

Illicit drug use: prevention and treatment

- 7.1 This chapter deals with the issues raised for the health care system by illicit drug use. Heroin, cannabis, psychostimulants and injecting drug use are considered. The committee also examines the inappropriate use of licit substances such as inhaling solvents, glue, petrol or paint.

Prevalence and costs

- 7.2 Illicit drugs are used far less than licit drugs in Australia. Fewer than one in six Australians aged 14 years and over who were surveyed by the National Drug Strategy (NDS) Household Survey in 2001 had used illicit drugs in the previous 12 months. Over one-third had taken an illicit drug at some stage in their lives with males being more likely than females to have done so. Use of illicit drugs since the last survey in 1998 had fallen from 22.0 per cent of Australians to 16.9 per cent.¹
- 7.3 The 2001 NDS Household Survey found that the illicit drug most commonly used in the last 12 months was cannabis; it was consumed by 12.9 per cent of Australians over 14 years of age. Other illicit drugs were much less frequently taken; the next most commonly used after cannabis were amphetamines, pain killers/analgesics and ecstasy/designer drugs, each taken by less than one person in 30 (3.4 per cent, 3.1 per cent and 2.9 per cent respectively).² However, according to the Australian Medical Association (AMA), the percentage of people over 14 years of age taking

1 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: First results*, Drug statistics series no 9, AIHW, Canberra, May 2002, pp xiii-xiv, 3, 20, 31.

2 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: First results*, pp 3, 22.

ecstasy doubled in the seven years before 1998, and in 2002 appeared to be still on the increase.³

- 7.4 Heroin was the drug cited in the NDS Household Survey by the majority of Australians as being of greatest serious concern to the community⁴, although it had been used at some stage in their lives by only 1.6 per cent of people aged 14 years and older.⁵ Hall et al estimated the number of heroin users in Australia between 1997 and 1998 to be around 74,000.⁶ The Household Survey showed that between 1998 and 2001, recent use of heroin dropped significantly.⁷ No explanation was provided from the survey on why the usage dropped. However, in 2001 the Australian Drug Trends 2001 reported 'there was a marked and sustained reduction in the availability of heroin, which was manifest in decreased prevalence and frequency of use in all jurisdictions ...'⁸ Further evidence on decreased prevalence is outlined in Chapter 8.
- 7.5 27.7 per cent of teenagers (14-19 years age group) who were surveyed in the 2001 NDS Household Survey, had used an illicit drug in the previous 12 months, and 35.5 per cent of 20-29 year olds had also used an illicit drug in the last 12 months.⁹ Cannabis was offered or available to 24.2 per cent of Australians surveyed, and to 48.3 per cent of 14-29 year olds. Curiosity, which was cited as the most common reason for trying illicit drugs, stood at 82.4 per cent, while peer pressure was also strong at 54.7 per cent.¹⁰
- 7.6 According to the Australian Institute of Health and Welfare (AIHW), illicit drugs are directly and indirectly a major cause of death and ill-health. Medical conditions associated with illicit drug use are overdose, HIV/AIDS, hepatitis C, low birth weight, malnutrition, infective
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3 *Party drugs: A new public health challenge*, 2002 AMA Drug Summit, National Press Club, Canberra, 11 April 2002, Australian Medical Association, Canberra, 2002, p 4.

4 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: Detailed findings*, Drugs statistics series no 11, AIHW, Canberra, December 2002, p 5.

5 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: First results*, p 24.

6 Hall W, Ross J, Law L & Degenhardt L, 'How many dependent heroin users are there in Australia?' *Medical Journal of Australia*, vol 173[10], 20/11/00, viewed 26/11/01, http://www.mja.com.au/publicissues/173_10_201100/hall/hall.html>.

7 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: First results*, p 25.

8 Topp L, Kaye S, Bruno R, Longo M, Williams P, O'Reilly B, Fry C, Rose G & Darke S, *Australian drug trends 2001: Findings of the Illicit Drug Reporting System*, NDARC monograph no 48, National Drug and Alcohol Research Centre, Sydney, 2002, p 51.

9 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: First results*, p 20.

10 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: Detailed findings*, pp 15, 40.

endocarditis (i.e. inflammation of lining of the heart), poisoning, suicide and self-inflicted injury.¹¹ The AIHW also reported that illicit drugs were responsible for 1,023 deaths in 1998 (up from 781 in 1996 and 864 in 1997) and 14,471 hospital separations in 1997-98 (up from 11,057 in 1995-96 and 11,882 in 1996-97).¹² Australian Bureau of Statistics data, as reported by in the 2001 edition of Opioid overdose deaths in Australia, revealed opioid overdose deaths for 15-44 year olds varied from 347 deaths in 1988, 958 deaths in 1999, 725 deaths in 2000 and 306 deaths in 2001.¹³ Collins and Lapsley estimated that the cost of health care for illicit drug-related problems in 1998-99 was \$64.7 million.¹⁴

National Illicit Drug Strategy

7.7 The National Illicit Drug Strategy (NIDS) 'Tough on Drugs' is the current major focus of the NDS, and comprises both demand and supply reduction measures. The five priority demand reduction measures are:

- treatment of users of illicit drugs, including identification of best practice;
- prevention of illicit drug use;
- training and skills development for front line workers who come into contact with people who use drugs or at risk groups;
- monitoring and evaluation including data collection; and
- research.¹⁵

11 Australian Institute of Health and Welfare. *Australia's health 2002: The eighth biennial health report of the AIHW*, AIHW, Canberra, May 2002, p 148.

12 Australian Institute of Health and Welfare, *Statistics on drug use in Australia 2002*, Drug statistics series no 12, AIHW, Canberra, February 2003, pp 35-36; Australian Institute of Health and Welfare, *Statistics on drug use in Australia 2000*, Drug statistics series no 8, AIHW, Canberra, May 2001, p 37.

13 Degenhardt L, *Opioid overdoses in Australia: 2001 edition: 2001 Australian Bureau of Statistics data on opioid overdose deaths*, National Drug and Alcohol Research Centre, Sydney, 2001, p 3, viewed 30/6/03, [http://ndarc.med.unsw.edu.au/ndarc.nsf/c2fabb74f3f54c22ca256afc00097c53/4341b152e43d5786ca256b4b007a9146/\\$FILE/ABS%20DATA%202001.pdf](http://ndarc.med.unsw.edu.au/ndarc.nsf/c2fabb74f3f54c22ca256afc00097c53/4341b152e43d5786ca256b4b007a9146/$FILE/ABS%20DATA%202001.pdf)

14 Collins DJ & Lapsley HM, *Counting the cost: Estimates of the social costs of drug abuse in Australia in 1998-9*, Monograph series no 49, Commonwealth Department of Health and Ageing, Canberra, 2002, p 58.

15 National Illicit Drug Strategy, 'Tough on Drugs', p 1, viewed 14/2/03, <<http://www.health.gov.au/pubhlth/strateg/drugs/illicit/index.htm>>.

- 7.8 Several of NIDS preventive measures have been discussed in Chapter 3 (the Community Partnership Initiatives, national drug information service and National School Drug Education Strategy). These are supported by the National Illicit Drugs Campaign designed to educate and inform the community about the dangers of illicit drug use. The first phase of the campaign, which was launched in 2001, targeted parents and included advice on their role in preventing illicit drug use by young people.¹⁶ An evaluation of the campaign found that it had been successful in informing parents and prompting them to talk about illicit drugs with their children. Young people and other members of the community were also influenced by the campaign material.¹⁷ The second stage of the campaign will target youth at risk.¹⁸
- 7.9 In addition to projects targeting specific dependencies, NIDS supports treatment through the Non-Government Organisation Treatment Grants Program (discussed in Chapter 4), and diversion of illicit drug users from the criminal justice system into education and treatment (covered in Chapter 8). Other NIDS measures include:
- increasing the number of needle and syringe outlets;
 - research to investigate barriers and incentives to illicit drug users accessing and remaining in treatment;
 - establishing best practice for therapeutic communities; and
 - the National Health and Medical Research Council's program for research in prevention and treatment of illicit drugs.¹⁹
- 7.10 Of the three remaining NIDS priorities previously outlined, training and skills development for health care workers is covered in Chapter 4.
- 7.11 In the 2003-04 federal budget the government provided funding of \$316 million over four years for a range of new and continuing measures to address illicit drug use in Australia.²⁰ Aspects of the package are noted in Chapters 4, 7 and 8. One component of this is that the government will provide \$2.8 million over four years for interdisciplinary research into the prevention and treatment of illicit drug use, and to provide sufficient

16 National Illicit Drug Strategy, 'Tough on Drugs', p 4.

17 Bertram S, Worsley J & Carroll T, *Evaluation of the launch phase of the National Illicit Drugs Campaign: Chapter 1: Overview*, research report, Commonwealth Department of Health and Ageing, Canberra, January 2002, pp 14-15, viewed 19/3/03, <http://www.health.gov.au/pubhlth/publicat/document/reports/nidc_eval_1.pdf>.

18 National Illicit Drug Strategy, 'Tough on Drugs', p 4.

19 National Illicit Drug Strategy, 'Tough on Drugs', pp 3, 5- 6.

20 *Budget measures 2003-04*, Budget paper no 2, Commonwealth Department of the Treasury, Canberra, May 2003, p 168.

resources to attract new researchers to the field. Priority will be given to research into the interaction between mental health and substance abuse and psychostimulant use and for investigator-driven research.²¹

Prevention and treatment

7.12 Table 7.1 was presented to the committee at its roundtable by Professor Saunders; it summarises the extent of knowledge about the effects of different licit and illicit psychoactive substances, whether effective treatments for addiction to these substances exists and, where it does exist, whether it is widely available. It is clear from Table 7.1 and Professor Webster's presentation to the committee's roundtable that very little is known about effective, preventive approaches and ways to intervene early in the development of illicit substance use and misuse. With the exception of heroin, there is little effective treatment for dependence on illicit drugs. This stands in stark contrast with the treatments available for the licit drugs, particularly tobacco, and our knowledge about how to prevent their use.²² Professor Mattick advised the committee that, while much has been done nationally and internationally over the last 20 years to address the deficits in knowledge and treatment of illicit drugs, investment in understanding cannabis, cocaine and amphetamines is now needed.²³

Table 7.1 Summary of knowledge about and treatment for different drug dependencies

Drug	Fundamental Knowledge	Evidence of Effective Treatment	Widespread Availability of Treatment
Alcohol	✓	✓	0
Tobacco	✓	✓	✓
Cannabis	✓	0	0
Heroin & other Opioids	✓	✓	0
Psychostimulants	✓	0	0
Inhalants	0	0	0

Source: Saunders J, presentation to roundtable, Canberra, 15/8/02, exhibit 42, slide 6.

21 *Budget measures 2003-04*, p 175.

22 Saunders J, transcript, 15/8/02, p 1089; Webster I, presentation to roundtable, Canberra, 15/08/02, exhibit 53, slide 4.

23 Madden A, transcript, 15/8/02, p 1122; Mattick R, transcript, 15/8/02, p 1099.

Specific dependencies

Heroin

- 7.13 Research has shown that one-third of the people who try heroin become dependent²⁴, and half of all heroin users die before the age of 50 years.²⁵ Prevention and early intervention could therefore have a significant impact. However, early intervention to prevent the onset of heroin dependence among non-dependent users is difficult as, according to Professor Mattick, they do not recognise that they have a problem.²⁶
- 7.14 Professor Mattick suggested that this problem could be addressed by more advertising by departments of health, outreach to vulnerable individuals and the involvement of a range of health professionals. However, there is considerable reticence on the part of some doctors and other health professionals in having 'anything to do with injecting drug users'.²⁷
- 7.15 Nonetheless, as discussed in Chapter 5 in relation to alcohol-related problems, primary health care providers are in a good position to recognise the early signs of substance abuse.
- 7.16 Professor Saunders pointed out that there is considerable debate about the main goal in combating opioid dependence and its effects on both users and the wider community. The question is: 'Do we want to reduce opioid use completely, or do we want to reduce harm and deaths?'²⁸ According to Professor Mattick, 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'.²⁹ As Professor Webster observed, 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 ...'³⁰
- 7.17 The committee believes that once in this position, there may be a chance of moving on to abstinence.
- 7.18 Professor Saunders outlined for the committee the three main approaches currently in use for treating heroin dependence in Australia. Two involve the use of pharmacotherapies which have been shown to substantially

24 Mattick R, transcript, 15/8/02, p 1110.

25 Darke S, 'Suicide among heroin users: the silent killer', *CentreLines*, National Drug and Alcohol Research Centre, May 2002, p 3.

26 Mattick R, transcript, 15/8/02, p 1110.

27 Mattick R, transcript, 15/8/02, p 1110.

28 Saunders J, transcript, 15/8/02, p 1091.

29 Mattick R, transcript, 15/8/02, p 1093.

30 Webster I, transcript, 15/8/02, p 1124.

reduce heroin use as long as the patients remain in treatment, as demonstrated in the National Evaluation of Pharmacotherapies for Opioid Dependence (NEPOD) described as follows.³¹

- Antagonist substitutes are the current benchmark treatment for heroin dependence. They are substances that act on the brain in the same way as heroin. The most commonly used are methadone and buprenorphine which are available on the Pharmaceutical Benefits Scheme (PBS). Newer agonists such as LAAM (levo-alpha-acetylmethadol) have been trialled on a small scale.³²
- Antagonist pharmacotherapies such as naltrexone block the brain's opioid receptors and remove the craving for heroin. Naltrexone is highly effective with about 5-10 per cent of opioid dependent people. As currently used, it is most suitable for highly motivated people with very good social support.
- Rehabilitation and supportive approaches are effective for some individuals but have a high attrition rate.³³

Further examination of the outcomes of different types of treatment is being carried out in the Australian Treatment Outcome Study of heroin users.³⁴

7.19 Dr Wodak pointed out that pharmacological approaches are effective in attracting and retaining people in treatment over reasonably long periods of time, and so provide important benefits across a range of health and social domains.³⁵

Methadone and other agonist substitutes

7.20 Professor Mattick reported to the committee the results of a Swedish trial of methadone which showed its effectiveness in averting death and assisting addicts to become abstinent (Box 7.1). Professor Mattick advised that results such as these 'have been replicated in a number of trials

31 NEPOD was carried out over three years, comprised 13 separate studies conducted by 250 clinical and research staff in six jurisdictions, cost \$7 million and studied 1,425 patients (National Drug and Alcohol Research Centre, *National evaluation of pharmacotherapies for opioid dependence (NEPOD): Report of results and recommendations*, NDARC, Sydney, 6 July 2001, p 12).

