Policy Document

Harm Minimisation in Illicit Substance Use

Background

The Australian Medical Students’ Association (AMSA) is the peak representative body of Australia’s medical students. AMSA believes that all communities have the right to the best attainable health. Accordingly, AMSA advocates on issues that may impact health outcomes.

In 2017, the Global Commission on Drug Policy (GCDP) highlighted the need to depart from repressive drug policies as misguided prohibitionist tactics of law enforcement have been largely ineffective: they have not reduced the production and consumption of illegal drugs, nor have they curtailed the drug market [1]. The GCDP found that government policies focused on prevention, treatment and harm reduction measures are more able to reduce the human cost of illicit drug use [1]. At present, illicit drug use falls under three categories: illegal drug use, abuse of pharmaceuticals for non-medical purposes, and other substances used inappropriately [2].

The Current Burden of Drug Associated Harm

In 2016, 3.1 million Australians reported using an illicit drug within the last 12 months to the National Drug Strategy Household Survey, with 43% of Australians aged 14 years or older reporting any lifetime illicit drug use. Overall, use of illicit drugs has been steadily increasing in Australia from 13.4% of people in 2007 to 15.6% in 2016 [3]. Misuse of pharmaceuticals, including prescription and over the counter medications, occurred in 4.8% of the population [3].

The reasons for the use of illicit drugs are diverse and can include for pleasure, to modulate emotions, to feel a sense of belonging, to conform to the perceived norm, to expand consciousness or to prevent the onset of an abstinence syndrome when a person has a physiological dependence [59].

Drug-associated harm currently takes many forms in Australian society and may be associated with acute and long-term use. Acute harms from the immediate use of illicit drugs include those stemming from high risk behaviours such as motor vehicle accidents, toxicity, mortality and drug-induced psychosis [4]. Harms not directly associated with the drug-induced state include cardiovascular disease, lung disease, addiction, blood-borne virus transmission, susceptibility to other infections, organ failure, stigmatisation, workplace injuries, domestic violence, acquisitive crime and violent drug-market related harms and psychological harms [4,5].

It was estimated that in 2011, illicit drug use contributed to 1.8% of the total burden of disease and costs the economy $8.2 billion each year [6]. There were 1,808 drug induced deaths in Australia in 2016, the highest number in 20 years, with the majority occurring due to accidental overdose (71.3%) and suicidal overdose (22.7%), and another 1,387 deaths in which drugs were deemed a contributory cause [7].

Injecting drug use is a risk factor for blood-borne viral diseases with 1% of HIV incidence, 4% of chronic hepatitis B infections [8], and 82% of existing hepatitis C infections related to intravenous drug use [9]. A significant proportion of drug users in Australia report experiencing high psychological stress and mental health problems, with depression and anxiety being the most common [10]. Illicit drug use disorders and use of cannabis [11], amphetamines [12], cocaine and opioids have been associated with psychosis beyond the acute intoxication and withdrawal syndrome of the drug [13]. Substance abuse, particularly of amphetamines [14], has a correlation with aggressive behaviours, including family violence and intimate partner violence [15].
The burden of drug-associated harm is distributed disproportionately across Australian society. Illicit drug use is 1.8 times higher among Aboriginal and Torres Strait Islander people and is a contributing factor to the gap in health outcomes between the Indigenous and non-Indigenous populations [3]. This can be attributed to the greater likelihood of socioeconomic and family disadvantage among the Indigenous population, which are independent risk factors for drug abuse [16]. Substance use is also recognised to be prevalent within the LGBTQ+ community worldwide, with evidence suggesting increased usage in the Australian LGBTQ+ community compared with the general population [17]. Research into drug use in this population has been identified to be limited and an area of need. According to the Australian Institute of Health and Welfare, those living in remote and very remote areas are also recognised to be at increased risk of substance misuse [3].

The social impacts of illicit drug use have diverse and far-reaching effects. These effects include the loss of social support networks, financial burdens, challenges accessing health services, difficulty finding meaningful employment and the endemic stigmatisation and discrimination faced by illicit drug users, especially amongst doctors and within the hospital system [18, 19].

