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INJECTED OPIOIDS DEMAND NEW APPROACH: IS YOUR NSP READY FOR PHARMACEUTICALS?

Increasing prescription opioids misuse is demanding new responses. Significant work is being undertaken to help shape the National Pharmaceutical Drug Misuse Strategy (NPDMS) and jurisdictions are coming on board to offer new injecting paraphernalia designed to help people who inject crushed pills.

With data pointing to significant increases in overdoses related to opioids other than heroin (as well as increasing harms from the injection of pharmaceuticals that are designed to be taken orally), needle and syringe programs (NSPs) have been adjusting to these new conditions.

Queensland Health is the latest jurisdiction to consider making wheel filters more accessible to injecting drug users in recognition that many users are injecting pharmaceuticals.

"We came to the conclusion that there are many parts of Queensland where injecting tablets is more common than injecting heroin," said Robert Kemp from Queensland Health.

"Pill injecting has always been part of broader patterns of injecting drug use. What we are witnessing is a resurgence in pharmaceutical opioid diversion, use and misuse driven by complex socio-economic and demographic factors, and embedded within significant increased patterns of use in the general population.

"We're moving to an evaluation of the use of wheel filters to decrease injecting related injury and disease this year, with a view of broadly introducing wheel filters in the next financial year," he said.

"Wheel filters have been provided to injecting drug users across Australia on a cost recovery basis since the 1980s. If the evaluation is positive we are looking at making them more accessible by subsidising their cost, and increasing the number of sites that use them.

"It seems like the logical next step is to promote pill filters and to develop new ways to make them more widely available in the community."

Recent evidence suggests that despite the strong evidence that diverted opioids are predominant in places such as Tasmania and the Northern Territory, the extent of diverted pill-based opioids being injected is increasing across the board.

According to the latest evidence obtained from the Australian NSP Survey National Data Report 1995 – 2010, "reports of pharmaceutical opioids (including morphine and oxycodone) as the drug last injected were common in Tasmania and the Northern Territory in all survey years, however reports have increased significantly in other jurisdictions since 2000" [2].

"In 2010, 16 per cent of all survey respondents reported injecting pharmaceutical opioids, making pharmaceutical opioids the third most common drug class last injected after heroin and methamphetamine."

'Working in partnership with other harm reduction services and NUAA, a workshop was held at MSIC in March 2011 to start the development of consensus principles for reducing harms associated with tablet injection'

The latest evidence from the Medically Supervised Injecting Centre (MSIC) is that opioid-based pharmaceuticals are the most commonly injected drug.

According to Jennifer Holmes from MSIC, the centre has been gearing up for the increased demand for injected pharmaceuticals with a special training session for users and staff conducted by Dr Raimondo Bruno from the University of Tasmania [3].

"MSIC has seen a steady increase in the number of prescription opioid tablets being injected since 2005. This follows similar trends seen in other western countries (such as the USA) and is related to increasing availability of sustained-release oral opioid medication, as well as new formulations on the market. There are now more supervised injections for prescription opioids at the Sydney MSIC than for all other drugs," said Ms Holmes.

In response to this increased injection of tablets, metal spoons, compressed cotton filters and wheel filters were added to the equipment provided at Sydney MSIC. Consultation and education sessions were held and there was an increase in the use of pill filters.

Educational resources were found and developed, however questions remained on best techniques and how to effectively instruct people in the use of filters. Marguerite White, Registered Nurse at MSIC, found that the research work by Dr Bruno and colleagues demonstrates that filtering significantly reduces the number of harmful particles with minimal loss of active drug.

"Working in partnership with other harm reduction services and NSW Users and AIDS Association, a workshop was held at MSIC in March 2011 to start the development of consensus principles for reducing harms associated with tablet injection," Ms Holmes said.

"Thirteen of the 39 participants at the workshop were people who inject tablets. Cotton wool, compressed cotton filters and wheel filters were used. In May this exercise was repeated with the majority of MSIC staff at our regular training day using first, a paracetamol mix and then filtering a mix using Oxycontin® tablets. Staff have reported that this hands-on practice of filtration has increased their confidence and skills in providing information to clients who are injecting tablets," she said.

"Key messages that consistently emerged from both workshops are cold preparation; use of at least 3-5mls of water to prepare mix; coarse particle filtering first followed by fine particle filtration (cotton and then wheel filters or dual wheel filters) to prevent blocking of wheel filters. Work is continuing to further refine principles and develop messages that are clear, concise and practical to disseminate to people who inject tablets," said Ms Holmes.

"The very limited availability of wheel filters in NSW remains a concern given the importance of filtering," she said.

The implications of not promoting the use of filters by those who inject can be heart breaking. Colin Coxhead, a manager of NSP programs in Scotland and Australia and currently working with

continued page 3

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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.

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PROFILE:

Francine Smith

A good apple in Tassie

Francine Smith has a unique relationship with Tasmania's needle and syringe program (NSP) workforce. Not only is she the NSP co-ordinator with the Department of Health and Human Services, she has trained all the Apple Isle's licensed NSP staff and still regularly works alongside them on the frontline.

Ms Smith first began working with adolescent drug users while at The Link youth health service. Years later she still sees her old clients during her regular shifts at two NSP services.

"It's a good opportunity for me to do things like promoting vein care, or just spend time with clients. You just pick up so much by having client contact," she said.

Ms Smith said that maintaining client contact helped her make policy and budgetary decisions on behalf of government.

"When it comes time to make policy decisions and other decisions in relation to clients in the NSP and NSP themselves, you've got first hand experience."

She gave an example of decisions to make wheel filters and butterflies available. This is very important in Tasmania where, according to the annual NSP client survey, pharmaceutical opioids and methadone are the most commonly injected drug.

Talking and engaging with clients and their needs has proven to be the best way to design effective programs.

"It's easy if you just look at the equipment and look at the clients that came through and the drug that they named," Ms Smith said.

"You might be able to come up with a calculation and be happy with that. But when you are working at an NSP, and you're talking to the client and you're asking them how many times they might need to use a winged infusion set to find a vein, how many times they might be wanting to filter tablets by using a pill filter and hearing the difficulties they have, or where they live, how easy it is to get access to NSPs and equipment. It may change the decision you may make because you're actually talking to the client and hearing their side of the story first hand," she said.

