Submission no. 282

Parliamentary Submssion

Harm Minimisation or Zero Tolerance

1. More effective means of treatment are required
2. Treatment is most effective when drugs are more difficult and more expensive to acquire
3. People seek treatment when they need it or are forced to change
4. Education to encourage people to seek treatment early and to feel confident about seeking treatment is required

Objections to the Use of Naltrexone

1. Naltrexone is non-toxic, non-addictive and with few and no serious side-effects
2. Naltrexone has never caused anyone to die
3. Naltrexone does not cause depression
4. Rights of drug users and society are better protected using Naltrexone Implants combined with counselling

Naltrexone Treatment and Implants

1. Naltrexone was never a 'miracle cure'. It is a valuable adjunct to treatment. Addicts know this, so do those knowledgeable in drug and alcohol
2. Rapid Opiate Detoxification is both effective (100%) and cost effective
3. Holistic programs which recognise and treat both the psychological and physical aspects of addiction needs to be implemented
4. Naltrexone Implants can ensure compliance and abstinence and provide an opportunity to change

Ross Colquhoun BSc (Hons) Psychology, MAPS, MACPCP, MASORC, MAPSAD
Clinical Psychologist and Specialist in Addiction Medicine
President of the Australian College of Private Consulting Psychologists

R & D Counselling and Group Therapy Pty Ltd, trading as Addiction Treatment and Psychology Services
Telephone: (02) 96993311 Facsimilie: (02) 96988878
Surry Hills Medical Centre, 569 Crown St., Surry Hills. NSW 2010

Parliamentary Submission

Naltrexone Treatment and Naltrexone Implants

1. Over the last four years we have, with a number of medical people, developed a safe, one-day, in-patient rapid opiate detox procedure, under specialist medical and nursing care, using a range of symptomatic medications, light sedation and naltrexone. This is highly effective (100% completion), compared to 20-30% for home or in-patient detox, with few after-effects and quick recovery. The form of detoxification does not predict long-term outcomes, only the number who complete the process and, therefore, the number who are able to commence the after-care program.

2. We have developed an after-care protocol of oral nalltrexone, 6 months out-patient counselling and family support, to ensure compliance, with results which are far superior to traditional after-care programs, including in-patient rehabs. Each patient is assessed and an individual treatment plan is developed.

3. Naltrexone implants, which are easily inserted under local anaesthesia, dramatically improve compliance rates and would seem to be a huge advance in the treatment of opiate dependency. The patients must be selected (see point 5) and implants are not seen as a panacea, but as an opportunity to complete an after-care program free of the cravings for opiates and the risk of relapse. The implants provide blockage of opiates for 6 to 12 months and can be readily re-inserted for much longer protection. This treatment is very cost effective compared to long-term maintenance. It is also ideally suited for those with minimal social support, eg leaving jail

4. Naltrexone is a very safe, non-addictive medication producing no euphoric or mind-altering effects which blocks the effects of opiates, preventing relapse or overdose and dramatically reducing cravings for opiates. It is far more effective for opiate dependency, compared to use with alcoholism, but is PBS listed for the latter and not the former.

5. Methadone or buprenorphine may be the better option for those who are mentally ill, who do not have any social support and who are not ready psychologically to detox from opiates.

6. I have developed a trial protocol, designed a research plan, completed an ethics application and have almost completed a paper on the early implant trials in WA. as part of my doctorate at Deakin University

In order to implement this trial:

1. We will need to meet with other senior politicians, especially at Federal Govt. level who are receptive and who support the trial of naltrexone implants

2. Communicate that the best interests of many opiate dependent people, their families and the public are better served by an implant trial rather than a heroin trial, which may be suitable for long-term users who are not interested in ceasing opiate use.

3. Gain public support for such a trial

4. Obtain funding for a properly conducted trial strictly using the guidelines of our program

5. Disseminating the results of the trial and setting up model programs in other jurisdictions as an alternative to methadone – estimated 35,000 to 70,000 dependent on heroin and 30, 000 already addicted to methadone and growing each year by 5% and nowhere to go from here!

