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Submission to the Inquiry into impact of illicit drug use on families

Submitted to:
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Improving "The Capacity to Care"

- *Dr George O'Neil*
- *Visiting Obstetrician KEMH, 25 yrs*
- *Managing Drug Addicted Mothers, 20 yrs*
- *Managing AMPRF Drug Treatment Service, 10yrs*
- *Inventing and Research relating to New Medical Procedures and Products, 20 yrs*
  - *Pain Management, Addiction Medicine, Management of Addicted Mothers*

Financial, social and personal cost to families having members using illicit drugs

- An estimated 6 family members are directly affected by the drug user
- For heroin addiction the direct cost to society is estimated at $300/day for an average of 10 yrs ($1M / addict) simply in the cost to supply illegal heroin
- The addict is separated from the family, initially by their dishonesty and removal of family funds and later by crime and the necessity to move out into a sub-culture with other addicts

Financial, social and personal cost to families having members using illicit drugs

- An estimated 6% of families in Scotland have a drug using parent with a significant problem and in WA we estimate this to be in the order of 7% based on KEMH figures which apply only to mothers. The incidence may be higher with males.
- The impact on these children may increase pre-natal as well as intrauterine development of the child and certainly affects the stability of the family and the ability of the family to provide proper nurturing, growth and development of the child.
- The increase in heroin supply from Afghanistan from 1000 tonnes of opium 6 yrs ago during Taliban control to 6000 tonnes parallels the drop and recent rise in heroin supply to Australian addicts. This information suggests that we may see a shift from amphetamines back to more opiates in the coming yr.
- Amphetamines have no confirmed pharmacotherapy and are causing significant violence and disruption of families

The impact of HARM minimisation programmes on families

- In 1985 there were 500 methadone patients in Australia and this has risen to approx 30000 – 35000 methadone and buprenorphine addicts who are dependant on Government supplied opiates. The question has to be asked; does putting patients on maintenance opiates delay recovery of young Australians and does it hold these people in the opiate dependent pool for a prolonged period of time? (ie does it delay recovery?)

The impact of HARM minimisation programmes on families

- Marijuana has been decriminalised in WA and the young addicts presenting remind us that their view is that it is legal and reasonable to grow their own plants.
- The Government has no health or education programme to screen the use of marijuana in primary of high schools. I hold the view that if one really believes in early diagnosis and early intervention with appropriate support this Government has totally failed in this area and shown no leadership.

