

Isolated fentanyl hotspot prompts urgent roundtable

A surge in overdoses amongst drug users injecting the powerful opiate fentanyl in the Albury-Wodonga region has alarmed police, ambulance and health workers.

Fentanyl is a potent opiate that is estimated to be 80-100 times more powerful than morphine^[1]. The United States Food and Drug Administration states that in the patch form it is intended for treatment of "moderate to severe pain in opioid-tolerant patients". In the form of a 'lollipop', it is prescribed to people with "break-through" pain for which other painkillers, such as oral morphine or oral oxycodone, are insufficient. The Australian Therapeutic Goods Agency information sheet regarding one of the fentanyl patch products says that it is intended for people with chronic pain (no mention of severity) who require "opioid analgesia", and does not mention opioid-tolerance. The NPS website (formerly Nationally Prescribing Service) states: "Reserve fentanyl patches for patients with chronic pain and established opioid needs who are unable to take oral morphine."

Fatal overdoses from fentanyl, or involving fentanyl, have been reported internationally for many years, including in Sweden, Canada and the United States^[2-6]. In 2002 the Medical Journal of Australia reported on a case of fatal overdose in Tasmania from injecting fentanyl from a patch^[7]. In early 2011, Queensland Health issued information for drug injectors via select NSP outlets in response to fentanyl-related incidents, including overdoses. The information cards are now available in other parts of Queensland where fentanyl is identified as an issue. However, there are no such resources or other harm reduction information guidelines concerning fentanyl elsewhere in Australia at present.

A closed seminar held in Wodonga on August 21st heard worrying accounts of seasoned injectors able to obtain fentanyl patches both from the black market and through prescriptions which are now appear to be more readily obtainable.

The seminar was convened by Anex in response to reports from areas including

Wagga Wagga, Albury and Wodonga. At least seven fatal overdoses involving fentanyl have occurred in the immediate region, and at least one in nearby rural Victoria.

A frontline worker said that "even seasoned opiate-dependent people are dying. They have tolerance to other drugs, but fentanyl seems to be overwhelming them." An ambulance officer reported six callouts to fentanyl-related overdoses (non-fatal, as victims were revived) in just one week in May.

Former NSW Health Department Clinical Advisor Professor Bob Batey told the audience of more than 60 that disturbing reports of fentanyl misuse in the area surfaced at least 18 months ago.

"The reality is that it has become a first-line agent for treatment of chronic non-malignant pain," Professor Batey said.

"This recent increase in overdoses from fentanyl indicates that a potentially serious new public health risk amongst drug injectors is occurring in at least that area, and possibly beyond," Professor Batey said.

"People who are regular opioid users may not understand the potency of fentanyl and are at risk of overdose from what may what may appear to be small doses of it," Professor Batey said.

Another frontline worker who deals with pharmacotherapy clients said that fentanyl was "becoming a drug of choice" for some, and that clients reported it difficult to resort back to other drugs, such as Oxycontin®, because "it just didn't do it for them any more".

Albury ambulance manager Laurie Evans told the seminar that the sudden surge in

overdoses earlier this year had come out of the blue.

Chief Executive Officer of the Northern Territory AIDS and Hepatitis Council (NTAHC), Craig Cooper, said fentanyl was now leading to overdoses in Darwin.

"The Palmerston and Darwin primary NSPs have received reports directly from clients stating there have been a number of fentanyl overdoses within this area this year," said Mr Cooper.

"It appears to have been a very recent phenomenon. It's an emerging issue that is being watched by our services, and is a very serious concern. I think a communications and education strategy needs to be quickly developed in response to the reports from clients. It's a reality. It's already happening. Drug users are speaking out and spreading the word, and we as service providers are being left behind because we aren't really prepared for it.

"Raising awareness is not about teaching drug users how to prepare the substance to inject. That's like the old argument that by distributing sterile injecting equipment you are encouraging people to inject. That's simply not true. It's about resourcing health workers so that they can respond appropriately if this issue is raised during an interaction with a client," he said.

Wagga Wagga health staff were concerned that some young people were aware of, and possibly using, fentanyl. Anex has spoken with a highly experienced health professional in a capital city who said she was approached by a 17-year-old girl from a rural area wanting to enter detoxification.

"She had been injecting fentanyl, and the worrying thing is that that was her pathway to injecting. She hadn't worked her way up through the other drugs," the woman told Anex in May.

