

Extract from Western Australian Parliament Hansard

ASSEMBLY -Tuesday, 23 February 2010

MR J.N. HYDE (Perth) [8.22 pm]: I would like to speak about a conference I attended in January called "Response Beyond Borders", which was hosted by the Asian Consortium on Drug Use, HIV, AIDS and Poverty.

It was the parliamentarians' session at the "Second Asian Consultation on the Prevention of HIV Related to Drug Use". I represented Australia's parliamentary group on population and development. It was a very important conference, particularly for those of us in Australia who live in a state that has adopted harm minimisation as the correct response to minimising drug use and dealing with the very complex issues of drug use in our society.

One of the speakers who was an Australian, Geoff Manthey, is a co-chair at UNAIDS. He detailed the impact of criminalisation on drug use, saying that it drives people underground, thus spreading HIV and other problems, and collects drug users in prisons where they can have access to drugs and creates HIV hot spots. He said that a harm reduction strategy is needed.

From the Asian Pacific Network of Sex Workers, Khartini Slamah said it was very important, again in terms of harm minimisation, to have access to confidential HIV treatment, and that prevention and inclusion policies are needed. We need to ensure that there is sex worker involvement, particularly women, in prevention and treatment programs. The denial of drug use in the sex worker industry is a huge obstacle. From the Global Fund, Mauro Guarinieri, a civil society officer, detailed how after 30 years, despite \$US1 billion being invested in HIV reduction every year, only one in 20 drug users in Asia has access to substitution treatments and only one in seven has access to clean needles. On the positive side, harm reduction and peer education works, but more is needed.

One of the most fascinating speakers was Mariam Claeson from the World Bank. She detailed how there is a nexus between policymakers and world economic outcomes. That is the very reason the World Bank and donors have an economic interest in getting drug and HIV policies right. There was a big World Bank presence at this conference. Its attitude is that it needs to make money work for those who are vulnerable and at risk.

The secretary general of the Asian Forum of Parliamentarians on Population and Development, Dr Pinit Kullavanijaya, is a senator from Thailand and a colleague of Barry Marshall and our other Nobel Prize winners in that field of medicine. He detailed, from the position of being a parliamentarian in Asia and also a medical doctor, how harm reduction has proven to be effective since its widespread introduction in the early 1980s, and how a large reason for its success was the fact that it was human rights

based. The World Health Organization's major study found that in 52 cities that operated without needle exchange and syringe provision, HIV infection rates had increased by an average of 5.9 per cent a year. In the 29 cities that had needle exchange and syringe provision arrangements, HIV infection rates decreased by an average of 5.8 per cent a year. Vietnam, one of the countries that have very hard and stringent policies on drug sellers and people trafficking drugs, has also moved towards harm reduction strategies for drug users, after years of having had a punishment response regime. There is no evidence to show that harm reduction leads to increased drug use; that was the continued mantra of both medical experts and public policy experts. Dr Pinit also said that parliamentarians need to work towards the eventual decriminalisation of drug use.

One of the most engaging speakers was Hon Madam Chong Eng, who is a member of Parliament for Penang in the Malaysian Parliament. Her view is that one has to convince the majority of the community that harm prevention policies will benefit the whole community. Members of Parliament must represent the majority, so they have to show how the majority will benefit. The majority will benefit from getting rid of disease in jails and reducing the number of presentations at hospitals. In Malaysia today more housewives than sex workers have HIV. The general population has been excluded from harm reduction policies, and many people in the broader community are in denial about these issues.

One of the co-sponsors of the conference is the Asian Network of People who Use Drugs, and another speaker at the conference was Jimmy Dorabji from the Burnet Institute, which operates out of Australia. His point was that moral assertions are made about illegal drug use that are not made about alcohol and tobacco use, and that people who use drugs do not have the will or the assistance to tackle associated problems in the way that many people who use alcohol and tobacco do. People who use drugs have a greater need for civil society.

