EDUCATION AND HEALTH STANDING COMMITTEE

INQUIRY INTO THE ADEQUACY AND APPROPRIATENESS OF PREVENTION AND TREATMENT SERVICES FOR ALCOHOL AND ILLICIT DRUG PROBLEMS IN WESTERN AUSTRALIA

TRANSCRIPT OF EVIDENCE TAKEN
AT PERTH
WEDNESDAY, 16 JUNE 2010

SESSION ONE

Members

Dr J.M. Woollard (Chairman)
Mr P. Abetz (Deputy Chairman)
Ms L.L. Baker
Mr P.B. Watson
Mr I.C. Blayney

Hearing commenced at 9.21 am

O'NEIL, DR ALEXANDER GEORGE
Doctor, Fresh Start,
examined:

CLAUGHTON, MR JEFF
Chief Executive Officer, Fresh Start Recovery Programme,
examined:

The CHAIRMAN: On behalf of the Education and Health Standing Committee, I thank you for your interest and your appearance before us today. The purpose of this hearing is to assist the committee in gathering evidence for its inquiry into the adequacy and appropriateness of prevention and treatment services for alcohol and illicit drug problems in Western Australia. You have been provided with a copy of the committee's specific terms of reference. At this stage I will introduce myself, Janet Woollard, and the other members of the committee present: Mr Peter Abetz, Mr Ian Blayney, Mr Peter Watson and Ms Lisa Baker. We have our principal research officer, Dr David Worth, and we also have Hansard with us today. This committee is a committee of the Assembly of Parliament. This hearing is a formal procedure of the Parliament and therefore commands the same respect given to proceedings in the house. Even though the committee is not asking you to provide evidence on oath or affirmation, it is important that you understand that any deliberate misleading of the committee may be regarded as a contempt of Parliament. This is a public hearing and Hansard will be making a transcript of the proceedings for the public record. If you refer to any documents during your evidence, it would assist Hansard if you could provide the full title for the record.

Before we proceed to the questions we have for you today, I need to ask you a series of questions. Have you completed the "Details of Witness" form?

The Witnesses: Yes.

The CHAIRMAN: Do you understand the notes at the bottom of the form about giving evidence to a parliamentary committee?

The Witnesses: Yes.

The CHAIRMAN: Did you receive and read the information for witnesses briefing sheet provided with the "Details of Witness" form today?

The Witnesses: Yes.

The CHAIRMAN: Do you have any questions in relation to being a witness at today's hearing?

The Witnesses: No.

The CHAIRMAN: In that case, we will start with George, would you please state the capacity in which you appear before the committee today?

Dr O'Neil: My capacity is probably as Dr O'Neil because I probably wear too many hats. I am the medical director of Fresh Start, so it is largely in that capacity, but I am also the proprietor of a family group, making implants, used to inventing, used to caring for patients in many different circumstances in the hospital setting, so it is best just as Dr O'Neil.

The CHAIRMAN: Thank you. Do you want to be referred to as Dr O'Neil or George?

Dr O'Neil: I prefer to be called George O'Neil, but just George.

The CHAIRMAN: And Jeff.

Mr Claughton: I am the CEO of the Fresh Start Recovery Programme and I appear here in that capacity.

The CHAIRMAN: Thank you. George, would you like to make an initial presentation? I believe you have a PowerPoint presentation that you want to walk us through as part of your submission. Would you prefer either to accept interjections as you are making your presentation or to wait until you have completed your presentation to accept questions from the committee?

Dr O'Neil: Janet, I am used to working with medical students and I expect them to interject any moment at any time!

The CHAIRMAN: Many thanks, George. In that case, would you like to start your presentation?

Dr O'Neil: I think that the butterfly [witness pointed to the PowerPoint slide] is symbolic of an organisation where you start with something that is not so attractive and release people from being trapped. The title "Antagonists in addiction medicine" is worthwhile explaining because in addiction medicine, doctors have got used to their role to play, the church has got used to its role to play and the 12-step programs have got used to their role to play. There has been a tendency for the doctors to keep people comfortable. There has been a tendency for the church to isolate you from the bad people and the bad place. There has been a role for the 12-step people to say, "Gosh, just concentrate on being good for the next three minutes and then the next three minutes and then the next three minutes." All three of these groups have a really useful place to play in the community.

I think the doctors have played an outstanding role, particularly doctors like Alex Wodak who are reminding people that these are really sick people and we have to accept them as they are; we have to be kind to them, because the community has not always been kind to them. So that sort of emphasis has come out. But in the process of bringing that emphasis out, you can be too kind to your children when they are bad. There is the process of love and discipline. It is my day-to-day circumstances to see the mother saying, "I can't cope with this person in my house anymore" or the wife saying, "He's drunk every single day", so the doctor can be kind in those circumstances, but you are left with the other party not surviving. Or you have the shire councillor who says, "We can't cope with these people in the centre of our town; we've got to move them out here." There is this transition of asking how long we can be kind, so the doctors have used what are called agonists. "Agonists" mean that if you are already a bit anxious or suffering dementia and you are taking pot every day so you are anxious, if I take the pot away from you, I give you a bucket of valium to keep you comfortable. But if I give you a bucket of valium to keep you comfortable, I am moving you from one thing that treats the anxiety to something else that is now addictive, or if you are on illegal heroin, I can move you to legal morphine or legal heroin. So we put up antagonists. Antagonists are otherwise known as blockers. Blockers need to be understood. I am talking on this slide for a fair while because I am trying to teach. If you have a five-year-old and the five-year-old is taken away and put into a quiet room where there are no adults, you can actually measure the pulse rate going up. If you had an intravenous line, you could measure the adrenalin going up, the noradrenalin going up, the corticotrophin-releasing factor going up and the steroids are being released. You could measure the opioids going up. You could measure the endogenous benzos going up, if you had very sophisticated equipment. As they go up, they occupy the receptor, and when you occupy the receptor, you wear out the receptors. When you wear out the receptors, your receptor tolerance goes down. When the receptor tolerance goes down, eventually you cannot produce enough opioids and you cannot produce enough valium, and the GP sits in front of this person saying, "You've got a very anxious child here. He's seven. He's got anxiety; if I give him a little bit of valium, it'll be the only way we can get to him sleep." So all these individuals who are sick and who are in front of you are essentially suffering from a stress-related disorder, and the stress-related disorder is from worn-out receptors. The use of antagonists is: if you put an antagonist into a worn-out receptor, you block that receptor giving feedback to some other part of the brain or if you put the receptor in just for a

