4.19 Dr Wodak and Friends.

Chapter 4

Harm reduction measures

4.1 Harm reduction is described as:

...an approach rooted in public health and human rights. It aims to improve the lives of people who are affected by drugs or drug policies through evidence-based programming and approaches, ideally that are developed in partnership with people who use drugs.[1]

4.2 A number of submitters and witnesses argued in support of increasing the amount of government funding for harm reduction, one of the three pillars of Australia's drug policy.

4.3 This chapter considers the definition of harm reduction; examines the benefits of the government's harm minimisation policy; discusses current approaches to harm reduction; and considers possible improvements in harm reduction to reduce the risks for users of crystal methamphetamine.

4.4 Finally, the chapter concludes with consideration of a submission to the committee's inquiry into the impact of new and emerging information and communication technology on Australian law enforcement agencies. This submission, from Dr James Martin, a senior Lecturer in Criminology at the Department of Security Studies and Criminology at Macquarie University, argues in favour of a harm reduction approach to drug trading via the darknet.

Defining harm reduction

4.5 The Australian National Drug Strategy (NDS) comprises of three pillars:

- demand reduction;
- supply reduction; and
- harm reduction.[2]

4.6 The NDS states that '[s]trategies to prevent and minimise alcohol, tobacco and other drug problems should be balanced across the three pillars'.[3]

4.7 The NDS provides the following definition of 'harm reduction':

Harm reduction strategies identify specific risks that arise from drug use. These are risks that can affect the individual who is using drugs, but also others such as family members, friends and the broader community. Harm reduction strategies encourage safer behaviours, reduce preventable risk factors and can contribute to a reduction in health and social inequalities among specific population groups.[4]

4.8 According to the NDS '[h]arm reduction requires commitment from government and non-government programs, industry regulation and standards, and targeted communication strategies'.[5] Strategies affecting harm reduction include:

- reducing risks associated with particular context, including creating safer settings;
- safe transport and sobering up services;
- protecting children from another's drug use;
- protecting the community from infectious disease including blood borne virus [(BBV)] prevention;
- reducing driving under the influence of alcohol or other drugs; and
- availability of opioid treatment programs.[6]

4.9 Victoria Police identified the following examples of prevention and harm reduction activities in that state:

- Provide users with referrals to treatment and other health services
- Increased focus on drug diversions.
- Regional youth officers to actively discuss drug-related harm issues in presentations with school children
- Run Passive Alert Detection Dog operations at major festivals and events where applicable
- Ensure child protection agencies are advised to conduct a health assessment and care for children at risk who are identified at clandestine drug laboratories.
- Use roadside drug detection as an opportunity to identify and intervene with individuals testing positive to use of [Aboriginal and Torres Strait Islander] (e.g. referrals to treatment and other support services)
- Work with other government agencies to identify the issues and impact of ATS use within the community, educate users and link in with community messaging[7]

4.10 Dr Terry Goldsworthy and Adjunct Teaching Fellow Laura McGillivray outlined an international definition of harm reduction:

The International Harm Reduction Association [(IHRA)] (2015) defines harm reduction by its aims to as the "reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption". The IHRA identify that features of harm reduction are framed within a human rights perspective as it focuses on the prevention of harm, rather than the prevention of drug use in those who continue to use.[8]

The benefits of harm reduction

4.11 There is a substantial amount of evidence that demonstrates 'that drug treatment and harm reduction are effective and cost-effective'.[9] For example, Dr Alex Wodak AM has stated that:

A review of the effectiveness and cost-effectiveness of needle syringe programmes in Australia estimated that these had prevented 25,000 HIV and 21,000 hepatitis C infections (by 2000),

4500 deaths from HIV and 90 deaths from hepatitis C (by 2010) resulting in savings (by 2000) of between AU$ 2.4 and AU$7.7 billion from an investment between 1991 and 2000 of AU$ 130 million (Health Outcomes International Pty Ltd., The National Centre For HIV Epidemiology and Clinical Research, & Drummond, 2002). A subsequent study confirmed these findings estimating that an investment of AU$ 243 million between 2000 and 2009 achieved short-term health savings of AU$ 1.28 billion. Thus for every AU$ 1, invested savings amounted to AU$ 4 in healthcare costs and with overall savings of AU$ 27. (National Centre for HIV Epidemiology and Clinical Research, 2009).[10]

4.12 Dr Goldsworthy and Adjunct Teaching Fellow McGillivray also described some benefits of harm reduction:

Harm reduction allows for input from a variety of theoretical perspectives to inform interventions, rather than being bound to one course of action. The view has been advocated across a variety of disciplines including psychology, nursing and social work because it is a form of health promotion whereby working to reduce drug-related harms simultaneously promotes health and wellbeing (McVinney, 2008). Therefore, given the growing intersection between these disciplines, services and methylamphetamine users, harm reduction appears to promote relevant and viable strategies.

Harm reduction has been found to be particularly effective in preventing HIV in injecting drug users. With the increase in crystal methylamphetamine or 'ice' users and therefore exposure to BBVs such as HIV, improving harm reduction services across Australia is a viable approach because it has proven to be successful, safe and cost-effective (Wodak & Maher, 2010) (World Health Organisation, United Nations Office on Drugs and Crime, & United Nations Programme on HIV/AIDS, 2009). This joint WHO, UNODC and UNAIDS (2009) review into needle and syringe programs (NSPs) concluded with the recommendation that countries affected or threatened by HIV and other BBVs among injecting drug users should rapidly establish and expand NSPs as a viable response to the problem. Similarly, early data from the War on Drugs suggest that policies which deny injection equipment and income support for injecting drug users will increase their risk of contracting HIV and therefore must be reconsidered from a public health perspective (Bluthenthal, Lorvicka, Krala, Erringera, & Kahna, 1999).[11]

