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Position Statement

Achieving a health-focused approach to drug policy in Australia and Aotearoa New Zealand

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About The Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of over 22,600 physicians and 9,600 trainee physicians, across Australia and Aotearoa New Zealand. The RACP represents a broad range of medical specialties including addiction medicine, public health medicine, general medicine, paediatrics and child health, clinical pharmacology, cardiology, respiratory medicine, neurology, oncology, infectious diseases medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, rehabilitation medicine and geriatric medicine. Beyond the drive for medical excellence, the RACP is committed to developing health and social policies which bring vital improvements to the wellbeing of patients, the medical profession and the community.

About the Australasian Chapter of Addiction Medicine (AChAM)

The Chapter of Addiction Medicine (AChAM) is a Chapter of the Royal Australasian College of Physicians (RACP) Adult Internal Medicine Division that connects and represents Addiction Medicine Fellows and trainees in Australia and New Zealand.

AChAM advances the study of Addiction Medicine in Australia and Aoetaroa New Zealand through training, research and collaboration with health professionals and organisations. The AChAM provides training and continuing professional development to ensure excellence in skills, expertise, and ethical standards. AChAM advocate on behalf of our members and act as an authoritative body for consultation in Addiction Medicine to ensure quality care for individuals with addiction disorders.

About the Australasian Faculty of Public Health Medicine (AFPHM)

The Australasian Faculty of Public Health Medicine (AFPHM) is a Faculty of the Royal Australasian College of Physicians (RACP). In its work, the AFPHM is driven to achieve a high standard of population health in Australia and Aotearoa New Zealand. AFPHM provides postgraduate advanced training in public health medicine, supports public health medicine research and development, advocates for the highest standard of population health, promotes public debate on matters that affect the health of the community and supports continuing professional development of Fellows as required to maintain specialist qualifications recognised by the Medical Board of Australia and the Medical Council of New Zealand (MCNZ).

In June 2023, the RACP enshrined an Indigenous Object in its Constitution which codifies its commitment to (a) respecting and promoting the principles as enshrined in the Uluru Statement from the Heart, Te Tiriti o Waitangi and the United Nations Declaration on the Rights of Indigenous Peoples; (b) advancing justice and health care for Aboriginal and Torres Strait Islander and Māori communities and (c) acknowledging the world views, protocols and cultures of the Aboriginal and Torres Strait Islander and Māori peoples.

We acknowledge and pay respect to the Traditional Custodians and Elders – past, present and emerging – of the lands and waters on which RACP members and staff live, learn and work. The RACP acknowledges Māori as tangata whenua and Te Tiriti o Waitangi partners in Aotearoa New Zealand.

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Executive Summary

The Royal Australasian College of Physicians (RACP) has developed this position statement to outline the rationale and evidence for a health-focused approach to inform policy development by governments and organisations across Australia and Aotearoa New Zealand.

We hope that this document will assist governments at all levels in Australia and Aotearoa New Zealand to develop an all-of-government, comprehensive response to illicit drug problems, that encompasses education, prevention, treatment and harm reduction approaches that are effective, ethical, empowering and evidence-based.

Drug use is common. In Aotearoa New Zealand, according to the latest data available, almost half of the adult population (49%) had used recreational drugs at some point in their lives.[1] This compares to almost 1 in 2 (47%) Australians aged 14 years and over having illicitly used a drug at some point in their life (including pharmaceuticals used for non-medical purposes).[2]

Drugs are used by people in all socio-cultural groups, are not explained by "individual failings", and should be responded to in a comprehensive, evidence-based way. Harmful drug use and dependence contribute to health risks and mortality rates, costing billions per year to society.

As physicians, we know that drug use can cause harm and risk of harm to the person and to others. Importantly, we recognise that both the ***use*** of drugs and our governments' ***response*** to the use of drugs can cause harm and that stigma surrounding drug use can have profound and far-reaching consequences for individuals who use drugs.

This position statement outlines evidence-based interventions which will most usefully enhance Australia and Aotearoa New Zealand's response to drug problems. Below are the key recommendations, which are expanded upon in the main text:

Education & Prevention

The RACP calls on governments to:

1. Implement a range of evidence-based measures to address and reduce adverse childhood experiences and trauma in the community.
2. Focus prevention efforts on strategies that are based on existing scientific evidence.
3. Support research efforts to contribute to the evidence base and evaluate interventions, as outlined in the UNODC/WHO International Standards on Drug Use Prevention[3] (2018).
4. Ensure all health professionals and those delivering essential services receive training in trauma-informed care and evidence-based alcohol and other drug treatment.
5. Ensure health and social institutions review their policies and frameworks to support the implementation of trauma-informed practices.
6. Commit to active and meaningful engagement with Aboriginal and Torres Strait Islander and Māori peoples to ensure trauma-informed care is available that acknowledges the harms associated with loss of cultural identity, racism, discrimination and negative stereotyping.
7. Commit to active and meaningful engagement with priority populations to ensure measures are culturally appropriate and to avoid unintended harms.

Harm reduction

1. The RACP supports current moves towards drug decriminalisation and calls for further steps to decriminalise the use of drugs and possession for personal use. Decriminalisation should be applied across drug classes and be accessible across the community to ensure sub-populations are not excluded. Decriminalisation should be evaluated to determine the impacts on people who use drugs and on the wider community.

The RACP calls on governments to:

2. Increase funding for evidence-based harm reduction measures which are linked to positive outcomes for people who use drugs and the wider community.
3. Ensure needle syringe programs (NSPs) are widely and freely available in a range of health and social welfare settings.
4. Establish a national overdose surveillance in Aotearoa New Zealand.
5. Make take-home naloxone (THN) available to anyone who is at risk of experiencing or witnessing an opioid overdose.
6. Increase the number of supervised consumption services (SCSs) across Australian cities and regional centres and introduce SCSs to Aotearoa New Zealand, improving accessibility for target populations of people who inject and smoke drugs.
7. Establish trials of regulated cannabis markets in Australia and Aotearoa New Zealand.
8. Expand use of court and police diversion programs for all people who have committed drug-related and non-violent crimes.
9. Review the use of drug detection dogs by Australian police services and consider reducing or eliminating their use.
10. Expand trials and evaluations of fixed and mobile drug checking sites in Australia, tailored to local communities with involvement and oversight from relevant experts.
11. Ensure the introduction and/or further implementation of real time prescription monitoring (RTPM) programs are undertaken alongside wider service planning and resourcing in addition to robust independent evaluation of their impact upon patients to ensure there is no inadvertent increase in harms to individuals.
12. Ensure peer programs are well-resourced, available, accessible and part of routine alcohol and drug service provision.
13. Offer safe and, where possible, permanent, non-abstinence-based housing to homeless or under-housed people without requiring a commitment to abstinence from using alcohol or illegal drugs.
14. Support trauma-informed harm reduction responses that acknowledge the impact of colonisation, racism, systemic discrimination and cultural oppression from the perspective of Aboriginal and Torres Strait Islander and Māori peoples.
15. Review driving regulations to optimise individual and public safety, while minimising unnecessary infringements upon civil liberties and avoiding stigma towards people who use drugs. The focus should be on deterring and detecting impairment as a consequence of drug use.
16. Ensure workplace guidelines regarding safety-critical industries include policies to deter and detect drug use.
17. Commit to active and meaningful engagement with priority populations, including people who use and inject drugs, to ensure measures are culturally appropriate and to avoid unintended harms.

Treatment

The RACP calls on governments to:

1. Increase resourcing of evidence-based drug and alcohol treatment services. Resources should be directed towards services and intervention models that are safe and effective and utilise resources efficiently.
2. Increase resourcing to facilitate a comprehensive approach to health care for people who use drugs and/or alcohol, delivered in partnership with other services, especially mental health. Comprehensive alcohol and other drug (AOD) treatment requires attending to co-existing physical and mental health conditions and social issues for patients, delivered in partnership with other services.
3. Ensure individuals are able to access care in a setting that is appropriate to them (e.g. community/primary care/tertiary healthcare setting) including an integrated care service if that is the most suitable option for their care.
4. Ensure AOD services for Aboriginal and Torres Strait Islander and Māori peoples are adequately resourced, accessible, culturally safe and developed and led by Aboriginal and Torres Strait Islander people and Māori.
5. Invest in and prioritise workforce development in addiction medicine and addiction psychiatry to ensure a sustainable and highly skilled AOD workforce.
6. Fund designated positions for Aboriginal and Torres Strait Islander people and Māori in the AOD workforce and peer workforce
7. Ensure adequate reimbursement for Addiction Medicine and other medical, nursing and allied health professionals in providing AOD treatment.
8. Implement quality and outcome frameworks for AOD services, including not-for-profit services and charities.
9. Invest in high quality research and evaluation into AOD treatments, including the establishment of a national AOD clinical research network that develops and strengthens partnerships between clinicians, consumers and academic researchers.
10. Commit to active and meaningful engagement with priority populations to ensure measures are culturally appropriate and to avoid unintended harms.

Purpose and scope of this position statement

This Position Statement outlines the RACP's position on effective drug policy including educational, preventative and harm reduction measures, evidence-based treatment services and regulatory options to reduce harm associated with drug use and criminalisation. It provides the rationale and evidence for a health-focused approach to inform policy development by governments and organisations across Australia and Aotearoa New Zealand.

This Position Statement focuses on those drugs which have been classified as illicit in most jurisdictions in Australia and Aotearoa New Zealand. These include cannabis (marijuana), heroin and other illicit opioids, cocaine, amphetamine type stimulants (ATS), other illicit stimulants, non-prescribed sedative drugs, hallucinogens and empathogens. Some prescribed medications are obtained illicitly, and these are also included. We will use the terms "psychoactive drugs" or "drugs" for short to encompass these drugs.

Tobacco (nicotine), alcohol, and medical use of prescribed medications are out-of-scope for this Position Statement as these are covered in other RACP policy documents.[4, 5, 6, 7, 8] Nonetheless, we note the considerable burden of disease that results from alcohol and tobacco use in both Australia and Aotearoa New Zealand.

Drugs and alcohol are substances that alter the way we think, feel and behave. People use drugs and alcohol for a variety of reasons including for enjoyment, to relax, to socialise, to avoid or reduce their psychological distress and/or physical pain. We must also recognise that many cultures have longstanding traditions of using psychoactive substances in their spiritual and healing practices.[9]

Key principles underpinning this position statement

1. As physicians, our perspective on drug use derives from:
    a. Drug use is common and is most often "episodic, transient and generally non-problematic".[10]
    b. Drug use can cause harm and risk of harm to the person and to others.
    c. Importantly, for policy, both the *use* of drugs and *our response* to the use of drugs can cause harm.
    d. As a society we should seek to reduce harm from drugs to the greatest extent possible, through the judicious application of evidence-based education, preventative, early intervention, treatment and harm reduction approaches.

2. We endorse the World Health Organization's (WHO) public health approach to drug use, recognising that it exists as a spectrum and that society's responses should adopt the most effective strategies relevant to (i) those whose drug use is low level and occasional, (ii) those at risk of harm, (iii) those experiencing harm, and (iv) those who have a drug use disorder and/or dependence**.**

The Australian and Aotearoa New Zealand contexts

In Australia, there were 1,693 drug-induced deaths (i.e. deaths attributable to drug use including due to acute toxicity and chronic use) in 2022[11] and there were 188 deaths from overdoses in Aotearoa New Zealand in 2023, a significant increase from 100 in 2016.[12] In addition to deaths

secondary to drug use, significant morbidity may result, including but not limited to brain damage and cognitive dysfunction, liver and kidney damage, and illness secondary to transmissible infections.

There are significant economic costs associated with the harmful use of alcohol and other drugs. These include household expenditure, decreased productivity and law enforcement and healthcare costs.[13] According to the latest report from The George Institute for Global Health on the social and economic costs of alcohol, tobacco and drug use in Australia, the cost of illicit drugs (opioids, methamphetamines and cannabis) amounted to $29.7 billion in 2022/23.[14] In Aotearoa New Zealand, the New Zealand Drug Harm Index 2023 estimated drug-related harm in Aotearoa New Zealand each year at over NZ $1.9 billion.[15]

The harms associated with drug use disproportionately affect Aboriginal and Torres Strait Islander and Māori peoples in both countries. This is the result of complex factors including the ongoing effects of colonisation, dispossession, and loss of identity, culture and land, intergenerational trauma and deprivation.[16, 17] Social determinants of health also impact on Māori and Aboriginal and Torres Strait Islander peoples' health: poverty, housing, environment, education, employment, social capital and racism, discrimination, and culturally unsafe health services all contribute to poor health outcomes.

Other priority populations that are more prone to experiencing disproportionate harms (both direct and indirect) from drug use include young people, older people, women, homeless people, culturally and linguistically diverse communities, sex workers, those living with mental health conditions and people identifying as lesbian, gay, bisexual, trans, intersex, queer (LGBTIQ+).

