Dissenting report – The Hon Graham Edwards MP and Mrs Julia Irwin MP

General Comments

As members of the committee since the inquiry began 3 years ago, we have no objections to the conduct of the inquiry. The range of submissions and evidence of witnesses allowed the committee the fullest opportunity to address the inquiry's terms of reference. The most valuable part of this report is in fact the submissions received by the inquiry, the volumes of testimony given by witnesses before the inquiry and in the forums conducted as part of the committee's information gathering process.

However, the consideration of evidence, the conclusions reached and the recommendations made must be seen as coloured by the personal views of committee members (including ourselves). This can be a strength of the political process. After all, elected representatives should be a sounding board for the views of the electorate. What are seen as socially acceptable recommendations can be expected to prevail.

But in reaching conclusions and making recommendations which reject the findings of scientifically based studies and by using assumptions and anecdotal evidence to support its recommendations, the committee's report loses credibility.

In many ways the report is not an objective assessment of the facts but a one sided argument in favour of a predetermined outcome. Surely the lives of thousands of young Australians should be above politics. Indeed the Australian people deserve an honest and open appraisal of drug policy. In the interests of redressing some of the shortcomings in the report, the following conclusions and recommendations of the committee's report are dissented from.

Recommendation 21

The committee recommends that the Commonwealth government, in consultation with the State and Territory governments:

- **provide additional funding for alcohol and other drug treatment so that the shortfall in services is eliminated and adequate numbers of appropriately qualified staff are employed to work in these services, *with the ultimate objective being to obtain a drug free status for the client;* and**
- **pay particular attention to needs of people who abuse substances and suffer mental ill-health, including those in prison.**

The inclusion of the clause ***with the ultimate objective being to obtain drug free status for the client;*** is opposed.

The clause is not essential to the main point of the recommendation which is the call for increased funding. By adding the rider that "the ultimate objective being to obtain drug free status for the client", funding authorities may take this to mean that priority in funding should be given to agencies that include this specific objective in their funding submissions.

This may skew funding to ends or outcome oriented services at the expense of front end services such as contact points and referral services. Services with objectives of stabilising the lifestyle of target groups may be excluded or limited in funding if the "ultimate objective" approach is used to determine funding.

Funding should be based on demonstrated need and the effectiveness of the service to meet a range of agreed objectives.

Recommendation 52

The committee recommends that, when providing:

- **methadone maintenance treatment to save lives and prevent harm to people dependent on heroin, the ultimate objective be to assist them to become abstinent from all opioids, including methadone; and**
- **in addition, comprehensive support services must be provided to achieve this outcome.**

The recommendation is opposed.

By including the requirement that "the ultimate objective be to assist them to become abstinent from all opioids, including methadone;" the committee ignores the advice of Professor Mattick (7.16)

> only one-third of heroin addicts achieve and maintain abstinence. For the remainder, heroin dependence is a chronic, relapsing disease, and 'we have to talk about management not cure'.

Professor Saunders (7.16) posed the question,

> Do we want to reduce opioid use completely, or do we want to reduce harm and deaths.

The committee has opted for the first alternative contrary to Recommendation 51 which calls for an increase in the number of addicts in treatment.

The evidence of Professor Webster (7.16) states:

> it is about 'trying to achieve an outcome where someone is socially functioning; we are trying to get them back to work and, presumably back to their families…

This is misinterpreted when the report leaps to the conclusion (7.17)

> The committee believes that once in this position, there may be a chance of moving on to abstinence.

While evidence was given outlining the disadvantages of methadone treatment, no evidence was given of success rates in weaning clients off methadone.

The danger of the recommendation is that it places pressure on methadone treatment facilities to move people off methadone long before complete abstinence has been achieved.

This is suggested by Dr Currie (7.30) when he,

> pointed out informally to the committee, moving people off methadone frees up places for those who need and cannot at present access it.

When taken with the evidence of Ms Madden (7.30) which pointed to the "huge waiting lists (for methadone treatment) all around the country." It is clear that funding pressures influence access to methadone maintenance treatment. There is a great risk that funding methadone maintenance treatment which requires a measurable outcome of patients becoming abstinent may simply become a revolving door with patients returning for further treatment at a later time.

