A critical time for Harm Reduction

The need to revitalise harm reduction in the context of new National HIV/AIDS, Hepatitis C and Drugs Strategies

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Harm reduction policies and programs may face threats on a number of different fronts in the near future. Members are encouraged to monitor developments and to raise the importance of national leadership in revitalising harm reduction when preparing their responses to the current consultations on the National HIV/AIDS and STI Strategy and National Hepatitis C Strategy.

1. Issues

Do the Strategies adequately acknowledge the need to revitalise harm reduction given current threats?

What harm reduction initiatives should the Strategies support?

Are the approaches of the three Strategies to HIV and harm reduction complementary and linked, or are there inconsistencies/conflicts?

2. Background

For some time, AFAO and AIVL have been concerned that harm reduction is being actively undermined as a key pillar of HIV policy. In coming years we are likely to see a further strengthening of the Government's *Tough on Drugs* policy, with the possibility of further diversion of resources away from harm reduction. The Family First Party opposes harm reduction and may use their position in the Senate to seek a winding back of harm reduction policies and programs from July 2005.

In recent federal budgets, substantial resources have been invested in supply reduction/policing strategies, abstinence programs and the piloting of retractable syringes. In the same period, some needle exchanges have been de-funded,

and peer education and advocacy services for people who use drugs remain under-resourced.

The 2002 Reviews of the National HIV/AIDS and Hepatitis C Strategies recommended that there be an improvement and expansion of current harm reduction strategies (Lead Review Team Rec. 9), as well as strong policy and funding support for harm reduction approaches (HIV Review Rec. 30). Rigorous evaluation of new harm reduction approaches was also recommended (HIV Review Rec 31; Hepatitis C Review Rec. 60) and the Hepatitis C Review noted the concern that support for harm reduction was being eroded.

The Government response to the Review stated its policy priority being "to reduce the demand for and uptake of illicit drugs" and did not accept the Review recommendations other than to "continue to support interventions, which reduce illicit drug use and the harm it causes, as a component of Australia's response to HIV/AIDS and hepatitis C epidemic."

3. Harm reduction content of current versions of Strategies

3.1 National Drugs Strategy 2004-2009

The new five year Strategy, finalised and released in June 2004, applies to illegal and legal drugs. The Strategy reasserts a harm minimisation framework comprising 3 parts:

- **supply reduction** – strategies to disrupt the production and supply of illicit drugs, and the control and regulation of licit substances;
- **demand reduction** – strategies to prevent the uptake of harmful drug use, including abstinence and treatment programs .
- **harm reduction** - strategies to reduce harm to individuals and communities.

The Strategy states the need for 'balance' between these three elements, although the final version of the Strategy has a reduced emphasis on harm reduction as compared to earlier drafts. Reference is made to the need for approaches that are 'targeted towards individuals and communities', partnerships with affected communities, and work with key service providers.

The Strategy states that "There will be integration" between the Drugs Strategy and the HIV and Hep C strategies to "ensure relevant trends in these areas are incorporated in the development of policies and programs under the National Drug Strategy." The Ministerial Council on Drugs Strategy "will ensure that Australia has a nationally coordinated and integrated approach to reducing the harm arising from drug use". There is no specific consideration or mention of HIV at all beyond this reference to "integration."

The intersection between the use of drugs such as crystal, harm reduction and sexual transmission of blood borne viruses are not referred to by the Strategy

(although the emergence of crystal and its 'health and psychological harms' do rate a mention).

In the Strategy consultation, AIVL argued for harm reduction objectives to include:

- reduction of the levels of discrimination experienced by people who use illicit drugs within the Alcohol and other Drugs Sector, generic health and social services and the broader community.
- the role of harm minimisation in the reduction of blood borne viruses particularly hepatitis C.

These were not taken up in the final version.

Tough on Drugs is a separate but related component of national drugs policy. The National Drugs Strategy encompasses alcohol, tobacco and pharmaceuticals as well as illicit drugs. Tough on Drugs relates only to illicit drugs. The Coalition's response to AFAO's pre-election question on harm reduction elicited the following response:

> "Tough on Drugs is a strategy designed to keep drugs out of Australia and off the streets, to rehabilitate drug users and to educate young people about the extreme danger of illicit drug use. Under *Tough on Drugs* the Coalition is committed to developing retractable needle and syringe technology in order to address community concerns about the risk of injury from needles and syringes inappropriately discarded in public places through pilot studies of the technology through selected primary Needle and Syringe Programmes. The 2003-04 Federal Budget allocated $38.7 million over four years for continuation of the COAG Illicit Drug Diversion Supporting Measures. This comprises funding to States and Territories for increased education, counselling and referral services through Needle and Syringe Programmes, and diversification of existing Needle and Syringe Programmes through pharmacies and other outlets, with the remainder allocated to national activities."

3.2 HIV/AIDS and STI Strategy Draft

There are contradictory messages regarding harm reduction in the Consultation Draft. Positive elements include the inclusion of harm reduction as a guiding principle of the Strategy, and the cost effectiveness of needle exchanges is strongly argued. It is noted that harm reduction includes needle exchanges, drug substitution and peer education. The potential for an explosive spread of HIV among people who inject is stated. People who inject drugs are identified as a priority population for prevention, but there is little detail on HIV prevention needs for drug users and threats to harm reduction are not acknowledged.

