Submission No 48

INQUIRY INTO DRUG AND ALCOHOL TREATMENT

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NSW Drug and Alcohol Treatment Inquiry

General Purpose Standing Committee No.2

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1. Executive Summary

The Royal Australasian College of Physicians (RACP) welcomes the opportunity to provide input to the General Purpose Standing Committee (No. 2) inquiry into drug and alcohol treatment in New South Wales.

This submission makes a number of recommendations for the Steering Committee to consider.

Drug and alcohol treatment policy in NSW should:

- Build on successes in reducing smoking rates across the population, with a focus on disadvantaged demographics;
- Ensure that alcohol prevention policies be better considered, in consultation with the Commonwealth Government;
- Examine ways to continue supporting the Medically Supervised Injecting Centre (MSIC) at Kings Cross;
- Review options for making harm minimization the focus of illicit drug treatment policy;
- Put in place practical measures to reduce the growth in consumption of prescription opioids and benzodiazepines;
- Examine options for fostering a culture that respects the medical field of drug and alcohol treatment; and
- Support the management of cognitive impairment cases by guardianship tribunals and the Mental Health Act.

2. Harm reduction

The RACP emphasises that harm reduction should remain the focus of treating illicit drug users. This means ensuring all people being treated for illicit drug problems should be managed appropriately, including provision of treatment for physical and mental health disorders, regardless of the setting in which the person presents. The NSW Government can work to expand the capacity, range and quality of pharmacological treatments available for illicit drugs by:

- Substantially enhancing the funding available for staff and expand staff training at drug treatment centres;
- Increase research funding and remove political constraints on research options; and
- Improve training for all health professionals working with drug dependent persons and improve quality of treatment premises.

Australia has a long history of taking a harm reduction approach, first introduced in response to the threat of HIV/AIDS in the mid to late 1980's. We are now reaping the benefits of this early response with Australian prevalence of HIV/AIDS being some of the lowest in the world. Harm reduction

recognises that many people throughout the world continue to use psychoactive drugs. Harm reduction aims to reduce the economic, social and health related harms associated with the use of drugs. It can complement those approaches designed to prevent or reduce overall levels of drug consumption.

3. Nicotine

Tobacco is responsible for the death and disease of more Australians than any other psychoactive drug. It is also responsible for far greater costs to the economy than any other psychoactive drug. Half of all smokers will die from a tobacco-related cause. The proportion of the Australian population who smoke has halved in the last quarter century. Tobacco-related deaths are also declining.

The reduction in smoking has been the greatest public health triumph in Australia in the last half century. Most of this reduction was achieved by prevention policies including increasing the price of cigarettes, reducing the availability of tobacco, eliminating tobacco advertising and promotion, supporting and bans on smoking. Most recently, the Australian Future Fund agreed to divest itself of all tobacco holdings.

As well as a reduction in the rate of initiation, the rate of quitting has also increased. Although most smokers quit on their own, support for smoking cessation has contributed to the reduction in smoking prevalence. A major challenge for tobacco policy is to extend the benefits of low smoking prevalence to disadvantaged populations including Indigenous Australians, prison inmates, alcohol and drug dependent persons and those with severe mental illness. More emphasis is needed on smoking cessation in alcohol and drug dependent persons.

4. Alcohol

Alcohol causes immense social and economic costs. These costs include considerable violent and domestic crime.

The division of Commonwealth/state responsibilities complicates the problem of responding adequately to alcohol. States have limited input into Commonwealth taxing of alcohol products. Better consultation with the Commonwealth Government to improve alcohol policy could lead to NSW improving its health outcomes, and reducing expenditure on related costs such as hospitals and prisons.

There is evidence that supports the following policies in reducing alcohol related harm:

- Increases in the price of alcohol together with move to volumetric taxation (taxation according to alcohol content regardless of type of beverage);
- Decrease in the number of alcohol outlets;
- Closer regulation of conditions for alcohol outlets including shorter trading hours; and
- Treatment, care and support for persons with alcohol problems.

NSW should have a voice in all of these matters and will need to take the lead in increasing funding for alcohol treatment in the state.

5. Illicit drugs

The RACP emphasizes that harm minimisation should remain the focus of our approach to problems associated with illicit drug use. Australia initiated a harm reduction approach in response to the threat of HIV/AIDS in 1985. Harm reduction recognises that despite society's best efforts, many people continue to use psychoactive drugs. Harm reduction aims to reduce the economic, social and health related harms associated with drug use. There is overwhelming scientific evidence to show that harm reduction interventions are successful and cost-effective. It should be noted that a harm reduction approach can complement approaches designed to prevent and/or reduce drug consumption.

The NSW Government must re-define illicit drugs primarily as a health and social issue, rather than a criminal justice concern. The Government should take a longer-term view of community benefits when selecting interventions and invest in more cost-effective interventions which provide the greatest social and health benefit, and reduce investment in interventions weakly supported by evidence of benefit.

