

CENTRE FOR RESEARCH EXCELLENCE INTO INJECTING DRUG USE (CREIDU)

SUBMISSION TO UNITED NATIONS GENERAL ASSEMBLY SPECIAL SESSION ON THE WORLD
DRUG PROBLEM

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This submission was written by CREIDU Executive Committee members Professor Margaret Hellard, Professor Paul Dietze, Associate Professor Mark Stoové and Professor Stuart Kinner on behalf of CREIDU.

The Centre for Research Excellence into Injecting Drug Use (CREIDU) is an Australian project which aims to:

- facilitate collaborations between researchers and workers in the fields of justice health, mental health, blood-borne virus infection, alcohol and drug use, addiction and policy research;
- provide education and training for students, early-career researchers and community sector workers in disciplines relating to the health of people who inject drugs;
- communicate research findings and translate into policy and practice;
- enable drug users and organisations representing drug users to have their voices heard and to contribute to debates regarding responses to drug use and related harm;
- provide seed funding to support new and novel research projects on the topic of injecting drug use.

The United Nations General Assembly Special Session (UNGASS) on the World Drug Problem offers a unique opportunity for discussing drug-related issues, opportunities and challenges associated with injecting drug use. Evidence-based policy is key to promoting the health of people who inject drugs (PWID), including the domains of blood-borne viruses (BBVs), harm reduction, and structural and legislative barriers to health and wellbeing. These three domains are discussed in this submission.

1. BLOOD-BORNE VIRUSES

PWID and those with a history of injecting drug use are at high risk of BBV infections. Global estimates vary, but there are thought to be approximately 15.9 million PWID worldwide, with around three million of these living with HIV.¹ The prevalence of hepatitis C virus (HCV) in PWID globally ranges from less than 40% to over 80%, but overall it is estimated that 60-80% of PWID have been infected with HCV.² Recent estimates indicate that 26% of all prisoners, and 64% of prisoners with a history of injecting drug use, have HCV.³ The risk of PWID contracting a BBV is exacerbated due to the illegal nature of injecting drug use in the vast majority of jurisdictions.

Needle and Syringe Programs (NSPs) and Opioid Substitution Treatment (OST) are the primary interventions to reduce BBV transmission among PWID. These are key elements of WHO, UNODC and UNAIDS packages and guidelines designed to respond to HIV, and more recently HCV, among PWID. However, despite these guidelines, global coverage of NSPs and OST is extremely poor.

The Reference Group to the United Nations on HIV and Injecting Drug Use 2010 reported that NSPs were present in 82 countries but absent in 69 countries where injecting drug use has been documented, with only 22 needles/syringes (range 12–42) distributed per PWID per year.⁴ The same reference group reported that OST was present in 75 countries but absent in 76 countries where injecting drug use had been documented and that globally only 8% PWID (range 6–12%) are in receipt of OST. This low coverage of NSPs and OST occurs despite evidence that in combination they reduce injecting risk behaviour, and growing evidence that such interventions reduce both HIV and HCV incidence.⁵⁻⁷

The World Health Organization has set elimination targets for HIV by 2030 and is in the process of setting elimination targets for hepatitis C and hepatitis B, by 2030.⁸ Key to meeting these elimination targets is the provision of improved antiviral treatments for all three diseases and the implementation of the highly effective hepatitis B vaccine. However, without changes in legislation on drug use to reduce stigma, discrimination and criminalisation associated with drug use, key populations who need to access treatment and care, namely PWID, will not access health services at the levels required to both benefit their personal health and reduce disease transmission. Importantly, the elimination models suggest that treatment alone will not be sufficient to meet the 2030 targets; treatment must be combined with high-quality harm reduction if the ambitious – but nonetheless achievable – targets of HIV, hepatitis B and hepatitis C elimination are to be achieved.

2. HARM REDUCTION

As discussed above, NSPs and OST are key harm reduction initiatives, and evidence consistently supports their continued use among PWID.

