T R A N S C R I P T

LAW REFORM, ROAD AND COMMUNITY SAFETY COMMITTEE

Inquiry into drug law reform

Melbourne — 8 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

Professor Dan Lubman, director,
Dr Matthew Frei, clinical director, and
Dr Christian Smyth, special adviser, Turning Point.

Necessary corrections to be notified to executive officer of committee

The CHAIR — I welcome the representatives of Turning Point. You may have heard in terms of written submissions we have had 220 written submissions come to us, and this is the first day of public hearings where we are actually able to hear from some selected groups that have made submissions to us and some who have not. I note Turning Point have provided us with a very useful submission, and this is your opportunity today to highlight some of the key issues and for us to tease those out as a committee.

You are aware that Hansard is recording all that is being said, and you will get a transcript of that in a couple of weeks to check over before it goes onto the public record. I think those are the key items that I need to make clear. It is a public hearing, as you are aware. If you need to discuss anything confidentially, if you highlight that, we can discuss whether we can do that. I will hand over to you to raise the issues that are in your submission and we will follow up with discussion.

Prof. LUBMAN — First of all thank you very much for the chance to present to today's inquiry. We really welcome the clinical spotlight that the committee is bringing into the area of addiction, and it is really welcome from our point of view.

It is a really great opportunity to present today, and just to give you a bit of context, for those of you who are not aware, Turning Point is a large national addiction treatment centre. We are very fortunate in terms of being unique in having three distinct arms that allow us to really have a comprehensive view around the area of alcohol and drugs and addiction. We have a very large treatment program where we see about 3000 people a year through our clinical services which are at the coalface talking to individuals and families about their issues. We also run major helplines both in Victoria and also nationally. We run the Ice Advice line and DirectLine, we run Family Drug Help after hours and we run the Drug and Alcohol Clinical Advisory Service, which is a service that GPs and pharmacists ring for advice around addiction. So again we get a very good picture of what is happening on the street and what issues that families, individuals and other professionals are dealing with in this area.

We also are a major training provider. We train multiple workforces in competency-based training, everything from short courses to masters programs, and we teach multiple workforces from police and education through to a range of health and welfare agencies. And so again we hear the issues that welfare, health and a range of other industries are dealing with in this area.

And, finally, we have a very large research program which we will talk a bit about today as part of our submission to this committee. We are very fortunate to have one of the leading national population health datasets in Australia and internationally. That gives us a really great picture around what is happening in the area of alcohol and drugs, and we also are at the forefront of developing clinical policy responses in this area.

I will not reiterate the submission that we gave you because we obviously want to give you as much time as possible for questions, but the context, as you would know, is alcohol and drugs. The whole area of addiction is in the public eye. We have a whole range of other areas in the health and welfare area that intersect, whether we are talking about mental health, homelessness, family violence or domestic violence — all overlapping in the area of addiction. We are seeing major changes in patterns and substance use. As many people would have already alluded to, we have got this whole issue of this increasing tsunami of prescription drug use and the challenges that that brings to the community, and there are three areas where we want to raise the attention of the committee. The first is in the area of surveillance. So in terms of surveillance, if we want to have good drug law, if we want to think about what we need to do in terms of policy and practice, we have got to have good data. I think there are opportunities in this space that we can talk to around what is the state of the data currently, where are the gaps and where are the opportunities? We have been leading, nationally and internationally, in terms of providing really robust, good datasets to really inform good policy for reform and good policy and practice initiatives.

The second area we want to raise is the area of pharmacotherapy, which I am sure other people would have raised. Prescription drugs are, I suppose, this hidden issue in our community. It is an issue that overlaps enormously with the area of addiction, but it is something that is yet to really raise its head in terms of its impact in the community. We have got some grave concerns around governance of this issue and there are some opportunities, I think, for us to think about how we manage this issue much better. We want to sort of raise those issues with you and to think about what that means in terms of what we need to do in the next two to three years.

The final area, I suppose, is just what other people would have raised as well, is the next steps in terms of particularly areas of harm reduction. Particularly it is really welcome to hear Fiona Patten leading a whole drive around the issue of trying to understand different harm reduction initiatives, and certainly we welcome that. I am sure other people will talk more eloquently about what is happening overseas, but we really support the idea of looking at evidence-based harm reduction initiatives.

