Harm Reduction

Windana's position statement

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WINDANA

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Contents

1. Introduction

Harm reduction belongs at the core of any truly client-centered response to substance use.

However, stigma, viewing drug use as a criminal issue, and a lack of access to harm reduction services is preventing people getting the support they need for their substance use.

Embedding evidence-based harm reduction approaches into responses to substance use issues will see more people receive vital information, support and treatment. This will lead to safer behaviour, safer spaces, and ultimately, more lives saved.

Below is a summary of Windana's positions and recommendations regarding harm reduction approaches.

2. Windana's positions and recommendations

Decriminalisation

People impacted by substance use need care and support, not judgment or punishment. Decriminalising substance use will help ensure that people can get the care and support they need, rather than the short and long-term harm caused by the punitive nature of the criminal justice system.

Possession of illicit drugs

Windana supports the decriminalisation of the use and possession of small quantities of illicit drugs in Victoria.

- As an organisation that supports thousands of people every year to reduce the harms and recover from drug problems through community support, withdrawal and rehabilitation, we see firsthand how viewing the possession of small amounts of an illicit substance as a criminal issue is failing our community.

Public drunkenness

Windana supports the decriminalisation of public drunkenness, including establishing permanent sobering-up centres that are connected to other alcohol and drug services to ensure continuity of care.

Access to Naloxone

Windana supports widely available and free access to Naloxone

Pharmacotherapy and opioid replacement therapy

With a critical shortage of pharmacotherapy prescribers in Victoria, new approaches and models of care for pharmacotherapy need to be considered, including:

- State-funded pharmacotherapy prescribers, as well as pharmacotherapy treatment centres/services staffed by salaried doctors and nurse practitioners.
- a review of the current Medicare funding model to consider an incentive program for GPs to cover the cost of bulk-billed pharmacotherapy consultations.
- administrative and/or case management support for GP clinics to increase their ability to see AOD patients.

Windana supports pharmacotherapy as an important treatment tool in recovery. We support calls for further trials for replacement pharmacotherapies (e.g. hydromorphone) to provide more options for treatment for substance dependent people.

Medically Supervised Injecting Facilities

Windana supports Medically Supervised Injecting Facilities as a proven and effective harm reduction approach for injecting drug users, including the introduction of additional Medically Supervised Injecting Rooms in Melbourne.

The location of any new facility must be based on a needs analysis of people using substances, and robust community consultation.

Needle and Syringe programs

Windana supports the Needle and Syringe Program model as a proven and effective harm reduction approach for injecting drug users, and as key hubs for Naloxone distribution and training.

Pill testing

Windana supports pill testing interventions in locations where illicit pills and tablets are likely to be consumed, including music festivals and night clubs.

3. Evidence summary

Introduction

Harm reduction generally refers to a type of public health strategy and therapeutic approach which aims to reduce the negative impacts of drug use, particularly for people who use drugs or are potentially likely to do so, and extending also to their friends, family and the wider community (Parliament of Victoria 2021, p. 208; Department of Health 2017, p. 13).

Harm reduction strategies typically seek to encourage safer behaviours, safer environmental settings and the use of 'evidence-based solutions' as a guide to reduce the harm caused by drugs (Department of Health 2017, p. 13; Turning Point 2022a, p. 1). Harm reduction strategies are considered to fall outside of the framework of the criminalisation and abstentionist approaches towards drugs (Harm Reduction Victoria 2020, p. 3).

Harm reduction, or at least many of those who advocate for harm reduction strategies, sees the complete elimination and prohibition of drugs as unachievable and harmful in its application (Parliament of Victoria 2021; Turning Point 2022a).

Harm reduction strategies generally take the view that the use of drugs, including illicit, alcohol and pharmaceuticals not as prescribed, is inevitable in any society, and therefore attention needs to be drawn to the areas where the foreseeable harms from the use of alcohol and other drugs may occur, instead of resorting to punishment (Harm Reduction Victoria 2020, p. 3; Marlatt, Larimer and Witkiewitz 2012, p. 7).

Needle and Syringe Programs

Needle and Syringe Programs provide sterile needles and syringes to people who inject drugs (O'Keefe et al. 2018, p. 1). Some are purpose-built centres which provide other supports for people who inject drugs, such as opioid replacement therapy, and others are located within health centres and hospitals (O'Keefe et al. 2018, p. 1). Needle and Syringe Programs have shown to be highly effective at reducing infection and transmission of blood-borne diseases such as HIV and Hepatitis C among those who inject drugs, which has had a flow-on effect in reducing HIV and Hepatitis C rates in the wider community (Abdul-Quader et al. 2013).

