



FRAMEWORK RELEASED

YEARS IN THE MAKING

2006:

1 The National NSP Policy and Practice Forum, convened by Anex comprising government and service representatives, discussed and endorsed the need for a strategic framework.

2006:

2 A Council Of Australian Governments (COAG) state and territory multi-lateral group meets. The Pharmacy Guild of Australia and its branches held a side-meeting which supported the need for a framework to encourage consistent NSP standards amongst pharmacies.

2007:

3 Australian Government Department of Health and Ageing (DoHA) agreed to fund Framework development as a project managed by Victorian Department of Human Services. Public tender issued and awarded to Anex for implementation with expert advice from Professor Steve Allsop (National Drug Research Institute), Professor Lisa Maher (National Centre in HIV Epidemiology and Clinical Research) and Professor Robert Power (Burnet Institute).

2008:

4 Anex convened a Project Steering Group with representation from the Australian, Victorian, NSW, Northern Territory and Queensland governments, as well as the Pharmacy Guild (Qld & Vic), Australian Injecting and Illicit Drug Users League (AIVL) and the Australian National Council on Drugs (ANCD).

Mid-2008:

5 Discussion paper distributed by Anex, followed by consultations with stakeholders in all capital cities. Written submissions from police, drug treatment and pharmacotherapy and users' organisations also informed direction.

2009:

6 Anex releases draft for consultation. Final approval by Project Steering Group, ending Anex's work on the Framework.

2009:

7 Draft Framework then discussed and further changes made through the COAG multi-lateral working group and submitted to DoHA.

Dec 2010:

8 Framework released by DoHA.

Nationally accredited core training for staff is one of seven key priority directions in Australia's first ever national framework for needle and syringe programs (NSPs).

Released in December 2010 by the Australian Government Department of Health and Ageing, the National Needle and Syringe Programs Strategic Framework 2010-2014 articulates the programs' goals for the next four years.

The Framework is designed to strengthen the links between services and across different states and territories to promote a coherent and evidence-based approach to the provision of NSP services.

The Framework document recognises that a consistent national approach to workforce training and development will improve the overall quality of service. Seven key result areas are identified through the Framework. It has been developed in consultation with a wide range of stakeholders across Australia – including Anex, state and territory health departments, and frontline services.

1. National standards

At present, there are no national benchmarks for NSPs. A set of universal minimum standards is proposed to be developed to ensure consistency across primary, secondary and community pharmacy NSPs to improve service planning and help identify any service gaps.

2. Increased availability of injecting equipment

The Framework aims to increase the availability of needle and syringe equipment by increasing NSP hours and sites, including syringe vending machines. In addition, less restrictive policies are encouraged regarding the amounts and range of injecting equipment and syringe equipment available at NSPs.

3. Data collection

Improved data collection and reporting systems, including a proposed nationally-consistent dataset, will help identify who is accessing NSPs and gaps in service delivery, while an independent agency will undertake a yearly analysis of data.

4. Peer education

Strengthen the evidence base for peer education.

5. National core training areas for NSP workers

A national training model for NSP workers is recommended to allow staff to feel skilled and supported to effectively engage with injecting drug users. Such training would encourage consistency and maintain a professional and effective workforce in primary, secondary and pharmacy NSPs and include an understanding of drug use, non-judgemental attitudes and

knowledge of the broader service system at basic, intermediate and advanced levels.

Training of NSP workers is seen as a critical and challenging issue, particularly for those in secondary and pharmacy NSPs where these duties are not their main role. These workers may not have NSP qualifications or training, or understand the full benefits of the service, the Framework notes. The Framework recognised that it is essential that these staff are aware of the public health benefits of the service, feel confident with clients and are able to refer them onto other services when required.

6. Improved referral to health and welfare services

The Framework recognises that NSPs are an important point of contact for referral to other healthcare services designed to meet the needs of injecting drug users. Acting as a gateway, NSP services provide referral opportunities for prevention, health promotion, treatment, welfare and housing. Referral should be available on all occasions of service and be undertaken both proactively and in response to client requests. The Framework calls for establishment of links with local health services to support referrals.

7. Improved and expanded evidence base for NSPs

The Framework recognises the crucial role that evidence plays for NSPs. The Framework's stated aim is "to regularly assess the effectiveness of NSPs through evaluation of the direct and indirect effects of NSPs and their impact on the prevention of drug related harm."

It recognises that improvement of the evidence base for NSPs will inform best practice in the prevention of blood borne viruses and sexually transmitted infections.

Future Challenges

A series of challenges and risks are identified in the Framework:

Integration of the NSP sector to general health is identified as a long term challenge. Integration is recognised to have greatest impact with (but not limited to) mental health (including homeless populations), alcohol and other drugs, youth work, indigenous health, sexual health and pharmacies. The Framework recognises that integration at policy level needs to be integrated into policies around injection safety and sharps management. Aligning NSPs across jurisdictional boundaries legislatively was seen as a challenge, as is the integration of community pharmacies. Injectors with mental health problems, injectors who are gay, those who are young and indigenous injectors were identified as particularly difficult groups to engage with.

Risks that are identified include inappropriate syringe disposal fuelling local opposition to NSP services, the gap that exists for prisoners who inject in prison, issues with the ability of the program to engage on Hepatitis C Virus (HCV) prevention, workforce development limitations and the impact of budget constraints.

The full version of the National Needle and Syringe Programs Strategic Framework 2010-2014 can be downloaded at: <http://www.health.gov.au/internet/main/publishing.nsf/Content/needle-frame>

Anex's vision is for a society in which all individuals and communities enjoy good health and well-being, free from drug-related harm. A community-based, not for profit organisation, Anex promotes and supports Needle and Syringe Programs (NSPs) and the evidence-based approach of harm reduction. We strive for a supported and effectively resourced NSP sector that is perceived as part of the solution to drug-related issues.

Chief Editor
John Ryan

Editor
Dr Patrick Griffiths

Writers
Kelly Eng
David Grant
Dr Patrick Griffiths

Correspondence
Anex: Bulletin
Suite 1, Level 2,
600 Nicholson Street
Fitzroy North VIC 3068
Australia

Telephone: 61 3 9486 6399
Facsimile: 61 3 9486 7844
Email: info@anex.org.au
Website: www.anex.org.au

Layout and Design
Kontrast Design

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L&R Print Services

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PRESCRIBED OPIATES: the position in Australia

In 2004, an estimated 3.1 percent (0.6 million) of the Australian population aged 14 years and over reported that they had used pain killers for non-medical purposes. In 2007 this figure was 2.5 percent. [7]

There has been a substantial increase in prescription opioid use in Australia in recent years. There was a 40-fold increase in oral morphine supply between 1990 and 2006, and a nearly four-fold increase in oxycodone supply between 1990 and 2003.

Much of the demand for prescription opioids has been attributed to chronic non-malignant pain. The condition is common (experienced by an estimated 20 percent of the population) and is expected to increase with an ageing population.

In some parts of Australia (for instance Tasmania), prescription opioids are the main opioid used illicitly^[8], reflecting scarcity of heroin, poor regulatory control of pharmaceutical opioids and/or inadequate provision of treatment for dependent opioid users.