The CHAIR — All right. In starting off, can I just ask you in terms of the data that you have on Victoria overall, what are the key issues? Richmond has been raised as a focal point perhaps, but in terms of looking at the picture across Victoria what are the key issues that your clinicians and so on are providing about the picture across the state overall?

Prof. LUBMAN — For those who are not aware, about 15 years ago during the last heroin crisis we were fortunate enough to get funding in partnership with the Department of Health, Ambulance Victoria and ourselves to create an internationally unique dataset, which is called the ambo project. Essentially we get clinical notes from Ambulance Victoria. We take those clinical notes and we have a team of coders who then go through those clinical notes and actually document a whole range of different variables in those clinical notes, and through that we are able to identify a whole range of alcohol and drug issues. We are able to identify prescription drug issues. We are able to look at a whole range of other comorbid factors — police co-attendance, where things happen. All the data is geospatially coded and time stamped so we know exactly when things happen, where they happen — whether they happen at the person's residence or whether they are happening in a particular location. More recently we have been coding for issues like violence, so we can look at where there is violence on the scene, and where there is violence towards police or towards ambulance or towards other people who were involved. We can code for whether children are present, for whether there is refugee status, whether there are family issues — a whole incredible richness. We are also now looking in that area around mental health as well, so around self-harm, suicide, self-injury.

The dataset gives us an incredibly rich dataset — feeding on from what the coroner talked about — around non-fatal harms related to alcohol and drugs, and to really see the huge burden that alcohol and drugs plays on our emergency services. That dataset really has been fortunately the go-to dataset for us and the state government in terms of a whole range of policy initiatives. But I do think there is a whole range of opportunities in that space in terms of how that dataset is potentially linked or explored with police data, because obviously there is a whole impact, as you would be aware, of alcohol and drugs on other emergency services, such as police, and I think there is an opportunity to think about how we bring those datasets together to have a much more nuanced view of the burden on the community and what impacts there are.

Because we are able to look at point of contact we can actually look at where things are happening, trends over time, and it gives us a very timely sort of indication of what is happening. We get the data two months after it has occurred, so it gives us a really great indication of when we are seeing changes. That allows us to think more broadly about population and planning, but it also allows us to think about hotspots, it allows us to even think about predictive forecasting — to think about if we could identify issues as they arrive, starting to model where that might happen across the state.

In terms of what we see in that dataset, we see an enormous amount of presentations in ambulance datasets around alcohol and drugs. Whereas for issues, for example, like a heart attack or a stroke, where it is really imperative for the person to get to hospital as fast as possible, we often see transit times under 30 minutes. In the area of alcohol and drugs and mental health as well, what we see are very complex social issues. So often there are one or two ambulances there, or often police are involved, and often rather than 30 minutes we are talking anywhere between 2 hours and 6 to 8 hours. So we are seeing a huge impact on our emergency services.

When we started working with ambulance services around this they used to say, 'Our core job is really treating physical illness'. What we find from our data is that about 30 per cent of call-outs are alcohol and drug or mental-health-related. So in fact they are a de facto alcohol and drug mental health service, yet paramedics do not train in this area, they have very limited knowledge and skills in this area, but it is something that they see every day. It is one of the things that we need to think about. When we are thinking about holistically the breadth of services that are actually involved in the treatment of alcohol and drugs, we need to think about our frontline emergency services and what role they have to play in this place, because many people who we see often present for the first time, they do not identify that they have an alcohol and drug issue, so there are opportunity for opportunistic linkage to a whole range of other services and supports.

The other thing that our dataset allows us to do is to drill down on particular drugs and drug types, so, for example, it is the only dataset that allows us to look at crystal methamphetamine and the issue of ice and how that is changing in the community. If we look at ED datasets, hospital datasets, they sort of code more broadly for the category of stimulants, which includes a whole range of other drugs, or the ambulance dataset looks at particularly codes for methamphetamine. So in that dataset what we have seen is a dramatic increase across all areas in presentations related to methamphetamine. We are also seeing dramatic increases in prescription drug presentations, particularly in regional areas where illicit drugs traditionally have been much more difficult to access but where prescription drugs are widely available and there is significant harm in that space.