As a former nurse, Ms Smith gave her perspective on why some staff in Emergency Departments may not be enthusiastic about providing injecting equipment to drug users, or might even oppose it outright.

"They only see the end product. They see the stoned, or the angry, or the hanging out or the injured. They see the end result of what drugs may have done to people so they make a judgement on what they see. If you're working in an ED and someone is off their face, or has overdosed or has some hideous injecting-related injury you (may) make a judgement from that.

"They don't see the other stuff that goes on. Most nurses work in a clinical setting a lot of the time. And they also come from a healing perspective where they are there to make people better. They make people better, send them out and do it all over again. I can see where they are coming from."

Ms Smith believes that although there may be a few young people starting to inject drugs, of those that do, many are not formally accessing NSP services quickly enough. Ms Smith believes that in order to reach early injectors more effort needs to be channelled toward working with experienced NSP clients.

"We should approach people who are already injecting, because very rarely do a whole group of young people who have never injected inject. Because they haven't got a clue. The first time a young person injects, there would be an experienced injector somewhere around them.

"You talk to older users and ask if you are going to be initiating people into injecting, or if you've got young ones around you who want to inject, what are you saying to them? What are you doing? If they are really insistent on wanting to inject, are you talking to them about washing their hands before and after, are they in a situation where they can have access to clean equipment, clean surroundings, sharps containers? All that stuff."

Ms Smith said the people committed to assisting drug users improve their health and welfare are working in a world where many people's attitudes can be demoralising.

"I did a session with a pharmacy just recently and one of the pharmacist said 'you should just let them die'… How do you have a comeback to that? If that's somebody's way of thinking, God help us."

She said such prejudice remained the biggest challenge.

"The biggest misconceptions are around Tasmania's drug use. I think too many people watch *A Current Affair* and *Today Tonight* and they think we are all on heroin down here.

"And I think that it's trying to get across to people that these people live in the community with us. They do not live outside the community behind a barbed-wire fence," she said.

Pietta Jackson, Francine Smith, Sonia Warmuth, Jo Harvey.

SWITCH IN TASSIE NSP

Anglicare Tasmania has established a needle and syringe program (NSP) in Hobart and Glenorchy.

It replaced the NSP previously run by the Tasmanian Council on AIDS, Hepatitis and Related Diseases which has decided to discontinue its NSP service.

Anglicare's NSP will be overseen by Ms Tamara Speed who was instrumental in establishing the Western Australian drug users' organisation WASUA and has also worked with AIVL.

Tasmania now has six primary outlets, 22 secondary outlets, 77 pharmacy-based outlets and three vending machines. Slightly more than one million needle and syringes were distributed in 2010. Winged infusion sets, bacteria filters and pill filters are provided free through the primary outlets. NSPs also give out 1ml to 20ml syringes.

Ms Speed said that the new NSP would be closely aligned with Anglicare's wide range of other drug and alcohol services as well as its broader social support programs.

The new program will also include Tasmania's third syringe vending machine which has been provided through State Government funding.

She said that one of the first initiatives that occurred following her appointment was to "investigate the opportunity for the alcohol and other drug service staff to be trained under the Tasmanian HIV Preventative Measures Act so that they could become licensed to distribute sterile injecting equipment in the context of their workplace management.

"For example, if they go out to work, or see a family in their home, they could do discreet NSP provision in that context."

Clarity of thought essential to handle CHAOS

Many NSP workers are faced with overdoses and need to be able to advise clients the appropriate ways to respond. Most heroin injectors have witnessed at least one overdose.

There are a few golden rules that NSP staff should try impart to clients, particularly younger ones who are inexperienced, according to ambulance paramedic, John.

It's important to explain the fundamental signs of opioid overdose, John said. "The most obvious is when the person isn't breathing, or has shallow breathing. Blue lips or fingers tips are another obvious sign."

Other key points to communicate:

- Snoring or gurgling sounds usually means the person is not able to breathe properly.
- There is a fine line between being on the nod and overdose.
- Not all overdoses happen quickly and sometimes it can take hours for someone to die.
- If you can't get a response from someone don't assume they're asleep and don't leave them to sleep it off.

In the case of opiate overdose it's best to call an ambulance. "We only call the police if the crew feels threatened or if the person dies," John said.

"Put them in the recovery position and call the ambulance. We'll have Narcan® on hand to revive them if possible," said John

The signs to look for with speed, methamphetamines, cocaine or ecstasy overdoses are different, John said.

"A person may appear confused, have severe headaches and feel hot but are not sweating. They may have trouble breathing and be agitated or paranoid to the point of hallucination. Chest pain is another sign and seizure and lapsing into unconsciousness are possibilities," John said.

The advice in this situation is different to opiates. "Of course, if they're unconscious call the ambulance immediately. However, if they are not unconscious, it can help to ask them to breathe slowly and tell them that everything is going to be okay. If they feel hot, try to encourage them to move somewhere cooler," he said.

"Staying calm helps calm the other person. Keep the area as quiet as possible – switch off music or get them to take off their headphones. If there are noisy people around, go to a quieter area," he said.

One of the most important things an overdose witness can do is to make sure there aren't too many people hanging around by the time the ambulance arrives, said John.

The Bulletin also interviewed a woman who has injected heroin for more than 21 years. One of the most important things to do when someone overdoses is to calm people down, said "Ann" who is in her mid-50s.

"With the police and ambulances, it can be confusing if there are too many people around. People have this thing where they have to open their mouths. So that's why I say, get rid of the riff raff and the bullshit," said Ann.

"Have one person there to talk calmly to the ambulance officers. Give them no bullshit and have as much information as you can. They will have the Narcan® and everything else they need," she said.

Sometimes the usual practice of trying to call an ambulance doesn't work, as Ann experienced a few months ago.

"There were three of us and one of the girls said she'd been using. She'd actually been off the gear for six months, but we didn't know that because we hadn't seen her in that time. She was greedy – she wanted a third of what we had," she said.

"We were in a little alley. We did it and then I noticed her out of the corner of my eye. She was dead man, she was dead. No pulse, no breath, nothing. She was grey.

"And the other person with us just fell to pieces. I told her to ring an ambulance, but instead she rang somebody else and told them to do it. It didn't work out."

Ann has done first aid courses through her local health service/NSP and knew what to do. "It was Dr ABC. I did full on cardiac for almost an hour. It was so scary. If I wasn't there she wouldn't have done it (drugs), so in a way I shouldered my own responsibility," said Ann.