4.13 The NSW Users and AIDS Association spoke to the economic benefits of harm reduction, noting that '[h]arm reduction programs and peer education are highly effective and cost effective, with the NSP program returning $4 in value for every dollar spent'.[12] The Western Australian Network of Alcohol and other Drug Agencies (WANADA) also highlighted the economic benefits of harm reduction approaches:

- for every $1 invested in treatment services, more than $7 is returned to the community through health and social benefits; and,
- for every $1 spent on needle and syringe exchange programs, the community saves $27 in future cost.[13]

4.14 The committee heard about the benefits of other approaches to combatting crystal methamphetamine use. For example, while recognising 'the need to provide harm reduction strategies such as needle and syringe exchange programs or adequate treatment for people

with drug use problems', the Australian Drug Foundation (ADF) advocated for an "upstream" approach, which would prevent 'people from commencing drug use rather than waiting for their drug use to become a problem that requires reactive "downstream" approaches'.[14]

4.15 However, as the National Association of People with HIV Australia (NAPWHA) observed, '[a] basic tenant of harm reduction is that there hasn't been, is not now, and never will be a drug-free society', a sentiment also expressed by Cohealth.[15] The NAPWHA explained that the risks associated with 'an overemphasis on drug and alcohol prohibition as a policy goal comes at the expense of more effective harm reduction strategies', stating:

There will always be a tension between the national harm reduction agenda and the criminalisation of illicit substances. The negative consequence of this is stigmatisation of the user and create health access and equity problems for the health system more broadly.[16]

Current approach to harm reduction

4.16 The NDS includes the following table, which provides 'a comprehensive summary of examples of harm reduction approaches'.[17]

Table 2: Examples of evidence-based and practice-informed approaches to harm minimisation [18]

Approach	Strategies
Safer settings	• Chill-out spaces • Availability of free water at licensed venues • Information and peer education • Emergency services responses to critical incidents • Maintenance of public safety
Diversion	• Diversion from the criminal justice system to treatment services
Blood borne virus prevention	• Hepatitis B vaccination • BBV and sexually transmitted infection testing, prevention, counselling and Treatment • Peer education
Safer injecting practices	• Diversity and accessibility of needle and syringe programs • Medically supervised injection centres and drug consumption rooms • Peer education • Prevent and respond to overdose including increased access to naloxone • Police policy to exercise discretion when attending drug overdoses

	• Non-injecting routes of administration
Replacement therapies	• Pharmacotherapy for opioid maintenance and other drug use

4.17 Many submitters and witnesses criticised the current approach to harm reduction. Indeed, the Scarlet Alliance observed that '[a]lmost every' one of the inquiry's terms of reference go to supply reduction or demand reduction, which:

...is typical of existing efforts to address crystal methamphetamine use in Australia, which emphasise supply and demand reduction from a law enforcement approach at the expense of accurate and honest information and effective harm reduction approaches.[19]

4.18 Dr Wodak similarly remarked that the inquiry's terms of reference illustrate 'the unbalanced approach to drug policy in Australia'.[20]

4.19 Dr Wodak acknowledged that 'Commonwealth law enforcement agencies do have a role in responding to the importation, manufacture, distribution and use of methamphetamine and its chemical precursors', but considered that 'the excessive fiscal and rhetorical reliance on law enforcement has proved to be an expensive way of making a bad problem worse'.[21] Dr Wodak therefore suggested that rather than increasing existing law enforcement measures, Australia should:

...increase the emphasis on demand reduction and harm reduction as these are more effective, safer and more cost effective than drug law enforcement and therefore provide a better return on investment from scarce resources. Drugs should be re-defined as primarily a health and social issue rather than primarily a law enforcement issue.[22]

4.20 In terms of the government's approach to harm reduction, the NAPWHA submitted that, although the national Intergovernmental Committee on Drugs 'considers harm reduction as amongst its central goals, in practice Australia's drug and alcohol policy has primarily focussed on decreasing supply of illicit substances to the community', and provided the following example:

...a 2013 report by the National Substance and Alcohol Research Centre noted that of the $1.7 billion spent in the 2009/10 financial year, only $36.1 million or 2.1 per cent was spent on harm reduction initiatives (not including drug treatment programs).[23]

4.21 The Network of Alcohol and other Drugs Agencies (NADA) observed that harm reduction initiatives were not included in the final report of the National Ice Taskforce (NIT), which it stated is inconsistent 'with the three pillars approach of the National Drug Strategy' and 'does not recognise the benefits of harm reduction strategies in reducing social costs'.[24] The NADA, together with the Network of AOD Peaks, therefore recommended that 'harm reduction initiatives are included as a matter of priority'.[25]

4.22 The Australian Injecting & Illicit Drug Users League similarly criticised the lack of focus on harm reduction in the government's response to the NIT's report, and consequently called for 'a long overdue increase in funding for harm reduction approaches'.[26]

4.23 The former head of the NIT, Mr Ken Lay, commented that in his personal view, 'there is a real attraction to harm reduction'[27] and if 'you invest in front end, you need to invest in harm reduction, you need to invest in education and you need to wrap services around people who are basically sick – they're not criminals'.[28]

4.24 Indeed, a recurring criticism of the current approach is the uneven distribution of government funding between the three pillars of the government's drug policy.[29] As discussed in chapter 5 (at paragraph 5.59), of the total $1.7 billion spent on illicit drug programs by all governments, 64.1 per cent (over $1 billion) was dedicated to law enforcement policies, whereas:

- 9.7 per cent (approximately $156.8 million) was spent on prevention activities;
- 22.5 per cent (approximately $361.8 million) was spent on treatment services;
- 2.2 per cent ($36.1 million) was spent on harm reduction measures; and
- 1.4 per cent ($23.1 million) on other activities.[30]

