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

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
WEDNESDAY, 18 AUGUST 2010

SESSION THREE

Members

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

Hearing commenced at 11.00 am

HULSE, PROFESSOR GARY KENNETH
Professor of Addiction Medicine, University of Western Australia, examined:

The CHAIRMAN: On behalf of the Education and Health Standing Committee, I would like to thank you for your interest and your appearance before us today. The purpose of this hearing is to assist the committee in gathering evidence for its inquiry into the adequacy and appropriateness of prevention and treatment services for alcohol and illicit drug problems. You have been provided with a copy of the committee's specific terms of reference. At this stage I would like to introduce myself, Janet Woollard; Mr Peter Abetz; Mr Ian Blayney; Mr Peter Watson; and Ms Lisa Baker, and then David Worth and John Pollard will be with us soon, and from Hansard we have got Keith with us.

This committee is a committee of the Legislative Assembly. This hearing is a formal procedure of the Parliament. Even though the committee is not asking you to provide evidence on oath or affirmation, it is important that you understand that any deliberate misleading of the committee may be regarded as a contempt of Parliament. As this is a public hearing, Hansard is making a transcript of the proceedings for the public record. If you refer to any document or documents during your evidence, it would assist Hansard if you could provide the full title for the record. 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?

Professor Hulse: Yes.

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

Professor Hulse: Yes.

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

Professor Hulse: Yes.

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

Professor Hulse: No, not yet, but I may.

The CHAIRMAN: At any time. In that case would you please state your full name and the capacity in which you appear before the committee today?

Professor Hulse: I am Gary Hulse. I am the Professor of Addiction Medicine, the University of Western Australia department of psychiatry. I am based at Sir Charles Gairdner Hospital, and I guess we are going to be talking about the sub-area, which is to do with medical education and training in alcohol and drugs.

The CHAIRMAN: We will actually invite you to make comments on the whole of the inquiry, and we may ask you some questions that relate to other aspects of the inquiry. We only have, unfortunately, 40 minutes because Parliament is sitting today, so what we might do is ask if you could give us, to start with, maybe a 10-minute presentation, so that you sum up the key areas. You may not be able to get through the whole of that presentation without interjections, but if you do, following that we will ask questions and give you also an opportunity at 11.40 to sum up with any points that have not come out through the questions. So I might put it over to you first, then.

Professor Hulse: Okay. Much of what I am going to say is to do with medical education and training, but I will just touch on a bit of background, which will give you a profile of what you might want to ask in questions. Let us start with the broad area. Basically, I have been involved in substance abuse treatment for about 25 years. I wore a much younger man's clothes when I first started this area. I worked in direct service delivery in running things like methadone programs and seeing patients directly. I had been on boards and committees of management of hospitals, where they have dealt with major substance use, from the western region of Melbourne to community-based treatment services, on the committees of management. I have worked for the health department in Victoria in the capacity of coordinating the state methadone programs and substance abuse programs, and policy and program initiatives as the director of policy programs. Then in about 1992, I took up a position with the University of Western Australia, and that is within the school of psychiatry, and I have always been based at Sir Charles Gairdner Hospital although I have had responsibilities for looking over at other hospitals. That is really blended clinical research, education and training together.

I guess the first thing to say about the whole issue to do with medical education and training is that you can spend a lot of time talking about knowledge, and you can talk about developing those skills and then translating them into clinical applications, which is really what we are in the job of doing. That is where alcohol and drugs differ from any of the other areas of medicine that we deal with, because people come in with preconceived ideas. Unless you have got the right attitudes towards the people you are actually dealing with, it does not matter how good your knowledge base and your clinical skills are, if you do not like the population, you are never going to deliver a good service. So in the end it really comes down to providing a positive environment. It is about showing people how you deal with people, the respect you pay them and giving them the foundations. If you do not take that the extra mile by giving them good guidance with this, you are never going to have a good service. We have really tried to focus in medical education to try to get away from this idea that you have to wait for someone to be sick before you actually do something, and really get back to the issue of identification and intervention, and that when you deal with someone with substance abuse, you are not only dealing with a person but you inherit all their psychosocial fabric—again it is the other people with them—and get them early to try to get them back into the community and reintegrate them, which means that you need a range of different knowledge about how to tap into different sorts of service deliveries.

