T R A N S C R I P T

LAW REFORM, ROAD AND COMMUNITY SAFETY COMMITTEE

Inquiry into drug law reform

Sydney — 23 May 2017

Members

Mr Geoff Howard — Chair
Mr Bill Tilley — Deputy Chair
Mr Martin Dixon
Mr Khalil Eideh
Ms Fiona Patten
Ms Natalie Suleyman
Mr Murray Thompson

Witnesses

Associate Professor Nadine Ezard

Necessary corrections to be notified to executive officer of committee

The CHAIR — Well, we'll resume now so welcome, Nadine Ezard, who is going to speak to us now. I'll introduce the panel to you, Nadine, and deal with the formalities: I'm Geoff Howard, the chair; Bill Tilley, the deputy chair and, going around the table, Martin Dixon, who's the member for Nepean, Khalil Eideh, who is the member for Western Metropolitan in Melbourne; Fiona Patten, member for Northern Metropolitan and Natalie Suleyman, who is the member for St Albans, and Murray Thompson, who is the member for Sandringham, so a cross-section of Melbourne and regional Victoria in the case of Bill and I.

You'd be aware that this parliamentary committee - or you may not be aware this is the second public hearing we've had after being open for written submissions for several months earlier in the year. We've had 220 written submissions come in - a mix of peak bodies and individuals who have particular focuses on issues they've wanted the committee to be aware of or to take action on. You would be aware that Hansard is going to record our discussion and so it will form part of the public record after you've had a chance to read the transcript and see that it's correct in terms of what you've said both factually and for typographical errors and that sort of thing.

You'd be aware that you're covered by parliamentary privilege in here. I don't know if that's relevant to anything you're going to say. We of course have enjoyed hearing from a range of people on this broad topic of drug law reform. We welcome your expertise and if you want to speak to us for a few minutes and then we'll have some questions to follow up.

Associate Prof EZARD — Fantastic, thank you - before I start I just want to acknowledge the Gadigal people of the Eora Nation as the traditional owners on which we're seated and paying my respects to elders past and present and any Aboriginal people that might be in the room with us today. I also want to thank you very much for inviting me to come to this hearing given that I'm now currently residing in New South Wales. I feel quite privileged to be asked my opinion on some of these matters. I am of course born and bred in Victoria - country Victoria, actually - so my heart is –

The CHAIR — Which part?

Associate Prof EZARD — I was initially from a place called Swift's Creek in East Gippsland - real bush.

Mr THOMPSON — Know it well.

Associate Prof EZARD — So my heart is still very much in Victoria and also with our rural constituents. Before I begin I just need to reassert that this submission is made in my own personal capacity and not on behalf of my employers and as such the views expressed are mine and not my employer's. I'm presenting here as an addiction medicine specialist. I first started working in the field in the mid-'90s, again in Victoria, in Melbourne. My concerns around the issues of drug law reform are very much from a clinical capacity, in the sense that the people that I see every day are people whose experience of harms are most definitely increased by their engagement with the criminal justice system for engaging in the criminality of drug use.

There are a number of issues around our current criminal justice system that actually promote shame and stigma, which prevents access to treatment and care, and the opportunity costs, which are not inconsiderable for the amount of resources which are diverted towards the criminal justice side of the problem and not towards the health side of the problem. I just wanted to give a little example of a client who I saw just recently who was referred to us actually from the injecting centre, so she was lucky enough that she actually did come into contact with caring health workers that managed to convince her to have her first ever treatment contact with the treatment system.

She was a young woman: she was on the run from being involved in some illegal drug-trading activities in Queensland, so she was homeless. She was every vulnerable. She had begun using oxycodone orally, so prescription drugs, and then quite rapidly transitioned to crushing up the pills and injecting them and then transitioned to heroin use, and was actually using very frequently intravenously by the time we saw her. She had not had any blood-borne virus screens and she was very much engaged in the kind of subsistence living that's required of someone homeless on the streets in a state that she hadn't been in before.

This despite the fact that she herself had quite a number of risk factors - she'd left home at 15 so she hadn't actually been diverted into the treatment and care sector until quite late in the piece, if you like. So she fortunately came to us but my argument for her whole case is that the criminal justice system didn't actually aid her presentation - in fact, it probably gave her a lot more harms. This is quite a distinction to some of the people who come to us about alcohol-use disorders; so for example a 72-year-old woman who's at home also with prescription drug issues and

alcohol issues and she is very much suffering from her dependence problems but she's not engaged in the criminal justice system in any sense.