Recommendation 54

The committee recommends that the Commonwealth, State and Territory governments ensure that sufficient funding is available to treatment services to provide comprehensive support to opioid dependent people who are receiving pharmacotherapy:

- **for as long as it is needed to stabilise their lifestyle;**
- **if possible, to assist them to reduce or eliminate their use of all opioids, including methadone;**
- **support further research and trials of promising new medications and techniques;**
- **continue to fund research into pharmacotherapies for opioid dependence;**
- **make widely available as a matter of priority any treatments that are found to be cost effective; and**
- **give priority to treatments including naltrexone that focus on abstinence as the ultimate outcome.**

The final Dot Point is opposed:

Give priority to treatments including naltrexone that focus on abstinence as the ultimate outcome.

While some medical evidence in support of naltrexone was received, its appeal appears to be from other groups, (7.35).

> As DrugBeat of South Australia noted, it is 'not a drug substitution treatment, but rather a treatment that promotes abstinence…' Support for its use comes from those, like The Festival of Light, who believe there should be greater opportunities for individuals to opt for abstinence rather than an opiate substitute like methadone, and from those who favour a range of treatments being available.

Medical evidence however raised some concerns (7.36).

> Professor Mattick pointed out that orally administered naltrexone is safe and effective as long as patients remain in treatment but it is not well accepted by many who try it. Compared with other pharmacotherapies evaluated, the study found that it is harder to retain patients in treatment with naltrexone, compliance is poorer, and risk of death and overdose is higher when treatment is ceased or intermittent.

The report (7.36) also notes findings that conclude "that there was insufficient evidence to evaluate the efficacy of naltrexone." But the committee sees naltrexone as a magic bullet, it concludes; (7.40), "The committee believes that greater emphasis should be given to expanding the use of naltrexone."

Clearly there is a need for further research into the effectiveness of naltrexone before recommending that priority be given to its use in treatments. This is the case in Recommendation 55 which calls for Commonwealth funding for a trial of naltrexone implants. Support for the use of naltrexone should be based on medical evidence not moralistic preference based on its promotion of abstinence.

Recommendation 56

The committee recommends that:

- **the Australian National Council on Drugs urgently determine best practice models of residential rehabilitation in consultation with service providers;**
- **the Commonwealth, State and Territory governments ensure funding to establish these models throughout urban and rural areas;**
- **residential rehabilitation providers establish programs to instigate, where it is not already provided, ongoing support for those needing residential rehabilitation; and**
- **given the complexity of delivery of rehabilitation programs, responsibility and coordination should be undertaken by the Commonwealth Department of Family and Community Services.**

Dot Point 4 of Recommendation 56 is opposed.

Residential rehabilitation must be considered as part of the overall treatment of addiction. It is essentially a health issue. Outcomes must be measured against health criteria. (See Recommendation 125). While some difficulties with access to social security support may exist, many services offer counselling and referral for clients in residential rehabilitation.

Responsibility for residential rehabilitation should remain the responsibility of The Department of Health and Ageing.

Recommendation 57

The committee recommends that trials of heroin prescription as a treatment for heroin dependence not proceed.

The recommendation is opposed.

The report concludes (7.51) "Noting that trials of prescription heroin are occurring in some countries this committee has not been convinced of the value of this form of treatment for heroin dependence."

Evidence presented to the committee (7.47) pointed to the results of overseas trials showing improvement of general health and social functioning, reduction in criminal behaviour and the amount of drugs used. Heroin prescription was described as a niche treatment, useful for a small number of dependent people, noting that it is prescribed for 5% of heroin users in Switzerland and 3-4 % in the UK. Professor Mattick gave its cost as 3 times more expensive than existing treatments.

The following alternative recommendation is preferred:

That the results of overseas trials of prescription heroin be closely monitored by government agencies and that, should a state or territory adopt a policy to conduct a trial, then the arguments in support of the trial be put to the Commonwealth government and that trial should be approved or disapproved on the strength and relevancies of the argument put forward based on the most current evidence available.

