



# Community Drug Summit

June 2001

**Reducing Harm To The Community And  
Individuals Caused By Continued Drug Use.**

This is an Issues Paper. The Community Drug Summit Office has formed no conclusion on any issue mentioned in this paper. The purpose of the Issues Papers are to encourage discussion in the lead up to the Community Drug Summit and to encourage persons or organisations to make submissions to the Community Drug Summit Office. The Issues Papers are not meant to restrict persons or organisations in any way. Respondents should feel free to raise other relevant issues.

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**Issues Paper Number 8**

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## **4.0 Summary**

# Issues Paper Number 8

## 1.0 Introduction

Australian drug policy is based on the idea of minimising drug related harm through a three pronged approach:

- supply reduction strategies aimed at disrupting production and supply (e.g; prohibiting, policing);
- demand reduction strategies aimed at preventing use (e.g; drug treatment, education); and
- harm reduction strategies aimed directly at reducing drug related harm to users and the community (e.g; needle and syringe programs, overdose prevention strategies).

This paper focuses only on harm reduction, and only in relation to illegal drug use. The introduction covers the definition of and rationale for harm reduction, drug related harms, and assessment of harm reduction strategies. The 'WA Context' gives a brief overview of drug use and drug related harm in WA. This is followed by consideration of a number of issues that have implications for WA drug policy. Key questions are raised in relation to each issue.

A number of issues relevant to harm reduction are not covered in this paper as they are addressed in other Issues Papers. These include harm reduction in relation to drug laws and prisoners, which are addressed in Issues Paper 7, and heroin trials and methadone maintenance treatment, which are addressed in Issues Paper 5.

### 1.1 What is Harm Reduction?

The aim of harm reduction is to reduce drug related harm by encouraging people who use drugs to do so more safely. Harm reduction is theoretically distinct from treatment, which aims to reduce use and hence harm. In practice, however, the distinction between harm reduction and treatment is less clear. For example:

- methadone maintenance is a drug treatment as it aims to reduce illegal drug use. It is also considered a harm reduction strategy, as it reduces overdoses and the transmission of blood borne viruses (BBV);
- drug treatment programs typically include some harm reduction because the majority of clients use drugs<sup>1</sup> at some time during or after treatment;
- harm reduction programs, such as needle exchanges, are important sources of treatment referral; and
- strategies to reduce the risk that users will become dependent, are not necessarily treatment or harm reduction, as they aim to contain use.

<sup>1</sup>The terms 'drug use' is often shortened to 'use' in this paper.

## 1.2 Why Harm Reduction?

Harm reduction accepts that all drug use is potentially risky and that abstinence is the most certain way of avoiding drug related problems. It is, however, pragmatic and accepts that many people refuse to be abstinent. Harm reduction therefore aims to reduce drug related harm, but neither condones nor condemns the drug use itself.

Harm reduction is a common approach for many non-drug behaviours. For example, young children are taught how to cross roads safely, cars are fitted with seat belts, the use of condoms is advocated to reduce unwanted pregnancy and transmission of sexually transmitted diseases and beach goers are urged to 'slip, slop, slap'. Harm reduction is also applied to legal drugs. For example, we are encouraged not to drink and drive, smoking is banned in most workplaces to reduce passive smoking and many prescription drugs carry warnings about avoiding operating machinery when taking the drugs.

### 1.3 What are Drug Related Harms?

Drug related harms can arise from various patterns of drug use:

- intoxication - single session use, e.g; overdoses, unsafe sex;
- regular use - frequent though not necessarily dependent use, e.g; financial difficulties, poor work performance, amphetamine psychosis; and
- dependent use - obtaining and using drugs dominates life, e.g; loss of employment and relationships, health and psychological problems

Drug related harms can occur in several spheres of life:

- health, e.g; hepatitis B and C<sup>2</sup>, overdose;
- social, e.g; relationship problems, domestic violence;
- work/study/leisure activities, e.g; job loss, lack of interest in leisure or study; and
- legal, e.g; arrest for drug use, dealing or acquisitive crime.

Drug related harm affects many sectors of the community:

- drug users;
- families; and
- general community e.g; householders, local businesses, local government councils, work places, law enforcement and justice systems, health facilities such as psychiatric units.