Needle and Syringe Programs can be used in many ways to reduce harms from injectable drug use. Harm Reduction Victoria, for example, sees the infection and transmission of HIV and viral hepatitis as a major harm that arises out of 'unsafe' drug use (Harm Reduction Victoria 2022). This is a position that is also echoed by the National Drug Strategy, National HIV Strategy, Turning Point among others (Department of Health 2017, p. 42; Department of Health 2014; Turning Point 2017, p. 10). A harm reduction policy that has sought to reduce the risk of HIV infection and transmission among those who inject drugs has been the Needle and Syringe Programs, which began in Australia in 1986 (Victoria Police 2020, p. 18).

Needle and Syringe Programs have been credited with achieving relatively low rates of HIV infection among people who inject drugs in Australia, with an estimated prevalence of 2.5% of all Australian's who use drugs and 1% for people who attend Needle and Syringe Programs (Kirby Institute 2021, p. 6).

The use of Needle and Syringe Programs in Australia has seen the rate of HIV among people who inject drugs and visit NSPs decrease from almost 2% in the nineties to the 1% figure that has existed for the last 15 years (Topp et al. 2011, p. 837). Further, concurrent with the rollout of Needle and Syringe Programs, people who use drugs were 58% more likely to be living with HIV than in 2009 and are more likely to contract HIV through other sources than through intravenous (IV) drug use (Topp et al. 2009, p. 837).

Moreover, Needle and Syringe Programs provide good return on investment. Research undertaken by the National Centre in HIV Epidemiology and Clinical Research has indicated that for every dollar invested in NSPs in Australia, more than four dollars in health-care cost savings are gained in the short term, with greater savings in the long term (National Centre in HIV Epidemiology and Clinical Research 2009, p. 8). When productivity gains and losses and patient costs are considered, then the cost savings are estimated to be $27 for every dollar invested in Needle and Syringe Programs (National Center in HIV Epidemiology and Clinical Research 2009, p. 8).

Therefore, the introduction of Needle and Syringe Programs represent a policy that has successfully reduced the likelihood of a serious harm that may arise from drug use, that being the transmission of blood-borne viruses such as HIV and Hepatitis C. It is important to note that, while the governments have not condoned or legalised drug use, it nevertheless understood the necessity of a harm reduction approach and provided an evidence-based service which significantly reduced the harm of the transmission of blood-borne viruses through IV drug use.

Naloxone

Another harm which arises out of drug use that may be sought to be reduced is the danger of overdosing. In the financial year 2020-21 alone, there were 15,780 ambulance attendances relating to 'illicit drugs' in Victoria and 17,898 hospitalisations in the financial year 2018-19 (Turning Point 2021). In 2020 in Victoria, there were at least 526 overdose deaths and over 2,000 unintentional drug-induced deaths across Australia (Coroners Court of Victoria 2021a, p. 5; Penington Institute 2020, p. 3).

Currently, in Australia, drug related deaths well surpass transport related deaths, a gap which continues to widen, and deaths are at a higher rate than in comparable OECD countries (Penington Institute 2020, p. 19). All of these figures, ambulance attendances, hospitalisations and deaths, have shown an upward trend over the last decade in Australia and in Victoria particularly. Therefore, the harms posed by overdosing are significant and give rise to serious health risks for people who use drugs, their families and the wider community.

A harm reduction strategy which seeks to reduce the significant harm caused by overdosing is the use of the drug Naloxone. Naloxone is an overdose reversal drug, which is generally injected intramuscularly, but can also be delivered through nasal spray (Turning Point 2020, p. 6). It is generally used by paramedics and in Medically Supervised Injecting Rooms in the case of serious overdose, where the provision of oxygen is insufficient in restoring the respiratory system. Naloxone temporary blocks opioid receptors in the body, thereby stopping the effect of the opioid and restoring the respiratory and central nervous system (Penington Institute 2018a, p. 11). Naloxone has relatively few side effects and no deaths have been recorded as a result of its use (Penington Institute 2018a, p. 11).