The impact of HARM minimisation programmes on families

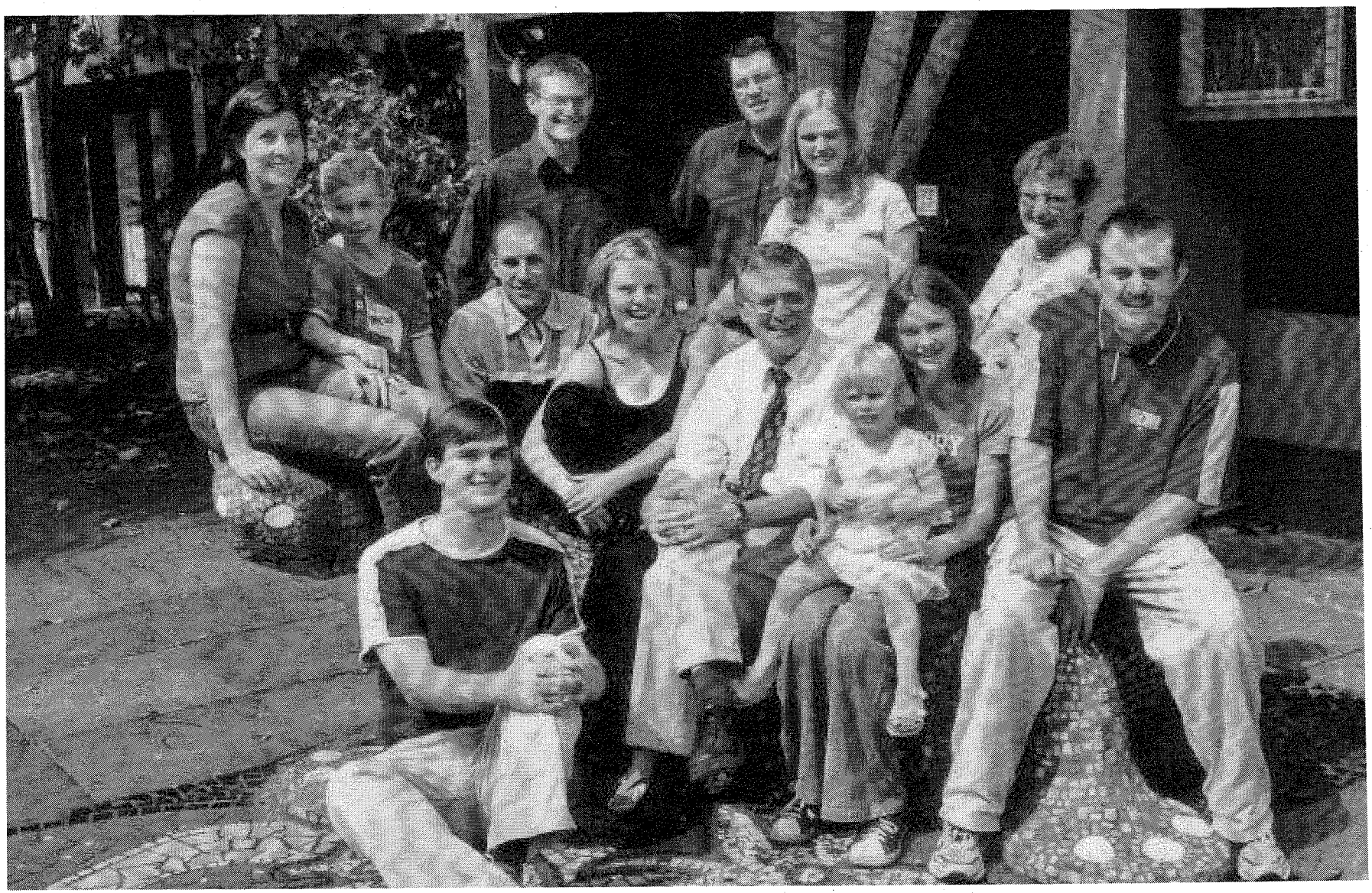
- For a 10yr period at a cost of $3-5M/yr we have provided Australia's largest and best known naltrexone service. With more than 30 publications and significant international support for our work we are disappointed that the Commonwealth in its main funding programmes has not contributed to pharmacotherapies that help patients cease opiates. We believe this failure is political more than scientific. We hope the politics changes.

Ways to strengthen families who are coping with members who are using illicit drugs

- Invest in assisting the addict the cease his drugs rather than maintain them so that the family can reconnect with a non-using, non-opiate dependent addict.
- The Government's current policy of simply putting the patient on opiates has not been effective in rebuilding families and reintegrating opiate dependent people with non-opiate dependent people.

Improving "The Capacity to Care" Premises

- Children and families constitute the vital infrastructure of our community
- We need the community to help us all to keep children safe
- Not all drug use is incompatible with being a good parent
- Pregnancy provides a window of opportunity for the problem substance using parents
- Most problem substance using parents are frightened of asking for help
- For most problem substance using parents, it is the incapacity to care and protect rather than lack of love that is the problem
- Respect and a non-judgmental attitude are essential to effective recovery and rehabilitation
- ***Treatment is the most effective way to cut drug use***



‘Hidden Harm’ (2003)

- Taskforce consisting of 29 experts from diverse fields who met for fifteen full days over two and a half years (2000-2003) and who were assisted by a secretariat of between four and five people
- Twenty one Government officials assisted
- Chaired by Dr Laurence Gruer – Professor of Public Health at Glasgow University

‘Hidden Harm’ (2003)