So her experience is quite different to the people who are involved in the drugs that are criminalised and the drug use that is criminalised. One of the other points I wanted to make is the lack of harmonisation then of those different drugs. So on the one hand we have alcohol which is legal, which is sold for a profit and probably our biggest public health problem in terms of drugs. Then we have other drugs that are considered illegal in an illegal drug system. One of the issues around that differential illegality if you like, is the issue we see with the drug-use paraphernalia. So we're fortunate in New South Wales that we have quite large access to needle syringe programs but we have a situation - it's the same in Victoria since 2010 - where the pipes for smoking amphetamine are actually criminalised.

So I've had clients that have transitioned to injecting because it's easier to get injecting equipment than smoking equipment, albeit they're engaged in treatment and we're working with them to try and do something about that drug use. They don't want to be injecting but they've transitioned because of this kind of slightly contradictory public health situation. The third point I wanted to make was about the kind of emerging problems that are coming to us: so there's two there. One is - I've already touched on that slightly - is the pharmaceutical drug use. We know that opioid deaths are rising around Australia and in particular in Victoria and that the majority of those are from prescription or pharmaceutical opioids.

We need to have a system that actually encompasses all those drugs. The other issue is the so-called new and emerging psychoactive drugs, which are now far exceeding the number of drugs that are under the conventions - the UN conventions - and we don't have really a coherent response to those drugs and they are causing problems for us. We had an example which we've published about in a hospital where 11 young people presented simultaneously to the emergency department, having taken an unknown substance. Four of them were very severely unwell and had to go to intensive care, overloaded the emergency department and at the same time, this was from a so-called party boat so it happened on a long weekend where alcohol sales - takeaway sales were actually prohibited so this party was advertised as a place where people can buy alcohol and drink alcohol for the whole afternoon on the boat.

Because it was billed as such there were reportedly a number of police in the queue lining up for the party-goers to actually go on to the boat, so the police had sniffer dogs there and under the pressure of that kind of surveillance - this is what people reported to us, I don't know if it's true or not - people consumed more than intended amounts of this unknown substance. So within a few hours the boat actually had to turn around because so many people were unwell on the boat and come back to shore and some police were called and were actually assaulted. So there were side effects for the police as well for this outcome and then a number of the people were very severely unwell.

So that kind of situation could have actually I think been avoided if we look at the kind of regulatory environment in which we are encouraging our young people to enjoy themselves.

The CHAIR — In that case –

Associate Prof EZARD — Yes?

The CHAIR — What would you have seen as the government regulations or what should have been in place, perhaps, to stop that particular situation?

Associate Prof EZARD — I think there are a few things going on here. One is that I think the evidence on the passive detector dogs is quite strongly that it's a very expensive intervention that is not very effective in terms of preventing drug use and sometimes has some of these unintended consequences, such as consumption of more than was intended or consumption of a substance which the person is not entirely aware of. So that was the first thing that I think could have been done a little bit differently. The second thing is we don't have a system yet in Australia for testing unknown substances. I look to the Netherlands as a good example of a health system that has put in place a surveillance system of 20 services around the country where people present voluntarily without fear of prosecution. They present a substance that they are intending to consume for the purposes of its psychoactive properties. That substance is then tested. It has a first-line screening test which is fairly qualitative in the sense that they use a colorimetric change test and they match it with a pill, they match it to a database and that's fairly qualitative. Then if it's a substance that is unknown to the front-line worker, it's then sent through to a central laboratory and some face-to-face harm reduction and health information is given to the potential consumer. But the

real strength for me for this system is you then have a network of 20 facilities around the country that is feeding into a diagnostic laboratory that has then the capacity to test in a real time of new and emerging substances that are appearing on the market.

That is one of the very useful kind of surveillance systems that is informing the whole of Europe in what's appearing on the market there and we don't have those kind of systems in Australia. Those systems can then be linked to databases from emergency departments, from ambulances, so we can do some triangulation so we can have some public awareness or some public health response if we do detect an emerging hazard that really is affecting the lives and the wellbeing of our young people and also older people in the community. So they're two things that I think we could have been doing. The third - I think there is some work that can be done in the kind of education environment with the organisers of parties and clubs and festivals to create safer environments and this - and not create a potentially hazardous environment as this one ended up being: a small boat on the harbour with many intoxicated people and probably no capacity to respond to that.

So that environment - we could be doing a lot more in terms of training party providers and organisers.

The CHAIR — Okay, all right - sorry, did I stop you in the middle –

Associate Prof EZARD — No, I'll stop now.

