

Harmful substance use, dependence and behavioural addiction (Addiction) 2017

AMA Position

The AMA:

- Believes that substance dependence and behavioural addictions (SDBA) are serious health conditions, with high mortality and disability. Those who are impacted should be treated like other patients with serious illness, and be offered the best available treatments and supports to recovery.
- Believes that current services offered to those with SDBA are severely under-resourced in terms of funding, personnel and geographical reach.
- Calls for governments to focus on those dependences and addictions causing the greatest levels of harm to individuals and society, regardless of whether it is socially unpalatable. This includes alcohol.
- Calls for a whole of government approach to promoting resilience, prevention, reduced drug use, early interventions and treatments. Such approaches must be adequately resourced and include provisions to support families and communities impacted by dependence and addiction.
- Supports a major change in funding priorities from policing and prosecution of substance users to interventions that avoid or reduce use, promote resilience, and reduce societal harms.
- Calls for responses and funding around substance dependence and behavioural addiction issues to be based on the best contemporary evidence base.
- Supports responses to substance dependence and behavioural addictions that also address underlying causes, or exacerbating factors, such as social isolation, lack of early childhood interventions and support, exclusion, poverty, discrimination, criminalisation, poor education, inadequate health resources and mental health issues.
- Supports the introduction of innovative policy models and trials, in a controlled manner, funded and evaluated appropriately, that might reduce harms and improve outcomes for users and society at large. For example: needle exchanges, pill testing, prisoner interventions and services, novel treatments and degrees of decriminalisation for some drugs etc.

Substance dependence is a chronic brain disease that involves the compulsive or uncontrolled use of one or more substances, and that has the potential for relapse as well as recovery.¹ Behavioural addiction is a similar condition that involves compulsive or uncontrolled behaviours or activities such as pathological gambling, compulsive buying, exercise and internet addictions.¹

Contemporary medical science recognises substance dependence and behavioural addictions as primarily health problems. These conditions are recognised as chronic diseases of the brain's reward, motivation, memory and related circuitry², and are characterised by clinically significant impairments in health, social function, and voluntary control over substance use or addictive behaviour.³

¹ The absence of proper nomenclature leads to variation in the language and terminology in this area. The term addiction is commonly used to collectively refer to substance dependence and behavioural addiction.

Behavioural addictions typically stimulate dopamine in a similar way to addictive substances, such as cocaine or nicotine. These 'rewarding effects' positively reinforce use and increase the likelihood of subsequent activity.

While the circumstances of each person's experience is unique, there are common cyclical factors including: binging and intoxication; withdrawal; preoccupation and anticipation. These stages may also be influenced by factors such as impulsivity, positive reinforcement, negative reinforcement and compulsivity. The predominant features of substance dependence and behavioural addiction includes:

- Impaired control;
- Social impairment;
- Risky use / engagement; and
- Pharmacological indicators / tolerance and withdrawal.

Substance use disorders can be divided into harmful use and dependence. Harmful use tends to be episodic and may result in physical and psychological harms; it can also contribute to social consequences. Dependence is a physiological adaptation that results in tolerance and withdrawal if substance use is abruptly stopped.⁴

Substance dependence and behavioural addictions are not inevitable. However, repeat exposure may increase the likelihood. Whether or not substance use progresses to dependence will be influenced by factors including: genetic and biological factors, the age at initiation, psychological history, innate and learned resilience, environmental factors such as family and peer dynamics, financial resources, cultural norms, exposure to stress, and access to social support.⁵

The consequences of substance dependence and behavioural addiction are extensive and detrimental to individuals and the community. While there is a vast array of legitimate concerns and areas of focus, the AMA has significant concerns about the following (many of which have their own separate AMA policy statements):

- [Alcohol](#);
- [Methamphetamine](#);
- Synthetic drugs;
- Poly substance use;
- [Problem gambling](#); and
- Prescription drug abuse.