R & D Counselling and Group Therapy Pty Ltd, trading as Addiction Treatment and Psychology Services
Telephone: (02) 96993311 Facsimilie: (02) 96988878
Surry Hills Medical Centre, 569 Crown St., Surry Hills, NSW 2010

Parliamentary Submission

Objections to the use of naltrexone.

Safety

The safety of naltrexone has been cited as a reason to oppose its use in helping heroin and methadone dependent people. Contrary to such concerns, pharmacological research over the last 20 years shows that naltrexone is non-toxic, it does not accumulate in the system of the patient, it is non-addictive and there are few and no significant side-effects even at doses much higher than the normal therapeutic dose.

The Therapeutic Goods Administration under the Special Access Scheme regulates the use of naltrexone and implants closely in Australia. Naltrexone is now registered for use for maintenance of abstinence from opiates and they have thoroughly audited the applications and consents for those who have had implants and have made no objection to their proper use.

Critics have stated that naltrexone has also been associated with overdose deaths. The fact is, anyone who ceases opiate use becomes less tolerant to opiates and are more at risk of overdose, whether they return to their environment after jail, a rehabilitation program, from overseas or having used naltrexone. Naltrexone has never caused any death. While a person is taking naltrexone they cannot relapse or overdose and the period of time they spend in their own environment, drug-free and learning new behaviours probably means they are less likely to overdose. The available research seems to support this conclusion.

Depression

Others have stated that naltrexone is associated with increased levels of depression. There is no evidence to suggest that naltrexone causes depression. As many drug users maintain their habit to self-medicate psychiatric then anyone who ceases drug use may experience feelings of depression. This needs to be managed medically and through counselling.

R & D Counselling and Group Therapy Pty Ltd, trading as Addiction Treatment and Psychology Services
Telephone: (02) 96993311 Facsimilie: (02) 96988878
Surry Hills Medical Centre, 569 Crown St., Surry Hills, NSW 2010

Rights of the Drug User

Another issue referred to by those who oppose naltrexone was that of the rights of the drug user and some mention has been made of 'enforced abstinence'. I might point out that anyone who receives naltrexone orally or as an implant will only do so having provided full and free consent while free from the influence of drugs. The period of time of the effect of the implant is limited to a few months unless the person opts for another implant, again after giving full and free consent.

This is contrary to the case when addicts are inducted onto methadone.

1. Studies show that 63% of people are still addicted to methadone and in the program at six (6) years in Australia. Many of the people who are not in the program have returned to illicit opiate use.
2. Moreover, they are often misinformed about the toxic nature of the drug and the risk of overdose and death;
3. they do not give consent when drug-free but when they are addicted to an opiate;
4. they are subject to enforced reporting to a registered and controlled delivery point, often a public methadone clinic where others can wait to accost them;
5. they are subject to identity checks and urine drug screens;
6. they are often denied the drug they need for infringement of rules they did not write;
7. their capacity to travel, and in some cases, to work because of opening hours to is severely curtailed and;
8. they are condemned to enforced addiction as it is very difficult to detox from methadone, there are no public funds for ROD (the only way to detox for many) and they are encouraged by authority figures to stay on it.
9. The cost of maintaining someone on methadone for 6 years is approximately $200,000. The cost of counselling and an implant each year for 6 years is $30,000.

Ross Colquhoun BSc (Hons) Psychology, MAPS, MACPCP, MASORC, MAPSAD
Clinical Psychologist and Specialist in Addiction Medicine
President of the Australian College of Private Consulting Psychologists

R & D Counselling and Group Therapy Pty Ltd, trading as Addiction Treatment and Psychology Services
Telephone: (02) 96993311 Facsimilie: (02) 96988878
Surry Hills Medical Centre, 569 Crown St., Surry Hills, NSW 2010