The high levels of morbidity, mortality and other costs associated with drug use highlight the need for an evidence-based approach to reduce harms.

Current government approaches to drug use in Australia and Aotearoa New Zealand

Current government approaches to drug use in Australia and Aotearoa New Zealand overwhelmingly focus on law enforcement to the detriment of education, prevention, evidence-based harm reduction, self-determination and treatment measures.

The focus on law enforcement responses and criminalisation of drug users by both the Australian and Aotearoa New Zealand governments causes harms to people who use drugs that disproportionately affects Aboriginal and Torres Strait Islander and Māori peoples in both countries.

The Australian National Drug Strategy 2017-2026[18] prioritises three broad approaches: demand reduction, supply reduction and harm reduction, as shown in figure 1 below.

Figure 1 - Australian National Drug Strategy 2017-2026's three pillars of harm minimisation[18]

It is estimated that in 2021/2022 less than 2% (1.6%) of the total budget allocated to addressing the use of illicit drugs was spent on harm reduction in Australia, despite clear robust evidence of effectiveness and cost effectiveness.[19] About a third of the budget (27.4%) was spent on treatment which has proven benefits[20] and 64.3% was spent on law enforcement, with little evidence of efficacy or cost-effectiveness.[19] This is in a context where the total budget spent on addressing the use of illicit drugs was less than 1% of total Commonwealth and State and Territory government expenditure, representing a spend of $209.61 per person.[19]

The Aotearoa New Zealand National Drug Policy 2015-2020[21] proposes three strategies to address drug use: problem limitation, demand reduction and supply control. There is little data available on Aotearoa New Zealand's expenditure on drug policy, however in 2022, the NZ Drug Foundation estimated that "the Government currently spends more than four times as much on drug law enforcement as it does on treatment and other health-based approaches."[22]

We recognise the importance of the enforcement of various regulations that apply in each setting - including law enforcement - as a necessary component to the overarching laws and regulations that apply to the community.[23]

To effectively reduce harms from drug use, governments need to prioritise addressing harmful drug use as a health issue, through effective regulation and treatment responses paired with investment in evidence-based prevention and harm reduction measures.

In Aotearoa New Zealand, the Crown has a relationship with Māori under Te Tiriti o Waitangi and a key part of Te Tiriti o Waitangi is a commitment to work in partnership to ensure equitable outcomes for Māori . Any changes to drug policy should be made in collaboration with Māori . In addition, a key part of Te Tiriti o Waitangi is that it affirms the right of Māori to be self-determining and exercise their tino rangatiratanga, a right also affirmed in the United Nation's Declaration on the Rights of Indigenous Peoples.[24] As such, Māori need to be supported to develop their own strategies and programs of action, policies, priorities, resourcing and systems of service delivery to reduce the harms from drug use.[25]

Stigma and discrimination surrounding drug use can have profound and far-reaching consequences for individuals who use drugs

Stigma is a social construct, often fuelled by misinformation, stereotypes, and fear. The criminalisation of drug use exacerbates the stigma faced by people who use drugs. It can manifest in various ways, from discrimination, internalisation and social exclusion that actively reduce access to healthcare services and employment opportunities. It can worsen the challenges faced by people who use drugs, making it harder for them to seek help and support and to receive appropriate care.[26]

By addressing stigma and discrimination, we can create a more inclusive and compassionate environment that empowers individuals to seek help and access healthcare services, leading to better outcomes for both individuals and society.

This requires further efforts to reduce stigma and discrimination against people who use drugs across all levels of health care (primary care, specialist services, hospitals). The integration of primary and targeted healthcare services (e.g. provision of hepatitis C virus (HCV) and human immunodeficiency virus (HIV) treatment, mental health services) in AOD services, needle syringe programs and supervised consumption services can be beneficial for those individuals for whom it is difficult to maintain access to mainstream healthcare services due to stigma and discrimination.

Importantly, to combat the harmful effects of stigma on people who use drugs, it is crucial to adopt a public health approach that prioritises education, prevention, harm reduction, treatment, and support over punitive measures, as outlined in this position statement.

Criminalisation of people who use drugs is harmful[27]

The criminalisation of personal drug use and possession results in health and social harms to the people who use drugs themselves, their families *and* the broader community. These harms are wide ranging and include:

- **Community harms**: an unregulated black market; drug overdoses resulting from unregulated supply; resort by drug users to crime to pay for drugs; the growth of criminal networks; corruption of public servants and reduced respect for the law. [28] In addition, criminalisation is expensive for the community, with increasingly large amounts of taxpayer funds spent on the justice system to prosecute and imprison people for drug-related offenses.[19]
- **Individual harms**: criminalisation, incarceration, separation from family and children, poorer access to health care and poorer employment opportunities. Loss of housing or beneficiary status due to drug use is common and leads to considerable injustice and inequality.

Criminalising people has not been effective in reducing drug use, and Australian as well as international research evidence suggests that the removal of criminal sanctions for drug use and possession:

- reduces the costs to society, especially the criminal justice system costs;
- reduces social costs to individuals, including improving employment prospects;
- does not increase drug use, and
- does not increase other crime.[29]

In Aotearoa New Zealand, the harms of criminalisation are disproportionally carried by Māori[30] where they make up 48% of people convicted of drug possession and 61.9% of people sentenced to prison and are charged nearly four times more often than non-Māori, as a percentage of the population.[31, 32] Rangatahi Māori rates of arrest and conviction were three times higher than non-Māori youth even when other factors (e.g. having a previous police record) were taken into account.[33]

In Australia, Aboriginal and Torres Strait Islander people are imprisoned at a rate 13.3 times higher than non-Aboriginal and Torres Strait Islander Australians;[34] they represent approximately 4% of the Australian population.[35] High rates of imprisonment underlie the critical issue of deaths in custody.

In addition, evidence shows that Māori and Aboriginal and Torres Strait Islander peoples have largely not benefited from drug law reforms that grant police discretionary powers on whether to charge individuals for possession of cannabis in Australia and Aotearoa New Zealand.[36, 37]

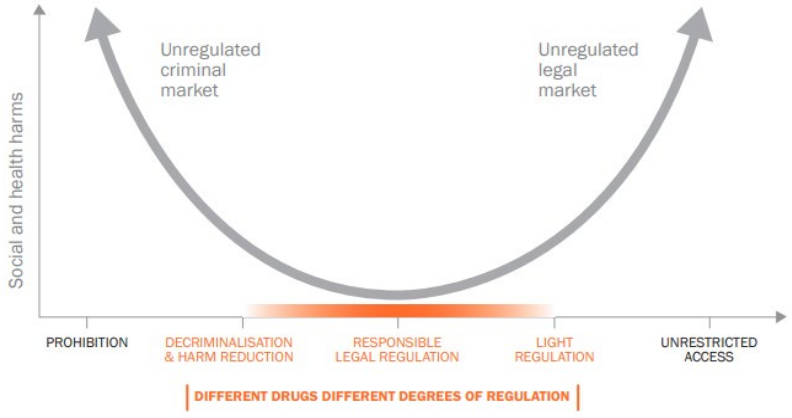
Criminalisation of certain drugs has historically impeded research efforts to explore potential therapeutic uses of these drugs. There have been changes in Australia recently regarding the capacity of approved psychiatrists to prescribe psychedelic drugs to treat depression, anxiety and existential angst (in palliative care), and the use of methylenedioxymethamphetamine (MDMA) to treat post-traumatic stress disorder (PTSD) which have removed barriers to accessing these drugs for research purposes. However, these barriers remain in Aotearoa New Zealand.

Whilst the removal of criminal sanctions for drug use and possession can be an effective strategy in reducing some harms to people who use drugs and wider society, it does not address problems associated with unregulated drug supply. We need to be prepared to address evidence of the possibility of perverse impacts of decriminalisation.

Drug laws and regulation should aim to minimise harm for those who use drugs and the broader community

Drug laws and regulation operate on a spectrum from prohibition to unrestricted access, as shown in figure 2 below. Both extremes lead to high social and health harms. Finding a middle ground is essential to ensuring that drug laws and regulation minimise harm to those who use drugs and the broader community.

Figure 2 - Regulation: Finding the Sweet Spot[38]



Examples of regulation that have resulted in decreased harm include:

- Strong regulation of tobacco advertising and sale along with education has resulted in decreased smoking and decreased harms thereof. [39]
- Restricting the availability of alcohol reduced incidence of assaults.[40]
- In Portugal, a dramatic decrease in overdose deaths and blood borne virus transmission has followed decriminalisation of personal possession of drugs when coupled with investment in treatment services. Drug supply and sale remains illegal. [41]
- In Aotearoa New Zealand, a program treating methamphetamine use as a health rather than criminal issue has resulted in a 34% decrease in post-referral crime harm.[42]

Regulation must capture drugs as they emerge, rather than retrospectively. An example of harm arising through failure to account for emerging drugs was the synthetic cannabinoid crisis in Aotearoa New Zealand, wherein the illegal status of traditional cannabis directed users towards more harmful drugs, which were not accounted for by the existing drug law.[43] Regulation and enforcement also need to attend to the harms of diverted prescription medications.

Education & Prevention

Prevention of drug use and harm must address the underlying issues that lead to drug use. It seeks to prevent use, delay the onset of use and prevent or reduce the negative effects and harms associated with drug use.

An important goal of prevention is to ensure that protective factors outweigh risk factors that can lead to harms from drug use.[44] Risk factors include genetic predisposition, intergenerational trauma secondary to colonisation, racism,[45] epigenetic factors, mental health issues, adverse childhood experiences, trauma and chronic stress, and social disadvantage such as unstable housing, poverty and unemployment.[46] Social inequality leads to adverse effects on child development; it affects biological, social and psychological development.[47] These build over time and create trajectories of greater inequality. The effects of social inequality are co-occurring, cumulative and interrelated and genetics, epigenetics and environmental factors transfer social inequality across generations.

Childhood factors that protect against harmful drug use across the lifecycle include engaged parental supervision and communication, structured activity, participation in positive activities with adult engagement, development of social and emotional competence, self-control, and connectedness to community.[48, 44]

In Aotearoa New Zealand, connectedness to whānau (family), culture and establishment of a positive cultural identity are considered key for Māori health and wellbeing. Indigenous research has consistently shown a strong correlation between this connectedness and the mental wellbeing of Māori.[49]

Preventing harmful drug use requires addressing childhood trauma

Childhood trauma, childhood maltreatment, and other adverse childhood experiences (ACEs) are common[50,51] and increase the lifetime risk for development of risky, harmful or dependent use of drugs and/or alcohol as an adolescent or adult. [50]

Childhood trauma is closely related to the social determinants of health at the level of the individual family, institutions, local communities, and society more broadly.[52] Preventing childhood trauma should be a clearly stated, urgent priority for governments, and be funded accordingly.

The table below includes strategies and corresponding approaches which have been shown effective to prevent ACEs.

Table 1 - Effective strategies and approaches to prevent adverse childhood experiences (ACEs) – Reproduced from Centers for Disease Control and Prevention (2019), Preventing Adverse Childhood Experiences: Leveraging the Best Available Evidence.[53]

Strategy	Approaches
Strengthen economic supports to families	• Strengthening household financial security • Family-friendly work policies
Promote social norms that protect against violence and adversity	• Public education campaigns • Legislative approaches to reduce corporal punishment • Bystander approaches • Men and boys as allies in prevention
Ensure a strong start for children	• Early childhood home visitation • High-quality childcare • Preschool enrichment with family engagement
Teach skills	• Social-emotional learning • Safe dating and healthy relationship skills program • Parenting skills and family relationship approaches
Connect youth to caring adults and activities	• Mentoring programs • After-school programs
Intervene to lessen immediate and long-term harms	• Enhanced primary care • Victim-centred services • Treatment to lessen the harms of ACEs • Treatment to prevent problem behaviour and future involvement in violence • Family-centred treatment for substance use disorders

Recognising and responding to childhood trauma in the healthcare sector

People with a history of trauma, especially childhood trauma, may find it difficult to access healthcare services and other support services. People with a history of trauma may also present to services in complex ways. Hence, a trauma-informed approach is essential to assist engagement with these essential services.

The use of Māori and Aboriginal and Torres Strait Islander frameworks of Trauma Informed Care that acknowledge the experiences of both historical and colonial trauma and current collective trauma and are based on Indigenous values and concepts has been shown to be

crucial for supporting the healing and recovery of trauma for Māori and Aboriginal and Torres Strait Islanders.[54, 55, 56]

Implementing a trauma-informed approach recognises the presence and real-world implications of childhood trauma, however, many professionals are not trained in detecting or addressing childhood trauma.[57] To address this gap, all health professionals should receive training in trauma-informed care, and healthcare institutions should deliver services through a trauma-informed framework. In addition, integrated trauma and addiction treatment should be available for people with substance use disorders (SUD).

