per cent of the total cost of treatment. There is no chronic health condition—diabetes or breast cancer or high blood pressure—where such a high proportion of the costs is paid for by the patient. We have to remember that we are talking about a very low-income group; so it is 30 per cent of a low income. One of the effects of having such under-treatment of this population is that we have high crime rates, high overdose death rates, bigger prisons and higher taxes. If you are a small government-low taxing kind of person, this should be an affront to all of us. The estimate—Nick I am sure would have more information about this than me—of benefit to cost is that for every dollar spent on methadone and buprenorphine treatment, the community gets between $4 and $7 back. So, short-changing treatment in this way is a considerable disadvantage to not only the drug users and their families, but also the whole community.

The CHAIRMAN: Nick, you were going to come in on some other issues.

Prof. Lintzeris: Well, Western Australia sort of exemplifies what is happening in many parts across Australia. Western Australia has actually had a smaller number of people in treatment in recent years with methadone and buprenorphine than it did about five years ago. So we have plateaued.

The CHAIRMAN: Is that because we are using naltrexone? I was going to leave naltrexone until the end, but is that one of the reasons that we have fewer people on methadone and buprenorphine?

Prof. Lintzeris: I do not think it is just that. I think there are a number of factors that have happened. Our treatment system for methadone and buprenorphine was largely designed in 1993. Little progress has been made in how we have conceptualised, how we deliver this and who the

targets groups are. We historically saw methadone treatment as a highly controlled and highly regulated treatment model for marginalised, dangerous heroin users who needed to be controlled and herded up into clinics. We now have a situation in which opioid dependence has taken on a different face. Pharmaceutical opioid use is ever expanding. There is a whole policy there. In Western Australia in particular, for many years now, when you go and look at injecting drug users, there is as much, if not more, morphine and oxycodone being injected—these are pharmaceutical opioids—than heroin. So we are seeing a different face to what opioid dependence is. Unfortunately, our treatment models have not moved with the times. So we still are using a 1993 model that is highly regulated and highly restricted. When it comes to this issue about how pharmacists do not want to do it, that happens for one reason only. That happens because we have a treatment funding model for methadone that is basically an S100 system. So, essentially the government pays for the methadone and buprenorphine—for the medication—and for the pharmacists, their labour is paid for by the patients. This allow pharmacists to opt out of doing methadone and buprenorphine. If this was part of a normal medication funding system, pharmacists could not opt out.

Unfortunately, Australia has fallen behind internationally, in that the rest of the world has seen the introduction of this new treatment model of methadone and buprenorphine, and more recently suboxone, and has largely recognised that here is a medication that, while there are concerns around its potential for misuse—injecting and so forth—the risks associated with suboxone are dramatically less than, say, with methadone in terms of overdose mortality risks and so forth. Most of the countries around the world have been looking at how do we scale up treatment—how do we go from a very small treatment base to a large treatment base—and they have largely looked at suboxone as an opportunity to release the reins and the control structures in place and to dramatically increase the treatment base.
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So the USA, for example, has gone within seven years or so from no-one giving morphine, to over a quarter of a million people on buprenorphine treatment. It took them 40 years to get a quarter of a million people into methadone. That is also the case in France and many countries across Europe. It can be done with methadone, but the only way you are going to increase treatment numbers with methadone to that extent is if you invest a lot in treatment. Some countries have done this—Spain and England have done this. They have had a dramatic increase in methadone numbers.

The CHAIRMAN: What about suboxone? Is that a daily oral dose? I know that methadone is a daily dose.

Prof. Lintzeris: It is a very similar framework, yes. It is largely a once-a-day tablet that you take. It is a subliminal tablet. You put it under your tongue. It is essentially a very similar kind of treatment model. But in Australia, Western Australia in particular has the most restrictive policies around takeaways of suboxone. In Western Australia, you cannot get a takeaway dose of suboxone in the first six months of treatment. That means going to a pharmacy, seven days a week, for the first six months. Only after you have been in treatment for more than 12 months, and in some cases for two years, do you then graduate to the situation where you are getting regular takeaways. Let us put this in some context. If you are a drug user, and you go to a general practitioner and you are able to get a script for MS Contin—morphine—out of them, you can then go and get that filled at the pharmacy. You can go to five different doctors on the same day and you can get a script for MS Contin from each one of them, and you can go to the pharmacy and get each of those filled out, and if you are on a Health Care Card, you end up paying $3.20 for it, and you can do whatever you want with those tablets. So we have created this very restrictive model of substitution treatment with methadone and buprenorphine. It is a system that is too expensive for our patients to participate in—most of them would spend $40 a week for the privilege of going to a pharmacy every day—and few practitioners want to engage in. The GPs are saying that they do not want to treat drug users, but meanwhile, on

average each of them has 10 opiate-dependent patients on morphine, codeine, tramadol or oxycodone.

