Australasian College for Emergency Medicine

Harm Minimisation Related to Drug Use

S769 V5

July 2026

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Document Information

Timeframe for review:	Every five (5) years, or earlier if required.
Next major review to be completed by:	April 2031
Content owner:	Public Health and Disaster Advisory Committee
Approval authority:	Council of Advocacy, Practice and Partnerships
Accessibility:	Public website

Revision History

Version	Date	Pages revised / Brief Explanation of Revision
V1	Jul-2006	Approved by Council
V2	Jul-2012	Approved by Council
V3	Jul-2016	S43 combined with Alcohol Harm in Emergency Departments (AHED) Project Alcohol Policy Statement. 'Purpose" was edited to remove dot points. Additional content added to 'Background'. 'Policy' updated to include AHED Project policy position.
V4	Jul-2020	Substantial revision and application of new publication style
V5	Jul-2026	Changes include: (1) Key concepts and terms defined (2) Addition of an ACEM Position section (3) Improved structural clarity (4) Strengthened articulation of the ED role (5) Enhanced bi-national representation

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1. Purpose

This document outlines the Australasian College for Emergency Medicine's (ACEM) position on drug-related harm minimisation and presents recommendations to reduce harm across emergency departments (EDs) and the wider community in Australia and Aotearoa New Zealand.

This document should be read in conjunction with S43 Statement on Alcohol Harm.

2. Terminology

Drugs

For the purpose of this statement, the term drugs refers to both illicit drug use and the misuse of prescription medications

Drug-related harm

For the purpose of this statement, drug-related harm refers to harms to the person who uses the drug (for example, drug-related mortality, drug-specific and/or drug related damage, dependence, loss of possessions, loss of relationships), and similar harms to others.[1]

Harm minimisation

Harm minimisation is a comprehensive framework for addressing drug use. *Demand reduction* aims to prevent uptake and provide appropriate treatment and support. *Supply reduction* involves regulating drugs and reducing their production and availability. *Harm reduction* focuses on reducing risky behaviours and creating safer environments for people who use drugs.

Social determinants of health

Social determinants of health are the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live and age, and the wider set of forces shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems.

Stigma

Stigma is defined as the labelling and stereotyping of difference, at both an individual and structural societal level, that leads to status loss (including exclusion, rejection and discrimination).[2]

3. Background

Harmful drug use remains a significant and growing public health issue in Australia and Aotearoa New Zealand, with wide-ranging impacts on individuals, communities and health systems. It is shaped by broader social and economic determinants of health, including unemployment, insecure housing and unmet mental health needs. Aboriginal and Torres Strait Islander peoples and Māori experience a disproportionate burden of drug-related harm, shaped by colonisation, intergenerational trauma, and structural disadvantage.[3,4]

When these vulnerabilities intersect with stigma and punitive policy responses, people are less likely to seek early support, increasing the risk of preventable harm. This includes personal and social impacts and cumulative effects on physical and mental health, relationships, employment and financial security.

Estimating the true prevalence of drug use is challenging, due to differences in data collection methods and reporting periods which limit direct comparison between jurisdictions. Nevertheless, available population data indicates that approximately 20 per cent of Australians reported using illicit drugs in 2022-23, while in Aotearoa New Zealand the prevalence of illicit drug use in 2023-24 was estimated to exceed 15 per cent of the population.[5,6]

People aged 18-35 represent one of the highest-prevalence groups of illicit drug users in Australia and Aotearoa New Zealand. Cannabis, ecstasy, cocaine and psychedelics are among the most commonly used illicit drugs in both countries, while data trends also indicate increases in methamphetamine consumption.[5,6] There has been an increase in ambulance attendances and hospitalisations due to gamma-hydroxybutyrate (GHB) overdoses, and sudden withdrawal in dependent individuals can be life-threatening and requires medically supervised management.[7,8] Nitrous oxide abuse is an emerging cause of neurological morbidity

among young people, with a growing number of related presentations being observed in EDs.[9,10] Prescription drug misuse and overdose are rising problems in Australia and Aotearoa New Zealand, where opioids and benzodiazepines account for the largest proportion of drug-induced deaths.[11,12]

Drug use contributes an estimated 2–3 per cent of the total burden of disease across the two nations and encompasses a broad range of harms, including substance use disorders, overdose and poisoning, injury and communicable diseases (such as hepatitis C, acute hepatitis B and HIV).[13,14]

4. Drug-Related Presentations to Emergency Departments

EDs sit at the frontline of community harms resulting from drug use, providing assessment, treatment and crisis care for people affected by acute intoxication, overdose and substance-related complications. Presentations span a broad clinical spectrum, from minor injury and behavioural disturbance to life-threatening medical emergencies.[15,16]

Many people whose presentation primarily involves alcohol and other drug (AOD) use, would be better served in the community. However, appropriate community-based services are not always available and patients discharged from the ED with addiction or problematic AOD use often have limited access to culturally appropriate specialist treatment programs to comprehensively address their needs.

