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**RACP Submission to the NSW
Parliamentary Inquiry into the provision of
drug rehabilitation services in regional,
rural and remote New South Wales**

December 2017

Introduction

The Royal Australasian College of Physicians (RACP) welcomes the opportunity to contribute to the NSW Parliamentary Inquiry into the provision of drug rehabilitation services in regional, rural and remote New South Wales, which has the following Terms of Reference:

1. The range and types of services including the number of treatment beds currently available
2. Specific details regarding rehabilitation services for those with amphetamine and methamphetamine (“ice”) addictions
3. The qualification to receive funding as well as the funding arrangements for services be they public, not-for-profit, for profit or on any other basis
4. Registration and accreditation process required for rehabilitation services to be established
5. The cost to patients/clients, including fee structures provided to families, for accessing rehabilitation services
6. The waiting lists and waiting times for gaining entry into services
7. Any pre-entry conditions for gaining access to rehabilitation services
8. Investigate the evidence regarding the efficacy and impacts of mandatory detoxification programs for those who self-harm or are subject to an Apprehended Violence Order (AVO)
9. The gaps and shortages in the provision of services including geographical, resources and funding;
10. Issues relating to the provision of appropriately qualified health professionals to fill positions in rehabilitation services
11. Evidence of rehabilitation services that have had both successful and unsuccessful outcomes, including what characteristics constitute a successful outcome and how reliable is the data collection and reporting mechanisms currently in place
12. Current and potential threats to existing rehabilitation services
13. Potential and innovative rehabilitation services and initiatives including naltrexone and
14. Any other related matters

This is a much-needed Parliamentary Inquiry into drug rehabilitation services, with its specific focus on regional, rural and remote New South Wales. We know that there are significant issues with people who have drug and alcohol problems being unable to access the services they need in these areas of NSW, and Australia more broadly, despite high demand and need. Nonetheless, there is currently a lack of available data and information relating to unmet demand, which is a major barrier to improving the planning, resourcing and delivery of these services to vulnerable populations who are using drugs and/or alcohol.

In addition, one key issue which does not appear to be included in the scope of this inquiry is the availability of drug treatment services within prisons or upon their release, such as the Connexions program run by Justice health (for a limited number of released prisoners). This is a key issue as many prisoners suffer with drug and/or alcohol substance use disorders and although they may be motivated to address their disorder, they find themselves unable to access appropriate support and services on release. Another key issue that the Committee could consider is the availability of culturally appropriate services when considering the range and types of services available. The RACP would strongly recommend that both issues are further investigated by this Committee.

The RACP sincerely hopes that the information provided to this inquiry from experts in the drug and alcohol sector will be used to positively contribute to improving equity of access to evidence-based drug rehabilitation and treatment services for vulnerable drug users in regional, rural and remote New South Wales.

The RACP is the largest specialist medical college in Australasia, and trains, educates and advocates on behalf of over 15,000 physicians and 7,500 trainee physicians across Australia and New Zealand. The RACP represents physicians from a diverse range of disciplines including addiction medicine physicians and public health medicine physicians. RACP members see first-hand the many and varied harms caused by addiction when treating their patients in Australia's addiction clinics, rehabilitation centres, liver clinics, cancer wards, and hospital emergency departments.

This submission

In this RACP submission, the use of the term 'drug rehabilitation' encompasses the whole spectrum of drug and alcohol treatment services as commonly used in the drug and alcohol sector. These services are varied and include withdrawal ('detoxification') treatment, medication-assisted treatment, individual comprehensive assessment of drug and alcohol and related problems (i.e. co-morbidities such as anxiety and depression and other medical conditions such as Hepatitis B or C and other infections as well as related social problems such as homelessness, unemployment, domestic violence, etc.), treatment planning, drug counselling, hospital-based drug and alcohol consultation-liaison interventions, intensive outpatient day care programs, inpatient/residential rehabilitation treatment and harm reduction programs.

Drug and alcohol services intersect with a broad range of other services including Emergency Departments, medical services (such as gastroenterology, infectious diseases, pain services), maternity, surgical, mental health, justice health, Aboriginal health, primary health care, and community services including child protection, violence prevention, housing and employment. Typically, people with mild drug use disorders should be treated in primary care, although many primary care practitioners do not feel they have the skills or capacity to manage this group.