The CHAIR — Okay, all right. There are other questions, then, that people want to ask.

Ms PATTEN — I think it was interesting - the story that you told us about the young woman who had sought treatment from you after a referral from the supervised injecting centre. I'm wondering if you've got any thoughts about how we can improve that referring from the centre, because as you said with testing and with other things, it brings people into contact, which is that first step, which is a great thing. But I think even Marianne would say that somehow the next referral can be - the numbers are somewhat modest and I'm wondering how you would recommend we improve that?

Associate Prof EZARD — Well, I mean, one of the issues I guess is that we don't have medically-supervised injecting centres or drug-consumption rooms at scale.

Ms PATTEN — Right.

Associate Prof EZARD — There is one service in the whole of Australia and it's small, so one way to access that proportion of people who may be ready at that time to seek treatment is we probably need to be having more of those kind of services, and located in the locations where people are actually using drugs and probably expanded to include other drugs as well. Interestingly, we had a visit from someone from Denmark - from Copenhagen - that works in one of the drug-consumption rooms there and interestingly the majority of people were inhaling methamphetamine in that particular service.

Ms PATTEN — Right.

Associate Prof EZARD — It was a group of people that were very marginalised: they were refugees largely; they were not employed, they weren't engaged in the system, as such, in Denmark. So this service provided a whole range of other services for that community in terms of linking into education or housing or language training or other kind of supports that people need to actually make transitions to healthier lifestyles.

Ms PATTEN — I found that really interesting, and you're the first person that I've heard mention the link between the ban on pipes, the ban on the sale of pipes and the move from inhaling to injecting. I think that is very interesting: have you seen any papers?

Associate Prof EZARD — I want to stress that that's anecdotal.

Ms PATTEN — Right.

Associate Prof EZARD — That many of my other colleagues have also seen it but we don't have data on that.

Ms PATTEN — Don't have data on it - okay.

Associate Prof EZARD — We did try and look to see if we could get data on the transition to injecting but we don't have the data, no.

The CHAIR — Martin.

Mr DIXON — Nadine, the pill-testing regime you're talking about - you know, there was just a quick colour –

Associate Prof EZARD — The colorimetric test?

Mr DIXON — Yes, and then that next step - how long does all that take?

Associate Prof EZARD — So the colorimetric is instant but as I said, very qualitatively. It only tests for a few drugs, it only tests for the dominant drug in the mixed compound.

Mr DIXON — Yes.

Associate Prof EZARD — The –

Mr DIXON — That might happen on site at the –

Associate Prof EZARD — In fact, the Dutch have moved from an event to a fixed-site model because they didn't have - because there were so many new drugs they didn't have the capacity to test.

Mr DIXON — Okay, yes.

Associate Prof EZARD — So they moved to a fixed-site model and incorporated it into their surveillance system and the laboratory - it took up to a week for those results to be SMSed, anonymously, back to the potential consumer. But for me the main argument is it's then incorporated into the surveillance systems for the public health system.

Mr DIXON — I was thinking it was on site and thinking, "Gee, that's a quick turnaround."

Associate Prof EZARD — No, it was a week. There are - in Vienna, where they have very, very big festivals - 100,000 people over several days - there is an example of a proper, gas chromatography mass spectometry machine they bring in a container with technicians and they can turnaround those results within 20 minutes, they say, but that is a big effort from the community. Then the other piece about how much that actually changes people's behaviour, we don't know, but it's another question that we need to study so that's why, for me, the strongest argument is having that centralised database of the new drugs that are emerging.

Mr DIXON — Yes, yes. Somebody obviously - "I'm going to use this drug on the weekend so I'll go and get it tested now".

Associate Prof EZARD — It does imply that people have intent and planning and what the health providers in the Netherlands told me was sometimes there would be one nominated person in a group of people that was testing on behalf of other people.

Mr DIXON — Yes.

Associate Prof EZARD — So it had follow-on effects for that group of people.

Mr DIXON — Okay - thanks.

The CHAIR — Murray.

Mr THOMPSON — Just a quick question in passing, Associate Professor: that is, is the quality of one pill the same as the batch? Does one pill reflect the full batch or can there be variance within the batch if it came out of the same laboratory?

Associate Prof EZARD — That is just a fabulous question and we don't know the answer because we don't have so-called good manufacturing products for the illegal or the illicit market. We don't know if one pill is the same as the next or the next, even if it comes from the same producer in the same backyard or laboratory or factory,

depending on where it's made. We just don't know and that is one of the problems with the illegal regime. So even if we do have that kind of centralised system, the main strength of that is that you can detect new drugs that perhaps haven't been detected before or detect very strong formulations.