The trend towards marginalising harm reduction approaches within drugs policy is evidenced in some parts of the Draft Strategy. For example, inclusion of language in the Draft that the "Government ….is doing its best in conjunction with law enforcement agencies …to stamp out illicit drug use" (page 18) suggests a zero tolerance approach that conflicts with harm reduction principles.

The need to link the HIV Strategy to the Drugs Strategy is noted (page 42) and it is proposed that a "Linkages will be strengthened between advisory structures such as MACASHH and the Australian National Council on Drugs through mechanisms such as common membership."

3.3 Hepatitis C Strategy Draft

Harm reduction is listed as a guiding principle of the Draft Strategy, and priority actions include to 'support and expand access to needle exchange programs' and 'support peer based drug user organisations to deliver peer education'.

The Strategy commits to a coordinated approach with the other Strategies and proposes that MACASHH forge links with the Intergovernmental Committee on Drugs to ensure that hepatitis C issues are considered in illicit drug policy and program development, and that the ANCD be represented on MACASHH.

4 Conclusions

4.1 Greater recognition required of threats to harm reduction

The HIV Strategy could be strengthened by noting concerns about harm reduction being actively eroded at both the policy level and through the withdrawal of support for some needle exchanges and peer support services at local levels. Both the HIV and Hepatitis C Strategies should note that NSPs need to be broadened in their reach as well as supported, because there are many regions in Australia where needles and syringes are still not freely available.

Both the HIV and Hepatitis C Strategies should provide a stronger articulation of the benefits and resource needs of drug user organisations, and their central role in harm reduction and addressing stigma. The growing resource-needs of needle exchange programs and the central role played in peer education and advocacy by drug user groups to underpin harm reduction could be asserted more strongly than in the current draft texts.

Harm reduction is fundamental to the success of the Hepatitis C Strategy and, as such, the Strategy would be strengthened if one of the Strategy's 'priority action areas' was to reaffirm government commitment to harm reduction as a means of improving health, social and economic outcomes. The Hepatitis C Strategy should include reduction of the levels of discrimination experienced by people who use illicit drugs and people with hepatitis C as important elements of harm reduction. Anti-discrimination education strategies relating to hepatitis C for the general public as well as for targeted audiences such as health care workers and employers support a comprehensive harm reduction approach.

4.2 Define clearer / stronger links between the Hepatitis C Strategy and Drugs Strategy

There is *nothing* in the text of the National Drugs Strategy itself on HIV and hepatitis C. Structural links will likely remain weak between MACASHH and the Drugs Strategy bodies. This lack of connection may have its advantages in

preventing undue interference from the drugs sector in HIV health promotion policy, given that harm reduction has more opponents in the drugs sector (those pushing an abstinence prevention agenda) than in the HIV sector. The downside for public health is that the Drugs Strategy 'prevention agenda' may remain poorly informed by experiences of successes in harm reduction in the HIV and hepatitis C sectors. Given the prevalence of hepatitis C among people who inject drugs, a priority should be given to ensuring that there are stronger linkages and clearer cross referencing between the Hepatitis C Strategy and the evolving prevention agenda of the Drugs Strategy. The Hepatitis C Strategy should provide more detailed explanation of how this integration might actually occur, given that the Drugs Strategy provides little if any guidance.

4.3 Need to monitor emphasis on 'prevention' under the Tough on Drugs Strategy

It will be important to scrutinize budgetary allocations under the Tough on Drugs Strategy to identify diversion of funds from harm reduction or de-prioritisation of harm reduction as compared to supply and demand reduction/prevention programs. The HIV sector needs to monitor the ways in which the evolving Drugs Strategy 'prevention' agenda is defined in more detailed policy statements on illicit drugs that are anticipated to be released to support implementation of the new National Drugs Strategy. The 'Prevention agenda' (ie, demand reduction through abstinence and rehabilitation programs etc) is increasingly proposed as an alternative policy model, rather than as a complement, to harm reduction. It is useful that the Drugs Strategy retains the pillar of Harm Reduction alongside Demand and Supply Reduction, but a high level of vigilance will be required to ensure that Tough on Drugs does not equate with a dramatically reduced role for the harm reduction.

4.4 Innovative harm reduction interventions need to be championed

Perhaps not surprisingly, the Strategies do not address innovative harm reduction interventions such as medically supervised injection facilities or needle and syringe exchanges in custodial settings. There is a common commitment, however, to evidence based policy and programs. This commitment to evidence based investments should be used as a rationale to continue to argue for piloting and evaluating of new approaches in harm reduction. (Fortunately, there is no mention of retractable syringes in any of the Strategies – although, as the Coalition's response to the AFAO election questions indicate, investing in retractables remains a commitment of the Government).

4.5 Crystal as a harm reduction issue

There is an argument that the HIV Strategy should mention up-front the evolving debate over the role of use of recreational drugs such as crystal in HIV transmission among gay men. The Strategy could support investment in behavioural research on this issue and propose that community based organisations lead a debate on how to apply harm reduction principles to HIV prevention in the context of gay men's use of psycho-stimulants. Given the current political context, there are risks in giving the issue too high a profile in the Strategy document itself, rather than letting it be picked up in the implementation of the national gay men's health promotion program.