Evidence-based prevention interventions

The United Nations Office on Drugs and Crime (UNODC)/WHO International Standards on Drug Use Prevention[3] (2018) stress that to be effective, a national drug prevention system needs two key elements: [3]

1. To be based on existing scientific evidence.
2. To support research efforts to contribute to the evidence base and evaluate interventions.

The UNODC/WHO International Standards provide a comprehensive overview of evidence-based drug prevention interventions from infancy to adulthood (see **Appendix A** for more information). Notably, the UNODC/WHO International Standards warn that media campaigns need to be employed carefully given that "badly designed or poorly resourced" media campaigns can 'worsen the situation by making the target group resistant to or be dismissive of other interventions and policies.'

Recommendations for Education & Prevention

The RACP calls on governments to:

1. Implement a range of evidence-based measures to address and reduce adverse childhood experiences and trauma in the community.
2. Focus prevention efforts on strategies that are based on existing scientific evidence.
3. Support research efforts to contribute to the evidence base and evaluate interventions, as outlined in the UNODC/WHO International Standards on Drug Use Prevention[3] (2018).
4. Ensure all health professionals and those delivering essential services receive training in trauma-informed care and evidence-based alcohol and other drug treatment.
5. Ensure health and social institutions review their policies and frameworks to support the implementation of trauma-informed practices.
6. Commit to active and meaningful engagement with Aboriginal and Torres Strait Islander and Māori peoples to ensure trauma-informed care is available that acknowledges the harms associated with loss of cultural identity, racism, discrimination and negative stereotyping.
7. Commit to active and meaningful engagement with priority populations to ensure measures are culturally appropriate and to avoid unintended harms.

Harm Reduction

In this Position Statement, we adopt the following definition of harm reduction from Harm Reduction International:

- *Harm reduction refers to policies, programmes and practices that aim to minimise negative health, social and legal impacts associated with drug use, drug policies and drug laws.*
- *Harm reduction is grounded in justice and human rights. It focuses on positive change and on working with people without judgement, coercion, discrimination, or requiring that they stop using drugs as a precondition of support. Harm reduction encompasses a range of health and social services and practices that apply to illicit and licit drugs."* [58]

This definition is grounded in a public health approach that accepts some people will use drugs and seeks to reduce the harms associated with drug use, both to people who use drugs and to the broader community.

Indigenous models of harm reduction founded on Indigenous learning methods, relational models and models of wellbeing which incorporate strategies that connect treatment approaches to culture, land, community and spiritual practices should be prioritised to reduce the harm to Māori[59], Aboriginal and Torres Strait islander people.

Evidence-based harm reduction interventions for individuals and communities

Evidence-based harm reduction interventions include but are not limited to:

- **Needle syringe programs (NSPs):**[60] These programs provide clean injecting equipment to people who inject drugs and have been shown to reduce the prevalence of blood-borne viruses such as HIV, hepatitis B and C among people who inject drugs, and in the broader community.[61,62,63]

  NSPs should be widely and freely available in a range of healthcare (e.g. primary care NSPs, peer-led NSPs, community pharmacies, AOD services, Emergency Departments (EDs), community health centres, supervised consumption services) and social welfare settings (e.g. homelessness services, social housing) as well as custodial settings. Vending machines are a low-cost method of providing around-the-clock access to NSPs and should be made widely available.

  A key deficit in current policy is the lack of availability of NSPs in custodial settings. Despite efforts by correctional services, injecting drug use occurs in custodial settings, and the absence of clean injecting equipment increases risks of the transmission of blood-borne viruses (BBVs) amongst people in custodial settings, which in turn increases risk for BBV transmission to the broader community after release from custody. Australian evidence suggests that when compared to community settings, the frequency of injecting drug use is reduced in prison, but the prevalence of needle sharing is increased.[64]

  The WHO, UNODC and the Joint United Nations Programme on HIV/AIDS (UNAIDS) recommended in 2007 that "prison authorities in countries experiencing or threatened by an epidemic of HIV infections among persons who inject drugs (PWID) should introduce and scale up NSPs urgently".[65] Whilst NSP programs have been established in a number of European countries,[66] no such programs exist in prisons in Australia or Aotearoa New Zealand, and there is an urgent need to introduce NSPs in these settings.

The RACP recognises the potential difficulties in introducing NSPs in custodial settings, and we recommend trial programs be established to address implementation issues before wider implementation.

- **Take-home naloxone (THN)**: Naloxone is a drug that can rapidly reverse opioid overdose. THN programs involve consumer and carer education regarding overdose prevention and responses, together with the supply of naloxone to be used by a first responder in the event of a suspected overdose. THN programs have been shown to be one of the most effective strategies to reducing overdose mortality. [67, 68]

  THN should be available and provided to anyone who is at risk of experiencing or witnessing an opioid overdose. This includes people who use prescribed or illicit opioids and their families, friends and carers as well as emergency services including police and fire brigade officers.

  In Australia, there has been considerable progress in distributing THN to people with a history of injecting opioid use (e.g. from community pharmacies, AOD and NSPs), however, access across the country remains variable.[69] Greater efforts are required to target people and their families using prescribed opioids (usually in the context of pain management), reflecting that pharmaceutical opioids were involved in 43.6% of unintentional deaths involving opioids in 2022.[70] Overdoses from nitazenes are now being seen in people who use stimulants (including cocaine or methamphetamine). These groups should also be targeted to access naloxone.

  THN interventions should be a routine component of a ‘quality use of medicines ’approach by all healthcare professionals providing opioid treatment, including general practitioners and pain specialists, and integrated as part of opioid stewardship programs in hospitals and Emergency Departments (EDs).

  In Aotearoa New Zealand, access to THN remains very limited although since 27 November 2023, needle exchange services have been able to provide naloxone containing overdose kits to service users.[71]

  THN should be available for at-risk individuals on release from all withdrawal management and AOD rehabilitation services and custodial settings - recognised as an extremely high-risk period for opioid overdose. At present, only a minority of prison services in Australia provide THN for people released from custody. This intervention is not provided in Aotearoa New Zealand.

- **Supervised consumption services (SCSs) integrated into communities**[72, 73, 74]: A SCS is a sanctioned and hygienic place where people can use drugs in a supervised healthcare setting. Evidence shows they prevent overdose deaths and public drug use. They also provide an opportunity to offer a wide range of health and social interventions. This includes support to access drug treatment, minimising the risk of injecting related injury and disease, preventing transmission of blood-borne viruses, diagnosing and treating blood-borne viruses, such as HIV and Hepatitis C, providing crisis counselling and assisting in the assessment and coordination of care for those experiencing significant mental and physical health issues.[75]

Current SCSs are only available in two Australian cities (Sydney, Melbourne), with only one in each city, and there are no SCSs in Aotearoa New Zealand. This severely limits the important public health benefits of SCSs, which should be geographically accessible to people who use drugs.

There needs to be an increase in the number of SCSs across Australian cities and regional centres and introduction of SCSs to Aotearoa New Zealand, increasing accessibility for target populations. They should be more widely accessible to all people who use drugs, including at risk groups such as pregnant women and young people.

The RACP calls for a trial of more diverse SCS models that consider local needs. There may be less resource intensive SCSs than current models (Medically Supervised Injecting Centre in Sydney[76] and Medically Supervised Injecting Room in Melbourne[77]) and could be more easily scaled up, localised and implemented across Australia and Aotearoa New Zealand. This could include a trial of SCSs in community based primary care NSPs.

The RACP recommends that the scope of SCSs in Australia and Aotearoa New Zealand should allow for non-injecting routes of administration (e.g. inhaling), as these are usually associated with fewer risks of harm than injecting and should be encouraged as an alternative to injecting.

- **Drug checking services (DCS)/pill testing**[78, 79]: The Aotearoa New Zealand Ministry of Health defines drug checking as "Drug checking services conduct scientific tests on substances in order to indicate their likely identity and composition. Services test unknown substances (which may be illicit drugs), interpret results, and provide harm reduction information to a person who provides a sample. The aim of these services is to help individuals to make better-informed and safer decisions about whether or how to use a drug. It does not promote illicit drug use nor claim that illicit drug use is safe."[80]

  A recent systematic review of DCS concluded: "DCS and the personalised interventions they provide can positively influence behaviour change, minimise harm, and reduce mortality. DCS are a viable public health intervention that requires cross-sector support beyond the legal frameworks and testing methods. Services will need to be tailored to meet the needs of their chosen setting, local drug market, and target audience".[81]

  The legalisation and introduction of DCS into Aotearoa New Zealand has led to benefits including improved engagement with people who may intend to use drugs, disposal of drugs which were found to not be "as sold" or to contain highly toxic substances, and an improved ability to provide timely and relevant drug alerts.[82]

  The RACP calls for the expansion of trials and evaluations of fixed and mobile DCS in Australia, tailored to local communities with involvement and oversight of relevant experts including clinical pharmacologists and toxicologists, addiction medicine physicians, public health medicine physicians, as well as input from those with lived/living experience.

- **Regulatory reform and harm reduction:** As stated earlier, the criminalisation of personal drug use and possession results in health and social harms to the people who use drugs themselves, their families *and* the broader community. Further, it has not been effective in reducing drug use.

As such, the RACP calls for the removal of criminal sanctions for personal drug use and drug possession for all drugs and for all individuals. Legal restrictions on possession and supply of equipment that allows for safer consumption of drugs (e.g. “ice pipes”) should also be removed as should criminal penalties for “secondary supply” of injecting equipment. Decriminalisation should be evaluated to determine the impacts on people who use drugs and on the broader community.

While the removal of criminal sanctions for drug use and possession can be an effective strategy in reducing some of the harms to people who use drugs and the wider society, it does not address problems associated with unregulated drug supply.

Problems associated with unregulated drug supply include:

- People using contaminated drugs of unknown purity and composition, which can contribute to increased ‘overdose ’risks (synthetic contamination of opioids, MDMA-related deaths, cannabis toxicity with high THC concentrates) and other health concerns.
- Maintaining contact with criminal networks (illicit drug dealers), which can increase exposure to a broader range and more harmful illicit drugs to consumers, and potentially other criminal activities.
- At a societal level, unregulated illicit drug distribution networks maintain criminal drug networks (and related activities such as money laundering), and the allocation of resources to the criminal justice system that could be more effectively used in prevention, harm reduction and treatment interventions.
- Missing out on potential taxation revenue that could be rechannelled into prevention, harm reduction and treatment efforts.

Whilst a regulated supply for some drugs such as methamphetamines may be difficult to logistically establish, many countries have introduced regulated supply systems for cannabis, and Aotearoa New Zealand and Australia have a sophisticated legal medicinal cannabis industry which could be adapted to providing regulated cannabis for their markets. However, regulated access needs to be carefully managed, addressing issues of consumer access (e.g. preventing sales to minors), community safety (including drug driving), advertising, commercial interests (avoiding ‘big business’ as has happened in some parts of the United States of America (USA)), quality control of products, and licensing.

As of November 2023, the following countries have legalised cannabis use: Canada, Germany, Georgia, Luxembourg, Malta, Mexico, South Africa, Thailand, and Uruguay as well as 24 states in the USA. Legal regulated cannabis markets exist in Canada, Thailand, and Uruguay.

The RACP calls for the legalisation of cannabis use and possession for personal use, and the development and implementation of a tightly controlled Australian regulated cannabis market, alongside comprehensive monitoring and evaluation of positive and negative impacts. Given the prevalence of use of cannabis (more than 10% of Australian and New Zealanders aged 15 to 64 in 2021); [83] the relatively low risk of harm associated with typical cannabis use when compared with other drugs, and the emerging evidence for the potential benefits of such an approach internationally,[84, 85] the RACP considers starting with cannabis to be a prudent first step. We also note broad community support for such an approach, with more Australians supporting cannabis legalisation than opposing it. [2]Such an approach should be considered for other drugs in future.

- **Police and court diversion programs**: Police in Australia and Aotearoa New Zealand have a range of options when someone is found in possession of a small quantity of drugs. Discretionary diversion into health assessment or a monetary fine are possible non-criminal responses, available only on a limited number of occasions. The RACP supports expansion of such non-criminal responses to personal drug use, including a fairer/more equitable application of diversionary options across drug classes, and an increase in the number of times such diversion is possible. Where these programs depend on police discretion, the RACP holds concerns that Aboriginal and Torres Strait Islander and Māori peoples, people from culturally and linguistically diverse communities and young people are more likely to receive a criminalised response in police interactions and calls for a move towards a more uniform application of drug laws.