We haven't seen that yet in Australia but certainly in the Netherlands they're having very, very strong MDMA or ecstasy pills of up to 330 milligrams, which is enough to overdose one person if they took that pill so that kind of information is important for public health authorities to do some kind of prevention activity.

Mr THOMPSON — Just as a corollary question: the use of pills at large public gatherings with music is a phenomena that is not prevalent within my own electorate or within my own wider experience.

The CHAIR — Not that you know about.

Mr THOMPSON — My colleagues might be more familiar - in fact I have one colleague next to me who represents the high country of Victoria –

Ms PATTEN — Boom boom.

Mr THOMPSON — Which has some of the great country in the nation there. But I was just wondering about your view about the social phenomenon of rave parties with the use of pills as a practice and whether it's in the interests of the nation and future generations if pill-testing regimes were introduced that might become a right-of-passage and a norm for young people as they progress through their teenage years?

Associate Prof EZARD — It's a good question. I think if we look to experience from overseas the presence of those pill-testing facilities - whether they're very accurate or not-so accurate - doesn't seem to change the prevalence of drug use or the acceptance of drug use in those festivals. So if the festival is already one in which people are using drugs, despite the presence of sniffer dogs and other deterrent activities the presence of public health responses doesn't seem to - there seems to be no evidence that it makes things worse, if you like. It doesn't make people take more drugs. On the contrary, there are examples from some of those facilities where people have actually discarded their drugs because they found out it's not what they intended to take.

If there is any kind of drug-checking it needs to be in the context of a health response more generally so safe spaces for young people; places where people can come forward and say, "I've got a concern: I've taken something and I'm not well," or, "My friend is not well," rather than actually being afraid of prosecution; having first aiders on site, having non-judgmental health information. Those kind of things are also very important to prevent drug-related harm - not only the pill-testing or the drug-checking. The drug-checking will only go so far in preventing some of those harms: it needs to be in a much more comprehensive health-oriented response, I think.

Also we have to remember that most of our drug-related deaths are at home. They're not in festivals and parties so we need to have a much more comprehensive approach as well.

Mr THOMPSON — Understood and going back just slightly, the role of pills as a recreational form of ingestion at a music event - is that social phenomenon that ought to be encouraged within society, noting the risks, or is it something that should be curbed or stemmed in the public health interest?

Associate Prof EZARD — I think to me with all respect the question is not the question we should be asking ourselves because people are already using drugs and taking alcohol and what we're doing at the moment isn't working. So the question for us is how can we keep our young people safe and what could we be doing differently to prevent some of those avoidable deaths and some of those avoidable harms? That to me is the more important question and there doesn't seem to be in our society at the moment a relationship between a drug's illegal status and the prevention of using of that drug or if you turn it around, if you look in Portugal, the change in the kind of criminal justice system around drug use doesn't seem to have encouraged use either. So it's about changing the way we try and approach safety for the community, I think.

Mr THOMPSON — Yes - I note elegance of your answer, which I understand. It's also a question of - so there is a cohort that we need to look after and protect because they're already ingesting drugs. It's just whether by supporting that cohort if it became a cheap form of people being better able to relate to others under certain environments - whether it could lead to a wider prevalence of that taking place, where there are other harms.

Associate Prof EZARD — My biggest concern from that respect is alcohol. Alcohol is being marketed for a profit to our young people for precisely those reasons: to make people feel like they can socialise more easily, to perhaps make people slightly euphoric in those moments and we're seeing far greater harms from alcohol so this is where we need to have a - quite a consistent approach across all psychoactive substances, I think, so to be in an environment where alcohol is marketed to young people but a pill or a powder might be criminalised, is not actually providing us an opportunity to have an open dialogue with young people about how to be safe and not providing us with an opportunity to manage some of those harms.

So someone might have taken an illegal substance and is too afraid to come forward whereas if someone's taken alcohol, they come forward: "I'm really drunk."

Mr THOMPSON — Thank you.

Mr TILLEY — We can just have a brief conversation - I noticed in your submission, just talking about interventions just in relation to pharmaceuticals, the rising use - we hear pharm parties and those types of things now - just your view on real-time prescription monitoring? Do you think that - I haven't seen any mention of it in your notes at this stage.

