anex bulletin
volume 8
edition 3
February 2010

Drugs In Hard Times was the theme of the Australian Drugs Conference held in Melbourne last October. More than 350 people attended the 16 sessions. Some of Australia's most respected researchers discussed recent and on-going studies, while drug and alcohol sector staff provided enlightening practical examples of field work. The conference got off to a thought-provoking start when ALEX WODAK provided an historical analysis of contemporary prohibitionist drug policies.

CONFERENCE REVISITED

REDUCING INEQUALITY CUTS DRUG HARMS

Racism is the twin of inequality and both have been critical to the development of global drug prohibition for more than 100 years, Dr Alex Wodak told the conference.

Inequality and racism are both consequences of drug prohibition, as its effects have predominantly affected the poor, the director of the Alcohol and Drug Service at St Vincent's Hospital, Sydney, said.

Dr Wodak is President of the Australian Drug Law Reform Foundation and a former President of the International Harm Reduction Association.

He argued that racism had been critical to the development and maintenance of drug prohibition in Australia. It started with our first drug prohibition, a ban on opium smoking in the late 19th century. Opium smoking in Australia was confined to Chinese working on the goldfields at the time.

A further illustration of the contribution of racism was the comment by US Federal Bureau of Narcotics Commissioner, Henry Anslinger, in 1937: "There are 100,000 marijuana smokers in the US and most are Negroes, Hispanics, Filipinos and entertainers. Their Satanic music, jazz and swing, result from marijuana use. This marijuana causes white women to seek sexual relations with Negroes, entertainers and any others."

Dr Wodak argued that no nation had been more important than the USA in establishing, expanding and maintaining global drug prohibition with Anslinger playing a critical role in the early decades of that development.

Drug prohibition was intensified and increasingly politicised after President Nixon declared a "war on drugs" in June 1971.

Dr Wodak noted that John Ehrlichman, a senior advisor to the Nixon White House said: "Look, we understood we couldn't make it illegal to be young or poor or black in the United States, but we could criminalize their common pleasure. We understood that drugs were not the health issue they were made out to be, but it was such a perfect issue for the Nixon White House that we couldn't resist it."

Dr Wodak said: "Global drug prohibition not only entrenches global and domestic inequality. It has also failed comprehensively and is a futile exercise."

Wars against drugs were really a political strategy, not a health policy, Dr Wodak said. Ehrlichman told a US Senate sub-committee in 1976: "Narcotics suppression is a very sexy political issue. It usually has high media visibility. Parents who are voters are worried about narcotics. They listen to a politician when he talks about drug suppression just as they seem to tune him out when he makes speeches about the energy problem. Therefore the White House often wants to be involved in narcotics problems even when it doesn't need to be."

"Global drug prohibition not only entrenches global and domestic inequality. It has also failed comprehensively and is a futile exercise."

The Autoimmune Deficiency Syndrome (AIDS) was first described in 1981 and the cause, the Human Immunodeficiency Virus (HIV), was identified a few years later. Dr Wodak showed maps, prepared by Professor Ernie Drucker, of the distribution of hospital admissions for immune-disorder in the New York borough of the Bronx from 1982 to 1985. Dr Wodak highlighted the correlations between higher rates of HIV in neighborhoods with lower income and poorer education at a time when two-thirds of HIV cases in the Bronx were attributed to drug injecting.

Education and income directly affect the rates of HIV, having a protective effect when they are high and becoming a risk factor for HIV infection when they are low, Dr Wodak said.

Turning to global drug markets and drug trafficking, Dr Wodak asked whether "narco-states" such as Afghanistan, Bolivia, Myanmar or Columbia become poor because they produce and traffic drugs, or do so because they are poor?

The prevalence of drug use in the developed world is higher in countries with greater inequality. Australia has high levels of inequality compared with other developed countries. So it is not surprising that the prevalence of drug use is high, Dr Wodak said.

Dr Wodak concluded by saying that reducing inequality was essential to harm reduction. Most importantly, he said, illicit drug consumption should be redefined "primarily as a health and social problem, and that means increasing funding available for health and social interventions which bring a much better return on investment."

J Eherlichman quoted in D Baum (1996) Smoke and Mirrors: the war on drugs and the politics of failure (1st Ed) Little, Brown and Company,

PHASE II HEP C VACCINE TRIAL
Page 3

DEALERS DON'T GIVE CREDIT
Page 4

PRISONS INCUBATE RISKS
Page 6

HR NEEDS PR
Page 7

anex

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

Editors
Liz Sutton
Patrick Griffiths

Writers
Emma Barnard
Nicola Cowling
Lorraine Mapfumo
Elke Mitchell

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

Production
L&R Print Services

The content of the Bulletin is intended to stimulate discussion and information-sharing and does not necessarily represent the views of Anex. The content of this Bulletin does not encourage anyone to break the law or use illicit drugs. While not intending to censor or change their meaning, Anex reserves the right to edit articles for length, grammar and clarity. Anex will consider credited reprinting by other organisations if prior approval is granted. Anex takes no responsibility for any loss or damage that may result from any actions taken based on materials within the Bulletin and does not indemnify readers against any loss or damage incurred. This publication has a targeted readership and is not intended for general distribution.

All written material in this publication may be reproduced with the following citation: 'Reprinted from vol. 8, no. 3 of Anex: Bulletin, published by Anex' and with credit to the author(s).

An Editorial Reference Group provides advice on the content and issues that the Bulletin includes.

The Anex Bulletin is funded by the Commonwealth Department of Health and Ageing which approve its content before distribution.

All article references for this edition of the Anex Bulletin can be found online at www.anex.org.au/publications_bulletin.htm

ISSN: 1447-7483

February 2010

Hanover House Chief Executive Mr Tony Kennan leads a panel discussion on links between homelessness and drugs.

DISADVANTAGE IN THE LUCKY COUNTRY

DRUG USE AND HOMELESSNESS

The social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices

World Health Organisation

Coalface harm reduction workers do not need reminding that wealth inequalities, inadequate housing and homelessness can be social determinants of drug misuse and associated poor health. Not surprisingly, housing – and the lack of secure accommodation - was one of the risk factors most acknowledged during the two day conference.

Gabrielle Bennett, from the Royal District Nursing Service's Homeless Persons Program (RDNS HPP) (West Melbourne) discussed the relationship between inequality and poor physical, psychological and social health. As Dr Alex Wodak did during his plenary speech, Ms Bennett drew attention to the recent study published as The Spirit Level: Why More Equal Societies Almost Always Do Better. Published by Penguin, it is available at www.equalitytrust.org.uk and through Amazon.