The area of alcohol and drugs really differs from any other area of medicine. If you look at things like paediatrics, surgery, general medicine, emergency medicine, obstetrics and gynaecology, they are distinct disciplines. People do placements in those areas and they learn particularly how to deal with that, and you can provide good mentorship. Alcohol and drugs are going to rise across those. It does not matter whether you are dealing with paediatrics, obstetrics, emergency medicine, psychiatry or public health, you have got the specklings of alcohol and drugs. That has always been a real difficulty, because if you have got a curriculum that you want to get out across medical training, who teaches knowledge at what level? At what level does that give examples of clinical skills? Who does the training; who does the mentorship? If we talk about the University of Western Australia, we have got a six-year program. We used to have 13 different disciplines all teaching a little bit. That created a real problem in terms of medical education, because often what we would find is that someone just assumed that certain information was so basic that someone else would be teaching it, and it did not get taught at all.

The commonwealth recognised that difficulty quite a while ago—I think when Bob Hawke's daughter had a heroin dependence issue and it brought on the national campaign. It precipitated the commonwealth looking at a lot of these issues and discussing how to address them. One of the things they did was create funding in medical schools for coordinators of alcohol and drug education and training. Their real job was to look at the vertical and horizontal integration; not necessarily doing the teaching but looking at how this was all taught within medical schools. The

other thing they did was put the area of alcohol and drugs as a standing item under the committee of deans of the Australian and New Zealand medical schools. That created alcohol and drugs in a very different place federally than any other group. We actually existed there. I actually chaired the committee called CADEMS, which is the Committee on Alcohol and Drugs Education in Medical Schools. I chaired the committee for the committee of deans of the Australian and New Zealand medical schools for about seven years. It meant that they were well funded for a position within each medical school to do this, and they used to attend those meetings. It meant that basically you could develop a core curriculum of what knowledge you want, what attitude and what skills, and then it was left up to the coordinators to go back to their individual medical schools and look at how that was then developed throughout the program in terms of their vertical and integrated system. As I said, that was for about three years, in the expectation that it would be picked up by the states. What happened in Western Australia was that it was picked up for a couple of years and then it drifted. Consequently, you have a situation at the moment where we do not have a coordinator across those disciplines.

[11.10 am]

So it is probably more fragmented—who knows—than it need be, and it is certainly more fragmented than it was before without someone to look at it. I know that a lot of the state attitudes were, "Well, if the universities want this, then they are federally funded, so they should really look at providing this position themselves." The problem is that the people who were actually being produced are the ones who are servicing the state, and so it becomes a spurious argument to say that someone else should be funding it, especially when it was such a small amount of resources that were being looked for.

The other thing I should say, as I said before, is clinical exposure—the opportunity to put your knowledge, skills and attitudes into clinical practice. We are the only state—in fact, we are the only state or territory—in Australia that does not have dedicated alcohol and drug services attached to teaching hospitals. In New South Wales there is St Vincent's Hospital and Westmead Hospital. You can go through the list; they have several. In Victoria, they have got —

The CHAIRMAN: We know that at Sir Charles Gairdner Hospital there is a nurse in the emergency department.

Professor Hulse: A nurse specialist, Etsa.

The CHAIRMAN: How do they have these dedicated positions then?

Professor Hulse: No, no. You have a hospital. Etsa's job is to provide education, training and assistance to other staff throughout the hospital. She is normally dedicated to psychiatry, but she works across. She works in emergency medicine; she works across the board and she provides training. I am talking about a specialist unit where people who have alcohol and drug problems then go in, are treated; where the medical students can do rotations through there; where you have specialists who are coming through, which may be from the emergency department, when they need to come through and look at those people; where you have psychiatry coming through. If you have got pregnant women and if they have children with them, you have your paediatrics issue if they are young, and you have this training process.