Associate Prof EZARD — No, no - I haven't commented on it. Certainly as health professionals we get very frustrated by not being able to have any data when we have someone who says to us, "Yes, I've been presenting to multiple doctors to get medication." They can't even really tell us what they've been purchasing and from whom. To access that information is very difficult: the doctor shopping line has a very high threshold for testing positive. People can be asked to sign a document to get the information from the PBS if it's funded by the public sector. If it's privately prescribed there is no data at all and there is a time lag for about up to three months before that data comes through. So we do need some other way of actually monitoring prescriptions.

The experience of Tasmania is positive but at the same time, Tasmania is a very small State with a very few number of prescribers and a small population so it's perhaps more feasible to operate an effective system in a small state like that. In the more populous states I think we're going to need a combination response that includes educating prescribers. The doctors are the ones that are actually prescribing the drugs under pressure from the pharmaceutical industry, so we need to fix up that piece as well as the prescription drug monitoring piece. But I agree that we do need some comprehensive response to prevent that because we are seeing those overdoses. The US calls it an epidemic and I think we're starting to get to that point in Australia too.

Mr TILLEY — Are you saying it's ignorance on the part of doctors - no, that it's more this pressure from pharmaceutical companies than ignorance or a mixture of both?

Associate Prof EZARD — It's a mixture of a whole range of different things and, I mean, certainly we've seen - when I first graduated we hesitated in prescribing something like codeine, 30 milligrams, and now young doctors are prescribing oxycodone quite readily for something that we may have prescribed paracetamol for in the past. There is a little bit of a decreased tolerance to the prescription of strong opioids. I think we're seeing far greater - we've got the invention of fentanyl - it's a very, very strong opioid on the market and so there is a whole increased range of medications that can be prescribed and I think that doctors aren't skilled up enough to know how and when to prescribe safely.

The role of opioids in the management of chronic pain needs to be really addressed with our prescribers. What we see in the addiction sector is that people sometimes have had chronic pain, have a long-time opioid prescription and then they get referred to us after several years of being prescribed opioids and the doctor actually then realises there's an issue and so does the patient, so then they come to the addiction sector. But we could and should do something much earlier.

The CHAIR — So how does that happen, because it's almost not - I mean, government can have an influence there but who would be a responsible body for overseeing both testing of the effects of different prescription medicines or drugs and then providing independent guidance to the medical profession in regards to that?

Associate Prof EZARD — I think it's difficult from a state perspective. This is probably largely a federal issue because many of these medications are federal funded through the Prescription Benefits Scheme. That is potentially a place that we can look at controlling and limiting prescribing because we don't want to prevent people who will benefit from opioids getting them but at the same time we don't want to be encouraging the dependence

on those drugs. So we need to look at the system from both a prescribing and regulatory end, I think. We had a good example in New South Wales with the rescheduling of alprazolam. Alprazolam is a short-acting benzodiazopine and it was creating many problems in the community with misuse of that drug so it was rescheduled and the problem went away pretty much overnight, which we had seen previously with the flunitrazepam rescheduling 10 years or so earlier.

So there is a lot that can be done in terms of the regulatory system but less from the state and more from the federal end, I think.

Mr TILLEY — Notwithstanding the advice you've given this committee on that, any view on that, a real-time prescription monitoring - would that give us better data on - or a better indication of what's going around, what schedule, what class of drug?

Associate Prof EZARD — I think if we can look at that effectively, the implementation challenges - it would need to be effective to be useful and I don't know in detail what the implementation challenges might be, particularly if we want to include private and PBS prescriptions.

Mr TILLEY — Okay.

Associate Prof EZARD — I think the implementation will be costly and the benefit would need to be weighed up. In an ideal world, absolutely, as a practitioner I would find it useful but if we can look at some of the other elements as well, might be more effective in terms of resources.

Mr TILLEY — Sure.

The CHAIR — Yes.

Ms PATTEN — Again, with the stories that you told us about - as an addiction specialist it seems that you get to see people at a far later stage than you would prefer to see them and certainly the illicit nature of some of those drugs would play into that. I wonder if you could reflect on the Portuguese model, which through that decriminalisation has enabled treatment by specialists to come in at an earlier stage. If you might expand on your thoughts?

Associate Prof EZARD — Thanks for that question. I think there's two interesting aspects to the Portuguese model and one is that - one of its aims is to decrease stigma around substance-use disorders and I think that is something we really need to be addressing and the other was, as you alluded to, an expansion of treatment places. So we're in the situation in Victoria and in Australia where we don't have enough treatment places for people with substance-use disorders and we're not going to have a public health impact until we do expand those treatment places and divert people into that treatment earlier than they are already. So the treatment delay for alcohol is about 20 years in this country: for methamphetamine it's probably about 10 years. So we do need, as you said, to close that gap before some of the other harms set in and - that are associated with substance use.