  Court diversion programs typically apply for someone who has been charged with a non-violent criminal offence - beyond drug use or possession. Typically, this is someone who has committed a non-violent acquisitive crime to fund their drug dependence and court diversion enables them to access treatment to address the behaviour which led to the original arrest. This may enable the person to avoid conviction and, in some jurisdictions, avoid a criminal record. Participation in these programs is voluntary and can be a way of reducing criminal convictions and addressing underlying substance use.[86] Drug Courts are available in Australia and Aotearoa New Zealand. The RACP supports investment in and expansion of court diversion and other diversionary programs.

- **A review of drug detection dog use by Australian police:** In Australia, drug detection dogs have been found to have high rates of inaccurate detections, and 'positive 'detections frequently lead to invasive searches, which disproportionately impact Aboriginal people and young people.[87] Their use has not been found to lead to improved health outcomes and has been associated with an increased likelihood of people taking illicit drugs in more hazardous ways.[87] The RACP calls for a review of their use by Australian police services and consideration of reducing or eliminating their widespread use.

- **Real Time Prescription Monitoring (RTPM)**[88]: RTPM programs provide information to doctors (prescribers) and pharmacists (dispensers) about a patient's history and use of controlled medicines and can assist in safer use of medicines. RTPM programs can result in decreases in high-dose pharmaceutical opioid use, however the findings of evaluations of RTPM programs are mixed,[89] and there have been some concerns (based on American experiences of such programs) that RTPM can divert people from prescribed to illicit drug use, which can then be linked to increased harms (e.g. transition from oral medications to injected heroin).[90] To be effective in reducing harm, RTPM needs to be implemented alongside wider service planning, resourcing and monitoring for adverse outcomes.

- **Peer programs:** These engage people with lived/living experience of drug use so they can play a role in the design of and advocacy for harm reduction and holistic peer support and navigation programs, which increase the effectiveness of those programs and their accountability to the communities they serve.

  The RACP calls for improved resourcing of AOD peer services and staff, as well as appropriate consultation with peer/user organisations in the development and delivery of drug health services and strategies.

- **Non-abstinence housing** (sometimes known as Housing First)[91] that offers safe and, where possible, permanent housing to homeless or under-housed people without requiring a commitment to abstinence from using alcohol or psychoactive substances. In Aotearoa New Zealand, Housing First has aligned with the principles of Te Ao Māori to ensure outcomes are optimised for Māori . To date, we are aware of very few examples of non-abstinence housing programs in Australia.

  The RACP supports expanded investment in housing, including non-abstinence housing, for people who use drugs. Further, the RACP supports the implementation of wrap-around support services to those newly housed to improve/increase their chances of maintaining their tenancy.

- **Driving regulations:** Driving regulations should be reviewed to optimise individual and public safety, while minimising unnecessary infringements upon civil liberties and avoiding stigma towards people who use drugs. The focus should be on deterring and detecting impairment as a consequence of drug use.

- **Workplace guidelines for safety-critical industries**: Workplace guidelines for safety-critical industries must ensure that policies are in place to deter and detect drug use.

Appendix B provides a valuable overview of principles to use for the delivery of harm reduction interventions in healthcare settings reproduced from Hawk, M. et al. (2017). [92]

Recommendations for Harm Reduction

1. The RACP supports current moves towards drug decriminalisation and calls for further steps to decriminalise the use of drugs and possession for personal use. Decriminalisation should be applied across drug classes and be accessible across the community to ensure sub-populations are not excluded. Decriminalisation should be evaluated to determine the impacts on people who use drugs and on the wider community.

The RACP calls on governments to:

2. Increase funding for evidence-based harm reduction measures which are linked to positive outcomes for people who use drugs and the wider community.
3. Ensure needle syringe programs (NSPs) are widely and freely available in a range of health and social welfare settings.
4. Establish a national overdose surveillance in Aotearoa New Zealand.
5. Make take-home naloxone (THN) available to anyone who is at risk of experiencing or witnessing an opioid overdose.
6. Increase the number of supervised consumption services (SCSs) across Australian cities and regional centres and introduce SCSs to Aotearoa New Zealand, improving accessibility for target populations of people who inject and smoke drugs.
7. Establish trials of regulated cannabis markets in Australia and Aotearoa New Zealand.
8. Expand use of court and police diversion programs for all people who have committed drug-related and non-violent crimes.
9. Review the use of drug detection dogs by Australian police services and consider reducing or eliminating their use.
10. Expand trials and evaluations of fixed and mobile drug checking sites in Australia, tailored to local communities with involvement and oversight from relevant experts.
11. Ensure the introduction and/or further implementation of real time prescription monitoring (RTPM) programs are undertaken alongside wider service planning and resourcing in addition to robust independent evaluation of their impact upon patients to ensure there is no inadvertent increase in harms to individuals.
12. Ensure peer programs are well-resourced, available, accessible and part of routine alcohol and drug service provision.
13. Offer safe and, where possible, permanent, non-abstinence-based housing to homeless or under-housed people without requiring a commitment to abstinence from using alcohol or illegal drugs.
14. Support trauma-informed harm reduction responses that acknowledge the impact of colonisation, racism, systemic discrimination and cultural oppression from the perspective of Aboriginal and Torres Strait Islander and Māori peoples.
15. Review driving regulations to optimise individual and public safety, while minimising unnecessary infringements upon civil liberties and avoiding stigma towards people who use drugs. The focus should be on deterring and detecting impairment as a consequence of drug use.
16. Ensure workplace guidelines regarding safety-critical industries include policies to deter and detect drug use.
17. Commit to active and meaningful engagement with priority populations, including people who use and inject drugs, to ensure measures are culturally appropriate and to avoid unintended harms.

Treatment

Treatment interventions for Substance Use Disorders (SUD)

Mild SUDs can have significant negative impacts on individuals and communities, particularly because of intoxication. Moderate to severe SUDs are chronic relapsing bio-psycho-social conditions that usually require long-term treatment to achieve and maintain positive health and social outcomes.

In general, AOD treatments are as effective as treatment approaches for other chronic health conditions.[93] There are a range of evidence-based treatment interventions for the management of SUDs, delivered in community, residential and hospital settings, either by trained generalist healthcare providers (e.g. primary care, hospital settings) or clinicians with specialist training in addiction medicine as outlined in table 2 below.

Targeted services are required for high-risk populations including pregnant women, people with comorbid physical and mental health conditions, people from culturally and linguistically diverse backgrounds, as well as older and younger people.

Table 2 - Evidence-based treatments for Substance Use Disorders (SUDs)

Intervention	Description	Evidence
Brief interventions	Interventions delivered in short (5 to 20 minute) sessions over 1 to 5 occasions which usually involve screening for SUD, goal setting, advice and monitoring. Can be delivered as opportunistic interventions in health settings, and/or using online platforms. Can also be used to screen for problem AOD use.	Can be effective for people with cannabis and stimulants with mild SUD. Not generally effective for treatment of moderate to severe SUD.
Withdrawal management	Delivered in ambulatory, residential or hospital settings. Involves assessment, psychosocial interventions, regular monitoring, medication and transfer of care to post withdrawal services.	Can be effective in interrupting regular drug use, ensuring patient safety, and engaging patient in longer term AOD treatment. Minimal long-term benefits in isolation. For opioids - risks of use/overdose on relapse - medication based treatment (methadone or buprenorphine) is more effective.
Psychosocial interventions	Evidenced based psychological interventions (e.g. cognitive behaviour therapy, motivational interviewing, relapse prevention, contingency management) are an essential element of SUD treatment. Can be delivered in individual, group or day programs. Case management and support services (e.g. housing, vocational, legal, financial, welfare) are often required	Can be effective for range of SUDs. More effective as part of integrated approach in combination with medications.

	to address range of health and social problems.	
Medication based treatment	May involve 'substitution' based treatment (e.g. methadone or buprenorphine for opioid dependence treatment), or 'relapse prevention' medications (e.g. naltrexone for opioid dependence).	Strong evidence for the effectiveness of agonist treatment for opioid dependence. Potential for psychostimulants and cannabis treatment - further research required. More effective as part of integrated approach in combination with psychosocial services.
Residential rehabilitation programs	Involve medium (1 to 3 month) or long term (3 to12 month) treatment in a residential setting. Incorporates AOD interventions (psychosocial, medications, peer support) delivered in a supportive and safe environment.	Intensive treatment modality that should be reserved for those with severe SUD not responding to less intensive treatment approaches and for those without social supports.
Peer support services	May involve 12-step programs (e.g. Narcotics Anonymous, Crystal Meth Anonymous), facilitated programs (e.g. Smart Recovery), and online support programs.	Can be effective support for patients.
Services for families and carers	Counselling and support services for families and carers of people experiencing SUD. Can include ongoing care.	Can be effective supports for families and carers.

Additional observations about treatment for SUD

1. <u>Opioid dependence treatment is at a crossroads in Australia</u>
   There are significant issues around the sustainability of treatment providers: ageing opioid agonist treatment (OAT) workforce, poor uptake of OAT in other sectors particularly in primary care, the mental health sector, hospitals and pain services. Strategies are needed to increase uptake in other sectors. Greater emphasis must be placed upon a range of possible service providers including community / private addiction specialists in delivering OAT, in addition to public health services and primary care. Other sectors that could further support and work with OAT include pain services, mental health, emergency departments and antenatal services.

   Governments and key stakeholders should work together to accelerate and expand trials of alternative opioid pharmacotherapy medications, including short-acting injectable opioids. OAT, including both methadone and buprenorphine as medication options, should be universally available without long waiting periods in prison settings. As outlined in the Penington Institute's report titled *Opioid pharmacotherapy at the crossroads: enduring barriers and new opportunities* "states and territories should implement enhanced case management models that connect people on pharmacotherapy exiting the justice system with public clinics, Aboriginal health

services, and nongovernmental organisations (NGOs) that can offer links to prescribers and additional social supports."[94]

2. Increasing use of psychoactive medicines (e.g. gabapentoids, antipsychotics, benzodiazepines, medicinal cannabis, psychedelics, ketamine, stimulants).
   There is an ongoing pattern of prescribing psychoactive medications, for a wide range of indications. We need to rethink how we approach the use of psychoactive medicines within health care - and the importance of a 'universal precautions' framework[95] to enhance quality and safer use of psychoactive medicines. This should include assessing all patients commenced on/already on psychoactive medications as potentially being at risk of non-medical use and routine practices to reduce the risk of non-medical use.
   Other considerations include:
   - the role of addiction medicine specialists as part of multidisciplinary teams / the treatment team, and
   - the role of RTPM.
3. Involuntary treatment
   Involuntary treatment for individuals with severe substance use disorders should only ever be used for a very small number of severely unwell and high-risk vulnerable individuals as a last resort once all other treatment options have been exhausted. In addition, it should always be led by specialist clinicians who have the clinical training and expertise required to assess the potential risks and benefits of different treatment options for a given individual.

   Access to quality treatment, delivered by a suitably trained workforce, is fundamental to address the complex needs of individuals struggling with addiction; this should be the main priority of all levels of government when considering policy development and investment in this area.

Individualised treatment, stepped care and integrated care: matching treatment to patient needs

Individual patients have different patterns of drug use, health conditions, social circumstances, cultural backgrounds, resources, expectations and beliefs. Treatment planning requires a comprehensive assessment, identification of patient goals, ongoing monitoring and review, effective communication and a collaborative approach with the patient. Patients may be suited to different interventions at different times, and treatment should be tailored to the strengths and needs of the individual.

The principles of individualised treatment planning involve the following:

Evidenced-informed medicine.[96] This involves the selection of treatment interventions by the treating clinician and patient, based upon:

- Evidence of effectiveness and safety of different interventions for different SUDs and related comorbidities.
- Individual patient factors, including prior treatment experiences, individual circumstances, patient beliefs, preferences and cultural background.
- Logistics of treatment services, including access to treatment services, cost of services for the patient and service provider

Stepped care. This is a key principle in navigating and planning treatment for patients, defined as “an evidence-based, staged system comprising a hierarchy of interventions, from the least to the most intensive, which can be matched to the individual’s needs”; it recognises there are a spectrum of needs, and that therefore, there also needs to be a spectrum of services.[97]

Treatment approaches for SUD range in their duration, intensity and complexity, and should be proportionate to the condition and patient’s needs. Within the Australian and Aotearoa New Zealand AOD treatment system, there has been a historical over-reliance on resource intensive treatment services at the expense of less intensive service models (e.g. inpatient > ambulatory withdrawal, residential rehabilitation > community based services). As we develop more effective treatment approaches that can be provided in community settings (e.g. counselling, medication assisted treatment, ambulatory withdrawal) and linkages with other sectors (e.g. housing, vocational), we should expect less emphasis upon residential or inpatient services that are more intrusive for patients and expensive to deliver.