The Current Drug Strategy
Australia’s National Drug Strategy 2017-2026 (‘the Strategy’) is a national framework to guide jurisdictions in developing their own drug responses and was created from a collaboration between state and territory governments and the health sector. The primary aim of this initiative is to prevent and minimise alcohol, tobacco and other drug-related health, social, cultural and economic harms [20].

The Strategy is built on the three pillars of harm minimisation:
- Demand reduction: to prevent the uptake and/or delay the onset of illicit drug use through education and community awareness, and to provide evidence-based treatment for people to recover from dependence;
- Supply reduction: reduction of the production and supply of illegal drugs; and greater regulation of legal drug availability and access;
- Harm reduction: minimising the adverse health and socioeconomic consequences of abuse of drugs [20].

The aim is to draw upon evidence-based approaches, collaborate across all jurisdictions, and seek a balanced approach across all 3 pillars. At present, comments cannot be made about the current Strategy as it has just been implemented and the expenditure of each of these three pillars are yet to be published.

However, the resource allocation for the 2010-2015 Strategy was problematic as it demonstrated significant asymmetry in spending between these pillars, despite the Strategy stating that ‘each of the pillars is equally important to the success of the strategy.’ There was a much greater allocation of resources for law enforcement programs that seized drugs and reduced supply [21]. Of the $1.7 billion spent on illicit drug interventions in 2009-10, 66% pertained to law enforcement, 21.3% to treatment, 9.2% to prevention, 2.1% to harm reduction and 1.4% to other programs [2].

Criminal vs. Harm minimisation approach
The Strategy, and its three pillars of harm minimisation, is a stark contrast to the prohibitionist and punitive policies of the 20th century. Many countries around the world and the United Nations have now adopted the evidence-backed view that drug use and abuse is predominantly a health issue, not a criminal issue [22]. Policies that are now in place due to this shift in thinking include opioid maintenance therapy, needle and syringe programs, medically supervised injecting rooms, drug courts and diversionary programs, pill testing, and the rescheduling of codeine medications.

Cross-sectoral collaboration and coordination, in terms of policy and their execution, between health care providers, law enforcement services and government can enhance the minimisation of harm to current substance users. The fear of prosecution from users engaging with harm reduction services such as needle and syringe programs and pill testing can greatly limit the effectiveness of these approaches. Therefore, it is vital that all systems are working synergistically for the same goal, which is now the health of the individual. Insight can be drawn from past operational collaborations, such as the 1999 Illicit Drug Diversion Initiative,
which saw police and courts refer minor drug offenders to assessment and support services, instead of a criminal charge and possible jail time. Another beneficial collaboration was conducted in Sydney during the introduction of needle and syringe programs and the medically supervised injecting centre. Legislative reform and changes to New South Wales police operating procedures had to be undertaken to encouraged police to exercise discretion when dealing with their local needle and syringe program. Police overdose policies were amended to avoid pursuit of minor possession charges in non-fatal overdose cases, a policy eventually adopted Australia-wide [23]. These are good examples of how traditional legal structures have changed with this new mindset.

The recent rescheduling of codeine, so that products containing codeine will not be available without a prescription, is a common-sense change driven by Therapeutic Goods Administration in consultation with relevant parties. Deaths attributable to over-the-counter codeine products, other opioids and synthetic narcotics are on the rise [7], with over-the-counter availability as a potential contributing factor to development of dependence on stronger opioids. This is a good example of the medical profession voicing their concerns about current laws and regulations, and those laws and regulations subsequently changing to the benefit of the individual.

Despite the use of diversionary policies such as the existing education and treatment sessions for low-level cannabis offenders, an illicit drug policy focused on punitive measures and prosecution were proven ineffective at suppressing the growing drug market [24].

**Principles of Harm Minimisation**

Harm minimisation or ‘harm reduction’ describes strategies and principles that aim to reduce or eliminate negative or destructive consequences directly caused by or related to illicit drug use and its outcomes [25]. Drug-related harm intersects with criminal justice issues, health, vulnerability and various complex social problems. Hence, there is a need for a comprehensive approach to tackle the illicit substance use problem that goes beyond the concept of personal culpability and subjective morality.

