15 November 2023

United Nations Special Rapporteur on the Right to Health
Palais des Nations
1211 Geneva 10, Switzerland
Via email ohchr-srhealth@un.org

To the Office of the Special Rapporteur on the Right to Health,

Re: Drug policies and responses: a right to health framework on harm reduction

The Alcohol and Drug Foundation (ADF) thanks the Special Rapporteur for the opportunity to comment on this framework. The ADF is an Australian non-governmental organisation that delivers evidence-based approaches to minimise alcohol and other drug harm. We recognise the power of strong communities and the important role they play in preventing problems occurring in the first place. A community-centric approach is at the heart of everything we do.

The ADF is strongly committed to advocating for harm reduction initiatives in Australia for people who use drugs. We see the impact of stigma towards people who use drugs leading to poor health outcomes. Destigmatisation is a fundamental component of the work to reduce the harm caused by illicit drug use in the community, as much harm is driven by systems that exclude, marginalise, or criminalise people who use drugs. While Australia has a relatively developed health system, and has had some history with the implementation of harm reduction services,

1. *While the concept of harm reduction has traditionally been applied to drug use, the Special Rapporteur is taking a broadened approach to harm reduction. What types of harm reduction policies, programmes, and practices are in place in your community, and what is their purpose or aim? How successful have they been at achieving that aim? Please provide data, as possible.*

The Alcohol and Drug Foundation has most familiarity with harm reduction practices in the alcohol and other drug sector. Examples of harm reduction practices in Australia include supervised injecting facilities in Sydney and Melbourne, drug checking services run in the Australian Capital Territory, and needle and syringe programs run throughout the country. Each of these programs is evidence based and has been reviewed as having positive impacts on health outcomes for

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people who use drugs. Examples include thorough evaluations for Sydney MSIC[1], Melbourne MSIR[2], CANTest drug-checking service[3], and needle and syringe prgorams[4, 5].

2. *How do legal frameworks affect the harm reduction policies, programmes, and practices (whether related to drug use or otherwise) that are available in your community, country, or region? Are there laws or policies that either facilitate or serve as a barrier to adopting or implementing certain harm reduction policies, programmes, and practices? Aside from legal and regulatory barriers, are there other obstacles in place? Please provide specific examples.*

Criminalisation of personal drug use remains a significant barrier to harm reduction practices in Australia. Despite evidence demonstrating the effectiveness of harm reduction services like drug checking, supervised injecting facilities, or even safer supply of illicit drugs (e.g. via prescribed heroin), only a small percentage of spending in Australia on illicit drugs is spent on harm reduction.[6] The Australian Capital Territory has had a fixed site drug checking service in place since 2022, and Queensland plans to trial drug checking over the coming Australian summer. Sydney has had a medically supervised injecting centre operating successfully since 2001, while Melbourne has had a medically supervised injecting room operating since 2018, with a campaign to push the government to open a second site underway. Ongoing criminalisation of drug use sits in sharp contrast to these harm reduction practices, and outside of this select settings, is the predominant policy response to personal drug use in Australia.

Australia has a history of peer-led and grassroots harm reduction. The provision of safe injecting equipment was pioneered amongst Australian drug using communities in the late 1980s, and has since been formalised through government and non-government programs. This legacy of progressive approaches to reducing harm for people who use drugs is at risk, however, due to the stigma that people who use drugs face when attempting to access needed healthcare. Stigma occurs in multiple domains within the community, including interpersonally, socially, in the media, and in the operation of systems and laws. Recent survey data collected by the Alcohol and Drug Foundation has found that people who use drugs experience the most stigma from family and friends, which can prevent them reaching out for support when needed.[7] Experience with the destigmatisation of other health conditions in Australia including HIV and mental health conditions demonstrates that it is possible to remove stigma and improve material outcomes. The reduction of stigma is therefore a key lever for enabling harm reduction.

Notably, Australia does not have needle and syringe programs in prisons. This is despite three quarters of people in Australian prisons having a background of alcohol and other drug use, and significant harms due to blood borne virus transmission and other injecting related health harms occurring in Australian custodial settings. This is a clear example of where stigma prevents the adoption of an evidence-based health measure that occur where populations have intersecting needs, when the same intervention is available outside of custodial settings.