Integrated care: Links between AOD and other health and welfare services. People with SUDs often have a range of other health and social conditions, sometimes referred to as comorbidities. These include physical health conditions (e.g. liver disease, chronic pain, sleep disorders, cardiovascular disorders, blood borne viruses), mental health conditions (e.g. depression, anxiety, psychosis, cognitive impairment), and social issues (e.g. homelessness, underemployment, literacy problems, violence, child protection issues, legal problems). Prevalence of these conditions varies by type of drugs used, age and gender profiles.

Comprehensive treatment of patients with SUDs usually requires these other health and social issues to be addressed as part of a holistic treatment plan with the patient. Given the chronic nature of SUDs and fragmentation of different parts of health and social care systems, the framework of integrated health care is useful for conceptualising services for patients.

Integrated health care involves the provision of seamless, effective, and efficient care that reflects the whole of a person's health needs: from prevention through to end of life; across physical, psychosocial, and mental health; and in partnership with the individual, carers, and family members.[98]

For Aboriginal and Torres Strait Islander people and Māori , these services need to be developed and led by Aboriginal and Torres Strait Islander people and Māori to ensure they are accessible and culturally safe. This requires designated positions for Aboriginal and Torres Strait Islander people and Māori in the AOD and peer workforce.

Integrated health care involves working with other health and social service providers to address the range of patient concerns and highlights the importance of a ‘medical home’ for the patient usually in primary health care settings, coordinating care across different specialist sectors (e.g. mental health, AOD, welfare services).

In this context, it is important to recognise that these models of care do not meet the needs of all individuals with SUDs. In some circumstances, AOD services may need to provide, or co-locate with, a broader range of health (e.g. co-location of primary health care, mental health, HCV and HIV treatment), and welfare services (e.g. access to legal, financial and vocational support services).

Whilst there are often advantages for some patients in a ‘one stop shop ’approach delivered through AOD services, it is important that AOD services are appropriately resourced (i.e.

appropriately skilled workforce, funding) to provide non-AOD services, and to recognise that many patients with SUDs prefer to access routine health care away from AOD services.

An important dimension of integrated health care and treatment planning is the emerging evidence of the need for integrated management of SUDs *alongside* the management of other health or social conditions (i.e. in 'parallel' with other services), and to move away from 'sequential 'treatment models historically applied by other sectors (e.g. deferring treatment of a mental health condition or access to housing until after the patient has become abstinent).

Treatment for SUD must be accessible and safe

Treatment services need to be accessible, culturally appropriate, and safe. This requires the following:

- A range of strategies are required to address stigma against people who use drugs. Stigma against people who use drugs is a major barrier to people engaging with health care - including generalist (e.g. primary care, hospital settings) and AOD services. Stigma can delay seeking treatment, undermines therapeutic rapport and open communication, and can endanger treatment safety.
- Trauma informed care should underpin all AOD treatment, recognising that many individuals with SUD have experienced significant trauma in their lives. Trauma informed care for Māori and Aboriginal and Torres Strait Islander people acknowledges the trauma linked to colonisation, racism and discrimination and should be informed by Aboriginal and Torres Strait Islander and Māori cultures.
- Culturally appropriate services are important to engage and retain individuals from diverse cultural backgrounds, including Aboriginal and Torres Strait Islander and Māori peoples,[99] those within culturally and linguistically diverse communities, those who are gender and sexually diverse, and people with age-related cultural issues (youth and older persons' services).
- Indigenous cultural interventions that take an Indigenous worldview and are developed and delivered by Aboriginal and Torres Strait Islander and Māori peoples.[100]
- AOD treatment is severely under-resourced in Australia and Aotearoa New Zealand, with inadequate availability of most forms of AOD treatment to meet demand.[101] All levels of government need to enhance funding for AOD services.
- SUDs are generally under-recognised in generalist healthcare services. Within hospitals, fewer than 30% of patients with SUDs are identified through routine care.[102, 103] Routine screening, brief intervention and referral pathways should be introduced across all tertiary hospitals and mental health services in Australia and Aotearoa New Zealand. AOD hospital-based consultation liaison (CL) services are essential for addressing SUD in hospital settings, yet many acute care hospitals across Australia and Aotearoa have no CL services.
- Health care and social services should operate on a 'no wrong door' approach, with multiple points of entry into AOD treatment. People with SUD can present at multiple points in the health care and social service systems, including primary care, acute care hospitals, specialist AOD services and other specialist health care (e.g. mental health, sexual health, chronic pain) or social services (e.g. criminal justice, community services, housing). However, health care and social services are often fragmented, and many patients, families and carers, and indeed service providers, experience difficulties in navigating appropriate AOD services. Telephone and online information and referral services should be available for consumers and service providers to assist in navigating appropriate AOD services for patients.

- Rural and remote populations seek AOD treatment more often than those in major cities, but often struggle to access care, and have to travel further to access treatment.[104] Accessible and acceptable treatment options for rural and remote populations should be prioritised, including expanding telehealth and mobile services.

Designing effective treatment systems to address SUD

The following need to be considered for the design of effective treatment systems that address SUDs:

- Adequate resourcing of AOD services:
    - Significant enhancements of the AOD treatment systems are required to meet demand in society. Resources should be directed towards services and intervention models that are safe and effective and utilise resources efficiently. Services must be accessible across both countries in a timely fashion as part of our public health systems (i.e. remain affordable).
    - Comprehensive AOD treatment requires attending to comorbid health and social issues for patients, delivered alongside other service systems, and in some cases, by AOD services. Collaboration between service providers requires resourcing and is inadequately factored into funding for AOD services.
    - AOD services appropriate for Aboriginal and Torres Strait Islander people and Māori require increased resourcing to ensure they are accessible, culturally safe, developed and led by Aboriginal and Torres Strait Islander people and Māori. This also requires designated positions for Aboriginal and Torres Strait Islander people and Māori in the AOD and peer workforce.
- Skilled and sustainable workforce:
    - Requires skilled and sustainable specialist workforce (Addiction Medicine, Addiction Psychiatry), and ensuring that other healthcare providers have appropriate skills to address SUD in their clinical practice, including other specialist physicians, General Practitioners, specialists who may have frequent encounters with people with AOD problems (e.g. Pain medicine, Emergency Medicine, Toxicology, Obstetrics, Paediatrics) and other medical specialties.
    - Basic Physician Training should provide the opportunity for trainees to be exposed to addiction medicine and to complete addiction medicine rotations where possible. Addiction Medicine should form a substantial part of medical training for under/post graduate medical qualifications. Interns and residents should have the opportunity to be exposed to addiction medicine services (e.g. through supervised terms).
    - Across all key healthcare disciples, including nursing, psychology, pharmacy, and other allied health, there should be adequate under/post graduate training and exposure to addiction medicine services early in their careers.
- Adequate reimbursement for Addiction Medicine and other medical, nursing and allied health professionals in providing AOD treatment. Addiction medicine specialists should be able to directly refer to key disciplines (e.g. psychologists).
- Implementation of quality and outcome frameworks for AOD services.

    - A National AOD Quality Framework needs to emulate broader quality frameworks.
    - Need to establish and implement a value-based health care framework for services, that includes measurement of outcomes that matter to patients and service providers.
- Research and evaluation are essential elements for the improvement of AOD services. Targeted resources are required to ensure research and evaluation activities that develop more effective AOD treatment interventions, and research that enhances their uptake in the health care system (translation to practice). To this end, the RACP calls for the establishment of a national AOD clinical research network that develops and strengthens partnerships between clinicians, consumers and academic researchers.

Recommendations for Treatment

1. Increase resourcing of evidence-based drug and alcohol treatment services. Resources should be directed towards services and intervention models that are safe and effective and utilise resources efficiently.
2. Increase resourcing to facilitate a comprehensive approach to health care for people who use drugs and/or alcohol, delivered in partnership with other services, especially mental health. Comprehensive alcohol and other drug (AOD) treatment requires attending to co-existing physical and mental health conditions and social issues for patients, delivered in partnership with other services.
3. Ensure individuals are able to access care in a setting that is appropriate to them (e.g. community/primary care/tertiary healthcare setting) including an integrated care service if that is the most suitable option for their care.
4. Ensure AOD services for Aboriginal and Torres Strait Islander and Māori peoples are adequately resourced, accessible, culturally safe and developed and led by Aboriginal and Torres Strait Islander people and Māori.
5. Invest in and prioritise workforce development in addiction medicine and addiction psychiatry to ensure a sustainable and highly skilled AOD workforce.
6. Fund designated positions for Aboriginal and Torres Strait Islander people and Māori in the AOD workforce and peer workforce
7. Ensure adequate reimbursement for Addiction Medicine and other medical, nursing and allied health professionals in providing AOD treatment.
8. Implement quality and outcome frameworks for AOD services, including not-for-profit services and charities.
9. Invest in high quality research and evaluation into AOD treatments, including the establishment of a national AOD clinical research network that develops and strengthens partnerships between clinicians, consumers and academic researchers.
10. Commit to active and meaningful engagement with priority populations to ensure measures are culturally appropriate and to avoid unintended harms.

Conclusion

Drug use is common in Australia and Aotearoa New Zealand. As physicians, we know that drug use can cause harm and risk of harm to the person and to others. Importantly, we recognise that both the *use* of drugs and our governments' *response* to the use of drugs can cause harm and that stigma surrounding drug use can have profound and far-reaching consequences for individuals who use drugs.

This Position Statement makes the case for the Australian and Aotearoa New Zealand Governments to prioritise a health approach to drug use to effectively reduce harms for individuals who use drugs and the broader community through effective regulation and treatment responses paired with investment in evidence-based prevention and harm reduction measures.

Appendix A - Overview of evidence-based drug prevention interventions based on the UNODC/WHO, International Standards on Drug Use Prevention, Second updated edition. 2018

Infancy and early childhood Children's earliest interactions occur in the family before they reach school age. Children may develop vulnerabilities through interaction with parents or caregivers who fail to nurture them, lack parenting skills and/or suffer from other difficulties associated with poor health or financial or other hardships (especially in a socially or economically marginalized environment or a dysfunctional family setting). Among other factors, the intake of alcohol, nicotine or drugs during pregnancy negatively affects developing embryos and fetuses. Such circumstances may impede a child from achieving significant developmental competencies and leave the child vulnerable and at risk of behavioural disorders later in life. The key developmental goals for early childhood are the development of safe attachment to the caregivers, age-appropriate language skills and executive cognitive functions such as self- regulation and pro-social attitudes and skills. The acquisition of those functions and skills is best supported within the context of a supportive family and community.				
Intervention type	**Brief description**	**Available evidence**	**Characteristics of prenatal and infancy visit programmes deemed to be associated with efficacy and/or effectiveness based on expert consultation**	**Characteristics of parenting skills programmes deemed to be associated with lack of efficacy and/ or effectiveness or with adverse effects based on expert consultation**
Prenatal and infancy visits	In programmes for prenatal visits or during infancy, a trained nurse or social worker visits mothers-to-be and new mothers to give them parenting skills and provide support in addressing a range of issues (health, housing, employment, legal, etc.). Normally, these programmes do not	No new reviews were identified in the new overview of systematic reviews. In the first edition of the International Standards, one review and one randomized control trial had reported	✓ They are delivered by trained health workers. ✓ Regular visits are made until the child's second birthday: at first, every two weeks, then every month, and less frequently	N/A

	target all women but only specific groups living in particularly difficult circumstances (a selective strategy with a developmental aim).	findings with regard to this intervention.[1] With regard to primary outcomes, according to the randomized controlled trial, these programmes can prevent substance use later in life, and they can be cost-effective in terms of saving future social welfare and medical costs. In addition, a review reported findings with regard to some secondary outcomes, as children involved in the programme were less likely to report having internalizing disorders and scored higher on the achievement tests in reading and math. Mothers taking part in the programme also reported less role impairment owing to alcohol and other drug use. The evidence is from the United States of America. *** Prenatal and infancy visitation programmes are also recommended by WHO to prevent child maltreatment.[2]	towards the end of the period. ✓ They provide basic parenting skills. ✓ They support mothers to address a range of socioeconomic issues (health, housing, employment, legal, etc.).	
Interventions targeting pregnant women	Pregnancy and motherhood are periods of major and sometimes stressful changes that may make women receptive to addressing their substance use and substance use disorders.	No new reviews were identified in the new overview of systematic reviews. In the first edition of the International Standards, two reviews had reported	✓ They improve the cognitive, social and language skills of children. ✓ They are conducted in daily sessions. ✓ They are delivered by trained teachers.	N/A

[1] Turnbull (2012), with Kitzman (2010) and Olds (2010) reporting on the same trial.
[2] World Health Organization (WHO), *INSPIRE: Seven Strategies for Ending Violence against Children* (Geneva, 2016).