Some drugs may increase a person's risk of violent or aggressive behaviours. Methamphetamine-related ED presentations are of particular concern as intoxicated individuals often present with acute behavioural disturbance and psychosis. Point-in-time prevalence studies indicate that methamphetamine-related presentations account for approximately 2–7 per cent of ED presentations in Australia and Aotearoa New Zealand, although these figures are likely underreported.[17]

Management of such patients is resource-intensive, requiring active clinical care alongside measures to ensure the safety of patients and staff. Acutely intoxicated patient presentations are associated with higher rates of restrictive practices, including physical, mechanical and chemical restraint.[18,19]

5. ACEM Position

- ACEM recognises that drug use arises from a complex interplay of social, economic, cultural, and environmental factors, and supports policy responses that address the underlying factors associated with drug use.
- ACEM supports the decriminalisation of illicit drugs for personal use and possession (as distinct from supply), recognising that law enforcement responses contribute to stigma, deter help-seeking, and are associated with poorer outcomes. ACEM supports a health-centred approach to drug policy that prioritises harm reduction, access to treatment, and people's wellbeing.
- ACEM recognises that Aboriginal and Torres Strait Islander peoples and Māori experience disproportionate rates of drug-related harm, shaped by ongoing impacts of colonisation, racism and structural disadvantage, and that culturally safe, self-determined responses are essential to achieving equitable outcomes.
- ACEM holds that that emergency physicians have an essential role in reducing alcohol and other drug related stigma by providing nonjudgmental, person-centred care; using non-stigmatising language; identifying and challenging structural stigma in the workplace; and advocating for systemwide reform.
- ACEM advocates that integrated, multidisciplinary models of care that address alcohol and other drug use alongside co-occurring physical and mental health conditions become the minimum service standard to ensure people receive comprehensive and coordinated support.
- ACEM highlights the need for EDs to have timely, straightforward access to psychosocial, alcohol and other drug, and mental health services. These should be person-centred and designed to reduce repeat presentations to the ED.
- ACEM strongly supports the availability and expansion of evidence-based harm reduction initiatives to reduce drug-related harm. These initiatives provide direct benefits to individuals, reduce avoidable ED presentations, support the early identification of emerging substances, strengthen public health intelligence, and inform timely and appropriate emergency healthcare responses.
- ACEM supports the efforts of governments and health agencies to increase community understanding,

promote safer behaviours, and prevent harms such as overdose, infection, injury, and acute toxicity, through the use of evidence-based, non-stigmatising and targeted public health messaging.

6. Harm Minimisation Framework

Harm minimisation does not condone drug use; rather, it recognises that some individuals will choose to use drugs and seeks to reduce the associated harms. Medical and abstinence-based treatments play an important role for many people, but harm reduction is essential to preventing avoidable harm across the broader population, particularly for those who are unable or unwilling to cease using drugs. These approaches are complementary rather than competing, and their integration is critical to improving individual outcomes, protecting health workers and reducing pressure on EDs.

6.1 Demand Reduction

Alcohol and other drug treatment services

Health professionals should be able to offer assertive interventions to people whose drug use has reached crisis point. Therefore, it is imperative that acute bed-based and community-based treatment services are available at a person's time of need. ACEM emphasises the need for a significant boost in service capacity for regional, rural and remote (RRR) areas, where the burden of AOD harm is higher and specialist services are limited.

Culturally appropriate models of care that respond to the co-occurrence of substance abuse and mental ill-health should be an essential consideration of system design and service planning. These integrated models enable earlier intervention, more coordinated care and improved patient outcomes. Additionally, ACEM recognises the potential benefit of virtual care services to increase both the geographical reach and access to after-hours services.

Brief interventions in the ED

Screening, Brief Intervention and Referral to Treatment (SBIRT) models enable ED clinicians to assess substance dependency risk, provide targeted advice and refer patients to appropriate inpatient or community-based treatment services.[20] While implementation can be challenging due to workforce and ED workload pressures, evidence suggests even brief screening and interventions can reduce harmful drug use and deliver meaningful population-level benefits.[15] Ongoing evaluation of ED-based interventions, including SBIRT and other embedded specialist models, is essential to determine their feasibility, cost-effectiveness and long-term impact on patient outcomes and service demand.

6.2 Supply Reduction

Medication stewardship and oversight

EDs play a key role in limiting opioid supply and reducing overprescribing. This requires regular review of prescribing practices, including careful consideration of the risks and benefits of initiating or continuing opioids, and alignment with Therapeutic Goods Administration guidance to minimise harm.[21]

A strengthened regulatory framework for prescription medicines, supported by centralised monitoring and interoperable health information systems (for example, Safe Script and Single Digital Patient Record), should be embedded as standard practice. This approach improves prescribing safety and benefits all prescribers through comprehensive access to accurate medication histories.

Supply reduction in relation to illicit drugs

ACEM does not condone illicit drug use. While routine involvement of law enforcement is not part of clinical care, police engagement may be appropriate where there is an immediate and serious threat to patient or public safety, or where reporting is required by law, including in circumstances of fatal overdose.