Naloxone has shown to be highly effective at stopping death from opioid overdose, with a review of all relevant studies indicating an efficacy rate of around 96%, even when applied by non-medical bystanders (Razaghizad et al. 2020, p. 8). Currently, in Victoria, Naloxone is able to be accessed through chemists either over the counter or with a prescription, along with it being carried by emergency services, hospitals and at the Medically Supervised Injecting Room in North Richmond. Recent changes made by the Victorian government in 2021 has made Naloxone more widely available and can now be given out by health workers in Needle and Syringe Programs, AOD treatment providers and other organisations that work with people who use opioids (Foley 2020).

From 1 July 2022, under the Federal government's 'Take Home Naloxone Program', Naloxone will be available for free without a prescription to anyone who may experience, or witness, an opioid overdose. While noting that Naloxone is not effective in reversing overdose in non-opioid drugs, these recent changes nevertheless reflect the effectiveness of Naloxone as a harm reduction measure, as it is a simple, cheap and highly effective way of reducing the serious harms associated with opioid overdose.

While the use of Naloxone may have the support of federal and state governments, other harm reduction strategies, such as Medically Supervised Injecting Facilities, pill testing/drug checking and drug decriminalisation have proved to be more controversial.

Medically Supervised Injecting Facilities

Medically Supervised Injecting Facilities are a type of Drug Consumption Room that seek to reduce harm and public order problems associated with IV drug use by offering a safe, hygienic and medically supervised environment for those who use drugs to administer externally acquired drugs (Marlatt, Larimer and Witkiewitz 2012, p. 172).

They aim to address the harms associated with public drug use and injecting, such as overdosing, discarding of syringes and anti-social behaviour, transmission of disease, crime and other negative health impacts (Parliament of Victoria 2017, p. 34). Staff at Medically Supervised Injecting Facilities are trained to respond to overdoses and generally offer advice on safer injecting and engage in other educational and counselling activities (Parliament of Victoria 2017, p. 34). Medically Supervised Injecting Facilities are currently operational in some European countries, Canada, Australia – with one in North Richmond, Victoria – and, most recently, in New York City (Parliament of Victoria 2017, p. 33; New York Times 2021).

Medically Supervised Injecting Facilities have been found to be effective in reducing the harms that arise from public injecting and drug use. The European Monitoring Centre for Drugs and Drug Addiction's, where the vast majority of Medically Supervised Injecting Facilities and Drug Consumption Rooms are located, comprehensive review in 2010 found that Drug Consumption Rooms were effective in reducing 'injecting risk behaviour', providing people who inject drugs with access to health and social care and that they do not increase levels of drug use or crime (EMCDDA 2010, p. 305). A further review by the European Monitoring Centre for Drug and Drug Addiction in 2018 found that they are effective in reducing deaths from overdose and in reducing emergency service callouts (EMCDDA 2018, p. 5).

Victoria has operated a Medically Supervised Injecting Facility in North Richmond since 2018, in response to increasing overdose deaths in the area and increased visibility of people who inject

drugs in the area (Medically Supervised Injecting Room Review Panel 2020, p. 7). In 2020, the official report by the Victorian Government's Medically Supervised Injecting Room Review Panel reviewing the first 18 months of operation found similar results regarding the effectiveness of Medically Supervised Injecting Facilities in reducing harm as the results seen internationally. The report found there had been a reduction in the number of ambulance attendances in the area, (1km radius around the North Richmond Medically Supervised Injecting Room), responding to overdoses and administering Naloxone declined by 25% overall and by 36% during the Medically Supervised Injecting Room's opening hours (MSIRRP 2020, pp. 70-71).

The North Richmond Medically Supervised Injecting Room has also acted as a gateway for people who inject drugs to access health and social assistance, with over 1,800 referrals made to both internal and external services, such as pharmacotherapy, withdrawal services and healthcare, while also providing drug treatment advice and information among other services (MSIRRP 2020, pp. 55-58).

Importantly, the North Richmond Medically Supervised Injecting Room has reduced the harm relating to overdoses. 2,657 overdoses were recorded at the North Richmond Medically Supervised Injecting Room in the 18-month period of the review, with 271 being classified as extremely serious and requiring the administration of Naloxone (MSIRRP 2020, p. 39). Without the North Richmond Medically Supervised Injecting Room, it is possible that many of those overdoses may have resulted in permanent injury, with the MSIRRP's modelling indicating that at least 21-27 deaths from overdose were avoided in the first 18 months of the Medically Supervised Injecting Room's operations (MSIRRP 2020, p. 39).