	Alcohol and drug use during pregnancy poses potential health risks to pregnant women and their babies, even in the absence of substance use disorders. All pregnant women should therefore be advised of the potential health risks to themselves and to their babies. As psychoactive substance use during pregnancy is dangerous for the mother and the future child, management of substance use and treatment of pregnant women with substance use disorders can and should be offered as a priority and must follow rigorous clinical guidelines based on scientific evidence. This is an indicated strategy with a developmental aim.	findings with regard to this intervention.[3] No reviews reported findings with regard to primary outcomes. With regard to secondary outcomes, providing evidence-based integrated treatment to pregnant women can have a positive impact on child development, child emotional and behavioural functioning, and parenting skills. The time frame for the sustainability of these results and the origin of the evidence are not clear. WHO guidelines include the following recommendations about substance use during pregnancy: Tobacco use Health-care providers should ask all pregnant women about their tobacco use (past and present) and exposure to second-hand smoke as early as possible in the pregnancy and at every antenatal care visit.[4] Substance use Health-care providers should ask all pregnant women about their use of alcohol and other substances (past and present) as early as possible in the pregnancy and at every antenatal care visit. Health-care providers should offer a brief intervention to all pregnant women using alcohol or drugs.	✓ They provide support to families on other socioeconomic issues.	

[3] Niccols (2012a) and Niccols (2012b).
[4] WHO, WHO Recommendations for the Prevention and Management of Tobacco Use and Second-Hand Smoke Exposure in Pregnancy (Geneva, 2013).

		Health-care providers managing pregnant or post-partum women with alcohol or other substance use disorders should offer a comprehensive assessment and individualized care. Health-care providers should, at the earliest opportunity, advise pregnant women dependent on alcohol or drugs to cease their alcohol or drug use and offer, or refer those women to, detoxification services under medical supervision, where necessary and applicable. For more detailed recommendations on the management of particular clinical situations in pregnancy (e.g., opioid dependence, benzodiazepine dependence, etc.), the reader is referred to the WHO Guide- lines for the Identification and Management of Substance Use and Substance Use Disorders in Pregnancy.[5]		
Middle childhood During middle childhood, increasingly more time is spent away from the family, most often in school and with same-age peers. Family remains the key socialization agent. However, the roles of day care, school and peer groups start to grow. Factors such as community norms, school culture and quality of education become increasingly important for safe and healthy emotional, cognitive and social development. The role of social skills and pro-social attitudes grows in middle childhood, and they become key protective factors, impacting also the extent to which the school-age child will cope with school and bond with peers. Among the main developmental goals in middle childhood are the continued development of age-specific language and numeracy skills, and of impulse control and self-control. Also at this age begins the development of goal-directed behaviour, together with decision-making and problem-solving skills. Mental disorders that have their onset during this period (such as anxiety disorders, attention deficit hyperactivity disorder and conduct disorders) may also impede the development of healthy attachment to school, cooperative play with peers, adaptive learning and self-regulation. Often at this time, children of dysfunctional families start to affiliate with peers involved in potentially harmful behaviours, thus putting themselves at increased risk.				
Intervention type	**Brief description**	**Available evidence**	**Characteristics of prenatal and infancy visit**	**Characteristics of parenting**

[5] WHO, Guidelines for the Identification and Management of Substance Use and Substance Use Disorders in Pregnancy (Geneva, 2014).

			programmes deemed to be associated with efficacy and/or effectiveness based on expert consultation	**skills programmes deemed to be associated with lack of efficacy and/ or effectiveness or with adverse effects based on expert consultation**
Parenting skills programmes	Parenting skills programmes support parents in being better parents, in very simple ways. A warm child-rearing style, whereby parents set rules for acceptable behaviours, closely monitor free time and friendship patterns, help to acquire personal and social skills and are role models, is one of the most powerful protective factors against substance use and other risky behaviours. These programmes can also be delivered to parents of early adolescents. While the reviews largely cover all ages together, and as principles are largely similar, the interventions are discussed only in this section. These interventions can be delivered at both the universal and the selective levels and are largely a developmental kind of intervention.	Five reviews reported findings with regard to this intervention, of which four are from the new overview of systematic reviews.[6] With regard to primary outcomes, these studies report that family-based universal programmes can prevent tobacco, alcohol, drug and substance use in young people, the effect size generally being persistent into the medium and long term (longer than 12 months). More intensive programmes delivered by a trained facilitator appear to be more consistently effective compared with single sessions or computer-based programmes. Also, particular gender-specific interventions targeting mothers and daughters were reported to be effective.	✓ They enhance family bonding, i.e., the attachment between parents and children. ✓ They support parents by showing them how to take a more active role in their children's lives, e.g., monitoring their activities and friendships, and being involved in their learning and education. ✓ They show parents how to provide positive and developmentally appropriate discipline. ✓ They show parents how to be a role model for their children. ✓ They are organized in a way to make it easy and appealing for parents to participate (e.g., out-of-office hours, meals,	✗ They undermine the parents' authority. ✗ They only provide information to parents about drugs so that the parents can talk about it with their children. ✗ They are delivered by poorly trained staff.

[6] Mejia (2012), Thomas et al. (2016), Foxcroft and Tsertsvadze (2012), Allen et al. (2016) and Kuntsche (2016).

		The evidence summarized above is from studies on family-based prevention interventions implemented in Africa, Asia, the Middle East, Europe, Australia and North America. WHO also recommends parenting skills programmes to support positive development, prevent youth violence, manage behavioural disorders in children and adolescents and prevent child maltreatment.[7,8] Also recommended to improve child development outcomes are parenting interventions promoting mother-infant interactions, preferably delivered within ongoing mother-and-child health programmes for poorly nourished, frequently ill and other groups of at-risk children.[9] Moreover, it is recommended that interventions to improve mothers' parenting skills be offered in addition to effective treatment and psychosocial support to mothers with depression or any other mental, neurological or substance use condition, in order to improve child development outcomes.[10] Finally, caregiver skills training should be provided for the	childcare, transportation, a small prize for completing the sessions, etc.). ✓ They typically include a series of sessions (often around 10 sessions, or more sessions in the case of work with parents from marginalized or deprived com- munities or in the context of a treatment programme where one or both parents suffer from substance use disorders). ✓ They typically include activities for the parents, the children and the whole family. ✓ They are delivered by trained individuals, in many cases without any other formal qualification.	

[7] WHO, Global Accelerated Action for the Health of Adolescents (AA-HA!), Guidance to Support Country Implementation (Geneva, 2017).
[8] WHO, INSPIRE: Seven Strategies for Ending Violence against Children (2016).
[9] WHO, "Maternal mental health interventions to improve child development: evidence profile" (2012).
[10] Ibid.

		management of children and adolescents with developmental disorders, including intellectual disabilities and pervasive developmental disorders (including autism).[11]		
Personal and social skills education	In programmes on personal and social skills, trained teachers engage children in interactive activities to give them the opportunity to learn and practice a range of personal and social skills. These programmes are typically delivered to all children via a series of structured sessions (i.e., this is a universal intervention). The programmes provide opportunities to learn skills to be able to cope with difficult situations in daily life in a safe and healthy way. They support the development of general social competencies, including mental and emotional well-being. These programmes comprise mostly developmental components. That is, they do not typically include content with regard to specific substances, as in most com- munities children at this young age have not initiated use. This is not the case everywhere, and programmes targeting children who have been exposed to substances (e.g., inhalants) at this very young age could, if wished, refer to the substance-specific guidance included for "Prevention education based on	Seven reviews reported findings with regard to this intervention, four of which from the new overview.[12] With regard to primary outcomes, according to these studies, supporting the development of personal and social skills in a classroom setting can prevent tobacco, alcohol and drug use, particularly in a longer follow-up period (longer than one year). Strategies focusing only on resilience were found to be effective only in relation to drug use. Most of the evidence originates in North America, Europe and Australia, with some studies from Asia and Africa. Non-specialized health-care facilities should encourage and collaborate with school-based life skills education programmes, if feasible, to promote mental health in children and adolescents.[13]	✓ They improve a range of personal and social skills. ✓ They are delivered through a series of structured sessions, often providing booster sessions over multiple years. ✓ They are delivered by trained teachers or facilitators. ✓ Sessions are primarily interactive.	✗ Such strategies use non-interactive methods, such as lecturing, as the main delivery method. ✗ They provide information on specific substances, including fear arousal. ✗ They focus only on the building of self-esteem and on emotional education.

[11] Ibid.
[12] Hodder et al. (2017), Salvo et al. (2012), McLellan and Perera (2013), McLellan and Perera (2015), Schröer- Günther (2011) and Skara (2003).
[13] WHO, WHO Mental Health Gap Action Programme, "Behaviour change techniques for promoting mental health: evidence profile" (2012).

	social competence and influence" in the section on "Early adolescence", below.			
Classroom environment improvement programmes	Classroom environment improvement programmes strengthen the classroom management abilities of teachers and support children to socialize in their role as a student, while reduc- ing early aggressive and disruptive behaviours. Teachers are typically supported through the implementation of a collection of non-instructional classroom procedures in the day-to-day practices with all students for the purposes of teaching pro-social behaviour as well as preventing and reducing inappropriate behaviour. These programmes facilitate both aca- demic and socio-emotional learning. They are universal as they target the whole class with a developmental component.	No new reviews were identified in the new overview of systematic reviews. In the first edition, one review had reported findings with regard to this intervention.[14] The review did not report findings with regard to the primary outcomes. With regard to secondary outcomes, according to this study, teachers' classroom management prac- tices significantly decrease problem behaviour in the classroom, including strong positive effects on disruptive and aggressive behaviour, and strengthen the pro-social behaviour and the academic performance of the children. The time frame for the sustainability of these results is not clear. All evidence reported above originates in the United States and Europe.	✓ They are often delivered during the early school years. ✓ They include strategies to respond to inappropriate behaviour. ✓ They include strategies to acknowledge appropriate behaviour. ✓ They include feedback on expectations. ✓ They have the active engagement of students.	N/A
Policies to retain children in school	School attendance, attachment to school and the achievement of age-appropriate language and numeracy skills are important protective factors for guarding against substance use among children of this age. A variety of policies have been implemented in low- and middle- income countries to support the attendance of children and improve their educational outcomes.	No new reviews were identified in the new overview of systematic reviews. In the first edition of the International Standards, two reviews[15] reported findings with regard to the following policies: building new schools, providing nutrition in schools, and providing economic incentives of various natures to families.	N/A	N/A

[14] Oliver (2011).
[15] Lucas (2008) and Petrosino (2012).

		The studies did not report findings with regard to the primary outcomes. With regard to secondary outcomes, according to these studies, these policies increase the attendance of children in school and improve their language and numeracy skills. Simply providing cash to families does not appear to result in significant outcomes, whereas conditional transfers do. The time frame for the sustainability of these results is not clear. All this evidence originates in low- and middle-income countries. Conditional financial incentives to keep children in schools are also recommended by WHO as a strategy to prevent youth violence.[16]		
Addressing mental health disorders	Emotional disorders (e.g., anxiety and depression) and behavioural disorders (e.g., attention deficit hyperactivity disorder and conduct disorder) are associated with a higher risk of substance use later in adolescence and later in life. In both childhood and adolescence, it is an important prevention strategy to support children, adolescents and parents to address emotional and behavioural disorders as early as possible.	No studies were identified in either the new overview of systematic reviews or the first edition of the International Standards. WHO recommends the following to support children and adolescents (as well as their carers) and to address such disorders as early as possible:[17] • Behavioural interventions for children and adolescents for the treatment of behavioural disorders.	N/A	N/A

[16] WHO, Global Accelerated Action for the Health of Adolescents (AA-HA!).
[17] WHO, mhGAP Intervention Guide for Mental, Neurological and Substance Use Disorders in Non-Specialized Health Settings—Version 2.0 (Geneva, 2016).

		• Psychological interventions, such as cognitive behavioural therapy, interpersonal psycho-therapy for children and adolescents with emotional disorders, and caregiver skills training focused on their caregivers. • Initiating parent education/training before starting to give medication to a child who has been diagnosed as suffering from attention deficit hyperactivity disorder, with initial interventions including cognitive-behavioural therapy and social skills training, if feasible. • Pharmacological interventions are offered only in specialized settings.		

Early adolescence

Adolescence is a developmental period when youth are exposed to new ideas and behaviours through increased association with people and organizations beyond those experienced in childhood. It is a time to “try out” adult roles and responsibilities. It is also a time when the “plasticity” and malleability of the adolescent brain suggests that, like infancy, this period of development is a time when interventions can reinforce or alter earlier experiences.

The desire of young adolescents to assume adult roles and more independence at a time when significant changes are occurring in the brain also creates a potentially vulnerable time for poorly thought-out decisions and involvement in potentially harmful behaviours, such as risky sexual behaviours, smoking of tobacco, consumption of alcohol, risky driving behaviours and drug use.

The substance use (or other potentially harmful behaviours) of peers, as well as rejection by peers, are important influences on behaviour, although the influence of parents remains significant. Healthy attitudes and social normative beliefs related to psychoactive substance use are also important protective factors against drug use. Good social skills, and resilient mental and emotional health remain key protective factors throughout adolescence.