32 In some overseas countries such as Switzerland, heroin itself is prescribed to addicts.

33 National Drug and Alcohol Research Centre, *National evaluation of pharmacotherapies for opioid dependence (NEPOD): Report of results and recommendations*, p 6; Saunders J, transcript, 15/8/02, p 1091.

34 National Drug and Alcohol Research Centre, 'The Australian treatment outcome study (ATOS): Heroin', viewed 31/1/03, <<http://notes.med.unsw.edu.au/ndarc.nsf/website/Research.current.cp26>>.

35 Wodak A, transcript, 16/8/02, p 1251.

internationally at different times, in different settings, with different investigators'.³⁶ A review by Professor Mattick and others concluded that methadone maintenance treatment (MMT):

- has been one of the best researched treatments for opioid dependence;
- is the only treatment for opioid dependence which has been clearly demonstrated to reduce illicit opiate use more than either no-treatment, drug-free treatment, placebo medication, or detoxification in clinically controlled trials; and
- is the most frequently prescribed pharmacotherapy in use globally for heroin dependence.³⁷

According to NEPOD, MMT is also the most cost-effective treatment for opioid dependence available in Australia.³⁸

- 7.21 There are also gains for the community from MMT. A review of the effectiveness of MMT showed that, for every dollar spent on methadone maintenance, the community benefits by \$4-\$5 in reduced health care, crime and other costs.³⁹ Hall et al summarised the results of randomised, controlled trials and observational studies of the impact of MMT on crime. These studies demonstrated that MMT reduced involvement in criminal activity and rates of imprisonment, and protected against HIV infection (but not against hepatitis B and C).⁴⁰ NEPOD found that MMT halved rates of property crime, drug dealing, fraud and violent crime.⁴¹

36 Mattick R, transcript, 15/8/02, p 1096.

37 Mattick R, Breen C, Kimber J et al, 'Methadone maintenance versus no methadone maintenance for opioid dependence', *The Cochrane Database of Systematic Reviews*, vol (issue) 3, pp 1-2. The Cochrane Collaboration provides evidence-based, systematic reviews of available medical treatments.

38 National Drug and Alcohol Research Centre, *National evaluation of pharmacotherapies for opioid dependence (NEPOD): Report of results and recommendations*, NDARD, University of New South Wales, Sydney, 6 July 2001, p 9.

39 National Drug and Alcohol Research Centre, *A brief overview of the effectiveness of methadone maintenance treatment*, quoted by Commonwealth Department of Health and Ageing, sub 290, appendix 11, p 2.

40 Hall W, Ward J & Mattick RP, 'The effectiveness of methadone maintenance treatment 1: Heroin use and crime', in Ward J, Mattick RP & Hall W, *Methadone maintenance treatment and other opioid replacement therapies*, Harwood Academic Publishers, Singapore, 1998, pp 51-53; Ward J, Mattick RP & Hall W, 'The effectiveness of methadone maintenance treatment 2: HIV and infective hepatitis', in Ward J, Mattick RP & Hall W, *Methadone maintenance treatment and other opioid replacement therapies*, p 68.

41 National Drug and Alcohol Research Centre, *National evaluation of pharmacotherapies for opioid dependence (NEPOD): Report of results and recommendations*, p 41.

Box 7.1 Outcomes of methadone treatment for heroin addicts

The trial involved two groups of 17 heroin addicts, of which one received methadone for two years and the other none. The outcome after two years was as follows.

Received methadone (N=17)		Received no methadone (N=17)
12	Abstinent from heroin	1
5	Still using heroin	14
0	Dead	2

After two years, the 15 survivors of the group that received no methadone were given the choice of having methadone and followed for a further two years with the following results.

Chose methadone (N=8)		Did not choose methadone (N=7)
6	Abstinent from heroin	1
2	Still using heroin	4
0	Dead	2

Source: Mattick R, presentation to roundtable, Canberra, 15/8/02, exhibit 43, slides 21-24 summarising results from Gunne & Gronbladh's study published in 1981.

- 7.22 The 2001 NDS Household Survey showed that Australians generally support the use of pharmacotherapies for heroin dependence and 63.7 per cent approved the use of methadone, 65.8 per cent drugs other than methadone, and 75.2 per cent naltrexone.⁴²
- 7.23 However, the proportion of dependent people in treatment is relatively low. According to Professor Mattick, about 45 per cent of dependent people are receiving treatment at present. He and Professor Saunders suggested that 80 per cent is what we should be aiming for if we want to reduce heroin-related harm and deaths.⁴³ One of NEPOD's conclusions was that 'A key challenge is to improve patient retention in all pharmacotherapies ...'⁴⁴

42 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: First results*, p 36.

43 Mattick R, transcript, 15/8/02, p 1100; Saunders J, transcript, 15/8/02, p 1091.

44 National Drug and Alcohol Research Centre, *National evaluation of pharmacotherapies for opioid dependence (NEPOD): Report of results and recommendations*, p 6.

Conclusion

- 7.24 The committee agrees that much more should be done to raise the number of people receiving treatment and starting them on the road, to eventual freedom from their addiction.
- 7.25 The committee agrees that good treatment outcomes for patients are a stabilised, improved life style in the first instance that may put them in a position to move beyond maintenance medication to achieve abstinence.

Recommendation 51

- 7.26 **The committee recommends that, as a high priority, the Commonwealth, State and Territory governments:**

- **increase the proportion of heroin addicts in treatment from 45 per cent to 80 per cent of the total number of heroin dependent people in order to reduce heroin-related harm and deaths; and**
- **increase the target to include everyone who requests treatment, as resources permit.**

- 7.27 Although methadone is very effective in stabilising people dependent on opioids, there are strong criticisms of the way in which it is used. When methadone is used to treat heroin dependence, it simply substitutes one opioid for another and continues the addict's opioid dependence. Some people, such as Major Watters, believed that 'we have tended to take a mechanical or pharmacological approach ...', and more effort should go into moving addicts towards abstinence through counselling and psychosocial support.⁴⁵ The committee was told by a former heroin addict, who now uses methadone, that the lack of assistance in this respect was disappointing:

... One of the things that I have been disappointed about in relation to my own treatment, and I know that it is an issue for others, is never having had a treatment plan developed for me. I have just continued on and I happen to have the wherewithal to be able to make my own decisions now. I certainly would not necessarily have said that when I first went on the program, but I could just have easily have got lost in it all and I know people do. It saddens me a great deal to see people turning up and going each

45 Watters B, transcript, 16/8/02, pp 1249-1250.

day [to collect their methadone doses] when no-one connects with them. I think there is so much lost potential there ...⁴⁶

- 7.28 Professor Mattick advised the committee that more support should be provided to those receiving methadone. He commented, 'If you want these treatments to be effective, they need to be supported adequately in a number of ways ...' He suggested that more ancillary services are required than are currently provided by state governments.⁴⁷ DRUG-ARM suggested that methadone programs should work towards 'a point of closure to ensure that clients' long term harms associated with long term exposure to methadone is minimised ...'⁴⁸
- 7.29 The disadvantages of methadone treatment were listed for the committee by Professor Mattick. They include methadone's side effects, the stigma attached to its use and the fact that it maintains dependence on opioids and is hard to withdraw from.⁴⁹ The need for daily dosing also places restrictions on the life styles of users.⁵⁰ Dr Currie and Mr Colquhoun of the R&D Counselling and Therapy Group pointed out how sharply methadone treatment impacts on an individual's capacity to lead a normal life in the community or hold down a job.⁵¹ Others have suggested that it may also expose them to unpleasant encounters involving discrimination or being accosted by dealers.⁵²
- 7.30 Evidence cited in the last paragraph illustrates the benefits of quitting to methadone dependent people. There are also benefits to the community in reduced costs, as indicated by the enormous health and crime costs associated with illicit drug abuse in paragraphs 7.6 and 8.4. Furthermore, as Dr Currie pointed out informally to the committee, moving people off methadone frees up places for those who need and cannot at present access it. Ms Madden told the committee that:

46 Madden A, transcript, 15/8/02, p 1128.

47 Mattick R, transcript, 15/8/02, p 1095.

48 DRUG-ARM, sub 199, p 10.

49 Mattick R, presentation to roundtable, Canberra, 15/8/02, exhibit 43, slide 7; Mattick R, transcript, 15/8/02, p 1094.

50 Mattick R, Kimber J & Breen C, 'Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence', *The Cochrane Database of Systematic Reviews*, vol (issue) 3, p 2.

51 R&D Counselling & Therapy Group, sub 282, p 4; Currie J, informal communication, 25/9/02.

52 House of Representatives Standing Committee on Family and Community Affairs, *Where to next? A discussion paper: Inquiry into substance abuse in Australian communities*, FCA, Canberra, September 2001, p 61; R&D Counselling & Therapy Group, sub 282, p 4.

... There are huge waiting lists all around the country. In some places, they do not even keep waiting lists any more because they are too demoralising for both the staff and patients.⁵³

Conclusion

7.31 In the committee's view:

- the need to help people on MMT to move beyond it and on to abstinence is one of the most important issues to be addressed in relation to heroin addiction;
- it is very concerned about the inadequate resources available to help those who are ready and want to move on; and
- it is vital that opioid dependent people are not left in 'liquid handcuffs', 'parked' on methadone.

Recommendation 52

7.32 **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.**

Recommendation 53

7.33 **The committee recommends that the Commonwealth government, State and Territory governments provide funding to determine the extent of very long-term use of methadone, including dosage rates, by opioid dependent people and its effect on the user, including its impact on the user's workplace, community and family roles.**

53 Madden A, transcript, 15/8/02, p 1122.

- 7.34 Alternative agonist substitutes to methadone like buprenorphine are available in Australia. However, according to NEPOD, more research is needed to better understand how to use buprenorphine and LAAM.⁵⁴

Naltrexone

- 7.35 Naltrexone is unlike other pharmacological treatments for heroin addiction which are opioid substitutes. Professor Mattick and Dr Currie told the committee that naltrexone blocks the opioid receptors from responding to opioids and so reduces craving for heroin and protects against its impulsive use.⁵⁵ As DrugBeat of South Australia noted, it is 'not a drug substitution treatment, but rather a treatment that promotes abstinence ...'⁵⁶ Support for its use comes from those, like Festival of Light, who believe there should be greater opportunities for individuals to opt for abstinence rather than an opiate substitute like methadone⁵⁷, and from those who favour a range of treatments being available.
- 7.36 Drawing on NEPOD's results, 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 the other pharmacotherapies evaluated, the study found 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.⁵⁸ A review by Kimber et al for the Cochrane Collaboration of all 11 of the available, methodologically sound trials of oral naltrexone treatment confirmed NEPOD's finding of low retention rates. It also concluded that there was insufficient evidence to evaluate the efficacy of naltrexone.⁵⁹
- 7.37 However, the committee learnt about others' experience of considerable successes with naltrexone treatment when patients are carefully selected for treatment and extensive social support is provided for them during their treatment. The committee was impressed during its visit to the Western Sydney Area Health Service Drug and Alcohol Services at

54 National Drug and Alcohol Research Centre, *National evaluation of pharmacotherapies for opioid dependence (NEPOD): Report of results and recommendations*, p 11.

55 Currie J, informal communication, 25/9/02; Mattick R, presentation to roundtable, Canberra, 15/8/02, exhibit 43, slides 10, 11.

56 DrugBeat, sub 271, p 21.

57 Festival of Light, sub 256, p 7.

58 Mattick R, presentation to roundtable, Canberra, 15/8/02, exhibit 43, slide 11, quoting results from National Drug and Alcohol Research Centre, *National evaluation of pharmacotherapies for opioid dependence (NEPOD): Report of results and recommendations*.

59 Kirchmayer U, Davoli M & Verster A, 'Naltrexone maintenance treatment for opioid dependence', *The Cochrane Database of Systematic Reviews*, issue 3, 2002.

Westmead Hospital by the results reported by Dr Currie. Mr Colquhoun of the R&D Counselling & Therapy Group also reported favourably on the impact of naltrexone treatment coupled with strong support.⁶⁰ Dr O'Neil in Perth supplements his treatment regime with a network of primary and secondary caregivers for each patient to ensure their compliance with the regime. He claimed that 100 per cent success is assured with this regime.⁶¹

7.38 In addition, according to Professor Saunders, naltrexone implants provide a promising long-acting form of treatment. They are effective for between two and six months, which avoids the problems associated with oral administration. Both Professor Saunders and Mr Colquhoun of R&D Counselling & Therapy Group recommended further trialling of implants.⁶² Professor Mattick advised that there has been little evaluation internationally of implant or depot or sustained release preparations. He suggested that there is a need for such an evaluation to be conducted, and Australia is in a position to carry out such work. The work would need to be foreshadowed or preceded by some attention to the release of the medication once it is implanted. It is normal to understand some aspects of the pharmacology and the activity or action of the medication implanted before attempting large scale trials. This would not preclude trials from proceeding, but is just a sensible first step.⁶³

7.39 The Commonwealth Department of Health and Ageing said that a Commonwealth Expert Advisory Committee has been appointed to investigate the feasibility of a clinical trial of sustained release naltrexone, including the safety, quality and effectiveness of sustained release naltrexone, and the methodological and medico-legal issues of the trial. The committee comprises a range of recognised experts and is chaired by Professor Saunders. The Expert Advisory Committee met in May 2003 and will report its findings by the end of 2003.⁶⁴

Conclusion

7.40 It is clear to the committee that there is a great need for more social support and counselling for opioid dependent people who are being treated with pharmacotherapies such as methadone and naltrexone. They need this help to successfully develop a more normal lifestyle and reach the point where they can move off these medications. These people should

60 R&D Counselling & Therapy Group, sub 282, p 2.

61 O'Neil G, *Understanding the treatment of heroin addiction: For patients and general practitioners*, Australian Medical Procedures Research Foundation, Subiaco, Western Australia, undated, p 8.