Whilst harm minimisation has been implemented across the world using different methods and approaches, harm minimisation in Australia is defined as following the three principles outlined in the National Drug Strategy: Demand reduction, supply reduction and harm reduction [20]. This approach centres around the public health model that three components contribute to drug use: the individual, the environment and the drug, and these must be considered comprehensively to achieve appropriate and wholesome reduction of harm.

Harm minimisation approaches use this framework in an effort to identify and address harms related to different stages and factors of drug use in the community. These approaches recognise that:

- **Drug use, both licit and illicit, is an inevitable part of society**
- **Drug use occurs across a continuum, ranging from occasional use to dependent use**
- **A range of harms are associated to different types and patterns of AOD use**
- **A range of approaches can be used to respond to these harms** [26].

As such, harm minimisation aims to address, not only harms related to use of illicit drugs, but uses a range of tools to address harms present at a policy level, harms to long term health and risk to the community.

The Australian Senate [24] and the AMA [27] have both acknowledged that an evidence-based harm minimisation approach is needed to reduce the negative impacts of drug use. Cross-sectoral collaboration and coordination in terms of policy and execution between health care providers, law enforcement services and government can enhance minimising harm to current substance users. Harm minimisation approaches are multi-faceted and must target a range of areas to be effective. Comprehensive community education must accompany strategies in all approaches [28] to ensure that the evidence and reasoning is clear, that stigma resulting from previous approaches is reduced, that all the community has knowledge and access to services, and that illicit drug harms are regarded as the public health issue that they are.

**Harm Minimisation Strategies**

*Policy Reform*
Reform of drug policy is crucial in restructuring the approach to illicit drug management. The Global Commission on Drug Policy in 2011 identified that hard-line, prohibitionist tactics of law enforcement to control drug use have been ineffective since their global introduction in the 1970s, and drug markets and drug-related harm are proceeding unopposed by the current sanctions [29]. Current Australian drug policy is centred around ‘harm minimisation’ which was officially defined as ‘supply reduction, demand reduction and harm reduction’ in the 1990s [28]. Supply reduction has become the focus of currently implemented strategies, occupying a higher proportion of funding than other aspects of policy. According to a government drug policy expenditure report, 65% ($1.123.3 million) was spent on law enforcement as compared to 2.2% ($36.1 million) on harm minimisation approaches [2]. Decriminalization is widely recognised as an important aspect of effective drug policy in terms of harm minimisation and is perhaps best evidenced by Portugal’s 2001 reform whereby possession of no more than a 10-day supply of illicit drugs was decriminalized, resulting in administrative outcomes rather than criminal charges [30]. The outcomes of this policy change in terms of harm minimization and contact with health services has been overwhelmingly positive, with a 60% increase in treatment uptake for drug related issues as of 2012, and a drug death rate significantly below the European average [31]. The policy also directed significant investment into drug treatment and drug prevention services in an effort to vastly expand harm minimisation efforts. Compared with countries with punitive drug policy, countries that have engaged in decriminalization and less punitive drug policy have not seen increased uptake of drug use, drug related harm or drug related crime [60]. Decriminalization has been implemented in a number of countries globally and is an important step in allowing perception of drug-related issues as health and social issues, rather than criminal [28].

**Pill Testing**

Pill testing, also called adulterant screening, is a harm reduction approach that strategically targets youth at music festivals and raves. Pill testing was first trialled in the Netherlands during the 1990s, and subsequently adopted as part of their national policy. Since then, several other countries have developed similar but privately funded initiatives. There are a variety of ways pill testing is carried out, mostly involving users anonymously volunteering samples of their drugs to find out its actual contents before use.

A Canadian survey of festival-goers at the 2013 Shambhala festival and found that up to 50% of users would discard their pills if certain compounds such as para-methoxymethamphetamine (PMA) are detected [32]. A follow-up study at the same festival in 2015 also showed 31% of checked drugs that contained hazardous compounds were actually discarded [33]. Australia’s first pill-testing trial at Groovin’ the Moo festival in Canberra in April 2018 [34] was hailed largely as a success with 130 patrons using the service and 2 novel substances detected in ACT for the first time [35].