The CHAIRMAN: So, basically you are talking about having within the hospital a clinical directorate for alcohol and drugs that would be at a MAC level within the hospital and would then coordinate. So if someone was admitted to the hospital and you realise on their admission that they have an alcohol problem, or during their care on one of the wards it became apparent that they had an alcohol or drug problem, a referral would go off to that clinical directorate to go and see that person.

Professor Hulse: Not necessarily.

The CHAIRMAN: I do not understand how you see this working.

Professor Hulse: It would mean that if you have someone who is admitted because they are in severe alcohol withdrawal, they have a dedicated unit to go to that knows how to manage alcohol withdrawal, rather than having to run around to different spots and try to train the people in emergency medicine or train people. We do not have a location where we say, "If someone requires alcohol withdrawal, this is the unit where they are treated. If they have a history of seizures to do with those withdrawals, these are the people with the skills who can deal with those." We do not have services that would say, "Who is going to deal with a person with iatrogenic pain management? Who is going to deal with someone who might be an opiate user who comes in and needs treatment?"

The CHAIRMAN: But how many beds? I can see what you are asking for, but I also come from a —

Professor Hulse: I am not asking for anything. I am just saying that I do not have one place to send a medical student who is on an alcohol and drug placement within a hospital where I can say, "Here is the unit that is dealing with alcohol and drug issues." If I want to provide medical education and training, I have to take random luck that there will be someone on one of those units and that they will be given competent treatment and that there will be someone there to do that. There is no repository where you can say, "Here is where the service is delivered, and in terms of trying to provide medical education and training, we can put people in there and we can teach them about withdrawal issues, about the long-term management, about the assessment of hepatitis C, about the morbidities, endocarditis—all those issues." It does not exist.

The CHAIRMAN: But that is the same across Australia, is it not?

Professor Hulse: No, it is not. That is exactly what I am saying. That was exactly where I started from. Even the Royal Darwin Hospital has a specialist unit.

The CHAIRMAN: With how many beds?

Professor Hulse: Canberra has a specialist unit. We are the only state that does not have specialist alcohol and drug services within teaching hospitals, and it ends up being a significant deficit, because you cannot organise your clinical placements of students so that they actually have access and exposure to the relevant elements that are going on. It is really pot luck whether they happen to be in obstetrics when something comes through or whether they happen to be in emergency medicine. At the same time, in terms of providing treatment services, it means that we need to try to educate the new registrars coming through in different areas, but they are often not in that specialist area to specifically look at alcohol and drugs; they have not chosen that. So Etsa runs around madly, bless her tiny little cotton socks, trying to dispense little bits of information across the hospital to people as opportunistically as they require it. So Etsa has got a very hard job.

The CHAIRMAN: With your academic background, have you prepared a paper that compares service provision throughout the different states that we can look at? We have had the doctors from emergency departments who have talked about the costs. I think that something like this would be supported, but, as a committee, we would need to look at the costings for such an enterprise if we are going to put something like that up to the health department as a suggestion.

Professor Hulse: I think there are two issues about it. One is about your service delivery. I have no doubt that we function well at Charlies because people have taken on additional roles. The other one is to do with trying to provide education to the medical students during their clinical placements so that they have a broad skill base that they put into application when they are coming out. That is where we fall down. John Saunders, who is a professor of addiction medicine and a psychiatrist in Queensland and was at Westmead for a long period of time in New South Wales, has written extensively on medical education and training, and there is no doubt that I can get hold of some papers from John. Silly me; I mean, I have not got time. This is an interest of mine; it is not my overriding drive or anything like that, and I am certainly not going to go and do research. I am just

pointing out that if you look at any other state, they have these services; we do not. We cope quite well in terms of clinical service delivery because we pinch little bits and because we have dedicated staff who work in and above their hours to run around and deliver a service. We need medical education and training, providing something for the students where you can put them in.