4.25 According to the Queensland Network of Alcohol and Other Drug Agencies (QNADA), the imbalance in investment between 'law enforcement responses' and harm minimisation 'is impeding our ability to reduce the demand for methamphetamine'.[31] The QNADA therefore recommended that 'the committee consider the distribution of government funding between supply, demand and harm reduction policy approaches to the issue of methamphetamine use in Australia'.[32]

4.26 NAPHWA observed that 'nearly two-thirds of the total spending on drug-related issues is spent on law enforcement, compared to other drug-related interventions, such as harm reduction, rehabilitation, support programs and other initiatives', and argued:

...it is worth looking at whether these measures have had sufficient impact on the use, supply and demand of these drugs and whether funding should be increased for prevention, treatment and harm reduction options, including substitution trials.[33]

4.27 Dr Goldsworthy and Adjunct Teaching Fellow McGillivray advised that '[a] growing body of literature indicates that interrupting the drug market through enforcement has detrimental public health and social impacts'.[34] Their submission referenced evidence that suggested law enforcement measures, targeted at heroin in the early 2000s, led to an increase in the use of other drugs, such as cocaine and other stimulants.[35] Further, anecdotal evidence indicates that the heroin shortage shifted drug users to injecting stimulants because they were cheaper and more readily available.[36] The authors noted that law enforcement initiatives can have unintended consequences on harm reduction initiatives, such as:

...disrupting the provision of health services to injecting drug users; increasing risky injecting behaviours exposing users to infectious diseases and overdose; and exposing previously

unaffected communities to the harms associated with illicit drugs (Kerr, Small, & Wood, 2005) (Maher et al., 2007) (Bluthenthal et al., 1999).[37]

4.28 By contrast, the Australian Federation of AIDS Organisations (AFAO) did not consider that harm reduction necessarily conflicts with law enforcement, but rather, suggested 'that law enforcement should be done in such a way that people who have problematic ice use are directed to health assistance—that it is a public health approach'.[38]

4.29 Several submitters and witnesses discussed in detail some current harm reduction approaches. The following sections address those most frequently raised in evidence to the committee.

Proposed harm reduction strategies

4.30 The committee received a large amount of evidence which suggested further investment should be made in harm reduction measures. However, as Mr Matthew Y Frei and Dr Wodak have observed, '[r]edefining drug use as a health and social issue within a harm reduction framework will require progressive policy'.[39]

4.31 Mr Frei and Dr Wodak stated that:

Consideration needs to be given to supervised consumption facilities in major drug “hot spots”. Drug consumption rooms have the potential to offer information about harm reduction and treatment, to decrease the risk of overdose and other drug-related morbidity, and to reduce the negative impact on neighbourhood amenity. Just as we support [NSPs], we need to evaluate the provision of ice using equipment (such as glass pipes to attract and accommodate the significant proportion of marginalised users who inhale rather than inject methamphetamine) and encourage more disaffected ice users to seek health and social assistance.[40]

4.32 The Drug Policy Modelling Program (DPMP)—a project by the National Drug and Alcohol Research Centre (NDARC) at the University of New South Wales—discussed a number of harm reduction strategies, such as:

- limiting the stigmatisation of methamphetamine use;
- peer education;
- expanding NSPs to reduce the harms associated with injecting; and
- a more nuanced portrayal of the relationship between methamphetamine use and psychosis.[41]

4.33 The Victorian Alcohol and Drug Association (VAADA), 'the peak body for alcohol and other drug (AOD) services in Victoria',[42] recommended enhancement of the capacity of emergency services to work with AOD affected populations, including with respect to activity related to harm reduction and referral.[43]

4.34 The National Association of People Living with HIV Australia recommended the implementation of the following tailored harm reduction strategies:

A. Advocate for decriminalisation of possession and use of current illicit substances to ensure harm reduction strategies can be successfully implemented, including support for interim measures that offer a therapeutic justice approach such as expansion of drug courts and diversion programs at the state and territory levels of government.
B. Increase peer-to-peer education and resources on substance use. Messaging should be culturally appropriate for subpopulations of people living with HIV and include information on poly substance use, safer injecting practices and alternative routes of administration;
C. Stigma-free alcohol and drug services that are sensitive to the needs of people living with HIV and the subpopulations they may be a part of including gay and bisexual men, Aboriginal and Torres Strait Islander people, and people from Culturally and Linguistically Diverse communities; and
D. Increased accessibility to and enhancement of [NSPs] including increased peer-to-peer distribution networks.[44]

4.35 Mr Matthew Creamer of the Western Australian AIDS Council (WAAC) sought to 'reinforce the importance of a harm reduction framework in respect to crystal methamphetamine in Australia' and raised 'three critical points for consideration' to be used 'when determining a harm reduction response to addressing community needs while delivering lasting outcomes':

- first, 'the need for an evidence-based response to the harms related to methamphetamine';
- second, that 'the evidence does not support the case that the number of users has increased', rather evidence demonstrates 'that there is higher usage amongst specific subpopulations'; and
- finally, that:

...negative media attention on similar and related health issues, such as HIV perhaps or hepatitis or other chronic health conditions, impede health promotion activities, prevention initiatives and access to suitable health care and treatment options.[45]

4.36 The following sections examine some of the most significant harm reduction strategies suggested to the committee.

Messaging and stigma

4.37 Users of crystal methamphetamine are often the subjects of stigma, which may affect their willingness to seek assistance. For example, it was suggested to the committee that the 'well-intentioned harm minimisation program, "ice ruins lives"', has stigmatised crystal methamphetamine users, as '[p]eople are portrayed in those commercials as being off their head, punching everybody and being this, that and the other'.[46]

4.38 The NAPWHA considered that this particular campaign 'uses fear to stigmatise substance users, which may discourage people from seeking medical assistance', and instead advocated for:

A more compassionate approach with the community [which] could encourage reaching out to those who might be seeking help for their substance misuse. The image of a person affected by methamphetamine in an emergency department having a physical brawl with the police does not positively reinforce the notion of being able to seek help without intervention by law enforcement.[47]

4.39 In order to avoid creating such stigmatisation, the AFAO suggested learning from the experience with HIV and advocated that the 'primary driver of the response to problematic ice use' should be 'a national strategy that frames the response around public health and harm reduction, with health promotion targeting affected communities', elaborating:

It is targeting that the HIV sector has learnt well and which applies. A failure to target was the problem with the initial response to HIV in Australia with the Grim Reaper campaign. We see similarities between what has been on television recently regarding ice and the Grim Reaper. The problem is that that sort of stuff does stigmatise communities that are truly affected by HIV and what can be related problems with problematic ice use. The big issue here is not to stigmatise and drive underground affected communities. It is to ensure that people in those communities are confident coming forward for treatment.[48]

4.40 The VAADA also recognised the 'need to ensure that adequate harm reduction measures and messaging are in place' for large populations that are in need of, but do not access treatment,[49] recommending that:

This messaging must be evidence based and delivered in a manner and format which is accessible to at risk populations and AOD consumers. Credible messaging such as the least harmful means of consumption, highlighting potential risks associated with poly substance use, provision of sterile injecting equipment, hydration and reinforcing means of reducing harms through unsafe sexual practices must be accessible to all at risk populations. Ensuring that this messaging is available and accessible to at risk population is key to reducing the harms associated with this substance.[50]

4.41 While the National Drug Research Institute (NDRI) at Curtin University stated that '[m]ass media campaigns in isolation are not generally recommended for issues that affect a relatively small proportion of the population' as this may 'increase interest and uptake', it noted that evidence also suggests that 'mass media campaigns can be made effective' and 'are most likely to have impact if complemented by':

...(i) other evidence based strategies that prevent drug problems emerging and developing; (ii) targeted strategies that aim to reach sub-populations most at risk, particularly early in the development of problems to encourage them to seek treatment; and, (iii) a range of appropriate treatment options from brief and early intervention, to upskilling community-based services (such as GPs, community clinical psychologists) to respond, as well as enhancement and development of specialist AOD services and mental health services for those experiencing more severe problems. Targeted interventions are important because there are diverse needs among: those who don't use; those who use occasionally; those with severe problems; families; those who use in connection with their employment; those who use in the

context of sexual risk taking; those in Aboriginal and Torres Strait Islander communities, etc.[51]

4.42 In respect of targeting sub-populations, Dr Louise Roufeil of the Australian Psychological Society (APS) informed the committee of the approach she would take as an academic:

...the first thing I would do is go and ask them what is going to make the difference. I think part of the problem is that we do not know. I certainly, as a 54-year-old person working inner-city Melbourne, do not know what the message is that is going to get through to those young people. I think the answer is we have to ask them. That is the only way we are going to get messages that are going to appeal to them and make a difference. The message that gets through to them will not be the same as gets through to the FIFO worker who is using on their weak off. It is not going to be the same message as gets through to the recreational user on the weekend either. They are going to be three different messages. It is perhaps easier for us to understand what is going to work for the FIFO worker than what is going to help the 15-year-old not just in what the message is but also the medium through which it is delivered. It may not be TV.[52]

4.43 The NDRI also stated that 'the terms in which public debate about methamphetamine is being conducted' is a key issue that is 'not yet receiving enough attention'.[53] The NDRI considered that:

Because of heightened public concern, great care needs to be taken when discussing methamphetamine use and its impact on the community (Moore & Fraser, 2015), which varies according to the very diverse patterns and contexts of its use and related problems.[54]

Media reporting guidelines

4.44 To help facilitate greater care and ensure appropriate, targeted and de-stigmatised messages are communicated to the public about AOD issues, the NDRI advocated for the implementation of media reporting guidelines.

4.45 Nationally endorsed media guidelines could be used to 'educate and inform discussions of methamphetamine and other drug issues in the public sphere', for use by, for example, 'journalists, policy makers and practitioners':

This is important, because, notwithstanding the human rights issues, stigma and marginalisation can contribute to a low perception of risk ("I'm not like that"), reduced likelihood of treatment seeking and disinclination to offer support by clinicians. Standards of reporting, such as those in place in Australia for reporting suicide or depression, could be developed to reduce the risk that media commentary and indeed prevention strategies unintentionally contribute to stigma and discrimination that in turn result in poorer public health outcomes.[55]

4.46 The implementation of a similar strategy has been previously achieved by the Australian Press Council's (APC) Specific Standards on Coverage of Suicide (the Standards). The

Standards are a set of legally binding guidelines to be upheld by members of the APC. The Standards 'are concerned with the coverage of suicide and related issues in print and online media'.[56]

4.47 The Standards are based on:

...a body of research evidence that indicates that the way suicide deaths are reported in the media can have an impact on rates of suicidal behaviour in the community (through suicide deaths, attempts and ideation).[57]

4.48 The Standards are available at Appendix 1 in their entirety, but in summary include:

- General reporting guidelines on issues relating to suicide, how to improve the public's understanding of the issue, warning signs, deterrence measures for those contemplating suicide, and support for families and friends affected by suicide. The Standards also specify that caution is required for material that is likely to be read or seen by vulnerable people (in particular if it relates to peers or celebrities).
- Reporting of suicide, including identification of the individual, must only be done if at least one of the following criteria is satisfied:
- clear and informed consent by relatives or close friends; or
- identification of the individual is in the public interest.
- Restrictions on the reporting of the method and location of a suicide, unless it is in the public interest to do so and outweighs the risk of causing further suicides.
- Reporting of suicide should not be sensationalised, glamorised or trivialised. Further, the media should not inappropriately stigmatise suicides or people involved in them and if appropriate, underlying causes such as mental illness should be mentioned.
- Media reports of suicide should not be given undue prominence (such as explicit headlines or images) and care should be taken to avoid harming those who have attempted suicide. And,
- Articles with material that relates to suicide must be accompanied by information about appropriate 24-hour crisis support services and other sources of assistance.[58]

Committee comment

4.49 The committee recognises that government messaging and media coverage, if implemented effectively, could significantly reduce the harm associated with the use of crystal methamphetamine by prompting drug users to seek treatment.