Therefore, in light of rigorous testing, Medically Supervised Injecting Facilities are being seen increasingly as an effective harm reduction facility which can prevent injury and deaths from overdose, and provide people who inject drugs with access to health and social services which they may not have been afforded previously. The effectiveness of Medically Supervised Injecting Facilities as a harm reduction measure is evidenced by the extension of the North Richmond MSIR until at least 2023 and plans to establish a second Medically Supervised Injecting Room in Victoria, located in the City of Melbourne.

Pill Testing and Drug Checking

Pill testing allows people in possession of drugs such as MDMA and other drugs often referred to as 'party drugs,' to have the content of the drug checked for any harmful adulterants (Thorne Harbour Health 2019, p. 2). Some tests can also determine the purity of the drug (Alcohol and Drug Foundation 2021).

Tests can also determine whether the drug is what the owner believes it to be, which is especially relevant considering the introduction of 'Novel Psychoactive Substances' (Thorne Harbour Health 2019, p. 2). Novel Psychoactive Substances are synthetic formulations which often seek to mimic established drugs such as marijuana or MDMA, and as information on them is very limited, the risk of harm is often heightened, especially when it is not the drug the user though it was (UNODC 2022).

For example, in Melbourne, eight people died and over 20 were hospitalised after taking Novel Psychoactive Substances disguised as MDMA in 2016-17, leading Victorian Coroner Spanos to call for a state-wide drug checking service, which has been echoed by Coroner Gebert in April 2022

after another NSP death (Coroners Court of Victoria 2022; Coroners Court of Victoria 2021b; The Age 2017).

Similar incidents have been well reported and publicised at festivals and nightclubs both in Australia and overseas. While pill testing/drug checking is often associated with festivals and nightclubs, its application and potential is much broader and can include a suite of measures such as public drug testing sites and public alert system, to broadcast when harms such as adulterants have been found circulating. International research has shown that when pill testing is implemented, often at places such as music festivals, a high percentage of drugs (24-40%) were not what they purported to be, representing a high risk for harm (Thorne Harbour Health 2019, pp. 2-3).

International research also shows that an overwhelming majority of people enact harm reduction methods after going through pill testing, such as disposing of the substance, reducing intake, with many indicating that they may stop or limit future recreational drug use after finding out the results of a pill test (Thorne Harbour Health 2019, p. 3).

Some countries such as The Netherlands, Austria and New Zealand have fully legal national wide pill testing and drug checking services (Alcohol and Drug Foundation 2021). The Australian Capital Territory has allowed for a trial pill testing service to operate at the 'Groovin the Moo' music festival in 2018 and 2019 and was due to continue in 2022, but was cancelled due to issues around insurance (Harm Reduction Australia 2022).

In 2021, the ACT government announced a fixed-site pill testing and drug checking pilot program to begin in 2022, making it the first of its kind in Australia (Harm Reduction Australia 2022). At date of writing, pill testing and drug checking remains unavailable in all other Australian jurisdictions.

Decriminalisation of Illicit Drugs and Public Drunkenness

A wide-ranging policy initiative that may work towards the goals of harm reduction is the decriminalisation of illicit drugs. In the broadest sense, drug decriminalisation refers to the removal of criminal penalties for the personal possession and use of illicit drugs (Turning Point 2022a, p. 2).

Decriminalisation does not mean the same as the legalisation of drugs. The legalisation of drugs would see currently illegal drugs being treated the same as alcohol and tobacco, with the establishment of a regulated market for the production and sale of those drugs (Thorne Harbour Health 2019, p. 2).The decriminalisation of illicit drug use would instead see the creation of infringements or administrative sanctions for the personal and use of drugs, moving these matters outside the remit of the criminal justice system and towards the public health system (Cabral 2017, p. 1). Much of the argument for drug decriminalisation is set against the perceived failures and harms created by the criminalisation and prohibition approach towards drugs, which is the dominant approach to drug policy ultimately in Australia and worldwide.

Firstly, it is argued that since the escalation of drug criminalisation and the 'war on drugs' in the latter half of the 20th century, drug markets have expanded and become more dangerous (Wodak 2014, pp. 192-3). The worldwide yearly production of opium has increased from around 1000 tons in 1980 to a high of just over 10,000 tons in 2017, while the production of cocaine has increased from just over 800 tons in 1998 to 1,784 tons in 2019 (UNODC 2021, p. 52). This rise in production

has happened concurrently with a rise in drug consumption, both in the Global North but also increasingly in the Global South (UNODC 2021, p.11). This has meant that there is more potential for risk and more people at risk of the harms presented by drugs themselves, such as HIV infection, overdose, adulterants and Novel Psychoactive Substances, increased susceptiveness towards illness among others.