The other part of this—the consequence—is that not only do we not have a formalised service for alcohol and drug treatment, but you have got to rely on education and training being provided by an external system, and the only dedicated service that is funded is Next Step. Now, if I look at what used to be provided, say, in 2003 to 2006, we used to get students and, as they did a psychiatry placement, I negotiated for them to do a two-day placement. One day they would go down and spend a day with the inpatient services, where at least they got to look at management of acute presentations to do with your opiate and your benzo and your alcohol withdrawal, and then they would spend a day working with the outpatient people to do with methadone, morphine, counselling—all these sorts of things—and they got to get an idea about the range of external services you needed to plug into if you were going to be effective—I am talking about housing and education—where those services reside in the Western Australia community. That is terribly important, because otherwise what you do is simply treat people at hospital, and then you do not take much responsibility for them afterwards. You need to plug them into all those services before they are going to hand them over. Now, that has really dropped off over the past number of years to currently where we get our students down there for three hours, and they are lucky if they get clinical contact with a doctor during that time.

Mr P. ABETZ: What is the reason for that being cut back?

Professor Hulse: I guess there are two reasons. One is that Notre Dame has come on board and they required somewhere that they would like to put their students. You have got some very hardworking doctors at the alcohol and drug services, but that is not their priority. They are not put there for medical education and training, so they only have so much time that they can actually put into that service delivery. But it means that in many respects, if we want to get our students down to a dedicated service, we are beholden to someone who is outside the medical education and training area.

[11.20 am]

There was a system that I set up a few years ago within the 50-year medical program. We have what is called options and students need to choose to do a two-week option during the year and they can put up certain electives. I negotiated with the alcohol and drug authority to put up options for them to be on placement down there for two weeks. It meant that medical students coming through in their final years who had an interest in alcohol and drugs could put up their hand and say, "I would like to go there for two weeks." That was terrific. That has been cut out basically because the doctors who have been interested in providing something down there feel that they are already putting their bit in to try to deal with Notre Dame and no-one else is putting up their hand. Again, it is not a slur on them; they are not funded to do that. They do not see that as being part of their primary activity. We found other options. We put them down at Fresh Start. I have student placements whereby they do one week at Fresh Start and one week with Etsa in the hospital system. They get exposure to both. Again, it is trying to rely on people outside. I have to tell you that my job is not the coordination of medical education and training. I find that I keep on taking on this job all the time and trying to beg, borrow and steal to try to put a comprehensive program together. Also, I think it is about providing a positive role model. If you have people who treat other people with dignity, you get the best outcomes. I often think that we can give people the knowledge and the clinical skills, but then you have to do a lot of myth busting. You have to get them to recognise that "there but for the grace of God go I" had you gone down a different pathway. You then need good role models. If you do not put the right ingredients into your mix, you do not end up with a good cake or you do not end up with the optimal one that you want.

The last thing I would probably say is about alcohol and drugs and mental health. If I look at the alcohol and drug problem population—those who are using heroin, who have abuse or dependence problems on heroin, benzodiazepines and alcohol—we know that 75 per cent of those people have comorbidity; they have co–mental health problems. If I go back to Charlie's and I walk down to the ward under my office, 75 or 80 per cent of those people who have severe psychiatric issues have alcohol and drug problems; the two go hand in hand together. Yet we develop services that, by and large, do not provide the alcohol and drug and the mental health at the same time; it seems bizarre to me. If you have a service that does not deal with major psychiatric morbidity or with major alcohol and drug problems, you have just lost 75 per cent of the population that you are meant to be servicing.

The CHAIRMAN: So you are suggesting that maybe those beds should be linked in the tertiary hospitals with mental health beds?

Professor Hulse: They have to be in the same area. For example, many, many years ago there was talk about abolishing the act that made Next Step a statutory authority and looking at places to do it and where should that go. There is huge benefit in looking at that. It could stay in the same location and be associated, but it would be used as a hospital unit. It would mean that not only do you have your medical students who would go through there for electives, but also your registrars would go there. Your emergency registrars, paediatricians, psychiatrists and infectious disease people would link with there and go through. Everyone from general medicine would do this rotation.

The CHAIRMAN: You want to rotate them through?