People with moderate to severe alcohol and/or drug use disorders require multiple types of treatment delivered by a trained workforce (i.e. addiction medicine physicians, addiction psychiatrists, specialist nurses, psychologists, etc.) over their lifetime and it is not uncommon for these needs to change over time. Comprehensive individual assessments are the appropriate starting point for treatment planning to identify the services needed for each individual presenting with substance use disorders.

We have structured this RACP submission as follows:

- Overview:
 - Drug and alcohol addiction: a complex, chronic and relapsing health issue
 - Illicit drug use in Australia
 - Alcohol and other drug treatment services: inaccessible, underfunded and overstretched across Australia
- Drug and alcohol use and limited access to drug and alcohol rehabilitation for people living in regional, rural and remote New South Wales
- Key principles for the planning and delivery of effective evidence-based drug rehabilitation services
- Concluding remarks

Overview

Drug and alcohol addiction: a complex, chronic and relapsing health issue

Drug and alcohol addiction is a health issue with complex biological, psychological and social underpinnings. It is a chronic relapsing, remitting disorder characterised by drug seeking and use that is compulsive, difficult to control and persists despite harmful consequences¹. The diagnostic term ‘substance use disorder’ in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) refers to recurrent use of alcohol or other drugs that causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. Substance use disorder is defined as mild, moderate, or severe.

The underlying causes of drug and alcohol addiction can be primarily attributable to environmental factors such as trauma, abuse, a chaotic childhood or home, parent’s use and attitudes, and peer and commercial influence, and also to biological factors including genetics, being male, and concurrent mental health disorders². Other social determinants that impact on a person’s substance use and dependency include their socio-economic status, housing status and security, and education. Substance abuse is a complex issue, not simply a personal choice. We are seeing the increasing emergence of intergenerational cycles of poverty, substance use, mental health and many other social problems.

Practitioners describe seeing the third or even fourth generation attending specialist treatment for substance use problems. It is also important to note that some substance abuse disorders result from drugs of dependence being prescribed by one or more doctors for the symptomatic relief of pain, insomnia and anxiety amongst other symptoms. While there are many reasons why people choose to try or take drugs – some highlighted above – it should be understood that repeated drug or alcohol use leads to changes to the brain that challenge an addicted person’s self-control and interfere with their ability to resist intense urges to take drugs.

The distinction between someone needing to quit drugs including alcohol because of a clinical need and their personal motivation to quit also needs to be recognised. Evidence and clinical experience shows that behaviour change is key to overcoming substance dependency; successful drug treatment requires some level of motivation from the individual involved to instigate and sustain this behaviour change. A 2016 systemic review found that current evidence on mandatory drug treatment is limited and in general does not suggest improved outcomes, while some studies showed potential harms³. We note there is a current review into the Involuntary Drug Treatment Program currently being run in NSW run at Royal North Shore and Bloomfield Hospitals.

The RACP believes that all drug rehabilitation and treatment services should reflect an understanding that:

- **Drug and alcohol use is complex and varied:**
 - Drugs and alcohol are substances that alter the way we think, feel and behave. People use drugs and alcohol for a variety of reasons (e.g. for enjoyment, to relax, to socialise, to avoid or reduce their psychological distress and/or physical pain, etc.).
 - The frequency of use varies widely from occasional use to regular and dependent use with a range of harms associated with different types of drug use, and different patterns of drug use. As such, although all drug and alcohol use has the potential to become harmful or risky and could reinforce maladaptive behavioural patterns, not all drug use will become problematic or cause health harms.
 - As the 1999 NSW Parliament Drug Summit showed, problematic drug use is associated with adverse childhood events including trauma and neglect, family violence, poverty, social inequalities, mental ill health, homelessness and isolation. Intergenerational cycles of deprivation and disadvantage are seen within families and across communities where

problematic drug use is most common. Thus if policies are to be effective at breaking this cycle, they should focus on health inequalities, and should cross portfolios outside health (such as housing, employment and education).

- Whilst we need to address the social norms that perpetuate views that drug and alcohol use can be an acceptable and effective way to cope, socialise, or to minimise internal distress, we also have to accept that **the use of drugs, whether licit or illicit, is a part of our society which we are extremely unlikely to eradicate fully and which will require ongoing regulation.** Thus, there is an ongoing need for effective, evidence-based policies focused on preventing and reducing harm to drug users, their families and society more broadly.