Tripti Tandon from the Lawyers Collective in India spoke on policy and treatment environments. Major criminalisation policies across some Asian countries reinforce a culture of blameworthiness. This leads to a situation where doctors do not blame lung cancer sufferers who have used tobacco, but an environment of blame exists in some fields connected with drug users.

The other big issue to consider—we often forget it here in Western Australia—is the effect of drug use on spouses and partners. That is why harm reduction programs are very important, because in addition to the harm being done to drug users, quite often the larger harm is done to the families and partners of drug users. In Nepal, for example, some 70 per cent of drug users are married. Across South Asia there are very high rates of drug use, and when HIV and hepatitis B are introduced into the mix of secretive drug use, the rate of transmission within marriage becomes very high. A couple of speakers concentrated on the issue of drug use by young people. I want to refer to this now, because I will be referring later to a submission from Mission Australia, Perth, that was made to a current inquiry by one of our parliamentary

committees. An interesting contribution to the “Response Beyond Borders” conference was made by Himakshi Piplani and Dave Burrows from Australia. They said that the raw statistic is that every day, 700 new young people are being infected with HIV. This came from a review of data from 17 countries through the AIDS projects management group for the UNICEF Asia and Pacific Shared Services Centre. The preliminary findings concentrated on users between the ages of 10 and 24 years. The study used very small sample sizes, and we were, therefore, cautioned about the validity of using such a study. What is coming out from that research is that HIV is 20 times more prevalent in at-risk kids. Therefore, particularly in areas such as Asia, we should not be wasting money on the general population in schools and on elite students. We should be targeting at-risk people, because they are the ones who need to get the message. The research shows also that young injecting drug users are hugely more at risk. Therefore, we need to start working with 12 to 16-year-olds on prevention. Of course this will be very confronting, not only for parliamentarians, but also for our broader community. Yet if we are dinkum about the rights of children, we need to accept that children, particularly 12-year-olds who are using drugs, are voiceless and disempowered. We are ignoring those children if we ignore their drug use. These young people are at risk. However, they are not able to make independent medical decisions. That raises huge liability issues when it comes to needle provision, for example. Therefore, this presents some very important and complex issues for us as parliamentarians and policymakers.

We need to debate those issues fully and openly.

One of the sessions at the conference was on harm reduction. That session was directed particularly at parliamentarians. We were given an overview by an officer from the Global Fund about the epidemiology of HIV and injecting drug use in Asia. One of the speakers at that session was Dr Suresh Kumar, a psychiatrist, who spoke about how drug users with HIV who engage in sex have a higher incidence of viral hepatitis and tuberculosis.

The challenges of formulating good policy and of putting that policy into practice were addressed by Mariam Claeson, a Swedish doctor who is also the program coordinator for HIV-AIDS at the World Bank. Her theme was that we need to target at-risk cohorts. She also made the point that it is wrong to use the South African doomsday model in Asia, because in Asia, unlike in parts of Africa, HIV has not wiped out a whole generation of the skilled workforce. The recurring theme at the conference was that we need to base local knowledge and advice on strict evidence. Another theme was that we need to use cost-effective strategies. These strategies need to be targeted at ministers for finance and treasurers, because in Asia, as in most communities, it is the worst off and the most poor who are most at risk. Of course there are also huge welfare costs if drug use and HIV infection are not addressed. On a broad fiscal cost analysis, it is much better financially to fund prevention rather than treatments. Of course, as we all know, people are not demonstrating in the streets for clean needles, but they are demonstrating for treatments once there is an explosion in HIV. We must get the agenda back onto funding prevention.