62 R&D Counselling & Therapy Group, sub 282, p 2; Saunders J, transcript, 15/8/02, p 1091.

63 Mattick R, informal communication, 9/4/03.

64 Commonwealth Department of Health and Ageing, sub 294, p 3.

be offered every opportunity to totally leave behind their dependence on opioids. The committee believes that greater emphasis should be given to expanding the use of naltrexone.

Recommendation 54

- 7.41 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.**

Recommendation 55

- 7.42 The committee strongly recommends as a matter of urgency that the Commonwealth government fund a trial of naltrexone implants, coupled with the support services required for efficacy.**

Therapeutic communities

- 7.43 Residential rehabilitation is another treatment option for opioid dependent people that impressed the former and current committee members who visited The Woolshed and Odyssey House. In addition, the current committee heard impressive evidence from Teen Challenge on their successes in residential rehabilitation. A review by Gowing et al of the limited research on residential rehabilitation showed that for those who completed the programs offered by therapeutic communities, drug**

use and criminal behaviour reduced and legal employment increased. Gowing et al also found the need for at least three months of treatment to achieve change for clients and that good outcomes depend on progress with treatment, not just time in treatment.⁶⁵

7.44 However, a survey of residential rehabilitation in Victoria and Gowing et al's review noted high drop out rates in the early stages of treatment in such communities.⁶⁶ Professor Mattick claimed that:

If you take the 32,000 individuals who are currently in methadone treatment and try to put them into therapeutic communities, you will have a lot of difficulty ... they do not have the desire.⁶⁷

In addition, as indicated in Chapter 3, another difficulty with residential treatment for opioid dependent people is that clients may not be able to afford it while maintaining other commitments.

Conclusion

7.45 The committee:

- was impressed by the therapeutic community programs they visited and the efforts of the many voluntary organisations and individuals involved with them;
- agrees residential rehabilitation is a valuable treatment for substance abuse;
- expresses its concern that there are so few residential programs operating and that they lacked adequate funding and support from all levels of government;
- believes it is desirable that therapeutic communities are established throughout each state and territory and in particular in rural communities;
- believes successful outcomes depend on effective links with governmental agencies such as housing, health, education and employment; and
- believes there is a need to provide ongoing support services on leaving therapeutic communities.

65 Gowing L, Proudfoot H, Henry-Edwards S & Teesson M, *Evidence supporting treatment: The effectiveness of interventions for illicit drug use*, ANCD research paper 3, Australian National Council on Drugs, Canberra, 2001, p xvii.

66 Gowing L, Proudfoot H, Henry-Edwards S & Teesson M, p xvii; McDonald P, 'Keynote speech to the World Therapeutic Communities Conference', *The World Federation of Therapeutic Communities: 21st World Conference*, Melbourne, 17- 21 February 2002, p 2.

67 Mattick R, transcript, 15/8/02, p 1106.

Recommendation 56

7.46 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.

Heroin prescription

7.47 The prescription of heroin has been suggested as a useful further tool in stabilising the lives of heroin addicts. Overseas trials have shown that such prescriptions can improve the general health and social functioning of heroin dependent people, reduce their criminal behaviour and the amount of drugs they use.⁶⁸ According to Dr Wodak and Professor Saunders, it is a niche treatment useful for a small number of dependent people; it is prescribed for five per cent of heroin users in Switzerland and 3-4 per cent in the UK.⁶⁹ However, as Professor Mattick pointed out, it is at least three times more expensive than existing treatments and claims for its potential to 'remove the black market' and 'stop deaths' are overstated.⁷⁰

68 Van den Brink W, Hendricks VM, Blanken P, Huijsman IA & van Ree JM, *Medical co-prescription of heroin: Two randomized controlled trials*, Central Committee on the Treatment of Heroin Addicts (CCBH), The Netherlands, 2002, Chapter 12 Conclusions, p 4, viewed 16/9/02, <http://www.ccbh.nl/rapport_engels_html>; Ali R, Auriacombe M, Casas M, Cottler L, Farrell M, Kleiber D, Kreuzer A, Ogborne A, Rehm J & Ward P, External Evaluation Panel, *Report of the External Panel on the Evaluation of the Swiss scientific study of medically prescribed narcotics to drug addicts*, April 1999, p 4, viewed 16/9/02, <<http://druglibrary.org/schaffer/library/studies/OVERALLS.htm>>.

69 Saunders J, transcript, 15/8/02, p 1101; Wodak A, transcript, 16/8/02, p 1247.

70 Mattick R, transcript, 15/8/02, p 1100.

- 7.48 With 65.5 per cent of Australian's (aged 14 years and over who were surveyed) opposed, and 34.5 per cent in favour of a trial of prescribed heroin according to the 2001 NDS Household Survey⁷¹, the Australian community predominantly opposed trials of heroin prescription as a useful approach to managing heroin dependence.
- 7.49 Individuals and organisations from both sides of the divide provided information and submissions to the committee. DRUG-ARM, for example, recommended that free heroin should not be provided to people dependent on heroin.⁷² Supporters of trials included the Public Health Association of Australia (PHAA), the AMA and the Law Society of New South Wales.⁷³ Families and Friends for Drug Law Reform (ACT) recommended that, 'without delay the Federal Government facilitate a scientific trial of prescription heroin among severely dependent drug users for whom existing treatments are inadequate'.⁷⁴ Mr Tony Trimmingham of Family Drug Support presented 339 petitions to the committee in favour of a trial⁷⁵, and the 2001 Western Australian Drug Summit also supported a trial.⁷⁶
- 7.50 Professor Mattick commented to committee members that the discussion in the community about heroin trials was not well-informed.⁷⁷ Professor Saunders said that it was particularly unfortunate that the debate about the most appropriate way of treating as many addicts as possible had been hijacked by the attention given to heroin prescription.⁷⁸ DRUG-ARM suggested that a better approach in these circumstances would be to invest in alternative treatments, such as naltrexone, buprenorphine and hydromorphone.⁷⁹

71 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: First results*, p 36.

72 DRUG-ARM, sub 199, p 10.

73 Australian Medical Association, sub 133, p 2; The Law Society of New South Wales sub 39, attachment – copy of The Law Society of NSW submission to the NSW Parliamentary Drug Summit, Sydney, 17-21 May 1999, p 17; Public Health Association of Australia, sub 159, p 4

74 Families and Friends for Drug Law Reform (ACT), sub 266, p 4.

75 Trimmingham T, 'Do you agree with a heroin trial? And the reasons for supporting a trial', personal petitions tabled at the committee's roundtable, Canberra, 15/8/02, exhibit no 25.

76 Government of Western Australia, *Community Drug Summit: Recommendations*, p 9, viewed 27/2/03,

<http://www.wa.gov.au/drugwestaus/html/contents/publications/reports_official/summit/recommendations.pdf>.

77 Mattick R, transcript, 15/8/02, p 1093.

78 Saunders J, transcript, 15/8/02, p 1101.

79 DRUG-ARM, sub 199, p 10.

Conclusion

- 7.51 Noting that overseas 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. However, the results of overseas trials of prescription heroin be closely monitored together with all other forms of treatment.
- 7.52 The committee also notes that laws, regulations and procedures governing the legality of a medical practitioner prescribing a drug of dependence for the treatment of a drug dependence are all state and territory laws.

Recommendation 57

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

Cost of treatment for opioid dependence

- 7.54 The Commonwealth government funds the wholesale cost of methadone and buprenorphine under the PBS. It spent \$3.396 million on methadone in 2000-01, and \$4.2 million on buprenorphine from the time it was listed on the PBS in August 2001 to May 2002. It also funds private methadone services and medical consultations through the Medicare Benefits Scheme. State and territory governments are responsible for methadone and buprenorphine programs within their jurisdictions.⁸⁰
- 7.55 According to advice from the Commonwealth Department of Health and Ageing, in recent years there has been a substantial shift from the public to the private sector in the provision of methadone maintenance.⁸¹ The Alcohol and other Drugs Council of Australia (ADCA) reported that in 1996 around 39 per cent of the approximately 19,500 people in Australia on methadone were treated through private providers, but by 2001 this figure had increased to about 67 per cent.⁸²
- 7.56 According to ADCA, dispensing fees charged by pharmacists for methadone vary across Australia, ranging from \$3.50-\$7 per day. The cost can place a considerable financial burden on individuals, particularly

80 Commonwealth Department of Health and Ageing, sub 290, appendix 11, p 1; Commonwealth Department of Health and Ageing, sub 238, p 35.

81 Commonwealth Department of Health and Ageing, sub 290, appendix 11, p 1.

82 Alcohol and other Drugs Council of Australia, informal communication, September 2002.

those who are already socially and economically disadvantaged.⁸³ The Pharmacy Guild of Australia recommended a Commonwealth subsidy for pharmacists who dispense and supervise methadone doses.⁸⁴ Reimbursing pharmacists who deal with young people on methadone programs was also recommended to the committee by the Youth Substance Abuse Service.⁸⁵

- 7.57 The cost of naltrexone for opioid dependent people is also high because, although available on the PBS for treating alcohol dependence, it is not listed for heroin dependence.⁸⁶ At the time of writing, the dispensed price for heroin dependence for thirty 50mg tablets is approximately \$167.00.

Conclusion

- 7.58 In the committee's view, it is absolutely essential that the cost of treatment be affordable so that those wishing to undertake treatment do not encounter hardship. Currently the cost of treatment can be prohibitive. It is important that a range of treatments are available and, as new treatments are found to be effective, they are rapidly made available at an affordable cost.

Recommendation 58

- 7.59 **The committee recommends that the Commonwealth government ensure that proven pharmacotherapies are available at low cost to all opioid dependent people undergoing treatment.**

Conclusion

- 7.60 As naltrexone has already been proved to be a cost-effective treatment, the committee believes that it should also be listed, as a matter of priority, for the treatment of opioid dependence.

83 Alcohol and other Drugs Council of Australia, informal communication, September 2002.

84 Pharmacy Guild of Australia, sub 151, p 3.

85 Youth Substance Abuse Service, sub 102, p 10.

86 Pharmaceutical Benefits Schedule, 'Schedule of pharmaceutical benefits effective from 1 February 2003', p 1, viewed 2/4/03, <<http://www.health.gov.au/pbs/scripts/search.cfm>>.

Recommendation 59

- 7.61 **The committee recommends that the Commonwealth government list naltrexone on the Pharmaceutical Benefits Scheme for the treatment of opioid dependence, particularly for heroin and methadone dependence.**
- 7.62 It is interesting that, according to NEPOD, treatment for opioid dependent people may be provided more cost-effectively by GPs than in clinics. NEPOD suggested that this issue should be explored further.⁸⁷

Conclusion

- 7.63 The committee notes that if the finding that treatment for opioid dependent people may be provided more cost-effectively by GPs than in clinics were to be confirmed, it would be possible for GPs to take a more prominent role in providing treatment. However as indicated above, some GPs might find this difficult because of their antipathy for managing injecting drug users.

Recommendation 60

- 7.64 **The committee recommends that the Commonwealth, State and Territory governments investigate the potential to deliver cost-effective treatment to opioid dependent people by the greater use of general practitioners.**

Cannabis**Medical use of cannabis**

- 7.65 According to the National Drug and Alcohol Research Centre (NDARC), there are a number of obstacles to the medical use of cannabis. It lacks widespread public support because of cannabis' association with dependence and the use of other illicit drugs, and a feeling that allowing the medical use of cannabis would 'send the wrong message' about illicit drugs. In addition, regular smoking of cannabis is associated with increased risk of cancer, lung damage and poorer outcomes of pregnancy, and so would not be suitable medication for a chronic condition. NDARC suggested that an alternative way of delivering the active agent, which is

87 National Drug and Alcohol Research Centre, *National evaluation of pharmacotherapies for opioid dependence (NEPOD): Report of results and recommendations*, pp 9, 11.

tetrahydrocannabinol or THC, would need to be found, if cannabis were to be used for medical purposes.⁸⁸

- 7.66 Notwithstanding these problems, ADCA supported the therapeutic use of cannabis⁸⁹, as did the AMA (NSW) and the Law Society of New South Wales. The latter advocated its use particularly for those who have failed to respond to conventional treatments.⁹⁰ Others, such as the Pharmacy Guild, cautioned that rigorous clinical trials of cannabis' efficacy should be carried out before any consideration is given to cannabis' use for medical purposes.⁹¹ Further clinical trials and surveys were also recommended in a recent report commissioned by the New South Wales government.⁹²
- 7.67 This report and the Victorian Drug Policy Expert Committee have both suggested leniency with:
- in New South Wales, recommendations that criminal sanctions not be imposed on those using cannabis for certain serious, debilitating conditions; and
 - in Victoria, proposals for discretion by police and courts.⁹³
- 7.68 On 20 May this year the New South Wales government announced that it was undertaking a trial of cannabis for the terminally ill. The trial will commence later this year and run for four years. The New South Wales government also said it is establishing a new Office of Medicinal Cannabis within the New South Wales Department of Health.