3. *How does the jurisdiction in place in your region/country/state approach the criminalisation (or decriminalisation) of drug use? Please provide disaggregated data, including but not limited to gender, age, race/ethnicity, status of poverty, sexual orientation and the number of persons deprived of liberty for drug possession or consumption.*

In Australia in 2020-21 there were 140,624 arrests for illicit drugs, of which, 122,824 were for personal use. Of these, 31,364 of people arrested identified as female.[8] While there are relatively few people imprisoned with personal drug use as their most serious offence – less than 400 – the vast majority of these are in a single jurisdiction in Queensland.[9]

Federally, the possession of illicit substances is an offence, but most illicit drug use is dealt with under state law. Federal law allows for the diversion of individuals under state law away from the criminal justice system. Decriminalisation and diversion practices differ by state and territory. The Australian Capital Territory decriminalised the possession of 9 substances up to a certain threshold quantity in 2023. An individual detected with this small amount will have it confiscated and face either a referral to a treatment service or a fine. South Australia and the Northern Territory have decriminalised cannabis possession for over 20 years. Other jurisdictions have a police run pre-court diversion programs, but these have exclusion criteria that prevent people with previous offences, or who have already accessed the scheme accessing it again. This means these diversion programs can tend to favour those who are less likely to be detected (e.g. occasional users instead of dependent users), and can fail to reduce harm for those who need support in the community.

4. *Beyond reducing the adverse health, social, and legal consequences of drug use, what other areas can benefit from harm reduction policies, programmes, and practices in furtherance of the right to health and related human rights? Examples may include, but are not limited to, the decriminalisation of sex work, the decriminalization of abortion, and safe sex programmes.*

No comment.

5. *What type of harm reduction policies, programmes, and practices, as well as mental health and other support (e.g., housing, legal, social, educational, and economic), are available for people who use drugs in the community, institutions, or detention facilities? Please share examples of the impact of criminalisation, discrimination, stereotypes and stigma on the different groups of the population e.g., persons in situation of homelessness, migration, or poverty, sex workers, women, children, LGBTIQ+ persons, persons who are detained or incarcerated, persons with disabilities, Indigenous Peoples, Black persons, persons affected by HIV or hepatitis, and persons living in rural areas, etc.).*

The Alcohol and Drug Foundation recommends the work of the Australian Injecting & Illicit Drug Users League (AIVL) as the peak body for people who use drugs in Australia for information about the experiences of stigma and other challenges faced by people who use drugs, including those experiencing intersecting challenges like blood-borne viruses and incarceration. An example of this work is here.

6. *Are there alternative measures to institutionalisation or detention? For example, are there outpatient or inpatient facilities available in your country for people using drugs? Please provide additional details (are they compulsory, voluntary; number available in urban and rural areas; entity in charge; type of support provided and type of staff working in these facilities/centres)?*

Australia has a range of alcohol and other drug (AOD) treatment services. These vary in scale, scope, and resourcing between jurisdictions. All jurisdictions have publicly funded and freely accessible treatment services, however, barriers can exist to accessing these services, and there remains significant unmet demand in the community.[10] Publicly funded AOD treatment services are a mix of outpatient services including counselling, case management, and information, residential and non-residential withdrawal services, and residental and non-residential longer term rehabilitation programs. Specific services exist for certain priority populations including women, young people, and First Nations Australians. Due to Australia's large geography and concentrated urban population, services tend to be less accessible in regional and rural areas. Services are generally available as voluntary, though often publicly funded services take clients who are required to engage in treatment as part of a court order. Certain programs are only available to clients within the justice system. Staff in these services are multi-disciplinary, including counsellors, social workers, nurses, support workers, harm reduction workers, peer workers, and medical professionals, depending on the service delivered.

7. *Please provide examples of harm reduction policies, programmes, and practices adopted or implemented with international cooperation or through foreign assistance in your country, as well as their impact on different groups within the population. What types of challenges can arise from reliance on foreign assistance? Please also provide examples focusing on the need for, and impact of, harm reduction policies, programmes, and practices on different groups of the population (e.g., persons in situation of homelessness, migration, or poverty, sex workers, women, children, LGBTIQ+ persons, persons who are detained or incarcerated, persons with disabilities, Indigenous Peoples, Black persons, persons affected by HIV or hepatitis, and persons living in rural areas, etc.).*

No comment.

8. *Are there programmes of research and innovation related to harm reduction from a right to health perspective (e.g., needle and syringe programmes, supervised injection and drug use facilities, opioid substitution therapy, and others beyond the area of drug use), including outreach and education programmes, in your community, country, or region? Please provide good practices and examples.*

Evidence regarding some of these programs in Australia is outlined above. The ADF provides evidence-based information regarding drugs and harms that are accessed by over 6 million people globally each year. This includes the ADF's Drug Facts information, the Drug Wheel, and Insights into AOD issues that are relevant to the community. These information sources provide people who use drugs, families, professionals, and policymakers with evidence-based non-stigmatising information on alcohol and other drugs.

Sincerely,

Dr. Erin Lalor
CEO

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