But further, criminalisation creates its own harms towards people who use drugs and to society more generally. It means that people who use drugs may not be able to access the health services they need and instead are pushed onto the margins, under the threat of imprisonment – depending on the country – and face significant stigma, thereby creating an environment of unsafe drug use and criminality to occur (Turning Point 2022a, p. 2).

Moreover, the criminalisation of drugs has led to the proliferation of the black market and organised crime (Wodak 2014, p. 196).

There are also the high costs of operating a drug criminalisation system. In Australia, around 65% of the overall drug budget goes towards law enforcement, which does little in reducing the supply, demand and harms of drugs (Turning Point 2022a, p. 1). At the same time, approximately 20% of the drug budget goes towards treatment and just over 2% goes towards harm reduction (Ritter, McLeod and Shanahan 2013, p. 39). This means that hundreds of thousands of Australians are not able to have access to alcohol and other drug treatment while tens of thousands face arrest and criminal sanctions (Turning Point 2022a, p. 1). For these reasons an array of experts including AOD organisations, the Royal College of General Practitioners and the Royal College of Physicians, former police commissioners, judges among others, advocate for a decriminalisation approach, which centres a harm reduction focus, instead of a punitive one (Thorne Harbour Health 2019, p. 3).

Most advocates of decriminalisation point towards Portugal's approach as a successful example of drug decriminalisation. Amid the backdrop of high-risk opioid use, a lack of policing resources and an evidence-based approach, in 2001, the Portuguese government decriminalised the public and private use, acquisition and possession of all illegal drugs, as long as it is less than 10 days' supply (Rêgo et al. 2021, p. 59). Instead of facing criminal sanctions, people who use drugs may face an administrative fine by the 'Commissions for the Dissuasion of Drug Addiction' (Commissions for the Dissuasion of Drug Addiction) (Rêgo et al. 2021, p. 59). Commissions for the Dissuasion of Drug Addiction are typically comprised of a legal expert, a health professional and a social worker (Thorne Harbour Health 2019, p. 3).

Once a person is referred to the Commissions for the Dissuasion of Drug Addiction, they will investigate whether the person has dependency issues or previous convictions (Cabral 2017, p. 2). If the person has a history of dependence, then the Commission for the Dissuasion of Drug Addiction recommends them treatment, however this is not mandatory, as the law believes that such programs work best when entered into on a person's own volition (Cabral 2017, p. 2).

If a person does not have a history of usage or dependence, or if they decide to take up treatment, then the proceeding is suspended and then archived after two years if no further infringements are made or treatment is successfully concluded, meaning that no fine is given (Cabral 2017, p. 2). This is the case in the overwhelming majority (81%) of cases (Reitox Portugal 2012, p. 102). It is important to note that the trafficking and production of illicit drugs is still severely punished in Portugal (Cabral 2017, p. 1).

Since the inception of the Portuguese decriminalisation law in 2001:

- The consumption of drugs, especially among young adults, has decreased and Portugal now has one of the lowest incidents of young adults using drugs in Europe (Cabral 2017, p. 3).
- The number of cases of HIV occurring in people who inject drugs has also significantly declined in that period. In 2001, Portugal had over 50% of all new HIV cases attributed to IV drug use in the EU, with 1,287 cases.; By 2019, even considering that cases in the EU declined during this period, that figure was 1.68% of the EU total, reducing to just 16 new cases (Transform Drug Policy Foundation 2021, p. 5).
- Drug-related deaths in Portugal have gone from being on the EU median in 2001, to being one of the lowest in Europe - 6 per-million aged 16-64, compared to the EU average of 23.7 per-million, and well below the Australian average of 72 per- million (Transform Drug Policy Foundation 2021, p. 2; Australian Institute of Health and Welfare 2022).

Therefore, by treating drug use as a health issue, drug decriminalisation, such as in Portugal, has been found to significantly reduce the harms associated with drug use and its criminalisation.