few minutes or an hour or two, you can actually rest the receptor and the receptor heals, so you up-regulate the receptors and make the receptors more sensitive. So each time you use an ordinary medication, an agonist, you will wear out the receptor more and the reason you are seeing these sick people is because their receptors are worn out.

So you have these three groups—the church, the doctors, the 12-step people—that have been fighting for many years. They have been fighting for funding. They have been fighting for a position in the community. In the process of fighting as the fight has gone on, the doctors have said, "We're the key people", the church has said, "We're the key people", the rehab people have said, "We're the key people", the methadone doctors have said, "We're the key people", the 12-step people have said, "We're the key people." As a committee you are exposed to these groups of people that are all competing for funding. The use of antagonists just has not occurred. Antagonists have been around for 46 years, but they involve a lot of skill to use and they were not delivered in the right package. The work you have seen is developing the right package, developing the right treatment systems, developing the right detox systems and this has occurred over the past 10 years.

[9.30 am]

It has actually occurred over the past 13 years today, if you mark it down. Today is the anniversary of the first patient being treated in our naltrexone services in Australia, except for a tiny research trial. In terms of the service work, today is the thirteenth anniversary. It took three years to move from that position to being able to start the implant work. With the growth of those things, doctors have moved to a new position in Western Australia where they do not just keep people comfortable anymore. The doctors in Western Australia are saying, "You've got two choices; you can keep people comfortable, which prolongs their addiction, or you can actually assist them to give up their addiction". So we can prolong the addiction or shorten it. This concept of prolonging the addiction or shortening it has been controversial. It has always been controversial, because the church was interested in shortening it. The church would take people to the farm. On the streets, a person has a 2.5 per cent risk of dying, on the farm a person has no risk of dying, but on return to the city a person has a five per cent risk of dying. That statement is from Capelhorn, who published a journal article headed "Substance Use and Misuse" in 1998. I beg forgiveness for not bringing any papers with me.

The CHAIRMAN: That is all right. George, you said that the difference in the doctors' treatment in WA and the eastern states, and I can see that the main —

Dr O'Neil: The difference is 3 000 people on methadone and 3 000 people on naltrexone. In Western Australia, you have this picture now, after eight years, that the doctors who said that patients were not interested in getting better were wrong. Patients have been coming in off the street at a massive rate, saying "Please, can you help me get better," and their wives, mothers and families are coming with them. The biggest difference is that if you just want to be comfortable, you go to other doctors who can keep you comfortable, but you do not take the wife and say, "I want to stay on opiates". This way, you are actually treating the anxious mother and the angry wife.

The CHAIRMAN: How many other doctors, apart from yourself, are treating those 3 000 people who you have said are currently on naltrexone in WA?

Dr O'Neil: I have about five surgeons who will relieve me, I have one doctor taking a very heavy brunt of workload at present, and two or three other part-time people who just take the edge off.

The CHAIRMAN: Are they mainly involved with Fresh Start or are they external practices? Are these 3 000 naltrexone patients through Fresh Start?

Dr O'Neil: At present it is focused through Fresh Start, because the expense has to fall on somebody. For instance, doctors in Queensland are trained and I get an emergency phone call from a patient in Queensland saying that the doctor wants $3 000 cash up-front, because that is the cost, and then he wants another $3,000 slowly, but the patient does not have it. I am constantly caught

with doctors who are really enthusiastic to do the same work but even for doctors who have learnt the technology, the labour cost of pulling three or four nurses in on the day and doing a detox event is a great deal, but that is the only reason—that is the barrier for it not spreading. The political barriers, I might say, have settled in the last 18 months or two years particularly, partly because of official registration of the manufacturing processes, partly because of recognising those processes to the level of reaching international manufacturing standards. Naltrexone has been available since —

The CHAIRMAN: Going back to the 40 per cent and the two per cent, is that 40 per cent with implants in Western Australia and two per cent with implants in the eastern states? Is that patients or clients—I am not sure how you refer to them—coming over from the eastern states to have the implant here and then going back there, or is there someone putting in the implants in the eastern states?

Dr O'Neil: Patients do come over here. There are also a few copy implants. There are people who have always made implants in pharmacies, and those will last five or six weeks. There are some Chinese copies of the work I am doing.

Mr P.B. WATSON: How long do yours last, George?

Dr O'Neil: At present it is closer to 300 days, but most of the publications are about 150 days at this stage. It is 150 to 300 days. The first publications were in 2004 and we were maintaining one nanogram per mil for 280 days. But we have been making some manufacturing improvements, which are allowing us to take it to 300 days. If the work is properly funded and you give me another two years, I would expect to see us getting to 600 days or longer, but that is a fairly big jump in expenses and manufacturing and we are keen to get what we have got registered, for a lot of practical reasons.

Mr P.B. WATSON: To take it up to 600 days, do you have to put a bigger dose in or do you have to make a bigger patch?

Dr O'Neil: It is almost confidential information to answer your question. I have to change the manufacturing, but it is a polymer change. I have to make the materials last longer. That is technically possible.