Sometimes the flavour of the month is detoxification programs, yet the medical research indicates that they are a waste. Ninety per cent of people go back onto drugs, particularly those in a prison population. Unfortunately, the reality is that prisons are often the places where injecting is taught and the epidemics start there. In terms of cost-effectiveness, detoxification is not valid but oral substitution therapies are. As an aside, it is interesting to recall that it was really only when parliamentarians moved to change to oral rehydration, rather than the doctors and the medical fraternity leading the charge, that child diarrhoea was tackled and addressed in widespread populations. The message coming back is that parliamentarians, not doctors, are the change agents in many situations. The evidence in Afghanistan is that \$1 invested now saves \$4 later. Communities within Asia should be proud that Asia is 98 per cent HIV free. We need to build on successes. According to the World Bank, we need to focus on science and compassion.

We also had a session on treatment reforms by the United Nations Office on Drugs and Crime. Dr Juana Tomas-Rossello is the coordinator of the UNODC. We need to be reminded that drug users have an addiction disease. No matter how much drug users are punished, unless the brain disease of addiction is treated, they will keep using drugs. What is needed is to reach out to those who are not accessing treatments. If we sit back and examine this, we see that this is nothing less than that which is expected for the treatment of any other disease, so why are we not treating the disease of addiction and the disease of drug addiction in the same way? Kunal Kishore, who is the project coordinator of prevention programs at the UNODC regional office in Delhi, gave feedback on the importance of funding from AusAID. South India is celebrating 10 years of direct aid from Australia for harm reduction and prevention programs. The Maldives also reported how important Australia had been in training experts and providing policy advice in health, leading to a growth in harm reduction programs.

[Member's time extended.]

Mr J.N. HYDE: One of the worrying aspects was reports from non-government organisations operating in Cambodia that harm reduction was being downplayed as a magic ginseng detoxification cure that had been brought in from Vietnam by some people with strong financial links and that this was forming the base of government policies. NGOs are not getting the same cooperation that they previously had been getting in Cambodia, and so their view is that Cambodia is no longer tolerating harm reduction strategies. There is an important message about how a change in government or a change in government policy can lead to a real deterioration in health outcomes. In Myanmar—as we stand by and let the junta have its illegal so-called election later this year—the rate of HIV acquired through sexual transmission by drug users is 67 per cent. It is estimated that there are 475 000 drug users in Burma, and, of those, 75 000 are intravenous drug users—a prevalence in that small cohort of 43 per cent. In Burma, drug users are excluded from HIV-AIDS services if they mention that they are using drugs or if their drug use is known.

Probably one of the greatest speakers at the conference was Datuk Zahman, who had been a very senior policeman in Malaysia. He was a very tough-on-crime, zero-tolerance policeman who was moved sideways by the government into running the prison system. After dealing with the locking up of and summary justice for criminals for 30 years, he suddenly got to go into prisons and saw just what prisons were doing regarding drug use. As the director of prisons, he changed the whole attitude towards drug use. Drug use within prisons in Malaysia was seen to be a health issue. Again, this replicates the situation in Vietnam. Vietnam has a very hard legal code for drug traffickers, but that is separated from the issue of drug users—drug use being seen as a health issue. Vietnam has introduced and is funding methadone replacement within community centres, and there is less use of a centralised compulsory centre. Vietnam is seeing its figures for drug use, including drug use within prisons, go down drastically. Therefore, both Thailand and Malaysia are moving drug treatment towards public health models.

One of the members of Parliament from India, Oscar Fernandes, said, accurately, that drugs are a scourge, that drugs have led to the spread of HIV and that the priority must be to treat drug addiction non-criminally. Later this year India will be introducing decriminalisation legislation.

One aspect of the “Response Beyond Borders” conference was that it was one of the first major conferences that had parliamentarians and drug users working equally, so we were able to get the perspective of drug users, and drug users were able to get the perspective of parliamentarians and policymakers. What came through time and again was that prevention and treatment—all services for drug users—have to be accessible, they have to be voluntary, they have to be comprehensive, they have to be evidence based and they also have to be compassionate. Hepatitis C is a huge, growing issue, even here in Western Australia. We know that with a 20-year time lag on hepatitis C, the real explosion in hepatitis C cases here in WA will not be seen until most of us have left Parliament.