Illicit drug use in Australia

Illicit drug use, defined as the misuse of licit (i.e. legal drugs such as over the counter or prescription pharmaceuticals) and the use of illicit (i.e. illegal) drugs is relatively common in Australia. According to the 2016 National Drug Strategy Household Survey (NDSHS),⁴ 77.5 per cent of Australians had ever drunk alcohol, with 25.5% reporting monthly risk of harmful use and 17.1% reporting lifetime risk of harm. 43 per cent (or 8.5 million) Australians had used drugs illicitly in their lifetime and 15.6 per cent of Australians aged over 14 (or 3.1 million) had illicitly used drugs in the past 12 months.⁵ Of those 15.6 per cent, 10.4 per cent had only used illegal drugs, 4.8 per cent had only misused pharmaceutical drugs and 3.6 per cent had misused painkillers. The differentiation between illicit and licit drug use is not intended to pre-suppose the harms associated with these categories, as licit drugs (e.g. prescription medicine) can be used illicitly (e.g. sold, injected). It does, however, highlight that illicit use in and of itself has additional harms associated with prohibition.

In 2011, alcohol use disorders were responsible for 5.1 per cent of the burden of disease. Alongside tobacco use at 9 per cent; these two preventable risk factors are key priorities for Australia's future health (with co-use of alcohol and tobacco being common). Early use of tobacco and alcohol is known to be associated with later problematic drug use^{6,7} – so both are likely markers of those most at risk. Illicit drug use, including the impact of injecting drug use, cocaine, opioid, amphetamine and cannabis dependence, was responsible for 1.8 per cent of the total burden of disease and injury in Australia (although this probably under-estimates harm related to methamphetamine over recent years).⁸

Tobacco and alcohol are in the top five risk factors that contribute to the burden of disease, with tobacco smoking the leading cause of preventable illness and death in Australia.^{9,10} The burden of disease attributed to drug use has been increasing, moving from the 10th top risk factor for disease and injury in 2003 to the 9th in 2011, while alcohol remains a leading factor in disease for the first four decades of life and in later life.¹¹

Drug use contributes substantially to social and family disruptions and can also be associated with community safety issues including crime and violence.¹² Drug use can also affect parenting abilities and children's development. The social and economic costs of alcohol were estimated at \$15.3 billion in 2008¹³, with a later estimate suggesting an additional cost of \$20 billion due to harm to others¹⁴. Illicit drug use has broad social and economic costs, which were estimated to total \$8.2 billion in 2004-2005.¹⁵ In 2009-10, the National Drug and Alcohol Research Centre, University of New South Wales estimated that the Australian Government spent approximately \$1.7 billion to tackle the issue of illicit drugs in 2009-10 with the bulk of it (64%) spent on law enforcement, compared with 22% on treatment, 9.7% on prevention and only 2.2% on harm reduction strategies.¹⁶

In 2016, the RACP, in collaboration with the Royal Australian and New Zealand College of Psychiatrists (RANZCP), released a comprehensive *Alcohol Policy* for addressing the significant harms caused by alcohol.¹⁷ This policy outlines in detail a number of measures to address these harms, including; putting the

right price on alcohol; further restricting its physical availability; penalising breaches of advertising and marketing restrictions; and, raising the minimum purchase age for alcohol to protect children and young people.

Alcohol and other drug treatment services: inaccessible, underfunded and overstretched across Australia

Alcohol and other drug treatment services in Australia are chronically underfunded and overstretched, despite compelling evidence of their cost effectiveness. The funding currently provided for alcohol and other drug treatment services is not commensurate with the needs of the population. In New South Wales, mental health treatments receive approximately 10 times the funding of alcohol and drug treatments, despite the fact that these conditions account for similar amounts of the total burden of illness¹⁸. A review in 2014 found that alcohol and other drug treatment services in Australia met the need of fewer than half of those seeking the treatment¹⁹.

The RACP and its Australasian Chapter of Addiction Medicine (AChAM) note that additional funding was provided to the drug treatment sector to support the National Ice Action Strategy, however this funding has not generally addressed the key needs of the drug and alcohol sector as its use is restricted under the terms of the funding agreement. The severe shortage of drug and alcohol rehabilitation services and specialists around Australia persists.