Ann said that even if injectors have received training on what to do "90 per cent of people still don't have that immediate wherewithal to know what to do" as panic often sets in.

The recent experience down the alley not only required Ann to apply cardiopulmonary resuscitation, but also to calm the situation down.

'...if they're unconscious call the ambulance immediately. However, if they are not unconscious, it can help to ask them to breathe slowly and tell them that everything is going to be okay. If they feel hot, try to encourage them to move somewhere cooler'

"She (the second woman who panicked) was worried about cops. But I talked her through it and gave her a job to do. It's important to speak calmly, clearly and thoughtfully. Even if you just get them to untie the other person's shoelaces and tie them off around their (overdosed person) fingers. It keeps them busy. It's no help at all, but it keeps them from screaming in your ear like fairy floss," said Ann.

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Anex, was shocked by the extent of amputation amongst non-Aboriginal and Aboriginal users of NSP programs in the Northern Territory.

"I've developed and managed many NSPs – but I have never seen anything like the Northern Territory in terms of the harms to people resulting from injected pill use," said Mr Coxhead.

"Many people, far more than I've seen before, have missing fingers on one hand or both, and/or deep and visible vein damage. In 40 years in the sector, it was a shock to see just how many people had serious injecting-related injuries."

The National Centre for Education and Training on Addiction (NCETA) at Flinders University has been leading stakeholder consultations and calling for submissions for the development of a new strategy to tackle a wide variety of prescription and over the counter (OTC) pharmaceutical drugs which are subject to non-medical use, misuse and/or diversion.

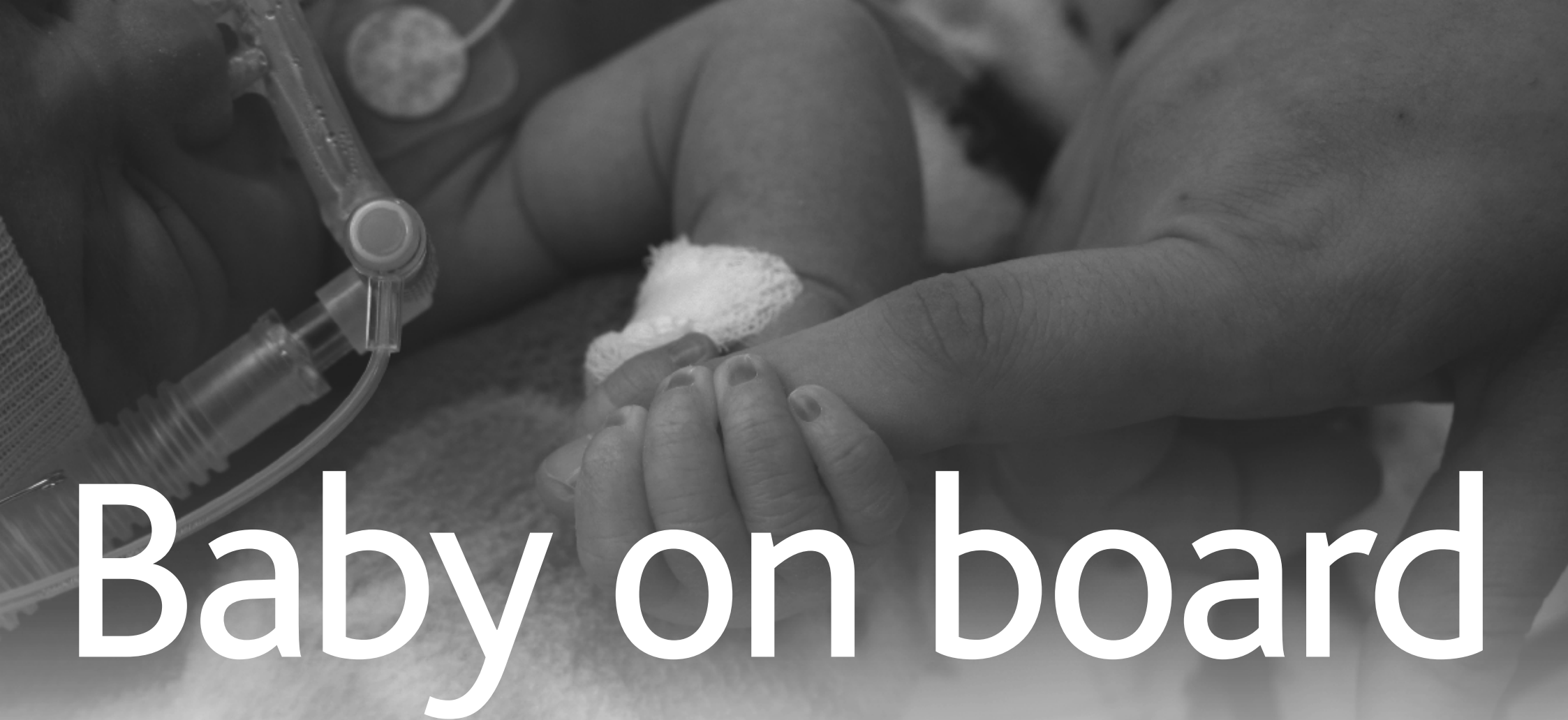
The prescription drugs being specifically targeted are opioids, benzodiazepines, psycho-stimulants, anti-depressants, anti-psychotics and performance and image enhancing drugs. The OTC drugs of relevance include codeine-containing analgesics, pseudoephedrine and anti-histamines.

When completed, the National Pharmaceutical Drug Misuse Strategy will focus on a number of key issues, including:

- "Medication monitoring and regulatory processes and their interface with the clinical environment;
- The healthcare workforce development needs to enhance quality use of these medicines, especially the workforce development needs of prescribers and pharmacists;
- Where necessary, recommending the development and implementation of guidelines to enhance the Quality Use of Medicine (QUM) in relation to conditions such as chronic non-malignant pain, anxiety, and insomnia;
- Examining what regulatory, monitoring and investigative resources might be required to effectively address medication shopping and the illicit supply of pharmaceuticals for profit, including consideration of the timely and appropriate information exchange between health and police agencies;
- National data availability concerning the extent and nature of misuse of these medications; and
- The measures required to minimise the harm from unsanctioned use of these medications"[4].

Anex has made a submission recommending improved measures such as greater resourcing of NSPs to meet the changing demands of those that inject drugs, and for an increased emphasis on workforce development and greater availability of wheel filters.