Mr EIDEH — Can you provide details on Portugal's public health model for treating serious drug addiction and what the evidence from Portugal could mean for Victoria, in your view?

Dr SMYTH — Portugal changed their drug policy early in 2001. They recognised that they were spending an overwhelming percentage of their money on police enforcement and basically they turned it upside down. When we look at the Portugal model it is always easy to just look at the flip in the model and the funding, but the most important thing I think Portugal did is it integrated social policy as well as the health changes that it made. It used the money that it would have used previously in enforcement to put into that area. So you are talking about changing your client group's relationship with their behaviour but then giving them connections — 'linkages' as Dan would say — into housing, into employment, into other areas, which takes the pressure off the welfare budget and that actually starts to change their possibilities. It provides hope.

So it was really thinking about not just putting bandaid solutions in, which is always really the problem in the AOD sector; it is the poor man of the health portfolio, and a lot of that is because we never really know quite what to do with this cohort of people. Portugal was really the first country or jurisdiction that thought, 'Actually, let's put a pathway in that takes them from their initial presentation all the way through to what the mental health commission would refer to as a "contributing life". Let's imagine these people getting to a place where they are so socially connected again that they can also provide connections for the next tranche of people who might be thinking about medicating in that way'. So it is health services integrated with workforce and with housing.

What Portugal had was that if you were caught I think it was two or three times with a certain amount of drugs, then you would go to, if I remember rightly, some sort of panel that would have an interaction with you and it was a much more empathetic interaction. What we have seen is that the war on drugs, unfortunately for tabloid thinking, does not really work; it is not the most cost-effective way of engaging with this particular issue. So we have to think: if we were looking at this from a cost-benefit point of view, we would be thinking much more intelligently about how we could engage with people in the communities. And as Dan has said, if we can get back to data and if we can get back to population health planning, like we would do with cancer treatment, with diabetes management, with any chronic disease management, we would be a lot further down the track than we are at the moment.

Mr EIDEH — So you recommend for this to be implemented in Victoria?

Dr SMYTH — I think that Portugal has started a conversation internationally in terms of addiction, treatment and policy thinking. Victoria has got a very good, long history of being progressive in terms of its policy approach in this area. I was at an addiction conference a couple of weeks ago where it was mentioned that when Sydney was looking like having the first supervised medical injecting centre Melbourne's policymakers were saying, 'We'll have five of these up before you get one'. That was the landscape back then in 2001. Things have changed a little bit unfortunately in this state. But I think actually at the moment there is an atmosphere for some possibility, some movement, in that space.

Mr THOMPSON — With a supervised injecting centre, who carries responsibility for the product that is injected at a supervised facility if it turns out to be deleterious and someone dies at the centre or within the precinct of the centre?

Prof. LUBMAN — It is about models of care, really, and good governance.

Dr FREI — What we have got to say about that is that there are people dying now because illicit drugs are of unknown composition and potency. I think the positive thing about a supervised drug-using facility is that it does have access not just to long-term treatment but to acute treatment. With nursing staff on site, I think that

model has been demonstrated to work in the King's Cross safe injecting facility. The way I would see it is that in a safe injecting facility there is immediate access to care, much better than people would get injecting in the alleys of Richmond. I am not sure if that answers your question, but that is —

Prof. LUBMAN — Maybe if I just follow up on that, I think it is clear when you look at drug policy globally that no matter the initiative, people still choose to take drugs. I mean, there is no country in the world that does not take drugs, and there is a diverse range of different approaches that are trying to make people not use drugs. Even in our prisons, which you would argue are the safest place to be, people are still using and injecting drugs, so if we cannot stop people using drugs in prisons, I do not think we have much hope in the community. So the question is, and it relates to the previous question around the Portugal model: if people are dying because they are choosing to inject things, what is our responsibility in terms of minimising harm related to that and reducing the risks in association with that?

You would be well aware of the history of the medically supervised injecting centre in Sydney in terms of it having three external evaluations over its tenure, all of which have had consistent results in showing that not only do they increase safety but they reduce the number of overdoses and they also get people into treatment. They reduce the amount of crime and other associated activity on the streets, and they are well received by the community.