Ms PATTEN — Has Portugal been able to do that?

Associate Prof EZARD — I don't know the data on whether they've actually managed to get people in earlier or younger, if you like - that's an easier metric to measure.

Ms PATTEN — Yes, yes.

Associate Prof EZARD — That would be a good question to look at. I'm not an expert on the Portuguese model but that would be a good question to ask.

Ms PATTEN — Yes. It's certainly something we're going to put to - so I think looking at age is an interesting point, because that would give an indicator of when people are coming into treatment intervention.

Associate Prof EZARD — Yes, age and gender also - I mean, we still struggle in this country in getting women into treatment and cultural diversity as well: so can we encourage people from a range of cultural backgrounds into treatment as well? So those things are important for the treatment sector. The kind of cost saving to the community are something that seem to be important from the Portuguese model in the sense that it seems to

be cheaper to treat than to jail people, which is probably what we would prefer to be doing in terms of public health approach as well.

The CHAIR — One comment that I'd be interested - you've worked in Victoria as well as New South Wales and in terms of medical professionals, capable, qualified to support people who have addiction problems - do we have a shortage there in Victoria? What needs to be done?

Associate Prof EZARD — There's a reason I'm in New South Wales and many of my other colleagues from Victoria are actually in New South Wales as well - the specialists in addiction medical profession is very small around Australia and aging, so there is probably about 100 in practice at the moment and very few of those are in Victoria so we do need to strengthen the specialists medical profession, but also the whole specialist treatment sector: not just doctors.

The CHAIR — But you're here in New South Wales - you say even though there's a shortage in Victoria so there are people who are prepared to pay you in New South Wales but not in Victoria? Is that the point you're trying to make?

Ms PATTEN — Right.

Associate Prof EZARD — In the public system, yes.

The CHAIR — Yes.

Ms PATTEN — So Victoria doesn't have an interest in –

The CHAIR — - funding in that area.

Associate Prof EZARD — The drug-and-alcohol treatment sector went through some reforms back in the early 2000s that saw - the late '90s, even - which saw a change in the model for the delivery of drug-and-alcohol treatment, through mainly non-government organisations and private providers. We're yet to see if the recent changes last year through Medicare for the billing of Medicare items by registered addiction medicine specialists, which was a big step forward for this country in November.

Ms PATTEN — Yes.

Associate Prof EZARD — Whether that will make a difference to the kind of distribution of addiction specialists around the country. We don't know yet. We need training places. We need to actually support the whole workforce to have the younger doctors training through.

Ms PATTEN — Is Victoria unique in that approach that we took?

Associate Prof EZARD — No. I think Queensland also went through quite some time there with very limited, quite restricted treatment providing as well. New South Wales is probably in a better position at the moment.

The CHAIR — But on that score, then, I'm still a little surprised to hear if you're saying that - as I understand it - the government sector didn't - or left that area and left it to non-government sector but then I'm still surprised that the private sector isn't employing people who have expertise in your area.

Associate Prof EZARD — Specialist doctors? No, not many.

The CHAIR — Okay - Murray?

Ms PATTEN — That's fascinating.

Associate Prof EZARD — It's not to say there aren't very, very good providers in Victoria: there are. I know of many good services but the population coverage is still, I would argue, inadequate.

The CHAIR — Yes.

Mr THOMPSON — Associate Professor, I understand that there has been an increased dependency on prescription medicines in Australia. What are the causes for that and what are the solutions to it?

Associate Prof EZARD — The causes are multiple. One of the important factors is the prescriber: someone has to be actually prescribing the drug of dependence. The other factors are individuals factors, so related to somebody's predisposition to developing dependence on anything. There might be social factors and one of the things that we see in our treatment population - particularly strong - is a history of trauma, multiple trauma, particularly in early childhood. So if you have any of those predisposing factors plus something else, plus doctors prescribing the medicines, plus the doctors encouraged to prescribe the medicine, plus remuneration framework that encourages shorter consultations at that first point of call, plus our medication funding support, system, which is great but also doesn't limit someone to an individual doctor as in the UK.