Conclusion (7.138) (Safe injecting facilities)

The committee believes that the most desirable way of dealing with injecting drug user problems is to get addicts into rehabilitation programs that lead on to longer term treatments, bolstered by a range of ancillary programs to give maximum support to individuals rather than creating more safe injecting rooms.

The Conclusion is not agreed with.

The longer term objective of getting addicts into detoxification programs overlooks the immediate health issue of preventing overdose deaths and bringing injecting drug users into contact with referral and treatment agencies.

It should be noted that policy decisions on safe injecting rooms are the responsibility of the States and Territories.

The following conclusion is preferred:

State and Territory governments should closely monitor the performance of the Kings Cross safe injection room trial and assess the suitability of injecting rooms based on those results.

Conclusion 8.27

The committee:

- **supports the development of this new national framework to deal with multi-jurisdictional crime, believing that it will contribute significantly to limiting the drug trade;**
- **applauds the government's commitment to limiting drug trafficking and associated activities in the 2003-2004 budget; and**
- **applauds all jurisdictions and agencies commitment to limiting drug trafficking and associated activities.**

We believe this to be a cheap attempt by government members of the committee to take credit for itself where credit is not due. The fact that the latter part of this inquiry was conducted during a period of 'heroin drought' caused in the main by factors external to Australia.

Instead of congratulating itself we believe the Government would better serve Australia if it gave recognition and greater support to the many parents, grandparents, carers, volunteers and front line drug workers who do most to assist those caught up in the horror and trauma of substance abuse.

Recommendation 93

The committee recommends that, as part of the trial recommended in Recommendation 55, naltrexone implants also be trialled to treat opioid dependent prisoners. Should the trial be successful, then the use of naltrexone implants be an ongoing treatment for opioid dependent prisoners. Participation in the trial must be voluntary and agreed between the doctor and patient.

The Recommendation is opposed.

While supporting drug treatment services for prison inmates, as a fundamental human rights concern, pharmaceutical trials should not be undertaken in a prison environment whether voluntary or not.

The report notes (7.36) in relation to naltrexone that:

> it is harder to retain patients in treatment with naltrexone, compliance is poorer, and the risk of death and overdose is higher when treatment is ceased or intermittent.

And that there is,

> considerable success with naltrexone treatment when patients are carefully selected for treatment and extensive social support is provided for them during their treatment.

The report Conclusion (8.137) offers the caution "if the trial of naltrexone implants recommended in Chapter 7 proves them to be safe and effective in treating opioid dependent people," not "as part of the trial" as stated in the recommendation.

The Conclusion (8.137) goes on to state "serious consideration be given to **requiring** the use of such implants with suitable heroin dependent prisoners." This is hardly "voluntary and agreed between doctor and patient."

We note the comments of the head of the NSW Prison Medical Service, Dr Mathews, (8.130) that "rehabilitation, although a laudable aim, is not logistically possible in the correctional setting"; since most prisoners do not stay in one place for very long.

These concerns should make prison trials of naltrexone inadvisable.

It should also be noted that as the states and territories meet the full cost of all medical treatment for prisoners, the high cost of naltrexone treatment would be carried by the states alone.

Recommendation 95

The committee recommends all personnel employed in correctional facilities should be subject to mandatory random blood or urine tests.

Recommendation opposed:

Industrial relations and privacy issues should preclude this proposal. There is no mention of any submission to the committee calling for this measure. No reasons are given for the proposal unless we make the assumption that persons who have used an illicit drug would be more likely to smuggle contraband into prisons.

Recommendation 106

The committee recommends that all new cars made in, or imported into Australia be fitted with alcohol ignition interlocks by 2006.

Recommendation opposed.

This would represent a high additional cost which is unnecessary for the great majority of motorists.

The alternative recommendation is made:

That motor vehicle third party insurers be encouraged to offer discounts where vehicles are fitted with alcohol ignition interlocks.