Illicit use of pharmaceutical opioids brings with it the risk of overdose, adverse events from injecting pharmaceutical drugs (such as systemic infections, respiratory fibrosis and loss of fingers and limbs) as well as blood borne viruses including hepatitis C, hepatitis B and HIV.

The Australian Chapter of Addiction Medicine in the Royal Australasian College of Physicians released a Prescription Opioid Policy in 2009 that seeks to improve the management of chronic non-malignant pain and prevention of problems associated with prescription opioid use.

The policy document opens with a quote attributed to the Honourable Justice Williams in the 1980 Australian Royal Commission of

Inquiry into Drugs where he concluded that "... any rational community action to limit the abuse of drugs must embrace all drugs, not merely those classified as illegal. The case for including legal drugs in any overall strategy aimed at minimising drug abuse is based not only on the seriousness of the problems associated with the abuse of these drugs, but also on the fact that the abuse of any one drug tends to be 'all of a piece' with the abuse of all drugs, legal and illegal alike."

The policy aims to target medical professionals, health departments and professional organisations responsible for the development, implementation and dissemination of evidence-based guidelines.

“Much of the demand for prescription opioids has been attributed to chronic non-malignant pain. The condition is common (experienced by an estimated 20 percent of the population) and is expected to increase with an ageing population.”

The policy recognises three overlapping markets for prescription opioids – 1) patients who have malignant pain, 2) patients who have chronic non-malignant pain, and 3) people who use opioids in unsanctioned ways (both problematic and illicit users).

The policy states that: "There is now good evidence that treatment of opioid dependence, whether arising from street heroin or prescription opioids, with opioid substitution treatment (OST) is generally effective. Well managed OST reduces illicit opioid drug use, achieves excellent retention, decreases criminal activity, reduces the risk of blood-borne virus transmission, and improves social functioning."

The recommendations contained in the policy are:

1. National expert advisory group to develop a coordinated approach to improve the management of chronic non-malignant pain and to reduce the unsanctioned use of pharmaceutical drugs. The formation of an expert group to lead the development of a national strategy is proposed.
2. Develop a set of guidelines that are primarily appropriate and useful for general practice. Guidelines need to incorporate a nationally standardised process for the assessment and management of patients with chronic non-malignant pain.
3. Enhance clinical practice particularly at the primary health care interface. Primary care settings were identified as pivotal points where pain patients have their first medical encounter.
4. Improve information systems. The development of a web-based, confidential and real time monitoring service was identified. This will enable prescribing doctors and dispensing pharmacists to monitor prescriptions, provide more safe and cost-effective health care, and for government to monitor the overall use of these medications and evaluate the effectiveness of policy and other interventions.
5. Regulation and control. Strategies need to be standardised across jurisdictional boundaries.
6. Minimising unmet demand for opioid substitution therapy (OST). There needs to be support for an adequately sized, appropriate resourced variety of OST options for the treatment of heroin and other opioid dependence. This will reduce the diversion of pharmaceutical opioids onto the black market.
7. Training and research. Medical colleges need to ensure that there is a strong commitment by medical practitioners for continuing medical education and research.

news brief: NATIONAL TOBACCO CAMPAIGN 2011 KICKS OFF



Every cigarette you don't smoke is doing you good.

The Australian Government has launched a \$61 million program to help Australians give up cigarettes as part of its efforts to tackle tobacco smoking.

Tobacco smoking has been one of the single largest causes of premature death and disease in Australia. Smoking kills more than 15,000

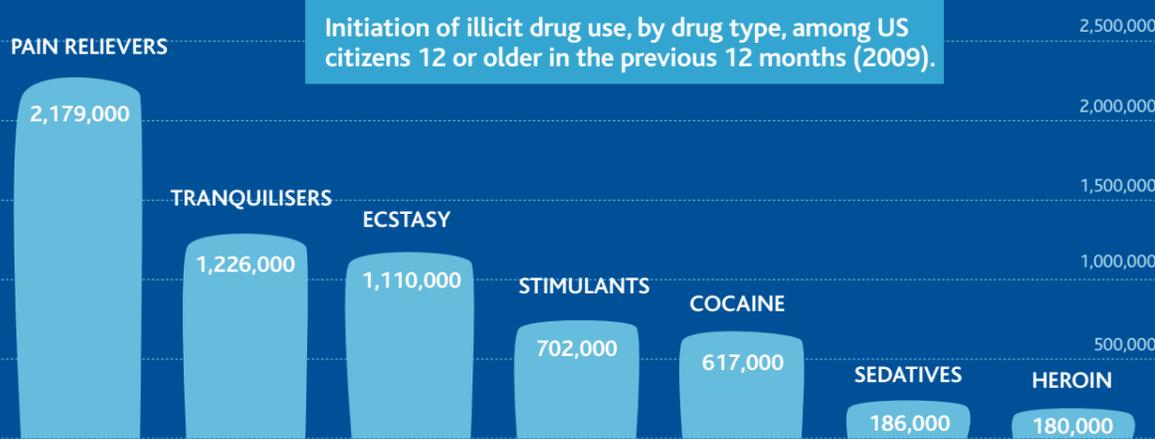
Australians each year and is estimated to cost the economy \$31.5 billion per year in social costs, including \$5.7 billion per annum attributed to absenteeism and a reduction in the workforce.

While smoking prevalence in Australia has declined over time, rates of daily smoking remain too high at 16.6 per cent of those aged 14 or older.

To learn more visit: <http://quitnow.info.au>

US and Canada Face Epidemic of Prescription Pills

"The drug supply in this new epidemic is a short chain connecting physicians and patients to non-medical prescription drug consumers. In contrast to the picture 40 years ago, today many of the non-medical drug consumers are medical patients, harkening back to the picture of opiate addiction at the end of the nineteenth century, before the Harrison Narcotics Tax Act of 1914, when most opiate addicts obtained their drugs from physicians or bought them from street peddlers, pharmacists, or through mail order catalogues." - Robert L. DuPont, MD



The United States of America and Canada are in the grip of an epidemic of prescription drug overdose that is confounding the traditional approach to dealing with drug use management, and which demands new approaches from medical practitioners, those that develop and market prescription drugs, law enforcement and drug educators [1-3]. While the situation is dire, it does provide some pointers for how Australia might deal with our own escalating prescription opioid problem.

Scale of the problem

According to the National Center for Health Statistics within the US Centers for Disease Control and Prevention:

- From 1999 through 2006, the number of fatal poisonings involving opioid analgesics more than tripled.
- Opioid analgesics were involved in almost 40 percent of all poisoning deaths in 2006.
- In 2006, the rate of poisoning deaths involving opioid analgesics was higher for males aged 35-54 years, and non-Hispanic white persons than for females and those in other age and racial/ethnic groups.
- In approximately one-half of the deaths involving opioid analgesics, more than one type of drug was specified as contributing to the death, with benzodiazepines specified with opioid analgesics most frequently.
- The age-adjusted death rate for poisoning involving opioid analgesics varied more than eight-fold among the states in 2006.