People can then actually develop a dependence and maintain that dependence for quite some time. So we need to be addressing all of those issues, as well as the broader social issues about why somebody might actually have a predisposition to a dependence in the first place, and why those issues aren't picked up earlier and people diverted into treatment earlier. Some of the responses need to be at a broader level: so even down to early childhood, some of those kind of early childhood support programs that you see in - Fitzroy Crossing has a great example. June Oscar presented a great example from Fitzroy Crossing where they are being providing support for the zero-to-threes, that actually encourages some prevention of intergenerational trauma passing on and providing some kind of structure for them, for the next generation coming through, as well as for the already-affected generation.

Those kind of initiatives we need to be looking at, as well as the kind of regulatory and legislative environment.

Mr THOMPSON — How addictive is the drug ecstasy, or the drug used in pills that are provided to rave parties?

Associate Prof EZARD — Sorry - could you ask the question –

Mr THOMPSON — How addictive is a pill that has ecstasy in it or how addictive is the drug ecstasy or is it a drug purely of choice with no addictive features?

Associate Prof EZARD — That's a really great question: we actually try and avoid this idea of a substance being more addictive than another but there are certainly some substances that tend to have a higher rate of dependency amongst the regular users than those that don't use at all. MDMA seems to be on the very low end, so clinically we rarely if ever see anyone who comes forward with a primary MDMA-use disorder. Some of the other substances are much more harm-promoting. We do occasionally see people presenting with an overdose, who may have had too much or may have taken MDMA in combination with some other anti-depressant-type substance that would increase the risk of some overdose effects.

So we do see those acute harms but in terms of those long-term dependency kind of harms, we rarely see them.

Mr THOMPSON — Thank you.

The CHAIR — Can I just ask - I'm surprised that you haven't at this stage talked about a heroin trial, for example, as somebody working in your area. If you just want to make a couple of comments about how that would assist?

Associate Prof EZARD — Thank you for the question. I do see many people for whom our current evidence-based interventions are not working - so methadone and buprenorphine. Many of those people are at extreme risk of harm or already experiencing harm and we're frustrated that we don't have something else to offer that very small group of people and I think that injectable opioids of some sort - heroin or some other injectable opioid - would be of benefit to that community. Certainly experience from Netherlands, UK, Germany, Switzerland, Denmark, suggests that for that small group of people, heroin-assisted therapy is actually quite effective.

It's very expensive to deliver on an individual basis. I'd like to see it as part of a more comprehensive access to drug treatment across the country. We still have less than half of the people who would benefit from opioid substitution therapy actually receiving it in this country so we do still have that treatment gap and the notion of getting people into treatment earlier and preventing some of the prescription opioid dependence: those things are at a public health level very, very important. But as a clinician, to have that other additional treatment option, that would be very useful, I think, in my mind.

The CHAIR — Khalil had a question too, didn't you?

Mr EIDEH — I'm wondering if you can elaborate more or further on your recommendation removing barriers for non-injecting goods routes of administration?

Associate Prof EZARD — Thank you. So that was the point I was mentioning before about the slightly, seemingly contradictory - from a public health point of view - situation wherein we have needle syringe programs and the use of injecting paraphernalia is not prosecuted. Whereas smoking paraphernalia is, and I know that that legislation was enacted to attempt to prevent the harm from smoking methamphetamine, particularly, but what we are seeing now is that kind of contradictory public health situation in which people may be encouraged to transition to injecting and not smoking.

Certainly some of the clients that I've had - patients that I've had contact with - have described that transition or described relapsing and not having access to pipes because they've thrown them all away and instead having more ready access to injecting paraphernalia, which potentially could be more harmful for them.

Ms PATTEN — Fascinating.

Mr EIDEH — Thank you.

Mr TILLEY — Just quickly if I may just go back to prescription heroin: you just made mention there why on an individual case it's so expensive. Is that to do with the PBS?

Associate Prof EZARD — Just in terms of the service-delivery model that I've seen from other settings, that requires multiple supervised injections in one day every single day. So setting up that kind of facility with health providers with two or three nurses on at any one time is quite an expensive facility and you'd need to have adequate through-put of patients who are taking the medication so the costing for that is quite an intensive kind of model.

Mr TILLEY — Okay.

Associate Prof EZARD — It would depend on the model. I mean, I know that in the UK they used to give people a week's worth of prescription and you take it home, so it would depend on the model. I do think there is probably an argument for injectable treatment even if it was legal. So it's the same argument that we look at for people who run into very severe problems with alcohol, that perhaps those people also would benefit from a structured environment where they're given alcohol regularly so even though it's a harmful drug, it's the structured environment that some people need.

Mr TILLEY — Yes.

Associate Prof EZARD — So I think it's a separate clinical question from the legal status of the drug.

Mr TILLEY — Okay.