<sup>2</sup>Hepatitis B and C are liver diseases transmitted easily by sharing used injecting equipment.

Drug related harms can stem from or be amplified by the illegal status of the drugs:

- increased risk of overdose because illegal drugs are of unknown composition;
- criminal records for drug use can impact on a person's life opportunities; and
- criminal activity to support expensive drug 'habits'.

People who use illegal drugs<sup>3</sup> vary enormously. For example, some have jobs and families and use occasionally; others are young people, perhaps studying, who use on weekends with friends or at clubs and dances; some are dependent; and some are attempting to stop and experiencing relapses. Some swallow 'party drugs', such as ecstasy and LSD, others inject amphetamines or heroin, some smoke cannabis and others use a range of illegal drugs in combination with benzodiazepines and alcohol. Many people who use drugs prefer to keep their drug use private, for fear of stigma or arrest, and avoid accessing services directed specifically at drug users. Others are comfortable with such services, and indeed avoid accessing more mainstream services for fear of being judged and treated poorly.

Given the broad range of harms that can occur, and the variations between people who use drugs, a variety of responses to drug related problems are necessary. One aspect of an effective overall response is a range of harm reduction strategies.

#### **1.4 How can Effectiveness of Harm Reduction Strategies be Assessed?**

The effectiveness of harm reduction strategies needs to be assessed in terms of their reduction of overall harm in a community: do they reduce the harms they are aimed at but not increase other harms or overall levels of drug use?

To date, most harm reduction strategies have only been evaluated in terms of their impact on the harms they are aimed at, rather than in terms of overall harm. Needle and syringe provision programs are one of the few exceptions, and have been found to be very effective in reducing overall harm. They reduce the transmission of BBVs (such as, hepatitis B and C and HIV) and produce no demonstrable increase in drug use or other problems (ANCAHRD<sup>4</sup>, 2000).

The cost effectiveness of harm reduction strategies should be also considered. For example, it is estimated that every HIV infection costs the community \$100,000 (Hurley and Butler, 1996), and every hepatitis C infection costs \$14,000 - \$19,000 in direct health care costs alone (detection and treatment) (Shiell and Law, 2000). Compared with lifetime costs of treating HIV/AIDS, costs of needle provision programs (Hurley and Butler, 1996) and methadone maintenance treatment (Capelhorn and Ross, 1995) are found to be highly cost effective. These studies did not include savings in terms of prevented hepatitis C infections.

## **2.0 Western Australian Context**

It was estimated from the National Drug Strategy Household Survey (NDSHS, 1998, WA results) that in WA in 1998:

- 648,061 people had used an illegal drug in their lifetime;
- 228,039 people had used an illegal drug other than cannabis in their lifetime;
- 314,763 people had used an illegal drug in the past year; and
- 122,462 people had used an illegal drug other than cannabis in the last year.

A number of drug trends are evident in WA (Hargreaves and Lenton, 2001):

- amphetamine is the most commonly injected drug;
- a stronger form of amphetamine often referred to as crystal methamphetamine (crystal meth, ice, or crystal) is increasingly available;
- more young people from more diverse backgrounds appear to be using heroin;
- cocaine use continues to be very low;
- ecstasy use is mostly by oral administration; and
- polydrug use (the use of more than one drug at a time) remains common. In particular, benzodiazepines (Valium, Serapax, Temazepam, Rohypnol) are often used in combination with opioid drugs.

<sup>3</sup>People who use drugs will, for short hand purposes, often be referred to as 'users' or if they inject drugs as 'injectors'.

<sup>4</sup>Australian National Council on AIDS, Hepatitis C and Related Diseases.

**Table 1**

**Prevalence (%) of use of illicit drugs by adults (18 years and over) and young people aged 14-19 in Western Australia in 1998. (NDSHS, 1998: WA results).**

Used	% Adults (18 years and over)		% 14-19 year olds	
	Ever	In last year	Ever	In last year
Cannabis	45	22	43	34
LSD/hallucinogens	12	4	12	9
Amphetamines	11	6	7	6
Ecstasy/designer drugs	7	5	4	4
Heroin	3	2	3	2
Cocaine	4	1	1	<1

It should also be noted that a heroin drought, experienced Australia wide since the beginning of 2001, has resulted temporarily in less heroin use and overdose deaths, but has been accompanied by considerably more reports of amphetamine use in WA, particularly use of crystal methamphetamine.