According to evidence submitted to the recent NSW Government Inquiry into Drug and Alcohol Treatment, current shortages of treatment services in NSW span from youth treatment services and residential rehabilitation places to ancillary services that support families of individuals affected by drug and alcohol use²⁰. Representations to the inquiry highlighted key workforce issues, in particular the insufficient numbers of addiction medicine specialists in NSW²¹ and poor retention of qualified staff due to a lack of service funding continuity. Access to quality treatment, delivered by a suitably trained workforce, is fundamental for anyone struggling with addiction, and this should be the main priority for policy development and investment in this area.

One of the key recommendations from the NSW Parliament's Final Report into Drug and Alcohol Treatment (2013) outlined that the NSW Government should ensure "that funding levels keep pace with the increasing demand for drug and alcohol treatment services".²² Exact data on waiting times is hard to obtain because it is dynamic – it may be as short as days to access in the private sector (which will be out of reach for people applying for welfare) and as long as weeks or months for public services. Our members indicate that there is currently a 6-12 week wait for alcohol and other drug treatment (depending on the type of treatment required) in many jurisdictions where treatment services are available.

Over many years, the RACP and the AChAM have repeatedly identified the underfunding of drug and alcohol treatment services as a matter requiring the urgent attention of successive governments. There is a shortage of addiction medicine specialists across Australia and this is felt most acutely in regional and rural Australia. In NSW, addiction medicine specialist positions are very difficult to fill outside the Sydney metropolitan area and there is currently no state or national approach to addressing these key workforce shortages. It is also common for rural areas to struggle to recruit nursing and allied health professionals for drug and alcohol services. Sustained, long-term funding to increase the capacity of drug and alcohol services to meet the demand for treatment, combined with real and persistent efforts to reduce disadvantage and inequities within society, is the only real solution to reducing substance dependency.

Due to the co-morbidities associated with substance use disorders, there is also a clear need for drug and alcohol rehabilitation services to collaborate closely with other mainstream health services including mental health, Emergency and Toxicology departments, community health, gastroenterology and infectious diseases, Aboriginal health, maternity services and child protection services, amongst others. However, many of our

members who are addiction medicine specialists have expressed significant concerns over the increasing merging of drug and alcohol services with mental health services and the negative impacts this is having on drug and alcohol clients. We are aware that this is a particular concern for our NSW-based members who have raised these issues over many years both at the State and Federal level. Of particular concern is the fact that target groups for drug and alcohol services and mental health services are significantly different, and therefore require different treatment model approaches as well as tailored clinical and corporate governance structures.

Drug and alcohol use and limited access to drug and alcohol rehabilitation for people living in regional, rural and remote New South Wales

Illicit drug use is most prevalent for people in remote and very remote areas as outlined in the latest available National Drug Household Survey Data (2017) which shows that “people in remote and very remote areas (25%) were more likely to have used an illicit drug in the last 12 months than people in major cities (15.6%), inner regional areas (14.9%) and outer regional areas (14.4%)”.²³

People in remote and very remote areas are “also more likely to drink alcohol in quantities that place them at risk of harm from an alcohol-related disease or injury over a lifetime or at risk of alcohol-related injury arising from a single drinking occasion” and “the proportion of those drinking at risky levels increased with increasing remoteness”.²⁴ The high levels of prescribing drugs of dependence, such as opioids, in rural and regional areas is also a key issue.²⁵ The National Rural Health Alliance (NRHA) identifies a range of interrelated contributing factors for illicit drug use in rural and remote Australia including “distance and isolation, poor or non-existent public transport, a lack of confidence in the future and limited leisure activities, [which] all contribute to illicit drug use in rural communities”.²⁶

The type of illicit drugs used amongst people living in regional, rural and remote areas of Australia also differs from their counterparts living in major cities and this aligns with the availability/unavailability of different types of drugs by location. As outlined in the NHRA’s Fact Sheet on illicit drug use in rural Australia (2015), “people living in remote and very remote areas were twice as likely as people in major cities to have recently used meth/amphetamines, but less likely to have used ecstasy compared with those from major cities. Cannabis use and the use of pharmaceuticals not for medical purposes is higher in remote/very remote areas than in major cities: 8 per cent compared with 11 per cent and 3.1 per cent, compared with 5.2 per cent, respectively”.²⁷