Further, there is also the social and fiscal cost savings of decriminalisation. The social cost in Portugal of the consumption of illegal drugs decreased by 18% since decriminalisation (Cabral 2017, p. 3). Neither increased crime nor the fears of Portugal becoming a 'drug-tourist' destination ever materialised (Cabral 2017, p. 2). Most of the savings has been through the reduction of legal system costs and health-related costs, meaning that more funds can go towards treatment and harm reduction, instead of on law enforcement costs and incarceration (Gonçalves, Lourenço and da Silva 2015, p. 200).

The decriminalisation of illicit drugs is increasingly being taken up by other jurisdictions.

In June 2022, the ACT government stated they would move to decriminalise the possession of a 'small quantity' of ten illicit drugs after a review of MLS Michael Pettersson's private member bill to decriminalise illicit drugs (Stephen-Smith 2022, p. 1). Instead of criminally prosecuting people with a personal possession of drugs, the new legislation will seek to divert drug offenders away from the criminal justice system and into treatment and education (Pettersson 2021, p. 1). People found with a 'small quantity' of illicit drugs will be served with a Simple Drug Offence Notice, which generally proscribes payment of a fine of $100, which, if paid, no conviction is recorded (Legislative Assembly for the Australian Capital Territory 2021, p. 7). Simple Drug Offence Notices may have alternatives to a fine, such as diversion to education and support services, as well as the option to waive the fine altogether, and all Simple Drug Offence Notices will come with information about treatment services (Stephen-Smith 2022, p. 5).

In May 2022, the Canadian government announced that it will begin a three-year trial of drug decriminalisation in the western province of British Columbia. Adults who are found with 2.5 grams or less of certain illicit substances will no longer be arrested, charged or have their drugs seized and will instead be offered information on health and social supports and will assist in referrals (Ministry of Mental Health and Addictions 2022). British Columbia has been one of the hardest hit regions in Canada relating to drug deaths, with an ongoing public health emergency being declared in 2016, as drug-related deaths increased from 211 in 2012 to 1726 in 2020 (Parent et al. 2021).

Decriminalisation of public drunkenness

In response to the 2017 death of Yorta Yorta woman Tanya Day, who died as a result of brain trauma sustained while in a police cell for public drunkenness, the Victorian government announced in 2019 that they would begin moves to decriminalise public drunkenness (Wright 2021).

In February 2021, the Victorian Parliament passed legislation to decriminalise public drunkenness with the changes to originally come into operation in November 2022 (Wright 2021). However, the Victorian government has delayed this to at least 2023 (The Guardian 2022).

Throughout the last few decades, many recommendations have been made to the government that public drunkenness be decriminalised as it unfairly targeted Aboriginal and Torres Strait Islander people and because police cells were seen as unsafe places for sobering-up (Wright 2021, pp. 5-6). As with drug decriminalisation, the new proposed model for public drunkenness is a health-based model, away from a law enforcement approach (Wright 2021, p. 16). Under the reforms, first responders to public drunkenness will preferably be health workers instead of police and will be immediately transported, preferably avoiding the use of police cars, to a place of safety, preferably their residence or a friend or family's residence (Wright 2021, p. 15).

The reforms will also set up sobering-up centres where individuals can rest and recover in a safe and supported environment (Wright 2020, p. 15). The government will run four trial sobering up centres in Victoria starting sometime in the second half of 2022 which will inform the specifics of the decriminalisation reform, with locations in the Cities of Yarra, Greater Dandenong, Shepperton and Castlemaine (The Guardian 2022).

Pharmacotherapy

Pharmacotherapy is a harm reduction measure which uses prescribed medicines to assist in the treatment of substance dependence (Turning Point 2022b). The main form off addiction pharmacotherapy is Opioid Replacement Therapy, which is also referred to as Opioid Agonist Therapy and Opioid Maintenance Therapy.

Opioid Replacement Therapy is the legal provision of prescribed opioids to a person with dependence issues in order to stimulate the opioid receptors in the brain and avoid withdrawal symptoms without causing intoxication (Penington Institute 2015, p. 5). Its aim is to stop the use of illicit opioids and thereby reduce a person's dependence on them.

The two legally prescribed medications for Opioid Replacement Therapy in Australia are Methadone and Buprenorphine, which is sometimes combined with Naloxone on a combination called Suboxone (VAADA 2022a, p. 1). In some European countries, such as in the UK or in Switzerland, diamorphine, a prescribed form of pharmaceutical heroin, is also given as part of Opioid Replacement Therapy, with the UK doing so for almost 100 years (Marlatt, Larimer and Witkiewitz 2012, p. 15).