In WA, opioid overdose and BBV transmission are priority areas for harm reduction, as they cause considerable mortality and morbidity each year:

- overdose - opioid overdose deaths have increased markedly around Australia since the early 1990s (a five fold increase in WA from 1991 to 1995), and in WA stabilised between 1995 and 2000 at around 80 suspected deaths a year; and
- transmission of BBVs - hepatitis C is the most common BBV among Australian injectors, with an average prevalence of 50% (range 8-95%), and an incidence of 15% (Crofts, Thompson, and Kaldor, 1999). Both prevalence and incidence have declined somewhat since 1995 (MacDonald, Wodak, Dolan, van Beek, Cunningham and Kaldor, 2000). Hepatitis B is the next most common blood borne virus among Australian injectors. HIV prevalence among Australian injectors is consistently low at 2% or less (MacDonald, et al, 1997).

Other issues are also important targets for harm reduction strategies, for example, general physical, psychological and social health of users; employment and housing; harms stemming from the illegal status of drugs; harm to families and the community (e.g; unsafe disposal of needles and syringes (N&S).

A broad range of harm reduction strategies has been implemented to reduce drug related harm in WA. They involve collaboration between many sectors of the community, and some will be referred to in relation to key issues for WA.

### 3.0 Issues For Consideration

#### 3.1 Overdose

Overdose facts:

- central nervous system (CNS) depressants, such as benzodiazepines and alcohol, increase the risk of opioid overdose;
- most overdoses in Australia occur in a home or other dwelling rather than in public places. However young users say they often use in public places because they live with parents (Loxley and Davidson, 1998);
- overdoses often occur in the company of other people. Those present can usually intervene and prevent death if they know what to do;
- many overdoses occur several hours after drug consumption (McGregor, Darke, Ali and Christie, 1998);
- witnesses to overdoses do not always call ambulances. Reasons given for not calling ambulances include fear of police involvement, feeling capable of handling the situation (Williams and Urbas, 2001), previous negative experiences with hospital staff (Gore, 1997) and ambulance costs (Loxley and Davidson, 1998); and
- drug users are often not well informed about the risks, process, and signs of overdose (Loxley and Davidson, 1998).

In WA:

- overdose victims attended by ambulances are revived, routinely transported to hospital for medical attention, and, in Perth and Fremantle are seen in hospital by a volunteer from the Emergency Department Opiate Overdose Prevention Project (OOPS!), who provides peer support and education.

Loxley and Davidson (1998) found that young users expressed concern about being taken to hospital for fear of parental notification, and possible police and welfare involvement. In other jurisdictions in Australia, overdoses are rarely transported to hospital. Instead they are revived, given information about overdose, and, if possible, left with a carer;

- the police refrain from attending overdoses unless there is death or violence, to remove fear of police involvement as a deterrent from calling ambulances;
- there is evidence that naltrexone treatment is associated with a higher opioid overdose mortality rate than no treatment, which in turn has a higher overdose mortality rate than methadone treatment (Fellowes-Smith and Edwards, 2001, under revision). This has also been found in international studies (Miotto, McCann, Rawson, Frosc and Ling, 1997). Overdoses occur with use of opioids after cessation of naltrexone, often in combination with benzodiazepines (Fellowes-Smith and Edwards, 2001; OOPS! data<sup>5</sup>); and
- anecdotal reports from drug users and a range of health professionals suggest there is a ready availability in Perth of a range of benzodiazepines, including Rohypnol.

A range of overdose prevention strategies has been implemented in Perth since 1996-97. They include:

- changes in police and ambulance policies to be more 'user friendly' (see above);
- strategies to educate and train users, service providers and the broader community about the overdose process and appropriate responses (call an ambulance, administer Expired Air Resuscitation - EAR);
- the establishment of a scheme through the Pharmacy Foundation of Australia which funds insurance to cover the cost of ambulance call outs to overdoses through donations of 50c per Fitpack® sold through participating pharmacies; and
- research into overdose situations, causes and responses.