According to Mr Coxhead from Anex: "Needle and syringe programs are often the only health service used by people who inject drugs. As such they are uniquely placed to engage with people who inject diverted pill-based medicines."



Baby on board

Drug users who are pregnant or parenting are a particularly complex client group with specific health, emotional and social needs. Pregnancy and motherhood alone can be an overwhelming and exciting experience, but fears of child protective service involvement, facing stigma from society, healthcare workers and uncertainty about their capacity to appropriately parent further complicates the experience.

The Sidney Myer Fund funded Anex to research drug users who are parenting. After interviewing service providers and male and females who use illicit drugs, some common issues emerged. These ranged from clients not knowing about what services exist, to needing more information on basic nutrition during pregnancy and how to prepare a bedroom for their new born.

Managing drug use

The research found that many women and men who use illicit drugs during periods of pregnancy wanted to manage their drug use. This varied from wishing to detox and be abstinent, to accessing a pharmacotherapy (mostly methadone) program, and using in small doses to manage withdrawal. Attempts to manage drug use were not always easy or successful. Many women were not able to find the supports they required to assist them through this process.

"Women feel bad and guilty about their drug use, but the addiction overrides this. They do not follow up on their care; they accept that their life is shit so there is no focus on looking after themselves. The guilt restricts them and it often leads to increased drug use." – *Service Provider*.

"[There is a] psychological aspect – hiding because of the shame associated with drug use during pregnancy, therefore you do not access the care and information that is needed. You cannot converse with anyone about this so it adds to the stress." – *Service Provider*

Welfare issues

Social welfare issues such as lack of housing and poverty were major factors that impact on the lives of women and men who use illicit drugs, which also have a significant effect on the pregnancy. Lack of a stable environment during the pregnancy, stress from housing and financial concerns, and inability to provide basic necessities for looking after a newborn were some examples.

"Often women don't know where to go. This causes a lot of stress. Couch surfing is common for chaotic drug users, but this is not appropriate for pregnant women. There is so much follow-up involved in accessing stable housing." – *Service Provider*

"We completed the application for public housing during the pregnancy and it took us more than two years to get into public housing. In the meantime we were with a child." – *Male client*

Navigating the health system

Many interviewees said that navigating the system could be difficult, from knowing what range of services are available to understanding what steps they could take to ensure a healthy pregnancy.

"You don't know where to go. I think I went for an ultrasound at about three to four months and then in the last few months I went and had antenatal check-ups. I did not know what to do, you have check-ups, but they don't tell you what to do next or you don't know what questions to ask." – *Female client*

Department of Human Services

The fear of the state's Department of Human Services (DHS) involvement and its consequences was palpable for both women and men. The fear (whether founded on fact or perceived) has the effect of preventing women from disclosing their drug use. This can put an unborn child at risk as a result of inappropriate medical care and prevents women from accessing services.

"Women are often isolated from health and welfare services. Whether it is reality or perception, they fear that services will take their baby away." – *Service Provider*

"I know women, who have had babies and have had another baby and their other older children have been taken off them by DHS and they are trying everything to try and hold onto the children that they have just had … They are so concerned, and I can't imagine that if they have already had kids taken off them that they would be accessing any services. They will specifically try and fly under the radar and not even tell their parents or anyone about it. There has got to be somewhere they can see someone." – *Male client*

Preparing to be a parent

Many first time parents are not prepared for what is to come. This can range from understanding infant withdrawal, to basic preparation for bringing the newborn home. Not having access to other parents and sharing experiences was also an issue.

"What to do with a newborn. The nurse tells you in hospital but you are so tired that you forget." – *Female client*

"Maternal health care centres host mothers groups. My partner and I went to one of those groups but I think because I was continuing to use, I felt very uncomfortable about going to the group… Perhaps I should of gone to more mothers' groups, but I really did not feel that I had much in common." – *Female client*

Healthcare workers – agents for change

Healthcare workers – whether they are frontline NSP staff, social workers or nurses – can play a significant role in assisting women and men who use illicit drugs to ensure a healthy pregnancy and healthy and stable environment for their newborn.

Addressing the shame and guilt that women may feel about using illicit drugs and pregnancy, and linking women with social supports are just some of the ways that healthcare workers can make a difference.

"Need to make a fuss about these women and their pregnancy. Then once you have developed some confidence in the client you can discuss whether this is what the women actually want. It is important to establish if there is ambiguity about the pregnancy, and if so, refer them to counselling. Make a fuss. Make the parents feel good." – *Service Provider*

"Having healthcare workers acknowledging pregnancy as a positive thing. Celebrate the pregnancy instead of looking down on the women." – *Service Provider*

WOMEN, MOTHERHOOD AND DRUGS FORUMS

Better outcomes for parents and their newly born

Anex conducted a series of forums on 'Women, motherhood and drugs – building capacity for young mothers to minimise drug harms and maximise health.'

Attendees were a mixture of NSP workers, drug and alcohol workers, midwives and community health workers.

The forums were used to network local services, build capacity amongst the workers and dispel myths by providing accurate information. Dorothy Campbell and Nicola Cowling from Anex ran the forums in conjunction with the Royal Women's Hospital, and found that most attendees had experience in the subject area.

"So far it's been a really positive experience. Everyone who has attended is extraordinarily interested and very keen to value add

INTERVIEW WITH SALLY

A mother of three tells the Bulletin about her sense of isolation when trying to access health and child support services.

Sally* (not her real name) has been a drug user for most of her life. After immigrating from Asia as a child, she experienced the freedoms of a more relaxed Australian society.

Sally was 12-years-old when she started using drugs and is now in her early thirties. At school she was with a group of girls who were heavily into drugs. One day she asked them what they were doing. One girl replied "nothing", and another girl said "I'll show you."

Heroin has always been her biggest problem, but she has also used pills and smoked marijuana.

In her youth she spent time with a rough crowd, ran away from home, got into crime and spent time in a juvenile detention centre. Sally said: "I hung out with girls, 10 years older than me who were prostituting themselves. They took me under their wing in a bad way I suppose. I never starting prostituting, but I started using full time."

Sally would "go to work with them," sitting outside in the car or inside a lounge room while her friends worked.

Sally was a "hard blown junkie" during her first pregnancy. She was doing strip work to get $600, and $400 of "that was going up my arm within an hour." Sally was also homeless and sleeping under a bridge at one point.