The Spirit Level identified evidence of an increased incidence of poor health and social outcomes amongst countries where the divide between rich and poor was the greatest. These discrepancies were assessed in relation to the following 11 social determinants of health: physical health, mental health, drug abuse, education, imprisonment, obesity, social mobility, trust and community life, violence, teenage births and child well-being.

Ms Bennett states that in her work it is common to meet individuals who are disadvantaged in many, if not all, of the 11 determinants noted above social determinants of health. Ms Bennett told delegates it was wrong to regard Australia as a "fair and equal society that champions the underdog" when so many communities are struggling, including "Indigenous communities experiencing high levels of illness."

Results from The Spirit Level study support Ms Bennett's observations from the real world of drug misuse. The study looked at incomes of the poorest 20 percent and the richest 20 percent of the population in more than 20 countries. It found that health and social problems in wealthier countries were related to the extent of disparity between the haves and the have-nots, rather than average income levels.

In countries where the gap between rich and poor was greatest, the incidence of physical and mental illness, incarceration and drug dependency was also significant. The bigger the gap, the greater the negative influence on issues of physical, mental and social wellbeing.

> *"Australia recorded the fifth biggest difference between the wealth of the top and bottom 20 percent, after Singapore, the US, Portugal and the UK. The study reported unacceptably high levels of health and social problems, particularly in regards to drug dependency and mental illness."*

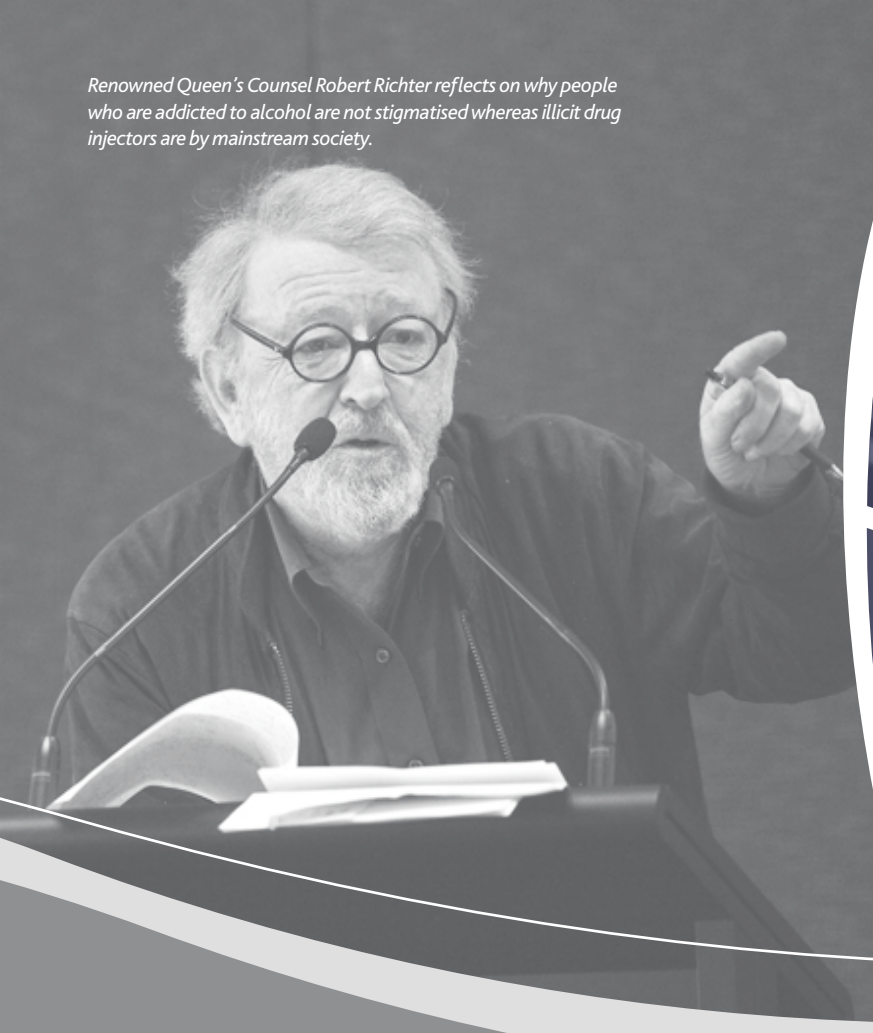
Australia recorded the fifth biggest difference between the wealth of the top and bottom 20 percent, after Singapore, the US, Portugal and the UK. The study reported unacceptably high levels of health and social problems, particularly in regards to drug dependency and mental illness.

Ms Bennett shared a case study to highlight the impact of such inequity. While the name is fictitious, the story is not. "Jo" is a young woman who started injecting heroin when she was 17. Jo was born when her mother was still a teenager. Both of Jo's parents used heroin regularly and struggled to get by on a low income.

When Jo was just three, her mum died from a heroin overdose. Jo had to assume a maternal role, helping to look after her younger sibling. As a result of this assumed responsibility Jo had a low level of education and literacy. Her dad died when she was 16. It was around this time that Jo began using heroin in an effort to self-medicate the sadness and pain she was experiencing.

Jo was living alone in a squat when she first presented to the Homeless Persons Program (HPP). Her boyfriend had recently been arrested and gaoled. HPP supported her during this time. In the years that followed, they helped her through two successful pregnancies, the first of which was when she was 18. RDNS HPP advocated on Jo's behalf to help her get housing, eat more nutritious food and enter drug treatment. Without the support, it was likely that Jo would struggle in much the same way her parents had. Today, Jo is in stable (public) housing and enjoying life with her two children.

Whilst RDNS HPP assisted Jo to get her life on track, Ms Bennett told delegates that there should be more of an "upstream approach". It should include contributing to government policy and highlighting the need to put greater resources toward striving for more equal communities. Ms Bennett's vision, shared by the Council To Homeless Persons, is that "an inclusive society committed to eliminating homelessness through national and state policy development, systemic and individual advocacy."



Renowned Queen's Counsel Robert Richter reflects on why people who are addicted to alcohol are not stigmatised whereas illicit drug injectors are by mainstream society.

Candidate HCV vaccine trials: challenges and opportunities

In her presentation to the Anex Conference, Professor Lisa Maher from the National Centre in HIV Epidemiology and Clinical Research (NCHECR) noted that while hepatitis C prevention approaches have been successful in reducing risk and harm, there is limited evidence of their impact on preventing new infections. This means that it is unlikely that the hepatitis C epidemic will be contained without an effective vaccine.