A research study on regional differences in injecting practices and other substance use-related behaviour among entrants into opioid pharmacotherapy treatment in New South Wales concluded that “participants from regional and rural New South Wales (NSW) were significantly more likely to report sharing of needles and other injection equipment and higher non-opioid drug use and polydrug use than their urban counterparts. In addition, they were more likely to be living with dependent children, to be unemployed, and to be experiencing greater psychological problems than their urban counterparts. Needle sharing also was independently associated with being younger, female, having been arrested, or having non-opioid drugs of concern”²⁸. People in regional and rural NSW face enormous barriers in finding GPs and community pharmacies willing to treat their opiate dependence, despite the robust evidence base for the effectiveness of this treatment.

People living in regional, rural and remote areas of Australia face significant barriers to accessing health services in general, and drug rehabilitation services and treatment are no exception. Research has shown that compared to their counterparts living in major cities, people living in regional, rural and remote areas experience the following issues with regard to access to drug rehabilitation and treatment services:

- limited access to general health services and drug treatment options
- relative scarcity of services and a limited range of services

- distance and isolation which impacts on client access and to the times and costs involved in outreach service delivery
- poor public transport
- concerns about confidentiality
- concerns about stigma and a relative lack of anonymity²⁹

As mentioned previously, there are severe shortages of alcohol and other drug treatment services across Australia with estimations that current services only meet the need of fewer than half of those seeking treatment.³⁰ This shortage is even more acute in rural, regional and remote areas and we would recommend undertaking a thorough assessment of current rehabilitation service availability and need as well as shortages and gaps across rural, regional and remote NSW using the Drug and Alcohol Services Planning Tool.³¹

The Drug and Alcohol Services Planning Tool is an innovative, cutting edge evidence-based planning tool used to estimate demand for drug and alcohol services, initially developed by NSW health (based on a mental health service planning model in use since 2001), that was commissioned in 2010 by the Ministerial Council on Drugs, funded as part of a cost-shared funding model. The model was developed using high level statistical modelling and through collaboration with key experts in NSW and other states/territories. The final model calculates resources required, including resource types (medical services, counselling, withdrawal, rehabilitation) for particular drugs, including alcohol, opioids, amphetamines and cannabis and provides a model of the estimate of an 'ideal' mix of services to allow appropriate access to people with all drug use problems of moderate to severe levels.

A final report on the Drug and Alcohol Service Planning Model Project (the 'model') was submitted to the Inter-Government Committee on Drugs (IGCD) for consideration in April 2013. This IGCD approved the project in July 2013 and it was subsequently submitted to the Australian Health Ministers' Advisory Council (AHMAC) and Standing Council on Health (SCoH). Unfortunately, AHMAC did not endorse the model in August 2013 and many in the sector have presumed that this was due to the possible financial costs of providing adequate access to drug and alcohol clinical services across Australia. This model could also have been used by the Commonwealth Department of Health to appropriately and effectively plan spending allocated to the National "Ice" Taskforce. As part of the Senate Inquiry into the Drug Welfare Reform Package, the model has also now been made public.^{32:33:34:35} Using a planning tool like this would be a major step forward for NSW, as it would facilitate an informed, evidence based approach to long term service planning across the State and should be adopted by the NSW Government as a matter of priority.

Key principles for the planning and delivery of effective evidence-based drug rehabilitation and treatment services

The differences in the types of drugs being used and the ways in which they are used in regional, rural and remote areas of Australia, as well as the significant barriers to access to drug rehabilitation, have important implications for the planning, resourcing and delivery of services in these areas.

Equitable access to evidence-based services for those most in need is essential and this requires increased public funding targeted at drug and alcohol rehabilitation services that are based on evidence-based frameworks, are tailored to local needs, are culturally safe and are accessible both in terms of cost and location.