Patterns

In Australia (2013):

- About 8 million people, or 42 per cent, reported having ever used an illicit substance, with 2.9 million, or 15 percent, reported use within the last 12 months;
- 15.5 percent of people reported consuming 11 or more standard alcoholic drinks on a single occasion;
- 2.1 per cent of people reported having used methamphetamines in the last year;
- 4.7 per cent, or 900,000 people, reported having misused a prescription pharmaceutical in the past 12 months;⁶
- There were at least 115,000 Australians who were seriously harmed by gambling and another 280,000 who are at significant risk.⁷

Prescription drug abuse

Prescription drug abuse is a growing problem. Over the counter painkillers and analgesics as well as prescribed painkillers, are more commonly misused, followed by sleeping tablets and tranquilisers.⁸ Consistent with the increasing misuse of prescribed medicines, the number of deaths attributable to prescribed medicines is also increasing. In at least one Australian state the number of deaths involving prescribed medicines (330 deaths) was higher than the number of overdoses involving illicit drugs (217) and higher than the road toll (252).⁹

Medical practitioners have a responsibility to choose the most suitable medicines, taking into account the potential for self-harm and the ability for the patient to adhere to a safe regime.¹⁰ However, the increases in prescriptions for medicines that can be misused, abused or on-sold, presents a number of challenges for medical practitioners as well as governments. The AMA supports well-funded, easy to access monitoring of those medicines that can be abused. For more information refer to the AMA position: [Medicines - 2014](#).

Consequences

The costs of untreated substance dependence and behavioural addiction is substantial with a range of physical and mental health comorbidities occurring more frequently among those impacted. In addition, there is increased likelihood of suffering financial, career and education disruptions, as well as social isolation. Research indicates that life expectancy is reduced by almost 14 years.¹¹ For the broader community, the costs extend to reduced employment and productivity, increased health costs and usage, reliance on social welfare, increased criminal activities (as victims and as perpetrators) and higher rates of incarceration.

Prevention and early intervention

Preventing experimentation and initiation of drug use, and subsequent dependence, is an important public health goal. School-based resilience building programs have been shown to reduce substance use¹² but programs that solely focus on drug use prevention show more limited success.¹³ Mass media campaigns that aim to educate young people about the risks associated with substance use are popular, but do not produce any firm conclusions about effectiveness.¹⁴ Internationally, there are some models that do appear to be successful in reducing experimentation and initiation of substance use among children and young people. The Youth in Iceland approach, for example, introduced a range of measures that have substantially decreased substance use.¹⁵

For those who have already initiated drug and alcohol use, there is evidence that brief interventions with health care professionals are an effective means of treating some substance use problems.¹⁶ Brief interventions are typically provided in person, but there is emerging evidence that some web-based brief interventions may also be effective.¹⁷

The role of medical practitioners

General practitioners

General practitioners (GPs) play an important role in the prevention, early detection and management of harmful substance use, dependence and behavioural addictions. GPs are a trusted and credible source of advice, and international research has shown that people with substance dependence may prefer to engage with their GPs, rather than attending outpatient drug dependency services.¹⁸ Despite this, there are a number of barriers for GPs in providing support for their patients with substance dependence and behavioural addictions:

- Perceptions that GPs do not have a mandate to enquire about their patients' drug and alcohol use;
- Lack of adequate training;
- Scepticism and pessimism about treatment effectiveness;
- Perceived patient resistance;
- Discomfort discussing substance misuse;
- Time constraints; and
- A perception that drug users are chaotic and non-compliant.¹⁹

Referring patients on to appropriate and timely treatment can be difficult for GPs. Primary Health Networks are responsible for commissioning treatment services in their jurisdictions. Given the diversity and complexity of demands for treatment service, the effectiveness of this approach remains to be seen.

Addiction medicine specialist and addiction psychiatrists

Addiction medicine involves the provision of medical care to people with substance use and addiction disorders, including drug and alcohol addiction and pharmaceutical dependency.²⁰ Addiction medicine includes primary, secondary and tertiary prevention of harm related to non-medical use of drugs,

management of acute drug related problems, and rehabilitation of people who have become dependent on drugs.²¹ Addiction medicine specialists should continue to be recognised appropriately under the Medicare Benefits Schedule.

Treatment

Untreated substance dependence and behavioural addiction results in costs to the individual and society, including disrupted relationships with family and friends, criminal behaviour, homelessness and financial instability, as well as reduced life expectancy.

Most patients eventually improve, and even among those with problems severe enough to enter treatment services, around two thirds will achieve stable and enduring abstinence after 20 years.²² However, some people may be reluctant to engage in treatment, despite the encouragement of medical practitioners, family and friends.

The lack of treatment services affects patient outcomes. In most instances demand for treatment outweighs its availability. This can mean people wait for extended periods to access treatment, which can result in withdrawal and deteriorations in motivation to engage in treatment. Timeliness in accessing suitable treatment is vital.

Not all treatment will need to be intensive. Outpatient and outreach programs may be suitable in a range of instances. Treatments that can address poly-substance use as well as behavioural addictions and other mental health conditions (including dual diagnosis) are also important. Relapse following the initiation of treatment is common and should not warrant the abandonment of treatment altogether.