88 National Drug and Alcohol Research Centre, 'The medical uses of cannabis', Fact sheet, pp 1-2, viewed 20/3/03, <<http://ndarc.med.unsw.edu.au/ndarc.nsf/website/DrugInfo.factsheets>>; Working Group on the Use of Cannabis for Medical Purposes, *Report of the Working Party on the use of cannabis for medical purposes: Volume 1: Executive Summary*, August 2000, pp 10, 15, 27, viewed 20/3/03, <<http://www.druginfo.nsw.gov.au/druginfo/reports/canrep1.pdf>>.

89 Alcohol and other Drugs Council of Australia, *Drug policy 2000: A new agenda for harm reduction*, June 2000, <http://www.adca.org.au/publications/Drug%20Policy%202000/65_cannabis.htm>.

90 The Law Society of New South Wales, sub 39, attachment – copy of The Law Society of NSW submission to the NSW Parliamentary Drug Summit, Sydney, 17-21 May 1999, pp 15-16. This recommendation is also contained in the attachment to that *submission Joint protocol between the Australian Medical Association (NSW) Ltd and The Law Society of New South Wales: Developing more effective responses to Australia's growing problem with illicit drug*, p 1.

91 Pharmacy Guild of Australia, sub 151, p 13.

92 Working Group on the Use of Cannabis for Medical Purposes, p 26.

93 Victorian Department of Human Services, Drug Policy Expert Committee, *Drugs: meeting the challenge*, quoted by Rickard M, *Reforming the old and refining the new: A critical overview of Australian approaches to cannabis*, Department of the Parliamentary Library, Research Paper no 6 2001-02, DPL, Canberra, 2001, p 14.

Conclusion

7.69 The committee believes that the medical use of cannabis is an important issue, but has not been able to collect sufficient information about it to reach a properly considered opinion and that further work should be done on this topic.

Recreational use of cannabis

7.70 One of the problems encountered in attempts to prevent and intervene early in cannabis use is the widespread belief, to which Australian Parents for Drug Free Youth referred, that cannabis is relatively harmless.⁹⁴ This belief was formed 20 or more years ago when, according to Professor Saunders, there were lower doses of the psychoactive ingredient in the cannabis used then and few serious health effects were evident. Current users receive a dose of the psychoactive agent, tetrahydrocannabinol (THC), which is, on average, 3.5 times greater than 20 years ago, and evidence is accumulating about the deleterious health effects of cannabis.⁹⁵ (A psychoactive substance is one that, when taken into the body, acts upon the central nervous system to affect behaviour, emotion and/or thought.⁹⁶) Professor Saunders claimed that:

... One could argue that cannabis use, as practised 20 years ago, was a relatively trivial form of substance abuse—that is not the case now. We are seeing an increasing number of people with cannabis dependence and the severe health effects of cannabis ...⁹⁷

7.71 Research by Hall and Swift reported in August 2000 stated that:

There probably has been a modest increase in the THC content of cannabis, but changing patterns of cannabis use have probably made a larger contribution to any increase in rates of cannabis-related problems among young Australian adults.⁹⁸

7.72 Hall and Swift stated that the more plausible explanation for the higher rates of cannabis-related problems among young Australian adults are: the more potent forms of cannabis ('heads') being more widely used ; and

94 Australian Parents for Drug Free Youth, sub 267, p 1.

95 Saunders J, transcript, 15/8/02, p 1097.

96 Ryder D, Salmon A & Walker N, *Drug use and drug-related harm: A delicate balance*, IP Communications, Melbourne, 2001, p 281.

97 Saunders J, transcript, 15/8/02, p 1091.

98 Hall W & Swift W, The THC content of cannabis in Australia: Evidence and implications, *Australian and New Zealand Journal of Public Health*, 2000, vol 25 no 5, p 503.

cannabis users are initiating cannabis at an earlier age, thereby increasing the prevalence of harmful patterns of use.⁹⁹

- 7.73 The Australian Drug Trends 2002 report stated that hydroponically grown cannabis is the predominant form of drug used, with over 70 per cent in all jurisdictions reporting hydroponic as the form most often used in the past six months.¹⁰⁰ The Australian Drug Trends 2001 report advised that 'The THC content of Australian cannabis has not been systematically tested, thus it is not possible to confirm whether the THC content has changed in recent years ...'¹⁰¹ The 2001 report also noted that there has been an increase in the use of 'bongs' or waterpipes that allow the more efficient smoking of the drug. They cool the smoke and therefore allow the smoker to hold the smoke in their lungs for a longer time so that absorption is maximised.¹⁰²
- 7.74 In a recent review, Hall, Degenhardt and Lynskey summarised the acute and chronic effects of cannabis on the health and psychological status of users; these effects are shown in Box 7.2. Hall et al identified three groups as being at increased risk of experiencing adverse effects: pregnant women; adolescents with a history of poor school performance or who start using cannabis in their early teens; and people with pre-existing conditions such as cardiovascular or respiratory disease, schizophrenia, or dependence on other drugs.¹⁰³
- 7.75 In addition, Rey and Tennant reported that there is growing evidence of an association between cannabis use and depression from US, Australian and New Zealand studies of adolescents who have been followed for seven or more years. There appears to be a dose-effect relationship between cannabis use and anxiety or depression, and this relationship is stronger for young women than young men.¹⁰⁴

99 Hall W & Swift W, p 503.

100 Breen C, Degenhardt L, Roxburgh A, Bruno R, Duquemin A, Fetherston J, Fischer J, Jenkinson R, Kinner S, Longo M & Rushforth C, *Australian Drug Trends 2002: Findings of the Illicit Drug Reporting System (IDRS)*, NDARC monograph no 50, National Drug & Alcohol Research Centre, Sydney, April 2003, p 9.

101 Topp et al, p 95.

102 Topp et al, p 95.

103 Hall W, Degenhardt L & Lynskey M, *The health and psychological effects of cannabis use*, Monograph series no 44, 2nd ed, Commonwealth Department of Health and Ageing, Canberra, 2001, pp xxv-xxvi.

104 Rey JM & Tennant CC, 'Cannabis and mental health', *British Medical Journal*, vol 325, 23/11/02, p 1183.

Box 7.2 Acute and chronic health and psychological risks of cannabis use**Acute effects**

The major acute adverse psychological and health effects of cannabis intoxication are:

- anxiety, dysphoria, panic and paranoia, especially in naive users;
- cognitive impairment, especially of attention and memory;
- psychomotor impairment, and possibly an increased risk of accident if an intoxicated person attempts to drive a motor vehicle;
- an increased risk of experiencing psychotic symptoms among those who are vulnerable because of personal or family history of psychosis; and
- an increased risk of low birth weight babies if cannabis is used during pregnancy.

Chronic effects

The most probable health and psychological effects of chronic heavy cannabis use appear to be:

- respiratory diseases associated with smoking as the method of administration, such as chronic bronchitis, and the occurrence of histopathological changes that may be precursors to the development of malignancy;
- an increased risk of cancers of the aerodigestive tract, i.e. oral cavity, pharynx, and oesophagus; and
- development of a cannabis dependence syndrome, characterised by an inability to abstain from or to control cannabis use.

The following **possible** adverse effects of chronic, heavy cannabis use remain to be confirmed by further research:

- a decline in occupational performance marked by underachievement in adults in occupations requiring high level cognitive skills, and impaired educational attainment in adolescents; and
- subtle forms of cognitive impairment, most particularly of attention and memory, which persist while the user remains chronically intoxicated, and may or may not be reversed by prolonged abstinence from cannabis.

Source: Hall W, Degenhardt L & Lynskey M, The health and psychological effects of cannabis use, Monograph series no 44, 2nd ed, Commonwealth Department of Health and Ageing, Canberra, 2001, p xxv.

7.76 On the basis of their review, Hall et al concluded that there is also abundant evidence from surveys and longitudinal studies of an association between regular cannabis use and the use of other illicit drugs such as heroin and cocaine. A typical sequence has been observed among adolescents in several countries: they began using alcohol first, followed in order by tobacco and cannabis; they then moved on to hallucinogens, amphetamines and tranquillisers and finally to cocaine and heroin. In every case, it was younger and heavier users who were more likely to progress through this sequence. Such observations as these gave rise to the

hypothesis that cannabis is a 'gateway' drug. This hypothesis posits that, as Hall et al pointed out, 'adolescent cannabis use may increase the chance that young people will use other more dangerous illicit drugs, such as cocaine and heroin'.¹⁰⁵

7.77 One explanation that has been advanced to account for the association between the use of cannabis and other illicit drugs is that cannabis has a direct pharmacological effect that predisposes users to the use of other illicit drugs. For example Nahas has hypothesised that 'the biochemical changes induced by marijuana in the brain result in a drug-seeking, drug-taking behaviour, which in many instances will lead the user to experiment with other pleasurable substances.'¹⁰⁶

7.78 Hall et al claimed that the evidence for this effect was not compelling and concluded instead that:

If there is a causal relationship between cannabis and other illicit drug use the explanation is more likely to be a sociological than a pharmacological one. The fact that cannabis use predicts an increased chance of using other illicit drugs reflects a combination of: (1) the selective recruitment to heavy cannabis use of persons with preexisting personality and attitudinal traits (possibly genetic in origin) that predispose to the use of other intoxicants; (2) their affiliation with drug using peers; (3) socialisation into an illicit drug subculture in which there is an increased opportunity and encouragement to use other illicit drugs; (4) increased access to opportunities to purchase and use other illicit drugs because of involvement in illicit drug markets as buyers and sellers; and possibly (5) a shared genetic vulnerability to use and become dependent on a range of different drugs.¹⁰⁷

7.79 More recent reports have confirmed some of the above points and pointed to areas where further research is needed.

- Lynskey and others studied 311 same sex Australian twin pairs who shared the same genetic and family environment and among whom one twin from each pair had started using cannabis before the age of 17 years of age. Lynskey et al found an association between early cannabis use and the later use of other drugs and their abuse and dependence. They suggested that this association 'may arise from the effects of the peer and social context within which cannabis is used and obtained'. In addition, early access to cannabis and its use may reduce

105 Hall W, Degenhardt L & Lynskey M, pp 103-104.

106 Hall W, Degenhardt L & Lynskey M, p 107.

107 Hall W, Degenhardt L & Lynskey M, p 109.

perceptions of its harms and the barriers to other drug use. Early access to cannabis may also provide access to other drugs.¹⁰⁸

- Drawing on a recent simulation of adolescent drug use in the US, Morral, McCaffrey and Paddock at the RAND Drug Policy Research Center claimed that a gateway effect is not needed to explain the observed association between the use of cannabis and other drugs. The association could be accounted for by differences in age at first use of these drugs and known variations in individuals' willingness to try any drugs.¹⁰⁹
- Kandel observed that the best way to test the gateway hypothesis may be by experimentation with animals. One series of animal tests showed that exposure to one class of drugs increases consumption of other classes, a result that is consistent with the gateway hypothesis.¹¹⁰

7.80 As Kandel commented, whether or not there is a true causal link between cannabis and other drugs, the association between the two is well-established, and programs aimed at preventing the use of 'lower stage' drugs seemed to stop or reduce the use of 'higher stage' drugs.¹¹¹

7.81 On the other hand, Dr Wodak and others suggested that:

All drugs have risks. Cannabis is not harmless, but adverse health consequences for the vast majority of users are modest, especially when compared with those of alcohol and tobacco ...

It is time to acknowledge that the social, economic, and moral costs of cannabis control far exceed the health costs of cannabis use ...¹¹²

7.82 The committee believes it appears that dispelling current misconceptions about cannabis by providing information about the dangers outlined above will help to prevent cannabis use.

108 Lynskey MT, Heath AC, Bucholz KK, Slutske WS, Madden PAF, Nelson EC, Statham DJ & Martin NG, 'Escalation of drug use in early-onset cannabis users vs co-twin controls', *The Journal of the American Medical Association*, vol 289, 22/29 January 2003, pp 427, 432.

109 Morral AR, McCaffrey DF & Paddock SM, Drug Research Center RAND, 'Reassessing the marijuana gateway effect', *Addiction*, vol 97, issue 12, 2002, p 1493.

110 Kandel DB, 'Does marijuana use cause the use of other drugs?' *The Journal of the American Medical Association*, vol 289, 22/29 January 2003, p 283; RAND, *RAND study casts doubt on claims that marijuana acts as 'gateway' to the use of cocaine and heroin*, media release, 2/12/02.

111 Kandel DB, pp 282-283.

112 Wodak A, Reinerman C & Cohen PDA, Cannabis control: Costs outweigh the benefits, *British Medical Journal*, 324 (7329), 12 January 2002, p 108.

7.83 Swift et al suggested that the legal ramifications of breaking the law should also be pointed out and methods of reducing harm be brought to users' attention.¹¹³ Swift et al warned, however, that:

... It is important not to underestimate the benefits cannabis use is perceived to provide (e.g. relaxation, 'time out'), which may be powerful motivators for continued use despite the simultaneous recognition of cannabis-related problems ...¹¹⁴

7.84 Professor Saunders stated that no pharmacological treatment currently exists to treat cannabis dependence. He suggested that:

- collaborative work with overseas research groups could usefully examine possible treatments; and
- although some psychological therapies have been trialled in Australia, more need to be carried out.¹¹⁵

The Commonwealth government is funding a number of cannabis cessation initiatives involving brief interventions and the provision of information to health professionals.¹¹⁶ In the 2003-04 federal budget the Government advised that under the program designed to develop resources for cannabis-dependent adults and adolescents, resources had been successfully developed and distributed and it redirected remaining funds to new initiatives on illicit drugs contained in that budget.¹¹⁷ Initiatives completed under this program to date include: adult intervention; adolescent intervention; nursing information sheets; update of National Drug Strategy Monograph No 25 on health and psychological consequences of cannabis use; indigenous research and intervention; and dissemination of cannabis education resource material designed for indigenous people.