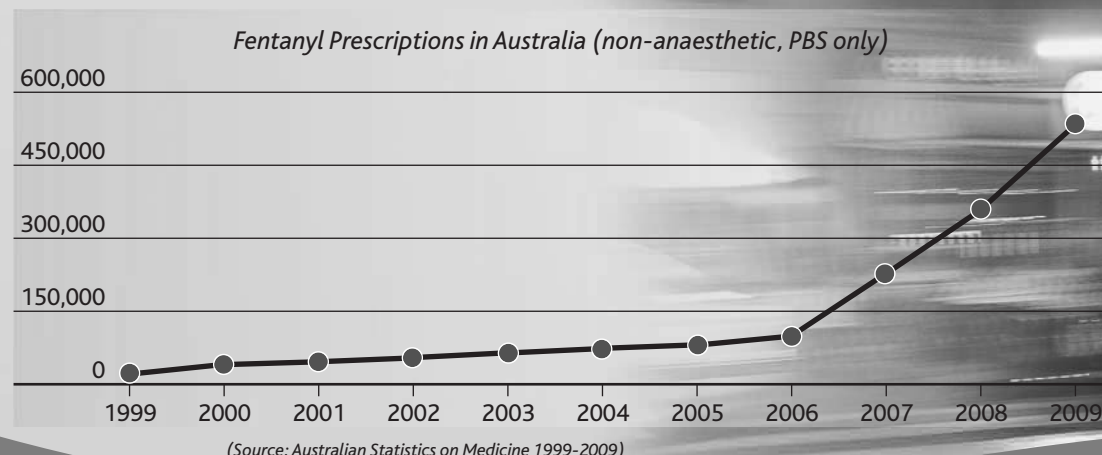
"It was frightening that, as a health professional dealing with injecting drug users, I didn't have the skills or knowledge to be able to assist this girl (apart from detox and accommodation). Not being able to discuss her injecting techniques or behaviour made me feel terrible. That hardly ever happens. Every other situation I'm familiar with, but this fentanyl thing is happening and we don't have the resources or knowledge to deal with it.

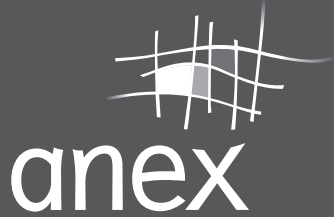
"I don't even know what kind of equipment they use, for God's sake. I've seen the size of the patches, and I don't know how people would safely extract the drug from it in a non-clinical setting. That's just one example of our ignorance on this particular change in drug markets. I'm upset that we are so far behind on this and I would like to know more about it."

The frontline staff who spoke with Anex said that a number of their clients using fentanyl claimed that at least one rural doctor on the NSW side of the border was prescribing it. Anex alerted the NSW, Victorian and Australian Government authorities, including the Coroners.

Senior Medical Advisor (Alcohol and Drugs) to the Victorian Government, Dr Malcolm Dobbin, issued an official alert to General Practitioners in the area following the reports from frontline staff.

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Anex's vision is for a society in which all individuals and communities enjoy good health and wellbeing, 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 being part of the solution to drug-related issues.

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Global reach and TV snoring ad in OD events

Ingenuity and a willingness to organise eye-grabbing and engaging activities characterised the diversity of events which brought International Overdose Awareness Day's messages of remembrance and prevention to the widest sections of society at home and abroad this year.

Solemn candle-lit vigils were held in many towns and cities across the United States in particular, where the Centers for Disease Control and Prevention (CDC) reported 36,500 drug poisoning deaths for 2008. Marches and vigils were staged in states from Texas to Connecticut.

Australian groups showed a clear preference for staging a barbecue or lunch to gather people informally. One of the more unusual venues for an event was Long Bay Correctional Centre, where the prison's health clinic provided badges and information about overdose prevention. With newly-released prisoners being one of the groups most at risk of overdose, this stands out as an event with huge potential to prevent harm, and even save lives.

The overdose awareness message went mainstream in Australia this year with the commercial TV networks and Foxtel screening a dramatic 30-second community service announcement framed around the danger of unusual snoring as an overdose sign.

Production of the advertisement was made possible via the generosity of SceneOn, which offered its services pro bono in order to get an important message across to the Australian public. The ad was also accepted by the Melbourne Underground Film Festival, which ran from August 24th to September 2nd.

Meanwhile, with the clock ticking, production began on a second overdose film. The documentary-style 15-minute film by former television staffer Marianne Latham centered on interviews with friends and family of overdose victims along with ambulance service spokespeople. After a gruelling production schedule, the film was shown for the first time at Melbourne's Federation Square's outdoor screen, where it was seen by thousands of passers-by during the evening rush.