- 4-6% of all children under sixteen who live in England and Wales have a problem drug using parent
- Parental problem drug use can compromise child health and development at every stage from conception on
- Reducing the harm to children from parental problem drug use should become a main objective of policy and practice
- Effective treatment of the parent can have major benefits for the child
- By working together, services can take many practical steps to protect and improve the health and well-being of affected children
- The number of affected children is only likely to decrease when the number of problem drug users decreases

The Australian Scene

- Drug use/misuse is primarily a disease of adolescence
- "Parental drug use is one of the most serious issues confronting the child welfare system in the last twenty years" (Ainsworth 2004)
- "The majority of women in drug treatment centres are of child bearing age" (Oei & Lui 2007)
- There are competing political, legal, health and child welfare philosophical approaches to help
- Negative attitudes to mothers who misuse drugs or alcohol and particularly to pregnant mothers who misuse them (Moore 2006)
- Constructed (manufactured) images of the 'bad mother' are rife (Swift 2002)

AUSTRALIAN NATIONAL CLINICAL GUIDELINES (2006)

Continuity of Care

- Effective engagement skills, including cultural awareness skills
- An effective system which clearly identifies the main case worker
- Individualised care planning made in consultation with the woman
- Timely and accurate documentation and communication
- A seamless referral system

"Women enter a complex care system when they become pregnant. If the woman or partner has drug use issues or presents with other 'problems', 'risks' or 'vulnerabilities', there is potential to interface with a formidable list of care professionals" (Wheeler 2006)

Heroin Use In Perth: Trends in uptake of drug abuse

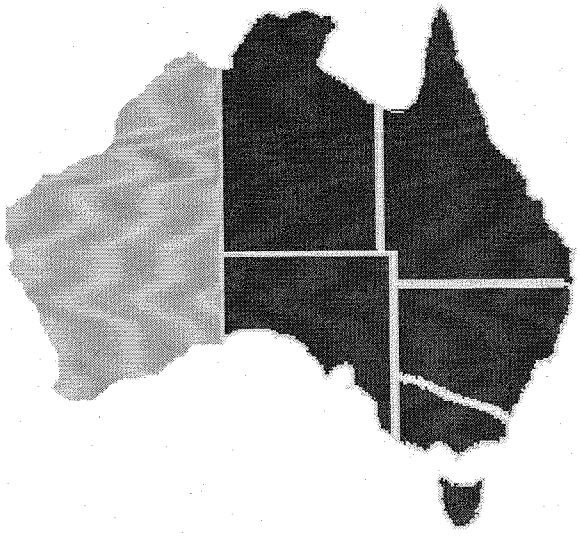
- Age of first use: Fresh Start Recovery Programme
  - By 16 years – 22%
  - By 18 years – 51%
  - By 22 years – 80%

Perth 8,000 addicts:

3000 on meth or bup

4,500 on Naltrexone

80-90% in pharmacotherapy (maintenance or antagonist)