To put it another way, dramatic increases in non-medical use of pharmaceutical drugs, particularly opioid analgesics, meant that in 2006, drug-induced overdose deaths in the US reached a high of more than 38,000.

"Overdose deaths have now surpassed the annual number of automobile crash fatalities in 16 states, are more than double the annual number of murders nationwide, and are greater than the annual number of suicide deaths" [1].

The situation is not much better in Canada where reports indicate that the number of annual deaths related to oxycodone use in Ontario increased five-fold between 1999 and 2004, and that there was a 41 percent increase in all opioid-related deaths (i.e. deaths from prescription and illegal opioids).

Oxycodone is not the only drug that features in these overdoses; other formulations have been reported included codeine, fentanyl, hydrocodone and methadone.

From pain management to overdose

So how it is that northern America is witnessing such sharp rises in overdose deaths? National data indicate that the non-medical use of psychotherapeutics has increased substantially since the mid-1990s. This is a reflection of the dramatic increases in the number of prescriptions, in particular for opioid analgesics, issued by doctors to treat pain [2].

Data from both the US and Canada shows that there is a relationship between the increase in the volume of oxycodone prescription and the rise in mortality from overdoses. In the US the Drug Abuse Warning Network (DAWN) surveillance system has gone further by suggesting that increased medical use of opioid analgesics is associated with increased abuse.

The 2009 US national survey into illicit drug use found that approximately seven million, or 2.8 percent of the 12-or-over population, were current non-medical users of psychotherapeutic drugs [4]. This is more than the total number of people who abused cocaine, heroin, hallucinogens, MDMA and inhalants combined.

"The highest rate of abuse of psychotherapeutics occurred among young adults aged 18 to 25, with nearly one third reporting use at some stage of their life. In addition, of the 2.9 million persons who used an illicit drug for the first time (reported in 2008), 29.6 percent initiated illegal drug use by using psychotherapeutics [1]. Since 2005, the number of individuals each year who initiated use of psychotherapeutics has surpassed the number of marijuana initiates."

"The non-medical use of prescription drugs is an ongoing problem among young persons. In 2008, 4.7 percent of high school seniors used OxyContin® for non-medical purposes, 9.7 percent used Vicodin®, 5.8 percent used sedatives, 6.2 percent used tranquilisers, and 2.4 percent used Ritalin®" [5].

In 2009, it was estimated that there were 584,000 "new initiates" to non-medical use of OxyContin®, compared with an estimated 180,000 who used heroin for the first time within the 12-months prior to survey [4].

‘The non-medical use of prescription drugs is an ongoing problem among young persons. In 2008, 4.7 percent of high school seniors used OxyContin® for non-medical purposes, 9.7 percent used Vicodin®, 5.8 percent used sedatives, 6.2 percent used tranquilisers, and 2.4 percent used Ritalin®’

Increases in prescription

The increases in prescribed pain medication seen in the US are nothing short of staggering. A report from the National Center on Addiction and Substance Abuse (CASA) found that from 1992 to 2002 the number of prescriptions for controlled drugs increased 154.3 percent. From 1997 to 2007, the number of prescriptions increased 72 percent; in this same time, the US population grew 11 percent [1].

The number of opioid prescriptions increased 59.5 percent from 1994 to 2003. As prescriptions for controlled substances – especially for opiates – increased, the number of people abusing prescription drugs and the indicators of problems generated by non-medical use of these pharmaceuticals increased.

Possible solutions

The continuing epidemic of pharmaceutical opioid prescription and overdose has generated discussions in the US and Canada about the best way to approach the complexity of issues involved [6].

Getting experts together – the research and medical communities

need to work together to devise ways of engaging with drug users and measuring both the level and impact of non-medical prescription drug use.

National public education campaigns – the nature of the epidemic in the US has been met with calls for a national education campaign directed at the general public and physicians.

Patients, particularly young people, need to be aware of the drug

harms associated with using prescriptions except as intended. The legal implications for diversion of prescription medications also need to be considered. Messages around the safe handling, storage, and disposal of opioid medication are also warranted.

Specific guidelines need to be developed for doctors to ensure proper procedures and education when prescribing opioid medication.

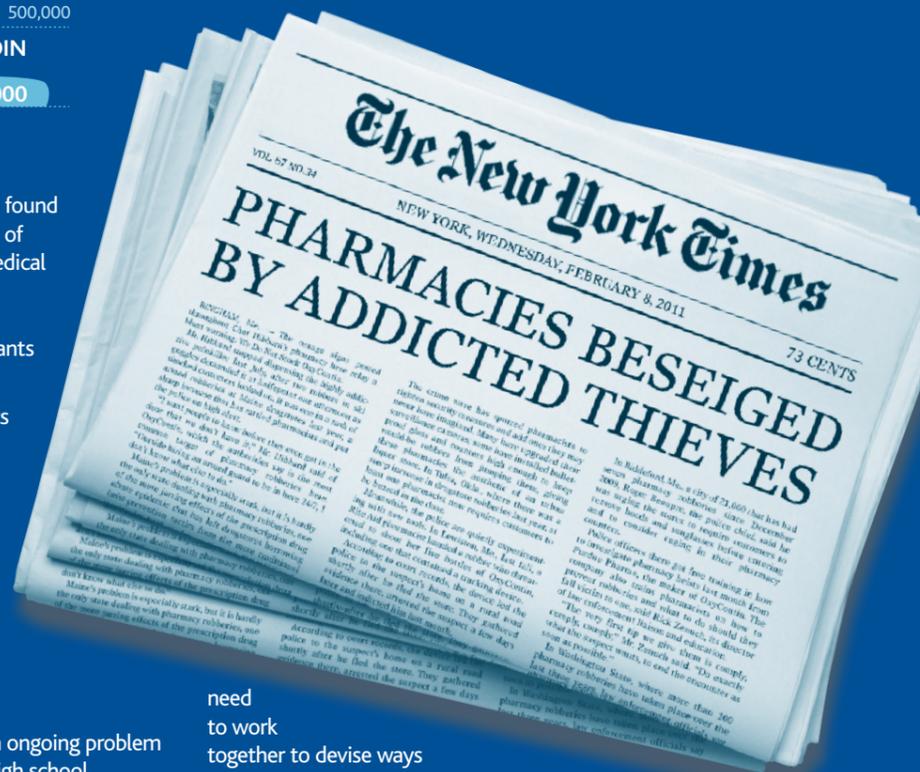
Devising new drug formulas – the development of unique abuse-resistant delivery systems of prescribed controlled substances is an approach to reduce unintended uses of prescription drugs while still ensuring legitimate therapeutic use.

Improved prescription monitoring – prescription drug monitoring programs are one way to reduce the chance of doctor shopping and reduce the chances for diversion.

Improve treatment – new ways of engaging with those dependent on pharmaceutical opiates should be considered.

(This article is based on the following paper: Prescription Drug Abuse: An Epidemic Dilemma, Robert L. DuPont, Journal of Psychoactive Drugs; June 2010; 42, 2).

SEE STRATEGY TARGET PILLS - PAGE 6.