<sup>5</sup>OOPS! Overdose/Naltrexone figures March 2000-March 2001.

### **Important Questions**

- Should the extension of existing overdose prevention programs and the development of new programs be funded?
- Should the apparent ready availability of benzodiazepines and other scheduled drugs be examined?
- Should further research into overdose prevention and management be commissioned?

### **3.2 Naloxone (Narcan) for Peer Administration**

Facts on Naloxone (Narcan) for peer administration include:

- narcan is a short acting opiate antagonist that reverses opioid overdose symptoms and is used to revive people who have overdosed on opioids. It has no effect on people who have not used opioids;
- narcan is legally prescribed for use on the prescription holder but not for administration to another person. Therefore, the use of narcan by an overdose witness to revive an overdose victim is an offence if the victim is not the prescription holder;
- adverse reactions and death have been reported with postoperative narcan use (1-3%), but it is unclear whether problems have been due to narcan or other factors, such as ill health. Problems are rarely associated with the use of narcan use for treating heroin overdoses (Strang, Darke, Hall, Farrell and Ali, 1996);
- there are some concerns about peer administration of naloxone<sup>6</sup>. Some key concerns include (a) possible undermining of other overdose response strategies; (b) the possibility that users would engage in more hazardous use because they believe their friends can revive them; and (c) that some people revived with narcan might reuse heroin or use other CNS depressant drugs before the narcan wears off and overdose again. From their review of the evidence, Lenton and Hargreaves (2000) suggested that user education may assist with these problems, and recommended a controlled evaluation of narcan provision to users for use in overdose situations;
- narcan is provided for peer administration in at least four locations around the world. Informal reports suggest the programs are perceived as useful by injectors, a number of whom have used narcan successfully in overdose situations (Lenton and Hargreaves, 2000); and

<sup>6</sup>See Health Department of WA (2000): Position paper on naloxene provision.

- if narcan was made available for peer administration, its proposed use would be to assist in reviving overdose victims while awaiting ambulance arrival.

### **Important Questions**

- Should legislation surrounding the prescription and use of narcan be amended to remove any threat of legal action against people who administer narcan to overdose victims?
- Should there be controlled evaluation of making narcan available for peer administration?

### **3.3 Needle and Syringe Programs (NSP)**

NSPs were established as a public health initiative in Australia from 1985 onward, before HIV spread among injectors but after hepatitis C was well established in this group. They aim to reduce the sharing of injecting equipment and the transmission of BBVs. They provide injecting equipment and, often, harm reduction education, drug treatment referral and other health, social and legal assistance.

Evidence summarised by ANCAHRD<sup>7</sup> (2000) indicates that NSPs:

- have greatly reduced the transmission of HIV among injectors in Australia. The current prevalence is 2%, well below prevalence in centres around the world where access to injecting equipment has been restricted, which can be as high as 70%;
- have reduced transmission of hepatitis B and C among Australian injectors;
- do not result in increased injecting drug use, according to research in a number of countries;
- do not increase the number of needles and syringes (N&S) discarded in public places, according to research in a number of countries; and
- have been evaluated in numerous studies as both effective and cost effective.

In WA:

- NSPs must be approved by the Commissioner of Health, and they must provide disposal containers with N&S;
- NSPs in WA operate primarily on a 'user pays' system, with the majority (67%) of N&S sold through community pharmacies in packs such as Fitpacks® for approximately \$6.00 each;

- two services in WA operate as true 'exchange programs' (new for old at no cost). These are the WA AIDS Council (WAAC) and Western Australian Substance Users Association (WASUA), which distribute 27% of N&S in WA and report high rates of return of used equipment (90-100%). N&S are sold at a cost recovery price if there is no exchange;
- some rural hospitals provide Fitpacks® at no cost, as an after hours 'back up' service. Approximately 6% of N&S are distributed in this way;
- N&S accessibility is poor at night as there are only two 24-hour pharmacies in WA that sell them;
- users have problems of accessing needles and syringes in many rural areas; and
- a vending machine recently successfully commenced operations in Kalgoorlie on a trial basis. Vending machines can increase hours of availability and provide anonymity.

