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living positive victoria
PEOPLE LIVING WITH HIV/AIDS VICTORIA

Victorian Parliament

Law Reform, Road and Community Safety Committee

Inquiry into Drug Law Reform

Submission March 2017

Fundamentally, repressive drug policies create far more harm than the drugs themselves. Thus, we need new approaches that uphold the principles of human dignity, the right to privacy and the rule of law, and recognize (sic) *that people will always use drugs. In order to uphold these principles all penalties both criminal and civil must be abolished for the possession of drugs for personal use.*

Global Commission on Drug Policy, 2016.

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Introduction

About Living Positive Victoria

Living Positive Victoria is a not for profit, community based organisation representing all people living with HIV in Victoria since 1988 and is committed to the advancement of human rights and wellbeing of all people living with HIV.

Harm reduction

Living Positive Victoria (LPV) supports a health, human rights and harm reduction perspective with regard to the consumption of all psychoactive substances be they legal or illicit. Harm reduction refers to a set of principles that do not require a reduction in use nor abstinence as end goals. LPV does not support the pursuit of a 'drug free society' as we are of the belief that drug use has and will always exist. Therefore, it is essential to identify ways to reduce harm, including reviewing applicable laws as is the subject of this inquiry.

Recommendations

A. Advocate for decriminalisation of possession and use of current illicit drugs to ensure harm reduction strategies can be successfully implemented, including support for interim measures that offer a therapeutic justice approach such as expansion of drug courts and diversion programs.

B. Increase peer-to-peer education and resources on illicit drug use that are evidence-informed. Messaging should be culturally appropriate for subpopulations of people living with HIV and include information on poly substance use, safer injecting practices and alternative routes of administration;

C. Stigma-free alcohol and drug services that are sensitive to the needs of people living with HIV and the subpopulations they may be a part of including gay and bisexual men, Aboriginal and Torres Strait Islander people, and people from Culturally and Linguistically Diverse communities;

D. Extend access to the Victorian Medicinal Cannabis Scheme to people living with HIV, in line with the recommendations of the Victorian Law Reform Commission;

E. Establishment of clinical trials to investigate the effectiveness of pharmacotherapy options for amphetamine-type substances; and

F. Increased accessibility to and enhancement of needle and syringe programs including increased peer-to-peer distribution networks.

Extent to which PLHIV are affected by drug laws

Prevalence of drug use among people living with HIV

The prevalence of drug use – both use of illicit drugs and illicit use of prescription drugs among people living with HIV (PLHIV) is higher than the general population.[1] Moreover, some subpopulations have higher prevalence of use again, for example, HIV-positive gay and bisexual men have a higher prevalence than their HIV-negative peers.[2] Higher prevalence of use does not necessarily equate to greater harms nor to greater prevalence of drug dependence or drug misuse. Therefore, for the majority of PLHIV, drug use occurs without harm or with minimum harm and does not result in problematic use.

HIV Futures is a cross-sectional survey conducted by the Australian Research Centre in Sex, Health and Society (ARCSHS) on people living with HIV since 1997. *HIV Futures 8*, published in 2016, surveyed 895 people living with HIV in Australia.[3] Data show the most commonly used drugs for non-medical purposes in the past 12 months were:

- pain killers/analgesics (22.4%, n=192),
- tranquilisers/sleeping pills (13.7%, n=116),
- marijuana (10.6%, n=90) and
- methamphetamine (7.1%, n=60).[4]

11.2% of respondents reported injecting meth/amphetamine and 1.2% had injected heroin in the previous 12 months.

In the Gay Community Periodic Survey (GCPS) for Melbourne 2016, run by the Centre for Social Research in Health (CSRH), UNSW Australia, 212 HIV-positive gay and bisexual men were surveyed. Data show the mostly commonly used recreational drugs used in the previous six months were:

- amyl nitrite (57.9%),
- Viagra or other erectile dysfunction medications (43.9%),
- cannabis (39.7%) and
- crystal meth (30.8%). [5]

17.8% of HIV-positive men reported any injecting drug use (2016), whilst among those HIV-positive who used crystal meth between 2012-2016, 51.6% reported any injecting drug use.

Prevalence of drug dependence and other harms among PLHIV

Despite the high prevalence of use of illicit drugs and the illicit use of prescription medication within some populations of PLHIV, there remains only a small group for whom their use is problematic, including harms as a result of misuse, dependence and frequent use that affects other aspects of their lives.

For example, in *Futures 8*, 4% of respondents indicated that their non-medical use of drugs affected their ability to work, while 3.4% of respondents had been diagnosed with a substance dependence disorder in previous 12 months.

The Flux Study is a longitudinal cohort study on drug use among gay and bisexual men across Australia. In these early stages of the study, data has not been disaggregated by serostatus. Despite this, it may give some indications of help-seeking behaviours in relation to "recreational drug use" within the gay and bisexual men subpopulation of PLHIV.