Her first child "was so withdrawn" and spent two months in intensive care. Sally said, "That was a shock. It was hard to see. When he was born I felt I'd done the boy such an injustice. He was sick for two months straight. The child's grandmother stepped in and adopted him straight away. She told me that I shouldn't have had the baby, but I wasn't thinking of anything but myself. I still have a photo, he looked terrible. I feel guilty about that."

Her longest dry spell was in her early 20s when she had a job and was living with her partner's mother. Although she was using in her following pregnancies, it was much less, and her second and third children were healthier.

Sally now has had three children. Her first child lives with his grandma, and her second and third child, who are both autistic, live with her.

Her experience of the health system has not always been positive. "Dealing with the system was scary. Everyone was so judgemental. It was obvious when I walked through the door I was a drug addict. They judged me straight away. It was really negative. I had human services on my case. They were ringing up, sending workers round. I understand from their point of view now, but all they did was scare me out of doing anything. It was all the negative stuff. I was constantly in fear of human services," she said.

Sally found more support with a primary NSP and health centre who "stepped in and helped straighten me out. While they never ever said that what I was doing was ok, they were willing to grab me and say we know you're in this situation, this is what we can do."

Sally is on methadone and is down to 30mls a day. She is trying to stay clean, but said "heroin is my biggest enemy." If she uses, she tries to do it when her children aren't with her. Her two sons are "healthy, happy, bright kids" and she is "trying very hard to be a good mum."

She'd like to start a group for other mothers who have been in a similar situation. Sally attended a playgroup in her local neighbourhood with "mainstream mums", but feels there is a lot of stigma. She says it's only the "mainstream mums" that come out while there are drug using mums "at home, alone and stressing."

"I am surrounded by young girls, who, if only they knew what I know now. A lot of them are struggling. I know I have a lot more work to do, but I could help someone else still. People never ask for help, but there's so much help out there."

'Participants recognised that women in chemical dependence units often have multiple and complex needs such as homelessness, domestic violence or mental health issues.'

to their practice, to capacity build. Although we were presenting to them, I also learnt a great deal from everyone who attended," Ms Campbell said.

Nicola Cowling from Anex added: "It was great to see so many participants chatting after the presentation, trying to get contacts so they could refer clients to other local services. Many people knew one another, but the forums really enhanced that. The service mapping exercise, in particular, really highlighted projects and services that people didn't know about such as child care for vulnerable families and material aid available including brokerage for new prams and cots."

One common issue for many attendees was that drug and alcohol use alone was not the single factor leading to difficulties for new parents. Participants recognised that women in chemical dependence units often have multiple and complex needs such as homelessness, domestic violence or mental health issues.

Ms Cowling noted interesting discussions took place. Some participants questioned the likelihood of pregnant drug users providing an honest and accurate drug history. The midwives in the group were quick to point out that the women they see are very concerned about the welfare of their unborn child and so are generally very honest about their drug use.

Due to the sensitive nature of the information, building an accurate account can take time and relies on establishing trust and rapport, Ms Cowling said.

The use of prescribed medications, particularly anti-depressants, was a common concern raised, and care and caution was necessary to ensure the medication prescribed protected the health of the pregnant woman and her baby.

Similarly, several alcohol and other drug workers expressed concern about the relatively high doses of methadone some of their pregnant clients were on. The trainers addressed these concerns by explaining higher methadone doses are often necessary to maintain the pregnant woman throughout the pregnancy and that doses must be reduced gradually (as is the guidelines for methadone reduction).

The trainers explained that greater methadone doses are not linked to a greater risk of infant withdrawal (neonatal abstinence syndrome).

With the support of the Sidney Myer Fund, Anex has developed a booklet called Keeping Mum and Baby Happy & Healthy which discusses parenting, pregnancy and drug use. To request a copy, please email your details to info@anex.org.au

From Russia w

Abridged version of Irina Tepplinskaya's speech at the 2011 International Harm Reduction Conference held in Beirut.

My life is like a small mirror showing a bigger, general picture of what's happening to millions of people using drugs in Russia and most other countries of the former Soviet Union. I am 44, and for the past 30 years I have been suffering from a chronic opioid drug addiction. According to the World Health Organisation and the United Nations Organisation, drug addiction is a chronic recurrent disease. However in my country, people suffering from drug addiction are outcast, socially isolated and deprived of their civic rights. When I was 14, I had my first experience with opium, and since then I have been living in my country as an outlaw, persona non-grata. I had multiple unsuccessful attempts to treat drug addiction in different clinics, but they all failed.

I spent 16 years in prison for purchasing and possessing drugs for personal use – which means, for behaviours directly caused by and symptomatic to my disease. My family abandoned me, I was homeless and lived on the street for two years. Whatever happened, I continued using drugs. I lost my battle with the disease. Through contaminated syringes, I have acquired hepatitis C and HIV. In prison I developed AIDS and had tuberculosis. HIV therapy in Russia is guaranteed by the government, but to get essential HIV medicines in prison, I had to go on hunger strikes and open my veins. As a result, I almost killed myself, and before it was too late I was sent from prison to a tuberculosis hospital.

I survived despite everything – even though nobody actually cared for me: not my family, friends or my country. I had no place to go. For two years I lived and worked as an aid-woman in the HIV-TB co-infection department of the tuberculosis hospital. I witnessed more than 100 friends and people I knew die. Almost all of them died for one reason – they were opioid-addicted, and they came for treatment in the last stages of the disease, when it was too late. Drug-addicted people have little opportunity to receive adequate HIV and TB treatment, as they just cannot stop being addicted, and their addiction forces them into never-ending hunts for drugs and money, often involving criminal activity.

All those officials responsible for the deaths of thousands of young people in Russia – through their lack of professional expertise, negligence, narrow-minded stubbornness, personal idleness – how can they sleep easily? I wish they saw people dying without help. I wish they looked into the eyes of those living without hope. Before they died, almost all of them asked for heroin, and I was bringing it to them. I also made injections, because many of these dying people could do nothing, not even find a vein. I could have been sentenced as a drug-dealer and if I was caught, the judge would not care that I did it to fulfil people's last wish.