6.3 Harm Reduction

Public health messaging

In Australia and Aotearoa New Zealand, government departments, government agencies and not-for-profit organisations have delivered effective public health campaigns that focus on providing evidence-based information, increasing help-seeking behaviours, reducing drug-related harms and reducing stigma.

Safer settings

ACEM is supportive of measures which seek to create safer environments to reduce harms from drug use. Examples include needle and syringe programs (NSPs), community and ED-based prescribing/provision of overdose prevention tools like Naloxone (opiate antidote), medically supervised safe injection rooms and drug checking services (for example, take-home fentanyl test strips and pill testing at music festivals). Evaluations of these programs consistently demonstrate a reduction in the transmission of blood-borne disease, reduced dependence and addiction, and a reduction in deaths from overdoses.[22-24] Importantly, research has shown that drug use does not increase with the presence of such programs.[25,26]

7. Enabling Conditions for Effective Harm Minimisation

7.1 Service Funding and Capacity

Models of care and supporting infrastructure

ACEM recognises the importance of infrastructure and models of care that strengthen the initial assessment and stabilisation of patients with acute co-occurring conditions. Dedicated Behavioural Assessment Units (BAUs), located within or adjacent to the ED, and led by multidisciplinary teams, can reduce behavioural escalation, enhance patient privacy and dignity, and provide a suitable setting for the initial phase of care.[27] However, these models should be embedded within a broader continuum of care and are not intended to represent the entirety of a patient's care journey.

Emergency department services

While ACEM advocates for increasing the availability of non-hospital alternatives, EDs will continue to receive a high-volume of AOD presentations and therefore must retain best-practice capability to manage these presentations. Embedding AOD specialists in larger EDs and providing all EDs with access to AOD specialists, can enhance continuity of care by initiating treatment and supporting transitions to ongoing specialist management. The effectiveness of ED-based responses relies on strong system-level support, including appropriate governance structures and service integration across health, mental health and addiction services.

7.2 Confront Inequity and Stigma

Addressing the underlying causes of drug use

The social determinants of health influence outcomes, and for some individuals, AOD use becomes a means to cope with psychosocial dislocation, arising from experiences such as stigma, racism, unemployment, trauma or mental illness.[28] While adversity alone does not predetermine substance dependence, people experiencing distress, social isolation, unstable home/family environments, or disengaged from education face higher risks. People who have issues with AOD use often face additional challenges, including poorer physical health, insecure housing/homelessness, financial disadvantage and increased risk of violence, arrest, self-harm or suicide. These complex needs are often exacerbated by stigma, which increases social exclusion, discrimination and poorer outcomes.

Stigma

People who use drugs experience some of the highest levels of stigma. AOD-related stigma is pervasive, operating at social, structural and individual levels. It is reinforced by misconceptions, negative stereotypes and systems that treat people as risky or undeserving, which compounds other forms of marginalisation, intensifying disadvantage and internalised shame. For Aboriginal and Torres Strait Islander peoples and Māori, AOD-related stigma intersects with racism and discrimination, creating compounded barriers that are distinct from those experienced by the broader population. Stigma is a major barrier for people who use

drugs; reducing the likelihood of help-seeking, undermining trust in services, and contributes to avoidable harm by delaying access to healthcare and support.[29]

7.3 Data Capture and Monitoring Systems

Enhanced data systems that capture emergency department workload

Data collected in EDs is critical to clinical care, identifying trends and gaps in healthcare delivery, and informing policy and funding decisions. However, evidence indicates that current clinical coding systems and casemix frameworks do not adequately capture the intensity and complexity of drug-related ED activity.[30,31] As a result, this workload is significantly under-represented in activity data and associated funding, creating a mismatch between service demand and resource allocation.[32] Standardised national data and coding frameworks should be improved and implemented to better capture drug-related ED presentations, their complexity, and associated harm minimisation activity.

Strengthen and sustain toxico-surveillance systems

Toxico-surveillance systems such as the Emerging Drugs Network of Australia (EDNA) and High Alert in Aotearoa New Zealand enhance responses to illicit drug harms by identifying new substances, their clinical effects and supporting ED clinicians in managing overdoses.[33, 34] ACEM advocates for the expansion of a national alert system in Australia, as found in Aotearoa New Zealand, to sustain national surveillance, support harm reduction, and contribute to global drug monitoring initiatives.

8. Related documents

Doc #	Document Name
P56	Policy on Public Health
S43	Statement on Alcohol Harm
S42	Statement on Tobacco Smoking and E-Cigarettes
S52	Statement on Health Equity for Aboriginal and Torres Strait Islander Peoples
S913	Statement on Health Equity for Māori
G26	Reducing the Spread of Communicable Infectious Disease in the Emergency Department
P32	Violence in Emergency Departments
P41	Policy on Access to Care for Patients With Acute Mental and Behavioural Conditions
S817	Statement on the Use of Restrictive Practices in Emergency Departments
S12	Statement on the Role Delineation of Emergency Departments and Other Hospital-Based Emergency Care Services

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