Pill testing services may be the first time individuals come into contact with health services and this may [32, 36] potentially reduce mortality and morbidity from drug related harm. Detection of novel entities provides useful information on the ever-changing trend of emerging substances and adulterants to better inform more effective prevention, research and treatment. This can lead to changes in public health communications, data collection and warnings, as reflected in the Trans European Drug Information database [37].

A potential pitfall of pill testing is the willingness of consumers to use the service as it is completely voluntary. An online survey by the Australian National Council on Drugs reported a majority of youth are supportive of having independent pill-testing facilities to provide information on the pills’ contents and risk advice, before making an informed decision [38]. In a separate study with Swiss attendees at a music festival, youth were similarly supportive of pill-testing facilities. However, further data showed that only 31.1% would routinely use the service with 41.6% using the service only if they did not know the dealer, substance or both [39].

**Needle and Syringe Programs**

Needle and Syringe Programs (NSP) provide sterile injecting equipment, health information and voluntary referral to welfare and health services to people who use drugs. The service is far reaching, with approximately 3500 NSP in Australia, providing approximately 49.4 million clean needles and syringes annually [40]. This strategy is often the single point of contact with many drug users to access healthcare. One in ten interactions with a client at NSP involves a referral [40]. Issues with the program result largely from constraints at meeting demands. The hours are variable and often insufficient to meet client requirements. Additionally, the structure of the service and thus the delivery varies between sites, resulting in inconsistent information, equipment, and health campaigns and initiatives between the NSPs [41]. Needle and Syringe
Programs have been shown to be “one of the most successful and cost-beneficial public health investments in Australia’s history.” [41] However, this is not reflected in the investment in resources and location development for NSP centres.

**Opioid Maintenance Therapy**

Opioid Maintenance Therapy (OMT) is another strategy to improve safer usage of drugs. The World Health Organisation considers methadone and buprenorphine essential medicines within established support programs due to the health and safety benefits [42]. Many studies, meta analyses and a Cochrane review have shown that treatment with methadone or buprenorphine (although methadone has significantly more evidence of efficacy) is more effective than non-pharmacological approaches in retaining patients in treatment, suppressing heroin use and improving HIV/AIDS prevention and care [43, 44, 45, 46]. There is substantial evidence that people on OMT have a substantial reduction in illicit drug use, an improvement in health and wellbeing, social support, psychiatric status, and quality of life; and a reduction in mortality and criminal activity [47]. People on OMT are more likely to engage with health approaches and work towards holistic treatment goals (such as counselling and rehabilitation) [48]. Maximising these health benefits from treatment rests upon the accessibility of the pharmacotherapy to the target group. The most discussed and key issue in accessibility is the affordability of treatment. The mean cost is $5/day [49] which is unsustainable particularly for the socioeconomic status of many people suffering from opioid dependence and often have issues with employment. Better access to OMT will aid in addressing the growing rates of prescription opioid misuse and overdose as well as illicitly used opioids. Under the present system, it is cheaper and easier to procure prescription opioids than OMT. Ensuring OMT is affordable is an important strategy to help stem prescription opioid as well as heroin addiction.