The CHAIRMAN: One last question and then back to Peter: going back to the 3 000 people in WA with naltrexone, is that 3 000 heroin addicts? What would the percentage be for heroin and other things, and what other things are you using naltrexone for?

Dr O'Neil: I was trying to keep the figures mainly for heroin. I think you will find that there are another 600 or 700 people who have had amphetamines and alcohol treatments. The figures will be around 3 000 for heroin and probably about 300 for amphetamines and about 300 for alcohol. But our alcohol numbers would be much bigger if we had some funding systems that would allow us to grow it. I spent yesterday in Carnarvon looking at the alcohol problems in Carnarvon. It would be worthwhile to be able to grow that side of the work, because it is very effective.

The CHAIRMAN: I think this morning we want to focus more on the treatment, but if there is not sufficient time this morning, we may possibly have some further questions for you to discuss the funding issues, simply because we were a bit late in starting this morning. Peter, do you have a question?

Mr P. ABETZ: I saw some figures recently that Western Australia seems to be the only state where the number of people on methadone and buprenorphine is actually declining, whereas in the other states it continues to rise. That would appear to be due to the fact that naltrexone is a significant part of the treatment regime available in Western Australia. Do you want to comment on that at all?

Dr O'Neil: First of all, I think that trend is in some of the data I have read. I would be more interested in not competing with the methadone and buprenorphine people, because to some extent they are capturing the 40 per cent off the street. I would be more interested in the concept that we

are actually moving up to 80 per cent of the people being recruited into treatment. I think by having two treatments available, you potentially are recruiting more of the population. If you were just recruiting the same numbers of the population, you would be doing a bit of good in moving people from a treatment that prolonged their illness to one that shortened their illness. I think what we have been achieving and seeing in Western Australia is that there is evidence emerging that we are actually having a positive effect on the population by decreasing the number of people addicted. I think everywhere else the number of people who are retained by government addiction will continue to increase.

The CHAIRMAN: Is that decreasing by re-implanting the naltrexone on an annual basis? How are you defining success for these people?

Dr O'Neil: The success is defined by a new pattern of behaviour. I find it easiest to communicate to a group of you by describing one patient among a group of patients. I talked to a patient who flew in from Brisbane who would appear to be successful and non-successful, from various people's points of view. She is a 36-year-old who used heroin every day from the age of 15 to 25. At the age of 25, we put an implant in her, which is 10 years ago, and then she will have had two or three implants. She was opiate-free for five years in a row. She rang last week to say, "Gosh, I am using heroin. I'm stuck in Brisbane. I don't know what I am going to do to get rid of my heroin. Will you please pay my fare to Perth?" I said that I could not really. Eventually, I did, because I could not find any other way of treating her—I chased the Melbourne people and I chased the Brisbane people. We do send implants to Melbourne and it is a good service, but we brought her across. The truth is that she has only used opiates now for three months in a second 10-year period. She was using opiates every day for 10 years. She wanted to be flown into town on Saturday so that she would not mess up her employer and could get back to work on Tuesday. So we are seeing success if you define it as moving from a totally disorganised lifestyle to one that is virtually living in the non-opiate world 98 per cent of the time. She did not have an implant for five years, but she had a repair job done quickly and efficiently when she needed it. We are moving people from a lifestyle that would be social services, unemployed, no optimism and no ability to control their problem. If you start taking opiates at 15, as she did, then you have a growing-up disorder to change as well. We are seeing that sort of success in dozens of patients.

[9.45 am]

Ms L.L. BAKER: George, are you saying that does not happen with the other treatments?

Dr O'Neil: I will use the next two slides to answer that question. The next slide is a quick picture of the government's Next Step program in Perth. In these pictures I am not trying to say that one is right and one is wrong. The service in Western Australia because of what has been happening in the past 10 years is more comprehensive than any other service in any other state. Good things have been happening here. It is more good news than bad news. On the right-hand side of the slide, you will see that I am talking about 47 opiate detoxes finished; 47 detoxes finished is talking about the whole detox problem. There are people on the street. They have a 2.5 per cent risk of dying according to Capelhorn. If we detox them and they have no heroin for a week and then open the door, 80 per cent of them will use within an hour or two and 95 per cent will use within a month. Doctors have become more and more discouraged about putting the effort in. It costs $8 000. You see $14 000 there because there were 83 to start off with, but the others ran away. The real cost is not $8 000, which will occur in the Drug and Alcohol Office statement. The real cost will be more like $12 000, $13 000 or $14 000 because so many people run away. Ten years ago —

The CHAIRMAN: I know the Next Step program is a three-day program. Are you saying that that they may go in for one or two days and leave the program?

Dr O'Neil: Sometimes the program is four, five, six or seven days if you are keen to really detox somebody. If you do three days off heroin, by that stage you still have vomiting and diarrhoea and will not have recovered. If you shortcut it to three days, you have a 99 per cent chance of people

going back to using. If you can hold them for seven days, you will get 95 per cent going back to using. If you hold them for six months, you will get 80 percent of them going back to using. The success relates to how long you hold them. Seven days is the maximum in most of the central detox units. Detoxing was popular but it did not work. I am a fellow of the college of addiction specialists. The word "abstinence" has become a dirty word. This is what happens when you try abstinence. You lock the door. You get a nurse to look after them. You get them off the opiates. On the first day they are feeling horrible. On the second day they are still feeling horrible with vomiting and diarrhoea. By the third day they have a bit of diarrhoea. By the fifth and sixth days they are still feeling pretty terrible. By the seventh day they are looking at the sky and saying, "I will change my whole lifestyle". However, if you open the door, take the protection away and send them back the suburb where they came from, they will not survive. Doctors and specialists around the country no longer believe in abstinence. They do not believe in abstinence because that is a fact. They took 300 detoxes a year quite validly down to 47. If we compare the 47 on the right of the slide with the 3 000 on the left of the slide, it effectively means that if you use the government service, there is a one chance in 64 that they will try to shorten their addiction, 63 times out of 64 they will try to prolong your addiction with another opiate. They are not trying to prolong the addiction, but it is the only thing left to offer.