### **Important Questions**

- Should there be an examination of ways to increase availability of injecting equipment to injectors in rural areas and after hours in metropolitan areas?
- Should there be an examination of the use of well situated vending machines to increase needle and syringe accessibility?

### **3.4 Disposal of Used Needles and Syringes**

Evidence relating to N&S disposal (ANCHARD, 2000) indicates:

- the disposal of N&S is essentially a litter problem, similar to, but not as, obvious or extensive as problems encountered with the littering of public places with broken glass from beer bottles;
- almost all needles and syringes are disposed of safely and appropriately;
- there have been no reports anywhere in the world of needle stick injuries from publicly discarded N&S resulting in HIV, hepatitis B or hepatitis C infection;
- criminal penalties can deter safe disposal. Although police in Australia refrain from maintaining a presence in the vicinity of N&S services. Some drug users report throwing N&S away quickly rather than taking the time to dispose of them safely for fear of being charged with possession of an illegal drug, if their used syringe contains drug traces; and

<sup>7</sup>Australian National Council on AIDS, Hepatitis C and Related Diseases

- retractable needles are often proposed as a means of reducing harm to the public from inappropriately disposed of N&S, but existing retractable devices are unsuited for use by people who inject drugs (Gosporadevskaya, Harris and Kermode (2001).
- In WA, an ongoing project involving the WA Drug Abuse Strategy Office, WA Police Service, Health Department of WA (HDWA), the Town of Vincent, City of Perth and WASUA has developed strategies and resources to educate both the general public and people who inject drugs in the practice of safe disposal of used injecting equipment.

### **Important Questions**

- Should legislation be amended so that carrying needles and syringes containing traces of an illegal drug ceases to be an offence, to encourage higher rates of safe disposal?
- Should funding be provided for collaborative community initiatives to reduce drug related harm?

### **3.5 Hepatitis Vaccinations**

Evidence on hepatitis vaccinations has shown:

- vaccination exists for hepatitis A and B, but not for hepatitis C;
- contracting hepatitis A or B with hepatitis C can seriously compound health damage;
- hepatitis B is readily transmitted through sharing injecting equipment and unprotected sexual activity;
- it is almost 20 years since the National Health and Medical Research Council recommended hepatitis B vaccination for all injectors because of their high risk status, but injectors are not routinely told that such vaccinations exist;
- a recent Perth study of 200 injectors found that 70% had been tested for hepatitis B but only 24% vaccinated, though many of the non-vaccinated were seronegative (Loxley, Davidson, Heale and Sullivan, 2000);
- a universal free hepatitis B vaccination policy exists for infants and pre-adolescents;
- free hepatitis B vaccination programs for injectors, who are extremely high risk, are very limited in WA. At present the service is available at WASUA, Sexually Transmitted Disease clinics at Royal Perth and Fremantle hospitals and a few medical practices;

- hepatitis A is an infectious disease, and 17% of clients tested recently at WASUA were found to have hepatitis A antibodies indicating previous infection; and
- hepatitis A vaccination is more than 10 times the cost of hepatitis B vaccination, which is relatively inexpensive.

### **Important Questions**

- Should free hepatitis B vaccination be offered and promoted for people who inject drugs?
- Should free hepatitis A and B vaccination be offered to users who have hepatitis C?
- If vaccination is supported, how should it be delivered?

### **3.6 Blood Borne Virus Testing**

Evidence on blood borne virus testing includes the following:

- blood borne virus testing is one of the most common ways that injectors make contact with health care services and therefore provides an opportunity for harm reduction and referral (e.g; to the Hepatitis C Council or drug treatment);
- pre and post test discussion are important in assisting clients to fully understand virus transmission risk reduction and the implications of testing and results; and
- a recent study in WA found that about 70% of a sample of injectors had been tested for hepatitis B and C, often multiple times; that a number were not aware of the full range of transmission risks; and that pre and post test discussion frequently did not occur (Loxley, Davidson, Heale and Sullivan, 2000).