While the global prevalence of hepatitis C is approximately three percent, people who inject drugs account for the bulk of infections. There are approximately 211,700 people living with hepatitis C in Australia and 10,000 new infections annually. The majority occur in people who inject drugs, contributing to the expanding burden of liver disease and the increased number of hepatitis C-related deaths.

The impact of hepatitis C prevention efforts have been studied rigorously. However studies of drug treatment, harm reduction, education programs and disinfection methods employed (for example, the use of bleach to clean used injecting equipment) have not provided conclusive evidence of efficacy. In particular, while studies have noted the protective effects of comprehensive harm reduction interventions and promising results from randomised controlled trials of hepatitis C peer education, evidence of the effectiveness of interventions to prevent HCV infection in people who inject drugs is limited.

Therefore, while prevention, treatment and best practice have had an impact on hepatitis C prevalence, further reductions in hepatitis C infection are unlikely to be achieved without large-scale and effective biomedical interventions, notably preventive vaccines, said Professor Maher.

Prophylactic and Immunotherapeutic Vaccines Now in Phase II Trials

Professor Maher

The University of New South Wales (UNSW) Hepatitis C Vaccine Initiative is funded by the UNSW Strategic Research Fund and aims to:

- Establish a comprehensive community, epidemiological, clinical and laboratory framework to conduct Australian field trials of candidate hepatitis C vaccines
- Develop a program for candidate hepatitis C evaluation
- Foster collaborative relationships with public and private sector biotech partners with candidate vaccines.

The Initiative involves three prospective cohorts, named HITS (Hepatitis C Incidence and Transmission Studies):

- HITS-c (Community)
- HITS-p (Prison)
- HITS-i (Incident cases).

The main aim of the Social Epidemiology and Prevention Studies arm, led by Professor Maher, is to determine the feasibility of conducting field trials of candidate hepatitis C vaccines in community settings. Key objectives of this arm are to:

1. Consult with community and other stakeholders
2. Identify higher risk populations with sufficiently high incidence to support a trial
3. Develop and test effective recruitment and retention strategies
4. Determine acceptability and willingness of people who inject drugs to participate in future vaccine trials
5. Develop appropriate educational methods to ensure ethical informed consent
6. Measure HCV incidence and associated risk factors
7. Identify factors associated with retention and adherence to the study protocol
8. Identify the impact of existing prevention strategies on HCV incidence
9. Provide estimates of incidence and loss-to-follow-up for sample size calculations
10. Develop instruments to accurately assess risk behaviour
11. Assess acceptability of a future efficacious vaccine in the target population
12. Estimate costs of recruitment, screening and follow-up.

UNSW's Professor Lisa Maher spoke of the challenges and opportunities for the Vaccine Initiative. One of the greatest challenges for vaccine preventable infections in people who inject drugs is low immunisation coverage. For example, hepatitis B vaccine has poor uptake and completion among people who use drugs. This has been due to low levels of awareness, cost, barriers to accessing to medical care, a lack of trust in health care providers, competing health and social priorities and the fact that the vaccination requires multiple doses over time. There is limited knowledge about the social and cultural dimensions of demand for vaccination and access to vaccination among people who inject drugs, she said.

Professor Maher also identified opportunities for the Vaccine Initiative including building capacity for effective and sustained community engagement in future trials and developing models of best practice for the conduct of vaccine trials in resource-rich settings.

LOW HEPATITIS B VACCINATION COVERAGE AMONG SYDNEY INJECTORS

The hepatitis B vaccine is 95-99 percent effective in the general population. It is safe, long lasting and inexpensive at approximately $45 per course.

The schedule consists of three vaccines administered over six months, although an accelerated schedule is available and can be administered over three months.

Bethany White from the UNSW explained that people are being vaccinated too late, and only vaccinating specific populations wasn't enough to achieve universal coverage.

Under the UNSW hepatitis C vaccine initiative, a prevalence study of hepatitis B vaccination was conducted as a part of the HITS-c cohort, a longitudinal study of hepatitis C amongst young people who use drugs.

HITS-c primarily investigates hepatitis C incidence and risk factors, the impact of existing risk reduction interventions, factors that influence retention and the acceptability of immunisation and willingness to participate in future hepatitis C vaccine trials.

White detailed how the study utilised a purpose designed van to recruit clients via outreach in five areas in Sydney (Liverpool/Cabramatta, Penrith, Mt Druitt, Campbelltown, and Redfern). The trial participants were followed-up at three, six and nine months.

Of the 95 clients recruited, almost half (46%) were susceptible to hepatitis B infection, suggesting low rates of completed hepatitis B vaccination.

Reasons offered by clients as to why they had never been vaccinated included:

- Never offered;
- Never given information/never heard about it;
- Never got around to it;
- Believed they weren't at risk.

Such high rates of susceptibility suggest that hepatitis B remains an important issue for young people who inject drugs. At-risk young people may be missing out on current school-based catch up programs. Alternative vaccination strategies are required to address the issue.

The continued promotion of blood borne virus (BBV) screening and hepatitis B virus vaccination is essential as is referring at-risk young people for testing. Even if they report being vaccinated it is important to confirm and regularly check on the sero-status of injectors.

DOCTORS PRESCRIPT
ADD TO TREATMENT QU

The source of most illicitly used opioid pharmaceuticals is a doctor's prescription rather than chemist break-ins or similar crime, addiction clinician Dr Matthew Frei told the conference.

The head of addiction medicine units at Victoria's Southern Health and Eastern Health, said we can't consider prescription opioids "without talk of misuse and abuse".

"We've known about the risk of dependence with pain medication since we've been using them; [there is] so much evidence it's almost redundant talking about it," Dr Frei said.

Recent Illicit Drug Reporting System data suggest that pharmaceutical opioids such as MS Contin and Oxycodone are readily available on the illicit market and are increasingly common in injecting communities.

There are also a great many individuals who become addicted to opioids prescribed legitimately to them by doctors for the treatment of chronic non-malignant pain, Dr Frei said. Dependence on such drugs can be difficult to address because they are relatively cheap and relatively easy to obtain.

He highlighted the availability of such drugs by contrasting their prescription rules compared with buprenorphine. Medical practitioners must complete specialist training in order to prescribe partial agonist drugs such as the buprenorphine preparations Subutex® and Suboxone®. But any doctor can prescribe opioid medications which are full agonists, he said*.