Ms L.L. BAKER: Wow! Is that the figure?

Prof. Lintzeris: Some estimates have come up with that kind of guess. There are a lot of opioid dependents out there, but at the moment it is in this area of pharmaceutical opioids. I am not saying that we should necessarily stop prescribing morphine and oxycodone, but what we need is a little more concern about how we control the use of morphine and oxycodone. To a certain degree, we want to "sell" our treatment models. That means that we need better marketing strategies than the ones we currently have, where you can hardly find a doctor; you can hardly find a pharmacist; it is highly regulated; it is a huge inconvenience; and you have to pay 20 per cent of your dole cheque for that.

The CHAIRMAN: So who are you recommending in terms of bringing on board allied health professionals? How do you think you can approach this to make it more effective?

Dr Wodak: Can I just link this to the policy document—I see you have a copy in front of you—on prescription opioids and chronic non-malignant pain, because there is a relationship to all of this. One of the many costs of having such a high proportion of unmet demand for opioid substitution treatment is that a lot of people are having difficulty in getting hold of heroin these days. Eighty-five per cent of drug users report that getting heroin is still easy, or very easy, in Australia. But people in Western Australia are finding it more difficult than the rest of the country, and always have. This is particularly the case since the heroin shortage. So they cannot get onto heroin. They have difficulties, as we have discussed, with getting onto methadone, buprenorphine or suboxone. So many of them turn to the prescription opioids. Then if demand goes up and supply is limited, the price will go up, and then people who could sell to the black market—people with cancer pain, people with non-malignant pain, and some of the other drug users—will sell increasing amounts to the black market, so the black market expands. I think this is one of the costs that we have of having such a large unmet demand for methadone and buprenorphine. One of the things that I think we need to do to get the prescription drugs under control again—this seems counterintuitive—is to expand the methadone/buprenorphine treatment. I am not so concerned about the pros and cons of methadone versus buprenorphine versus suboxone. They do have their pros and cons. Buprenorphine and suboxone are much more expensive than methadone, and that also has to come into the calculation somehow. I am much more concerned about the fact that such a high proportion of people are under-treated. I think the question of whether they are in one kind of treatment or another kind of treatment is an important issue. Choice does really matter in drug treatment, as it does in politics for that matter. But I think the major issue is that such a large number of people are under-treated. Yes, you are right. Someone asked the question: is that not like the situation in other countries? Unfortunately, that is true. But we should not really be comparing ourselves to international best practice, because international best practice in this area is so poor. What we should be doing is comparing the treatment of drug users, I think, to the treatment of people with other chronic medical conditions.

The CHAIRMAN: Maybe then we should bring in Alex and his submission on naltrexone. In Perth the naltrexone program is currently going through the TGA system—they are doing the paperwork for that—but it does seem that that is a drug that for some reason people have to take on a daily basis. But once the implant is in, it lasts for three to six months.

Dr Wodak: Perhaps I could respond, if I may, because I wrote the submission. My response would be that we have a tradition that has developed over the last 40 years since the thalidomide catastrophe really woke us up. This tradition has been growing over the years, and when we ignore it we often find ourselves getting into trouble. This tradition is that new interventions in medicine have to satisfy at least two, these days sometimes three, criteria. They have to be shown to be effective, they have to be shown to be safe, and these days we also often ask them for them to be

shown to be cost effective. Now that is what we require for new treatments for heart disease or for kidney disease or for any other aspect of medicine, particularly for medical treatments, but also now for surgical devices. Now the fact is that, whether we like it or not, we really do not have that evidence that naltrexone is effective, safe or cost effective.

Mr P. ABETZ: Implants, do you mean? It is already registered with the TGA for tablet use. That has already satisfied the TGA requirements. It is the implants that is the issue, is it not?

Dr Wodak: Okay. The evidence on oral naltrexone is very clear. It is the most effective treatment we have, but it is a treatment that nobody takes.

Mr P. ABETZ: The tablet form, yes.