4.50 The committee is therefore concerned by evidence that government messaging and media coverage can stigmatise users of crystal methamphetamine. The use of stigmatising language, especially if it is sensationalised, marginalises drug users by reinforcing negative stereotypes. The result is discouragement of drug users seeking assistance for their AOD issues, to their detriment.

4.51 Instead of governments and the media using stigmatised messaging to deter illicit drug use, the committee supports an approach that engenders compassion towards drug users, and

is targeted at and informs those people with the objective of encouraging them to seek treatment and support.

Recommendation 9

4.52 The committee recommends that the Commonwealth government ensures that future public awareness campaigns engender compassion towards drug users, and are targeted at and inform those people with the objective of encouraging them to seek treatment and support.

4.53 Indeed, lessons can be learnt from the national HIV campaign and the media guidelines about suicide. The implementation of the APC's Standards provide an excellent model for governments and media agencies to develop appropriate and compassionate coverage of drug-related content. The committee is therefore supportive of measures that:

- Provide general reporting guidelines on issues relating to drug use, measures to improve the public's understanding of why people use drugs, deterrence initiatives and support for families, friend and communities.
- Restrict media reporting that sensationalises, glamorises or trivialises drug use, and require reporting that does not stigmatise people who use drugs.
- Target at-risk individuals and communities. And,
- Require media reporting of drug use and related issues to be accompanied by information about AOD treatment services.

4.54 The committee recommends that the Australian Press Council develops and implements media reporting standards for coverage of drug use.

Recommendation 10

4.55 The committee recommends that the Australian Press Council develops and implements media reporting standards for coverage of drug use.

Education

4.56 Dr Goldsworthy and Adjunct Teaching Fellow McGillivray suggested that health education, as a form of harm reduction, 'is considered a more beneficial, safe and effective approach to reducing the demand for illicit drugs like methylamphetamine, or at best reducing associated risky behaviours'.[59] They explained that:

Education is fundamental for those drug users who are unlikely to cease use because it enables harm reduction to the user and the wider community. It encourages safer injecting and drug-taking practices and increases user exposure and access to much needed health services. Although there is yet to be rigorous evidence that education injecting drug users about HIV or associated drug issues helps to reduce the spread of such infections, it is considered a plausible and inexpensive strategy (Wodak & Maher, 2010). Evidence from US trials indicates behavioural interventions such as peer-education programs are proving beneficial for reducing the risk of HIV and hepatitis C acquisition (Garfein et al., 2007) (Latka et al., 2008).[60]

4.57 Peer education—'learning from one's peers' via 'spontaneous informal peer education; intentional informal peer education; or formal peer education'[61]—was also raised by a number of submitters and witnesses as an effective harm reduction strategy.[62]

4.58 For example, the Australian Injecting and Illicit Drug Users League argued that 'the lived experience of people who use or who have used methamphetamine is the greatest and perhaps most underutilised resource in creating effective responses to methamphetamine-related harms', elaborating:

When implemented alongside other harm reduction initiatives, such as needle and syringe programs and opioid substitution therapy, peer-based responses of the community of people who use drugs in Australia has achieved some globally significant results...We have evidence that harms to the broader community are better managed through greater social inclusion, peer education and service responsiveness. This is backed up by the UN and WHO, who have consistently identified peer-based organisations as the best practice when working with highly marginalised people—particularly people who use drugs.[63]

4.59 Indeed, the DPMP highlighted that '[r]esearch in the drugs field has shown that peer education has been effective for mobilising change', referring to research from the United States and the United Kingdom, and submitted that:

Peer education approaches have been shown to be effective for reaching people who may not be reached through other avenues (and, as such, can be used in such a way to link them with mainstream services) (AIVL, 2006). Peers may be regarded as more credible and trustworthy sources of information as they 'speak the same language' which is important for communication in situations where people may feel stigmatised (AIVL, 2006). Moreover, accumulated research evidence demonstrates that peer education and outreach interventions are effective for reaching people who use drugs who are not currently engaging with treatment (WHO, 2004) and is regarded as cost effective due to the use of volunteers (UNAIDS, 1999).[64]

4.60 The Alcohol, Tobacco and other Drugs Council of Tasmania (ATDC) argued that a current gap in AOD policies, processes, program design and evaluation is the AOD users' voice.[65] The ATDC argued that a requirement of good policy is that it:

...involves top down (expert) and bottom up (constituency, service user) perspectives working together. Ostensibly service users act to put a 'real world' perspective to research and expert opinion, ensuring that services are responsive and appropriate. *Any* approach that does not involve bottom up processes at each stage – from design to implementation to evaluation - will be, by its nature, compromised. The [AOD] consumer voice is not an optional 'add-on'- to the [AOD] service system, it is a critical part.[66]

4.61 The ATDC stated that without AOD users' perspectives, the policy making process and AOD treatment services are 'hampered in their quest for appropriate service provision'.[67]

4.62 Another harm reduction initiative, the Penington Insitute's Anex Bulletin, plays an important part in promoting drug education and harm reduction initiatives.[68] This

publication provides front line health professionals 'with the latest research and evidence-informed strategies on illicit drugs'.[69]

4.63 The committee had been informed that Commonwealth funding to the Anex Bulletin had been discontinued;[70]however, on 31 October 2017, the Penington Institute received notification that the DoH had extended its funding until June 2019.[71]

Committee comment

4.64 The committee recognises the benefits of education for decreasing the demand for and risks associated with the use of crystal methamphetamine. Evidence to the inquiry demonstrates AOD education services, when combined with peer-education, are an effective tool to address AOD use and target at-risk populations.