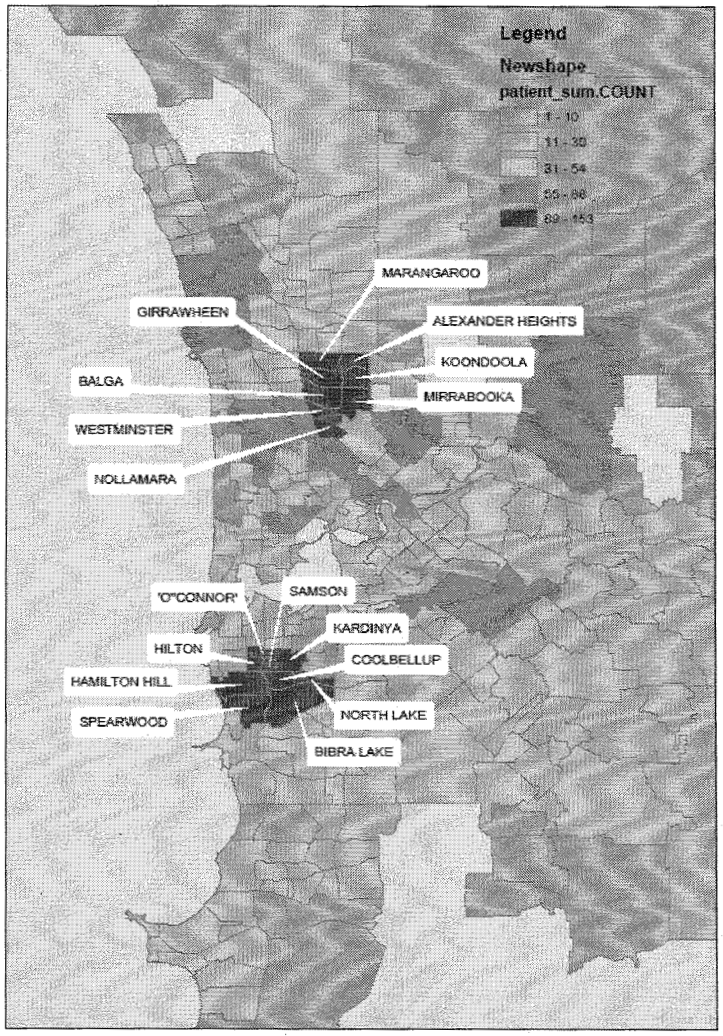


Sydney:

Less than 1% of addicts given naltrexone

30-40% in pharmacotherapy (maintenance or antagonist)

Improving “The Capacity to Care”



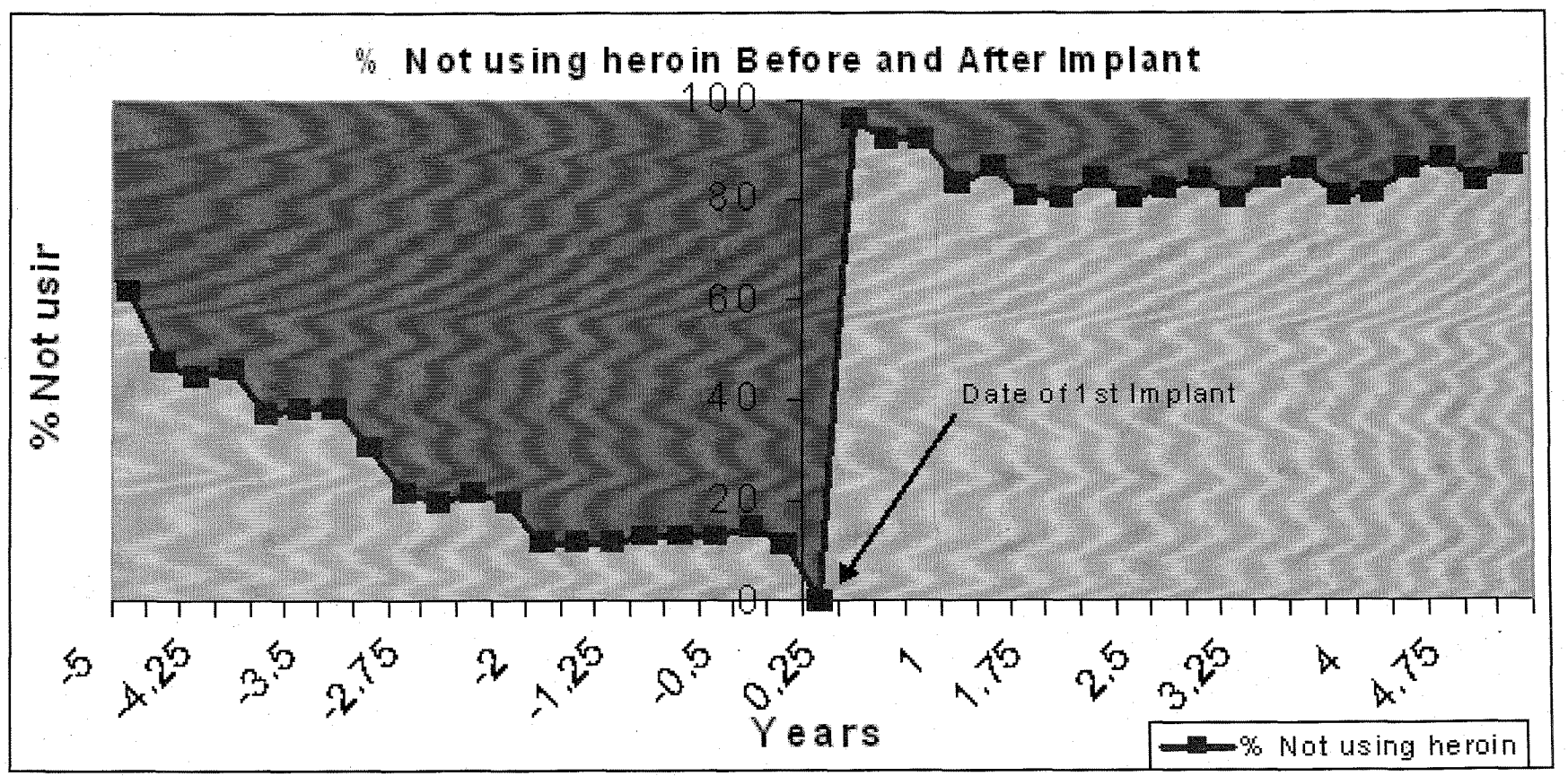
The Perth Naltrexone Service; an overview of the first five years