Doctor Tariq Chaudhry is an MP in Pakistan. His overview of 20 years’ work was that the lack of community involvement in some countries such as Pakistan and an over-focus on non-evidence-based services had held back treatments and good health outcomes. However, he said that we need to be able to put harm reduction in context for MPs, and MPs must be able to harmonise public health, public security, human rights and development approaches. The key message to come through was that for MPs to be able to successfully advocate for harm reduction, they need, firstly, solid, credible, convincing arguments; secondly, models that have worked; and, thirdly, evidence based on good data.

The confusion between some non-government organisations that are purely advocacy groups and other non-judgemental groups that are involved in the health outcomes and harm reduction is also evident. We need to deal with that issue. Having been parliamentary secretary to the Minister for Health in Western Australia, it was really interesting that, in the Asian context, there was perhaps a greater understanding that

advocacy had to go hand in hand with getting the health outcomes right. AusAID implemented a new strategy last year that reinforced harm reduction, and it is funding major projects in Indonesia and South Asia. It was wonderful to listen to Sumatran Muslim female members of Parliament and doctors talking about the importance of AusAID and harm reduction strategies.

It is important that this government, which has been in power for almost two years and is looking at making changes to drug legislation this year, talks to the Minister for Health and the independent experts in the Drug and Alcohol Office who know that harm minimisation works and that criminalising drug use does not work. We can refer back to the 1909 International Opium Commission, since which we have had 100 years of punishment based prohibition and deterrence to drugs, which has not worked. Drug use has never been stronger across the world, and it has never been cheaper to obtain drugs.

I am sure that when we get to this legislation later in the year some people in this chamber will raise the issue of if the source of drugs is removed, the problem will clear up. There is only one place in the world where removing the source of drugs has worked, and that was in one of the Latin American countries, where they had a huge, huge crackdown on cocaine; it totally went from being a cocaine-using community to becoming a heroin-using community. In early 2009, Portugal brought in major harm reduction policies, and what some people would call decriminalisation; the result has been a huge drop in people being sent to prison, a huge drop in heroin deaths, and a huge drop in associated health problems. All the research has told us that every dollar spent on methadone saves \$25 on health treatments. If the government is really dinkum about cutting the health budget in this state, it would look at more prevention strategies, particularly for drug use, which would result in a decrease in spending on crime reduction.

I have referred to this conference in this speech because of the Premier's Statement today, which ignored the harm that drug use can do to users, their families and our society. The Premier's Statement ignored the evidence that criminalising drug use and imposing harsher penalties does not minimise crime. Illicit drug offences continue to be the largest offence type in WA, with 496 indictment lodgements for the year ended December 2009—an almost 17 per cent increase on the previous year. That increase occurred under the tough-on-talk rhetoric reign of the Barnett government, yet in the Premier's speech today he congratulated himself, stating — Western Australians gave this Government a mandate at the 2008 election to reduce antisocial behaviour and crime in this State. We have accepted that challenge and the results so far are positive.

In the first full year of government there was an 8.5 per cent drop in overall reported offences against the person and property.

No mention is made there of the biggest driver of offences, which is illicit drug offences. The same government that does not understand the problem wants the WA community to trust it to solve the complex issue of drug use.

I refer to the current inquiry of the Education and Health Standing Committee into the adequacy and appropriateness of prevention and treatment services for alcohol and illicit drug problems in Western Australia. I will refer quickly to a submission from Mission Australia. It recommends that the evidence base, content, implementation and resourcing, including teacher training for health education and other interventions on alcohol and illicit drugs for school-age students, must be adhered to and increased. Mission Australia is recommending harm minimisation. It wants support for early intervention and prevention programs for young people experiencing family alcohol and other drug issues in both regional and metropolitan WA. Mission Australia's argument is that harm minimisation focuses on the reduction of any harm arising from drug use and that this approach realistically recognises that young people will try to use alcohol and drugs and aims to minimise the risks to them by providing accurate information about possible harm. Clearly, this state must reinforce its policy in support of harm minimisation.