The Flux study shows the use of formal alcohol and other drugs (AOD) services among this cohort was low (1.0% for AOD support groups, 1.0% for 12-step program, 0.6% for group therapy and 0.6% detox or rehab clinic).[6] It is encouraging that 11.4% of participants consulted their doctor about their drug use, 6.1% consulted a psychologist and 3.6% used other forms of counselling, potentially demonstrating a preference for one-on-one support.[7] It is well documented that mainstream AOD services are not culturally appropriate in facilitating LGBTI and/or PLHIV experiences. This highlights the need for AOD services that address the unique challenges of working with LGBTI[8] and PLHIV[9] communities.

The interaction between mental health conditions, living with HIV and drug use needs to be further explored. *Futures 8* data shows that "more than half the participants… had been diagnosed with a mental health condition at some point in their life,"[10] with depression and anxiety being listed as the two most prevalent mental health conditions. Data also shows that "PLHIV may experience poorer mental health than the general population."[11] Whether the mental health condition existed before a HIV diagnosis, as a result of the HIV diagnosis, as a result of current or past drug use, or that drug use is one indicator of a mental health condition, is yet to be analysed. Agencies working with PLHIV need to be cognisant of these complex intersections.

HIV notifications relating to injecting drug use

According to the latest HIV Surveillance Report issued by the Department of Health and Human Services, for 2016, 14 cases of HIV were associated with injecting drug use in Victoria.[12] The number of cases of HIV acquisition associated with injecting drug use in Victoria over the last three years total 20, 28 and 20 for 2013, 2014 and 2015 respectively.[13] Furthermore, according to the Kirby Institute, in 2015 there were 2,402 cases of HCV diagnosed in Victoria.[14] Approximately 90% of new HCV infections are related to the sharing of 'used' injecting equipment.[15] These cases of HIV and HCV are entirely preventable.

It is worth noting that the epidemiology of HIV among people who inject drugs in Australia is not comparable to the global HIV epidemic among PWID, largely due to the early intervention of needle and syringe programs. Globally there is evidence that shows a relationship between criminalisation of drugs/drug use and increases to HIV risk among people who inject drugs.[16] While in Australia, criminalisation may not have a direct impact on HIV transmission, some harms can be described as a result of criminalisation, in particular, the impact of stigmatising attitudes toward illicit drugs is disproportionate to the harm relating to drug use and is a result of the illicit nature of the drug. With the intersection of other forms of stigma, for example, injecting drug use compared with other drug consumption methods or a person's HIV and/or hepatitis status, there is the potential for multiple layers of stigma that may act as a barrier to accessing health services, support for problematic drug use or drug treatment options.

The effectiveness of laws, procedures and regulations relating to illicit and synthetic drugs and the misuse of prescription medication in minimising drug-related health, social and economic harm

Needle and syringe programs

Needle and syringe programs have been operating in Victoria since 1987.[17] Since their introduction as a four-site pilot, over 200 locations now provide clean injecting

equipment for people who inject drugs (not including retail community pharmacies).[18] The effectiveness of these programs is demonstrable. Between 1999 and 2008, over 81 million syringes were distributed,[19] averting an estimated 5,516 HIV infections and 18,878 HCV infections.[20] This approximates to a net financial saving of $153 million to the Victorian healthcare system in the ten-year period of 2000-2009.[21]

The above data comes from an evaluation undertaken by the Kirby Institute, UNSW Australia in 2009. Since then, the reach of needle and syringe programs has extended through the provision of vending machines in some high-demand sites. In addition, the work of Harm Reduction Victoria's Peer Network Program in establishing formal peer-distribution of clean injecting equipment in conjunction with health promotion is to be commended. In some subpopulations of PLHIV where literacy around safer injecting practices is low, there is an opportunity for Living Positive Victoria to partner with Harm Reduction Victoria and the Victorian AIDS Council to further the reach of peer-distribution and peer-education models.

Victorian Drug Court

The Victorian Drug Court is an example of therapeutic jurisprudence that diverts drug users from incarceration. This approach recognises in part that drug use is a health issue and that incarceration does not necessarily assist the individual in their drug dependence. In fact, there is evidence to suggest that for low level drug offences, a criminal record causes more harm to an individual than the drug use itself.[22]

Living Positive Victoria has some issues with the current model that the Victorian Drug Court operates their Drug Treatment Orders within. In particular, that abstinence as an end goal (the requirement for Phase 3 'graduation') may not be a realistic nor in the individual's best interest. Abstinence can be effective for some people but not for others and therefore should be part of a suite of options that are tailored to an individual's needs and concerns. The psychological barrier of achieving abstinence – that any drug use is considered a failure – can have a negative impact on an individual's ability to continue addressing their drug misuse.

At the very least, the Victorian Drug Court should be expanded to ensure that all Victorians who qualify to access this justice approach are able to do so. Ultimately, under a model of decriminalisation of personal drug use (discussed later in this submission), drug courts should operate as administrative courts as part of the healthcare system rather than as part of the justice portfolio.

