

# Harm reduction in Australia: progress and setbacks for alcohol and drugs in the last quarter century

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## TOPICS

This paper will deal with the following topics:

- What is 'harm minimisation'?
- Alternatives to harm minimisation?
- Does harm minimisation really work?
- Who supports harm minimisation?
- Who opposes harm minimisation?
- What is the future of harm minimisation?
- Summary

## WHAT IS HARM MINIMISATION?

'Harm minimisation' is a simple concept often used in discussions about legal and illegal mood-altering drugs. Similar approaches are also used widely in clinical medicine and public health. Yet harm reduction continues to arouse some controversy and is bitterly opposed by a minority. Some key principles underpin this simple notion. A core component of harm reduction is the concern that reducing drug-related harms must be an even more important priority than reducing drug consumption. Harms and consumption of the legal drugs, alcohol and tobacco, are generally closely correlated. This is because the toxicity of the legal drugs is inherent in their pharmacology. But the relationship between consumption and harm is much less certain for illegal drugs because much of the harm with drugs like heroin results from the black market distribution system which often emerges when demand persists in the absence of a legal source of supply. When heroin is lawfully prescribed as a medication under medical supervision, the risks are low and about the same as with morphine. When heroin is provided by criminals and corrupt police, a new set of risks arises including drug overdose because of uncertainty about the concentration of street drugs, infections from unhygienic practices and complications from adulterants.

The International Harm Reduction Association defines harm reduction as "Reducing the adverse health, social and economic costs of mood altering drugs without *necessarily* reducing consumption". The word *necessarily* is emphasised because reducing adverse consequences can be achieved with or without a reduction in consumption. Both are considered acceptable. The International Harm Reduction Association argues that reducing drug consumption for its own sake regardless of the consequences is unacceptable.

Given the current threats to global health and well-being, it is especially important to ensure that national and international responses to drugs facilitate the control of HIV among and from injecting drug users. AIDS is now the biggest threat to global health since the Black Plague of the fourteenth century. By 2010, the epicentre of AIDS will have shifted from sub-Saharan Africa to Asia, home to half the global population. In most of the countries in Asia where AIDS is already a serious problem, injecting drug users are the major affected risk group. Interest in harm reduction was stimulated in the early 1980s following the recognition of AIDS and the realisation that injecting drug users were a critical risk group.

An important principle used in harm reduction is the notion that it is often far better to set and achieve sub-optimal goals than set and fail to reach utopian goals. A similar maxim often cited in public health is to “never let the best be the enemy of the good”. It is better to win a certain silver or bronze medal in the Olympic Games than risk not even finishing for an improbable gold.

## HARM REDUCTION IN OTHER CONTEXTS

Harm reduction is a standard approach used widely in clinical medicine and public health. Doctors and nurses are used to having to make difficult clinical choices. Should an elderly man with a few gangrenous toes be encouraged to have an early limited amputation which is likely to be successful or avoid surgery and accept medical treatment which is most unlikely to be successful? Harm reduction approaches are also standard in public health. Australia has been very successful in reducing the incidence of skin cancer from sun exposure. It would be unrealistic to aim to keep all citizens indoors from dawn to dusk. A variety of approaches have been invoked. Public education has encouraged Australians to reduce their exposure to solar damage. Materials have also been provided to reduce the risk of solar damage for those who cannot or will not avoid going into the sun.

Australia has made impressive progress in reducing road crashes deaths and severe injuries in recent decades. A variety of effective measures have been introduced including compulsory car safety belts, motor cycle helmets and random breath test. Road crash deaths fell from 27/100 000 in 1975 to 10/100 000 in 2000 despite an increase in car ownership and distance travelled per passenger. Every effort has been made to reduce the chance of drivers being intoxicated. Reducing the risk of death and injury in the event of a car crash, such as with car safety belts, has saved many lives and prevented many severe injuries. At the time of the introduction of car safety belts, critics argued that drivers would compensate for their greater safety by driving faster and more irresponsibly. Research confirmed the huge net benefits even though some drivers may have compensated for their new found greater safety. There are many other examples of harm reduction in road safety policy. Wherever possible, heavy and inflexible objects (such as light poles) have been moved from the vicinity of the roadside. Where this is not possible, frangible poles are installed which give somewhat on impact.

Methadone maintenance treatment for heroin dependence involves the provision of a drug of addiction to treat a drug addiction. While this arouses spirited criticism from a noisy minority, others prefer to focus on the substantial improvement in outcomes with an 80% reduction in mortality and a substantial reduction in crime, HIV infection and drug use. Many patients in methadone maintenance treatment improve their social functioning. These improvements include better parenting, completion of education and training and gaining employment. Many patients in methadone maintenance treatment make slow and steady improvements over some years starting from a position where their life was in utter chaos. Some require many years of treatment while a small minority continue methadone maintenance treatment indefinitely either because of several relapses after ceasing treatment or because of a great fear of relapse.