Conclusion

7.85 The committee:

- believes that, in the absence of proven treatments for cannabis dependence and in view of the health and psychological harm that cannabis can cause, it is vital that information about the severe, negative effects of cannabis be made widely available;

113 Swift W, Copeland J & Lenton S, 'Cannabis and harm reduction', *Drug and Alcohol Review*, vol 19, 2000, pp 104-107.

114 Swift W, Copeland J & Lenton S, p 104.

115 Saunders J, transcript, 15/8/02, p 1091; Table 7.1 in this chapter.

116 Commonwealth Department of Health and Ageing, sub 296, pp 3-4.

117 *Budget measures 2003-04*, p 174.

- is concerned about the serious dangers associated with regular cannabis use. The possible links between cannabis and opioid use, are not understood by the majority of Australian people;
- is alarmed that, according to the 2001 NDS Household Survey, cannabis was offered or available to nearly a quarter of Australians and to nearly half the 14-29 year olds surveyed;
- believes that it is particularly important to provide credible, accurate and comprehensive information about these dangers;
- notes the increasing concern about the nature of the link between the use of cannabis, mental health and opioid use. It believes that investigations of these links should be a priority;
- believes the body of evidence supports real concerns about the impact of cannabis use on: (i) mental health (ii) in conjunction with other drugs (polyuse) and (iii) as a gateway to addiction, and that immediate efforts to inform the community about these concerns be undertaken; and
- calls for definitive outcomes from research on treatment for cannabis dependence including the urgent development and dissemination of cannabis cessation strategies.

Recommendation 61

7.86 The committee recommends that the Commonwealth, State and Territory governments:

- **widely disseminate information to inform the Australian community about the levels of cannabis use including impacts on mental health and possible gateway to addiction and other drug use;**
- **evaluate the effectiveness of these information campaigns;**
- **trial innovative, preventive approaches to reduce the use of cannabis;**
- **develop consistent national policy and legislation which reflect the dangers of cannabis use; and**
- **in the interim monitor the effect of State and Territory specific legislation dealing with cannabis use and regularly report on the health, social and criminal outcomes for each State and Territory.**

Recommendation 62

- 7.87 **The committee recommends that the Commonwealth, State and Territory governments fund research into pharmacological and psychological treatments for dependence on cannabis.**

Recommendation 63

- 7.88 **The committee recommends that the Commonwealth, State and Territory governments give priority to funding research into the nature of the link between cannabis use, opioid and other drug use, and mental health.**

Psychostimulants

- 7.89 Psychostimulants include amphetamine-type substances (ATS), cocaine, nicotine and caffeine, but we are dealing here with only the first two. According to Professor Webster, very little is known about prevention and early intervention with cocaine and amphetamines.¹¹⁸ However, the Commonwealth Department of Health and Ageing reported that they are, among the substances used as ‘party drugs’ which are emerging as an issue of concern.¹¹⁹ An AMA summit entitled *Party drugs: A new public health challenge* held in April 2002 noted that prevention strategies aimed at “party drug users” would need to take into account that many of the users are highly educated and well-informed about the drugs they are using. There are also many subgroups of users in the community so a variety of approaches would be required.¹²⁰
- 7.90 Research on treatment for psychostimulants has yet to yield positive results, according to published reports and Professor Saunders. Trials of pharmacological treatments for amphetamine dependence have shown little or no promise to date, and the same is true of cocaine.¹²¹
- 7.91 Given the growing use of ATS and the fact that far fewer ATS users than heroin addicts are in treatment, ADCA stressed that ‘Investment in

118 Webster I, presentation to rountable, Canberra, 15/8/02, exhibit 53, slide 4.

119 Commonwealth Department of Health and Ageing, sub 238, p 6. Party drugs include but are not limited to ecstasy (MDMA), liquid ecstasy (GHB), acid (LSD), ketamine (a veterinary, also known as special K) and speed (metamphetamine).

120 *Party drugs: A new public health challenge*, pp 4, 6.

121 Saunders J, transcript, 15/8/02, p 1092; Srisurapont M, Jarusuraisin N & Kittirattanapaiboon P, ‘Treatment for amphetamine dependence and abuse’, *The Cochrane Database of Systematic Reviews*, issue 3, 2002, p 2.

research into the treatment of ATS dependence is urgently required and should be a priority for the Commonwealth and State/Territory Governments'. ADCA therefore suggested that a trial comparable to the recent NEPOD be conducted.¹²²

- 7.92 Professor Saunders recommended that research should also be conducted into psychological therapies for psychostimulants, including into those that have been proved useful for other forms of substance abuse and might be effective for ATS dependence as well.¹²³ The AMA summit *Party drugs: A new public health challenge* held in April 2002 called for a national party drugs research agenda.¹²⁴
- 7.93 The Commonwealth government is currently funding an evaluation of cognitive-behavioural therapy for amphetamine use and the update of a monograph on intervention and care for psychostimulant users.¹²⁵
- 7.94 In the 2003-04 federal budget it was announced that \$2 million will be provided over two years to address problems associated with the increased availability and use of psychostimulants, in particular, evaluation of treatment options and development of guidelines for front line workers.¹²⁶

Conclusion

- 7.95 In the committee's view, there is an urgent need to raise the public's awareness of the dangers associated with the use of psychostimulants. This is another area in which education is needed as a matter of priority.

Recommendation 64

- 7.96 **The committee recommends that the Commonwealth, State and Territory governments continue to fund research into pharmacological and psychological treatments for dependence on psychostimulants.**

122 Alcohol and other Drugs Council of Australia, *Federal budget submission 2003-2004*, p 7, viewed 28/1/03, <www.adca.org.au/policy/submissions/federalbudgetsubmission03.pdf>.

123 Saunders J, transcript, 15/8/02, p 1092.

124 *Party drugs: A new public health challenge*, p 6.

125 Senate Community Affairs Legislation Committee, Examination of Budget Estimates 2002-2003, Additional information received, vol 3, Outcomes: Whole of portfolio, 1 & 2, Health and Ageing Portfolio, November 2002, p 61.

126 *Budget measures 2003-04*, p 175.

Recommendation 65

- 7.97 **The committee recommends that the Commonwealth, State and Territory governments, as part of the National Drug Strategy, urgently inform and warn the Australian community about the dangers of psychostimulant use.**

Managing harm associated with injecting drugs

- 7.98 Only a very small number of Australians are injecting drug users: in the 2001 NDS Household Survey, 0.6 per cent of over 14 year olds reported having injected an illicit drug in the previous 12 months and 1.8 per cent had injected at some stage in their lives.¹²⁷ The majority of these users injected at least once weekly (66.2 per cent) and 15.7 per cent did so daily.¹²⁸
- 7.99 Injecting drug use is associated with major harms such as overdoses. Degenhardt using Australian Bureau of Statistics data reported that the numbers of opioid overdose deaths among 15-44 year old Australians each year in 1988, 1999, 2000 and 2001 were 347, 958, 725 and 306 respectively.¹²⁹ He suggested the dramatic decrease in deaths in 2001 is likely to be attributable to primarily the marked reduction in heroin supply in Australia in 2001; and likely to be attributable secondarily to the continued expansion of access to an increasing array of treatments for opioid dependence.¹³⁰ The 2001 National Heroin Overdose Strategy indicated that there were between 12,000 and 21,000 non-fatal overdoses each year.¹³¹
- 7.100 Data from the Illicit Drug Reporting System showed that the availability of heroin increased in 2002 and its cost fell. However, use had not returned

127 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: First results*, pp 3-4.

128 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: Detailed findings*, p 83.

129 Degenhardt L, *Opioid overdose deaths in Australia: 2001 edition: 2001 Australian Bureau of Statistics data on opioid overdose deaths*, p 3.

130 Degenhardt L, *Opioid overdose deaths in Australia: 2001 edition: 2001 Australian Bureau of Statistics data on opioid overdose deaths*, pp 1-2.

131 *National Heroin Overdose Strategy: Summary*, endorsed by the Ministerial Council on Drug Strategy, Commonwealth Department of Health and Aged Care, Canberra, July 2001, p 3, viewed 30/1/03, <http://www.health.gov.au/pubhlth/nds/resources/publications/heroin_summary.pdf>.

to the levels seen before the heroin drought in 2000.¹³² According to the ANCD, preliminary figures from Victoria suggested that, at least in that state, the number of overdose deaths in 2002 remained at the low level of the previous two years.¹³³

- 7.101 The committee also heard evidence on another major harm related to injecting drug use, that being, the current epidemic of hepatitis C. The committee was told about 91 per cent of newly acquired cases in 2001 were estimated to be related to this practice. In addition, the longer a person has been injecting the more likely he or she is to test positive for the disease. Hepatitis C is the most common notifiable communicable disease in Australia, and 75 per cent of those who develop antibodies to it develop a chronic infection and the risk of subsequent serious disease. It was estimated that 16,000 new infections occurred in 2001, up from 11,000 in 1997.¹³⁴
- 7.102 The committee notes that a number of measures have been put in place to minimise the harm experienced by injecting drug users and those associated with them. They include needle and syringe programs (NSPs) to reduce the spread of HIV/AIDS and hepatitis C, initiatives to prevent and manage overdoses, treatment for hepatitis C and AIDS, and education for injecting drug users. These initiatives are discussed in detail below.

Needle and syringe programs

- 7.103 In their report on NSPs, Health Outcomes International Pty Ltd (Health Outcomes), the National Centre for HIV Epidemiology and Clinical Research and Professor Drummond stated that:

... NSPs are a public health measure funded to reduce the spread of blood borne viral infections such as HIV and hepatitis C among injecting drug users and are supported by the National Drug Strategy's harm reduction framework. They provide a range of services that include provision of injecting equipment and disposal facilities, education and information on reducing drug-related harms, referral to drug treatment, medical care and legal and other

132 Illicit Drug Reporting System, *Drug trends bulletin*, December 2002, p 4.

133 Major Brian Watters, ANCD, *Heroin: Flood or drought?*, media release, 26/2/03, p 2.

134 Australian Institute of Health and Welfare, *Australia's health 2002*, pp 94, 151; Australian National Council on AIDS, Hepatitis C and Related Diseases, Hepatitis C Sub-committee, *Hepatitis C Virus Projections Working Group: Estimates and projections of the hepatitis C virus epidemic in Australia 2002*, National Centre in HIV Epidemiology and Clinical Research, August 2002, p 1, viewed 21/3/03, <http://www.ancahrd.org/pubs/pdfs/epidemic_02.pdf>; Australian National Council on AIDS, Hepatitis C and Related Diseases, Puplick C, Chair, *New hepatitis C infections still increasing*, media release, undated, p 1, viewed 21/3/03, <http://www.ancahrd.org/media_releases/02/60ct.pdf>.

services ... The aim of providing sterile injecting equipment is to prevent the shared use of injecting equipment, which can lead to the transmission of blood borne viral infections ...¹³⁵

- 7.104 The report noted that the proportions of government and non-government run programs and the service model varies across jurisdictions. The service models used in Australia are: primary outlets (stand alone agencies specifically established to provide injecting equipment and sometimes with primary medical care), secondary outlets (needle distribution and exchange as one of a range of other health or community services), mobile services, outreach services and vending machines. To ensure their accessibility NSPs tend to be located in relatively public places. Generally the schemes provide 1ml syringes, which can be purchased, or, in NSW, exchanged free on return of a pack with used syringes.¹³⁶ In 1999 Dolan, Topp and MacDonald reported that there were over 3,000 NSPs in Australia and the service commenced in 1987.¹³⁷
- 7.105 Details on expenditure and the number of needles distributed in 1999/2000 are shown at Table 7.2. Trends in expenditure on NSPs from 1990/91 to 1999/2000 are at Table 7.3. However there is no central register on the number of syringes distributed.
- 7.106 Health Outcomes reported that over 40 countries operate NSPs including Belgium, Brazil, Bulgaria, Canada, China, Croatia, Czech Republic, Denmark, Estonia, Finland, Germany, Greece, Hungary, India, Kazakhstan, Latvia, Luxembourg, Nepal, Netherlands, Norway, Philippines, Poland, Portugal, Slovak Republic, Salvador, Slovenia, Thailand, Ukraine, UK and USA.¹³⁸

135 Health Outcomes International Pty Ltd in association with the National Centre for HIV Epidemiology and Clinical Research and Professor Michael Drummond, Centre of Health Economics, York University, *Return on investment in needle and syringe programs in Australia: Summary report*, Commonwealth Department of Health and Ageing, Canberra, 2002, p 3.

136 Health Outcomes International Pty Ltd in association with the National Centre for HIV Epidemiology and Clinical Research and Professor Michael Drummond, Centre of Health Economics, York University, p 3.

137 Dolan K, Topp L & MacDonald M, *NSP: Needle & syringe programs: A review of the evidence*, Australian National Council on AIDS, Hepatitis C and Related Diseases, Sydney, 2000, p 8.

138 Outcomes International Pty Ltd in association with the National Centre for HIV Epidemiology and Clinical Research and Professor Michael Drummond, Centre of Economics York University, p 3.

Table 7.2 Expenditure and needles distributed by NSPs by State/Territory, 1999/2000⁽¹⁾

	Government Expenditure (\$'000)	Consumer Expenditure (\$'000)	Total Expenditure (\$'000)	Needles Distributed (000)
ACT	\$531	\$8	\$539	593
NSW	\$9,827	\$463	\$10,290	11,566
NT	n.a.	-	n.a.	604 ²
QLD	\$1,678	-	\$1,678	5,300
SA	\$787	\$43	\$830	3,018
TAS	\$484	\$138 ²	\$622	1,381 ²
VIC	\$4,767	-	\$4,767	6,177
WA	\$1,227	\$2,349 ²	\$3,576	3,209
TOTAL¹	\$19,673	\$3,001	\$22,674	31,848

¹ Data relates to government-auspiced NSPs only. Exclude expenditure on needle and syringes sold through pharmacies on a commercial basis.