Mr THOMPSON — I'm just trying to get my head - trying to understand that. So I've been advised by other clinicians that suggest to me that heroin in its purest form - in a pharmaceutical grade - is the cleanest, probably safest if it's administered properly than anything else when it's clear of cutting agents and other rubbish and everything else that comes onto the street. Would that be a fairly accurate statement?

Associate Prof EZARD — Pharmaceutical heroin?

Mr THOMPSON — As being clean and the purest of its class?

Associate Prof EZARD — Well, it's a pharmaceutical opiate like morphine so in that sense it's - if it's pharmaceutical grade, it is free from the other risks of not knowing the dose or the contaminates or being able to administer a clean product.

Mr THOMPSON — But as being administered in the longer term on the persons ingesting it - I mean, the effects on their body are in stark comparison to what's been.

Associate Prof EZARD — It's certainly much safer. Before we were in this kind of environment that we are now, there are examples of very high-profile, high-functioning people who were heroin-dependent. So it does

depend very much on the dose and what else is adulterating the substance and how it's used and preventing those repeated small overdoses that people sometimes have that gives them hypoxic brain injury, presenting injecting-related complications like endocarditis or thrombosis or any of those other kind of blood-borne virus transmission. So we can prevent all of those by having a pharmaceutical product, absolutely.

Mr THOMPSON — Yes, okay - thank you.

The CHAIR — Fiona.

Ms PATTEN — I just wanted to touch on what you mentioned about access to treatment and we - the system for opioid replacement therapy in New South Wales is slightly different, a different model to Victoria. But we're coming to some circumstances that there are retiring chemists, retiring prescribers: so we're actually coming to a dangerous position where we're not going to have the providers for replacement therapy. Can you think of how we can get more people into opioid replacement therapy? Do we need to fund it better so the financial burden is not there? I'm wondering how we can better establish our ORT?

Associate Prof EZARD — Yes, I mean, removing some of the financial barriers to access are important: removing some of the stigma around access to treatment are important.

Ms PATTEN — Right.

Associate Prof EZARD — Training up - we've been trying to do this, we still haven't really worked out how best to do it - but training up primary care providers to prescribe Suboxone (R) (buprenorphine naloxone) preparations. That's quite a safe drug, it's quite easy to learn how to prescribe it and will increasingly have a place in the management of prescription opioid dependence as well. So skilling up the primary care sector and having a strong referral network then, to provide that specialist advice for more complex presentations and more severe dependence so that the GPs are also not afraid that they will be caught in a situation that they really can't manage and that can be quite unsafe. The mortality rate in an opioid-using population is far higher than a non-opioid-using population.

So rightfully, doctors are afraid to work in that setting if they don't feel adequately skilled, so we do need to provide the referral networks, we need to provide the training support and we need to expand access in a primary level to some of the other medications that are not methadone but other opioid treatments. I think some of the new preparations that are coming through might also have an opportunity for us - some of the injectable preparations may be useful; injectable buprenorphine. We need to, as a community, be providing research effort into the field as well, to be working out how to better treat some of these problems, like opioid dependence.

Ms PATTEN — Thank you.

The CHAIR — Murray has got the last one.

Mr THOMPSON — Associate Professor Ezard, the committee has received evidence about the potential role of GPs to provide localised early interventions to relieve pressure on drug treatment services - what is your view on this?

Associate Prof EZARD — Yes, thanks for that question. As we were just discussing I do support the strengthening of the primary care sector in managing early intervention and also providing some of the more advanced intervention such as opioid substitution therapy for less complex presentations with the support of a referral network. So it is very important to not only skill up the general practitioners but provide them with the regulatory environment where they can actually prescribe some of these medications like buprenorphine, naloxone, but also referral networks so that they feel supported in advice and in ongoing referral support for people that are more complex.

Mr THOMPSON — There is the network infrastructure on the ground to enable this to be undertaken through the GP networks and training?

Associate Prof EZARD — We're hoping that the primary health networks might offer an opportunity in that space. We're yet to see how that will evolve and I imagine it will be different in each of the 31 primary health networks. So there does need to be some effort in coordinating those networks and in coordinating the GPs and

strengthening them and that's something that could be done at a statewide level, I think. We're yet to see those very strong networks that we can build on at the moment. There are some initiatives that I can think of that are very exciting and are going some way towards skilling up some of the GPs but we need to be doing more.

Mr THOMPSON — Thank you.

The CHAIR — Okay. Thank you, Nadine.

Associate Prof EZARD — Thank you.

Witness withdrew.