Another innovative idea was to persuade radio stations to play music by musicians who had overdosed.

The www.overdoseday.com website played a vital role in extending the reach of the day. An early indication was the steady stream of orders for the distinctive silver badge that began flowing in the day after the site went live. Within weeks, thousands had been ordered and supplies were running low.



International Overdose Awareness Day

prevention and remembrance

While many Australian observances had a memorial theme, other events took an educational approach. The Alcohol, Tobacco and other Drugs Council (Tas) held an International Overdose Awareness Day Information Seminar with a focus on naloxone. Associate Professor Paul Dietze from the Burnet Institute spoke about naloxone access, after which a local panel of experts addressed relevant issues.

Anex went regional with a launch and seminar event in the Victoria-New South Wales border town of Wodonga on August 21st in response to a cluster of fentanyl overdoses. Since the problem was known to extend into central NSW and along the Murray and northern Victoria, registrations from regional health workers were strong, with a solid turnout from regional AOD workers, NSP staff, health workers, police, ambulance, doctors, pharmacists and policy makers.

Meanwhile, back in the States, the Harm Reduction Coalition in San Francisco threw itself into organising a series of community events and activities. In keeping with San Francisco's status as the seat of flower power in the late 60s, the Harm Reduction Coalition produced scores of paper flowers to be filled in with the names of overdose victims.

Offering "strong coffee and good company", the Coalition urged people to help cut out paper flowers and then write tributes on them. The flowers were eventually carried in a memorial march on August 31st and will become part of a memorial installation.

Meanwhile, on July 31st the Coalition held a Talk to Folks community outreach training seminar for volunteers willing to be at exchange sites to talk with people about Overdose Awareness Day, invite them to marches or processions or to share stories about their experiences with overdose.

On August 31st there was a march of the SF Drug Users Union, with participants carrying posters, pictures of loved ones and paper flowers. The message was "we want our loved ones to be remembered in the most beautiful, powerful and colorful way possible!"

Pharmacotherapy cohort increasingly older

A report from the Australian Institute of Health and Welfare (AIHW) shows that Australians receiving pharmacotherapy treatment is an ageing population.

The National Opioid Pharmacotherapy Statistics Annual Data collection: 2011 report took a "snapshot" of a day in June 2011 and examined the use of methadone, buprenorphine and buprenorphine-naloxone. The day profiled 46,446 clients and 1444 prescribers.

AIHW spokesperson Anna White said: "The proportion of clients aged 30 years and over increased from 72 per cent in 2006 to 85 per cent in 2011, with the median age of clients in 2011 being 38 years."

Close to one in 10 clients identified as Aboriginal or Torres Strait Islanders.

The report found that methadone was still the most commonly used pharmacotherapy treatment for opioid dependence - 69 per cent of clients were taking it, compared with 14 per cent using buprenorphine. The proportion of clients taking buprenorphine-naloxone has increased from five per cent in 2006 to 17 per cent in 2011.

"Buprenorphine-naloxone was used more by younger clients than older clients, with methadone more likely to be used among clients older than 40 years," Ms White said.

The number of prescribers was stable between 2010 and 2011, despite fluctuations among jurisdictions. There were 2264 pharmacotherapy dosing point sites in 2010-11, an increase of 64 sites from 2009-10.

Read the full report here:
<http://www.aihw.gov.au/publication>

Diazepam misuse linked to UK drug deaths

UK addiction experts are warning of a rise in deaths associated with Valium (diazepam) misuse. The drug is increasingly being produced in illegal labs in response to a growth in demand.

Some drug workers believe the rise of diazepam misuse (the drug is prescribed for stress and tension) is contributing to a decrease in heroin use. Many people are reporting online that mixing diazepam with alcohol helps "sedate" them for days at a time.

UK drug and alcohol treatment agency Addaction said that, whereas people once misused diazepam that had been stolen from pharmacies or diverted from prescriptions, recently there had been an increase in the amount of the drug bought from online pharmacies outside the EU, mainly in India or Pakistan.

In addition, police in Scotland have discovered amateur laboratories creating illegal versions of the drug. Kenny Simpson of the Scottish Drug Enforcement Agency said: "It's a relatively new phenomenon, but we suspect that there are diazepam production operations going on up and down the country."

The illegal diazepam trade is sophisticated, to the extent that many tablets bear the manufacturers' logos. Gareth Balmer from Addaction's service in Dundee said: "Counterfeiting causes a range of problems, not least because the user does not know what drug it is they are taking, how strong it is and how their body will react to it."