Unfortunately we are in, as you would be aware, a very complex space. I suppose I am always amazed when I think back on my training. I trained as a doctor, and when I started training I used to see people come and present to me when I was doing, say, general surgery training. Women used to come and present with end-stage breast cancer. They would come with big fungating breast tumours. That is largely because there was so much stigma around cancer in those days and people did not feel there was an adequate treatment, so people used to be so embarrassed about it and used to cover up and not seek treatment. We used to have this huge delay between people recognising they were having problems and overcoming that stigma and coming to seek treatment.

In the last 34 years people have been raising money for cancer. They are always proud, everyone is out, everyone is talking about it, and now we are into early intervention people want to get to treatment as fast as possible. We have seen this massive change around stigma and around cancer. If we look at skin cancer and how people respond to skin cancer, we have seen these massive changes. The biggest issue we have in addiction is that, on average, from the time you develop a problem to a full recovery is 27 years. The reason that is is because on average it is a decade from when you develop a problem to when you actually seek help. That is largely because there is this massive stigma in the community, because we have a whole range of messages in the community that basically demonise you and tell you that you are a very bad person. It is very embarrassing to get help.

When I started in psychiatry we used to have this period when people developed psychosis. On average it was five to 10 years before people got help when they were psychotic. Then we had a whole national approach which said, 'This is not good enough. We need to get people in early. We need to stop the trajectory. We need to have early intervention'. Now we have all these early intervention services that target reducing the duration and treated illness for psychosis down to about 18 months. We have had a massive investment, a massive change in campaign and a massive change in attitudes.

I think the big elephant in the room is the fact that we have very mixed messages out there in the community about alcohol and drugs, so people do not seek help, families do not seek help and families do not seek support. Then we are left with people doing things that are pretty desperate and that most of us cannot understand because it seems like, 'How can you do that when you know there is a risk of you putting your life in harm's way?'.

I think there is a bigger question here about what we do about the stigma. How do we overcome the stigma? How do we change community attitudes? How do we make people get help quicker? How do we even make help accessible? We have all these treatment services. We have run DirectLine for 20 years. It has never, ever been advertised or promoted. If we look at all the messaging around gambling, around cancer, around smoking, there are messages everywhere, but in terms of alcohol and drugs we have never had a positive media campaign about the fact that there is help available — you know, 'Ring this number. There's lots of help available. Treatment works'. All we hear is essentially messages in the media that basically say, 'If you use drugs, you are an evil person and you should call the police because people are dangerous'.

When we think about drug law reform and think about the messages more broadly, how do we overcome that stigma? How do we make sure that by the time people present for treatment they have not blown all their bridges and they have not ruined their social networks and social supports? How do we make sure that they are not in an alleyway shooting up because they have got nowhere else to go because they are homeless? How do we make sure we catch them early, provide support — like we do for any other health condition — and get people the treatment they need as quickly as possible?

Ms PATTEN — I have not heard that cancer analogy before. It is a really interesting way of thinking. Looking at the statistics, Australia really is punching above its weight on overdoses at 88 per million compared to anywhere else. Why? Why are we so much worse than the UK? Our laws are not that different. With the UK's approach to harm minimisation, maybe they have gone in leaps and bounds ahead of us, but why are we so significantly higher than the rest of the world?

Prof. LUBMAN — I will make a couple of comments and pass it over. I trained in the UK and worked in the UK. I think for all its faults with the NHS, the issue is at least there is a systemised approach to health care. It is a really clear mechanism and pathway where you go for treatment. The first port of call is always your primary care provider.

Ms PATTEN — And there is more training at that level?

Prof. LUBMAN — There is more training. There is training for all primary care providers in addiction. I used to work in an alcohol and drug service in the UK. The way they configure them in the UK is they have community drug teams and alcohol drug teams that are based at primary care. They sit in community health, so they sit alongside the general practitioner, so there is a really clear pathway for that. They have had a whole range of campaigns — the FRANK campaign — around having the conversation about alcohol and drugs, promoting that treatment works, promoting the different treatment options. There is a whole systemised approach and there is a whole strategy around making sure that people get help.