The RACP is of the view that the following principles should underpin the delivery of all drug rehabilitation and treatment services in regional, rural and remote New South Wales, and across Australia more broadly:

- An understanding that drug and alcohol use is a chronic health condition with a high rate of relapse estimated between 40 to 60%. The American National Institute on Drug Abuse (NIDA) highlights that

“relapse rates (i.e., how often symptoms recur) for people with addiction and other substance use disorders are similar to relapse rates for other well-understood chronic medical illnesses such as diabetes, hypertension, and asthma, which also have both physiological and behavioural components”.³⁶

- Recognising the importance of the delivery of multi-disciplinary clinical care, including; medical practitioners (GPs, addiction medicine specialists, addiction psychiatrists); nurses and nurse practitioners; psychology and other allied health workers; and Aboriginal Drug and Alcohol workers to provide treatment.
- Understanding the need for a wide range of interventions: from hospital consultation liaison and hospital withdrawal, to community based services including assessment, withdrawal, counselling, medication assisted treatment, day care, residential treatment and harm reduction services.
- Recognising the need for services for to support parents, families and consumers of drug treatment services.
- Understanding and addressing the wide range of Social Determinants of Health³⁷ which play a key part in an individual’s drug use and recovery.
- Placing harm minimisation at the centre of rehabilitation and treatment services.^{38,39} At present, patients on medication assisted treatment for opioid dependence, who are treated through a community pharmacy, pay out-of-pocket costs directly to the pharmacist of \$25-\$45 per week. Medicare does not currently provide rebates for these treatments, which are unaffordable for many who are unemployed and a key reason for people discontinuing treatment prematurely, resulting in poor clinical outcomes.
- Using the best research evidence available to plan, design and implement these services.
- Undertaking ongoing monitoring and independent evaluations of treatment outcomes.
- Being led by medically qualified health professionals and specialist physicians, noting that in very remote areas, generalist health service providers may need to be up-skilled to provide AOD services.
- Ensuring equity of access for those most in need – this includes facilitating affordable access and also ease of access to the location of the required rehabilitation and treatment services.
- Adapting services to individual’s needs: this includes tailoring the approach to the particular drugs being used (e.g. withdrawal from methamphetamine requires more time than from heroin, so services need to be adapted. Some drug users are also likely to require access to other health professionals such as mental health, etc.).
- Providing services that are culturally safe for Aboriginal and Torres Strait Islander people. This includes developing strategies in consultation with, and where possible led by, the affected communities, and ensuring the community controlled sector plays a key role in developing and implementing these strategies, as well as ensuring access to a long term, supported, multidisciplinary workforce.
- Improving the integration and coordination between withdrawal/detoxification programs and drug residential services to minimise the risk of relapse. The wait time between completing a withdrawal program and being admitted to a residential service is an issue and it is not uncommon for clients to experience a relapse during this period, further prolonging their admission.
- Providing high quality after-care/follow-up care post-residential treatment.
- Ensuring seamless evidence based care during transitions to and from corrections.
- Working towards uniformity of regulations across States and territories.

Concluding remarks

As outlined in this submission:

- Drug addiction is a complex and relapsing health issue which is strongly influenced by a wide range of social determinants.
- Repeated drug or alcohol use leads to changes to the brain that challenge an addicted person's self-control and interferes with their ability to resist intense urges to take drugs or alcohol.
- Illicit drug use is relatively common in Australia and highest amongst people living in rural, regional and remote areas, who face a number of interrelated contributing factors including isolation, limited or no access to public transport and limited leisure activities.
- People in regional, rural and remote areas also face significant barriers to accessing drug rehabilitation and treatment services, all of which need to be addressed to meet the need of the most vulnerable drug users and to manage the impact of drug addiction on themselves as individuals, their families and communities more broadly.
- In NSW and across Australia, alcohol and drug treatment services are significantly underfunded and are estimated to only meet the need of fewer than half of those seeking help. In regional, rural and remote areas, a lack of access and availability of these services is even more pronounced than in major cities.
- The NSW Government needs to provide increased funding for evidence-based drug rehabilitation services led by medically-trained health professionals and specialists to meet the needs of vulnerable drug users and their communities in regional, rural and remote NSW.

Once again, the RACP wishes to thank the NSW Legislative Council's Portfolio Committee No. 2 – Health and Community Services for this opportunity to contribute its input into the NSW Parliamentary Inquiry into the provision of drug rehabilitation services in regional, rural and remote New South Wales.