Because there appears to be increasing opioid misuse related to prescribed opioids, there is ongoing interest in developing pharmaceuticals with tamper-resistant formulas and drugs are being developed that are harder to misuse.

"Drugs that you can hit with a hammer, run over with a steam roller and still can't get into a spoon and dissolve," Dr Frei said.

He suggests the problem has arisen because "we are managing pain better" with a greater range of preparations available, including slow release preparations.

It was necessary to review models of care for long-term opioid users given that treatment services and pharmacotherapies - traditionally for heroin - are increasingly used to treat opioid dependence.

Dr Frei referred to studies cited by Nick Lintzeris, which found that between five and 15 percent of people on long-term treatment with prescribed opioids will become dependent.

One of Dr Frei's male clients had been injecting the prescribed oral slow release morphine (SROM) for at least 10 years. The patient went to the hospital with a discoloured hand and arm - and resultant necrosis – due to accidentally injecting into an artery.

Another male client had been prescribed SROM for a spine infection which was related to heroin

DEALERS GIVE CREDIT
CHEMISTS DON'T

Unsubsidised buprenorphine or methadone dispensing fees should be considered a breach of human rights for low income clients, RMIT University researcher Dr James Rowe told the conference.

"I've gotten seven evictions in the last few years because it's: do you pay the chemist or do you pay your rent? Being on methadone keeps me stable ...at least I know I've got that. So to me, I will pay for that before I'll pay for anything else. Try and explain that to someone – people don't get it. They say I'd rather have a roof over my head – I can fight the [eviction] thing in court later but it's how I am going to be today..."

(Rebecca, 38 years)

The Pharmaceutical Benefits Scheme (PBS) was effectively discriminating against those on pharmacotherapy by not subsidising dispensing fees, he said.

People may ask the question "if you can afford $500 on heroin, why can't you afford $60 per week [for pharmacotherapy]?," Dr Rowe said. "That is a major sticking point for tabloid journos who have some divine gift to know what is morally right."

However, such arguments did not "recognise that people want to get into treatment for a range of reasons" and "a lot have a desire for a degree of stability in their lives including living on a legitimate income," he said.

The audience considered an example of a single parent receiving $493 per week via the pension.

"If you imagine that individuals pay $180 per week for rooming house accommodation, they are left with just $133 to cover living costs for themselves and their child," said Dr Rowe.

"If they were to subtract the cost of pharmacotherapy payments - on average $30-35 per week - they would be left with under $70 for food, transport and other costs for an entire fortnight."

Pharmacotherapy costs can often result in clients prioritising payments ahead of other basic necessities, including housing and health.

Dr Rowe said that clients racking up debt with pharmacists caused tension, and accumulated debt was a reason people gave up treatment and returned to illicit drug consumption.

"In fact, dispensing fees are cited by clients as the single greatest obstacle to retention in opioid maintenance treatment and the greatest contributor to involuntary discontinuance of treatment," said Dr Rowe.

He referred to his 2008 study "A Raw Deal" which interviewed 120 people across primary health centres and NSPs (Rowe, 2008)

In the study, he described the "genuine desire to remove oneself from dependent heroin use [being] typically accompanied by a desire to leave the endless cycle of crime and/or sex work undertaken to support the exorbitant costs of their drug use" (Rowe 2008: 7).

Pharmacotherapy allowed individuals to limit, reduce or even abstain from illicit drug use. Even in the worst case scenarios pharmacotherapy allowed a reduction in illicit use.

In light of this, Dr Rowe suggested the "knowledge that people are continuing to use on top of the program doesn't give cause to dismiss them from the program" as they are "probably using, and spending, a great deal less".

IONS EUES

injection. The man began injecting his morphine. He developed a heart valve infection and died in intensive care.

Dr Frei finished his presentation by calling for ongoing GP education: "Even more than that, [we need] a more holistic multidisciplinary approach to pain. It's bigger than education; it's a reframing of a health care system that [currently] encourages quick consultation."

He said the system perpetuates a "pill at the end of the consultation type of model" and fosters a culture of patients telling GPs "this is what I want".

Therefore, Dr Frei argued, treatment services need to take into account that a lot of people are getting addicted to prescription opioids.

The misuse of prescribed opioids is not restricted to, but is mainly among injecting drug users and people with chronic non-malignant pain who are not being adequately managed.

GPs and other medical practitioners can prescribe opioids for acute pain, but if a patient needs opioids prescribed for more than a month, the GP must get an authority from Medicare Australia to prescribe for the patient. This authority requires renewal on a monthly basis.

The problem of opioid misuse in people with chronic pain is not that opioids allow us to manage pain better. The problem is that chronic pain is not being managed well. The availability of opioids for pain treatment (both chronic and acute pain) is not a bad thing. The problem is how these opioids are prescribed and a misunderstanding of the nature of opioid dependence.

In April 2009, the Royal Australian College of Physicians Addictions Chapter released a Prescription Opioid Policy for treating chronic non-malignant pain and the problems associated with prescription opioid use. In addition, the Draft National Pain Strategy is currently undergoing public consultation http://www.painsummit.org.au/strategy/Strategy-NPS.pdf/view.

Victorian Chief Magistrate Ian Gray describes the pilot Victorian Court Integrated Services Program (CISP).

RESULTS FROM THE 2008 AUSTRALIAN NSP SURVEY

The annual Australian NSP survey is conducted over two weeks in October. It provides sentinel surveillance and annual data on HIV and hepatitis C sero-prevalence. The survey involves NSP service clients completing a brief questionnaire and providing a capillary blood sample, usually taken by a finger prick. This survey is often referred to as the annual finger prick survey.

There were 2018 participants in the 2008 survey.

Dr Jenny Iversen from the Viral Hepatitis Epidemiology and Prevention Program at the National Centre for HIV Epidemiology and Clinical Research (NCHECR) explained that the survey asks participants about their recent injecting behaviour and about reuse and cleaning of injecting equipment.

A summary of the survey data in relation to reuse and cleaning reveals that:

1mL syringes are the most frequently used, reused and cleaned item;

Half of all respondents report recent reuse;

40 percent of respondents reported multiple reuse and cleaning;

There are high rates of cleaning for all items distributed;

The majority of respondents clean their own equipment;

The majority of current cleaning is likely to be ineffective for decontamination of hepatitis C and HIV.