WHERE THERE'S A WHEEL THERE'S A WAY

Tasmanian researchers have investigated the efficacy of wheel filtering based on injectors of pharmaceutical opioids' accounts of preparation, filtering and injecting techniques.

Lead researcher, Dr Raimondo Bruno, said that particles as small as 10 micrometres (about one tenth of the width of a human hair) can block the smallest blood vessels in the body and cause harm. Larger particles block larger vessels and are correspondingly harmful.

Tablets of morphine (eg: MS Contin®) are commonly used by injecting drug consumers in Tasmania, he said.

"It is not possible to prepare an injection to pharmaceutical standard without clean facilities, as particles and micro-organisms from the environment will contaminate the preparation," he said.

"We wanted to know how people filter morphine for injection, whether these methods are useful in removing particles, and whether they affect the amount of morphine received," Dr Bruno said.

"We surveyed 260 injecting drug users in the Hobart area to determine the filtering methods they applied on their last occasion of morphine injection. The survey revealed that, on their last occasion of morphine injection, one third used no filter, 41 percent used cigarette filters and 21 percent used syringe filters," he said.

"People typically prepared tablets by removing the tablet coating, crushing them and stirring the powder in cold or heated water. While many people did not filter at all, common filters included hand-rolling cigarette filters, cotton balls and commercial syringe filters (0.45 or 0.22 micrometres)," Dr Bruno said.

"One reason IDUs do not filter their injections is a belief that some of the dose will be lost in the process. We found that this

need not be the case, since by rinsing the filters, the morphine could be recovered without significant loss," he said.

Samples were prepared using hot and cold methods and before and after filtering. The number and size of particles in each sample was determined by examining the solution under a microscope.

The key findings

Unfiltered solutions of morphine were cloudy with visible particles and estimated to contain millions of particles large enough to block blood vessels.

Morphine content was largely unaffected by any filtering technique, provided that the filters were rinsed with small amounts of extra sterile water to recover any solution held up in the filters.

The roll-your-own cigarette filters and cotton balls produced cloudy solutions. Those cigarette filters removed most of the very large particles, but had limited effect on smaller particles.

Commercial syringe filters tended to produce solutions that looked clear to the eye, but they blocked easily. Virtually all of the particles from the tablet were removed if solutions were first filtered using a cigarette filter, and then filtered again by a commercial syringe filter.

The finding that the problem of blocked filters was removed by a simple pre-wheel filtering step (using roll-your-own cigarette filters) is a good example of the importance of the requirement for educating IDUs about the most effective use of these filters, rather than solely providing the equipment, Dr Bruno said.

If the filters were rinsed with a small amount of sterile water at each stage, there was no change in the amount of morphine recovered by this two-step filtering process. While the solution looked perfectly clear there were still some particles large enough to cause harms, but this is similar to the level seen in the control solutions (sterile water only).

Preparing the tablets by heating them produced a new set of problems, Dr Bruno said.

"Some of the waxy components of the tablet would melt due to the heat, and could be passed through the filter if the solution was even slightly warm," Dr Bruno said. "While the solution cooled, these waxy parts re-solidify and are liable to cause harm."

Heating should therefore be avoided, the study found. Hot preparations did not contain more morphine than preparing injections without heat.

Syringe filters (0.45 or 0.22 micrometres) can remove the vast majority of particles, but they tend to block easily unless a coarse filter, such as a hand-rolling cigarette filter, is used first.

If the filters are rinsed with a small amount of sterile water at each stage, very little of the morphine is lost in the process, Dr Bruno said.

None of the filtering techniques could produce perfectly particle-free solutions that would achieve the medical standard required to be considered safe. However, the harms from injection of these tablets are substantially reduced by a combination of an initial coarse filter and a syringe filter.

The finest syringe filters (0.22 micrometres) are preferable as they can remove bacteria that cause infections around injection sites and internally. Skin preparation with an alcohol swab is also essential to minimise the infection risk.

The study had potential implications for NSPs, he said, including the recommendation that all NSPs product range should be extended to include at least 0.22 sterile syringe filters capable of filtering crushed tablet extracts in a single operation. NSPs should also provide information on how to use filters correctly.

Access far from consistent

Filters are not always available as standard distribution across the NSP networks nationally, and different NSP services will provide various sized filters.

Injectable solutions prepared from pharmaceutical tablets, such as morphine, contain not only the active ingredients, but also other inactive components such as talc, cornstarch and wax.

Although wheel filters can remove microorganisms and other particles when used properly, an experienced NSP worker from an inner-city service told the Bulletin that, in her experience, there "is a concern among some drug users that filters complicate the injecting process".

The NSP worker said: "Those who are unfamiliar with wheel filters for example, have told me that if the wheel filter was to become detached from the syringe while they are pushing the drugs through, then some or all of the contents could be spilt. If that occurred, then naturally they lose their drugs.

"Some people think that filtering contributes to dose loss even without a spillage; that is, some of the active ingredient getting stuck in the filter itself. In other words, there may be less bang for the scarce buck. Of course, if they are using the right filter correctly there is little or no risk of dose loss," she said.

"But you can appreciate why people who've gone to a fair bit of effort financially and time-wise to arrange their gear don't want to miss out on anything," she said.

Another NSP worker who is skilled at instructing clients on correct filter set-ups said some clients have complained of their mix being stuck or blocked by a filter.

"When the filters are used correctly, including sufficient diluting of drugs, this shouldn't be the

case. Leur Lock* barrels, which are screwed on, greatly reduce the likelihood of the filter coming off. In fact it's virtually impossible," he said.

ACT Directions NSP co-ordinator in Canberra, Ms Tammy Waters, said ACT Health funds filters and their availability greatly reduced incidences of vein-care related problems in clients.

Clients can receive up to six filters per day free of charge, but 12 on Fridays "so they won't run out on the weekend", Ms Waters said.

"In an ideal world, nobody should shoot up pills. But it happens. Wheel filters are one of the best harm reduction strategies to come out in a long time. People's health improves dramatically. Years ago we had people losing limbs and getting abscesses – it was shocking," Ms Waters said.

"But now there is far, far less of that. It's a real health benefit for clients to have access to this. It is well worth the investment by the government," she said.

"We have long-term diverted methadone users, for example, who were showing health problems from injection. When they use filters their health has improved dramatically," she said.

Ms Waters said: "We have the Sartorius® filters, starting at 5.0 microns for chalky pills such as MS Contin® and for when clients may be using quite large volumes of pills. Then we go down to the 1.2 microns which is also for chalky pills, but for a lower volume such as 'eccies' or dexamphetamines.

"We recommend that they run them through a series of filters if they are using big quantities. We also have the 0.8, which is more for pills covered with wax such as benzodiazapams, valium or Ducene® etcetera," she said.

"Then we have the 0.2 - our anti-bacterial filter which we recommend for most things such as heroin, cocaine, methamphetamines. And also for diverted methadone or bupe," Ms Waters said.

Ms Francine Smith is responsible for Tasmania's NSPs within the Department of Health and Human Services. She said filters were "particularly important in Tasmania because of the high rate of injecting using prescription medication such as morphine, methadone and dexamphetamines."