The RACP and its Australasian Chapter of Addiction Medicine (AChAM) would be very happy to nominate one or more representatives to attend the Inquiry in person to provide further expert input should this be of interest to the Committee.

Please contact Claire Celia, RACP Senior Policy Officer, on Claire.Celia@racp.edu.au for any further information regarding this submission.

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- Illegal drugs—a drug that is prohibited from manufacture, sale or possession in Australia—for example cannabis and cocaine
 - Pharmaceuticals—a drug that is available from a pharmacy, over the counter or by prescription, which may be subject to misuse—for example opioid-based pain relief medications and over-the-counter codeine
 - Other psychoactive substances—legal or illegal, potentially used in a harmful way—for example, inhalants (such as petrol, paint or glue), kava, synthetic cannabis and other synthetic drugs (MCDS 2011).
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³² http://parlinfo.aph.gov.au/parlInfo/download/publications/taledpapers/29f5a1d2-6add-4d07-9135-ee5360a81aee/upload_pdf/OPD%20drug%20and%20alcohol%20letter%20.pdf;fileType=application%2Fpdf#search=%22publications/taledpapers/29f5a1d2-6add-4d07-9135-ee5360a81aee%22

³³ http://parlinfo.aph.gov.au/parlInfo/download/publications/taledpapers/5766a0ce-dbc0-405d-9118-3335bb8b2617/upload_pdf/ATT%20B%20-%20Technical%20Manual_Final_V4.15_2013_4%20final.pdf;fileType=application%2Fpdf#search=%22publications/taledpapers/5766a0ce-dbc0-405d-9118-3335bb8b2617%22

³⁴ http://parlinfo.aph.gov.au/parlInfo/download/publications/taledpapers/36dba59f-6d3b-4713-aadc-c3263f0be410/upload_pdf/Attach%20C%20-%20Item%205.3_Attachment%20A_Drug%20and%20Alcohol%20Service%20Planning%20Model_issued%2005-...pdf;fileType=application%2Fpdf#search=%22publications/taledpapers/36dba59f-6d3b-4713-aadc-c3263f0be410%22

³⁵ http://parlinfo.aph.gov.au/parlInfo/download/publications/taledpapers/29d7f87e-9457-4c34-899c-3441ff3dd73e/upload_pdf/ATT%20D%20-%20D13-275608%20%20DA-CCP%20estimator%20tool.pdf;fileType=application%2Fpdf#search=%22publications/taledpapers/29d7f87e-9457-4c34-899c-3441ff3dd73e%22

³⁶ American National Institute on Drug Abuse (NIDA) (2014), webpage: Drugs, Brains, and Behavior: The Science of Addiction. <https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/treatment-recovery>. Last accessed 16/11/17

³⁷ Note: As defined in the College's Health in All Policies document published in 2016, "an individual's health is shaped by socioeconomic factors, which can be broadly defined as the conditions in which people are born, grow, live, work and age. These social characteristics are influenced by political and economic systems, social and economic policies, and development agendas which shape the conditions of daily life. These influences are collectively known as the social determinants of health (SDoH). The key domains of life in which the SDoH have an impact are broad and include (but are not limited to): • Intrauterine development • Early life and childhood development • Educational attainment • Access to health care • Health literacy • Socioeconomic status • Family and relationship stability • Gender • Social security • Housing • Food security • Tobacco, alcohol and illicit drug use • Contact with the criminal justice system • Natural, built and physical environments • Social exclusion."

³⁸ Note: As outlined in the National Drug Strategy 2017-26, harm minimisation consists of three pillars:

1. Demand reduction: Preventing the uptake and/ or delaying the onset of use of alcohol, tobacco and other drugs; reducing the misuse of alcohol, tobacco and other drugs in the community; and supporting people to recover from dependence through evidence- informed treatment.
2. Supply reduction: Preventing, stopping, disrupting or otherwise reducing the production and supply of illegal drugs; and controlling, managing and/or regulating the availability of legal drugs.
3. Harm reduction: Reducing the adverse health, social and economic consequences of the use of drugs, for the user, their families and the wider community.

³⁹ Department of Health (2017), National Drug Strategy 2017-27 - A national framework for building safe, healthy and resilient Australian communities through preventing and minimising alcohol, tobacco and other drug related health, social and economic harms among individuals, families and communities