Alcohol and other drug harm-minimisation

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– Not Government Policy –

Alcohol and other drug (AOD) harm

Harm from alcohol and other drugs arise from:

- **The drug itself** – for example, some drugs are more likely to lead to dependence; some drugs are more potent and more likely to cause immediate harm.
- **The context in which it is used** – for example, using alcohol or other drugs while alone can be riskier than using them with other people around; people who use illegal drugs may come into contact with the criminal justice system.
- **The person who is using it** – for example, people who have experienced trauma are more likely to use alcohol and other drugs and also more likely to have problems with them; people with poor health are more likely to be affected by taking alcohol or other drugs than a healthy person.

Harm may occur from immediate use (acute harm) or accumulate over a period of time (long-term harms).

Harm may be physical, such as overdose; psychological, such as mental health symptoms; social, such as relationship problems; economic, such as costs to the community; or legal, such as arrest.

Approaches to AOD harm are two-pronged, designed to minimise and reduce harm. Harm minimisation refers to the overarching **policy objective** of creating an environment of least harm from alcohol and other drugs in Australian society. It uses a range of measures to achieve this. Harm reduction refers to **specific measures** or activities that are designed for people who already use drugs to reduce the harms from using. It is a subset of harm minimisation.

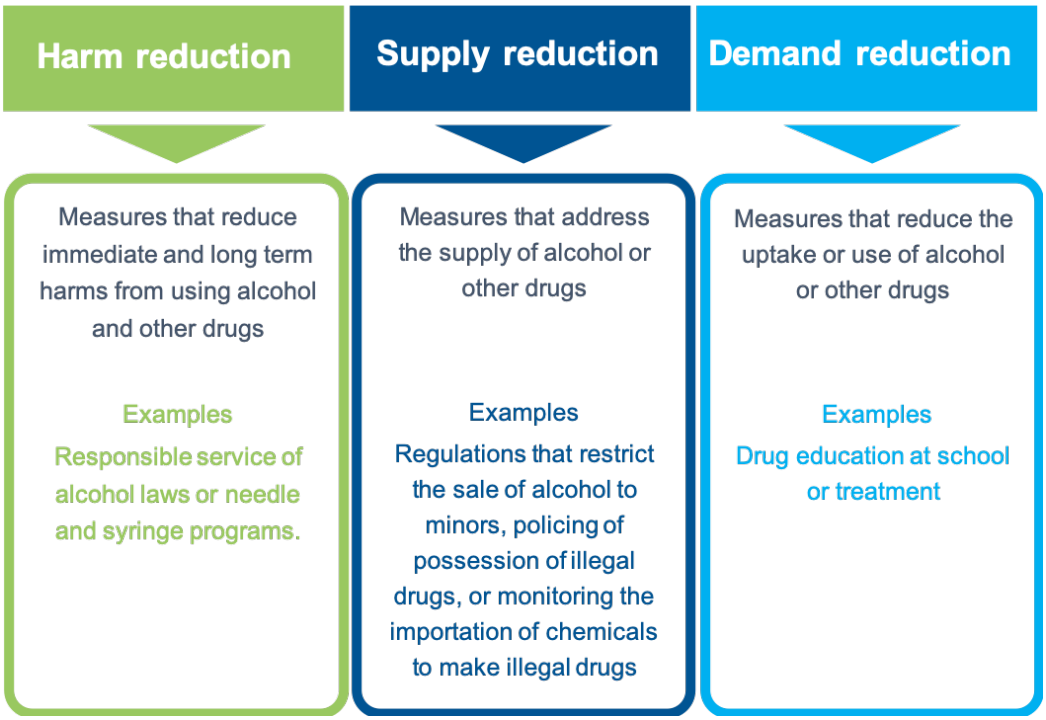
Harm minimisation

Harm minimisation is an umbrella term that describes Australia's official approach to drug policy, outlined in the National Drug Strategy. The strategy's aim is to reduce the negative health, social and economic effects of alcohol and other drugs for individuals and society.[1]

This approach accepts that some people in the community will use alcohol or other drugs even though there are some risks. Harm minimisation seeks to create a society with as little harm from alcohol and other drugs as possible.