Professor Hulse: They would get a rotation. At the moment, the people who are looking at, for example, infectious diseases might work in the liver transplant unit with Gary Jeffrey at Charlie's and they might see a few injecting drug users come in, but they do not get the opportunity to deal with the injecting drug users on the site and look at what is going on. It would create a rotation for those people who are specialising in medical areas to go down somewhere. I think that is important because you then change the whole senior medical education structure because you have a rotation. There is a different ethos that follows, and you change the whole structure. Having the statutory body is terrific because in one respect, it should be like the starship *Enterprise*—it should be able to go where no other man can go. It should be able to do things that are outside the government structure. I know that in other states it has been the statutory bodies that have set up needle and syringe programs. Kirketon Road, which is down near the Cross, used to fund the prostitute collective to deliver needles and syringes on the roads and the street kids used to come in just for a shower. They could do things that government services may be criticised about doing, and that is the big benefit of having a statutory body. But if the statutory body does not do that and it simply becomes isolated, you lose all the benefits that are associated with being outside a government structure. The benefits of being inside the government structure or in a hospital structure is that you get the rotation and the flow backwards and forwards and you can coordinate things and your staffing changes. It becomes a much more integrated and comprehensive service.

The CHAIRMAN: But, Gary, is Western Australia not up on a pedestal in terms of the Drug and Alcohol Office? A lot of the other states look up to us. I agree with you in terms of mixing the two, but I would not want them to lose sight of the work that they are doing. I think that could be done without a rotation. I think the rotation that you are suggesting is important.

Mr P. ABETZ: What I am hearing you say, Gary, is that when our medical students finish their training and go out into general practice in Bunbury or Albany or wherever, most of these guys have not had hands-on experience of working with drug people. I ran drug rehab support for a number of years in Willetton. The reality was that the GPs are totally out of their depth. Most of them have no experience with this thing at all, which really creates a problem. If GPs had more expertise in that area, it would help the wider community to address the whole alcohol and drug issue. I see that as a real deficiency from what you have highlighted. My question flows on from

that. In a sense, if Next Step were to come under the umbrella of the health department again and become, say, a subsection of Charlie Gairdner's or whatever, the doctors could rotate through and they would get the benefit of that. This goes back a few years now, but when I was running the drug rehab group, there was a sense among the recovering addicts and their families that Next Step was very moribund in terms of their approach and that if you did not fit exactly in that box, they were not interested in you. George O'Neil treats eight times as many people a year as does Next Step because people do not fit in there, whereas he will treat anybody who knocks on his door. Do you think that problem would be resolved to a large degree if Next Step became part of the health department again and came under the supervision of a hospital program?

Professor Hulse: First of all, I think you are correct, Peter. What I am really trying to say is that what you want is when people go out into general practice or come across someone on drugs, they have already had good model exposure and they can have an idea about how to deliver a service and they have the right attitude and they have seen it done before. It should not be something that they have to think about or think about referring to someone else, which I think is what happens now. People feel out of their skills and they think that they will just refer it to someone else. It is no wonder the small services get inundated. It is really the luck of the draw whether students, during their medical term, happen to have been in the right location when they have had that type of exposure. We need to look at some way of trying to do that, and having dedicated services within teaching hospitals is one way of doing that and certainly it is the way that has gone on.

[11.30 am]

I really like the idea of having a statutory body. Forget about Next Step or anything like that for the moment. Statutory bodies, I think, are terrific if, as I said, they become the starship *Enterprise*, because they can go and do things that governments are not going to be hit with. And then that body, which is doing it, has their own committee, but they have to be good enough to go and do that.