In Tasmania, pharmaceutical opioids were reported as the "last drug injected" by more than a quarter of people who completed the national NSP survey in 2009^[8].

This compared with the national average of 16 percent in 2009, and is far higher than in NSW, for example, where pharmaceutical opioids were reported as the last drug injected by 10 percent in 2009.

TasCAHRD's Ms Mandy Wilton said: "Primaries in Tasmania receive a set amount of eight boxes of 50 filters per month. Some outlets, like ours at TasCAHRD, do sell them on a cost-recovery basis in addition to what consumers receive for free – our outlets charge \$1.10 per filter."

FILTERS: A GUIDE FOR FRONTLINE WORKERS

The following information has been compiled to assist frontline NSP workers understand wheel filters and when and how they are used. The wheel filter measures mentioned below are in microns. A micron is a metric unit of length equal to one millionth of a metre.

WHICH FILTER?

There are quite a few different sizes around. These sizes are a guide only.

0.2 micron wheel filter

The only filter that removes bacteria! Good filter for bake or homebake, crystal amphetamine (white speed), methadone liquid or cocaine.

1.2 micron wheel filter

Suitable for most substances, including MS Contin®, Subutex®, Kapanol®, OxyContin® and amphetamine sulphate (brown or discoloured speed).

5.0 micron wheel filter

This is a big one intended to get rid of the chalk from prescription tablets like benzos, dexamphetamines, physeptone and other recreational drugs like ecstasy. Proceed to the smaller filter after this one.

Illicit Drug	Pre Filter	Filter	Final Filter
Methamphetamines (Ice, Speed, Meth)			0.2
Heroin			0.2
Cocaine			0.2
Ecstasy	5.0	1.2	0.2
Non-illicit Drug			
Buprenorphine (Bupe, B, Subutex®)	5.0	1.2	0.2
Methadone (Done, Biodone)	5.0	1.2	0.2
OxyContin®	5.0	1.2	0.2
Morphine-based pills, MS Contin®, Morphine, Morph, Kapanol®	5.0	1.2	0.2
Physeptone		1.2	0.2
Dexamphetamine (Dexies)		1.2	0.2
Ritalin® (methylphenidate)		1.2	0.2
Pethidine®		5.0	1.2
Benzodiazepines, Diazepam (Valium®, Ducene®), Oxazepam, Alodorm®, Mogadon®, Temazepam (Normison®, Euhypnos®, Temaze®)	5.0	1.2 or 0.8	0.2



THE FILTERING PROCESS FROM A USER PERSPECTIVE:

Step 1. Wetting (Priming) the Filter

- Draw up small amount of water into the mixing barrel.
- Peel back the cover from filter package.
- Carefully push barrel into the filter (but not so tight that you can't take it off again).
- Point the barrel and filter upwards and slowly push the plunger until a bead of water appears. This wets (primes) the filter ready for use.
- Remove wheel filter and place back in filter package taking care not to touch the end of the filter.

Step 2. The Mix

- Crush pills as finely as possible between two spoons. Prepare the mix with at least 3ml of water per pill.
- Use the plunger end from the filtering barrel to mix the water and pill.
- Wash hands with soapy water &/or swab finger tips before making a cotton filter. This is to filter out unwanted larger particles.
- Attach the 19g tip (needle) to the 10-20ml filtering barrel, then draw up mix into barrel.

Step 3. Pre-loading

- Take the 19g tip off the filtering barrel and place the primed wheel filter back on the barrel.
- Dispose of the used tip safely.
- Attach the 25g tip to the other end of the wheel filter and remove the safety cover.

Step 4. Loading

- Pull the plunger back on the 5ml injecting barrel, but leave it in the barrel. Do not have the tip attached.
- Insert the 25g tip on the 10-20ml barrel (with wheel filter attached) into the injecting end of the injecting barrel.
- Slowly squirt the mix into the injecting barrel.
- Attach a new 27g tip to the injecting barrel.

Step 5. Injecting

- Wipe the injecting site once in one direction with an alcohol swab.
- It is now ready to be injected.
- Dispose of everything safely after use.

PRACTICAL TIPS

Promote cleanliness - washing hands

Encourage cleanliness through the use of swabs or similar. Encourage the use of new sterile injecting equipment.

Filters should only ever be used once

Encourage consumers NOT TO put warm or hot liquids through filters because waxes pass through them when warm or hot, and hot liquids destroy the filter membrane. Pushing liquids through filters is easier than pulling through or drawing up.

Equipment involved in filtering:

Equipment used:

Two barrels - 3ml, 5ml, 10-20ml for filtering & 5ml injecting

Needle tip for drawing up - (19g)

Needle tip for loading injecting barrel - (25g)

Needle tip for injecting - (27g) or a butterfly (orange 25g)

Wheel filters - (see chart)

Alcohol swabs - plenty

Something to crush pill - eg 2 tablespoons

An initial filter for large particulate matter (cotton wool/roll-your own cigarette filter)

"We have the 0.22 and the 0.45. The 0.22 is the bacterial filter and the 0.45 is the purpose-designed pill filter," Ms Smith said.

Ms Carol Holly from SAVIVE in South Australia said they sell a wide range of filters (including Sterifilt®) at cost recovery.

"We have a variety starting from 0.2 microns up to five microns. So that's the 0.2, 0.45, 0.8, 1.2, and 5.0. The larger filters, such as the five, would be for larger amounts where the client would remove larger particles first before scaling down to the smaller sizes, such as 0.22, to get rid of smaller particles," Ms Holly said.

Victoria does not provide specific funding for filters, but syringes with Luer Lock* technology, which accommodate commercial filters, are distributed to NSPs. Without set funding for filters, there is some variation amongst the primary outlets concerning price and promotion.

At Healthworks in Melbourne's western suburbs, 0.45 and 0.22 filters are sold for \$1.20, and Sterifilts® for 30 cents. According to NSP worker, Mr Chris Howie, their "usage has increased a bit in recent times, but they are still not widely used."

It is a situation that Healthworks would like to change, according to Mr Howie: "We think it's a

bit of a new frontier that we need to work on in regards to reducing more harm, because we are doing well with blood borne virus prevention, but there are still some harms being done with poor filtering which can lead to vein injuries."

Healthworks ran a campaign in 2010 where filters were given out for free and staff gave lessons in how to set them up.

"We are looking at having some more campaigns later this year, and have workshops where the clients can sit down with staff and get practice at using them so they can become more confident. Hopefully, the people we teach can pass on the knowledge to their peers," Mr Howie said.

Barwon Health, which includes the regional city of Geelong, gives out far fewer filters, according to NSP co-ordinator, Mr Joe Kim.

"We give out Sartorius® 0.22 and 0.45. We can give them away for free at the moment because the numbers are quite low - about only 20 per month because there has not been a history of promoting them in our service," Mr Kim said.

"If demand was to go up as more people know about them then we'd probably have to look at charging, perhaps about \$1.20," he said.

A pharmacist in Newtown in Sydney, Mr Grant Ovens, has joined a Pharmacy Guild (NSW) program aimed at further increasing the private sector's participation in overall harm reduction strategies.