There are three 'pillars' of Australia's harm-minimisation policy:

Harm Minimisation Framework



The three pillars are intended to be balanced to achieve the overarching goal of harm minimisation. The success of the National Drug Strategy requires cooperation between law enforcement, health agencies, and other sectors to achieve harm minimisation.

Such cooperation across the three pillars can be seen in the Australian approach to tobacco. Strict restrictions on the sale of cigarettes (supply reduction), coupled with the wide availability of nicotine replacement therapy (harm reduction), and sustained public education campaigns (demand reduction – prevention), and the development of

more effective and widely available treatments (demand reduction – treatment) have seen smoking rates drop from close to 40 per cent of the population in the 1970s to just 11 per cent in 2019.

The three pillars require adequate and balanced funding to ensure they play a mutually supportive role in achieving harm minimisation. A 2013 report to the Australian Government found that 66 per cent of the $1.7 billion spent on illicit drug interventions in 2009-10 went to supply reduction (law enforcement), with demand reduction (treatment and prevention) accounting for 30.5 per cent and harm reduction accounting for 2.1 per cent.[2]
A 2014 national report of Australia's drug expenditure found that treatment funding was only adequate to meet half the existing demand.[3] It found that every $1 spent on treatment resulted in a $7 cost saving to the community. These reports highlight a need to increase funding for demand reduction and harm reduction, and to consider where supply reduction funding is focused to achieve the best health outcomes.

The *Shifting minds: Queensland Mental Health Alcohol and Other Drugs Strategic Plan 2018-2023 (Shifting minds*) calls for greater balance in the implementation of demand, supply and harm reduction strategies, as well as growth across the continuum of alcohol and other drug services.[4] Community support for an equitable distribution of funding was revealed in a major 2019 survey, with most respondents supporting significantly greater spending on demand reduction.[5]

Harm reduction

Harm reduction refers to **specific measures** or activities designed reduce harm for people using (or affected by someone using) alcohol or other drugs. The key feature of harm reduction is that its focus is solely on the prevention and reduction of harm, not the prevention of use. Harm reduction does not condone or encourage alcohol or other drug use but recognises that some people will use substances despite the risks.

There are many reasons that someone might continue to use alcohol or other drugs. They might use only in a social context and have very few problems and wish to continue (for example, someone who has a few drinks once or twice a week); they might experience some problems but the benefits still outweigh the issues (for example, someone who occasionally drinks too much and has a hangover the next day); or might experience problems but have difficulty stopping (for example, someone who is dependent on alcohol).[6]

Harm reduction is not a concept that applies only to alcohol and other drugs. An everyday example of harm reduction can be found on our roads. More than 1000 people die each year in road accidents. Acknowledging that driving has benefits to individuals, rather than banning cars, measures such as seatbelts and speed limits are in place to make driving safer. Seatbelts do not prevent crashes, but they significantly reduce injury and death when a crash occurs. They are not 100 per cent effective but reduce harm significantly: There is a 90 per cent reduction in injury if people wear a seatbelt.

Likewise, alcohol and other drug harm reduction is not expected to be 100 per cent effective but is designed to significantly reduce harm.

The efficacy of harm reduction strategies can be measured through factors including injury rates, overdose, mental and physical health, and dependence.[7] Reduction in use is not an expected outcome, but could be a side-effect.