² Includes figures imputed from data provided by State/Territory health authorities.

Source: *Health Outcomes International Pty Ltd in association with the National Centre for HIV Epidemiology and Clinical Research and Professor Michael Drummond, Centre of Health Economics, York University, Return on investment in needle and syringe programs in Australia: Summary report, Commonwealth Department of Health and Ageing, Canberra, 2002, p 4.*

7.107 Details of seven Australian national and numerous state/territory based NSP projects to June 2002 are outlined in the *Evaluation of Council of Australian Governments' initiatives on illicit drugs*.¹³⁹ The evaluation revealed that the seven national projects¹⁴⁰ have 'developed and disseminated a range of resources and related materials that assist NSP workers and pharmacy workers in their interaction with people who inject drugs, and enhance their skills in this area.'¹⁴¹ The evaluation also stated that reports

139 Health Outcomes International Pty Ltd in association with Catherine Spooner Consulting, National Drug and Alcohol Research Centre and Turning Point Alcohol and Drug Centre, *Evaluation of Council of Australian Governments' initiatives on illicit drugs: Final report to Department of Finance and Administration: Vol 3 – Supporting measures*, Health Outcomes, Kent Town, October 2002, pp 29-43 and *Appendix A – COAG-NIDS funded activities in needle and syringe programs in states and territories, 1999-2001*, 87p.

140 National projects to June 2002 are: National Hepatitis C Resource manual; National Needle and Syringe Worker Training Package; research into the availability, usage and quality of electronic information resources on HIV/AIDS, Hepatitis C and other blood borne viruses; National Illicit Drug Training Program for Pharmacists and Pharmacy Workers; National Forum on NSP Workers; Needle and Syringe Program Workers Information Resources Project; study of referral practices and outcomes; Return on investment in needle and syringe programs in Australia (see Health Outcomes International Pty Ltd in association with Catherine Spooner Consulting, National Drug and Alcohol Research Centre and Turning Point Alcohol and Drug Centre, *Evaluation of Council of Australian Governments' initiatives on illicit drugs: Final report to Department of Finance and Administration: vol 3*, pp 30-35).

141 Health Outcomes International Pty Ltd in association with Catherine Spooner Consulting, National Drug and Alcohol Research Centre and Turning Point Alcohol and Drug Centre,

on activities in the states and territories for 2000/2001 indicated 'there has been a considerable increase in both the capacity of NSPs and their workers, the development of wider networks of service providers, and improved communication between NSPs across all jurisdictions.'¹⁴²

Table 7.3 Expenditure on NSPs, Australia, 1990-1991 to 1999-2000 (\$'000) (Year 2000 prices)¹

1990-1991	1991-1992	1992-1993	1993-1994	1994-1995	1995-1996	1996-1997	1997-1998	1998-1999	1999-2000	TOTAL
Overhead and Infrastructure Costs										
\$441	\$455	\$530	\$560	\$541	\$539	\$714	\$757	\$841	\$1,153	\$6,531
Direct Operating Expenditure on Public NSPs										
\$7,215	\$7,730	\$8,172	\$8,710	\$9,089	\$10,251	\$12,213	\$13,250	\$13,690	\$15,243	\$105,562
Subsidies to Community Pharmacies										
\$826	\$1,045	\$1,129	\$1,318	\$1,497	\$1,551	\$2,079	\$2,347	\$2,975	\$3,278	\$18,045
Consumer Costs										
\$1,091	\$1,183	\$1,608	\$1,905	\$1,865	\$1,555	\$2,043	\$2,625	\$2,930	\$3,001	\$19,807
Total Government Direct Expenditure										
\$8,042	\$8,774	\$9,301	\$10,028	\$10,586	\$11,802	\$14,292	\$15,597	\$16,664	\$18,521	\$123,607
Total Government Expenditure										
\$8,483	\$9,230	\$9,831	\$10,589	\$11,127	\$12,341	\$15,006	\$16,354	\$17,505	\$19,673	\$130,138
Total Expenditure										
\$9,574	\$10,413	\$11,438	\$12,494	\$12,992	\$13,897	\$17,048	\$18,979	\$20,435	\$22,674	\$149,944

¹ These data cover expenditure on NSPs operating within the programs managed by State and Territory health authorities. It excludes costs associated with the many retail pharmacies that also sell needles and syringes on a commercial basis, for which reliable data is not available on the number of needles sold or the level of expenditure by consumers.

Source: *Health Outcomes International Pty Ltd in association with the National Centre for HIV Epidemiology and Clinical Research and Professor Michael Drummond, Centre of Health Economics, York University, Return on investment in needle and syringe programs in Australia: Summary report, Commonwealth Department of Health and Ageing, Canberra, 2002, p 11.*

7.108 One of the projects funded at the national level was the Return on investment in needle and syringe programs in Australia which was undertaken by Health Outcomes in association with the National Centre for HIV Epidemiology and Clinical Research and Professor Michael

Evaluation of Council of Australian Governments' initiatives on illicit drugs: Final report to Department of Finance and Administration: vol 3, p 43.

¹⁴² Health Outcomes International Pty Ltd in association with Catherine Spooner Consulting, National Drug and Alcohol Research Centre and Turning Point Alcohol and Drug Centre, *Evaluation of Council of Australian Governments' initiatives on illicit drugs: Final report to Department of Finance and Administration: vol 3, p 43.*

Drummond of the Centre of Health Economics York University.¹⁴³ This evaluation looked at the effectiveness of NSPs in preventing transmission of HIV, and hepatitis C in Australia from 1991 (that is, from when NSPs were well established in all jurisdictions except Tasmania) to the end of 2000. The authors stated that the study highlighted that, in the 10 year period, the nearly \$150 million invested in NSPs had saved between \$2.4 billion and \$7.7 billion and resulted in an estimated 25,000 cases of HIV and an estimated 21,000 cases of hepatitis C being avoided. It was also estimated that by 2010 over 5,000 lives would have been saved by NSPs. The authors stressed that the savings were conservatively estimated and stated the results reinforce original findings by Hurley, Jolley and Kaldor.¹⁴⁴

7.109 One of the parties launching that evaluation, Major Watters, Chair of the ANCD, commented that:

... the importance and value of NSPs has been more than demonstrated by the release of this report today. It is hoped that this will further enhance the public's awareness of the purpose and value of NSPs and help in overcoming the misunderstanding that these programs somehow condone or encourage the injecting of illicit drugs ...¹⁴⁵

7.110 In presenting the above results Health Outcomes noted that:

It is not possible to separate the effects of the implementation of NSPs from the other HIV prevention strategies ... In most settings, introduction of NSPs is one component of a broader harm reduction package to reduce the risk of transmission of blood-borne viruses and other harm associated with injecting drug use ...¹⁴⁶

7.111 An indication of the variation around the estimated benefits of NSPs is provided by the outcomes of the recent study by Jim Butler for the Commonwealth Department of Health and Ageing on public health programs to reduce HIV/AIDS reported in publication *Returns on*

143 Health Outcomes International Pty Ltd in association with the National Centre for HIV Epidemiology and Clinical Research and Professor Michael Drummond, Centre of Health Economics, York University, p 21

144 Health Outcomes International Pty Ltd in association with the National Centre for HIV Epidemiology and Clinical Research and Professor Michael Drummond, Centre of Health Economics, York University, pp 10, 11, 15.

145 Australian National Council on Drugs, *National Council backs investment on needle programs*, media release, 23/10/02, p 1.

146 Health Outcomes International Pty Ltd in association with the National Centre for HIV Epidemiology and Clinical Research and Professor Michael Drummond, Centre of Health Economics, York University, pp 8-9.

investment in public health. This study looked at HIV only for the longer time period 1984-2010, and examined the main public health response to HIV covering securing the bloods; introducing NSPs for injecting drug users; and educating the population about the virus and the consequences of infection. Its authors estimated the number of HIV infections avoided due to the education and prevention programs was 6,973.¹⁴⁷

7.112 In a presentation to the International Pharmaceutical Federation 61st World Congress in Singapore in 2001, Dr Helen Dodd, of the Karana Medical Centre Pharmacy in Queensland, reported that there is a lack of a register to report community needle stick injuries and as a result a lack of accurate data on the number of injuries in the community. For example she said the Queensland Injury Surveillance Unit reports injuries only from 14 Hospital Emergency Rooms with 154 needle stick injuries in community settings from 1998-2000 and that general practitioners in Australia do not report cases of community acquired needle stick injury.

¹⁴⁸

7.113 Dodd also stated that ‘The risk of contracting HIV/AIDS is 0.4%, Hepatitis B is 5% and Hepatitis C is 3.5% after a needlestick injury.’¹⁴⁹ She went onto say:

- there is no effective vaccine available for Hepatitis C or HIV/AIDS;
- the cost of testing per person after a needle stick injury is \$1100 paid for by Medicare;
- treatment with immunoglobulins is a standard procedure for hospital workers who have any exposure to blood;
- treatment costs for Hepatitis C is \$100,000 - \$150,000, paid for by health funds, Medicare or privately;
- treatment costs for HIV positive patient is \$400,000; and
- compensation payments for maintenance workers – a maintenance manager in Shell Service Station in Albury NSW contracted HIV a year after he had received a needle stick injury while changing a toilet roll. He was awarded \$429,000 compensation in November 2000.¹⁵⁰

147 Butler J, Public health programs to reduce HIV/AIDS, in *Returns on investment in public health: An epidemiological and economic analysis prepared for the Department of Health and Ageing*, Commonwealth Department of Health and Ageing, Canberra, June 2001, pp 61-62.

148 Dodd HJ, Karana Medical Centre Pharmacy, Karana Downs Qld, Solutions to a serious health problem through safer needle technology, presentation to *2001 Annual Congress of Pharmacy and Pharmaceutical Sciences, International Pharmaceutical Federation’s 61st World Congress, on Combining practice and science to extend horizons, Singapore, 2-6 September 2001*, p 3.

149 Dodd HJ, p 4.

150 Dodd HJ, p 5.

- 7.114 Dodd also reported that HIV-1 is viable in syringes and can survive for over one month at 22°C; HIV-1 in blood remains viable after 60 minutes exposure to UV light laboratory conditions; and HIV remains viable for 28 days at room temperature.¹⁵¹
- 7.115 The committee notes that retractable syringes could assist in reducing the number of needle stick injuries. During the inquiry the committee received a demonstration of retractable syringe technology from Unित्रact. Duesman and Ross in a United States 12 months survey, in calendar year 1997, of automated retractable syringes in 26 hospital facilities using 86,300 3mL syringes (Vanishpoint), demonstrated no accidental needle stick injuries documented over the 12 month period.¹⁵²
- 7.116 The comparative cost of 1mL retractable needle syringes with a fixed needle syringe for community use are shown at Table 7.4.

Table 7.4 1ml Retractable needle syringes for community use

	Becton Dickinson	Retractable Technologies Inc	Occupational Medical Innovations	New Medical Technology Inc	Retractable Trading
Name	Fixed Needle	VanishPoint	Sharp Safe	NMT Syringe	Unित्रact
Needle type	Fixed Needle	Retractable Needle	Retractable Needle	Retractable Needle	Retractable Needle
Country	USA	USA	Australia	Scotland	Australia
Assembled components	6	10	7	16	>16
Price per Unit for 20 million	15c	40c	15-20c	70c	70c

Source: Dodd HJ, Karan Medical Centre Pharmacy, Karana Downs Qld, Solutions to a serious health problem through safer needle technology, presentation to 2001 Annual Congress of Pharmacy and Pharmaceutical Sciences, International Pharmaceutical Federation 61st World Congress, Singapore, 2-6 September 2001, p 7.

- 7.117 In a move to address needle stick injuries, the Commonwealth government announced funding of \$27.5 million over four years in the 2002-03 federal budget for an implementation strategy for the introduction of retractable needle and syringe technology.¹⁵³

151 Dodd HJ, p 9.

152 Duesman K and Ross J, Survey of accidental needlesticks in twenty-six facilities using Vanishpoint (R) automated retractable syringe, *Journal of Healthcare Safety, Compliance and Infection Control*, 3/1/98, 6p.

153 *Budget measures 2002-03*, Budget paper no 2, Commonwealth Department of the Treasury, Canberra, 2002, p 119.