Mr Ovens is particularly in favour of offering filters as part of a full range of equipment. "We have 0.2 and the 1.2 filters, which seem to be the ones most people want. I will expand it to other sizes," Mr Ovens said.

"We do barrels and butterflies as well. We are aiming to be a one-stop shop. It fits in with my personal philosophy on needle exchange," he said. "It's just something that I have come around to. I've enjoyed dealing with them, the clients. I try to have a bit of a chat to them to say they are welcome to come in," he said.

"I would like to see harm minimisation become a bit of specialisation for some pharmacists. Not every pharmacy is going to want to do it, but if you had one in every suburb, then you're providing better access and better service and really saving lives and the community a hell of a lot of money. If we could do it like that, then it would be a positive for everyone," Mr Ovens said.

Mr Scott Dodd from Queensland Injectors Health Network (QulHN) said filters were sold at \$1.30 for one or \$1.10 for 10 or more.

"In terms of varieties, we have the 0.2 microns for bacteria, 0.8 which do most of the morphine tablets such as MS Contin® and OxyContin®, or 'subbies' (Suboxone®). The five micron filter is for the chalky drugs, such as dexamphetamines, physeptone, ecstasy and benzos. People can use the filters in combination," Mr Dodd said.

Demand for filters tended to be partly influenced by drug availability: "It can also depend on heroin availability, as people move across to pills if there is less heroin around," he said.

The QulHN peer education program, MixUp, includes instructing clients on how to correctly assemble filters. "A while back we were doing a lot more demonstrations, but more people seem to know how to use them these days," Mr Dodd said.

*What is a Luer Lock?

The Luer taper is a system of small-scale fluid fittings used for creating leak-free connections between a male-taper fitting and its mating female part on medical instruments, including syringe tips and needles. Named after the 19th century German medical instrument maker Hermann Wülfig Luer.

Eminent Australians support trial of NSP in prisons

Nobel Prize winner Professor Peter Doherty is among a list of eminent Australians who have endorsed recommendations that a trial of needle and syringe programs (NSP) be conducted in Australian prisons.

Emeritus Professor Sir Gustav Nossal has also publicly endorsed calls for a trial, which is consistent with the following national health strategies: the Third National Hepatitis C Strategy, the Sixth National HIV Strategy, and the Third National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy. These strategies state:

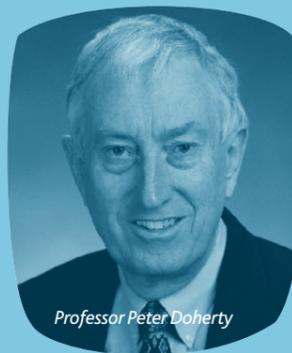
"In view of the well-documented return on investment and effectiveness of Australian community-based needle and syringe programs, combined with the international evidence demonstrating the effectiveness of prison needle and syringe programs it is appropriate throughout the life of this strategy for State and Territory Governments to identify opportunities for trialling the intervention in Australian custodial settings."

The government of the Australian Capital Territory is considering establishing a trial NSP in the Alistair Maconochie Centre (AMC), which began operations in 2009. Although a decision has not been

made, as a weapon against prison staff. Prisons with Needle and Syringe Programs maintain drug control measures and can increase access to voluntary drug treatment.

Establishing a controlled Needle and Syringe Program in prison is not going soft on drugs. It is getting tough on preventable drug harms."

Anex CEO, Mr John Ryan, said: "The absence of controlled sterile needle and syringe provision inside prisons is a glaring



Professor Peter Doherty

‘Illicit drugs enter Australian prisons regardless of the level and sophistication of security measures. Prisons are incubators of blood borne infections, including HIV and hepatitis C, because prisoners share injecting equipment.’

made, the ACT Health Minister, Hon. Katy Gallagher MLA, has stated that she is in favour of establishing an NSP in the AMC. The Minister's office told the Bulletin that an independent evaluation of the first 18 months of AMC operations had recommended a trial. A decision on whether or not to proceed was expected to be made by the ACT Government sometime in April, the Minister's office said.

Professors Nossal and Doherty are amongst a number of leading experts who lent their name in support of a trial in a recent advertisement placed by Anex in the daily broadsheet newspaper, The Canberra Times. The advertisement stated:

"Illicit drugs enter Australian prisons regardless of the level and sophistication of security measures. Prisons are incubators of blood borne infections, including HIV and hepatitis C, because prisoners share injecting equipment.

Until governments and prison administrators can guarantee a totally drug-free environment, it is their duty to manage the risk of infections that are contracted by sharing unsterile injecting equipment in prisons.

Needle and Syringe Programs reduce HIV and hepatitis C infections by providing access to sterile equipment.

This saves our community an estimated \$27 for each \$1 invested by governments. Currently prisoners do not have access to sterile equipment. They share needles and contract infectious diseases.

Almost all prisoners return to our communities. Reducing hepatitis C and HIV transmission in prison by allowing access to sterile syringes will protect the health of the whole community. Infections prevented in prison will reduce healthcare costs.

Numerous Needle and Syringe Programs have been implemented successfully in prisons overseas and syringes have never been used

weak link in Australia's response to blood borne infection control, including HIV and viral hepatitis."

Prison-based NSPs would contribute to a stronger continuity of care by more closely aligning prison health services with those provided in the community, Mr Ryan said.

"This would mean a significant reduction in risk-taking injecting behaviours, which as most prisoners return to the community, would have far reaching public health benefits," Mr Ryan said.

National organisations that support the trial include:

- Alcohol and Other Drug Council of Australia.
- Australian Drug Foundation.
- Australian Injecting and Illicit Drug Users League.
- Australian Medical Association.
- Australian Health Ministers Conference.
- Australasian Society for HIV Medicine.
- Drug and Alcohol Nurses Association.
- Hepatitis Australia.
- Family Drug Support Australia.
- The Pharmacy Guild of Australia.
- Public Health Association Australia.
- Royal Australian College of Physicians.

The NSW Liberal-National coalition has stated that it "will consider supporting the trial of a needle and syringe programme in appropriate correctional facilities with independent evaluation of the outcomes of any such trial".

For more information visit www.anex.org.au/prisons

Strategy Targets Pills

Ministers responsible for illicit and legal drugs met in Canberra in 2009 to tackle some of the big issues facing governments and the community with regard to the harm caused by drugs and alcohol.

Ministers discussed concerns about the diversion and misuse of pharmaceutical drugs and emerging evidence of the costs and harms associated with pharmaceutical misuse. Ministers agreed to develop a National Pharmaceutical Misuse Strategy, in close consultation with the Australian Health Ministers Conference (AHMC) and with expert groups.

The issue of prescription drug misuse has been identified by both law enforcement and health agencies across Australia as an emerging issue of significant concern. Ministers agreed there was a need for a consolidated national response and endorsed the development of a strategy that would address prevention, reduction of supply, reduction of drug use and related harms and improved access to quality treatment.

The Australian National Drug Strategy includes specific measures to control the supply of pharmaceutical drugs^[9].

According to the National Drugs Strategy 2010-2015:

"Supply reduction for alcohol, tobacco, pharmaceutical and other legal drugs involves activities targeted toward the regulation of legitimate supply and the detection and interruption of illegal markets.