The notion of “making the world safe for drunks” existed before the recognition of AIDS. Policy makers realised that there would always be some people who, despite all the best efforts by the community, continued to drink alcohol to the point of intoxication in public places. Pragmatic efforts to “make the world safe for drunks” complement, and are not a substitute, for measures intended to reduce public drunkenness.

Virtually all states and territories have amended their liquor licensing legislation in recent years to nominate harm reduction as the paramount aim. Some extent of alcohol-related harm in the vicinity of licensed premises is unfortunately inevitable. It is realistic to attempt to reduce this level of harm. Replacing glass drinking vessels with plastic containers prevents intoxicated patrons breaking the glasses into shards which can be used as a makeshift knife. Heavy furniture bolted to the floor prevents intoxicated patrons from picking up light chairs and tables and throwing them in the course of an alcohol-fuelled fight.

The similarity between nicotine replacement therapy (NRT) for cigarette smokers and methadone maintenance treatment for heroin dependence is instructive. NRT helps smokers quit and therefore avoid cancer, heart and lung disease. A small minority of smokers continue NRT indefinitely. Although former heroin users now leading a useful and normal life but continuing to take methadone maintenance treatment indefinitely arouse the wrath of methadone critics, there are no criticisms of former smokers who cannot or will not stop taking NRT.

Sexual health physicians attempting to control sexually transmitted infections in a community recognise that sustainable eradication of non-monogamous relationships in a population is rarely achieved. Promotion of sexual abstinence and monogamy has its place but this should not be at the expense of also promoting condoms.

The concept of ‘moral hazard’ in finance and economics involves the notion that increasing the financial risk for an individual, company or nation, may result in unwanted increased risk behaviour. Thus the provision of fire insurance may encourage premium holders to reduce expenditure on fire alarms and protection. Even worse, some premium holders might perversely be encouraged to commit arson in order to obtain a pay out exceeding the value of the property. At a global level, the International Monetary Fund anguishes about the possibility that bailing out a country recently bankrupt after reckless economic policies might encourage other countries to pursue similar high-risk strategies knowing that the IMF will always come to the rescue.

Psychologists refer to the ‘risk compensation hypothesis’ as a possible link between reduced risk and compensatory increased risk behaviour so that the overall risk level remains at an equilibrium. There are some clear instances where risk behaviour increases when a situation has been made safer but this is not universal. Only empirical research can establish whether a policy which increases safety provides net benefit or harm to a community. This is why research is such an important part of harm reduction.

Interest and support for harm reduction has grown since the 1980s, especially in developed countries. But the same spirit of determined pragmatism is found in many cultures. The Paramount Leader of China, Deng Xiao Ping, said “it doesn’t matter what colour the cat is as long as it catches the mouse”. Harm reduction has much the same attitude. Support for harm reduction has recently increased in Asia (Malaysia, Indonesia, China, Vietnam and Burma) and some Moslem countries (Iran, Morocco). Harm reduction should not be thought of as a purely Western phenomenon.

## HISTORY OF HARM MINIMISATION IN AUSTRALIA

Harm Minimisation was adopted by the Prime Minister, all Premiers and both Chief Ministers in Canberra on the 2 April 1985 as the “official national drug policy”. Following a review of the National Drug Strategy carried out every few years by an independent body with, on each occasion, a recommendation to renew the commitment to harm reduction, this commitment has been endorsed several times by the Ministerial Council on Drug Strategy (MCDS), Australia’s supreme drug policy making body. MCDS comprises the nine state, territory and Commonwealth Health Ministers, the eight state and territory Police Ministers and the Commonwealth Justice Minister.

In the current official definition, harm minimisation is considered to comprise supply reduction, demand reduction and harm reduction. The current Prime Minister and some senior Ministers have strongly advocated zero tolerance and spoken of their contempt for harm reduction. Controversial harm reduction symbols, such as the heroin trial and the Medically Supervised Injecting Centre, have been relentlessly and trenchantly criticised. Although this is all well known, it is less well known that the current government has discretely continued to support harm reduction privately including increasing funding for some harm reduction interventions. Thus the attacks on harm reduction appear to be more a political strategy than a public policy. Given the wealth of scientific evidence now supporting the effectiveness and cost-effectiveness of several harm reduction interventions, it would be delinquent of its public health and fiscal responsibilities for the government not to support harm reduction. The current status of harm reduction in Australia is that zero tolerance appears to be just a political strategy, with harm reduction regarded as the public policy.