Australia has its pros and cons. We have a really good healthcare system, but it has a number of different components to it that do not necessarily talk so well to each other. We have primary care, which is a great system, but largely it is private practitioners running their own practices. They are sort of disconnected then from the alcohol and drug agencies, which are often state run. There is not a really good intersection with them. There is no overarching narrative around alcohol and drugs and treatment — where to get treatment and how to navigate the system.

We have been involved in a number of major studies looking at clients' pathways and families' pathways through the treatment system. I think a common narrative that comes through that is that it is almost impossible to navigate the system. It is very difficult to know where to go, how to get help. Since then we have seen it recommissioned in Victoria, but we have not really done further research around whether that is working or not. Certainly people calling our helplines are still very confused about where to get help. We run the Drug and Alcohol Clinical Advisory Service for GPs and pharmacists, so I can tell you GPs who call us do not understand how the system works. They find it very challenging to refer to the system. They feel the system is unresponsive to their needs, and they find it very difficult to know what to recommend to their patients.

The other bit of history that I think is really important for you to understand is the era of the asylum. When there were still institutions, there used to be mental health and alcohol and drug services in those institutions. If I was a doctor training, whether to be a general practitioner or a physician, and I did my rotation at mental health, I would also rotate through the detox and I would see a whole range of alcohol and drug clients.

With deinstitutionalisation, what we saw was mental health move out into clinical mental health, into clinical hospitals, but the alcohol and drug system has been largely run through the NGO sector, which has been good, but there has been no medical oversight of that. In the last 15 years, if I had wanted to train in medicine as a GP, I do no rotation to any alcohol and drug services, so I do not see any alcohol and drug patients. So when I see alcohol and drug patients coming to my practice, I have as much knowledge about treating addiction as the general public. Because of that, I do not know what to do, so typically what I do is I do not ask questions. What we know from surveys and working with general practitioners is they do not ask because then they do not have to find out so then they do not have to do something about it. If they do find out, they do not know what to do and often they are at a loss. Often it is about, 'Who can we move this on to, because we feel out of our depth?'. There is a fundamental issue in the education of our primary care practitioners and a lack of knowledge,

attitudes and skills in that space that fundamentally affects early detection and early support of people with addiction and family members as well. That is a fundamental issue I think that we are still yet to address.

Mr SMYTH — It is also worth saying the quality of the data in terms of the end point, the coroner's data, I actually did ask the coroner's office that same question when I was putting those numbers together, and the anecdotal suggestion is that the Australian system records death data better in terms of what the causality might have been than the UK and other jurisdictions. But it does say something — —

Ms PATTEN — So it is not apples with apples, possibly.

Mr SMYTH — It is not necessarily apples with apples, although it is often apples and lemons with the health system, but it does say something if our overdose rates have been that high and they have been that high for quite a long time and we are still not doing much about attending to them. What do we refer to as quality of life? Is one person different to another as a human being just because of the behaviour that they engage in? Why are they behaving in that way?

Just one point that came to mind regarding your point, Mr Thompson, about the supervised centre in Sydney is that one of the fears in 2001 was that the consumption of heroin or the indication that now there was somewhere to go would encourage an expansion or increase in the number of heroin users. From what I remember the numbers did not increase. What did happen was that the number of avoidable overdoses reduced because they were happening in a clinical setting and people were able to get there and clinicians were able to respond appropriately at the right time.

It is worth also pointing out that just recently in New York the 27 000 Manhattan police force has been issued with naloxone so that they can attend to people straightaway, because that first half an hour or so is when you can address an overdose most effectively. There is a much more compassionate relationship with people and overdose. The fact that we know that more people overdose here than in the UK or elsewhere is something that perhaps we should be thinking about

Ms PATTEN — Yes.

Mr TILLEY — I can concur with that. The number of times people overdose in the street, and you say, 'You're going to have to breathe', and you are waiting and waiting there for someone from AV to turn up. Those are some interesting observations.

Just going off the back of when you were talking about the state of Victoria and mental health, has Victoria deinstitutionalised too much? Have we gone too far?