7.118 However, Ms Madden of the Australian Injecting and Illicit Drug Users League warned the committee that ‘it is very likely that injecting drug users will not accept these devices’ because ‘people will not use different syringes’.¹⁵⁴ She also expressed considerable concern about ‘the cost of retractable syringes compared with the very cost-effective current needles and syringes available through needle and syringe programs ...’¹⁵⁵ Ms Madden suggested that a better approach than development and introduction of retractables to reduce publicly discarded injecting equipment would be to run broad community education campaigns which really has never been done before on this issue, and establish local networks to develop local solutions to the problem.¹⁵⁶

7.119 According to the ANCD, injecting drug users who fear apprehension for self administration or possession of injecting equipment are more likely to toss away used needles than they would if the legislation targeted unsafe needle disposal instead.¹⁵⁷ The ANCD recommended that:

... all governments, in consultation with appropriate community-based organisations, should consider the removal of legislative impediments to the proper disposal of used injecting equipment, specifically offences related to self-administration and possession of injecting equipment.¹⁵⁸

Major Watters reiterated this point late last year.¹⁵⁹

7.120 In the 2003-04 federal budget the following measures related to NSPs were addressed:

- due to the significant increase in the number of commercial providers developing retractable needle and syringe technology, the government redirected \$8.7 million over two years from the introduction of needle and syringe technology to other initiatives in the illicit drugs area;
- continued to provide \$17.5 million over three years to address community concerns about the risk of injury from needles discarded in public places through funding for the final phase of research and

154 Madden A, transcript, 15/8/02, p 1119.

155 Madden A, transcript, 15/8/02, p 1120.

156 Madden A, transcript, 15/8/02, p 1120.

157 Australian National Council on Drugs, informal communication, 26/2/03.

158 Australian National Council on Drugs, *Needle and syringe programs: position paper*, ANCD, Canberra, undated, p 5, viewed 18/6/03
http://www.ancd.org.au/publications/pdf/pp_needle_syringe.pdf

159 Australian National Council on Drugs, *National Council backs investment on needle programs*, media release, 23/10/02, p 2.

development, including pilots of the technology in selected settings and the implementation of retractable technology across NSPs nationally;

- provision of \$16.3 million over four years for the distribution of injecting equipment to illicit drug users through NSPs in an increased number of pharmacies and other outlets; and
- maintained funding (\$22.4 million over four years) for education and counselling and referral services through community-based NSPs.¹⁶⁰

Conclusion

7.121 The committee acknowledges the benefits of the two evaluations related to NSPs discussed. The committee also questions the increase in use of NSPs when data provided through the 2001 NDS Household Survey indicated that heroin use had dropped significantly. However, it is concerned that there is no easily available data on the number of needles distributed. This raises the question of the level of accountability of the needle and syringe programs. They also had concerns about the lack of data related to needle stick injury. The committee believes there is a need for a complete evaluation of all components of the NSPs including education and counselling and the impact on both HIV and hepatitis C. The committee is pleased that the effectiveness of retractable needle and syringe technology is being investigated. It believes that the technology merits examination to ensure its introduction is successful and cost-effective.

7.122 Of particular concern to the committee was the escalating incidence of HIV and hepatitis C despite the quantity of syringes distributed (not necessarily exchanged) nationally under this program.

Recommendation 66

7.123 **The committee:**

- **recommends that a complete evaluation of needle and syringe programs be undertaken by the Australian National Audit Office. Issues that should be assessed are distribution, inadequate exchange, accountability and associated education and counselling programs and the impact on both HIV and hepatitis C; and**
- **supports the recommendation of the Australian National**

¹⁶⁰ *Budget measures 2003-04*, pp 174, 176 and 177.

Council on Drugs calling for the removal of legislative impediments to the proper disposal of used injecting equipment, specifically offences related to self administration and possession of injecting equipment.

Preventing and managing overdoses

- 7.124 The National Heroin Overdose Strategy, announced in July 2001, was adopted by all jurisdictions through the Ministerial Council on Drug Strategy. The strategy 'provides nationally agreed priority areas for reducing the incidence of heroin related overdoses in Australia and for reducing morbidity and mortality where overdose does occur.'¹⁶¹ While entitled the National Heroin Overdose Strategy, it recognised a range of opioids are involved in overdose, including methadone and morphine, and encompassed them; and recognised that polydrug use plays a major role in overdose fatalities, particularly the use of central nervous system depressants such as alcohol or benzodiazepines in combination with opioids.¹⁶²
- 7.125 Risk factors identified in the strategy are: polydrug use; resumption of opioid use following periods of reduced consumption or abstinence increases the risk of overdose; and drug users injecting alone decrease the chances of resuscitation in the event of an overdose.¹⁶³
- 7.126 The Heroin Overdose Strategy suggested the strategies that might be adopted to prevent heroin related overdose include:
- provision of timely access to a diverse range of evidence based treatment services including pharmacotherapies;
 - diversion of opioid users away from the criminal justice system to treatment;
 - expanding provision of drug treatment services in prisons and ensuring those treatments are linked to community based services;
 - education for families, friends, NSP workers, health workers, police who come into contact with opioid users regarding the factors which increase or reduce the risk of overdose; and

161 *National Heroin Overdose Strategy: Summary*, p 2, viewed 30/1/03, <http://www.health.gov.au/pubhlth/nds/resources/publications/heroin_summary.pdf>.

162 *National Heroin Overdose Strategy: Summary*, p 2, viewed 24/6/03, http://www.health.gov.au/pubhlth/nds/resources/publications/heroin_summary.pdf

163 *National Heroin Overdose Strategy: Summary*, p 3, viewed 24/6/03, http://www.health.gov.au/pubhlth/nds/resources/publications/heroin_summary.pdf

- develop pre and post release education, information and support programs for prisoners and individuals completing detoxification programs.¹⁶⁴
- 7.127 Strategies suggested to reduce overdose related to morbidity and mortality included:
- developing clinical protocols supported by training which addresses attitudes, knowledge and skills for accident and emergency workers to manage overdose; and
 - developing local partnerships between police, paramedics, accident and emergency staff and specialist drug treatment services which encourage provision of information, referral and follow-up of opioid users who experience an overdose.¹⁶⁵
- 7.128 The drop in overdose deaths in the last few years is very welcome and appears, according to the ANCD, to be due to a combination of factors including:
- ... the disruption of key importers by Australia's law enforcement agencies at local, national and international levels; cyclical changes in drug use; the increased availability of residential and pharmacotherapy treatments; the introduction of a national diversion program for drug offenders and; the introduction of key peer based overdose reduction strategies.¹⁶⁶

Safe injecting facilities

- 7.129 In its paper on safe injecting facilities (SIFs), the Drugs and Crime Prevention Committee of the Victorian Parliament defined such facilities as 'establishments whose specific and officially sanctioned purpose is to provide injecting drug users with a safe environment in which to inject their drugs'. It pointed out that clients inject drugs that they have acquired, no drugs are administered or distributed, and staff do not help clients to inject.¹⁶⁷
- 7.130 According to the Victorian parliamentary committee:

164 *National Heroin Overdose Strategy: Summary*, p 4, viewed 24/6/03, http://www.health.gov.au/pubhlth/nds/resources/publications/heroin_summary.pdf

165 *National Heroin Overdose Strategy: Summary*, p 5, viewed 24/6/03, http://www.health.gov.au/pubhlth/nds/resources/publications/heroin_summary.pdf

166 Major Brian Watters, *Heroin: Flood or drought?*, media release, 26/2/03, p 2.

167 Parliament of Victoria, Drugs and Crime Prevention Committee, *"Safe injecting facilities": Their justification and viability in the Victorian setting*, DCPC, Parliament of Victoria, Melbourne, undated, iii unpaginated.

... The safety of SIFs [safe injecting facilities] revolves primarily around their capacity to reduce the risk of fatal overdose, as well as the risk of blood-borne viral infections associated with unsafe injecting practices ...

SIFs should also play a secondary health and welfare role for users through

- the provision of education and advice to users on safe drug use;
- the provision of primary health-care and medical treatment ...
- the increased access to and availability of drug treatment and rehabilitation;
- the increased access to advice and help with life-skill problems ...¹⁶⁸

7.131 The Victorian parliamentary committee drew attention to safe injecting facilities that have been established in Germany, Switzerland and the Netherlands. In cities with these facilities, public drug use and numbers of overdose deaths declined, as did the numbers of discarded syringes and complaints about public nuisance. Some clients entered treatment as a result of attending and, those who also attended life skills programs reduced their overall drug use.¹⁶⁹ It concluded that there were ‘potentially strong advantages in having properly organised and operated SIFs ...’ but there were also ‘possible disadvantages, as well, and there are dangers in viewing SIFs as a panacea for all the harms of street-based injecting ...’¹⁷⁰ Some of the disadvantages cited by the Victorian committee were: SIFs need to be properly targeted and sensitively managed in the context of community consultation and education; have the potential to produce significant harms including the possibility of a further entrenched local drug market and related crime, perception of condoned drug use and entrenching drug injecting as the major route of administration; the need for full consideration and resolution of legal issues including criminal liability, observance of international treaties and civil liability; may not sufficiently remove the problems of public nuisance they are designed to overcome; and may not be able to effectively administer to the intended target group given the way SIFs are intended to operate.¹⁷¹

168 Parliament of Victoria, Drugs and Crime Prevention Committee, *“Safe injecting facilities”: Their justification and viability in the Victorian setting*, unpagged.

169 Parliament of Victoria, Drugs and Crime Prevention Committee, *“Safe injecting facilities”: Their justification and viability in the Victorian setting*, unpagged.

170 Parliament of Victoria, Drugs and Crime Prevention Committee, *“Safe injecting facilities”: Their justification and viability in the Victorian setting*, unpagged.

171 Parliament of Victoria, Drugs and Crime Prevention Committee, *“Safe injecting facilities”: Their justification and viability in the Victorian setting*, unpagged.

- 7.132 While the Victorian government has not established a safe injecting facility, the New South Wales government, after extensive consultation, supported the establishment of the Kings Cross Medically Supervised Injecting Centre in Sydney, which opened in May 2001.
- 7.133 The preliminary findings of an evaluation by NDARC indicated that the centre had helped prevent overdose harm and fatalities. Among the 3,818 clients registered at the centre there were 424 drug-overdose related incidents that required clinical management during the 18 months covered by the evaluation. This was equivalent to a rate of 7 overdoses per 1000 visits.¹⁷²
- 7.134 In addition, the evaluation found that:
- on approximately one in every four visits, a health care service was provided to the clients; and
 - in one in every 41 visits clients were referred to other services, 43 per cent of which were for treatment for their drug dependence.¹⁷³
- 7.135 However, the Kings Cross centre has been a controversial strategy. This was reflected in vehement opposition to it and to any extension of the trial in submissions to the inquiry, including those from Dr Santamaria and the Community Coalition for a Drug Free Society.¹⁷⁴ Among the concerns expressed were those of Mr Beswick:

Official injecting rooms give the appearance of community acceptance of the behavior and will lead teenagers especially, unsettled and looking for 'something', to experiment with the crowds at such centres who apparently have found 'some thing'
...¹⁷⁵

- 7.136 DRUG-ARM said it:

... does not support the provision of injecting rooms ... DRUG-ARM will reassess its position on both of these strategies if the research and evaluation of proposed injecting room trials in Australia supports the stated goals of reducing the number of deaths, and the number of heroin overdoses of young people. This

172 National Drug and Alcohol Research Centre, *Key findings from the 18-month report of the Medically Supervised Injecting Centre*, media release, 25/11/02, viewed 13/1/03, <<http://ndarc.med.unsw.edu.au/ndarc.nsf/website/News.pressreleases.MSICNov.2002>>.

173 National Drug and Alcohol Research Centre, *Key findings from the 18-month report of the Medically Supervised Injecting Centre*, media release, 25/11/02.

174 Community Coalition for a Drug Free Society, sub 251, p 1; Santamaria J, sub 231, p 11.

175 Beswick P, sub 42, p 3.

change in policy position would occur only if DRUG-ARM members supported such a change.¹⁷⁶

- 7.137 The final report of the evaluation by NDARC was released on 9 July 2003. The report concluded in summary that: it is feasible to operate the injecting centre in Kings Cross; there was no detectable change in heroin overdoses at the community level; the Medically Supervised Injecting Centre made referrals for drug treatment, especially among frequent attendees; there was no increase in risk of blood born virus transmission; there was no overall loss of public amenity; there was no increase in crime; and the majority of the community accepted the Medically Supervised Injecting Centre initiative.¹⁷⁷

Conclusion

- 7.138 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.

Recommendation 67

- 7.139 **The committee recommends that the Commonwealth, State and Territory governments work to establish a wider range of detoxification and rehabilitation centres bolstered by a range of ancillary programs to give maximum support to individual drug users.**

Education

- 7.140 The committee notes that injecting drug users need advice on issues such as the safe disposal of injecting equipment and injecting practices that will minimise harm to themselves from blood borne disease and overdose. NSPs and safe injecting rooms are places where they can be targeted with advice. At the time of Warner-Smith et al's review of the situation, the quality of some of the information provided at NSPs was poor.¹⁷⁸ More recently, according to one of the review team, there has been an improvement in both the quality and quantity of the material available

176 DRUG-ARM, sub 199, p 10.

177 Kaldor J, Lapsley H, Mattick RP, Weatherburn D & Wilson A, MSIC Evaluation Committee, *Final report of the evaluation of the Sydney Medically Supervised Injecting Centre*, MSIC Evaluation Committee, Sydney, July 2003, p xvi.

178 Warner-Smith M, Lynskey M, Darke S & Hall W, p 42.

and injecting drug users' understanding of how to minimise harm to themselves.¹⁷⁹

7.141 The former Commonwealth Department of Health and Aged Care reported that injecting drug use is a risk factor for the transmission of HIV and hepatitis C, and education about their transmission is a feature of the national strategies targeting both these diseases.¹⁸⁰ According to the AIHW, most cases of HIV infection result from sexual contact between men, with relatively little transmission (less than 20 per cent of cases diagnosed in 2000) from other sources.¹⁸¹ However, as the National Hepatitis C Strategy points out that, approximately 90 per cent of newly acquired cases of hepatitis C are related to injecting drug use. Individuals can therefore play an important role in reducing the transmission of hepatitis C, for example by avoiding high risk behaviour such as injecting. Education and counselling are important in this respect, including peer education which has been shown to be effective among drug users.¹⁸²

7.142 However, according to Ms Madden, a heroin user for 15 years and on MMT for eight:

... although we have a fantastic national hepatitis C strategy—it is well written and it has some fantastic strategies and ideas in there—it is an unfunded strategy. If we have a great strategy but no funding to implement it, we simply cannot implement the strategy and get the runs on the board in relation to hepatitis C ... so we have major work to do on that issue, and we cannot do it without adequate funding.¹⁸³

7.143 The committee considers that it is also important to run education campaigns on an ongoing basis to ensure that new users are made aware of the health issues related to injecting drugs as early as possible in their using careers.