## ALTERNATIVES TO HARM MINIMISATION?

The alternative approach to harm reduction is that the reduction or elimination of illicit drug consumption is even more important than the reduction of adverse consequences of drug use. This approach is usually known as zero tolerance (or sometimes referred to as ‘use reduction’). The United States of America is the most forceful exponent of this approach in the world. However, the high prevalence of HIV among injecting drug users in the USA and the poor health and other outcomes for illicit drug use has meant that support for zero tolerance has been declining in recent years. Zero tolerance has been an effective political strategy in the past but voters in many countries are showing increasing support for more pragmatic and effective approaches.

How far would zero tolerance supporters wish to go? Would they support scrapping needle syringe programs, methadone treatment and car safety belts? If needle syringe program are scrapped, would we then find that HIV has become the epidemic that Australia has to have?

## DOES HARM MINIMISATION WORK?

In a study commissioned by the Commonwealth Department of Health and Ageing and conducted by independent experts, needle syringe programs in Australia were estimated by 2000 to have prevented 25 000 HIV infections, 21 000 hepatitis C infections, cost governments \$130 million but saved governments \$2.4–7.7 billion (Return on Investment in Needle and Syringe Programs in Australia, Health Outcomes International, National Centre for HIV Epidemiology and Clinical Research, Commonwealth Department of Health and Ageing, 2002). It was further estimated that by 2010, needle syringe programs will have prevented 4500 AIDS deaths and 90 hepatitis C deaths. These estimates were based on an analysis of data from

103 cities where cities with needle syringe programs averaged an 18.6 %/year decline in HIV prevalence while cities without needle syringe programs averaged an 8.1 %/year increase in HIV prevalence. A recent review of the international evidence for needle syringe programs commissioned by the World Health Organisation has conformed their effectiveness, safety and cost-effectiveness (Wodak A, Cooney A. Evidence For Action Technical Papers. Effectiveness of sterile needle and syringe programming in reducing HIV/AIDS among injecting drug users. World Health Organisation, Geneva, 2005.

[http://www.who.int/hiv/pub/prev\\_care/en/effectivenesssterileneedle.pdf](http://www.who.int/hiv/pub/prev_care/en/effectivenesssterileneedle.pdf)

The effectiveness, safety and cost effectiveness of methadone maintenance treatment has also been confirmed by compelling evidence. Methadone maintenance treatment has been extensively researched, the findings clear and consistent, the individual and community impact on major health, social and economic outcomes has been shown to be powerful. The reduction in overdose deaths is substantial (about 80%) and major reductions in HIV incidence and prevalence have been confirmed. Reduction in drug use has been shown in many studies. A substantial reduction in crime at the community level has been recently demonstrated. The Bureau of Crime Statistics and Research has estimated that for every 100 patients in methadone maintenance treatment in NSW for 12 months, there are 12 fewer robberies, 57 fewer break and enters and 56 fewer motor vehicle thefts(BOCSAR, Lind B, Chen S, Weatherburn D Mattick R. 2004)

## **STRENGTHS AND WEAKNESSES**

The major strength of harm reduction is its empirical support. The major weakness is that harm reduction is to some extent counter intuitive, and therefore open to rhetorical attack. This is a major problem in such a sensitive area.

## **WHO SUPPORTS HARM MINIMISATION?**

Support for harm reduction exists over many past decades, long before the concept received its present name. Thus an influential official committee in the United Kingdom 80 years ago concluded that "... indefinite administration of morphine or heroin would be permitted for those... who are "capable of leading a fairly normal and useful life so long as they take a certain quantity, usually small, of their drug of addiction but not otherwise" (Ministry of Health, United Kingdom, 1926). In other words, outcomes are even more important than the presence or absence of mood altering substances.

The WHO Expert Committee on Drug Dependence in 1974 wrote of their "concern for preventing and reducing problems rather than just drug use".

The Advisory Committee on the Misuse of Drugs, United Kingdom determined in 1984 that "prevention includes both the prevention of drug use and the prevention of drug related harm".