Recommendation 107

The committee recommends that the Commonwealth, State and Territory governments give high priority in the national Road Safety Action Plan to:

- **work towards all States and Territories making it an offence to drive with any quantity of illicit drug present within the system;**
- **have all States and Territories enacting legislation to test and prosecute drug drivers;**
- **fund and coordinate roadside drug testing with a model similar to that of alcohol random breath testing; and**
- **continue research into the relationship between drugs and driving impairment.**

With the exception of the last Dot Point, the recommendation is opposed.

The suggested offence outlined specifies "any quantity of illicit drug" without reference to any relationship between drugs (and their level in the system) and driving impairment as has been established for alcohol and for which further research is called for in Dot Point 4.

While this recommendation may be aimed at illicit drugs it will inevitably be extended to cover licit substances under a policy of 'zero tolerance' with the main target being alcohol. The legal limit for alcohol in Australia is 0.05 and the committee was presented with no evidence to say that a change to a zero level would be workable or practical.

Recommendation 122

The committee recommends that the Commonwealth, State and Territory governments replace the current focus of the National Drug Strategy on harm minimisation with a focus on harm prevention and treatment of substance dependent people.

Recommendation opposed:

The report discusses in detail the background and development of "harm minimisation" as one of the key principles of Australia's drug strategy. While some submissions supported the concept, (11.5),

> Turning Point Drug and Alcohol Centre which claimed that harm minimisation was seen as a way of recognising that drug use is a continuum from no use to dependent use, and allowing for 'a sound balance of practical responding which is, at the same time, humane'.

Fitzgerald and Sewards (11.11), claimed:

> the term 'harm minimisation', has lost a lot of meaning…[and] can no longer provide strategic direction for drug policy. Without agreement over the meaning of key terms, the framework can no longer hold people together as it once did.

At (11.4) Fitzgerald and Sewards make the observation that:

> a feature of Australia's drug policy making has been 'the deliberate avoidance of electoral politics and public conflict by attempting to maintain consensus and accommodation…' The National Drug Strategic Framework is intended to bring together in a consensual way the people who are dealing with drug issues.

While the AMA (11.10), warns that:

> terms such as harm minimisation, while they may have been useful in drawing people together in the past, now appear to be polarising them instead.

The report mentions the criticism by The Festival of Light of needle and syringe programs (11.8), and preference for restrictive policies over harm minimisation by such groups as Keep our Kids Alive (11.9). The term "harm prevention" which this recommendation (122) seeks to replace harm minimisation, came from the submission of Drug Free Australia.

But Fitzgerald and Sewards warned (11.14) that:

> were a prevention framework to be adopted, it is important that the framework is inclusive and: '…cast in terms greater than simply prevention of illicit drug use. Prevention from its earliest use in 1985 has focused on the prevention of problems and harms as well as prevention of illicit drug use. Maintaining this broad definition of prevention will be a key element to a prevention framework.
>
> When prevention is cast only in terms of use, some members of the policy community could be excluded. Drug user

> groups, who are central to the Australian approach, may suffer if prevention of drug use is a central priority.

The report ignores this advice and concludes (11.15):

> It will be clear from the earlier chapters in this report that the committee believes that much more effort needs to go into both preventing the uptake of smoking and illicit drug use and providing treatment that leads to abstinence and, in the case of alcohol, responsible use.

The wording of the recommendation which calls for governments to: **replace the current focus of the National Drug Strategy on harm minimisation with a focus on harm prevention and treatment of substance dependent people**, does not attempt to explicitly include what is understood to be harm minimisation as one of the key principles of harm prevention.

Even allowing for the inclusion of "**and treatment of substance dependent people",** without the explicit inclusion of the key principles of harm minimisation, the recommendation cannot be supported. Since Conclusion (11.15) specifically endorses only treatments that lead to abstinence, it does not go far enough to include all key principles of harm minimisation.

It is believed that the term **harm prevention** will rapidly become understood to mean zero tolerance. The consensus referred to by Fitzgerald and Sewards (11.4) would quickly be destroyed and the polarisation warned of by the AMA will become a reality (11.10)

The adoption of this recommendation by governments will place the majority of health professionals working in this field outside the ambit of the National Drug Strategy and put at risk the coordinated and cooperative approach developed over more than a decade.

The Hon Graham Edwards MP

Mrs Julia Irwin MP
Deputy Chair

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