7.144 Ms Madden's comments about the lack of attention to this issue was therefore concerning:

There has not been a major HIV prevention campaign with injecting drug users for many years now. Unfortunately—sadly—

179 Darke S, informal communication, 24/2/03.

180 Commonwealth Department of Health and Aged Care, *National Hepatitis C Strategy 1999-2000 to 2003-2004*, p 21; Commonwealth Department of Health and Aged Care, *National HIV/AIDS Strategy 1999-2000 to 2003-2004: Changes and challenges*, Commonwealth Department of Health and Aged Care, Canberra, 2000, pp iv, 12.

181 Australian Institute of Health and Welfare, *Australia's health 2002*, p 94.

182 Commonwealth Department of Health and Aged Care, *National Hepatitis C Strategy 1999-2000 to 2003-2004*, pp 21-22.

183 Madden A, transcript, 15/8/02, p 1123.

when we talk to drug users on the ground they no longer say that HIV is the main health issue they think about ...¹⁸⁴

- 7.145 In the 1999-2000 federal budget the Government provided \$12.4 million over four years (\$1.5 million in 1999-00, \$3.6 million in 2000-01, \$3.6 million in 2001-2 and \$3.7 million in 2002-03) for the Hepatitis C Education and Prevention Initiative. Funds were provided for improved education, prevention and health maintenance initiatives for those currently infected and those at risk of becoming infected to lower the current rate of transmission of hepatitis C in Australia.¹⁸⁵ Funding of a total of \$15.9 million for the program was maintained in the 2003-04 federal budget for a further four years (that is \$3.8 million in 2003-03, \$3.9 million in 2004-05, \$4.0 million in 2005-06, and \$4.1 million in 2006-07).¹⁸⁶

Conclusion

- 7.146 The committee believes that education programs on hepatitis C must be addressed in a way that is commensurate with the seriousness of the problems it creates.

Recommendation 68

- 7.147 **The committee recommends that the Commonwealth, State and Territory governments continue to give a high priority to funding education campaigns to:**
- target the general population as well as at high risk groups; and
 - inform high risk groups about HIV/AIDS and hepatitis C and, in particular how to prevent the transmission of these diseases.

National Hepatitis C Strategy

- 7.148 The National Hepatitis C Strategy 1999-2000 to 2003-2004 aims to reduce the transmission of hepatitis C and to minimise the social and personal impacts of the disease.¹⁸⁷ While understanding of the hepatitis epidemic

184 Madden A, transcript, 15/8/02, p 1122.

185 *Budget measures 1999-2000*, Budget paper no 2, Commonwealth Department of the Treasury, Canberra, May 1999, p 107.

186 *Budget measures 2003-04*, p 187.

187 Commonwealth Department of Health and Aged Care, *National Hepatitis C Strategy 1999-2000 to 2003-2004*, Commonwealth Department of Health and Aged Care, Canberra, 2000, p 1,

has improved over the last decade, the Commonwealth government is continuing 'to pursue research and surveillance in order to improve the evidence base for the development of public policy programs'.¹⁸⁸

According to the Australian National Council on AIDS, Hepatitis C and Related Diseases (ANCAHRD), priorities for research have been identified, with three national research centres providing significant resources aimed at managing the epidemic.¹⁸⁹

7.149 NSPs and education are important elements of the strategy and have been discussed in the last sections of this chapter. Improved treatment for hepatitis C infection and assistance to people affected by hepatitis C to maintain their health are among the priority areas for the strategy.¹⁹⁰

According to ANCAHRD, treatment has improved but 'a widely available and practicable cure for the virus eludes us'.¹⁹¹ The former Commonwealth Department of Health and Aged Care regards the search for a cure as critical in view of the speed with which the disease is spreading and its association with a diminished quality of life, cirrhosis of the liver, and liver cancer.¹⁹²

7.150 Core funding of \$7.3 million was provided in 2001-02 for research into preventing the spread of HIV and hepatitis C infection, reducing harm from HIV, and improving the quality of life of people living with these two diseases.¹⁹³

7.151 As foreshadowed in the National Hepatitis C Strategy the strategy was to be subject to an independent, external review mid-term of the strategy's implementation.¹⁹⁴ The Commonwealth Department of Health and Ageing indicated that the National Hepatitis C Strategy was reviewed in 2002, and the review will be considered by the Minister for Health and Ageing in the context of the 2003-04 federal budget.¹⁹⁵

188 Senate Community Affairs Legislation Committee, *Answers to estimates questions on notice: Health and Ageing Portfolio: Budget estimates 2002-2003*, 5 and 6 June 2002, p 40.

189 Australian National Council on AIDS, Hepatitis C and Related Diseases, 'Research', pp 1-2, viewed 3/4/03, <<http://www.ancahrd.org/research/index.htm>>.

190 Commonwealth Department of Health and Ageing, 'Commonwealth action on hepatitis C: the Australian response', p 2, viewed 3/4/03, <http://www.health.gov.au/pubhlth/strateg/hiv_hepc/hepc/response.htm>.

191 Australian National Council on Aids, Hepatitis C and Related Diseases, Puplick C, *New hepatitis C infections still increasing*, media release, undated, p 2.

192 Commonwealth Department of Health and Aged Care, *National Hepatitis C Strategy 1999-2000 to 2003-2004*, pp 6-7.

193 *Commonwealth Department of Health and Ageing annual report 2001-02*, Commonwealth Department of Health and Ageing, Canberra, October 2002, p 61.

194 Commonwealth Department of Health and Aged Care, *National Hepatitis C Strategy 1999-2000 to 2003-2004*, p 63.

195 Commonwealth Department of Health and Ageing, sub 297, p 3.

- 7.152 In the 2003-04 federal budget the Commonwealth government announced that it will maintain funding by providing \$15.9 million over four years to continue the Hepatitis C Prevention and Education program that reduces the transmission of hepatitis C in the Australian community by providing education, prevention and health maintenance initiatives for those currently infected and those at risk of becoming infected with hepatitis C.¹⁹⁶
- 7.153 In June 2003 there were newspaper articles drawing attention to a report, not yet publicly available, that was critical of the approach to hepatitis C and calling for: a national public awareness campaign; better partnerships with groups working with drug injecting users; action to boost prevention and safety; and more funds to deal with the problem. It was reported that 'A spokesman for Senator Patterson said part of the report would be released next month, while the Government had allocated \$16 million to reduce transmission.'¹⁹⁷
- 7.154 A media release by the Australian Hepatitis Council commenting on the above report stated:

... the Australian Hepatitis Council, supports the assertion in the review that the national response for hepatitis C has been poorly implemented ...

The Australian Hepatitis Council maintains that a second National Hepatitis C Strategy must be accompanied by an implementation plan and funding from the Commonwealth Government or, despite its intentions, it will fail to address the discrimination, care, support and treatment needs of a quarter of a million Australians with hepatitis C.

In the recent budget, the government allocated \$15.9 million over four years for hepatitis C Education and Prevention. Whilst welcome support for existing hepatitis C initiatives, this money will not be able to meet the ever increasing needs of the sector ...¹⁹⁸

Conclusion

- 7.155 The committee welcomes the 2003-04 federal budget allocation of \$15.9 million over four years to continue the hepatitis C prevention and education programme.

196 *Budget measures 2003-04*, p 187.

197 Schubert M, Drug law blamed for hep C epidemic, *The Australian*, 13/6/03.

198 Australian Hepatitis Council, Wallace J spokesperson, *Time to act on Hepatitis C*, media release, 13/6/03, 1p.

7.156 The committee believes that:

- given the current hepatitis C epidemic, concerted efforts must be made to better understand the disease, how to contain and treat it, and how to assist those affected by it; and
- insufficient recognition has been given to the problems that hepatitis C sufferers experience, especially in rural areas.

Recommendation 69

7.157 **The committee recommends that the Commonwealth government evaluate the outcomes of the 2003-04 budget funding for the National Hepatitis C Strategy over the four year period to ensure that the issues outlined in 7.153 are being adequately addressed.**

Recommendation 70

7.158 **The committee recommends that the Commonwealth, State and Territory governments continue to fund research into the prevention and management of hepatitis C infection.**

Misuse of licit substances

7.159 The committee notes that a number of licit substances are misused in the sense that they are employed for purposes other than those for which they are supplied. The misuse is triggered by a desire to induce or enhance a drug experience, to enhance performance or for cosmetic purposes. Substances that are misused in this way include prescription and over-the-counter drugs, and volatile substances like petrol, solvents, glue and aerosols.

7.160 Table 7.5 shows some of the substances that are misused in this way. As can be seen from Table 7.5, which shows results from the 2001 NDS Household Survey, the proportion of Australians who reported in 2001 that they had misused such substances at some stage in their lives was relatively small. It varied from one in 17 for pain-killers/analgesics to three in 100 for steroids. The proportion of Australians that was misusing

these substances fell significantly between 1998 and 2001 for all substances except steroids and barbiturates.¹⁹⁹

- 7.161 Nonetheless, the committee considers that the harm caused to those who misuse them is considerable and some of these substances are very addictive.

Table 7.5 Summary of drugs ever used and recently used: proportion of the population 14 years and over, Australia 2001

Drug/Behaviour	Ever used (per cent)	Recently used (per cent)
Pain-killers/analgesics	6.0	3.1
Tranquillisers/sleeping pills	3.2	1.1
Steroids	0.3	0.2
Barbiturates	0.9	0.2
Inhalants	2.6	0.4

Source: 2001 National Drug Strategy Household Survey: first results, Australian Institute of Health and Welfare, Canberra, May 2002, p 3, 4.

- 7.162 The committee received little evidence about the use of drugs in sport and the misuse of prescription and over-the-counter medication. There was also insufficient time to pursue them to the extent that would allow well-based decisions to be reached. The committee therefore decided not to consider these topics in this report. It proposes to deal here only with inhalants.

Inhalants

- 7.163 The practice of inhaling solvents and 'chroming' (specifically inhaling from an aerosol paint can) is a matter of concern to the committee. According to the AMA, inhaling volatile substances is 'highly dangerous'.²⁰⁰ While inhaling appears to be relatively rare, the report from a recent forum on chroming indicated that there are some pockets of particularly disadvantaged people who become intensive users, for example in some Aboriginal communities. Elsewhere inhaling tends to occur among younger secondary students.²⁰¹

199 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: First results*, pp 3-4.

200 Australian Medical Association, Position statement on 'Use and misuse of medicines and drugs', 1998, attachment to AMA sub 133.

201 Victorian Alcohol and Drug Association, *Chroming: Beyond the headlines: Final report*, April 2002, p 3, viewed 23/1/02, <<http://www.vaada.org.au/Chroming%20Forum%20Report.htm>>.

- 7.164 The use of inhalants recently received attention in several Australian states:
- in the inquests, carried out Coroner W C Chivell, into three deaths of Anangu Pitjatjantjara people who died as the result of inhaling petrol fumes²⁰²;
 - in an inquiry into the inhalation of volatile substances by the Victorian Parliament's Drugs and Crime Prevention Committee²⁰³; and
 - by the Northern Territory Legislative Assembly Select Committee on Substance Abuse.²⁰⁴
- 7.165 Reports from the inquests, the Victorian inquiry and work by others summarised ways of addressing inhaling and suggested improvements to current efforts at prevention and treatment. For example, Coroner Chivell called for state, territory and Commonwealth action to urgently address petrol sniffing in Anangu communities; coordinated approaches are needed to 'avoid the fragmentation of effort and confusion and alienation of service-providers which are features of current service delivery'.²⁰⁵
- 7.166 The Victorian Drugs and Crime Committee stressed that responding to the problem of inhaling must be led at a national level, and recommended a national committee be formed to coordinate prevention and treatment policy and activities.²⁰⁶
- 7.167 The Victorian committee's report provided detailed discussion of many aspects of dealing with inhaling; some of the report's conclusions were as follows.
- The Victorian committee did not recommend that volatile substance use be criminalised as it felt that such a move would be unlikely to be

202 *South Australia: Finding of inquest*, delivered by W C Chivell, Coroner, September 2002, paragraph 13.2.5, viewed 24/2/03, <http://www.courts.sa.gov.au/courts/coroner/findings/findings_2002/kunmanara_hunting.htm>.

203 Parliament of Victoria, Drugs and Crime Prevention Committee, *Inquiry into the inhalation of volatile substances: Final report*, DCPC, Parliament of Victoria, Melbourne, September 2002, 662p.

204 Northern Territory Legislative Assembly, Substance Abuse Committee, *Seeking public input to the Substance Abuse Committee*, media release, 3/4/02, viewed 15/5/02, <<http://www.nt.gov.au/lant/parliament/committees/substance/Termref.shtml>>.

205 *South Australia: Finding of inquest*, Recommendations, delivered by W C Chivell, Coroner, September 2002, pp 79-80, viewed 24/2/03, <http://www.courts.sa.gov.au/courts/coroner/findings/findings_2002/kunmanara_hunting.htm>.

206 Parliament of Victoria, Drugs and Crime Prevention Committee, *Inquiry into the inhalation of volatile substances: Final report*, pp v, viii.

effective and could be counter-productive. Instead, intoxicated persons should be detained and intoxicants seized.

- It did not support the introduction of age restrictions on the sale of certain volatile products. It recognised, however, that there was strong support for such a move among significant sections of the community. It recommended that the proposed national committee investigate this matter further.
- The Victorian committee recommended continuing work by government and private industry in developing safer spray paint products.²⁰⁷

Conclusion

7.168 The committee believes that the Commonwealth government should take a greater role than at present in relation to inhalants and could usefully lead a nationally coordinated response to the problem.

Recommendation 71

7.169 **The committee recommends that the Commonwealth government take a leading role as a matter of urgency in establishing a national committee to coordinate policy and programs to prevent the use of inhalants and treat dependent users.**

207 Parliament of Victoria, Drugs and Crime Prevention Committee, *Inquiry into the inhalation of volatile substances: Final report*, pp ix, x, xiii.