I think one of the difficulties with Next Step—and you talked about the difficulty of getting referrals in, and I am sure Etsa and the people from YDEP—is that you have to remember that they do not have good back-up service. If they have an emergency, they do not want to take the severe cases. Why? They do not have emergency beds there. If they suddenly have someone who needs it, they do not have an emergency registrar that they can fall on to get down there. Even though they are sitting half a block away at Royal Perth, there is an emergency registrar there. So what you do is limit the service you can provide because you are not linked into a broader system which you can call on should something go wrong. I know there is a lot of criticism that is often thrown at Next Step saying, "We can never get people in." If you do not have the back-up services for those instances, you do not enter into dangerous territory unless you know you have the services to provide. And they do not want to have someone going there and suddenly having a death. So what you do by not linking them into the other services is actually reduce the potential service they could be providing at that location. Then it really means that you get comments like I have heard in emergency medicine a number of times, and from other people: "We try and get referrals down and the only referrals we can actually get in are the ones that we would be happy about discharging home because they seem well enough." The reason why those are being accepted as referrals is because there is not the back-up services for them, so they are only willing to take them. Of course, you keep those in a hospital, and if something goes wrong once you take them home, there is a call made and they are suddenly back into the structure again and you can deal with that. And so, again, if you want to maximise the service you are providing, you need to make sure they can take on the severe cases, which may go into seizures, which may have problems; that you have bed space that you can transfer them to; and that you have specialist neurologists and emergency medicine people who can get down there and do the assessment. That does not exist at the moment. So there is also merit in having them linked in, because I think you would keep the same beds, you would keep the same services; you would just increase the ability.

Whether you can still keep it a statutory authority and do that, I am not quite sure. But we are certainly limiting the service we provide by not having it linked in another way and we certainly do not have a robust environment so we can guarantee that students, when I see them at graduation going to sixth year, have the ability to deal with alcohol and drug problems. This is where Etsa comes in, because then she runs around with the first-year interns and second-year interns playing catch-up with them because as they have medical issues on alcohol and drugs arising, she runs around trying to provide the training we should have provided before that. It is just that we have not had the medical facility to have them in, and they have not opportunistically been in the right environment where they have had the ability to look at how to manage that situation.

Mr P. ABETZ: So basically the Next Step type of facility should be co-located at Charlie Gairdner or one of the other major hospitals so that they can tap into that?

Professor Hulse: Of course.

Mr P. ABETZ: So, rather than being a stand-alone facility over here, re-located so that it is there in terms of the statutory authority still and let the legals be worked out?

Professor Hulse: No, but I do not understand why we have only got one service. As I said, if you went to Victoria, then St Vincent's, Alfred—name any of the hospitals out there—they all have a dedicated unit because that is where their students get trained. Their students go through, they do the training, and it is just an issue of reorganising services. I can guarantee that if I had a crystal ball and I could look into the hospital, I would find that scattered across the different areas of the hospital there are enough to fill the unit. It is just that they are spread out somewhere. And who knows where they are at the time or what service they are getting? I am sure we have got people in the hospital too to provide those services whether we are getting them to them, because we have got a scattergun approach.

The CHAIRMAN: I think you are right in that we need more facilities within the tertiary hospitals for people who have alcohol problems.

Professor Hulse: Absolutely!

The CHAIRMAN: And maybe we will have to look at how that is addressed.

Ms L.L. BAKER: Professor, I am going to take you a little bit off education and onto the research, I hope. I am wondering if you would like to comment on the research evidence that is around or that you are aware of, or indeed you might have been involved in, around the difference between the theoretical models of addressing drug and alcohol addiction, illicit drugs particularly. I am thinking about harm minimisation, which has been very much part of this country's focus for a while now, and other views about no drugs, you know —

Mr P. ABETZ: The abstinence—or the focus on.

Ms L.L. BAKER: Yes, the abstinence versus the harm minimisation. Have you got a comment or a view?

Professor Hulse: Yes, they are good; thank you.

Ms L.L. BAKER: Thank you; okay, that was easy.

Professor Hulse: No, no; anything. I have looked at the different definitions which have arisen over the last 25 years to do with harm minimisation; I mean, really, anything which minimises harm. Methadone is harm minimisation as far as I am concerned. They all minimise harm. And it depends on the longer you leave people. I see kids, all the time; so you see kids having a good time and they might start to use some heroin or something and at that particular stage it is something which adds to the tapestry of their life. You know, it is great: they live at home with mum and dad, it is affordable, they are trying to be savvy about it in terms of their injecting, they read up about it, they get clean-needle syringes. At that stage they probably go to school or they have got a job and they have got friends that are non-drug users and it is just something that adds to the tapestry of their life