The CHAIRMAN: When you said the 3 000 previously, is that 3 000 each year or 3 000 clients in total over the past 12 years?

Dr O'Neil: I am talking about implant patients over the years. Becky was the Queensland patient I was talking about. I will not use her surname. She will have had three implants; one at the beginning of the 10-year period, one in the seventh year and one in the tenth year. She is attached to the program. She will ring every couple of months say "I am doing fine, I am doing fine" Suddenly she will ring and say "I am in trouble". That is a different program to coming in and having methadone each day. It is just a friendly phone call.

The CHAIRMAN: Is she one of the 3 000?

Dr O'Neil: Yes. It is a program where 600 or 700 people will need a repair job each year or who will come in for the first time each year. It is a different sort of service.

Mr P. ABETZ: For clarity, this is about Next Step, which is the government one, because that has 3 000 on it as well.

The CHAIRMAN: I was referring to the 3 000 that George gave us.

Dr O'Neil: Janet had a good understanding of it.

One of the questions that came out of that—for clarity for everybody else—was that with the naltrexone program you come along and you say "I want to change my whole lifestyle". You go on to naltrexone. The naltrexone gives artificial protection for 300 days. At the end of 300 days, 50 per cent of patients come back and have their implant. The other 50 per cent say "I am fine", "I am living with my mum" or "I have a good husband". They go quite well until they crash. When they crash, they need a quick repair job. They are in a program where they do occasional repair jobs, but very few of them use more than a couple of days. In a typical five-year period, people use for 10 or 20 days and they come for their repair job within a week or so. The repair job is necessary and appropriate. Fifty per cent of them never need a repair job. It is a different program from a methadone program where you come every day. Returning to the slide, I was trying to say that 47 on the right compared with 3 000 on the left brings you up to this one in 64 chance.—that is just historically because abstinence has become unpopular. It is expensive to do a detox. When we look at detoxes and the outcomes, Neil McKeganey—he is coming to Perth to give a lecture in a few months—has retrospectively been looking at thousands of patients in Scotland. He has come out and asked what we are doing. If you have 1,000 people who started on the methadone program, three years later 97 per cent are still using drugs. What tends to happen in reality is that you go on to

methadone for four months and you slide back to heroin for four months; you go on methadone for four months, you go on to heroin for seven months; you go back to buprenorphine for three months, you go back to methadone for four months. If you talk about being drug free, these people are on drugs 97 per cent of the time. The period of time of being drug free is very small if you follow them for three years. Again, these people are comfortable. They are not using as much—about 50 per cent of methadone people are using heroin as well. They are not driven to do as much crime as they would normally, but they are not getting better. A mother who is addicted to heroin—it does not matter whether she is addicted to heroin or methadone—is a little bit more ordered if she on methadone, but she is still addicted and she at risk of being stoned. She is still at risk of not noticing her child's needs, because you cannot notice other people's needs as much if you are full of opiates. The efficiency of people has decreased. The unemployment does not get back to normal as quickly as if they become opiate free. Unfortunately, Australia has become very methadone dependent. America was probably the leader in pushing methadone. Britain and Scotland have become particularly methadone dependent. But if you google "methadone" and "Scotland", you could spend the next half hour just looking at the newspaper articles. The public is now starting to ask if this is a good thing, whether we should be doing something different and whether they can do something different. Neil McKeganey looked at the rehab people and three years later he is saying that even if the rehabilitation cost $100 000, if you have a 25-year-old in front of you, although it might cost $100 000 to lock someone in rehabilitation for six months and do the retraining properly, at least 33 per cent of people are drug free three years later, and that is 10 times better than putting them on methadone if your aim is to get people drug free.

The next slide is a summary statement and is trying to get a picture of what is going on. With methadone, basically three per cent of people are drug free three years later. Detox is expensive and it really does not get people better. Rehab brings you up to 33 per cent but it costs a fair bit to provide care for somebody for a year. A naltrexone plant stops a person using and almost achieves the same as rehabilitation because it stops them using but they are at home interacting with people.

The CHAIRMAN: What are the side effects of naltrexone?

Dr O'Neil: There are side effects from oral naltrexone and side effects from implant naltrexone. With oral naltrexone a very high percentage is broken down in the liver straightaway. Nausea is on the list of side effects. With the implant, you are using a lower dose and it is delivered directly into the blood stream, so it bypasses the liver. You do not see the same level of nausea-type side effects. I think out of the 7 000 or 8 000 procedures, we would have removed a couple from nausea and a couple for chronic pain. People often go through a period of being stressed and they just want to back to heroin. Some of those people change their minds and ask for their implant to be removed. We went through a period of making fast-releasing implants, slow-releasing implants and medium-releasing implants. We had some fast-release implants that caused tissue reactions. That is now controlled.

The CHAIRMAN: George, a condition of the government's $500 000 grant last year was the appointment of an independent academic to assess and validate the current data held by you and the Fresh Start Recovery Programme and to provide a report on the suitability and rigor of the data in support of the application to the TGA for the full registration of the implants. Has that academic been appointed? Are you able to tell us who that person is?

Dr O'Neil: The advertisements are out. We are waiting for people to apply.

The CHAIRMAN: The second condition of the $500 000 grant was that an independent financial audit must be conducted into the Australians Medical Procedures Research Foundation and Go Medical Industries, which is the company that produces the implants. Have those audits been conducted; and, if so, can you provide the committee with a copy of them?