Currently, the US Centres for Disease Control and Prevention (CDC) still states that the best way to reduce viral decontamination is still the 2 x 2 x 2 method. That is, flush the barrel twice with cold water, twice with bleach while shaking for 30 seconds, and then reflush with cold water twice more.

According to the survey, 92 percent of syringes are not effectively cleaned, and less than one percent of syringes are cleaned following the 2 x 2 x 2 method recommended by CDC.

AIVL agrees

Ms Laura Santana then presented on behalf of the Australian Injecting and Illicit Drug Users' League (AIVL) and endorsed Dr Rowe's position.

Approximately 80,000 Australians identify as opioid dependent, with roughly 41,000 of these individuals on either methadone, Subutex® and Suboxone®, Ms Santana said.

"I have committed three crimes in the last two and half years, and [all] to pay [for] my methadone – that is pretty wrong. Especially cause after you have done the crime, if you have got a bit of conscience you feel sorry about it… I really hated that, you know, [but] there was no other way out… They are the times you are left in the lurch…you know I could have ended up in jail [to pay for a medical treatment]."

(Chad, 47 years)

AIVL has looked at pharmacotherapy across Australia and Ms Santana drew attention to some national inconsistencies.

She questioned why pharmacotherapy dispensing wasn't free when the medicine was, and why pharmacies were allowed the right to set their own dispensing costs.

She also stressed the issue of "trade offs" for pharmacotherapy. That is, people forgoing payment for rent, food, medicine, education and transport so they can afford dispensing payments to stay on the pharmacotherapy program.

An audience member commented that, rather ironically, there is evidence of people selling their methadone takeaways to pay their dispensing fees.

One person said it was unfair that when going on holidays for a month you still pay for 30 days of dispensing fees even though the takeaways were dispensed just once.

This triggered discussion amongst conference delegates about the issue of subsidisation and human rights. While there is already a subsidy of pharmacotherapy to pharmacies, delegates felt it could be argued that dispensing fees challenge the notion of equal access to health care and this is a human rights issue.

It could be argued that subsidisation of pharmacotherapy dispensing fees would represent a substantial saving to the government and community; by reducing the costs of theft by those whose treatment has been discontinued. It would also remove the risk of injecting and other drug-related illness and disease.

Most importantly, it would "remove the intangible, immeasurable sense of loss amongst family members and friends who must deal with the consequences of another, sadly avoidable, fatal heroin overdose" (Rowe, 2008: 17)

(Rowe, 2008), A Raw Deal? Impact on the health of consumers relative to the cost of pharmacotherapy, Salvation Army & RMIT

Excerpts from Rowe 2008

"The true cost is really hidden… in a round about way government ends up paying when the chaos starts to happen it just spills over into other government funded services anyway."

- Participant comment to Dr Rowe and Ms Santana.

"I am coming off my 'done because I can't afford it. I can't afford 60 bucks a fortnight that could be going towards food. My daughter needs new school shoes at the moment … I've got to apologise to my kid some nights and say, 'I'm sorry darling tonight we're just having toasted sandwiches and an egg'."

(Michaela 48)

CAT BURGLAR BECOMES MAN OF LORE

Jack Charles, 66, tried buprenorphine before methadone, but didn't like it. Before a captivated conference audience, the acclaimed actor described himself as a man of honour. But he joked that this claim was funny coming from one of "Melbourne's better class cat burglars".

Jack's mob is from Melbourne. Born in 1943, Jack describes the new documentary Bastardy as "one stolen person's story". Jack wants to take the film and show it to people in prison around the country. He feels an urge to share the journey with those inside, the lost tribes, both black and white.

In 1971 he founded the first Aboriginal theatre company, Nindethana. He's worked with some of Australia's best known artists, including Geoffrey Rush, Neil Armfield, John Romeril and Tracey Moffat. His work has spanned feature films, TV series and hundreds of plays including The Chant of Jimmie Blacksmith, Bedevil, Ben Hall, The Marriage of Figaro and the 1972 Bastardy, the play about the life of Jack Charles, which the new film title comes from.

Jack has been using heroin since the 1970s, about the same time as his acting career began. He describes using Aboriginal culture and his Aboriginality to pull himself up and out of a life of using, saying "it's not an Aboriginal thing to be shoving white powder in your veins." Jack remembers smuggling new fits into prison. He recalls watching 17 people share one fit while he was locked up in Melbourne's old Pentridge prison. Five of those people were Aboriginal. He fondly recollects some good times in the nick, especially being trained as a pottery teacher. He said that he learned to live within his means, which is a skill he's passing onto others.

He entered the methadone program at 60, and now at 66, he is off the program. Jack describes street drinking as "like airing Aboriginal dirty laundry for people to see, it is a loss of culture. Alcohol has kept Aboriginal people oppressed from developing their full potential". Jack considers himself a role model, the Bastardy documentary having empowered him to play a sort of a "kadaitcha man" ... a law man of the streets of Collingwood and Fitzroy where he works with people living on the street. He says it only takes one person to start the process.

Jack is now part of the Black Action Group (BAG) which seeks to address Indigenous issues, such as the Northern Territory intervention and the problematic politics of Aboriginal organisations. Jack describes the development of BAG as a "lesson for hardliners". He is proud to be developing his role as a public spokesperson for those who feel compelled to "jump off".

To see a preview of Jack's film Bastardy go to http://www.sbs.com.au/films/movie/3556/Bastardy/type/trailer/id/56147

WOMEN HELP PEERS VISUALISE HIDDEN RISKS

A group of young women with injection experience have produced a snappy risk reduction video for schools.

Based on peer education principles, Whitelion (Young Women's Support Service Program) and Hepatitis C Victoria trained the women, all of whom had contact with the Youth Justice System.

The project is called Young Women's Hepatitis C Prevention and Early Intervention Project.

The aim of the project was to increase young peoples' understanding of safer injecting drug use, because research indicates that one in five new hepatitis C infections occur in young people aged 15-19 years.

"Engaging sensitively with young people who have not yet injected to promote healthy behaviours is often a challenging task," said Hepatitis C Victoria programs manager, Ms Emily Adamson.

Once trained, the young women conducted information sessions in selected schools. Their target audience was other students who have had a run in with the law, or were at risk of leaving or being suspended from school.

The four films have become an essential tool for the women's peer education. The DVD covers topics including: what is hepatitis C?, how it affects you, how hepatitis C is transmitted and how to prevent contracting or spreading it.

Schools were eager to harness the positive capacity of young people's peer relationships.