Dr Wodak: Yes, the tablet form. So that is clear. Because people take heroin intermittently and naltrexone intermittently, we have the worst of all possible worlds. We have a drug with an overdose death rate that is seven to eight times higher than without any treatment. The oral [implant??] treatment is unfortunately ineffective and unsafe. It is also highly cost ineffective. The implants are not registered anywhere in the world for the treatment of heroin dependence by any pharmaceutical regulatory body—still not. The reason for that is that the evidence of effectiveness and safety, and also cost effectiveness, is inadequate.

The CHAIRMAN: It is not there.

Dr Wodak: It is not there. It is clear that there is no evidence for naltrexone implants as a routine measure yet. Now, there used to be a situation in nursing, when we were considering whether a treatment might get enough evidence accumulated in the future to be introduced as a routine measure—that is, when there were good theoretical grounds for believing that a treatment might be helpful, but we did not have the evidence—where we would say, "Yes, you can provide this treatment, provided it is handled as a rigorous scientific research project".

The CHAIRMAN: We went to the needle clinic last night, which is still a pilot study.

Dr Wodak: We have a system in Australia, which is very good by international standards, of NHMRC guidelines for human research and ethics committees, and any research project involving humans has to go though a committee that is founded on those principles. This principle has been ignored—this whole framework has been ignored—with the naltrexone implants since they were introduced in 2001.

We have several other things that I think are very disturbing.

Firstly, we have a number of anecdotal reports about significant harm coming to people who have had naltrexone implants. One of those series of cases written up by Nick and his colleagues, published in *The Medical Journal of Australia* in April 2008, with an accompanying editorial by me and three colleagues, highlighted the dangers of this approach.

Mr P. ABETZ: I have a question on that point. I am familiar with the paper that you have written. I have been given to understand that naltrexone implants have been imported from China and also some were imported for a very short term from the USA. It is my understanding that the paper that was published in the medical journal revolving around 12 cases in Sydney —

Dr Wodak: That is correct.

Mr P. ABETZ: —which were implants that were not supplied or manufactured by Go Medical Industries Pty Ltd in Western Australia; therefore, there is a difference in manufacture.

Prof. Lintzeris: We highlighted there, though, the difference in manufacture; one is made in China and one in Australia. The real difficulty is quality control, in that while we all want to buy Aussie made, where is the quality control demonstrated around the Chinese, Australian, British or American product? This is one of the real concerns. The Go Medical product has not acquired good manufacturing procedure approval.

Mr P. ABETZ: I am aware that is in Alex's submission. I have done a little bit of homework on that and I actually have the document from the TGA, which was issued in 2005, which actually gives the GMP status for the manufacturer. I have it on my computer here, if you want to see it. On what basis was that assertion made, seeing as I have sighted the document and I have a scanned it onto my computer here, which I am happy to show you?

Prof. Lintzeris: We had always been informed that there was no GMP approval for it and that the reasons why the Therapeutic Goods Administration had suspended the export of it was that there was no GMP. Again, I stand to be corrected.

Ms L.L. BAKER: You are working on the Therapeutic Goods Administration's take on the status of that GMP?

Mr P. ABETZ: TGA issue the GMP licence.

Ms L.L. BAKER: But they told you they had not?

Mr P. ABETZ: It was a restricted licence given to the facility specifically for the manufacture of the implants. My understanding of why they are no longer being able to export the ones that were made under that licence to other countries was because there was a change of staff at TGA, who had a slightly different understanding of the regulations surrounding that issue. My understanding is that has now been resolved and Go Medical is now again allowed to supply other countries with implants for the purpose of clinical trials in other countries.

Dr Wodak: They have never been allowed to supply other countries. That has never been the case.

Mr P. ABETZ: My understanding is —

Mr P.B. WATSON: Come on! Let us listen to the professor, not your philosophy.

Mr P. ABETZ: It is not my philosophy. I was trying to point out that Go Medical have on file the letters of commission from the TGA for those exports.

Dr Wodak: Jane Halton, the Secretary of the Department of Health and Ageing, gave evidence, which I assume is sworn evidence, to the Senate Standing Committee on Community Affairs on 22 October last year, and she said, according to *Hansard* —

> I can tell you that there has been a very long conversation with Dr O'Neil —

Who is the director of Go Medical —

> about the need to ensure that, if he is manufacturing, he meets good manufacturing practice. That has not happened, —

This is 22 October last year —

> and the TGA is basically discharging its regulatory responsibilities in its dialogue with Dr O'Neil

She went on to say —

> … as has been pointed out to Dr O'Neil I do not know how many times, he can ensure that his manufacturing practice meets the standard that is required of every other manufacturer in this country. I do not think that is unreasonable

That suggests to me that the information you have been given is not correct.