There are different ways to love and remember those who died. Everyone does what they can: mourning, praying or bringing flowers to their tombs. Some choose to act instead of talking. This was my reason to become an activist: if the government does not care about us, we will protect our own rights. I took a number of training courses and started to work at an AIDS service organisation for drug users with HIV. Being drug-addicted, I had some difficulties, struggling with withdrawal symptoms and trying to get drugs or money. Many times I failed, lost everything and had to start all over again. Everything changed last year when I met Anya Sarang, President of the Andrei Rylkov Foundation – the only non-governmental organisation in Russia openly advocating for substitution treatment programs for opioid drug users. I became a member of the Working Group on Advocacy of Substitution Therapy in Russia, and finally had the opportunity to protect my and other Russian drug users' human rights.

'When I was 14, I had my first experience with opium, and since then I have been living in my country as an outlaw, persona non-grata. I had multiple unsuccessful attempts to treat drug addiction in different clinics, but they all failed.'

Many young people in Russia die every year because opioid substitution therapy is prohibited (despite being recommended by the United Nations and used in all developed countries of the world). Needle and syringe programs have recently been banned in Russia, too – although according to the General Assembly of the United Nations Organisation, they are a major component of comprehensive HIV prevention programs among people who inject drugs. Even scientific discussions of issues related to the use of methadone is considered illegal and can be classified as "propaganda of drug use" in Russia.

Russia officially approves prohibitory approaches in drug addiction treatment, based on forced abstinence and involving humiliation and deprivation of rights of people using drugs. Drug use-related stigma is so high in our country that even human rights professionals often do not consider us humans with undeniable rights. Pregnant women are not given any specialised narcological assistance; they have to terminate the pregnancy or continue to use illegal drugs till they have their babies.

In October 2010, I appealed to Mr Anand Grover – UN Special Rapporteur on the Right of Everyone to the Highest Attainable Standard of Physical and Mental Health – asking for an international decision or other measures to make Russia provide proper treatment to drug users. My actions received wide media coverage and many interviewers asked me: "You want Russia to pay compensation to you by decision of the European Court? You do not want to get treatment to stop using drugs, but you request that your country provides you drugs at the expense of public funds?"

No, I do not want Russia to compensate me! Thousands of my friends have died of AIDS, tuberculosis or overdose and I've lost everything in my life: how can one assess that in terms of money? Does anyone really think I did it all on purpose, just to avoid treatment?

with ♥

I want to have access to sterile syringes, to prevent thousands from getting infected with HIV and HCV through contaminated injections, to have access to HIV, tuberculosis and hepatitis treatment. I don't want my friends to sell sex for drugs, I want them to be protected against violence and be able to have healthy babies and raise their children. I do not want lives to be broken every year in prisons for minor drug-related offences. I want the health officials to give us treatment!

In February 2011, Navanethem Pillay, from the UN High Commissioner for Human Rights, visited Russia. I participated in her meeting with Russian human rights organisations. I had the privilege to ask her to intervene to protect the human rights of people with drug-related problems in Russia, particularly their right to health. I handed the Commissioner a letter signed by 17 international organisations in the HIV/AIDS and harm reduction fields that also called for measures to improve the situation with violations of right to health of drug users in Russia.

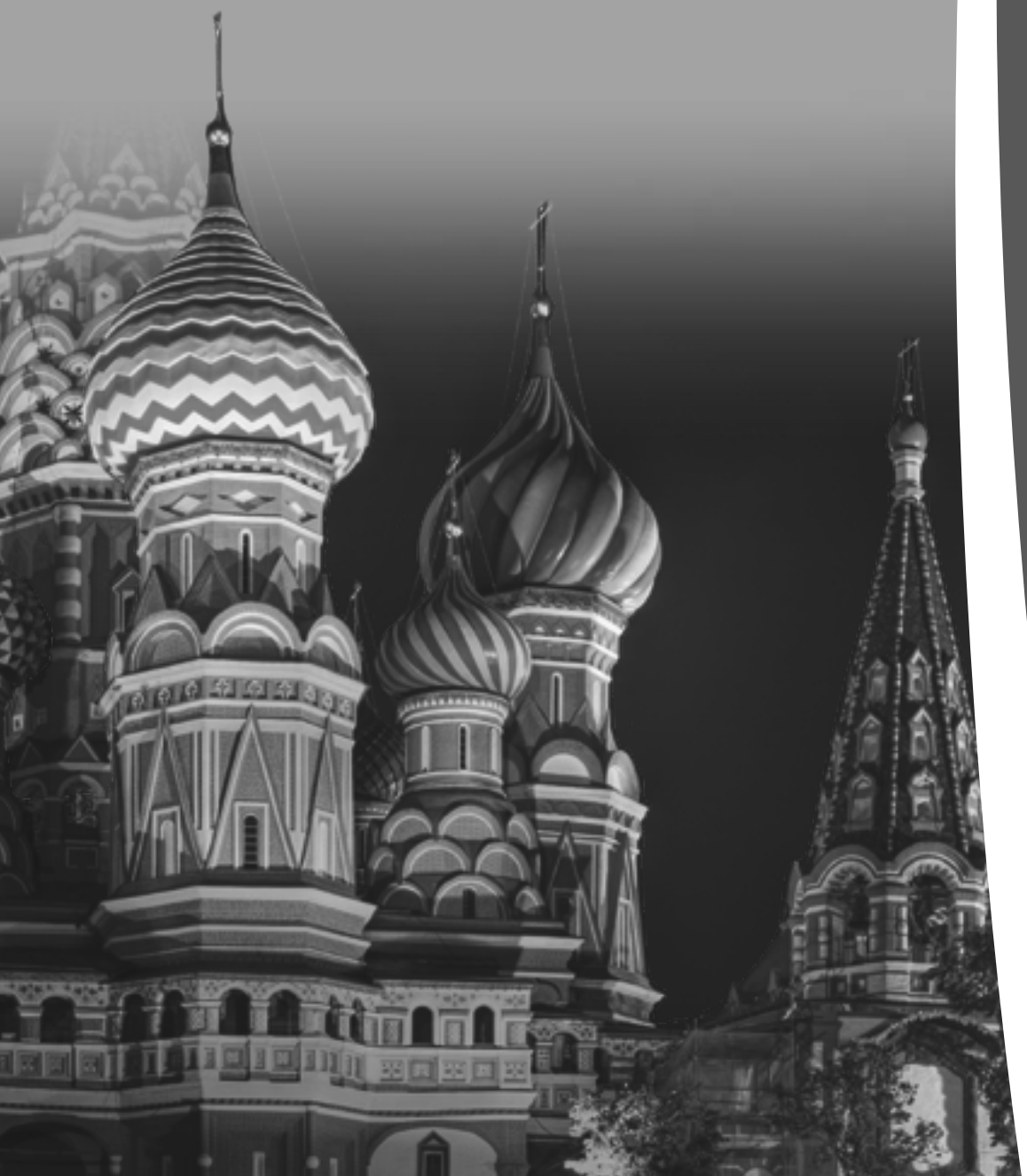
Following our meeting, the UN High Commissioner for Human Rights delivered two recommendations to the Government of Russia:

1. Remove legal restrictions and launch pilot programs of substitution treatment in Russia.
2. Provide financial and political support to needle and syringe programs, to ensure comprehensive HIV prevention measures, as well as drug users involvement in and adherence to health services.