Naloxone distribution for overdose reversals

Anex has released its updated position paper on distribution of naloxone to reverse opioid overdoses.

It covers the recent exciting policy changes in the USA in support and encourages all Australian governments (not just the ACT) to establish programs.

Download the paper at
www.anex.org.au/
<http://www.anex.org.au/what-we-do/current-interests/access-to-naloxone/>

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"While many medical practitioners may regard patches as a formulation resistant to misuse, there are numerous methods by which they can be misused ... the most serious of which appears to be injection of the drug extracted from the patch. "Injection may include the readily available household products used for extraction and other by-products of extraction including adhesive and fibres from the patch."

According to frontline workers, the supply seemed to have dried up shortly after the issue was raised, as fewer reports of overdosing were being reported.

"This does not mean that the issue has gone away," said Professor Batey. "We have to learn from this. A sudden public health crisis emerged quickly and took authorities by surprise. It shows us that our intelligence gathering systems lag behind. This shows us

Professor Batey said there should be a widespread education program for frontline NSP workers and other health professionals.

that in addition to official databases and the like, there needs to be intensive communications with frontline services to pick up trends as they emerge," he said.

"This is particularly the case in regional and rural areas where the drug markets are different, and not very well monitored through our official channels."

Coroners' records being investigated

Concern about fentanyl misuse has led to a national rapid research. Contact Anex if you have heard of something in your area. Confidentiality will be respected.

Professor Olaf Drummer told the Bulletin that Monash University's Department of Forensic Medicine has recently obtained ethics approval to investigate the incidence and circumstances of unintentional deaths that have involved the illicit use of fentanyl patches via administration of the drug in an

injectable fashion or through non-injectable means.

"The source of data will be the National Coronial Information System (NCIS)," Professor Drummer said. "It is envisaged that the findings obtained from this research will elucidate underlying risk factors, heighten awareness of the issue and stimulate the development of improved safety initiatives to help prevent such deaths in the future."

International precedents

A study based on interviews with street-based injectors of fentanyl in Toronto revealed that potency and variability in extraction and usage made it particularly dangerous. The study, published in 2009, found: "Respondents acknowledged that due to the different quantity and time-release formulation in conjunction with the extraction techniques applied, the potency and effects of the fentanyl solution eventually injected - also

compared to other POs [a treatment taken orally] which come in oral capsule formulation - is hard to gauge and hence presents a high risk for overdose. Respondents recognised the risk of 'going under' from extracted fentanyl use as very high, yet accepted this due to the drug's highly desired effects compared to other opioid substances available on street markets [4]."

In Estonia, fentanyl is common amongst injecting drug users (IDUs). An assessment involving interviews with more than 300 IDUs found that "injection of fentanyl is associated with elevated injecting risk behaviour derived from injection practice and situational risk factors, and needs urgently targeted interventions [2]."

Professor Batey said there should be a widespread education program for frontline NSP workers and other health professionals to point out the "reality that fentanyl injection is already here in Australia, is unlikely to disappear without structural changes and presents an ongoing and serious overdose and injury threat to drug users in this country."

City visit an eye-opener

Watching seasoned professionals work with injecting drug users' multiple issues at a fully-funded city Needle and Syringe Program (NSP) was an eye-opener for a rural nurse whose secondary NSP has little capacity to engage with clients.

"I cannot begin to imagine what it must be like to be so often treated as being on the perimeter of society, then to come to a place such as this and be treated as an intelligent being deserving the respect we all pine for," said Nikki, whose tiny NSP operates out of a small country hospital's emergency department.

Nikki was invited by NSP managers Melinda and Shane to spend an afternoon in their busy metro service that has long operated in a suburb with a low socio-economic status and which is associated with inter-generational alcohol and drug issues.

It was a chance for both rural and metropolitan health staff to compare stories about how they serve clients. The experience left Nikki, who manages a full suite of community health interventions, feeling guilty that her secondary service doesn't have the staff or time to build open rapport with NSP clients.

Nikki kept notes for the Bulletin, which record her observations.

"Melinda sits at the desk serving, enquiring and responding to client-initiated conversation regarding children, housing situations, legal issues and the like - all of which are discussed in an open manner by those using the service," she wrote.

"It's a testimony to the trust that is clearly present between client and service provider.

"Immediately I have a pang of guilt: as a secondary NSP outlet I have done nothing to build any of these relationships with NSP clients. They simply walk through our doors, politely request equipment and leave.

"No one asks how their kids are, or if they are okay today. They could be having the worst day of their life and have just presented to a health service. And no one asks how they are. We simply don't have the capacity to build the relationships," Nikki continued.