"Schools recognise that this model can deliver explicit safer drug using messages that are often impossible in the normal school context," Ms Adamson said.

The peer educators have already reached 85 students within three alternative schools.

"However, the sessions were well received by both teachers and students," Ms Adamson said.

The project sought to coordinate a response to hepatitis C that was relevant, meaningful and led by young people using the principles of youth participation and health promotion.

Hepatitis C Victoria and Whitelion are evaluating the project and a report will be soon available.

If you would like to know more about the project, contact Hepatitis C Victoria. If you would like to check out one of the films in the DVD, go to **www.hepcvic.org.au**

PRISONS INCUBATE RE-OFFENCE RISKS

Australia's prison population is increasing at a rate well in excess of our general population growth, Queensland University academic Stuart Kinner told the conference.

The most recent census reported 27,615 adult prisoners in Australia, representing an imprisonment rate of 169 per 100,000 adults. According to the Australian Bureau of Statistics, our imprisonment rate has increased by 20 percent in the last decade (ABS, 2008).

Although the prison population is escalating, the demographic profile of prisoners has remained much the same. That is, individuals with a history of chronic disadvantage and entrenched health and social problems continue to make up the majority of our incarcerated community.

"And as one of our most marginalised communities, it should come as no surprise that illicit drug users feature heavily amongst this mix." Dr Kinner said.

In the Australian correctional system, the vast majority of prisoners report a history of illicit drug use, with over half reporting a history of injecting drug use (Butler & Milner, 2003; Johnson, 2004; Makkai & Payne, 2003).

"Prisoner drug use and dependency can therefore be regarded as both a health issue and a criminal justice issue," he said.

Of course, most issues faced by ex-prisoners, including illicit drug use, are a continuation of issues experienced before imprisonment, and while in custody (Hobbs et al., 2006; Kinner, 2006).

And though our incarcerated community, like most marginalised communities, has been the subject of a great deal of research, most research has focused on offending behaviour, failing to recognise the importance of prisoners' ongoing health and psychosocial needs in terms of reoffending risk (Lines, 2006).

This is currently being addressed by the Passports to Advantage study, a National Health and Medical Research Council (NHMRC) funded randomized controlled trial which Dr Kinner is conducting.

"The study recognises that the majority of our incarcerated community have experienced chronic social disadvantage, poor physical and mental health and high rates of risky drug use. Many prisoners enter custody with these problems, and despite the existence of some intervention programs in prison, most will leave with the very same problems," he said.

The majority of ex-prisoners will re-offend at some point in their life, and almost a third will return to prison within two years of release," Dr Kinner said.

Poor access to services such as drug treatment both while in prison and post-release means many offenders will continue to engage in problematic drug use. Post-release stressors such as unemployment, poor access to housing, mental health problems and discrimination and stigma exacerbate this risk, increasing the likelihood of re-offending.

The Passports study has commenced recruiting 1500 adult prisoners in Queensland, randomly assigning participants to an intervention or control group.

At the point of release, participants are given a kit consisting of a backpack, a book of positive stories about getting on post-release and most importantly a "passport", which is a personalised booklet. It contains a post-release checklist, a summary of the person's health status and needs, and a tailored list of health and social service providers in the community.

In the first 4 weeks post-release, participants receive weekly calls from trained support staff, who explain how to use the passport, check how the person is going (in terms of health, housing, social support etc), and encourages them to access appropriate services in their community.

A Consumer's Guide to DRUGS IN PRISON

With so much serious stuff discussed at the conference, it fell upon The Golden Phaeton to inject some dark humour into the otherwise serious topic of pharmacology in prisons.

This is A Consumer's Guide to Drugs in Prison, describing my personal experiences within the Victorian penal system with specific regard to the provision of pharmacotherapies, illicit drug use and drugs in general.

Of necessity, it will be a wholly subjective view, but I hope you will be able to glean at least some interesting food for thought. Before I begin, I'd like to put to rest any conjecture over why I was in prison. My case – which remains unresolved – involves the open-air cultivation of marijuana in my Mt Waverley backyard - and, of course, an anonymous community-minded neighbour.

In March this year, I was travelling smoothly, life was routine and I had no idea that the sword of Damocles was about to fall. I suspect that I was similar to much of the population, in that I underestimated or ignored the extent to which I was reliant on drugs.

Not just the buprenorphine, which I had been taking for about eight years, but also valium, which I relied on to treat anxiety and occasional insomnia, Zoloft the anti-depressant, of course cannabis, which owing to my compromised liver, I was deliberately using as a substitute for alcohol, and nicotine – or rather nicotine replacement therapies in their various forms which I had been well addicted to for more than a decade. And then, out of the blue, I was busted, and precipitously extracted from my life. Now my dependencies were brought into stark relief. When normally I would have dropped a valium to control my incandescent panic, I could not. And my last nicabate lozenge was rapidly dissolving against my gum. I would have to brave the depersonalising labyrinth of the criminal processing system without the chemical tools I normally had at my disposal – and certainly my dependencies barely figured on the radar of my captors, to whom I was nothing more than an easy day's work.

I could only thank the fates that I had picked up my "bupe" before the raid. Late that first night a second prisoner was hauled into my cold concrete cell at Ringwood Police Station. He most certainly had not picked up his dose, because through that night I was an involuntary witness to a brutal textbook case of opiate withdrawal syndrome. It was a horrible night, particularly for him.

At Ringwood, the next day I saw a nurse who allowed me to begin a valium regime, which I suspect is almost standard in prisons. Two 5mg tablets three times a day, decreasing over a week. I must say I was grateful for that, though it meant the early part of gaol experience was somewhat hazy.

Although valium was one of my customary medications, I learnt I would be very lucky to receive it beyond the first week. The authorities seem loathe to dispense it in prison, apparently preferring drugs like seroquel. The nurse also allowed me an occasional nicabate lozenge from my possessions, but after Ringwood, this blessing was to end. She promised to advance my bupe prescription, but although my lawyer made specific mention of it to the magistrate in two early hearings, it was yet to materialise.

Some 30 hours later I was transported to the cells beneath the Melbourne Magistrates Court, known to most as the "Submarine". It was crowded, inhospitable, concrete and near to mind-destroying. There is nothing worse than experiencing a continuous high-level fight-or-flight response where there is realistically nothing to fight and nowhere to flee.