**Medically Supervised Injecting Centres**

Medically Supervised Injecting Centres (MSIC) are legal supervised facilities to provide hygienic and safer environments for the injection of drugs. There are 88 MSICs internationally in 58 cities across 9 countries [50]. In Australia, there is the well-established and validated MSIC in Kings Cross, Sydney as well as a trial underway of an MSIC in North Richmond, Victoria. The Uniting MSIC in Kings Cross was established in 2001 as a harm reduction strategy, the ethos being “We concentrate on reducing the negative consequences of drug use on a person’s health and well-being. The Uniting MSIC does not support or promote drug use; it acknowledges that it is part of the community and seeks to provide assistance that is practical and sound.” [51] Following a ten-year review of the centre by the NSW Government, it was found that the MSIC has facilitated improved overdose management with 3,426 overdose events with no deaths onsite, generated more than 9500 referrals to health and social welfare service, halved the number of publicly discarded needles and syringes in the Kings Cross and decreased the number of ambulance call outs to Kings Cross by 80% [52]. In addition, it has not lead to an increase in local crime or drug use and has been shown to save the NSW Government over $650,000 per annum without compromise of health outcomes [52]. Following the evidence and high incidence of heroin overdose in the North Richmond area in Victoria, the Victorian Government have agreed to a two-year trial of a MSIC modelled off Sydney [53, 54]. Additionally, internationally there is a move to include controlled inhalation of drugs such as crack cocaine, heroin and ice in these centres as well and this could be considered in Australia with the rising epidemic of ice use [55, 56]. Despite the international and national evidence of the benefits of Medically Supervised Injecting Centres [52, 57, 58], there is only one operating centre and one in the pipeline in Australia, only serving two inner city communities. Considering the reduction in crime, blood borne viruses, and the lives saved, Australia should consider opening more centres throughout Australia.

**Position Statement**

AMSA believes that policy surrounding illicit drugs should be evidence-based and focused towards a public health and human rights approach. We advocate for an approach to illicit drugs whereby there is adequate distribution of resources to best reflect the intended goal of minimising harm to individuals.

**Policy**

AMSA calls upon:
1. The Australian Federal Government to:
   a. Prioritise development of appropriate illicit drug use policy as an important public health issue;
b. Engage with validated measures of harm reduction, external experts and private stakeholders to assess and improve the efficacy of illicit drug policy.

c. Ensure funding is allocated to the national drug approach in an evidence-based and appropriate manner, specifically ensuring support is allocated to public health strategies to minimise harm to individuals.

d. Consider an evidence-based decriminalisation approach to possession of illicit drugs.

e. Ensure equitable access to services such as needle and syringe programs and safe injecting rooms across Australia, including rural and remote areas.

f. Support prevention and treatment that is tailored to the specific needs of high-risk populations, particularly Indigenous Australians and the LGBTIQ+ population.

g. Develop, in conjunction with medical practitioners, a national health approach for illicit drug use including national guidelines for the treatment of illicit drug abuse.

h. Provide increased and ongoing support for national drug prevention and education programs with a focus on harm minimisation.

i. Provide programs and training aiming to reduce stigmatization around drug use.

j. Recognise the potential harm to families and communities associated with illicit drug use and ensure strategies address both individual and social harms.

k. Improve ongoing and up to date research on illicit drug use and associated harms in order to inform harm minimisation strategy.

l. Provide support to researching the efficacy of novel harm minimization strategies, such as pill testing, in Australia.

m. Ensure access to harm minimisation strategies such as opioid maintenance therapy, needle and syringe programs and safe injecting rooms is affordable.

2. State governments to:
   a. Work collaboratively towards a national health approach to illicit drug use;
   b. Share expertise across states regarding effective measures of harm minimisation.

3. Universities to:
   a. Ensure medical students receive appropriate training on:
      i. The health and sociocultural effects and risk factors associated with illicit drug use;
      ii. Current government prevention policy guidelines;
      iii. Evidence-based harm minimisation techniques e.g. needle and syringe programs;
      iv. Ethical and equitable care of people who use illicit drugs.

4. Medical practitioners and other health professionals to:
   a. Provide equitable treatment for all patients regardless of drug use or socioeconomic status;
   b. Ensure that healthcare is delivered in a holistic manner, focusing on the broader health and social circumstance of drug users, beyond just cessation assistance;
   c. Advocate for access to evidence-based harm minimisation resources e.g. safe injecting rooms;
   d. Provide evidence-based education to patients and communities around illicit drug use and harm minimisation techniques.

References


Policy Details

**Name:** Harm Minimisation in Illicit Substance Use (2018)

**Category:** F – Public Health in Australia

**History:**
Adopted Council 3 2015
Reviewed Council 2 2018 - adopted