and it is terrific, you know? So, wonderful, you know? Then what happens is at some point, rather than it just being a component of the tapestry of life, it then becomes the driving force. If we can get people at that stage when it has become problematic and we can address the substance-use problem while they still wake up in the morning and eat Weeties with mum and dad at home and while they still have friends who are non-drug users, we can actually turn those people around quite quickly. We can intervene and we can set them back on it. That is one of the reasons, as I said, I used to run methadone programs. And like the time we used to put people on methadone and we used to try to keep them as healthy and infection free and try to reduce the amount of crime for 10 or 12 years until one day they would suddenly say, "I don't feel like using any more." Why they say that at 10 or 12 years, I have no idea. They would say, "I don't feel like using", and they would suddenly stop. I mean we would have to get them off 'done, which was the difficult thing, but they would get to that stage.

One of the things about the new pharmacotherapies coming up is that if you can give someone sustainable-release naltrexone—and I do not care if you are talking about the American or the local version—but if you can create a window of opportunity where they cannot use for a period of time, it is much easier if you get them earlier then to get them back into the saddle and into the community. And you do that. But then if you have not got them in that time and you have let them go on, then of course we need a different range of services because their psychosocial fabric has unwound. And so you inherit all that and you need to piece it back together. I have never met a heroin user, for example, who loves being dependent. In fact I have just hopped off a plane from overseas—I do not know if you know that—so I have just come straight from the airport.

Ms L.L. BAKER: For goodness sake!

Professor Hulse: So, what happens is you speak to these people. I spoke to a little girl that I just talked to before I went away who basically said, "I don't like who I am. I don't like who I have become. I don't like the fact that I rip off the people who are closest to me. I don't like the fact that I lie and cheat to my mum and dad and sister and take his guitar and sell it at Cash Converters. I hate where I am. I hate what I've become. I hate what it's doing. I hate the fact that I'm selling my body for twenty-five bucks to guys I despise. I hate all this. Did I forget to tell you I love to use heroin?"

And so the problem is that you have got this charismatic stuff where people can go back there. If you can arrest that situation while they have still got things going on and get them back into it, it is the same with alcohol and all those issues, but some people will go down. And so the range of services you might need and how you put them together. I mean I presume you are aware that we used to get referrals from drug and alcohol services for hepatitis C infection at Charlies. Gary Jeffrey used to get them all the time.

[11.40 am]

Perhaps one out of every 10 patients would front up, which made running a hospital clinic very difficult. Under the federal government's requirements for provision of anti-viral medication they have to see a GP, then a specialist, and get certain things done. It was not working. He spends one day a fortnight down at Fresh Start, and during that day they do all the hepatitis C stuff. Patients go into one room and see the general practitioner there then go into the next room, which is a designated hospital room. Gary does all his paperwork, sees them as the specialist, and they are off and running. It is an issue about how we put the services together and make them work. Years ago, someone in a hospital would have said, "No, we're the hospital; we don't do these things". In fact, Gary published a paper on that. Everyone said that we cannot treat heroin users with hepatitis C treatment because they will re-infect. He published a paper to say that this was how we do it, and that we get outcomes that are just as good as non-injecting heroin users in terms of treatment. In Western Australia we have some real pluses that other people look at. In fact, they often ask

whether it really happens. We have some real pluses here, but again, it is because we have the goodwill of people who will put themselves out there.

The CHAIRMAN: Thank you. Because of the time I will need to draw this to an end. Thank you for your evidence before the committee today. You certainly have given us all food for thought in terms of how this area is being addressed in other states and deficiencies that we may have here. A transcript of this hearing will be forwarded to you for correction of minor errors. Any such corrections must be made and the transcript returned within 10 days from the date of the letter attached to the transcript. If the transcript is not returned within this period it will be deemed to be correct. New material cannot be added by these corrections and the sense of your evidence cannot be not altered. Should you wish to provide additional information or elaborate on particular points, please include a supplementary submission for the committee's consideration when you return your corrected transcript of evidence. Thank you once again.

Professor Hulse: My pleasure.

Hearing concluded at 11.41 am