Several initiatives supported by credible evidence include:

- Random alcohol breath-testing, which reduces road crashes and deaths.[8] Accidents decrease as random breath-test rates increase.[9]
- Restricting smoking in public places reduces non-smoker and smoker exposure to the harmful effects of second-hand smoke.
- Needle and syringe programs offer both health benefits and cost savings and are estimated to prevent thousands of HIV and hepatitis C infections and save millions of dollars every year. Every $1 spent on providing clean needles results in a $4 saving to the community.[10]
- Medically supervised injecting facilities decrease overdose deaths; reduce ambulance call outs; reduce the spread of blood-borne viruses; reduce public injecting and needle litter; and increase access to treatment.[11-15]

- Removing criminal penalties for illicit drug use and possession, and introducing police diversion programs reduces the number of arrests without an apparent increase in use.[16]
- Nicotine replacement therapies such as nicotine patches, gum and e-cigarettes continue to deliver nicotine to people who are dependent but reduce smoking health risks such as asthma, cancer and heart disease.
- Opioid replacement therapies such as methadone and buprenorphine reduce overdose and criminal activity and improve physical and mental health and rates of employment.[17-19]
- Naloxone, a drug that reverses opioid overdose, reduces overdose deaths[20-22] and does not increase opioid use.[23]

Measures supported by reasonable evidence (but would benefit from further research) include:

- Drug-checking (or pill-testing) using laboratory equipment to test illicit drugs then provide feedback about the contents to the person who intended to use them increases access to health information and treatment and makes it more likely people will discard their drugs. It reduces drug-related hospitalisations and intention to use.[24-29]
- Using a general alert system, through social media or other channels, to advise the public when drug-checking reveals particularly dangerous or potent illicit provides harm-reduction information for people who use drugs and enables general information about contents of drugs to reach potential users.

Harm reduction is the least resourced of the three pillars in Queensland and throughout Australia. Increasing funding for evidence-based harm-reduction activities will reduce harm and reduce costs to the health system.[32]

Harm reduction programs that operate in other states but are not yet available in Queensland include drug checking/pill testing services at music festivals and fixed site locations and a drug alert system similar to the joint NSW Police and NSW Health public drug warning program. Queensland has a take-home naloxone program, but it is limited compared to some jurisdictions.

Many regional areas in Queensland have access only to 'secondary' needle and syringe programs operating outside the alcohol and other drug specialist sector. This means that there is less opportunity to provide harm reduction information or to answer questions about access to treatment for people collecting clean needles at these locations. Expanding primary needle and syringe programs would improve access to harm reduction information.

Supply reduction

The aim of supply reduction is to reduce the availability of alcohol and other drugs to indirectly influence demand and harm. Supply reduction involves strategies to control, manage or regulate the availability of alcohol and other drugs, including what can be used, who can use them and where they can be used.

There has been limited research into the effectiveness of supply reduction activities.[33,34] Supply reduction targeted at legal drugs has more evidence to support it than supply reduction for illicit drugs.[33,34] Evidence that is available suggests levers to control legal drugs are more effective than those to control illegal drugs. This could suggest that legislative changes could aid supply reduction approaches.

Restricting trading hours and limiting the density of alcohol venues in an area reduces alcohol-related assaults, intoxication, crime and overall alcohol consumption.[34,35] Restricting the sale of medicines, such as codeine, decreases availability and can reduce harm. For example, the recent Australian rescheduling of codeine resulted in a 50 per cent drop in overdoses and sales.[36]

Street policing of illicit drugs, including seizures, does not appear to significantly reduce use, supply or harm.[33]For example, despite hundreds of thousands of drug seizures and arrests each year, supply markets for methamphetamine, cannabis and heroin have remained stable, and the cocaine market appears to be stable or expanding.[37] Police presence, drug-detection dogs and strip searches at festivals show no impact on purchasing and supply, and potentially increase harm.[38]

Shifting the focus of policing efforts from use and possession to investigating high-threat criminal networks involved in trafficking illicit drugs reduces harm to people who use drugs through fewer arrests for use or possession, and may

also reduce stigma.[39]The evolution of online drug market and global drug supply chains presents unique challenges for law enforcement and require specific resourcing and ongoing investment in technologies and training for police.