Additionally, VAADA is arguing for hydromorphone to be used as part of a supervised injectable opioid treatment regime, as Methadone and Buprenorphine is ineffective for some people who use opioids (VAADA 2022a).

Opioid Replacement Therapy is considered to be the 'gold standard' treatment for opioid dependence issues (VAADA 2022a, p. 1). International systematic reviews have found that enrolment in Opioid Replacement Therapies reduces 'all-cause' mortality by 63% compared to those not in Opioid Replacement Therapy, and reduces the likelihood of 'overdose-specific' mortality by 84% compared to those not in Opioid Replacement Therapy (Bhaji et al. 2019, pp. 318-19). Retention rates internationally in Opioid Replacement Therapy after six months are typically around 70% (Lawrinson et al. 2008, p. 1490).

Opioid Replacement Therapy, when combined with other harm reduction measures such as Needle and Syringe Programs, reduce the odds of Hepatitis C infection in people who inject drugs by nearly 80% and significantly reduces the likelihood of HIV infection and risky injecting use (Turner et al. 2011; Gowing et al. 2011).

Opioid Replacement Therapy has also been found to reduce the likelihood of using illicit drugs by up to half, as compared to those in treatment but not in Opioid Replacement Therapy, although this number could potentially be higher now as, in some cases, Methadone and Buprenorphine can block the effect of other opioids (Mattick et al. 2009; Centre for Addiction and Mental Health 2016). It has also been found to reduce the likelihood of committing criminal activity by over 60%, although these findings are only relevant for Methadone Maintenance Programs (Mattick et al. 2009).

In Victoria, the provision of Opioid Replacement Therapy is usually made through General Practitioners (who prescribe) and community pharmacies, (who dispense). In order to prescribe Opioid Replacement Therapy in Victoria, practitioners have to opt-in to the system and have to attain a permit from the Department of Health in order to do so (Department of Health and Human Services 2016, p. 22). General Practitioners can take on five patients without taking specialist training and must do so if they are to prescribe to more than five patients (Department of Health and Human Services 2016, p. 22).

As it is an opt-in system, that means that under 10% of GPs in Victoria are prescribing Opioid Replacement Therapy, with this mainly being skewed towards older doctors, as newer GPs are reluctant to opt-in (VAADA 2022b, p. 36).

Further, for the 15,000 Victorians on Opioid Replacement Therapy, most are being seen by just six percent of the total 1043 prescribers in Victoria, with some GPs prescribing for hundreds of patients, which creates serious shortfalls when one of these doctors retire, as there are few practitioners available to take up the hundreds of clients who were dependent on that GP (The Sunday Age 2022). Similarly, many chemists are reluctant to opt-in to the system, meaning that access to Opioid Replacement Therapy is limited (Penington Institute 2018b).

Harm Reduction as Therapeutic Practice

Finally, it is important to note that harm reduction is more than a specific set of policies and practices such as the ones mentioned previously. For those on the ground and who work with people who use drugs, such as those who work at Windana's Therapeutic Communities, harm reduction means a more holistic, therapeutic approach, which centres the absence of punishment, judgement and of coercing residents and clients to do things.

From a harm reduction practitioner's point of view, it is an important aspect of harm reduction to be present with the resident or client and to use their position to educate and inform residents or clients of the harms of the drugs they are using, the dangers of mixing drugs and the effects the drug will have on the person.

But it is important to consider that these goals and conversations should be driven by the resident/client or person who is using drugs, and that goals, such as abstinence, should only be approached if the person is ready and wants to (Vakharia and Little 2017, p. 66).

Under the harm reduction approach, it may not be the final goal of every resident or client to achieve abstinence and complete sobriety. Harm practitioners should support the resident or client and ensure that, if they continue to use drugs, that they do so in the safest way possible while understanding the implicit risk present in all drug-taking. The goals and how residents/clients achieve those goals is to be determined and driven by the residents/clients themselves.

A central premise of harm reduction practice is to meet people where they are at and encourage them through a 'collaborative working alliance', which is driven by the self-determination and autonomy of the resident/client. This means that practitioners need to take care not to be judgmental or stigmatising and instead they should be open, empathetic and compassionate. Indeed, under the harm reduction paradigm, the removal of stigmatising attitudes in society towards people who use drugs and alcohol is important because of the harmful role that stigma has on people who use drugs and alcohol. From this point of view, harm reduction is seen as humane and empathetic, but also practical and evidence based.

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