Prof. Lintzeris: At the end of the day, this is not a matter of opinion; it should be a matter of fact. We should be able to get to the bottom of just what is the legal status. The other thing that should be worthwhile exploring is that there was a randomised controlled trial study being conducted around the control time. Gary Hulse was running a study in a small number—I think it was about 16-odd—of individuals, and it might be worthwhile exploring whether or not that approval was for that

control study for 16 individuals, not necessarily for the thousands of individuals. It would be worthwhile exploring.

Mr P. ABETZ: It has been renewed, actually.

Dr Wodak: Another very significant problem that I have with this area—many of my colleagues have very similar profound reservations about this—is the fact that the clinicians doing this, whether with the Chinese product or the Western Australian product, go through a process that is called category A of the Special Access Scheme. This is a scheme that was designed for people with terminal conditions who are likely to die very soon; in fact, quoting directly from the web site the criteria is that people who are eligible are "persons who are seriously ill with a condition for 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." There is no question in my mind, and in the minds of almost all of my colleagues, that heroin dependency, however tragic and unfortunate and desperate it may be, does not satisfy those criteria. And to allow this to go on is an affront. This is more important than just naltrexone implants. The reason I say that is that the whole system of regulation of medicines is a very important of the public health system in Australia and in all other countries. We learnt that with thalidomide. And major gaps are emerging now in the regulatory process—I think this is a very significant gap. We are seeing other people using the same mechanism for equally implausible or even more implausible approaches, and then not being followed up. We all want to know what is at the bottom of all of this, and I guess this is what we are here to discuss.

I think, Mr Abetz, if I may say so, the dialogue that we had about the regulatory stage that naltrexone has reached illustrates—I agree with Nick's comments—that this should be established in fact. It is very difficult to establish in fact. I do not think the public, or politicians, are able to distinguish this at the moment, and it could be that we have significant flaws in the Therapeutic Goods Act. It could be that we have significant flaws in the administration of that act by the Therapeutic Goods Administration; or it could be—as the Therapeutic Goods Administration maintains—that the bodies that are supposed to regulate professional behaviour have not done their jobs properly. There the TGA is referring to the Medical Board and also to professional bodies like the College of Physicians. It could also be that all of those three explanations are occurring in some kind of a culmination. I do not think, with due respect, that your group will be able to get to the bottom of this, but I think that we should all be pressing for a commonwealth independent rigorous inquiry. This matters for many reasons. One of the reasons this matters is that your state, Western Australia, has provided Go Medical—according to publicly available information—$9 million. Personally, I think it is outrageous.

Mr P. ABETZ: It is actually to AMPRF; it is not to Go Medical. The funding that the Western Australian government has provided has not been for naltrexone implants; it has actually only provided funding for the social work and housing et cetera of AMPRF, which is the rehabilitation organisation that George O'Neill has set up.

Prof. Lintzeris: Is that conditional, then, only available for those patients who have had the implants?

Mr P. ABETZ: Yes.

Prof. Lintzeris: So it is not open to anyone who needs housing; it is only for people who get implants. So it is money going into that form of treatment.

The CHAIRMAN: I am going to come in at this point. Because of the time factor, I am going to make you aware of the fact that we did meet yesterday with Richard Matlink, who said to us during the discussion that it looked like the NHMRC may be looking at this issue in November, so where Alex has said that the professional bodies, like the College of Physicians, the NHMRC and other professional groups, I think that is happening. Because of the time, again coming back to our terms

of reference, I am going to give both of you, Nicholas and Alex, just two minutes each, because I am being kicked under the table up this end, to summarise and flag for us what you see as key points that maybe we have not given you an opportunity to present and then thank you again for submissions. If there is anything further that you would like to get to us, we will take that on board, but we very much appreciate the information that you have given us today. Maybe we could go with Nicholas first and then Alex.