It was here that I began to feel the beginnings of withdrawal; 55 hours had ticked by, and still, as much as I complained, no relief was forthcoming. I think - in these first days - when the levels of fear and anxiety are at their height, it would only be humane to provide a prisoner his customary medications. And I was not the only one. One guy in particular, a jovial rotund Greek, had not had his methadone for three days and I vividly recall his expression when, just before I was trucked out of the Submarine, I at last received my dose and he did not.

My next port of call was the Melbourne Assessment Prison or MAP, a turbulent place where prisoners of all stripes are massed together in units set around a rectangular concrete courtyard.

During my week there, I had a number of cell mates, one of whom stood out. He wore a handlebar moustache and bore a strong resemblance, both in appearance and manner, to Eric Bana's screen portrayal of Chopper Reid. Thankfully, he warmed to me and enjoyed freaking me out with hair-raising prison tales.

On my arrival at MAP, I was processed medically by a doctor who changed my prescription to Suboxone from Subutex, which was not allowed in prison. I took the opportunity to raise my dose and then brought up the subject of my nicotine lozenges. (Please note that they were lozenges, not gum, which I am told can be used to disable locks.) The doctor took one look at them and elected not to stick his neck out. "No way,' he said. "They'll become a currency". And that was that. No matter that cigarettes themselves were already a primary prison currency. The lozenges went back into my property and there they stayed. Obviously, it was not a good time for me to give up nicotine, so, at Her Majesty's insistence, I started smoking. Heavily. White Ox. When I ran out of money, I even committed that lowest of acts - to which even the hardest cases will not stoop – of risking hepatitis alphabeticus by trolling the yards for discarded butts and rolling up the salvaged shreds. I won't mention nicotine again, but once my legal problems are put away, it may be something I take up with the ombudsmen. From the word go, every doctor, every screw, every fellow bupe client drummed it into me that I must divulge to no one that I was on bupe. Because bupe is like gold in gaol - and you'll be heavied for it. Stood-over. Naturally, I took them at their word and kept my mouth shut. Thankfully, I never encountered any sort of pressure regarding my dose. Every afternoon, I would wait with increasing desperation for my name to be called through a distorted PA-system. Then I would travel across the gaol, through a number of manned stations to the dispensing area. When my turn came, I'd be called up for a pad-down and pocket search, then another, almost ritualistic investigation by a latex-gloved screw with a torch, who probed the recesses of my mouth, where I might potentially be hiding the tools of drug diversion. I'd then be directed to wait, sometimes with one or, at most, two others, several metres from the dispensing counter - against a wall of grey filing cabinets, and under the unblinking eye of a guard. When I was called forward I'd sign. My suboxone was ground to a fine powder and placed in a cup which I emptied under my tongue. The cup went in a bin. I returned to the grey cabinets and waited for the dose to dissolve. If I happened to move my hands from my sides, even just to scratch my nose, sharp words would issue from the screws. It was impossible not to feel hurried at this point, by screw and prisoner alike, but it was my dose, a crutch that was pretty much all that was keeping me going, and I always gave it sufficient time to dissolve - after which I was required to drink a cup of water, throw the cup in the bin, and submit myself to another torch-assisted mouth search. It's impossible in this short form to really address the issues raised by my observations. I'll simply end by saying that if you feel your rights and dignity are threatened by the policies of your dispensing pharmacist who makes you sign a contract (for example, to not finger any of his precious merchandise), spare a thought for the buprenorphine patients in prison who – whether reasonably or not – each day must endure a truly convoluted and depersonalising security gauntlet. For full, and even more interesting, version of The Golden Phaeton's conference presentation, visit **www.anex.org.au**

Understanding BBV risks for Aboriginal and Torres Strait Islander people who inject drugs

Trends in HIV transmission associated with injecting are of concern. Unique characteristics related to cultural, social and geographical factors increases risks for a generalised epidemic of HIV within Aboriginal communities in Australia. Whilst there is currently a very low prevalence of HIV among Aboriginal IDU overall, significant vulnerability exists. Consider the differences in identified source of transmission listed below:

HIV notifications 2001-2007 Aboriginal & Torres Strait Islander

- 138 cases
- (men who have sex with men) MSM 45%
- IDU 19%
- Women 30%
- Non Aboriginal & Torres Strait Islander
- 5457 cases
- MSM 71%
- IDU 3%
- Women 10%

"The numbers of notifications haven't increased, but the rate of exposure reported due to injecting drug use has increased significantly," - Dr James Ward, Program head Aboriginal and Torres Strait Islander Health, National Centre in HIV Epidemiology and Clinical Research, UNSW.

Hepatitis C

In 2006 the rate of hepatitis C was 163 per 100,000 for Indigenous people, while 52 per 100,000 for non-Indigenous people.

Hepatitis B

In Australia, approximately one percent of the population has hepatitis B. The rate is higher among Indigenous people, varying from three to 35 percent.

STIs

Where accurate and reliable data is available, sexually transmitted infection (STI) rates are reported up to eight times higher in Indigenous communities than the broader population. This coupled with Indigenous people's lower access to appropriate health services poses particular risk, as the transmission of HIV is deemed easier if other STIs are present.

From: Increasing access to services in NSW for Aboriginal people at risk of contracting or who have blood borne infections/Aboriginal Health and Medical Research Council of New South Wales {and} Mandala Consulting. Strawberry Hills, N.S.W. AH&MRC Consultancy Service, 2006.

Correction

In the Vol. 8 Ed. 2 edition of the Bulletin, primary health service Living Room was incorrectly referred to as Living Space. The NSP service, Foot Patrol, was omitted as one of the organisers of the World AIDS Day event photographed in the edition. This mistake was made in production.

HARM REDUCTION NEEDS GOOD PR

Locating needle syringe programs (NSPs) and other services for drug injectors almost always raises concern within communities. NSPs do not increase drug consumption, but as the above quote illustrates, some people still think that such services entice injectors to an area.

A conference session was therefore dedicated to the difficult, but achievable, task of addressing potential community resistance through carefully planned and executed advocacy strategies.

The first presention was by team leader at Footscray's Healthworks, Andrew Sinclair, and Burnet Institute's Rebecca Winter. They discussed community concerns when a new NSP was established in Braybrook, which is also in Melbourne's west. Their work compared community opinion before the NSP opened, one month afterwards and then a further five months later.

Setting up the Braybrook NSP included a consultation phase in which residents voiced concerns that an NSP may:

- Increase aggressive or other inappropriate behaviours in the area;
- Increase exposure of young people and others to illicit drug use;
- Increase injecting litter in the vicinity; and
- Negatively impact on traders.