Australia is fortunate to have a comprehensive evidence-based public health approach to preventing drug-related harm. This approach was initiated in the mid-1980s and continues to this day. Key components of the approach include BBV prevention, drug treatment and diversion of offenders from the criminal justice system in the case of minor drug-related offences. The cornerstone of BBV prevention activities is the implementation of large-scale NSPs across the country. NSPs significantly mitigated the HIV epidemic amongst PWID in Australia, to the extent that only 30–40 cases of HIV per year are transmitted via injecting drug use.⁹ Further, although HCV prevalence has remained fairly steady at around 50-70% of PWID since the introduction of NSPs in Australia,¹⁰ the incidence of HCV appears to be declining among PWID.¹¹ Importantly, evidence from mathematical modelling studies suggests that by averting infections, NSPs have saved the Australian healthcare system up to \$220 million in the period 2000–2010 and up to \$950 million in future costs.¹⁰

Consistent with international evidence, the mainstay of Australia's public health approach to treatment for opioid dependence is OST. Methadone and buprenorphine are both available as OST medications in Australia, reflecting evidence that these medications are effective in reducing drug-related harms.¹²⁻¹⁴ Models of treatment access vary between states, but there were an estimated 48,000 people receiving OST in 2014.¹⁵ Diversion for minor drug-related offences has been established as a core principle of Australian drug law enforcement since the late 1990s.¹⁶ These programs are designed to reduce the burden on an overcrowded criminal justice system and ensure that prison is a last resort for the majority of offenders.

Finally, Australian jurisdictions have begun to implement take-home naloxone programs,¹⁷ consistent with WHO guidelines¹⁸ that highlight the life-saving potential of these programs, particularly in resource-poor settings. Naloxone is a particularly safe drug, with no known misuse potential, that has been used in emergency medicine to reverse the effects of opioids for over 40 years.¹⁹ Expanding access to take-home naloxone to at-risk opioid consumers and their peers and family members should be a priority. Recent developments in the UK, USA and Australia will allow for easier access, including over-the-counter access through pharmacies and other services, that should be monitored closely²⁰ and implemented widely if evaluation proves positive.

3. STRUCTURAL AND LEGISLATIVE FACTORS

Key reasons for the limited scale-up of effective harm reduction measures are modifiable structural and legislative factors. These barriers contribute strongly to the maintenance of high rates of health and social harms among PWID. The prevalence and severity of drug-related harms varies regionally and between countries, with increased harms invariably associated with punitive legislative frameworks that impede legitimate harm reduction activities and contribute directly to risk practices, marginalisation and stigma.²¹⁻²³

The ongoing criminalisation of drug use and normative behaviours for people who are drug-dependent, such as the possession of small drug quantities for personal use or the possession of paraphernalia, has resulted in a gross over-representation of drug-related offenders in prison and enormous harms to individuals and costs to communities.²⁴ The interpretation of ‘social supply’ (where an individual purchases drugs to supply to their direct social networks) as a drug dealing/trafficking offence has also resulted in the conviction of many drug users for serious drug offences.^{25,26} Direct health costs can be attributed to the criminalisation of the possession of drug paraphernalia; in the case of injecting drug use, contributing directly to the sharing of injecting equipment and BBV transmission²⁷ and overdose and mortality related to the physical space in which injecting occurs and hurried injecting to minimise time in possession.²⁸⁻³⁰ Ultimately, there is a global imperative to reform international and domestic drug laws to reduce the harms associated with drug use; such reforms can comfortably exist under current UN drug control conventions.³¹

Beyond legislative barriers for the prevention of drug-related harms, many structural gaps regarding harm and demand reduction service systems exist globally. In many parts of the world very few resources are available for harm reduction, drug dependence treatment services^{32,33} and the treatment of HIV and other BBVs.³⁴ This, combined with often excessively restrictive treatment eligibility criteria for drug users³⁵ and treatment protocols that lack evidence of effectiveness or breach individual human rights,³⁶ contributes to the ongoing enormous and preventable burden of disease associated with drug use globally. It is crucial that the research and experience regarding the implementation and effectiveness of high-coverage drug harm reduction and treatment services, accumulated over several decades, be translated into regions where the coverage of such services is limited.

Finally, the lack of equivalence of drug dependence treatment and harm reduction measures for drug users who are incarcerated continues to breach fundamental human rights and international conventions.³⁷ The worldwide undersupply of treatment and harm reduction services in prison should provide further impetus to law reform that avoids the routine incarceration of people for offences related to their personal use of drugs.

CONCLUSIONS

PWID experience significant physical, mental and social harms worldwide. There is a significant and growing body of evidence which indicates that several measures, including provision of clean needles/syringes, Opioid Substitution Therapy and naloxone, show efficacy across many jurisdictions. In order to prevent or reduce harms, PWID need to be able to access these measures. However, key legislative barriers stemming from the criminalisation of drug use have resulted in

barriers to PWID accessing effective harm reduction measures, particularly in incarcerated populations. Policies must take this evidence base into account in order to reduce harms experienced by PWID.

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