Note: Parenting skills interventions can be implemented in middle childhood and early adolescence. The studies identified through the research do not disaggregate results by age. Therefore, rather than repeating the section on parenting skills programmes here, under “Early adolescence”, the reader is referred to the previous section. The same applies to the strategy of “Addressing mental health disorders”, which is discussed under “Middle child- hood”, above. Similarly, many of the interventions and policies of relevance to older adolescents can prevent substance use in early adolescence. For reasons of expediency, those interventions and policies, namely alcohol and tobacco policies, media

campaigns, brief intervention and community-based multi-component initiatives, are discussed in the following section, on adolescence and adulthood.				
Intervention type	**Brief description**	**Available evidence**	**Characteristics of prenatal and infancy visit programmes deemed to be associated with efficacy and/or effectiveness based on expert consultation**	**Characteristics of parenting skills programmes deemed to be associated with lack of efficacy and/ or effectiveness or with adverse effects based on expert consultation**
Prevention education based on social competence and influence	During skills-based prevention programmes, trained teachers engage students in interactive activities to give them the opportunity to learn and practise a range of personal and social skills (social competence). These programmes focus on fostering substance and peer refusal abilities that allow young people to counter social pressures to use substances and in general cope with challenging life situations in a healthy way. In addition, they provide the opportunity to discuss, in an age-appropriate way, the different social norms, attitudes and positive and	Twenty-two reviews reported results for this kind of intervention, 15 of which from the new overview.[18] With regard to primary outcomes, according to these studies, certain programmes based on a combination of a social competence and social influence prevent tobacco use, alcohol use and drug use (preventive effects are small but consistent across studies, also in the long term (longer than 12 months)). A review of school-based programmes for the prevention of smoking specifically for girls concluded that there was no	✓ They use interactive methods. ✓ They are delivered through a series of structured sessions (typically 10–15 sessions), taking place once a week, often providing booster sessions over multiple years. ✓ They are delivered by a trained facilitator (also including trained peers). ✓ They provide an opportunity to practise and learn a wide array of personal and social skills, in particular, coping,	✗ They use non-interactive methods, such as lecturing, as a primary delivery strategy. ✗ They rely heavily on merely giving information, in particular to elicit fear. ✗ They are based on unstructured dialogue sessions.

[18] Ashton et al. (2015), Champion (2013), de Kleijn et al. (2015), Espada et al. (2015), Faggiano et al. (2014), Foxcroft and Tsertsvadze (2012), Hale et al. (2014), Hodder et al. (2017), Jackson (2012), Jones (2006), Kezelman and Howe (2013), Lee et al. (2016), McArthur et al. (2015), McLellan and Perera (2013), McLellan and Perera (2015), Pan (2009), Roe (2005), Salvo et al. (2012), Schröer-Günther (2011) and West (2004).

	negative expectations associated with substance use, including the consequences of substance use. They also aim to change normative beliefs on substance use addressing the typical prevalence and social acceptability of substance use among peers (social influence).	evidence that such programmes have a significant effect on preventing adolescent girls from smoking, with some promising indication for gender-specific programmes and programmes delivered together with media campaigns. Programmes targeting individual and environmental resilience-related protective factors in school settings were reported to be effective in preventing the use of drugs, but not use of tobacco or alcohol. Programmes based on the provision of information only, as well as the Drug Abuse Resistance Education (DARE) programme, were reported not to be effective. It was reported that using peers to deliver programmes, relating to all substances, was effective, with the caveat that care should be taken not to use this method for high-risk groups, as there is a danger of adverse effects (e.g., an increase of substance use). Computer-based delivery methods were gener- ally reported to have a small effect size, for all substances. In this context, there are indications that programmes targeting young adolescents might better prevent substance use than programmes targeting younger or older children. Most of the evidence is for universal programmes, but there are	decision-making and resistance skills, espe- cially in relation to substance use. ✓ They change perceptions of the risks associated with substance use, emphasizing the immediate consequences. ✓ They dispel misconceptions regarding the normative nature and the expectations linked to substance use.	✗ They focus only on the building of self-esteem and emotional education. ✗ They address only ethical and moral decision-making or values. ✗ They use former drug users to provide testimony of their personal experience.

		indications that universal skills-based education may be preventive also among high-risk groups, including young people with mental health disorders. While most of the evidence originates in North America, Europe and Australia, some studies originated in Asia and Africa. Programmes that include a social and emotional learning component are also recommended by WHO to prevent youth violence.[19]		
School policies on substance use	School policies on substance use mandate that substances should not be used on school premises or during school functions and activities by either students or staff. Policies also establish transparent and non-punitive mechanisms to address incidents of use, transforming it into an educational and health-promoting opportunity. These interventions and policies are universal but may include indicated components such as screening, brief interventions and referral. They are often implemented jointly with other prevention interventions, such as skills-based education and/or school-wide policies to promote school attachment and/or supporting parenting skills and parental involvement.	Four reviews reported findings for these interventions, three of which from the new overview. Three of the reviews studied tobacco policies in schools,[20] and one studied interventions in tertiary education settings (colleges and universities). With regard to primary outcomes, the three reviews on tobacco policies, including one on school-based incentives for tobacco prevention, reported different results, with few studies in those reviews reporting evidence of effectiveness and more than half reporting no evidence of effect. The studies providing findings did find a lower probability of tobacco smoking in schools with a smoking ban and a higher probability in schools with more liberal attitudes. There was	✓ They support normal school functioning, not disrupt it. ✓ Policies are developed with the involvement of all stakeholders (students, teachers, staff and parents). ✓ They clearly specify the substances that are targeted, as well as the locations (school premises) and/or occasions (school functions) to which the policy applies. ✓ They apply to everyone in the school (student, teachers, staff, visitors, etc.) and to all psychoactive substances (tobacco, alcohol, drugs).	✗ Inclusion of random drug testing.

[19] WHO, Global Accelerated Action for the Health of Adolescents (AA-HA!).
[20] Coppo et al. (2014), Galanti et al. (2014), Hefler et al. (2017) and Reavley (2010).

		some evidence that the formality of the policy (e.g., a written policy) and its enforcement had an additional impact on smoking behaviour. In colleges and universities, some environmental interventions, social norms marketing campaigns and cognitive-behavioural/skills-based interventions might have benefits with regard to the prevention of harmful use of alcohol, with the strongest evidence relating to brief motivational interventions and personalized normative interventions (both computer-based and face-to-face interventions). Although most evidence originates in North America, Europe and Australia/New Zealand, there is also evidence originating in Asia.	✓ They address infractions of policies through positive sanctions by providing or referring to counselling, treatment and other health-care and psychosocial services, rather than by punishing. ✓ They enforce consistently and promptly, including positive reinforcement for policy compliance.	
School-wide programmes to enhance school attachment	School-wide programmes to enhance school attachment support student participation, positive bonding and commitment to school. These interventions and policies are universal. They are often implemented jointly with other prevention interventions, such as skills-based education, school policies on substance use and/or supporting parenting skills and parental involvement.	Two reviews reported findings for this intervention, one of which from the new overview.[21] With regard to primary outcomes, one study reported that these strategies contribute to preventing use of all substances, and another study reported results only for drug use and no significant results for tobacco and alcohol. Although most evidence originates in North America, Europe and Australia/New Zealand, there is also evidence originating in Asia.	✓ They support a positive school ethos and commitment to school. ✓ They support student participation.	N/A

[21] Fletcher (2008) and Hodder et al. (2017).

Addressing individual psychological vulnerabilities	Some personality traits, such as sensation-seeking, impulsiveness, anxiety sensitivity or feelings of hopelessness, are associated with increased risk of substance use. These indicated prevention programmes help those adolescents who are particularly at risk to deal constructively with emotions arising from their personalities instead of using negative coping strategies including hazardous and harmful alcohol use. Therefore, they consist mostly of developmental components.	No new reviews were identified in the new overview of systematic reviews. In the first edition of the International Standards, two randomized control trials had reported effect with regard to this intervention in early adolescence and adolescence, [22] and one review had reported evidence with regard to this intervention in middle childhood.[23] With regard to primary outcomes, according to these studies, programmes addressing individual psychological vulnerabilities can lower the rates of drinking and binge drinking in a two-year follow- up period. With regard to secondary outcomes, this type of intervention can impact individual mediating factors affecting substance use later in life, such as self-control. All evidence originates in Europe and North America.	✓ They are delivered by trained professionals (e.g., psychologist or teacher). ✓ Participants have been identified as possessing specific personality traits on the basis of validated instruments. ✓ Programmes are organized in a way that avoids any possible stigmatization. ✓ They provide participants with skills on how to positively cope with the emotions arising from their personality. ✓ They consist of a short series of sessions (2–5 sessions).	N/A
Mentoring	"Natural" mentoring refers to the relationships and interactions between children/adolescents and non-family-related adults such as teachers, coaches and community leaders, and it has been found to be linked to reduced rates of substance use and violence. Mentoring	One systematic review reported findings with regard to this intervention.[24] With regard to primary outcomes, this study provided some evidence of the effect of mentoring in	✓ They provide adequate training and support to mentors. ✓ They are based on a highly structured programme of activities.	N/A

[22] Conrod (2008), Conrod (2010), Conrod (2011), Conrod (2013) and O'Leary-Barrett (2010) reporting on the same trial.
[23] Piquero (2010).
[24] Thomas et al. (2013)

	programmes match young people, especially young people from marginalized situations (selective prevention), with adults, who commit to arranging activities and spending some of their free time with the young person on a regular basis.	preventing alcohol and drug use among youth. The evidence originated in the United States and Europe. WHO recommends mentoring as one of the interventions identified as evidence-based interventions to prevent youth violence.[25]		
Adolescence and adulthood As adolescents grow, interventions delivered in settings other than the family and the school, such as in the workplace, the health sector, entertainment venues and the community, become more relevant. Note: The evidence summarized for interventions and policies for young adolescents to be delivered in schools (i.e., preventive education, addressing individual vulnerabilities, school policies on substance use), as well as mentoring, report effectiveness also for older adoles- cents, without disaggregating the data by age group. Those interventions will not be further discussed in the present section.				
Intervention type	**Brief description**	**Available evidence**	**Characteristics of prenatal and infancy visit programmes deemed to be associated with efficacy and/or effectiveness based on expert consultation**	**Characteristics of parenting skills programmes deemed to be associated with lack of efficacy and/ or effectiveness or with adverse effects based on expert consultation**
Brief intervention	Brief interventions consist of one-to-one counselling sessions that can include follow-up sessions or	Forty-eight reviews reported findings for this intervention,[26] 38 of which from the new overview.	N/A	N/A

[25] WHO, Global Accelerated Action for the Health of Adolescents (AA-HA!).
[26] Ashton et al. (2015), Baker et al. (2012), Bertholet (2005), Carey et al. (2012), Carey et al. (2016), Carney (2012), Carney et al. (2014), Christakis (2003), Davis et al. (2017), Dedert et al. (2014), Dedert et al. (2015), Diestelkamp et al. (2016), Donoghue et al. (2014), Dotson et al. (2015), Dunn (2001), Elzerbi et al. (2015), Elzerbi et al. (2017), Foxcroft et al. (2015), Foxcroft et al. (2016),

	additional information to take home. They can be delivered by a variety of trained health and social workers to people who might be at risk because of their substance use but who would not necessarily seek treatment. The sessions first identify whether there is a substance use problem and provide immediate appropriate basic counselling and/or referral for additional treatment. The sessions are structured and typically last from 5 to 15 minutes. Brief interventions are typically delivered in the primary health-care system or in emergency rooms, but they have also been found to be effective when delivered as part of school-based and workplace programmes, and when delivered online or via computers. Brief intervention sessions typically employ motivational interviewing techniques, which is a psychosocial intervention in which a person's substance use is discussed and the patient is supported in making decisions and setting goals with respect to his or her substance use. In this case, the brief intervention is normally delivered over the course of up to four sessions that can be up to one hour long, but usually consist of sessions of a shorter duration.	With regard to primary outcomes, these studies show that brief interventions and motivational inter-viewing may significantly reduce substance use. This evidence of effect was found regarding different substances (tobacco, alcohol and drugs) and different age groups (adolescents and adults), with effect sizes reported to be small and not to persist beyond 6–12 months. The reduction of excessive alcohol consumption among people with psychotic disorders was also reported. Indications of reduction in consumption of alcohol and/or harmful patterns of use were also reported both for youth out of college and in college. Within the school-based setting, one study concluded that there was limited quality evidence demonstrating that brief school-based interventions were more effective in reducing substance use (tobacco, alcohol, drugs) than the assessment-only condition, and were similar to information provi-sion. Other studies reported some effectiveness with regard to cannabis use and similar results with regard to tobacco and alcohol.		