Harm minimisation

Harm minimisation is an overarching strategy that aims to prevent and reduce the harms associated with substance use in the community.²³ Harm minimisation considers the consequences for individuals and the community, and is based on the following principles:

- Substance use, legal and illegal, is an inevitable part of society;
- Substance use occurs across a continuum, ranging from occasional use to dependence;
- A range of harms are associated with different types and patterns of substance use; and
- A range of approaches can be used to respond.

The approaches harnessed as part of a harm minimisation response include: supply reduction, demand reduction, and harm reduction. Supply reduction has historically received the majority of government funding, however, there appears to be an increasing acceptance of the need to focus more resources on demand reduction and decreasing harmful use.

As some substances are administered via injection, there is increased risk associated with the transmission of blood borne viruses. For more information see the AMA position statement [Blood Borne Viruses \(BBVs\) – 2017](#).

Medically supervised injecting centre/s

Medically supervised injecting centres enable people to inject substances, such as heroin, in a sterile environment with clean injecting equipment, under the supervision of trained staff. Research confirms that medically supervised injecting centres are associated with a range of positive outcomes for the individual and the community.²⁴

Diversionsary programs

In Australia, there are a number of programs that divert people who have been apprehended or sentenced for minor drug offences. These programs seek to minimise contact with the criminal justice system. Four in five, or 82 per cent, of diversion episodes were completed successfully.

Approximately one quarter of those seeking drug and alcohol treatment have been diverted (diversion clients are likely to be younger, male and non-Indigenous). People may be diverted to treatment by police or by courts. Despite significant variations in diversionsary programs, a national assessment

found that compliance with diversionary programs was high and recidivism was reduced in both the short and long term.²⁵

Mandatory treatment

In a number of state jurisdictions there are legislative provisions for mandatory treatment for people deemed to have severe dependence problems.²⁶

Although there is some argument that involuntary commitment may save lives in the short term, there is a lack of evidence around the medium and long term efficacy of compulsory residential treatment for non-offenders.²⁷ The unresolved questions about the efficacy of mandatory treatment programs make the evaluation of such programs a matter of priority.

Decriminalisation

Given that drug use is widespread, and predominately non-violent, the preference of governments to criminalise those individuals who use or possess drugs is being questioned. In the context of increasing prison populations, and recognising addiction as primarily a health problem, the issue of decriminalisation is increasingly pertinent. Decriminalisation typically refers to the removal of criminal sanctions for drug possession for personal use offences, with the optional imposition of civil penalties such as fines or administrative sanctions, diversionary programs or no penalty at all.²⁸

A significant percentage of the prison population is incarcerated due to drug related crimes. In 2010, 10.2 per cent of sentenced prisoners had a drug defined crime as the most serious offence for which they were imprisoned. Around 66 per cent of prisoners reported using illicit drugs in the 12 months prior to incarceration, and 62 per cent of people arrested by police tested positive to illicit drugs.²⁹

Given the scale of drug use, the Global Commission on Drug Policy argues that punitive approaches to drug control fundamentally undermine the relationship between individuals and the State. Further the Commission suggests that such policies:

- Contribute to discrimination and marginalisation of drug users;
- Justifies criminalising people who cause no harm to others and punishing those who are suffering; and
- Limits scientific research about the medical utility of illicit substances and build obstacles to the prescription of pain relief and palliative medication.³⁰

Jurisdictions that have adopted non punitive responses to drug possession and/or use have not experienced major increased prevalence of drug use.³¹ One of the best examples of decriminalisation is Portugal, where drug possession for personal use was decriminalised in 2001. A number of positive health outcomes have occurred since then, including:

- A reduction in drug use among certain vulnerable populations;
- Increases in the number of people accessing treatment services;
- Significant decreases in HIV transmission rates and new cases of AIDs among people who use drugs; and
- A significant reduction in drug related deaths.

Decriminalisation creates an environment that reduces stigma and allows people to feel more comfortable should they need to access treatment services. However, decriminalisation alone is unlikely to be successful. In order to mitigate the health problems associated with problematic use, significant investments in harm reduction and treatment services are also required.

For any meaningful improvement to occur in Australia, there will need to be open discussion and consideration of those policies that effectively reduce consumption and that also prevent and reduce the harms related to drug use and drug control. This discussion must recognise the probable benefits of shifting the focus from criminalisation and penalties for drug users to providing suitable health care and treatment for those who need it.

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