Dr O'Neil: I will ask Jeff to answer that question because he is most up to date with the current status.

Mr Claughton: The financial audit of Fresh Start is substantially completed. We just had a meeting. We are waiting for the auditor to complete its audit into Go Medical statements. It is a two-part audit. One was a full audit of Fresh Start for 2008-09. That has substantially been completed. The audit of Go Medical —

The CHAIRMAN: So Fresh Start is the Australian Medical Procedures Research Foundation?

Mr Claughton: Yes, that is our trading name.

The CHAIRMAN: So that part has been done?

Mr Claughton: Yes. As far as I know the auditor has completed all the fieldwork on that. He is still completing some of the fieldwork on the Go Medical audit, which is an audit of the cost of the production of the implants. We had a meeting last week at which that was advanced a little further. I understand that he has substantially completed the fieldwork for that audit as well.

The CHAIRMAN: Can we have a copy of the Fresh Start/Australian Medical Procedure Research Foundation audit? This report is not due to be tabled in Parliament until the end of November. When the audit is completed for Go Medical Industries, could you provide a copy of that?

Mr Claughton: I will make both audit reports available as soon as they come to hand, which I expect will be in July. That is the time frame the auditors have given us for producing their report.

The CHAIRMAN: Following on from that, the ultimate goal of the government's grant in May last year was for the naltrexone implants to achieve full registration with the Therapeutic Goods Administration. When do you anticipate full registration to be achieved?

[10.00 am]

Dr O'Neil: I was somewhat optimistic. If I could remove the clinical load from my back, which is not that easy to do, and if we could get the right resources together over the next six months, we might be able to compile all the documents, and that is speaking with a degree of optimism and with good insight as well. Then there is a 12-month process of that data being assessed by the TGA. That brings with it a formal marketing licence. We have a formal manufacturing licence, which has probably taken four years to achieve, but the formal marketing licence will take 12 months. Normally it is 280 commonwealth public servants' working days, which is formally a year, I understand. When that registration process is complete, but not before, we can then apply for PPAC listing; again, that is 280 working days under normal circumstances. We are talking about two and a half years from now before we actually see formal commonwealth funding support.

The CHAIRMAN: If it is two and a half years before that full commonwealth support and having heard you talk this morning about the heavy workload that you have with these people, the government has given this $500 000 grant, but have you approached the pharmaceutical companies to assist? I would have thought that if it is successful and it is approved, the pharmaceutical companies would see the profit in this method of treatment in the future. Have you approached them or have they approached you?

Dr O'Neil: Yes, and they have usually bargained to say there is a $6 million load that we have to carry. While continuing to give free implants or implants that I am not paid for to heroin addicts, they have said that I have to speak commonsense with them and they cannot do that. I said that I am not doing business with them. We have had that sort of discussion year in, year out. We are carrying a $6 million load in costs of just treating whoever is coming. We put a sign up outside 10 years ago to say that we will treat anybody, whether they can pay or not. The girl from Queensland insisted we pay the airfare as well as treatment costs. She did not insist but there is no other money for her.

The CHAIRMAN: Is the $6 million debts owed?

Dr O'Neil: No. If you treat people coming through, I have to take the responsibility for working with them and find the money to guarantee that I can treat the patients for 10 years in a row while everybody watched.

Mr Claughton: Can I make a comment as I think it might be helpful?

The CHAIRMAN: Yes.

Mr Claughton: Very clearly, there are two elements to this program. One is the development and manufacturing of the implant itself. Go Medical Industries is the O'Neil family company that manufactures the implants. The other element is the Fresh Start Recovery Programme, which is a not-for-profit program operated by an independent board and which agrees to treat patients for addiction, whether they can pay at the time or not. We currently have several hundred people on our books paying us $20 a week out of their social security to cover that treatment cost. If that is all they can pay, which it often is, it will take them up to six years to pay for the cost of one treatment.

The CHAIRMAN: For one year?

Mr Claughton: One treatment costs $6 000. Everybody gets a bill for $6 000. We get as many people as possible because less than one in 50 would pay the $6 000 up-front. Most people who can pay anything pay us over a long period, typically $20 a week. The Fresh Start Recovery Programme agrees to treat people, whether or not they can pay for the implant and the service at the time.

I believe we run an $8 million program; that is, for the 700 or 800 patients a year that we treat—we do 562 opiate detoxes in that—we estimate that the total cost of that, including the implant cost, the surgeon's cost, the GP costs, the nurses and administration costs, the rehabilitation and follow-up cost, is about $8 million per year. As CEO my job is to do that with less than $4 million cash. That is almost mission impossible. We do that because the O'Neil family provides the implants from Go Medical. It only invoices us when I say we can pay some of the money that we have collected from the patients. That is typically about 15 per cent of the cost of those implants. The O'Neil family company provides us with about 2 000 implants a year and we pay it maybe $300 000 to $400 000 for that. Dr O'Neil provides two days of surgery—they are typically 12-hour days—each week and does not charge us for that surgery time. In addition, we have 46 volunteers on our books who contribute their time free of charge. That makes up around $500 000 worth of contributed services. We get other contributions of goods and services to make up about $1 million worth of cost and we get about $1 million a year in donations. Basically, we run an $8 million program on about $4 million in cash, of which the state government contributes $1.2 million. That is really how I would like to form a picture of Fresh Start, which is the body that I am responsible for, and the O'Neil family, through Go Medical.

The CHAIRMAN: Jeff, you said that about 700 people come onto the program each year. Since it started 10 years ago, 50 per cent of the people who have come from the program are still involved.