Gulliver et al. (2015), Hennessy and Tanner-Smith (2015), Hennessy et al. (2015), Jensen (2011), Jiang and Gao (2017), Kaner (2007), Kazemi et al. (2013), Landy et al. (2016), Leeman et al. (2015), McGinnes et al. (2016), Merz et al. (2015), Moreira (2009), Newton et al. (2013), Oosterveen et al. (2017), Park and Drake (2015), Peirson et al. (2016), Reavley (2010), Riper (2009), Riper et al. (2014), Scott- Sheldon et al. (2014), Scott-Sheldon et al. (2016), Smedslund (2011), Smedslund et al. (2017), Tait (2003), Tait et al. (2013), Vasilaki (2006), Watson et al. (2013), Wood et al. (2014) and Young et al. (2014).

		It was reported that computer-based and Internet-based delivery had small effects that were not sustained in the long term (beyond 12 months) for alcohol, with less evidence available with regard to interventions targeting tobacco and cannabis use. One review reported the effectiveness of interventions delivered by telephone. Effect sizes were higher for interventions delivered face-to-face. One review studying programme delivery in emergency settings noted that the integration of results was hampered by the heterogeneity of studies on both adolescents and adults, and for alcohol and drugs. Effectiveness was noted, including for females and for patients qualifying for treatment. However, the interventions focusing on alcohol consumption primarily for adolescents and young adults may have limited evidence on tobacco use. Evidence for interventions relating to cannabis were reported to be scarce and inconclusive. Brief interventions and motivational interviewing benefit both adolescents and adults alike. However, the long-term impact on reducing alcohol use was less clear. The reduction of excessive alcohol consumption among people with psychotic disorders was also reported.		

		WHO recommends screening and brief interventions for hazardous and harmful alcohol use in non- specialist health-care settings, except in areas of low prevalence of alcohol use where the screening of all patients may not be cost-effective but brief interventions can still be appropriate for identified drinkers. Screening for hazardous and harmful alcohol use should be conducted using a validated instrument that can be easily incorporated into routine clinical practice (e.g., the Alcohol Use Disorders Identification Test (AUDIT) and the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)). In settings in which screening is not feasible or affordable, practitioners should explore the alcohol consumption of their patients when relevant. Patients with a hazardous and harmful alcohol use should receive a brief intervention. The brief intervention should consist of a single session of 5–30 minutes duration, incorporating individualized feedback and advice on reducing or ceasing alco- hol consumption, and the offer of follow-up. Patients who on screening are identified as having alcohol dependence should be managed according to the existing WHO recommendations.[27] WHO recommends offering a brief intervention to individuals using		

[27] WHO, mhGAP Intervention Guide for Mental, Neurological and Substance Use Disorders.

		cannabis and psychostimulants when they are detected in non-specialized health-care settings (comprising a single session of 5–30 minutes duration, incorporating individualized feedback and advice on reducing or stopping canna-bis/psychostimulant consumption, and the offer of follow-up). In addition, WHO recommends that people with ongoing problems related to their cannabis or psychostimulant drug use who do not respond to brief interventions should be considered for referral for specialist assessment.[28] WHO has developed the ASSIST screening test package to facilitate screening and brief interventions for all psychoactive substances including alcohol, tobacco and psychoactive drugs. The effectiveness of interventions for adults has been demonstrated, and further work is required to establish effective- ness of ASSIST-based interventions among adolescents.		
Workplace prevention programmes	The vast majority of substance use occurs among working adults. Substance use disorders expose employees to health risks and difficulties in their relationships with fellow employees, friends and family, and expose them to safety risks in the workplace. Young adults are at particularly high risk, as job strain has	Four reviews reported findings with regard to this kind of intervention,[30] two of them from the new overview. With regard to primary outcomes, according to these studies, workplace prevention can prevent alcohol use, with possible variability of effect according to gender, as one	✓ They are developed with the involvement of all stakeholders (employers, management and employees). ✓ They guarantee confidentiality to employees.	N/A

[28] WHO, "Brief psychosocial interventions: evidence profile" (2012).
[30] Kazemi et al. (2013), Chan and Perry (2012), Thomas (2008) and Webb (2009).

	been found to significantly increase the risk of young adults who use drugs developing substance use disorders. Employers also bear a significant cost of substance use. Employees with substance use problems have higher absenteeism rates and lower productivity, are more likely to cause accidents and have higher health-care costs and turnover rates. Moreover, employers have a duty to provide and maintain a safe and healthy workplace in accordance with the applicable law and regulations.[29] Prevention programmes in the workplace are typically multi-component, including prevention elements and policies, as well as counselling and referral to treatment.	study reported a positive effect on reducing alcohol consumption among women, but not among men. One review found no effect on the prevention of tobacco use. In addition, with regard to other health behaviours, another review indicated that workplace interventions may have a positive effect on physical fitness. The period for the sustainability of these results is not clear. Most of the evidence is from North America and Europe, with some research emerging in Australia and Asia.	✓ They are based on a policy on substance use in the workplace that has been developed by all stakeholders and is non-punitive. ✓ They provide brief interventions (including web-based), as well as counselling, referral to treatment and reintegration services to employees who need them. ✓ They include a clear communication component. ✓ They are embedded in other health- or wellness-related programmes (e.g., for the prevention of cardiovascular diseases). ✓ They include stress management courses. ✓ They train managers, employees and health workers in fulfilling their roles in the programme. ✓ They include alcohol and drug testing only as part of a comprehensive programme with the characteristics described in the points above.	
Community-based multi-component initiatives	At the community level, mobilization efforts to create partnerships, task forces, coalitions, action groups, etc., bring together different actors in a	No new reviews were identified in the new overview of systematic reviews.	✓ They support the enforcement of tobacco and alcohol	N/A

[29] International Labour Organization, Management of Alcohol- and Drug-related Issues in the Workplace. An ILO Code of Practice (Geneva, International Labour Office, 1996).

	community to address substance use. Some community partnerships are spontaneous. However, the existence of community partnerships on a large scale is normally the product of a special programme providing financial and technical support to communities to deliver and sustain evidence-based prevention interventions and policies over time. Community-based initiatives are normally multi-component and take action in different settings (e.g., schools, families, media, enforcement).	In the first edition, 13 reviews had reported findings with regard to this intervention.39 With regard to primary outcomes, according to these studies, community-based multi-component initiatives can prevent the use of drugs, alcohol and tobacco. Although most evidence reported above originates in the United States, Canada, Europe and Australia, a few studies on community-based multi-component initiatives, particularly with regard to tobacco, originate in Asia. Mobilizing communities to prevent the selling of alcohol to, and consumption of alcohol by, underage drinkers, and to develop and support alcohol-free environments, especially for youth and other at-risk groups is one of the areas of action identified as effective by the WHO global strategy to reduce the harmful use of alcohol.[31]	policies at the local level. ✓ They work in a range of community settings (families and schools, workplace, entertainment venues, etc.). ✓ They involve universities in supporting the implementation of evidence-based pro-grammes and their monitoring and evaluation. ✓ Adequate training and resources are provided to the communities. ✓ Initiatives are sustained in the medium term (e.g., longer than a year).	
Media campaigns	Media campaigns are often the first and/or only intervention delivered by policymakers concerned with preventing the use of drugs among the population, as they are highly visible and have the potential to reach a large number of people relatively easily.	Six reviews reported findings for this kind of intervention, five of them from the new overview.[32] With regard to primary outcomes, these studies reported contradictory findings with regard to effectiveness in preventing tobacco, alcohol and	✓ They precisely identify the target group of the campaign. ✓ They are based on a solid theoretical basis. ✓ The messages employed are designed on	✗ Media campaigns that are badly designed or poorly resourced should be avoided as they

[31] Bühler (2008), Carson (2011), Carson (2012), Foxcroft (2011), Gates (2006), Jackson (2012), Jones (2006), Müller-Riemenschneider (2008), Roe (2005), Schröer-Günther (2011), Skara (2003), Spoth (2008a) and Spoth (2008b).
[32] Allara et al. (2015), Carson et al. (2017), Ferri et al. (2013), Gould et al. (2013), Guillaumier et al. (2012) and Hopkins (2001).

		drug use, with the exception of campaigns focusing on tobacco in combination with other prevention components. The evidence reported originates from North America, Australia, New Zealand and Europe.	the basis of strong formative research. ✓ They strongly connect with other existing drug prevention programmes in the home, school and community. ✓ They achieve adequate exposure of the target group for a long period of time. ✓ They are evaluated systematically. ✓ They target parents, as this also appears to have an independent effect on the children. ✓ They are aimed at changing cultural norms about substance use, educating about the consequences of substance use and/or suggesting strategies to resist substance use.	can worsen the situation by making the target group resistant to or dismissive of other interventions and policies.

Entertainment venues	Entertainment venues include bars, clubs and restaurants as well as outdoor or special settings where large-scale events may take place. These venues can have either a positive or negative impact on the health and well-being of citizens, as they provide social meeting spaces and support the local economy, but at the same time they are identified as high-risk settings for many risky behaviours, such as alcohol and drug use, drugged driving and aggression. Most prevention programmes focusing on entertainment venues have multiple components, including different combinations of the following: training of staff and managers and the managing of intoxicated patrons; changes in laws and policies, e.g., with regard to serving alcohol to minors or to intoxicated persons, or with regard to driving under the influence of alcohol and/or drugs; high-visibility enforcement of existing laws and policies; communication to raise awareness and acceptance of the programme and to change attitudes and norms; and offering treatment to managers and staff.	Three reviews reported results with regard to interventions of this kind,[33] one of which is from the new overview. With regard to primary outcomes, according to these studies, training of staff, policy interventions and enforcement reported some indication of effects on intoxication, risky alcohol consumption and alcohol-related harm, including in the context of sport events. All evidence originates in North America, Europe and Australia.	✓ Staff and management receive training on responsible serving and handling of intoxicated clients. ✓ They provide counselling and treatment for staff and management who need it. ✓ They include a strong communication component to raise awareness of the programme and encourage its acceptance. ✓ They include the active participation of the law enforcement, health and social sectors. ✓ They enforce existing laws and policies on substance use in the venues and in the community.	

[33] Bolier (2011), Brennan (2011) and Kingsland et al. (2016)

Appendix B - Overview of principles to use for the delivery of harm reduction interventions in healthcare settings.

Table reproduced from Hawk, M., Coulter, R.W.S., Egan, J.E. et al. Harm reduction principles for healthcare settings. Harm Reduct J 14, 70 (2017).

Principle	Definition	Approaches
1. Humanism	• Providers value, care for, respect, and dignify patients as individuals. • It is important to recognize that people do things for a reason; harmful health behaviors provide some benefit to the individual and those benefits must be assessed and acknowledged to understand the balance between harms and benefits. • Understanding why patients make decisions is empowering for providers.	• Moral judgments made against patients do not produce positive health outcomes. • Grudges are not held against patients. • Services are user-friendly and responsive to patients' needs. • Providers accept patients' choices.
2. Pragmatism	• None of us will ever achieve perfect health behaviors. • Health behaviors and the ability to change them are influenced by social and community norms; behaviors do not occur within a vacuum.	• Abstinence is neither prioritized nor assumed to be the goal of the patient. • A range of supportive approaches is provided. • Care messages should be about actual harms to patients as opposed to moral or societal standards. • It is valuable for providers to understand that harm reduction can present experiences of moral ambiguity, since they are essentially supporting individuals in health behaviors that are likely to result in negative health outcomes.
3. Individualism	• Every person presents with his/her own needs and strengths. • People present with spectrums of harm and receptivity and therefore require a spectrum of intervention options.	• Strengths and needs are assessed for each patient, and no assumptions are made based on harmful health behaviors. • There is not a universal application of protocol or messaging for patients. Instead, providers tailor messages and interventions for each patient and maximize treatment options for each patient served.
4. Autonomy	• Though providers offer suggestions and education regarding patients' medications and treatment options, individuals ultimately make their own choices about medications, treatment, and health behaviors to the best of their abilities, beliefs, and priorities.	• Provider-patient partnerships are important, and these are exemplified by patient-driven care, shared decision-making, and reciprocal learning. • Care negotiations are based on the current state of the patient.

Principle	Definition	Approaches
5. Incrementalism	• Any positive change is a step toward improved health, and positive change can take years. • It is important to understand and plan for backward movements.	• Providers can help patients celebrate any positive movement. • It is important to recognize that at times, all people experience plateaus or negative trajectories. • Providing positive reinforcement is valuable.
6. Accountability without termination	• Patients are responsible for their choices and health behaviors. • Patients are not “fired” for not achieving goals. • Individuals have the right to make harmful health decisions, and providers can still help them to understand that the consequences are their own.	• While helping patients to understand the impact of their choices and behaviors is valuable, backwards movement is not penalized.

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