Six months after the establishment of the NSP, Ms Winter and Mr Sinclair found there had been no actual change in instances of aggressive or other inappropriate behaviour in the area. However, the local community's perception was that public aggression had increased since the NSP opened. Those surveyed also believed that exposure of young people and others to illicit drug use had increased since the NSP had opened.

Similarly, whilst the study found no evidence of an increase in the levels of inappropriate disposal of injecting equipment in the local area, the community's perception was that discarded injecting equipment had increased since the NSP opened six months before.

Communications preparation is vital

Challenging prevailing community attitudes and misconceptions was also a theme of Patrick Kennedy's presentation. Mr Kennedy is the Managing Director of Kennedy Communications and manages community and media relations for the medically supervised injecting facility in Kings Cross, Sydney. He emphasised to delegates the importance of establishing a comprehensive communications plan.

Mr Kennedy stressed that, as the first such facility in the English speaking world, managing information that would either fuel or dispel community misconceptions hinged on acknowledging that the media needed information from the facility operators. He emphasised the value in actively managing the media by providing printed material, images and TV-ready footage that they could use.

Conflicting community attitudes

Anex's Business Development Manager, Libby Ward-Christie, discussed the importance of identifying and understanding the community's attitudes on illicit drug use. Anex recently surveyed 503 people to measure knowledge of drug-use issues and attitudes towards drug use.

"We need to understand what the broader community, outside the drug and alcohol sector, knows and thinks if we are ever really going to have a society equipped to deal with the challenges presented by drug use," Ms Ward-Christie said.

The Anex research found that the general public was fearful when it comes to drug issues. Eighty-six percent of respondents stated that they would be extremely concerned if someone close to them was using illegal drugs, 84 percent stated that illegal drugs could not be taken without causing harm to the user, and 62 percent said they believed taking illegal drugs would cause addiction. The majority of the general public also regarded illegal drugs as a serious (85 percent) and growing (77 percent) issue for society.

The Anex research also found that there is very little understanding in the general community about harm reduction initiatives. Consistent with the experience of the establishment of the Braybrook NSP, the Anex study found that 30 percent of the respondents believed that NSPs encouraged increased drug injection, while another 35 percent were unsure. Less than half of the respondents (41 percent) knew that NSPs do not dispense the actual drugs.

The Anex study, which is unpublished, also found that many people in the broader community are not open to learning more about drug issues, with 46 percent believing they are already "well informed". A further 16 percent believed that drug use is not an issue that is relevant to them. Despite a high degree of public misconception about drugs, people rate their knowledge of drugs and drug issues highly.

Ms Ward-Christie said the survey indicated a conundrum: people need to be better informed of the complexities of drug issues and what is being done to address them, but many were not open to learning. One possible solution would be more targeted communications and marketing of harm reduction information.

"We need to understand as much as we can about how people's attitudes in the community vary, and what drives these differences. Effective communication of the importance and effectiveness of harm reduction initiatives relies on us exploiting these drivers in the same way marketers create demand for previously unwanted products and services," Ms Ward-Christie said.

INDIGENOUS INJECTORS

Blood borne viruses (BBVs) have the potential to pose significant health, social and economic risks to Aboriginal communities. Several presentations at the Anex conference highlighted the need for harm reduction strategies to reduce risks of hepatitis C, hepatitis B and HIV transmission.

Monique McEwan is a harm minimisation officer from the Aboriginal Health and Medical Research Council (AH&MRC) of NSW. She strives to increase Aboriginal people's access to NSPs. She made reference to the 2006 report Increasing access to services in NSW for Aboriginal people at risk of contracting or who have blood borne infections.

The report identifies the benefits of a holistic approach, recognising that Blood Borne Virus (BBV) cannot be successfully addressed in isolation, as would be the case under a disease model of treatment. Other issues affecting physical and psychological health should be considered in addition to social and cultural wellbeing. Encouraging and supporting individuals to take responsibility in protecting themselves against BBVs, means that any other impediments to their health and well-being must be addressed, Ms McEwan said.

Drug and alcohol issues, mental health issues, maternal and child health all have significant relevance to the risks of contracting BBVs. But the potential for direct blood borne virus transmission via injecting drug use should be of particular focus for harm reduction strategies.

As in any other community, the issue of injecting drug use amongst Aboriginal people is one frequently associated with stigma, shame and marginalisation. The AH&MRC report highlights this marginalisation as a major barrier for Aboriginal injectors accessing harm reduction services such as NSPs and services that offer BBVs screening and treatment. Other factors include:

- perceived loss of confidentiality and privacy;
- transport to and from services;
- decline in bulk billing by GPs;
- the cost of treatment;
- the history of services in terms of their relationship with the Aboriginal community;
- the stigma associated with BBVs; and
- the largely asymptomatic nature of HIV, hepatitis B and C which may induce complacency.

In a similar project, the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) and Anex have partnered to help improve the health of Aboriginal Victorians who inject drugs. The partnership was forged in response to the disproportionately high levels of blood-borne viruses among Aboriginal communities, and a perceived reluctance by some Aboriginal people to identify as an IDU.

Peter Waples-Crowe from VACCHO spoke of the need to effectively address these barriers and improve access to harm reduction strategies, whilst reducing the stigma associated with injecting drug use and BBVs. The project also encourages development of partnerships and collaboration in regional areas between mainstream services and Aboriginal Community Controlled Health Organisations (ACCHOs).

The project will promote and provide workforce development opportunities to enable better service delivery.

Many of the partnership's findings to date mirror that seen by the AH&MRC particularly in regards to barriers to service access. Additional factors identified by the VACCHO/Anex partnership include:

- The negative impact of high staff turnover;
- The benefits of more creative service delivery, including outreach;
- Increased fear around lack of anonymity in smaller regions; and
- Greater recognition/support for treatment and abstinence focus over harm reduction.

Both speakers discussed working with Aboriginal and mainstream organisations to effectively promote harm reduction strategies. In the mainstream, this included highlighting the benefits of regular cultural awareness training. For Aboriginal organisations, this included increasing community awareness and understanding whilst promoting ownership. Working in close collaboration with Aboriginal elders, particularly board members of ACCHOs, was considered a positive step in achieving these goals.

Citation: Increasing access to services in NSW for Aboriginal people at risk of contracting or who have blood borne infections/Aboriginal Health and Medical Research Council of New South Wales {and} Mandala Consulting. Strawberry Hills, N.S.W. AH&MRC Consultancy Service, 2006.