Mr Claughton: In total, 6 700 people have been treated in the program. About half of those were treated with oral naltrexone when that program was running and the other half have been treated with the implant. We currently have about 3 000 active patients.

The CHAIRMAN: Of those who are not active patients, how many would you consider as success stories and how many have declined to use the service any more?

Dr O'Neil: You are asking me for information as accurately as I can give you. When we started a naltrexone service, people used oral naltrexone. We went to a lot of trouble. We followed them for long periods and confirmed that 60 per cent of them were doing well. I am left with an impression that about 2 000 of the first 3 000 patients got better and about 1 000 of them were still left on the heroin scene. They all have a risk of going back to the heroin scene some time after that but we made a big impact on a lot of very young users between 17 and 25 who grew out of their heroin addiction during the time we were treating them through the treatment and through their family falling into place. We have treated thousands of people who are better now. As Peter said, the impact on the Western Australian figures is starting to show compared with some of the eastern states trends.

Ms L.L. BAKER: I am trying to get some sense of some of the outcomes that you are talking about, Jeff. I need to confirm that I am thinking correctly about this. You said that it costs $8 million a year to run the service.

Mr Claughton: We are delivering value of about $8 million a year based on a treatment cost of $8 000 per patient.

Ms L.L. BAKER: If I multiply $8 000 per patient by 700, that gives you an approximate —

Mr Claughton: That would be $5.6 million.

Ms L.L. BAKER: Is that about what you think the actual costs of running the service are?

Mr Claughton: Can I just make the point that we if we had to pay for the implants, we would need to find $2 million. If we had to pay for the surgical costs, we would probably have to find another $1 million.

Ms L.L. BAKER: You can relax; I am not an economist. There are people who are economists who read this stuff so we need to be very clear.

Mr Claughton: That is how I get to that value. George is busting to tell you that there is plenty of statistical evidence that will tell you the cost of delivering an effective treatment. George often uses a figure of $6 000 and there is other evidence out there of $8 000 per patient. That coincides with the sort of data that we have available from our Fresh Start Recovery Programme.

Ms L.L. BAKER: I am getting there. I am not there yet so I will probably need to ask a few more questions.

Mr P.B. WATSON: Are these McKeganey stats from Australia or from overseas?

Dr O'Neil: They are from Glasgow. Those sorts of measurements have not been done in Australia. They provide a strong basis for understanding quite a lot of what is going on. I am very sure that patterns are similar here to overseas with regard to treatment.

I wanted to try to give a picture in terms of value for money. The first part of the picture in giving a comment on value for money was really just to make the statement that 80 per cent of our health budget goes into the last two years of life, so it is quite likely that if you get cancer of the oesophagus at 84, we will take the oesophagus out, look after you very well, put you into an intensive care unit and spend a lot of money on you but we will get an extra three or four weeks of life out of you in terms of quality of life. We are talking about 25-year-olds and babies born this week. This year 25 000 babies will be born in Western Australia. Eight to 10 per cent of those babies will be delivered into families with mothers significantly affected by addiction. The number of fathers affected by addiction will be higher than the number of women—probably a ratio of two to one. We are talking about 3 000 babies arriving into Western Australian families where one or both parents, maybe even 4 000 but certainly in the order of 3 000, have a very significant drug-related illness. The drug-related illnesses are affecting the reproductive age group and that continues to affect that baby and those two individuals around it. That runs DCP, it runs the jails and it runs the social services and people who give out the dole money. It is an enormous cost. The people who start smoking marijuana at the age of 13 produce 30 per cent less income per lifetime, according to the US figures and the National Institute on Drug Abuse.

Ms L.L. BAKER: When you start "start smoking", do you mean develop an addiction to marijuana or do you mean have a joint?

Dr O'Neil: The statisticians have looked at people who are marijuana positive at the age of 13 and followed them for 20, 30, 40 years and confirmed that they become non-motivational, involved in drug addiction, involved in jails and all those sorts of things. The cost to the government of detoxing for seven days is $8 000 and 50 per cent or 60 per cent run away, so it really costs $12 000 for an effective detox. These figures come from the NEPOD study from 2001, which you can pick up. It looked at these costs of detoxing and the fact that detoxing does not work. When you want to

get somebody free of drugs for another six months, you have to add this extra $20 000 on, which means that if you want to get somebody detoxed and free of drugs for six months, you are talking about costs of $40 000 to $50 000 because you take this $12 000 and you have to add $20 000 or $30 000 to it because it costs that much in government contributions to rehab. It really costs about $40 000 to get one person free.

[10.15 am]

If we can get 1 000 people, we have the sort of service that can get 1 000 people drug-free and clean every time we put an implant in. We could treat 12 people today, and I can tell the committee that none of those people will be opiate dependent for the next six months. To do that any other way would normally cost $40 000. If we multiply that by 1 000, we are talking about $40 million. If we invest $40 million, it does not matter; we are talking about young people who will get 50 years of benefit out of it. If we look at investing $40 000 in a young person who is 25, we can put it down to the fact that if they are 25 now, they will be around for another 50 years, and we will get our money back. It is actually very good value for money. We are not asking the government to give us $40 000 per patient, but we are saying that the government should give us a chance to treat 1 000 people a year. If the government gave us $8 million, we would be able to treat 1 000 people a year, and I do not have any doubt we will treat 1 000 people a year. Our clinic is closed every second week because we cannot find the money to make the implants; I have had to go and ask my wife for money.

Mr P.B. WATSON: We all do!

Dr O'Neil: I have asked my wife for $90 000 since December to buy the materials I need to make the implants. I am paying staff full wages—$100 000 a year to engineers and people who I have trained very carefully, but I cannot fund the materials to make the implants. I then have to close the clinic and the whole ship just comes to a halt. I am inefficient at present just because I am underfunded. But even though I am inefficient and underfunded, I keep the clinic open most of the time.