### **Important Questions**

- Should there be a campaign to increase the awareness of health care professionals and users about the importance of pre and post test discussion in relation to BBV testing?

### **3.7 Supervised Injecting Facilities (SIF)**

The following summarise the existing information regarding supervised injecting facilities around the world (Dolan et al., 2000):



- Some 45 SIFs operate in a number of cities in Switzerland (since 1986), Netherlands (since the 1970s), and Germany (since 1994). A SIF has begun operating in Kings Cross, NSW, this year. Some are stand alone facilities, other are smaller facilities integrated into other services;
- most SIFs have been established as harm reduction measures in areas of high levels of visible public drug use and dealing, and poor health conditions for users; and
- all are officially sanctioned, most prohibit on site drug dealing and regulate entry. They provide supervised injecting, sterile injecting equipment, immediate resuscitation after overdose, primary health care, referral to drug treatment and some provide other services, such as showers and meals.

Few thorough evaluations have been published on SIFs, and little has been published in English. Existing evidence suggests that in some areas there have been a number of benefits:

- reduced public nuisance (discarded N&S, intoxication, visible drug use and dealing);
- reduced overdose complications and deaths;
- reduced BBV risk behaviours;
- improved health and social functioning of clients; and
- treatment referral.

Common objections include:

- attracting more users to the area;
- increased criminal activity in adjacent areas;
- delaying seeking drug treatment; and
- sending the 'wrong message' by being seen to condone drug use.

Perth does not have highly concentrated public drug using and dealing areas, such as those found in Kings Cross and other eastern States cities. This has been the impetus for establishing SIFs in other cities. Nevertheless, problems are identified in various areas from time to time, and research conducted with a sample of injectors in Perth found that two thirds of respondents said they would use a SIF located in Northbridge (Blum, Krishnarajah, Santa Maria and Streitberg, 2000). Any decision to establish a SIF in WA would need to consider the small size of the Perth street using population, and perhaps consider models that involve integrating a SIF into existing services.

### **Important Questions**

- Is there a need for Self Injecting Facilities in WA?

### **3.8 Registers**

The HDWA maintains a register of Notified Drug Dependent People. Those judged by medical practitioners to be dependent on illegal drugs (other than cannabis) are supposed to be placed on this register. In practice, most people on the register are those on methadone or buprenorphine treatment, and medical practitioners vary in terms of which other drug dependent people they register. People judged to be dependent on benzodiazepines (Schedule 4), however, are not registered on this or any other register.

Anecdotal evidence suggests that users, and often drug treatment workers, are ill informed about the register. Some users are unaware of its existence, and others avoid services, even those that do not place people on the register (e.g; counselling and ambulance service), for fear of being placed on it. Anecdotal evidence also suggests that the existence of this register is a barrier to treatment for many users.

The HDWA also has a system of registering hepatitis C infections. Again, anecdotal evidence suggests misinformation among users and some avoidance of services (e.g; testing) for fear of identification.

### **Important Questions**

- Should the review of the *Drugs of Addiction Notification Regulations 1980 of the Health Act 1911* include broad community input?
- Should procedures for registering hepatitis C infections be reviewed?
- Should procedures for registering people as drug dependent be better publicised?
- Should procedures for registering notifiable diseases be better publicised?

### **3.9 Primary Health Care for Users**

A primary health care service for drug users, which offers health promotion, prevention and referral services and operates on short term funding grants, opened at WASUA in August 1999. BBV and sexually transmitted disease testing and free hepatitis B vaccination are important aspects of the program.

The service particularly targets 'hard to reach' young drug users who are homeless or at risk of homelessness, but does not deny services to any users. It is minimally staffed by a nurse and a medical practitioner. The Health Centre has been integrated with WASUA's existing services, including the treatment referral, peer education and N&S services, to provide a 'one stop shop' for client needs. Client feedback from a confidential evaluation questionnaire is extremely positive, with the safe, non-judgemental, non-discriminatory approach of the service cited as the main attraction.