- 1466 patients treated (up to December 2005)
- 2,800 treatment episodes
- 4,327 patient years studied
- 2,063 patient years of active treatment
- 2,264 years after active treatment
- Average exposure to naltrexone treatment of 858 days

These sustained-release implants (Go Medical Implants) have previously been described by Hulse and O'Neil (Addiction Biology 2004) and deliver naltrexone for approximately twelve months with blood levels maintained above 1ng/mL for 272 days.

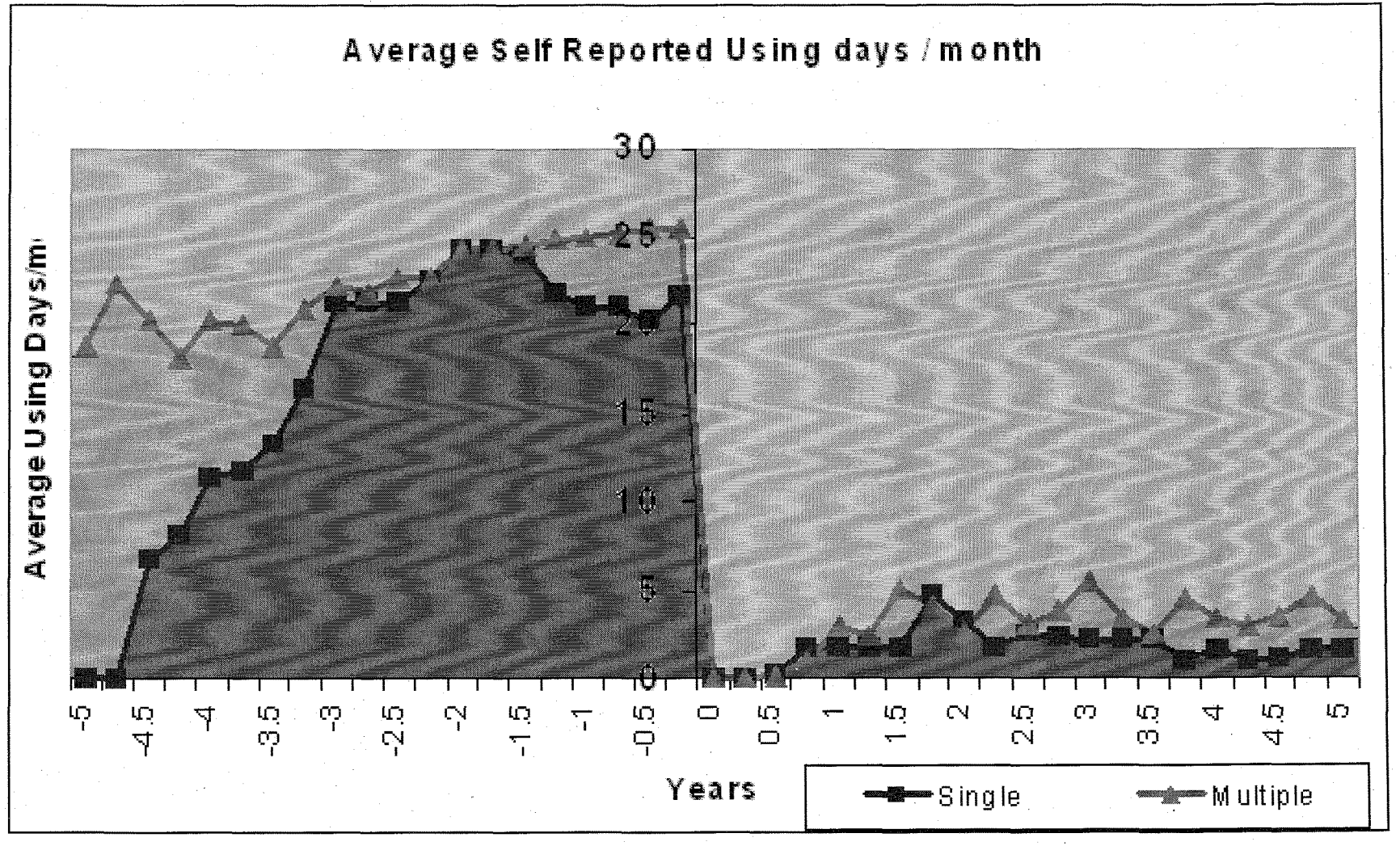
Percentage Not Using Heroin Before and After Implant (Telephone Survey 2006)