Dr FREI — I would think that the devolution of drug and alcohol services some 25 years ago to non-government organisations, as Dan has said, has had some positive points, but I think it also in some senses was an issue in that it basically was the death knell for public clinics and government or community clinics that had employed medical practitioners and a multidisciplinary team. In that sense it has had some unintended consequences. I think the motives were pure and good, but the outcome has been in this state that we have got a very, very shrunken public system to deal with drug and alcohol.

Prof. LUBMAN — I think the other comment I would make on that is that often, as you would be aware, the costs associated with alcohol and drugs are much broader. When we think about the department here in Victoria, the focus is very much on people struggling with addiction, but we know the costs associated with addiction are actually across our healthcare system. Many of the people who present to emergency departments and who stay in our hospitals are often there because of the contribution of alcohol and drugs to their illness or injury. Often because alcohol and drugs are a distinct sector that sits outside the public hospital system there is nobody actually in the hospitals supporting medical colleagues and nursing colleagues in that space to identify if there is an issue or to identify if there is something that can be done to link those people to treatment and support them.

So there is that huge gap in terms of the alcohol and drug system that sits within the treatment space, but then the broader healthcare system, both primary care and the public hospital system, are sort of disconnected from the alcohol and drug system. That means we are missing a huge number of people who are impacted by alcohol and drugs but about whom you would not have that stereotypical view that they are an alcoholic or a drug user.

They are middle-class people who are working, who drink too much and who fall over and hurt themselves or develop a variety of conditions — heart disease, liver disease. You might present, and because we have not trained any specialists they do not ask about alcohol.

We just did a study in a sleep clinic recently, and you would think that people who have problems sleeping and who go to a very expensive sleep laboratory would have a very detailed alcohol and drug history. We discovered that 10 per cent of people who were being referred had alcohol dependence and that the staff there were not really asking about alcohol. So I think part of this issue is, like I raised before, the fact that we are not actually training our medical colleagues to understand the role of alcohol and drugs more broadly in health diseases. It means that generally there is this agreement that we will not ask about it, so we do not ask about it in hospital settings, and we do not ask about it in primary care. We treat all these other conditions. We liberally treat other conditions without actually identifying that often alcohol and drugs might be the core of why people might be presenting.

I think this gets onto the issue of prescription drugs, which is obviously this whole issue of pain, chronic pain and what is chronic pain. What we have seen in the US is that there has been a very successful campaign by drug companies over a decade in terms of making pain the fifth vital sign so that everyone has to ask about pain, nobody should have unnecessary suffering and we should actively and aggressively treat people for pain, which has seen this explosion in treatment with opioids.

There is no evidence for treatment with opioids in non-malignant pain for longer than 30 days in terms of treatments. We have seen this massive explosion, and now in the US we are seeing the carnage associated with that — with doctors being sued, with a huge diversion of people from prescription opioids onto heroin. When they brought in real-time prescribing in New York, what we saw was a 25 per cent increase in heroin-related deaths. As people were refused their pain medications, or as the doctors felt uncomfortable prescribing them, they went and got something that was much more cheap and available, which was heroin, and we saw this massive increase in heroin.

I suppose one of our concerns is that real-time prescribing is a really great public policy initiative, but we also need to think about the supports that go in around that in terms of how we support the public and our medical colleagues in having the most appropriate clinical support in dealing with this issue.

Mr SMYTH — It is a bit like the metaphor of painting the walls in your house over and over again. Real-time prescribing is finally going in and taking all those layers off. What have you got underneath? An awful lot of infestation —

Ms PATTEN — You find that really ugly wallpaper.

Mr SMYTH — rotten floorboards and all the rest of it

Mr TILLEY — So I am just tipping that this committee has not had any submissions from any of the drug companies, have we?

Ms SULEYMAN — No.

Mr TILLEY — When we had the previous witness — I am not sure whether you were in the gallery at that stage — I asked a question: it is not the panacea, but I am interested to know a view in relation to naltrexone implants. In the state of Victoria over a long time there has been a lot of push back, but if there is something that you — —

Dr FREI — I think it is like anything. One of the things that I was thinking about when we were talking about evidence and Dan was talking about the training of medical staff is that when I started working in a hospital setting what I noticed was that a lot of senior medical staff would have an opinion about how to treat a drug use disorder or alcohol problems just based on watching television or general knowledge. They are getting better, but it seemed like the evidence was not an issue, whereas they would not proffer an opinion on, for example, how to treat heart disease or diabetes. There has been a different approach to the level of evidence for treating drug use disorders.