4.65 In addition to peer-education, the committee supports the ATDC's call for AOD consumers' perspectives to be integrated into the development and evaluation of AOD policy and treatment services. Failure to engage with illicit drug users' experiences in the AOD treatment system may undermine attempts by governments and services providers to develop effective treatment and harm reduction measures.

4.66 The committee supports the Penington Institute's Anex Bulletin and is pleased that the DoH has continued to fund it to 2019.

Needle and syringe programs

4.67 A number of submitters and witnesses supported an increased focus on needle and syringe programs (NSPs),[72] a harm reduction strategy which provides:

...a range of services that aim to prevent the transmission of BBVs, including the provision of sterile injecting equipment, safer sex materials, information and education on reducing harms associated with injection drug use and referral to a range of health and welfare services. Injecting equipment provided by NSPs primarily includes sterile needles and syringes and containers for the safe disposal of used injecting equipment, and may also include other injecting equipment such as alcohol swabs and ampoules of sterile water.[73]

4.68 The first NSP in Australia began as a pilot program in Darlinghurst, Sydney, on 12 November 1986 in breach of the (then) provisions of the *Drugs Misuse and Trafficking Act 1985* (NSW):

Those involved in the pilot argued that HIV was already being rapidly transmitted among [people who inject drugs (PWID)] in the community, supporting this claim with data from a survey of HIV among PWID in Sydney (Blacker, Tindall, Wodak, & Cooper, 1986). Subsequently, a study supported the case for a pilot involving the testing of returned syringes, which showed an increase in HIV prevalence over time (Wolk et al., 1988).[74]

4.69 Subsequently, in 1987, the New South Wales (NSW) government 'agreed...to begin establishing a needle and syringe program throughout NSW', a move that was followed in other

states and territories such that 'by late 1988 a national NSP system was operating across Australia'.[75]

4.70 In 2015-16, 'Australia's network of NSP services was comprised of 102 primary, 786 secondary and 2,321 pharmacy NSPs...supplemented by 300 syringe dispensing machines (SDMs)'.[76]

4.71 Some submitters and witnesses also gave evidence about NSP programs in specific jurisdictions.

4.72 For example, the South Australian government set out the work it is undertaking in respect of NSPs:

South Australia's Clean Needle Program provides access to sterile injecting equipment and other harm reduction services at a range of sites across the state. Clean Needle Program statistics indicate that amphetamines are the most commonly injected drug among the program's clients, with 46.6% of contacts in 2012-2013 identifying amphetamines as the intended drug to be injected (in the same period opiates accounted for 36.7%). Clean Needle Program sites include participating non-government organisations, pharmacies, non-metropolitan hospital emergency departments, and outreach services (e.g. for at-risk groups). In Adelaide clients can access sterile injecting equipment after-hours through vending machines and a primary Clean Needle Program site which operates 24 hours 7 days a week.

SA Health's Clean Needle Program Peer Education project, delivered by Hepatitis SA, works to successfully engage identified priority populations in harm reduction strategies and aligns with the prevention actions within the National Hepatitis C Strategy 2014–2017.[77]

4.73 In Western Australia (WA), the Mental Health Commission (MHC) developed a 'key planning tool for the mental health, alcohol and other drug sector': the *Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025* (the Plan).[78] The Plan identifies harm reduction strategies, such as NSPs, as 'a long-standing, public health community support response for people with alcohol and other drug problems',[79] and aims to:

Continue to expand harm-reduction services and further develop a high quality, personalised, effective and efficient community support service sector that provides individuals with support to create or rebuild a satisfying, hopeful and contributing life and provides carers, and families with support for their own wellbeing.[80]

4.74 One such community support service in WA is the WAAC NSP, which has been operating for over 28 years[81] and is used by 5000 individuals per annum.[82] Mr Creamer of the WAAC informed the committee that:

Around 50 per cent of our clients regularly report methamphetamine as the last drug they injected. Many of our clients are very long-term. Importantly, the nature of our exchange service means that injecting equipment is returned to us for disposal rather than discarded. We have a 94 per cent exchange rate resulting in improved public health and community health outcomes. Other services delivered by us to marginalised and vulnerable individuals include

one-on-one counselling, care and support with individual clients who many report methamphetamine or problematic methamphetamine use.[83]

4.75 As indicated above, funding for NSPs has a significant return on investment. Indeed, Hepatitis NSW noted that from 2000 to 2009, it is estimated that 'NSPs...directly averted' 32 050 new HIV infections and 96 667 new Hepatitis C infections.[84]

4.76 In its submission, Hepatitis NSW called for 'strengthening the NSP', which 'should be a focus of any response to injecting drug use in Australia, including crystal methamphetamine use', as:

With new hepatitis C treatments currently being considered by the Commonwealth Government that are both more effective, but also more expensive, than the existing standard of care, the cost effectiveness of additional investment in, and expansion of, the needle and syringe program would likely be even higher today.[85]

4.77 The Penington Institute described NSPs as 'a key public health intervention to reduce the social and health burden of injecting drug use and the resurgence of crystal methamphetamine use brings new challenges to this sector'.[86] The Penington Institute discussed some shortcomings with respect to the current operation of NSPs, including that they are 'a one size fits all approach':

There are numerous populations who inject that are less likely to access these services including women, young people, culturally and linguistically diverse populations, people who identify as ATSI and people who identify as gay or lesbian. NSPs require more consumer focused service delivery in order to ensure they meet the needs of diverse populations providing them with targeted harm reduction information and appropriate sterile injecting equipment.[87]

4.78 Further, the Penington Institute noted that, at present, 'there are no minimum training requirements for workers within the NSP sector in Australia', which is problematic because:

...NSPs are typically accessed by people with a range of complex social and health needs including poverty, homelessness and mental health issues. Further, NSPs may be the only contact injectors have with the health system. It is thus essential that the NSP workforce has the capacity to provide appropriate and prompt referral and health advice as well as consistent, high quality and relevant information and support.[88]

4.79 The Penington Institute also identified that '[s]econdary NSP outlets are important services for people who use methamphetamine', as they 'play a vital role in regional and rural communities where there are fewer primary NSP'.[89]

4.80 The Penington Institute continued:

...as secondary NSP outlets may be an adjunct to more mainstream services (such as community health services), there is the possibility that they are accessed by methamphetamine users who may not have contact with primary services. However, additional

support is required for secondary NSP so that they may play a far greater role in brief counselling interventions and referral to other services, particularly AOD counselling and Submission to the Parliamentary Joint Committee on Law Enforcement Inquiry into Crystal Methamphetamine treatment. Until it is possible to have NSP-specific staffing permanently located at every NSP outlet, some level of dedicated NSP-trained support is needed at every NSP outlet across the system, commensurate with the level of NSP activity.[90]

4.81 The Penington Institute therefore made a number of recommendations to address these issues, including that resources for NSP workforces across Australia should be increased; and that 'strategies to provide 24-hour access to sterile injecting equipment such as NSP Secure Dispensing Units and outreach' should be developed and implemented.[91]

4.82 The AVIL noted 'a distinct lack of focus on those methamphetamine users who inject, as opposed to those who only smoke the drug'.[92] In terms of injecting crystal methamphetamine, the AVIL warned that:

People who inject methamphetamine, as with any drug, are at an increased risk of [BBVs] including hepatitis C and HIV, and a variety of injecting related problems such as abscesses, vein collapse and localised infections. While harm reduction services exist in all major Australian cities, these have historically been targeted more towards opioid users; but now is the time to increase their capacity to address the issues related to methamphetamines.[93]

4.83 As noted in chapter 2, AIHW data shows that since 2009–10 there has been a significant increase in the number of people consuming amphetamines intravenously.[94]

4.84 Despite evidence being 'sparse', the committee heard that there are also risks associated with smoking ice, although the outlawing of glass pipes—which has occurred in NSW—is 'not in the spirit of harm reduction':[95]

...glass pipes used to smoke crystal meth can sometimes involve cracked pipes and bleeding of the mouth and gums, and there is a potential [for hepatitis C] transmission risk there as well.[96]

4.85 The Scarlet Alliance raised the difficulty faced by prisoners who are dependent on crystal methamphetamine, and the inadequacy of the government response:

Anecdotal evidence suggests that banning smoking in prisons is producing negative unintended consequences. Many prisoners chose to smoke rather than inject drugs in the prison setting to avoid contracting BBVs. Prisoners are switching to injecting due to the unavailability of lighters due to the implementation of no-smoking policies in prisons across Australia. Given the existing environment in Australian prisons, where there is no harm reduction approach and no [NSPs], the risk of transmission of BBVs is further increased.[97]

4.86 This was also reflected in the evidence from the AIDS Council of NSW:

The need for safe injecting equipment is particularly clear in custodial settings with increasing rates of hepatitis C, particularly among Aboriginal and Torres Strait Islander people (The

National Hepatitis C Strategy notes that 43% of Aboriginal and Torres Strait Islander people in custody are living with hepatitis C). There are currently no NSPs operating in any Australian prisons, despite growing evidence they are 'safe, beneficial and cost-effective' (Duvnjak, Wiggins and Crawford, 2016).[98]

Committee comment

4.87 The committee acknowledges the success of NSPs in reducing rates of infectious disease amongst injecting drug users, and the increasing number of crystal methamphetamine users accessing these services. The committee recognises that some of the risks faced by injecting users of crystal methamphetamine are reduced by NSPs, and supports the continued provision of these programs.

Safe injecting rooms

4.88 Australia's only medically supervised injecting centre (MSIC) in Kings Cross, NSW is a form of harm reduction strategy which 'is a compassionate and practical health service that seeks to connect with people and welcome them in a non-judgemental, person-centred way'.[99] As discussed in the following section, there are also plans to open a MSIC in Richmond, Victoria.

New South Wales

4.89 Australia's first MSIC opened in Kings Cross on 6 May 2001.[100] To this day, it is the only MSIC operating in the southern hemisphere.[101] This MSIC initially operated on a trial basis, with the following objectives:

...to decrease drug overdose deaths; provide a gateway to drug treatment and counselling; reduce problems associated with public injecting and discarded needles and/or syringes; and reduce the spread of disease such as HIV and Hepatitis C.[102]

4.90 In 2010, and as a result of the success of the MSIC in Kings Cross, the NSW Parliament legislated for this MSIC to operate on an ongoing basis.[103]

4.91 Kings Cross MSIC provides services to users of substances including 'heroin, cocaine, prescription pain medication such as oxycodone and morphine, methamphetamines and benzodiazepines'.[104] To access the MSIC, clients must:

- be an injecting drug user;
- be 18 years of age or over;
- not be pregnant or accompanied by a child; and/or
- not be intoxicated.[105]

4.92 The benefits of the MSIC are set out in a KPMG evaluation report covering the MSIC's extended trial period from June 2007 to April 2010.[106] Previous independent evaluations and analyses commissioned by the NSW government, since the commencement of the trial in 2001, found:

...that the MSIC positively impacts on clients, has a high level of support from local residents and businesses, has not been shown to cause an increase in local crime or drug use and saves at least $658,000 per annum over providing similar health outcomes through other means in the health system.[107]

4.93 The KPMG evaluation of the extended trial period found that:

- in respect of clients, 'the MSIC has reached a socially marginalised and vulnerable population group of long-term injecting drug users'; and
- the trend in visits 'has remained relatively stable, with a modest downwards trend', consistent with findings from previous evaluations and the objectives of the trial.[108]

4.94 KPMG concluded that its findings are consistent with and build upon those findings in previous evaluation reports; that is, there is an overwhelming benefit of this service to both users and the community:

The MSIC provides a service for, and was utilised by a socially marginalised and vulnerable population group, many of whom had not previously accessed drug treatment or support services.