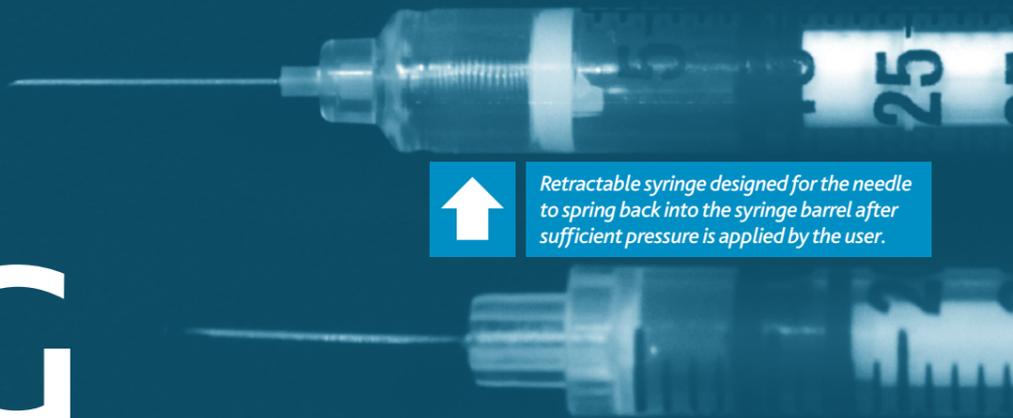
"An emerging and challenging issue is the misuse of pharmaceutical drugs – including opioids, stimulants and performance- and image-enhancing drugs. An effective supply reduction response will require a collaborative cross-sectoral approach that balances the need to ensure the availability of these drugs for medicinal purposes while, at the same time, restricting illegal access and diversion to illegal drug markets. Legislative and regulatory frameworks exist and require constant monitoring to ensure they support the appropriate prescribing and supply of pharmaceutical drugs. These frameworks also need to be supported by demand reduction strategies such as information and education campaigns that engage the health sector and community and serve to raise awareness of this issue.

"For legal substances like inhalants (petrol, paint and glue) that are readily misused, a balance also needs to be found between access for legitimate purposes and regulation of supply. This balance needs to take account of the prevalence of misuse and the harms from these substances."

Suggested actions

- Improve and strengthen the regulatory framework surrounding the promotion, sale and supply of legal drugs (both from domestic and overseas sources) to prevent misuse, diversion and consequent harm.
- Increase and improve the enforcement of regulatory mechanisms concerned with the supply and availability of legal drugs (including via the internet) that are subject to misuse and harm.
- Further foster relationships between all levels of government with industry, relevant agencies and the community to assist in regulating and reducing inappropriate access to legal drugs that are subject to misuse and harm.
- Increase training and support to those at the point of supply of pharmaceutical drugs (eg: doctors, pharmacists) to reduce the inappropriate supply, misuse and diversion of these drugs into the black market.
- Increase the community's understanding of the inappropriate supply and diversion of alcohol, tobacco, pharmaceutical and other legal drugs and the associated consequences through targeted public information campaigns, information sharing and social marketing.
- Research, investigate and gather information on all aspects relating to the supply of alcohol, tobacco, pharmaceutical and other legal drugs, including the impact upon individuals and the community.
- Research the effectiveness of strategies aimed at curtailing the inappropriate supply of alcohol, tobacco, pharmaceutical and other legal drugs.

RETRACTABLE SYRINGES TO INCLUDE WARNING



Retractable syringe designed for the needle to spring back into the syringe barrel after sufficient pressure is applied by the user.

Concerns have been raised that retractable syringes recently released on the pharmacy market present health risks to drug injectors because of possible “blood splatter” and the potential for vein damage.

In August 2010 the Therapeutic Goods Administration (TGA) approved the sale of retractable syringes manufactured in China for Queensland-based company, Chelsea Medical.

The five-pack of retractable syringes being made available through pharmacies for IDUs includes 1.0ml x 27g x 1/2inch syringes. It began to appear on the Queensland market last year, and is also now available in some Victorian pharmacies. The company intends to promote the retractable – as well as its non-retractables – to pharmacies nationwide.

A retractable syringe is designed for the needle to spring back into the syringe barrel after sufficient pressure is applied by the user, which could be a medical practitioner or an injector of illicit drugs.

“Blood splatter” refers to when blood, even microscopic amounts, is propelled off and/or from within the needle by the concentrated jolt that occurs when the needle – after having been withdrawn from the vein – suddenly springs back into the barrel.

“A retractable syringe is designed for the needle to spring back into the syringe barrel after sufficient pressure is applied by the user, which could be a medical practitioner or an injector of illicit drugs.”

Such droplets could then potentially mix with other equipment, such as a mixing spoon, which poses a risk of transmission of a blood borne virus such as hepatitis C.

The TGA has issued a statement to the Bulletin which states:

- “The TGA has recently been involved in investigating retractable syringes and has conducted testing to confirm the extent of blood splatter under laboratory conditions.
- Blood splatter from any source represents a health hazard and, in order to minimise the risks associated with blood splatter from retractable syringes, the TGA is in the process of amending instructions for use for this type of syringes.

- The TGA is requiring companies who supply retractable syringes to amend their labels to require retraction while the needle is in the injection site, to minimise the risks of blood splatter if the needle is retracted outside the injection site.”

Dr Louis Loizou is the Vice President of the Australasian College of Phlebology. Phlebology is a medical sub-speciality devoted to disorders of veins.

According to Dr Loizou, who regularly performs injections, there should be no reason to be concerned about vein damage if a needle was automatically retracted while it was still in a vein.

“I inject veins all day. When we are injecting veins, we pull out the needle – and usually very quickly. If you are using a retractable, instead of manually extracting, the device will do it ... it’s the same thing as if it was done manually with a normal syringe. It’s not removing the needle that will cause damage to the vein. It’s what you inject into it,” he said.

The Pharmacy Guild of Australia has advised its members to “exercise caution” with selling retractable syringes to people who inject drugs, although its statement does not differentiate between illicit and non-illicit drugs.

HOUSTON we have a problem

Mark, who lives in a metropolitan area well serviced by needle and syringe programs, was caught by surprise with his first and last experience with a retractable syringe in December last year.

A tradesman, Mark is on opioid replacement therapy. He didn’t want to enter his dispensing pharmacy when he was caught out on a weekend without his injecting equipment.

“Normally I get my stuff from the NSP which is just near the pharmacy, but it was a weekend. And that is the pharmacy I get my ‘bupe’ from, so I didn’t want to go in there. So I got a mate to go in and buy them for me,” Mark told the Bulletin.

His friend handed him the needles, which they both presumed were the normal ones they would use. Much to his surprise, the needle sprang back into the syringe while he was in the process of preparing his drugs.

“I went across to the toilet and went to do my thing. I was mixing up, and used the end of it. Then all of a sudden, it (the needle) just disappeared and I thought ‘what the f@*%!?’ I didn’t have a clue what these were, because I didn’t even know these (retractables) existed.”