The next day, a number of federal papers were published. State officials declared that according to their data, there was no evidence of OST programs efficiency; substitution treatment was not a proper treatment, just a replacement of one drug with another; and pilot syringe programs, previously held in some regions of Russia, failed to decrease HIV transmission among people injecting drugs and had no influence on the HIV situation

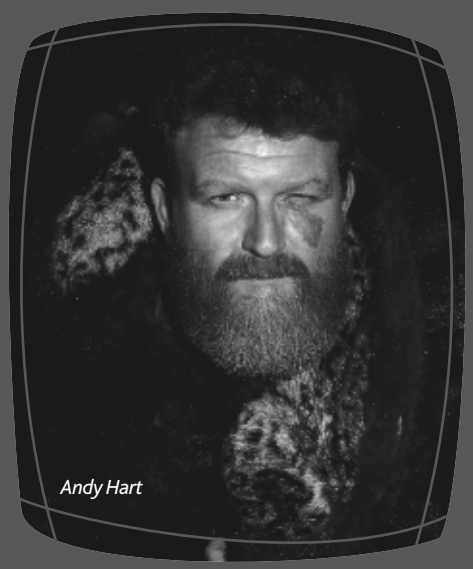
I decided I would not be speechless, I was not going to wait until I died of AIDS or overdose. I am sick of being frightened, of going through withdrawals, of hunting for money to get illegal drugs, of failing to adhere to HIV treatment program: I was going to appeal to international organisations for help. The right to health is one of the fundamental, inalienable human rights, guaranteed by a number of international conventions as well as the Constitution of Russia and the national law.

I know it might be too early to hope my appeals will influence the Russian government, but I am glad that supporters are growing in my country. I've had enough; I am ready to fight for my rights till the end, because I am a human and I am a citizen of my country!



VALE ANDY HART

By Felicity Sheaves and Maggie Sherden



Andy Hart

Legendary NSW harm reduction worker and syringe vending machine entrepreneur Andy Hart passed away on April 19, aged 51. His early death followed an 18 month battle with cancer of the oesophagus.

Four weeks before Andy's death, family, friends and colleagues celebrated his life at the iconic Penrith Panthers rugby league club. During the evening he was awarded "the Golden Beard Award" for his service to the field because "he gave a fit, disposed a fit and vended a fit". Over the years he had also been the recipient of three NSW NSP Workers forum Golden Fit Awards, so the Golden Beard was a timely acknowledgement.

Andy had an opinion on everything and wasn't afraid to share it. His 23 years working in the harm reduction field was legendary, as the many tributes on the NSP forum demonstrate.

Andy spent 14 years in the public sector focussing on HIV and hepatitis C prevention (1988 – 2002), before moving into private business and forming Vendafit (2002 – 2011), his manufacturing business for disposal bins and vending machines. His mission was to increase access to sterile injecting equipment by installing syringe vending machines across the nation. Andy said, "In my experience with vending machines, it is very important to get the right location".

Andy cut his teeth as an NSP worker and manager in Western Sydney. One of the highlights of this period was the TRIBES Project (1996), where they worked with NSW Users & AIDS Association's (NUAA) to target 'Westies' in AIDS prevention. "If you wear black t-shirts with Megadeth on them, love heavy metal music and are proud to call yourself a westie, Andy Hart wants your ear for a few minutes" (Blacktown Advocate, 1996).

During the TRIBES campaign Andy and NUAA produced the video One Shot. Now a priceless artefact, the video is introduced by a much younger Andrew Denton, imploring drug users to use a new "fit for each hit". Andy organised his biker networks to provide the club house setting and venue for the video as well as providing harm reduction information from a Harley Davidson.

He organised a bus to be painted, bearing the slogans "Speed thrills, a dirty needle kills" and "Hot car, hot night, wanna' hit, clean fit" as well as a number of cartoons in popular motoring magazines. The grand finale was a rock concert featuring the 1980s band, The Radiators. There were a lot "petrol heads" in western Sydney and Andy was one of them.

In 1997, Andy took up the position of NSP Manager in the former Wentworth Area Health Service. At that time St Mary's NSP, the only primary outlet in the area, was under political attack. It was the last of the heady days of butterflies and big barrels, and St Mary's (part of Western Sydney) was part of the methadone capital of NSW. Andy had the pleasure of attending a public meeting where the then Minister for Health, Dr Andrew Refshaugie, announced the closure of the St Mary's NSP.

But Andy maintained momentum. Within three weeks he had purchased a Volkswagen transporter van, consulted clients, negotiated with local authorities and set up the fledgling Wentworth NSP mobile outreach service. It was the beginning of five years in the outer metro wilderness and a long period of homelessness for the service. Three mornings were spent in the dirt car park at St Mary's station (rain, hail and shine) and two mornings at the truck stop outside the Australian Defence Industry site on the edge of Mount Druitt. The afternoons were spent stocking secondaries and providing opportunistic outreach, and Andy spent a lot of time contemplating injection related injuries, modes of service delivery and harm reduction equipment.

In 2002 Andy and Elizabeth O'Neil negotiated a site for a new primary outlet on Nepean Hospital Campus (for the service that would become South Court Primary Care). One of the innovations for the new NSP was the establishment of a nurse clinic to provide expert advice and clinical attention for many of the injection-related injuries that Andy and the staff had become familiar with during the outreach years.