Access to medicinal cannabis

The establishment of a medicinal cannabis scheme in Victoria is timely, given the both the increasing body of evidence for certain conditions (such as HIV) and the level of community support. The Victorian Law Reform Commission in its report on Medicinal Cannabis, August 2015, recommended:

> *The Commission has identified a set of conditions and symptoms as the basis for initially making medicinal cannabis available:…*
>
> - *severe pain arising from cancer, HIV or AIDS*
> - *severe nausea, severe vomiting or severe wasting resulting from cancer, HIV or AIDS (or the treatment thereof).*[23]

Since the report, the government introduced and passed legislation establishing the Victorian scheme, however many of the recommendations of the VLRC were not adopted, including access to medicinal cannabis for people living with HIV. Some members of this inquiry's committee highlighted these concerns during the Second Reading of the bill by introducing amendments which were not supported by the government.

Given the data provided in this submission from *Futures 8* on the prevalence of illicit use of prescription drugs (painkillers/analgesics and tranquilisers/sleeping pills) and cannabis among people living with HIV, the ability for PLHIV to access medicinal cannabis may have a diversionary effect on the use of these illicit drugs.

The practice of other Australian states and territories and overseas jurisdictions and their approach to drug law reform and how other positive reforms could be adopted into Victorian law.

The Portuguese Experience

As has been demonstrated in Portugal, where the personal possession of all substances was decriminalised in 2001, levels of substance use are now well below the European average.[24] Substance use has declined among 15 to 24 year olds; those in the population most at risk of initiating substance use. Rates of past-year and past-month substance use among the general population have decreased. The numbers of newly diagnosed HIV infection among people who inject substances has dramatically declined over the last decade (from 1,016 in 2001 to 56 in 2012), with similar trends for hepatitis B and C.[25]

Australian law enforcement agencies could refer users of illicit substances to the public health system rather than the criminal justice system. This acknowledges that for people experiencing problematic use, there may be underlying complexities to the reason for their use, including trauma as a result of systematic discrimination. Taking a public health approach would result in better and positive outcomes for people who use substances.[26]

Pharmacotherapy for amphetamine-type substances

Opiate substitution therapy (OST) is an example of an effective pharmacotherapy option for people with a dependence on opiates. Currently no pharmacotherapy options are available in Australia for dependence on amphetamine-type substances (ATS). In a recently published article in the Medical Journal of Australia, Matthew Frei and Alex Wodak write in regard to methamphetamine (ice):[27]

> *In Australia and other countries, research into medication-assisted treatment of psychostimulant use problems is limited to a handful of reports, mostly with small sample sizes.[28] Large scale studies of methamphetamine pharmacotherapies in combination with psychosocial support are needed. Substitution therapy has been remarkably successful for people dependent on opioids, particularly those who have not benefitted from first line psychosocial interventions.[29]*

Given the high prevalence of use of methamphetamine among some subpopulations of PLHIV, it is vital that as a community we consider all possible evidence-informed treatment options. Living Positive Victoria recommends the Victorian government look into localised trials that involve a range of affected subpopulations including PLHIV.

Peer-to-peer education

Education programs targeted to populations at risk, supported and delivered by community peer-led organisations such as LPV, Harm Reduction Victoria, Hepatitis Victoria and Vixen Collective in ways that reduce stigma and minimise the harm caused by misuse of substances, should be prioritised. Specifically, for PLHIV, programs could include safer injecting practices (including alternatives to injecting), potential substance interactions associated with 'polydrug' use and mental health and wellbeing

Psychological interventions and culturally appropriate treatment

Currently substance-use treatment programs in Australia have been primarily developed to deal with the misuse or problematic use of opioids and alcohol. Crystal methamphetamine and other ATS require complex treatment options due to the impact methamphetamine can have on the brain.[30]

Psychological support and treatment such as Acceptance and Commitment Therapy and Cognitive Behavioural Therapy are current standard of care practices and have modest effectiveness in reducing ATS use.[31,32] Developing culturally specific programs would predict better responses in the absence of proven pharmacotherapy interventions.

Enhancement of these programs could be achieved through the greater contribution of peers including the peer-delivery of programs targeting individuals before use becomes problematic, as well as programs design and delivered by peer-based and community controlled organisations.

Conclusion

Gathering local data systematically on the harms resulting from problematic use of illicit drugs is paramount to developing targeted strategies to at risk populations including PLHIV; Aboriginal and Torres Strait Islander peoples; people living in rural and remote areas; young people; and people who identify as LGBTI, especially men who have sex with men. PLHIV need to have meaningful involvement in data surveillance at all levels so as to avoid inadvertent stigmatisation of subpopulations with PLHIV. These strategies are best delivered by the appropriate community-based organisations with existing credibility and access to the populations that need to be targeted in addressing problematic use. As evidence shows, criminalisation of illicit drug use exacerbates and increases the problem and must be avoided in all situations.

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