Northern Territory Harm Reduction Strategy for Addictive Behaviours – public hearing

LEGISLATIVE ASSEMBLY OF THE NT
TABLED DOCUMENTS
Committee: RAB
Paper No: 8 Date: ..../..../....
Tabled By: Dr Hickey CAHS
Signed:

Briefing note

The Royal Australian & New Zealand College of Psychiatrists

Purpose

To provide information about the RANZCP's position with regard to harm reduction strategies for addictive behaviours. This is in preparation for Dr Bernard Hickey's appearance at the public hearing of the Select Committee on a Northern Territory Harm Reduction Strategy for Addictive Behaviours Standing Committee on Health, Aged Care and Sport on Tuesday 6 November 2018.

RANZCP positions

Overview

- There is a severe shortage of drug and alcohol services in the Northern Territory. This requires urgent investment for expansion.
- Particular investment is required for forensic populations. There is currently a lack of follow-up after release and linkages with other addiction services.
- Forensic patients with a history of opiate dependence require overdose prevention training and the provision of naloxone at the point of release.
- Harmful substance use is a psychiatric condition, and therefore deserves a public health response. This means diverting people from the criminal justice system into the health system wherever appropriate.

RANZCP policies

- Particular addictive behaviours deserving of increased focus include:
  - Alcohol (for specific recommendations, including a minimum floor price for alcohol, see Position Statement 87)
  - Methamphetamine (for specific recommendations, see Position Statement 82)
  - Gambling (for specific recommendations, see Position Statement 45)
  - Tobacco (for specific recommendations, see Position Statement 97 and the Tobacco Policy).
- E-cigarettes and vaporisers may provide a less harmful way to deliver nicotine to those who are unable or unwilling to stop smoking tobacco – for more information, see Position Statement 97.
- The RANZCP has supported calls in Victoria for a medically supervised injecting centre – see the Victorian Branch submission to the Victorian Inquiry into the Drugs, Poisons and Controlled Substances Amendment (Pilot Medically Supervised Injecting Centre) Bill 2017.
- Pill testing services carry many public health benefits including:
  - detection of toxic pills before consumption (particularly important in light of several recent deaths as a result of toxic pills being consumed in social settings including music festivals, nightclubs and parties)
  - increased access to provide support and information for people who use illicit drugs (including typically hard-to-reach populations, such as young recreational drug users)
  - improved data collection methods with useful data used for health promotion strategies, and to support the identification and removal of hazardous drugs from the market.

  Pill-testing should be nested within services that provide accurate interpretation of test results and educate individuals about potential risks.

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- The RANZCP has provided submissions to government enquiries regarding the involuntary treatment of people with substance dependence, including for South Australia and Western Australia. Developing a binational policy on this issue is a priority for the RANZCP.

  Without robust evidence, it is difficult to determine the effectiveness of civil commitment regimes for the involuntary treatment of people with substance dependence, or the ideal set-up for a scheme. However, there are a number of practical difficulties associated with such schemes including with regard to treatment delivery, human rights, resourcing implications, the targeting of vulnerable population groups, and legislative requirements governing principles, access criteria and safeguards.
- The RANZCP also supports the integration of addiction and health services with targeted programs for at-risk population groups including Aboriginal and Torres Strait Islander people.

Other policies

- The RANZCP does not support compulsory drug testing of welfare recipients or the expansion of cashless debit cards trials. While these policies will likely affect people in the Northern Territory, we note that they are federal policies.
- The RANZCP supports the development of a quality framework for AOD services, including a formal accreditation process and minimum standards. This framework should apply to the public and private sectors, particularly in light of a number of issues which have arisen in private rehabilitation services. However, it may be preferable that the framework is a national one.
- The RANZCP does not have a position on the legal status of individual drugs, including with regard to debates on decriminalisation and blanket bans for synthetics.

  However, the RANZCP believes that a balanced policy approach to harmful substance use should aim to reduce demand, supply and harm, but with a greater emphasis on health and harm reduction than is currently the case. This is because punitive responses to drug users may present health risks including through the disincentivisation of help-seeking behaviours.
- The RANZCP does not have a position on a Banned Drinkers Register.

Dr Bernard Hickey MB BS FRANZCP
ADDICTION PSYCHIATRIST
Alice Springs Hospital Alcohol and Other Drugs Unit
Gap Road, Alice Springs NT 0870 mob 0421 464 654

6 November 2018
Presentation to:

LEGISLATIVE ASSEMBLY OF THE NORTHERN TERRITORY
13th Assembly
Select Committee on a Northern Territory Harm Reduction Strategy for Addictive Behaviours

The current scale and trends of illicit drug-use in the Territory and its impacts upon health, justice, drug and alcohol and law enforcement activities.

CENTRAL AUSTRALIA
Geologically, botanically, zoologically and culturally rich and diverse.
60% population Alice Springs, 40% remote.
Australian Aboriginal 60% of whole population . Majority of these English as second language.
High rates of poverty, unemployment and crime, especially alcohol and substance related.

ADDICTIVE BEHAVIOURS
Over riding of brain reward circuitry, by chemical or behavioural habit.
Loss of control a defining feature, often leading to breaking of social rules and crime.
Brain damage measurable, recovery possible , but takes time and effort repetition to grow new brain circuits, learn new skills to over ride hardwired addiction circuitry.
Classified as disease by medical and psychiatric diagnostic criteria. (ICD 10, DSM 5)
Strong evidence base for this. Genetic and environmental vulnerabilities.
(Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health, 2016)
Flourishes in situations where there is lack of access to rewards for constructive behaviours eg poverty, stress, trauma.
Can be commercially exploited eg, gambling, liquor, drug dealing, pharmaceutical-opioid epidemic in USA, New Psychoactive Substances (NPS)

REDUCING ADDICTION RELATED HARMS REQUIRES ACTIONS AT ALL STAGES
Prevention
Reduce poverty, promote gainful esteemable activity
Reduce causes of and treat trauma related illness
Reduce and regulate access eg BDR, Liquor restrictions Halls Creek, Fitzroy Crossing, Tennant Creek, Blanket Bans on New Psychoactive Substances (UK, WA, VIC)
Early intervention
Primary Care, Community Drug and Alcohol workers

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Culturally accommodating interventions and treatments at all stages, including Aboriginal Liaison Officers, and affordable and timely access to trained interpreters/translators

Recovery- Justice Diversion programmes eg NT Commit- need to be long term , wherever outcomes of these evaluated results show positive outcomes and enormous cost savings. Serves as form of mandatory treatment.
Physician Health Programmes and Pilot programmes in the USA have 80% long term full recovery rates- combining treatment, support, and sanctions.
Need vigourous in prison programmes that are linked to pathways in community treatment and care.

- Decriminalize where possible to allow recovery path to responsible citizenship eg decriminalize use quantities of illicit substances eg Portugal

Appropriately trained and qualified staffing including cultural understanding and remote access and family involvement
Support peer support, developing a recovery community to support recovery long term
Abstinence aim for severe end of addiction spectrum is evidence supported.
Medication assisted recovery needs to be available where necessary
Treat Comorbidity- eg psychiatric, trauma, physical.
Reduce harms in users- syringe needle exchange, overdose kits

Measurement of epidemiology and intervention outcomes to guide treatment need and response to interventions.