At the end of 2002 Andy resigned his post as Wentworth NSP Coordinator to set up his company, Vendafit. Up until his death, Andy provided a fantastic service to many NSPs in NSW and the ACT. He was still fixing and installing vending machines and disposal bins up until a few weeks before he died. The business is continuing with Sharryn Hart, Andy's wife.

We farewell Andy with the last verse from John Cooper Clarke's poem *Kung Fu International*.

"Thanks to that embryonic Bruce Lee
I'm a shadow of the person that I used to be
I can't go back to Salford
the cops have got me marked
Enter the Dragon
Exit (Andy Hart) Johnny Clarke"

The NSW Minister for Mental Health and Minister for Healthy Lifestyles, Kevin Humphries and Dr Ingrid Van Beek agree that the centre is an important mainstream health initiative.

MSIC has bi-partisan support

The New South Wales O'Farrell Government supports the Medically Supervised Injecting Centre (MSIC) in Kings Cross.

A who's who of NSW drug and alcohol harm reduction gathered in Sydney in May to mark the tenth anniversary of the Centre's opening.

The Minister for Mental Health and Minister for Healthy Lifestyles, Kevin Humphries, declared "on behalf of the Premier Barry O'Farrell and the Health Minister Jillian Skinner, we express our commitment to the Medically Supervised Injecting Centre and to the great work that you've done."

Minister Humphries said the days of the politicisation of the Centre were over. "That's not going to happen," he said.

MSIC medical director Dr Marianne Jauncey praised staff: "Parts of society say to you, 'your job isn't worthwhile, what you're doing is wrong'. (But) Everyone that works there and in the field of drugs and alcohol has a deep and abiding commitment to make a difference. And the wonderful thing is we do, we do make a difference."

Founding MSIC medical director, Dr Ingrid Van Beek, paid tribute to the former Labor Government led by Premier Bob Carr under whom the Centre was established following the 1999 NSW drug summit. She also commended those in Opposition at the time who crossed the floor in support of the enabling legislation and subsequent debates on the MSIC extension, and noted that many of them have "key roles" in the new NSW government.

"We should also think of drug users who have used the facility, Dr Van Beek said. "The people whose lives have been saved, the people who have been referred to drug treatment, some of whom no longer use drugs at all and who have gone on to have very fruitful lives.

"Also think of the drug users who have, despite making every best effort, have remained mired in the vortex of drug dependence and for whom it has not been so easy to find the route out. For those who, worse than that, have died as a result of their drug use over the last 10 years – it does still continue to happen – but we know for sure that it happens a lot less than it did 10 years ago," she said.

During the anniversary celebration a number of high profile religious, health and political figures reflected that successfully advocating for the facility required a mix of "evidence" and strong moral conviction.

Former Liberal Opposition Leader, John Brogden, stressed that for him it was the morality of preventing deaths rather than "evidence" that persuaded him to take the bold and critical step of allowing Liberal MPs a conscience vote when the legislation to extend the original trial was before the NSW Parliament in 2003.

Mr Brogden said: "I don't particularly care about the evidence (but) – I am pleased that it does support the case. But, what I care about is that there are people who are still alive."

From a treatment and referral perspective many speakers pointed out that the MSIC fulfilled two basic needs – the need to provide information and support and the need to have resources available whenever a person is contemplating change.

Dr Jauncey said one of the most important aspects of MSIC was that people can arrive at the centre and be given an opportunity to be provided information and support when a person makes a decision to access support, including treatment.

"The thing about the injecting centre is that it is always there, available to grab that moment when the person is ready," she said.

Dr Jauncey said "a supervised injecting centre no more sends a message that drug use is acceptable than a hospital emergency department sends a message that head-on motor vehicle accidents are acceptable. They are both just trying to make the best of a bad situation. They are both grounded in reality, however unfortunate that reality may be. And they are both a pragmatic, evidence-based and compassionate response."

'Dr Jauncey said one of the most important aspects of MSIC was that people can arrive at the centre and be given an opportunity to be provided information and support when a person makes a decision to access support including treatment.'

Former Labor Premier Bob Carr, whose government established MSIC in 2001 after opposing calls for heroin trials, said that establishing MSIC "became a remarkably easy debate to manage because public support was real."

"You could feel it. People understood the argument that we as a government were leading them through. The sense I had was the people followed the argument," said Mr Carr.

Mr Brogden said it was "fascinating" that no other state was considering a safe injecting facility.

"There are drug addicts in Melbourne, in Adelaide and in Brisbane. But no other government in the country of either (major) Party has had the guts to pursue it," Mr Brogden said.

The basic argument for a medically supervised injecting facility had three simple points, Mr Carr said. They were:

1. "You don't want your son or your daughter to be on that dangerous white powder.
2. "But, if they are, you want something like this to exist to support them for that day when, like the vast majority of heroin users, they make the decision to have a change in their life and get off the stuff.
3. "This is about keeping them alive until they reach that decision."

A social worker at MSIC, James Clarke, said that the biggest lesson he had learned was that "people have histories and traumas and all sorts of difficulties that lead them to addiction. It's not just simply a matter of walking away from it. People need to be nurtured, and supported and helped and guided, and allowed to have relapses. It's a chronic condition," he said, before adding that assistance should be "grounded in the experiences of that person."

Mr Brogden said that a conversation with an ill street-based sex worker many years ago was a tipping point for him.

"I asked if she would use the injecting room, and she said 'I had an overdose three nights ago and I was brought back from it. And yes, I would use a medically supervised injecting room'," Mr Brogden recalled.

"I had just turned 30 and I asked if she would mind if I asked her how old she was. She looked about 50. She said she was 30. That was the point that turned me very clearly. It wasn't for someone who had a relative life of privilege (himself) to deny that person an opportunity to keep living," he said.

Mr Brogden said some nervous politicians urged him to change the term from "conscience vote" to "free vote" because "if it's a free vote" they didn't have to use their conscience. Others preferred it to remain a Party vote because it would offer them some political protection.

When MSIC came to a vote, one newly elected Liberal parliamentarian crossed the floor and voted with Labor, at great political risk to herself. As she sat on the Labor side of the Parliament beside Mr Brogden, they looked across the Chamber to where most of their Liberal and National Party colleagues were set to vote against MSIC going ahead.

Mr Brogden said that he was surprised she was taking the political risk: "She said, 'John, I am nurse. I have been a nurse for 25 years and have seen people overdose and die. And I have two teenage daughters – if they were to be drug addicts and overdose I would want them to do it there and not on the street'."