N = 58



Average Self Reported Using Days Per Month for the 5 Year Period Before and After Single and Multiple Implants (Telephone Survey 2006)

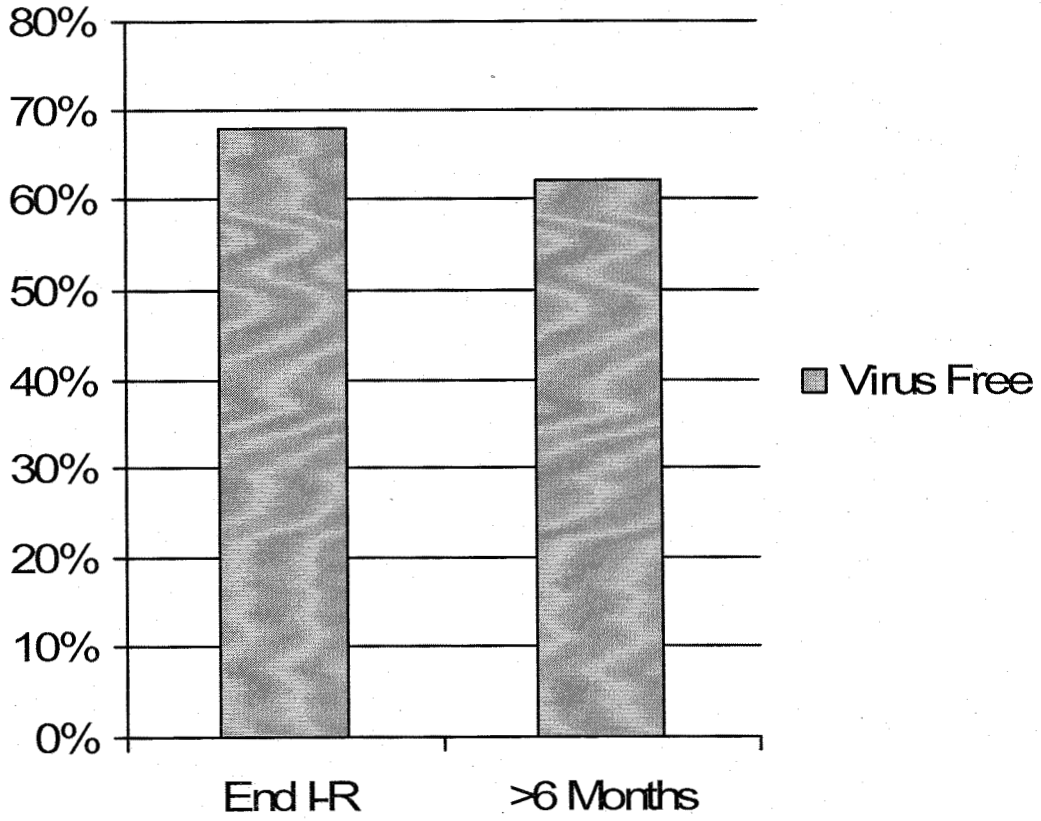
(Single implants: N = 22; Multiple Implants: N = 36)