That goes to therapies for drug use disorders, like naltrexone implants. They have got a role, and they have shown some benefit in other parts of the world, but I think the level of evidence probably is not quite there yet.

My view is that we have got some really good treatments, particularly for opioid use disorder, where naltrexone has had a lot of focus, and that is methadone and buprenorphine. Particularly in this state I do not think we have quite got them right yet. They are treatments that we know are very, very effective. I think naltrexone will always have some usefulness, but it will be a bit of a niche market in a small group.

Prof. LUBMAN — I sat on the AH&MRC panel, which reviewed the evidence for naltrexone implants. I think Matthew's point is exactly right. Unfortunately in this space, I suppose in the whole area, there has not been much investment in a whole range of areas, including in looking at treatments. Drug companies particularly are not very interested in this market because it is a very stigmatised market, and it is not a very sexy thing to sell for them. Looking at treating heart disease or diabetes — nice, clean clinical disorders where there is no associated bad image — is something they want to focus on. Drug companies and pharmaceutical entities are really not wanting to invest in this area, and because it is a very small sector and because there has not been that much investment in research, there are very limited resources in terms of the development of pharmacological strategies.

Coupled with that we have families that are desperate to find a solution. As you would have heard, particularly when we talk about private rehabs, there are a lot of people in this sector, particularly in the private sector, who make grandiose claims around the efficacy of their approaches. In terms of pharma therapies like naltrexone implants I think the boasts around what can be achieved with naltrexone implants outweigh the evidence. Certainly what we found on that committee is that it is a very promising drug, but more research is needed, like it is in any area. We need a licensed product, we need to do rigorous testing, and then like any other product in medicine we need to then make recommendations to the public. But I think that because families are desperate there is often a call to sort of skip the evidence bit, like we do for other parts of medicine, and just say, 'Here's a panacea'. I think the evidence around naltrexone is not there at the moment.

Mr TILLEY — But if there is a finding and a recommendation possibly by the committee if this goes on, would it be a reasonable recommendation that a program in the state of Victoria, at the very least, be funded to have a look at some of those datasets? It is only one small part, let me assure you.

Prof. LUBMAN — Yes, I know. Certainly that was a recommendation of the committee. We would love to be involved in seeing a clinical trial get up and running in Victoria. Like in any area, people want options, and it is not one fix for everyone, so the more options we have the better. Certainly seeing some investment in a range of clinical trials for a range of different products to see what is more efficacious would be very welcome.

Mr TILLEY — Just one more word before you change over. We have not had this with any of the witnesses yet: synthetics. Can you give us some commentary in relation to synthetics?

Prof. LUBMAN — Synthetic drugs more broadly?

Mr TILLEY — Yes, we have not had anything on that.

Dr FREI — They more than anything challenge the kind of model of 'We've got to ban stuff' and 'We've got to regulate to keep this out of the hands of our young people and other people'. I think the issue around these novel psychoactive substances is quite interesting because legislation keeps trying to keep up with what is being developed offshore. In the UK they have had it very difficult, and I think here they find it very difficult. They are a good example of interconnectivity gone mad in that they are so accessible that people talk about these drugs, people order them online, and I think it is going to be very difficult to regulate them. My view is that we need to really think a bit more broadly and laterally about how to manage these new drugs, because I am not sure we will get on top of them by making them illegal.

Prof. LUBMAN — Can I just make a point on that. I think it comes down to surveillance again. One of the opportunities is to increase both the awareness of emergency services and frontline providers but also the community in terms of what is available, what is dangerous and what people should do about it. I do not know if anybody else has presented evidence, but there are certainly very good models overseas, particularly in the Netherlands, where they have a whole range of surveillance mechanisms around looking at emerging psychoactives, looking at dangerous drugs, getting them government tested and providing advice to the police, to ambulances, to ED and to the community about what is safe and what is not. Being on call for DACAS we constantly get calls from ED physicians saying, 'Somebody has come in. They've obviously taken something. They're in a terrible state. Can you let us know what the latest thing on the streets might be?'. Unfortunately we

do not have access to that data, so often those people are stuck in EDs or are taken to ICU, they are worked up and they are very expensive in terms of time and resources because people do not have the information.