An influential book on alcohol policy concluded in the early 1980s that making "the world safe for drunks" by "modifying environments so that when drinking or drunken activities occur, they are less likely to cause or exacerbate damage" (Alcohol and Public Policy, National Academy Press, 1981)

But the discovery of an HIV epidemic in injecting drug users in Scotland in 1985 led to a report which had a dramatic impact in the United Kingdom and other countries. The conclusion was that ... the gravity of the problem is such that on balance the containment of the spread of the

virus [HIV] is a higher priority in management than the prevention of drug misuse ... On balance, the prevention of spread should take priority over any perceived risk of increased drug use.(HIV/AIDS. The Scottish Home and Health Department, 1986)

The Advisory Committee on the Misuse of Drugs, the United Kingdom followed this up in 1988 with a report which argued that “the spread of HIV is a greater danger to individual and public health than drug misuse. Accordingly, services that aim to minimise HIV risk behaviour by all available means, should take precedence in development plans”.

Support for harm reduction has spread from academics and clinicians to politicians. The Home Affairs Select Committee, United Kingdom, 2002 concluded that “If there is any single lesson from the experience of the last 30 years, it is that policies based wholly or mainly on enforcement are destined to fail ... [therefore] ...harm reduction rather than retribution should be the primary focus of policy towards users of illegal drugs.”

Support for harm reduction then became evident at the United Nations with the agreement at a high level meeting that there was a “need for ‘a balanced approach’”. The same document referred to the need for “reducing [the] adverse consequences” [of drugs] (Communiqué, United Nations General Assembly Special Session on Drugs, 1998).

The Communiqué of the United Nations General Assembly Special Session on HIV/AIDS in 2001 went further and declared that “‘harm reduction’ would be made available by member states by 2005”.

In 2000, the Director General of the WHO declared that “The key to limiting the spread of HIV lies in harm reduction among intravenous drug users”.

In 2004, the 2003 Report of the International Narcotics Control Board conceded that “The ultimate aim of the conventions is to reduce harm”.

Numerous international bodies have now explicitly come out in support of harm reduction including UNICEF, the World Bank and the International Federation of Red Cross-Red Crescent Societies.

Community support for harm reduction is also increasing. This can be seen in Australia in the National Drug Strategy Household Survey where support has increased from 1998 to 2001 for needle syringe programs (50%, 59 %); methadone maintenance programs (58%, 64%).

## **WHO OPPOSES HARM MINIMISATION?**

Opposition to harm reduction from the USA has increased since November 2004. The USA draws some support for its hostile attitude to harm reduction from a few countries including Japan, Russia and Saudi Arabia. Strident criticism of harm reduction from Sweden is now less clear cut as a fierce debate between pro- and anti-harm reduction supporters is being waged. A few, small influential community groups and some prominent journalists maintain their opposition to harm minimisation.

## **WHAT IS THE FUTURE OF HARM MINIMISATION?**

Support for harm reduction is increasing in the UN system and globally, especially in the Asian region (China, Malaysia, Indonesia, Vietnam, Burma). The evidence base is getting stronger. In many parts of the world now, harm reduction has become the mainstream. The intellectual

debate between harm reduction and zero tolerance is now over. It is clear that the evidence for harm reduction is overwhelming.

## **DRUGS IN AUSTRALIA: LAST 25 YEARS**

Although there is often wide spread despair about interventions to reduce alcohol and drug problems at either the individual or the community level, results in Australia have been very impressive.

A decline in alcohol-related deaths has occurred among men and women in the 1990s. A 25% decline in per capita alcohol consumption between 1981 and 1995 made a substantial contribution but there have also been many advances in harm reduction policy. For example, the fortification of flour with thiamine in the early 1990s has virtually eliminated the Wernicke Korsakoff syndrome.

Tobacco-related deaths are now declining in men and women in Australia. This followed the substantial decline in smoking prevalence in Australia over recent decades.

Australia has seen dramatic improvements in prevention, treatment and research on alcohol and tobacco.

After a relentless increase in illicit drug consumption and drug overdose deaths the 1960s to 2000, the heroin shortage commencing in 2001 was followed by a dramatic and welcome reduction in drug overdose deaths.

Australia managed to avert an HIV epidemic in the 1980s. There is little doubt that the acceptance of harm reduction enabled the rapid adoption of needle syringe program and expansion of methadone maintenance treatment. Avoiding a major HIV epidemic represents a major public health triumph.

## **SUMMARY**

Harm reduction is a standard approach in clinical medicine, public health and in the alcohol and drugs field.

Interest in harm reduction received a major boost in the early 1980s with the recognition of AIDS and the importance of injecting drug users in achieving HIV control.

There is now a vast evidence base conforming that harm reduction is effective, safe and cost effective. There is no convincing evidence that harm reduction increases illicit drug use.

Alternative approaches to harm reduction are ineffective, costly and accompanied by serious unintended negative effects.

Support for harm reduction is growing rapidly but harm reduction will always be somewhat controversial.