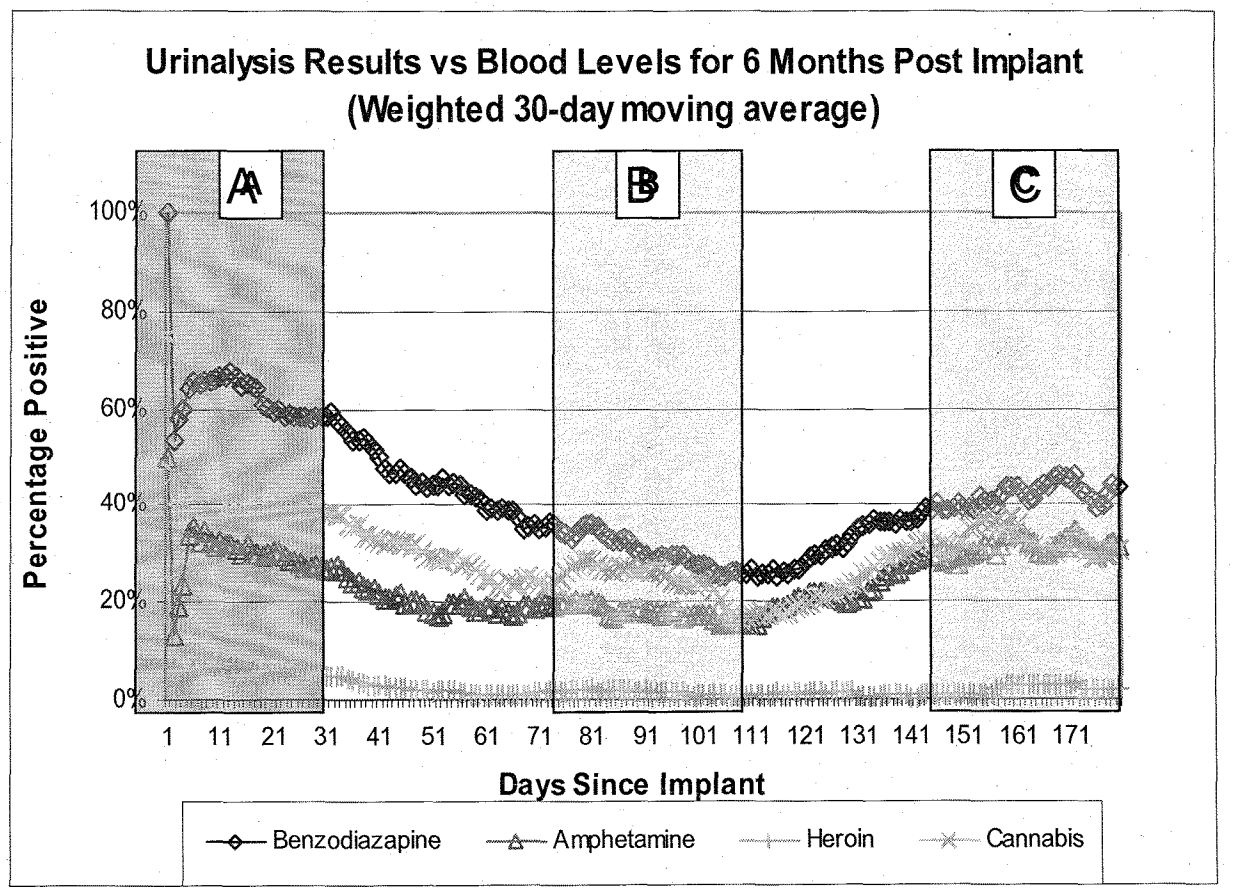


SUCCESSFUL HEPATITIS C VIRUS ERADICATION IN INTRAVENOUS DRUG USERS MAINTAINED WITH SUBCUTANEOUS NALTREXONE IMPLANTS

Gary P Jeffrey et al.

Submitted to 'Hepatology and Liver Transplantation'





The values for segment A compared with segment B and segment B compared with segment C are significantly different for benzodiazepines, amphetamines and cannabis but not for opiates.

Figure 1a		Benzodiazepine	Amphetamine	Heroin	Cannabis
A	1 - 30 days	58.3%	26.9%	5.0%	38.4%
B	81 - 110 days	26.1%	15.0%	0.6%	16.7%
	Fishers Exact	P<0.0001	P = 0.0022	P = 0.0057	P<0.0001
C	151 - 180 days	43.5%	31.5%	2.2%	30.4%
	Fisher Exact on increase	P = 0.0058	P = 0.0024	P = 0.2650 (not significant)	P = 0.012

AMPRF TREATMENT MODEL

PHREE

- [**P**]HYSIOLOGY
- [**H**]OUSING
- [**R**]ELATIONSHIP
- [**E**]DUCATION
- [**E**]MPLOYMENT

The P.H.R.E.E. programme is to:

1) **Change in *P*hysiology**

   Eg **Fluamzenil blocks** **benzodiazipines**

   Naltrexone blocks **Alcohol**

   Benzodiazipines

   Opiates

   Impulsive behaviour

2) ***H*ousing (Home where you know you belong)**

   Essence of a home is love, joy, peace, patience, gentleness, kindness and self-control.

3) ***R*elationships**

   - **Self, God, family, community**

4) ***E*ducation**

   - **Cease pot**
   - **Short term employment**
   - **Career / University**

5) ***E*mployment**

   - **Occupational therapy**
   - **Short term / Long term**

Competing Approaches

- Risk focus
- Single discipline
- Child or mother focused
- Short term
- Judgmental
- Hostile
- Narrow
- Waiting lists
- Individual service

- Assessment focus
- Multidisciplinary
- Child and mother focused
- Sustained care continuum