In the Netherlands if they identify a bad batch, all of the hospitals and everyone is notified. So if somebody comes and presents to ED, you know that if somebody presents like this, this is what is most likely to be, this is the best way to treat it, this is what the best response is. We do not have that in this state. The police know, but nobody else knows, and I think there are opportunities in terms of keeping everyone on top of what is happening.

Ms PATTEN — But continuing to prohibit that will hamper that. Continuing reactive prohibition is going to hamper the evidence and data collection.

Mr TILLEY — We will have a bit of a chat later. There is the surveillance issue with just putting these measures in place first before you — —

Mr HOWARD — I am just concerned we have gone a fair bit over time. We will need to wrap it up in a moment. Natalie had a question too.

Ms SULEYMAN — Just a very quick question. Thank you for your presentation. I am really interested in harm prevention and early intervention. I think you mentioned the fact that there was a real issue with the connection between agencies, departments and in particular with alcohol and drugs being with the NGOs and not really linking to primary care in hospitals and so on. Previous presentations submitted were in relation to GPs having a lead role in prevention, and you have spoken about the education that is required in this field. My question is: how is it best to bring these bodies and the connectivity back and to have a first point of call for someone who already has a number of issues, including drug addiction maybe just in the early stages, without getting too lost in the system?

Prof. LUBMAN — I think an investment in developing clinical care pathways like we have for other disorders is needed. Again the analogy is: if I have a breast lump, I go to my GP. It is a really clear pathway of where I go, who I see, and everyone is aware of it. If I present to my GP with a methamphetamine issue, first of all I do not know whether he is going to see me or not, and if he does see me, I do not know what he is going to suggest and where he is going to send me. So there is a huge discrepancy in terms of clinical care pathways for other health disorders and for addiction.

I think the challenge is that we have got state government-funded AOD services; we have got commonwealth-funded primary care providers; we have got the PHNs now in this mix, who are commissioning services and commissioning different services; and then we have private providers. So I think we need to try and get into the room to have clarity of developing clinical care pathways in terms of understanding, when everyone is on the same page, what a consistent and efficient process for referral is. What can we agree on in terms of what should happen? What are the processes in terms of feedback loops, so the GPs are aware of what is happening? What do we need to do in terms of better support of them?

One of the challenges I raised before is around the role of the addiction medicine workforce. In every other area of health, if you have a problem, the standard model is that GPs refer to a specialist. They refer to a cardiologist, a respiratory physician or an oncologist. In the addiction space unfortunately there has been this disinvestment in the whole area of addiction medicine, so there are not clear addiction specialists to refer to. GPs are asked to refer to our kind of services, which are essentially faceless services to some degree. They do not have that personal relationship, and most of medicine works on the premise of having relationships — like in any other industry — knowing who you are referring to, having confidence in that person and knowing where to refer.

I think there are some challenges there in thinking about how we ensure there are adequate numbers of addiction medicine specialists in Victoria. I think you see in our submission that there is a huge dearth of specialists in this space. That means that GPs are not confident in terms of knowing who to refer to, and so we need to think about how they are supported. As Matthew has already said, because of the way that the services are funded, they are not funded to provide specialist medical support, so most of the NGOs do not have any link to an addiction medicine specialist. There is that sort of discrepancy between how we practice medicine and how medicine works for every other health condition compared to how we manage addiction.

Mr SMYTH — I will also just say, and we were talking about this before, that bed occupancy rates are relatively low at the moment in public rehab and detox centres, but the number of private detox and rehab facilities are going up, and they can charge anywhere between $5000, $10 000, $15 000 or $20 000 a month for individuals to go through what is a very traumatic and challenging time for them. In this vacuum there are others who are circling and thus seeing an opportunity, and I think there is a duty of care for those individuals there.

Mr HOWARD — Being aware of the time again, it has been a very interesting contribution. You are helping us immensely, and we will contact you, no doubt, if there are further things that we would like to follow up on at another time. Thanks for coming along.

Prof. LUBMAN — Pleasure.

Witnesses withdrew.