The MSIC provides a safe injecting environment and has a record of managing overdose events. Findings indicate that the MSIC provides a service that reduces the impact of overdose-related events and other health related consequences of injecting drug use for MSIC clients, and provides access to drug treatment with a high degree of uptake of referrals.

Since the commencement of the MSIC, data sources indicate that there has been a decline in the total number of discarded needle and syringes collected in the vicinity of the MSIC and reduced sightings of public injecting. Results from a random survey of local Kings Cross residents and business operators indicate that there is strong support for the MSIC that has trended upwards over time. There was also consistent support for the MSIC voiced by relevant local service system representatives during interview (including NSW Ambulance, local Emergency Departments, NSW Police, public and private alcohol and drug services and mental health services). Further, interviews conducted with current and former clients of the MSIC described the positive impact of the MSIC's services.[109]

Victoria

4.95 On 31 October 2017, after initially opposing the establishment of an MSIC in that state,[110] the Victorian government announced an $87 million *Drug Rehabilitation Plan*, which 'builds on the work done through the *Ice Action Plan* to save lives, treat users, keep our streets safe, and to crack down on dealers'.[111]

4.96 This plan includes 'an initial two year trial of a medically supervised injecting room at the North Richmond Community Health Centre' which will commence operation in June 2018, with 'an option to extend the trial for a further three years'.[112] It also includes the establishment of '[n]ew residential rehabilitation facilities...in key regional

areas to stop the devastating effects of ice and other drugs in communities across the state'.[113]

4.97 However, while the MSIC will be available to heroin users under medical supervision, and builds on the Victorian government's *Ice Action Plan*, 'the government has vowed to keep the drug ice out of the two-year trial'[114] at the North Richmond Community Health Centre as '[i]t's a different type of drug and a different type of risk...comes with it'.[115]

Committee comment

4.98 The committee recognises the important role the MSIC in Kings Cross in providing injecting drug users with a safe place to inject drugs. The MSIC also facilitates engagement with health professionals and access to treatment services with a high rate of uptake of referrals.

4.99 The committee welcomes the announcement by the Victorian government to introduce a MSIC in Richmond but suggests that access to this facility should not be limited to heroin users.

Harm reduction and the darknet

4.100 In addition to the harm reduction measures outlined above, the committee received evidence, as part of its inquiry into the impact of new and emerging information and communication technology on Australian law enforcement agencies, about harm reduction and trade in illicit drugs on the darknet. A submission from Dr James Martin, a senior Lecturer in Criminology at the Department of Security Studies and Criminology at Macquarie University, argues that 'Australian drug policy should aim to reduce drug related harms by ensuring that illicit drug markets function as safely as possible'.[116]

4.101 Dr Martin recognised that a logical response to the darknet's facilitation of drug trading is to enhance police resources and powers; however, he advised that research 'indicates that such a response would be costly, ineffective and likely to amplify, rather than reduce, a range of drug-related harms'.[117] Instead of pursuing a law enforcement response to this issue, Dr Martin made three recommendations that prioritise a harm reduction approach.

4.102 Dr Martin's first recommendation is for law enforcement agencies to de-prioritise investigations into 'darknet drug trading in comparison to conventional, street/inter-personal based drug trading' because the darknet drug trade 'is a safer, less harmful alternative for drug users'.[118] Dr Martin asserted that a drug user is not only more physically safe, but the drugs sourced through the 'darknet tend to be better quality and less adultered than drugs available via conventional means' and that:

Customers have better access to information regarding the drugs they consume, as well more knowledge regarding safer usage practices than they would if purchased via conventional means.[119]

4.103 User feedback systems, similar to those used by Uber and Airbnb, provide drug users with information about the drugs they wish to purchase. Drug dealers also provide drug users with information about the strength and composition of the drugs they sell. Dr Martin noted that this system is 'far from perfect' but is 'preferable to the complete lack of knowledge consumers typically have when purchasing drug via conventional means'.[120] Drug user forums are also available for users to 'share information regarding safer usage practices'.[121] Dr Martin also argued that the darknet provides drug dealers with physical safety and anonymity thus reducing their 'exposure to violence at the hands of customers, competitors and other predatory criminals'.[122]

4.104 Dr Martin recommended that governments ensure that sentences imposed upon individuals found guilty of darknet drug trading do not exceed the penalties 'imposed for conventional dealing offences of a similar scale'.[123] He warned that harsher penalties would create an 'incentive for dealers to engage in conventional, offline dealing that is associated with increased harms to the public'.[124]

4.105 Finally, Dr Martin recommended the prioritisation of 'demand and harm reduction drug strategies over supply-side intervention strategies'.[125] He was critical of the Commonwealth government's attempts to restrict supply of drugs via postal screening facilities, and argued that this does not deter online dealers, who implement more sophisticated practices to conceal drug consignments.[126] Further, Dr Martin contended that restricted importation of drugs via the darknet forces drug users to:

...simply preference a domestic online or street dealer as an alternative source. Perversely, enhanced mail screening therefore protects the profits of local dealers and the organised crime groups who supply them, who are able to capitalise on the reduced foreign competition inadvertently afforded to them by Australian border protection agencies.[127]

Committee comment

4.106 The committee acknowledges the evidence of Dr Martin to the inquiry into the impact of new and emerging information and communication technology on Australian law enforcement agencies. His submission highlights the need for governments and law enforcement agencies to consider how the trade in illicit drugs via the darknet influences drug supply and demand in Australia.