The Global Commission on Drugs in 2011 and both Australia 21 reports on illicit drugs in 2012 acknowledged the failure of drug prohibition. Mr Mick Palmer, former Commissioner of the Australian Federal Police, said in 2012 'Australian police are now better trained, generally better equipped and resourced and more operationally effective that at any time in our history, but, on any objective assessment policing of the illicit drug market has had only marginal impact on the profitability of the drug trade or the availability of illicit drugs.'

Health and social interventions are much less expensive and much more effective than criminal justice interventions. Yet the majority of drug-related expenditure is on law enforcement measures.

Drug treatment has been substantially under-resourced in NSW for decades. Capacity should be expanded, quality improved and flexibility increased. Drug treatment should be treated like all other branches of the health care system and should be based on scientific evidence for effectiveness, safety and cost-effectiveness. Funding for demand reduction and harm reduction initiatives should be raised to the same level of, if not higher than, what is currently being allocated to drug law enforcement.

6. Medically Supervised Injecting Centre (MSIC)

A substantive weight of evidence has shown that the MSIC in Kings Cross is a policy success on multiple fronts: it is saving lives, does not contribute to a rise in crime rates, represents an evidence-based approach to minimizing harms associated with injected drug use, and does not attract drug users to the area. During its first 11 years of operation, MSIC successfully managed 4,376 drug overdoses without a single fatality. Immediate intervention in non-fatal overdoses significantly reduces risk of injury. In the case of hypoxia (oxygen deprivation), tissue damage is directly related

to the duration of tissue hypoxia. Where adequately trained staff and medical equipment are available to intervene immediately and treat hypoxia, such as in the Sydney MSIC, permanent damage can be prevented.

Supervised injecting centres have operated in Europe since the late 1980s; however the first in the English speaking world opened in Sydney in 2001. Since this time there has been a large amount of scientific research reviewing their effectiveness, predominantly focussing on the Sydney and Vancouver sites. A recent review by the Drug Policy Modelling Program of UNSW showed that there were more than 130 published papers on supervised injecting centres, with research indicating some positive outcomes in relation to overdose risk, at-risk injecting practices, improved access to drug treatment, improved amenity, and reduced crime.

7. Pharmaceutical drugs

Prescription opioids and benzodiazepines are psychoactive pharmaceutical drugs of major concern in Australia at present. Consumption has been increasing for more than 15 years. Australia is following similar trends to the USA where high and increasing consumption of prescription opioids causes 15,000 accidental overdose deaths per year and many individuals seek help because of dependence on prescription opioids. Prescription opioid overdose deaths are also increasing in Australia, and now outnumber heroin overdose deaths. This is a difficult problem requiring national leadership and involvement of Commonwealth, state and territory departments of health. Short acting benzodiazepines are a particular concern and are mainly used by young Australians. National policy is being developed for benzodiazepine use. Improved funding of pain services that are available to all chronic pain sufferers is imperative if this problem is to be contained, as opioids are often prescribed for chronic pain due to inaccessibility of other, more effective options.

8. Attitudes to drug treatment

It is important when considering drug treatment to recognize that drug dependence is a chronic, relapsing-remitting condition. This means that for most drug-dependent people their condition lasts for many years and is often marked by periods of abstinence (remission) and sudden and often unpredictable returns to drug use (relapse).

Overall, the results of treatment for alcohol and drug problems are similar to the results achieved in many other areas of medicine dealing with chronic, complex, relapsing-remitting conditions such as obesity, diabetes, mental illness and hypertension. Many patients with alcohol and drug problems do improve. Some improve for only a short period, others for much longer. A lucky minority abstain from all drugs almost immediately following treatment and never relapse.

The community generally respects the views of doctors, especially specialists. Doctors study for a basic medical degree, spend years learning a specialty before spending decades providing treatment to thousands of patients, teaching, keeping up with advances, and conducting research. The NSW Government should work to foster a culture that adequately respects the views of doctors working in the alcohol and drug field.

The placement of Alcohol and Drug Treatment under Mental Health in NSW and other states/territories in the last decade has made drug treatment more difficult. Many senior clinicians working in the alcohol and drug field oppose this arrangement. Senior clinicians want to be able to relate closely to general practitioners, emergency departments of hospitals, public health and mental health. Changing this arrangement should lead to less stigmatisation for drug and alcohol patients.

9. Mandatory treatment

The only time when compulsory treatment is used in medicine is when an individual's capacity is impaired by cognitive impairment or mental illness. Cognitive impairment is currently managed well by Guardianship Tribunals and mental illness is managed by the Mental Health Act. These approaches can be, and are, used very successfully for people with alcohol and drug problems just as they are for people with other sorts of health problems.

Compulsory treatment is not more effective than voluntary treatment but it is more expensive and reduces the civil liberties of people with alcohol and drug problems. Severely intoxicated persons can be a short-term risk to themselves and others. Short-term compulsory care may be justifiable if used selectively and with appropriate oversight.

It is possible that expensive and cost *in*effective involuntary treatment for a small number of at-risk people would compromise less costly yet more effective voluntary treatment for a greater number of people with less severe problems. If evidence emerges in future that compulsory treatment is more effective, safer and more cost effective than voluntary treatment, then this policy should be re-considered.

10. Acknowledgments

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