Ongoing evaluation of the service indicated two key issues:

- widespread client support for increasing the hours of operation. Many referrals come from the N&S services, which is open seven days per week. These referrals are more successful if clients can go directly to the Health Centre rather than having to make an appointment for a later time; and
- strong client demand for a SIF at WASUA. Indeed, 26% of clients surveyed with the evaluation questionnaire after using the health service volunteered, without prompting, from staff or questions in the questionnaire, that a SIF was the service they would most like to see at WASUA.

### **Important Questions**

- Should funding be provided to expand the services of the Health Centre at WASUA to provide a more comprehensive range of health services to drug users?
- Should primary health care centres for drug users be established in other areas of WA?

### **3.10 The Adoption of Harm Reduction Strategies by Users**

In Australia, an epidemic of HIV among injectors has been successfully prevented, but hepatitis C remains a major problem, as does opioid overdose.

Reasons for ongoing harms include not only the imperfect provision of harm reduction information and resources to drug using communities, but also that drug users themselves do not utilise available harm reduction strategies and resources 100% of the time. Reasons for imperfect utilisation of harm reduction strategies by people who use drugs include a number of factors already mentioned in this paper, such as lack of knowledge, fear of police, lack of access to resources, fear of being treated badly and fear of registers.

Social reasons are also important in relation to sharing injecting equipment. The reasons include:

- sharing is something done with friends or lovers to reflect trust and intimacy;
- not wanting to spoil the ritual of having a hit by asking others about their disease status;
- 'trusting' those you know well to declare if they have a BBV;
- believing that if you have sex with someone then you might as well share injecting equipment with them;
- and knowing that if you do not share, you could incur loss of goodwill, trust or loss of the drug (Dear, 1995).

### **Important Questions**

- Is there a need to examine ways to increase adoption of harm reduction strategies by users?

### **3.11 Research**

Monitoring of trends in drug related harm is an important part of any response to drug issues. An effective monitoring system has been established to track opioid overdose deaths and HIV prevalence and incidence. No effective methods exist in WA to monitor hepatitis C prevalence and incidence among drug users. This is difficult but can be achieved through studies that follow groups of drug users over a long period of time.

The recent increase in amphetamine use - particularly methamphetamine use - in WA has been accompanied by anecdotal reports from users and treatment agencies about various harms, including psychosis, aggression, and difficulties in engaging heavy users in treatment. However, no recent formal research has been conducted into this area in WA.

The use of 'party drugs', such as ecstasy and LSD, continue to be popular in WA. Most users of these drugs are not dependent, do not publicly identify themselves and do not attend treatment services. No recent research has been conducted into harms and harm reduction in relation to these drugs in WA since a study was undertaken among a group of participants in the rave scene in Perth in 1995 by Lenton and colleagues (Boys, Lenton and Norcross, 1997; Lenton and Davidson, 1999; Lenton, Boys and Norcross, 1997).

There continues to be a lack of clarity about the extent and nature of long term harms associated with cannabis use, which can only be rectified by collecting long term epidemiological data. A number of strategies have been proposed in the literature for reducing the health, legal and social consequences of cannabis use (Swift, Copeland and Lenton, 2000), but evaluation of such strategies also relies on collection of long term epidemiological data.

### **Important Questions**

- Should funding be allocated to research directed at monitoring the prevalence and incidence of hepatitis C among drug users in WA?
- Should research into amphetamine related harm and harm reduction in WA be funded?
- Should research into harm and harm reduction in relation to 'party drugs' in WA be funded?
- Should funding be allocated to the collection of long term epidemiological data on cannabis related harms and harm reduction in WA?
- Are there any other drug related harms that are not being monitored and should be?

## **4.0 Summary**

This paper has raised a number of questions regarding harm reduction in relation to illegal drug use in WA. Harm reduction strategies aim to save lives, enhance health and reduce the impact of drug use on the broader community. The strategies are part of an overall framework that includes prevention, education, treatment, care, law enforcement, research and strategies to integrate people who use drugs into the broader community. There are no quick fixes to the drug problem. It is a community problem, and effective responses require community wide responsibility and collaboration. In WA, harm reduction strategies that have been successfully implemented have involved partnerships between various community organisations including user groups, non-government organisations, the health care system, pharmacies, all levels of government, police and private enterprise. Many good results have already been achieved, and only by extending and strengthening community partnerships will they be improved.

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