The 2019 Queensland Productivity Commission report into imprisonment and recidivism[40] recommended reviewing policy options for illicit drug offences in Queensland. In response, the Queensland Government made a commitment to explore opportunities to increase the range of responses to low harm offending and noted that health based solutions were an important part of the solution.[42]

The rate of risky alcohol use in Queensland is above the national average.[5] There is a higher proportion of at least weekly risky drinking (15.3 per cent compared to the Australian average of 13.1 per cent) and a greater percentage of people at risk of injury from drinking (29.8 per cent compared to 25.7 per cent).

Queensland's 2019 Tackling Alcohol-Fuelled Violence Policy introduction of state-wide restrictions on trading hours has seen a corresponding reduction in assaults, ambulance attendances and hospital admissions. There has been no measurable impact on tourism or the number of liquor licences.[43] A review recommended further reform, including:[44]

- A two-year moratorium on liquor licences for licensed premises except for restaurants and cafes.
- A minimum unit price for alcohol.
- Greater liability for venues that sell to intoxicated people.
- Consideration of the impact of violence, particularly family violence, when approving increases to liquor outlet density.
- Improved collection of alcohol sales data.

In light of the limited research into supply reduction activities, routine evaluation of outcomes and impact, as well as currently measured outputs, would guide investment.

Demand reduction

Demand reduction refers to measures that reduce use regardless of availability. The two main types of demand reduction are measures to prevent or delay uptake of alcohol and other drug use ('prevention'), and measures to reduce use ('treatment').

Prevention includes drug education in schools, as well as public and targeted education campaigns. The evidence to support such measures to reduce demand is mixed. A full review of prevention activities is the focus of a separate consultation paper in this series.

Evidenced-based alcohol and other drug treatment is an effective way to reduce demand.[51-53] Treatment reduces both drug use and harm, and has flow-on effects to improving participation in the community (for example, employment and training), improving health and well-being, and reducing criminal behaviour. Every $1 spent on drug treatment saves about $7 in health, welfare and other costs to the community.[54]

The Queensland Drug and Alcohol Court was reinstated in Brisbane on January 2018, following a comprehensive review that found that court-based intervention programs could reduce drug-related offending in a cost-effective way.[56]

Alcohol and other drug treatment is most effective when there is a range of options, including withdrawal, rehabilitation, counselling, care coordination and aftercare, as well as brief interventions.[55]

Alcohol and other drug treatment in Queensland, and indeed across Australia, is unable to meet demand. Assessments by various Primary Health Networks in Queensland highlight a need for:

- tailored services for Aboriginal and Torres Strait Islander peoples[57-61]
- tailored services for young people[57,59,62]
- greater access to residential rehabilitation[57,60]
- more withdrawal services[57-60]

- better access to treatment in rural and remote areas[57,59,61]
- transition services for clients exiting prison[57]
- coordination between alcohol and other drugs and other sectors[57-62]
- aftercare and outpatient care services[59,61]
- monitoring and evaluation of outcomes.[57,61,63]

In its response to the Queensland Productivity Commission report, the Queensland Government committed to expanding key treatment services.

Diverting people who use drugs to assessment, education or treatment is more cost-effective than traditional criminal justice processes and leads to better rehabilitation outcomes, so expanding police diversion programs would have an impact on demand.[40] In Queensland, police diversion to treatment is applied only to minor cannabis offences, thus Queensland has one of the lowest rates of diversion in Australia.[40]

A review of the Queensland Illicit Drug Diversion Initiative noted that diversion programs were underutilised by police and relied too heavily on police discretion.[40] In its response to the Queensland Productivity Commission report, the Queensland Government has made a commitment to progressing delivery of appropriate alcohol and other drug screening, assessment, referral pathways, and treatment programs for people referred from the criminal justice system.

Effective harm minimisation relies on maintaining an adequate balance between harm reduction, supply reduction and demand reduction activities. It also relies on the application of evidence-based interventions in all three areas.

There is an ongoing commitment in the national policy to a greater focus on a health perspective across all three pillars. At the supply reduction level, a shift in focus from the policing of use and possession to policing high-threat criminal networks involved in trafficking illicit drugs is consistent with the growing evidence base in effective alcohol and other drug policy.

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