The CHAIRMAN: The $6 million that you put on the table—or $8 million, depending on where it comes from—is that Go Medical Industries, or is that Fresh Start?

Mr P. ABETZ: It is Fresh Start.

The CHAIRMAN: You are saying, George, that you are currently funding Fresh Start?

Dr O'Neil: Let me try to explain. I have to use my enthusiasm to go out and find the money to fund everything. I have to use that enthusiasm to fund all these people and run around to keep everything going. There are 90 wages that have to be found each week for Fresh Start. In addition, I have 15 staff who do nothing but make implants for Western Australian patients. These are high-quality guys; there are two or three with engineering degrees, and there are five or six of them on more than $100 000 a year. I cannot afford to not pay them $100 000 a year because I will never get those sort of people again. I have put the team together and I cannot afford to drop that team, because I am still growing and keeping the service going. I cannot run it on any less.

Mr Claughton: Part of that reason is that I cannot pay George for the cost of the implants he is supplying; I can only transfer to him what the patients pay us for the implants, and that, typically, amounts to about 15 per cent or maybe 20 per cent of the value of the implants that are being supplied.

The CHAIRMAN: You have now been open for 13 years; it is your 13-year anniversary. Has the situation got better or worse? I believe the research is now showing that the supply of opiates is not on the market at the moment, so the number of users is possibly —

Mr P. ABETZ: That is not true.

Dr O'Neil: No, that is not true.

The CHAIRMAN: Did I get that wrong?

Dr O'Neil: Yes, that is wrong.

Mr P. ABETZ: In 2000 there was a dip, but it has come back up.

Dr O'Neil: Yes, that is wrong, Janet.

The CHAIRMAN: I will first ask: has it got better or worse? Then we will talk about the numbers.

Dr O'Neil: There are two questions I will try to answer: whether things have got better, and whether there is adequate treatment in the country. The Taliban are a fantastic group in some ways; they tackled the suppliers in Afghanistan and took the supply of opium from 4 000 tonnes a year down to 1 000 tonnes a year; then the Americans moved in. When I say they are fantastic, obviously they are not really fantastic; there are a lot of things wrong with them!

Ms L.L. BAKER: I think we know what you mean!

Dr O'Neil: But somehow they took the world supply of opium from 4 000 tonnes down to 1 000 tonnes; please do not misquote me on the Taliban! That was a dramatic drop. In Australia there was a very large heroin supply and more than 1 000 people a year were dying; it was a terrible problem. Suddenly, 1 000 tonnes was not enough for the world, so the Australian supply dried up, because Australians do not pay as much for heroin as the Americans and Europeans do. Australia does not know what happened, but suddenly, in February and March 2000, there was a massive sudden drop in the heroin supply. The deaths went way down and it looked as if we would not see heroin for a while, but after the Americans moved in it went from 2 000 tonnes to 4 000 tonnes, then to 6 000 tonnes and 8 000 tonnes; production has gone up by 800 per cent. We are now seeing that on the streets; we are seeing people coming in. We are seeing heroin right around the country. People from Adelaide flew in last week and said to me, "George, it's down to $200 a gram; it was $600 a gram three or four months ago." It is a very significant problem that has not gone away. When it is not there it does not matter much, because the OxyContin the doctors are supplying have kept their business going because pensioners with back pain buy OxyContin for $100 a tablet. That business flourishes whenever the heroin supply dries up, so the number of people detoxing each week has not changed much over the past 10 years. The brand changes from government-supplied opiates to Afghanistan-supplied opiates. It is just a change in brand, but the numbers coming through stay pretty well the same.

The CHAIRMAN: We will have to finish soon because we have someone coming in at 10.15; there is someone waiting outside. You said that you are using Naltrexone for heroin, alcohol and amphetamines. Treatment for alcohol has been a large part of this inquiry. I think you said you had 300 patients or clients. Is that over the ten-year period, or are you using Naltrexone more now for people who have alcohol addictions? Has there been a change in the use of Naltrexone for alcohol or amphetamines?

Dr O'Neil: Alcohol presentations have increased a lot in last three years, but we have tried to keep it quiet because we are primarily trying to concentrate on treating our opiate patients. Alcohol patients are being sent to us more and more. We did a SHRAC study—State Health Research Advisory Committee—and we had 55 patients who were in and out of hospital, costing the state on average $10 000 per patient, and in the year following the treatment, 22 of those patients did not even turn up to hospital, and many of the others claimed that they were a lot better. That saved the state, just from 55 patients, $220 000 in fewer hospital admissions. That study should be available to the committee by asking for it.

Mr Claughton: I can make that available.

Mr P. ABETZ: You work with volunteers, which keeps the costs down. You were talking about around $8 million as the total value of the service that Fresh Start would provide if you were paying everybody an enormous wage for the professional services. I understand that you are struggling to

keep the doors open; you get about $1 million a year in donations and $1.2 million from the standard government grant, and last year you got $500 000 as a top-up grant. There is obviously a very significant shortfall there. What sort of money would you require in the interim until you can get the TGA registration? What sort of extra money would enable you to keep the doors open to the opiate-addicted patients who come to see you? Would an extra million dollars a year tide you over if the government grant went from $1.2 million to $2.2 million? What are you actually looking for?

Mr Claughton: I will answer and then George will answer, I am sure. I am looking for a recognition of the service work that we are actually doing. If we were able to receive part payment for each of those patients that we treat, it would go a long way towards making sure that the service was sustainable. I believe that that is the way to approach it, rather than saying, "Give me $1 million or give me $2 million". I can justify figure of between $1 million and $3 million; $1 million a year would be survival money and $3 million a year would mean that I could pay the sort of people that I need to put into place to ensure that we run a First World service, rather than a service that I am constantly told looks like a Third World service. That is a criticism that I find hard to bear, but I get it often.