In an exercise that he said took “about an hour”, he curiously worked out that there was a spring-loaded action involved. He then finished mixing and – to avoid a sudden retraction in his vein – Mark injected less quantity than he normally would.

“After that first one I got another and pushed it to try to work out what had happened, and then I realised sort of what it was. I thought, ‘What the f@*% has he (his mate) got me here? Is this some sort of needle from NASA or something?’ It was all high-tech.

“I was a bit dodgy (wary) on that, so then I mullied up again with the third one and didn’t push as hard. I was a bit scared, because I didn’t

know if it was meant to retract in me or what ... like, is it meant to be used for this?,” he said.

Mark said that some years ago a friend had a needle stuck in his arm which they used tweezers to get out. That made him nervous with the retractable: “I didn’t want to push it all the way because I was worried that it would end up in my arm if it didn’t retract properly.”

So Mark deliberately didn’t push the plunger all the way in. “I lost about a ‘10’ ... which was no good because, as my mum used to say with the cough medicine, the last bit’s the best bit,” he said.

Mark said he would normally fill the syringe up to the 80 units mark, so the loss was one-eighth.

Mark said that in principle he could see why retractables – if they were safe – may be useful from the perspective of allaying people’s fear when they see needles laying around.

“In a way it’s not a bad idea. I think they are on the right track. I can see the sense of them, but I was just unsure going IV” (intravenous).

Mark bought another pack to show his friends what they were, but has not used another one since.

“If I was doing steroids where you go into the muscle it may not be a problem, but going IV is a bit different. I’d rather trust myself than a mechanical thing – whenever there’s a new thing, there’s always a bit of ‘what if?’,” he said.

LET THE WORK BEGIN

The inaugural national strategic framework for needle and syringe programs should signal the start of “concrete action” toward more integrated and uniform approaches to policy and hands-on practice, according to Queensland Health’s harm reduction manager Mr Robert Kemp.

“The framework is only the first step. The real challenge is turning words on paper into concrete actions and following through on them,” Mr Kemp said.

“This is particularly the case with the sections regarding workforce development, training and career paths. Those are the obvious things that will directly affect people working in the sector already, or those considering it.”

The Framework is a potential roadmap for operationalising illicit drug-related components in the implementation of HIV and hepatitis prevention strategies announced last year.

“It will be useful at state and national planning levels, not only for people working directly in NSPs, but also for those working in areas impacted by injecting drug use such as HIV and hepatitis C and B – in terms of giving them a clearer understanding of strategic thinking around NSPs. There simply hasn’t been a national NSP document available before,” said Mr Kemp.

“My personal hope is that it will start to actually provide – if we work on it and don’t just leave it as a dead document – I would hope it would start to shape up into what we have never had – a national needle and syringe program,” Mr Kemp told the Bulletin.

“As it is, programs vary across jurisdictions, so what we are working for in the first place is national consistency, and then, over time, working toward a national program delivered jurisdictionally – but core elements should be best practice developed on a national level. This approach has already happened in relation to Opioid Replacement Treatment (ORT),” said Mr Kemp.

He was referring to the way in which needle and syringe programs are administered through

states and territories and thus include variations between jurisdictions and even within them.

“There is no reason why someone who is an injector in one state should be getting any less level of service than someone in another,” said Mr Kemp.

“We should be trying to reach equity, and we should be aiming for consistently high standards of service delivery.”

Another state-based health department officer involved with formulating the Framework told the Bulletin that “it will assist with dealing with

“The Framework is a potential roadmap for operationalising illicit drug-related components in the implementation of HIV and hepatitis prevention strategies announced last year.”

some of the issues emerging, such as workforce development and career paths for staff. It helps create a formal structure in which the entire sector can operate.”

The official endorsement of specific measurable goals for NSP improvement and evidence-based reduced the risk that the sector could be deprioritised, the official said.

“I think we were very fortunate in 1987 to have had the political environment that enabled the very rapid roll-out of a national program that had bi-partisan support”, he said.

“It was also fortunate that the Federal Government supported specific NSP funding that ensured the continued development of NSP models and structures in each state and territory. But we can’t rely on luck. There is no

guarantee that bi-partisan support will be there in future, or specific funding will be available. For example, now under Australian Health Care Agreements, there is no NSP-specific funding streams with deliverables tied to funding. We need this Framework to assist with maintaining a focus on NSPs in each jurisdiction,” he said.

The Pharmacy Guild of Australia provided momentum toward the Framework when it endorsed the concept during a special all-branch meeting five years ago.

“The Pharmacy Guild and its members welcome the release of the Framework,” said Guild national president Mr Kos Sclavos.

“It will assist the community pharmacy sector become further integrated into Australia’s highly successful and diverse approach to both needle and syringe program delivery and opioid replacement therapy,” he said.

Mr Kemp said: “I would say that the full potential of the community pharmacy NSP

hasn’t been realised, and the Framework can assist in this. This is particularly important because in reality, community pharmacy has a far wider network and by extension a far greater reach, than either government or non-government organisation providers.”

Mr Sclavos said: “We recognise that harm reduction is a long-established and highly cost-effective approach to public health. With over 2500 community pharmacies involved in NSP provision contributing to health outcomes for injecting drug users on a daily basis, the Framework will facilitate national consistency in NSP delivery through community pharmacy.”

The Framework formalised the legitimacy of NSP work which was particularly complex.



Mr Robert Kemp,
Harm Reduction Manager,
Queensland Health.

“A lot of the complexity is in terms of administrative institutions that have been established. It happens that NSP bridges a lot of them, and that leads to complexity,” a state-based harm reduction officer said.

“Because it’s working with injecting drug users, it puts it within sections dealing with drugs obviously. It is further complicated in that we are dealing with services that don’t stop people using drugs, but to make it safer for users,” he said.

“Because it bridges public health and drugs on one hand, it is complicated further again because the behaviour it works with is illicit. So it needs to be working with police and corrections to allow the NSP to continue to work as a public health intervention. Another thing that complicates it is the high level of mental health issues amongst NSP clients.”

Mr Kemp said the Framework “helps formally define where NSPs sits in relation to other issues and strategies. For example, it may influence national ORT or dual diagnoses strategies. Although the incidence of people with mental health problems injecting is probably not large, the incidence of people who inject having mental health problems probably is. The sub-population of people who inject drugs have higher prevalence of mental health (co-morbidity) than the general population.”

STRATEGIC FRAMEWORK VERSUS ACTUAL PROGRAMS

what’s the difference?

While Australia formally established a Needle and Syringe Program in 1987, we have never before had a nationally consistent Strategic Framework to guide the future direction of NSP services.

Without a consistent strategic framework to guide the Needle and Syringe Program, each jurisdiction has taken on unique characteristics based on:

- Differing legislation, health infrastructures, and emerging priorities
- Differing government policies
- Differing health system structures
- Different health models
- Responses to different patterns of drug use in each state and territory.

While the diversity of approaches still provides significant challenges to the national Strategic Framework, there are many goals across all jurisdictions that are shared.

In the long term the development of the Strategic Framework means that NSPs will move towards greater consistency across jurisdictions.