Prof. Lintzeris: Very, very quickly, and I will not touch further on the naltrexone issue at this point. In terms of the ways forward for how we deal with drug and alcohol issues in Western Australia and elsewhere in Australia, I actually think we have a very good template in front of us of how to respond to this complex issue, by looking at what mental health has done in the last decade. Mental health went from a service sector that was largely specialist and isolated in big, public institutions to broaden out, with major inroads into primary care—broadening out beyond just medical interventions, to incorporate other allied health as well, with a sustained and concerted public health campaign that mental illness is enormous; so an awareness campaign, and by recruiting primary health, but retaining the role of the specialist sector. That is one thing we have not touched upon. Primary health is a good place to situate things but you cannot do it at the expense of, "We don't need the specialist anymore." I think that beyondblue campaigns and all that kind of approach—a combination of good public health campaigns and community awareness, engaging primary care and refining the role of the specialist sector and bringing both public and private service providers into those kinds of networks and partnerships—that is the kind of framework that I think we should be considering, rather than looking at "how does Sweden do it" or "how does America do it", because for some interventions we cannot compare, yet we can look at what they have done with mental health and ask, "Could we do a similar thing?" Yes, we could. It will take some money and some time, but personally I think that is the most obvious direction that we should be moving in.

Dr Wodak: I think the first point to make is that these problems—the psychoactive drugs, alcohol, tobacco, prescription and illicit drugs—are huge problems. They affect large number of your constituents and their families. They have a big impact—health, social and economic—on the community. Secondly, the problem is not that we do not know what to do. We pretty well know what works and what does not work. Amongst people like Nick and myself, within Australia and around the world, there is an astonishing degree of concensus about what works and what does not work. That is true for alcohol, tobacco, and prescription and illicit drugs pretty well. The frustration I have, and many of my colleagues have, is that what is popular does not work and what works is not popular. That is largely true. This is the difficulty you face, because you have to ultimately sell the community things that are going to get implemented and it is very hard to do that when the community has expectations that certain things work, when the evidence is that they really do not. I am very pleased that you started off focusing in this discussion this morning about alcohol. Clearly, that is the biggest problem. It is a huge problem in Australia.

Mr P.B. WATSON: It is where it all starts.

Dr Wodak: It all starts, and we always have to come back to that as the number one issue. We have to remember that Australia has made huge strides in reducing the problems due to alcohol, and in many cases we have led the world in certain things like safety belts and randomised breath testing. People forget that Australia has been very advanced in its thinking about that. Clearly, the number one thing we need to do with alcohol is have a comprehensive tax reform. You can say, "It's a commonwealth matter; what's it to us?", but it is not; it is really a state matter. It is a state matter because the commonwealth taxes it but the states are responsible for the bulk of the expenditure, so there is a vertical-fiscal imbalance. That is why I would hope that the states and territories should be jumping all over the commonwealth and demanding a say in the setting of the alcohol tax rates. It is the single most effective intervention, best supported by evidence across the board, of all the interventions for alcohol. Peter Costello, the former Treasurer, used to say again and again and

again that alcohol taxation in Australia is a dog's breakfast. It should be reformed on economic grounds alone, and, for goodness sake, the grounds for reforming in terms of public health are even greater. If we are serious about closing the gap with Aboriginal health, we have remember that alcohol is responsible for 25 per cent of that gap in the life expectancy. If we want to close that gap, we have to do something about the low taxation rates for cask wine in Australia.

Turning to other issues, with alcohol the second issue—unfortunately we did not discuss it this morning—is alcohol outlets. We have to reduce the number of outlets, and it is difficult to do politically, but we have to make the conditions more restrictive and we also have to do something about the system by which alcohol outlets are regulated. At the moment the alcohol beverage industry has far too much say and the community has far too little say in how many outlets there should be and what the conditions should be. The industry is much too powerful. All I want is a level playing field, nothing more than that.

In terms of other matters, I agree with Nick. It is very important that we look at alcohol and drug treatment as a very important part of the whole package. I do not like the idea that alcohol prevention and treatment are in some kind of competition. They complement each other. People like me—I spend all my time in treatment and yet I find that this is a very effective base for advocating effective prevention strategies. I think there is a lot of complementarity to it. I think in terms of unfulfilled things that we need to do, I think one of the most urgent tasks we need to do is to do something serious about that unmet demand for opiate treatment of all kinds, but principally the pharmacological method of buprenorphine to suboxone and doing something serious about reducing that high co-payment that people have for opiate substitution treatment for everybody's benefit, and also to reduce our insurance premiums and to reduce the size of our prisons.

The CHAIRMAN: Thank you very much for your evidence before the committee today.

Briefing concluded at 9.40 am