Dr O'Neil: I was in Carnarvon yesterday working with the Aboriginal people there, and observed that every second person said that their son was in prison. We were talking about the one bed reserve in hospital for detox patients, which costs the hospital more than $8 000 a week, if there is a patient in. They were asking me how many patients they could send to me to be treated with my implants so that they would not have to be detoxed in the hospital. I told him that I am really short of implants and asked them to not send too many for the moment. That is how bad my inefficiency is. I would be saving the hospital $8 000 and saving the jails $100 000 for the year if I treated those people. It is like having my hands tied. In reference to the question that Janet asked earlier, I cannot go to the shareholders on St Georges Terrace and ask them to join me, because I am not making amazing profits and I do not have any intention to do so. I cannot go into a partnership with the pharmaceutical companies who want to work with me because they are not interested in spending $6 million or $8 million on local people. That ties my hands in that direction also. That is why I am coming to government and saying, if you are spending $6 million or $8 million every time and I can do it better, put down a figure for a detox that you think is reasonable—$2 000 or $4 000, whatever you want to contribute—and you will see us flourish and survive and actually treat the patients better, but you will not be able to effectively do a detox for less than $8 000. If it is government policy to keep them all addicted, it is bad policy.

The CHAIRMAN: It is a shame that you did not go for this TGA approval many years ago.

Dr O'Neil: That is an unfair comment, just like the statement about heroin. It is a grossly unfair comment. It takes 15 years and costs $800 million to develop a new pharmaceutical; that is the average cost. Everybody thinks I am doing badly; it takes 15 years, normally. The American government spent $3 billion trying to get Naltrexone to last long enough to be useful. At the end of the $3 billion they got a 28-day product that does not work, because 28 days is not long enough. They made business decisions along the way. I have actually done very efficiently to get this far in a 10-year period. To the people who are slinging mud and saying that I should have registered five years ago, I say that you cannot do this development program in that time; it is a very big development program. This is an enormous job that normally costs $8 billion and 15 years, and I have got there with $50 million inside 10 years. I have actually done well, and that is not a fair comment.

The CHAIRMAN: I was not aware of the fact that it normally took 15 years, but if you improved the efficacy, the money would be there today for these people.

Mr Claughton: I believe that we have proven the efficacy. We had two papers published last year. These were studies that started in 2005 and the papers were published in 2009, so that gives the committee an idea of the sort of time lag that this sort of work always suffers from. The fact is that

Vivitrex is an injectable form of Naltrexone. It is manufactured in the US and cost $3 billion to develop. It is a 28-day product, and we have people flying from the US to Perth, obviously full-fee paying patients to get our implants, because they have been on Vivitrex for 12 months and they actually want to do something better.

[10.30 am]

Dr O'Neil: It costs them $14 000 a year to be on Vivitrex for 12 months.

The CHAIRMAN: I have to wind up, but one other thing that you might like to consider is that when you say that the pharmaceutical companies are not interested because of the people who cannot —

Mr Claughton: They are very interested.

The CHAIRMAN: But because of the current terms that you have where people cannot pay, if you are looking for further funds from the government, maybe it needs to be looked at in terms of a public–private partnership. It is a lot of money. I will read the papers that say that this is successful but we have to make sure that the dollars are wisely invested.

Mr Claughton: I agree that the public–private partnership is well worth pursuing on the basis of the services that we provide.

Dr O'Neil: Can I make a cautionary comment? I have been to many meetings at the National Institute on Drug Abuse. NIDA has sat there with a dozen pharmaceutical companies in the room and me and asked why it has taken 46 years to develop the process of naltrexone properly. The big pharmaceutical companies are negotiating with me and the American government. Those pharmaceutical companies have recognised that this is a product where only two per cent of the people belong to families who will pay for it—as Jeff said, that is one in 50. The pharmaceutical companies have made deliberate decisions to not work with us because they know that 95 per cent of my patients will be non-paying and that it will take years to convince governments to join us. That is why the pharmaceutical industry is not responding. At the end of the day, you have two options with naltrexone implants. The first option is to treat the top three per cent of the population in America, Britain and in the European countries and Australia. That is considered to be the proper pharmaceutical business, which means maximising the dollar returned. Alternatively, you can go down a different route and decide to treat 95 per cent of the population because you change the country from which you operate, but you cannot do that unless the government joins you. Normal pharmaceutical practice does not apply if you choose to do that. When I say "normal", I have gone to the business meetings with at least eight companies, including the people making Vivitrol, and negotiated with them and the US government. The US government has told me to keep gradually getting there because none of the pharmaceutical companies who have had the opportunity of investing have ever got there. They have not got there because they did not take it seriously. I do not think that I am going to win by joining with a pharmaceutical group that will exclude 95 per cent of people in the world from getting this treatment. That route would be unethical in my eyes. I have tested it. I am not guilty of not going out and searching for it.

The CHAIRMAN: Thank you both very much for your evidence before the committee today. A transcript of this hearing will be forwarded to you for the correction of minor errors. Any such corrections must be made and the transcript returned within 10 days from the date of the letter attached to the transcript. If the transcript is not returned within this period, it will be deemed to be correct. New material cannot be added via these corrections and the sense of your evidence cannot be altered. Can we have a copy of the PowerPoint presentation?

Mr P. ABETZ: We have it.

The CHAIRMAN: Should you wish to provide additional information or elaborate on particular points, please include a supplementary submission for the committee's consideration when you return your transcript of evidence. Thank you for coming in. I do not mean that —

Dr O'Neil: You are supposed to ask me hard questions. I just wanted to thank the committee for giving us an opportunity to present.

Hearing concluded at 10.35 am