- Accepting
- Engaging
- Comprehensive
- Immediate service
- Collaborative

(Intergovernmental Committee on Drugs 2005)

Improving "The Capacity to Care" Urgent Needs

- Supported Rehab Housing for Mothers and Children (Rehab setting)
- Grandmother Supported Housing to be available on an acute 4 hour notice basis
- Specialised housing available to mothers with limited capacity to care with appropriate daily support
- Legal aid for all parents under criticism by Government departments

Improving "The Capacity to Care" Urgent Needs

- Parents who are separated from their children for prolonged periods should be allowed to communicate with a paediatrician or child psychiatrist who has been appointed for the child.
- The paediatrician or child psychiatrist should be allowed to use his clinical judgement as to when communications in writing should be allowed and also decide when communication should enlarged for the child's benefit.

Improving "The Capacity to Care"

- Recommendations
- Paediatricians and Drug treatment doctors should be included in the management teams reviewing drug affected families.
- Drug affected families can make rapid improvements which require a rapid review system with a team headed by a paediatrician for the child to maximise the chance of the child's family being re-established. The courts should empower these paediatricians to constantly review clinical changes rather than impose long periods of separation between family members.
- Specialised treatment and housing services should be available to facilitate rapid recovery of parents affected by drugs as well as giving support rebuilding their families

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