She said that what she observed in her NSP was in stark contrast to the usually open and lengthy interactions between the health staff and clients with other needs, such as vaccinations, sexual health lessons or run-of-the-mill cuts and bruises.

"I have to wonder if our clients realise what they are missing out on by not being serviced by a primary NSP, where staff have the opportunity to provide support such as I witnessed in the city."

The wide range of injecting equipment available, reflecting the diversity of an urban drug market, also caught her eye, as did Melinda's ability to keep tabs on what goes out.

"Individualised service is offered. Melinda asks what is required at each transaction; so different to the one-size-fits-most approach we provide at our secondary site," Nikki wrote.

"To be fair, we offer a variety of equipment, but the idea of clients being able to ask for two, seven or 16 syringes is just not feasible. We offer stock-standard five-packs, boxes of 100, swabs, etc, and of course barrel syringes and their tips. But it just seems a lot more

tailored here," she continued. "I see huge gaps in what we provide. Being completely unfunded there is no provision to offer spoons or cotton balls. We don't offer water or tourniquets for sale."

After hearing how Nikki's tiny outlet runs, Shane reflected on the challenges of trust-building in a country town with a stretched, low-demand NSP that is often staffed by people who are not necessarily from a health background.

"As Nikki said, realistically her service could never manage this type of operation, where people are able to come in and speak at length with a trained worker if they want. They already have to meet the needs of a team of 20 Primary Health Clinicians, as well as those of visiting services. It's a matter of meeting the needs of everyone. Extra time at NSP transactions in reality is just not practical (without partly funded positions)," Shane said.

Melinda would give out more needles per day than Nikki did in a month. But, she said, each and every piece of the overall Australian NSP jigsaw served a purpose.

"We, and some of the clients she spoke to, reassured her that what they were doing went a long way in assisting the greater picture of harm minimisation in their community," said Melinda.

Nikki wrote in response: "This still doesn't help on the other level, though. I keep revisiting the guilt feeling I can't quite shrug for not establishing relationships that could service preventative health measures."

Nikki said that the single most impressive aspect of the NSP workers' skill sets was their

ability to "not miss a beat" while giving out equipment, recording transactions and being kind to people who, for example, were worried about child support agency staff taking their children.

"Melinda astounds me: for each transaction the relevant data is entered into the computer. To her credit, she never lets this task stand in the way of engaging with the people who breeze in and out of her office," she wrote.

"While I sit here, wondering how in the heck she is going to remember the last three transactions that are still waiting to be entered, she calmly discusses housing and custody issues with those who require her attention."

Nikki's service gives out lots of condoms, including to the town's youth, and has now even started offering dental dams, which are used to prevent infections through oral sex. She took away a simple idea that she'll replicate up the bush.

"I notice that in the office there is an A4 display sheet of condoms available at the service. This is an idea I will take away and implement. Such a simple thing to adopt, but one of the reasons we really do need to look into the backyards of others," she wrote.

"How envious I have become of Shane and Melinda in my short time with them. How rewarding it would be to have the opportunity to provide a more holistic service to the clients. The work they do by listening and referring is a whole other spectrum of harm minimisation - one that the government would have a much harder time putting a return for investment figure on, I suspect."

30 portraits 30 days promotes Lucid

From 23rd June to 29th July, Anex's new social enterprise Lucid ran the 30 portraits 30 days exhibition at NGV Studio, Melbourne.

Acclaimed artist Vincent Fantauzzo painted 30 inspirational Australians in as many days to raise awareness and break through the stigma surrounding alcohol and other drug addiction. Portrait subjects included the Hon. Bob Hawke AC, Anex Patron Professor Emeritus David Penington AC, ballet dancer Li Cunxin, singer Kimbra and AFL footballer Harry O'Brien.

To see all 30 portraits, visit www.lucid.org.au/3030

The project was Lucid's first community awareness and fundraising campaign in collaboration with the National Gallery of Victoria. Lucid's activities provide a logical counterpoint to those of its parent organisation: many people are not directly engaged in the area in which Anex operates until their alcohol and other drug problems are severe. By going "upstream", Lucid seeks to make a real difference by preventing and resolving such problems as early as possible.

Lucid also seeks to help and encourage employers to see substance misuse as a health and welfare concern, not just a matter for disciplinary action. Through the Lucid at Work program we help and encourage organisations to address the issue holistically.

For more information on 30 portraits 30 days, the Lucid at Work program or our Drink Drive program, please visit www.lucid.org.au



Di Fingleton
Former Queensland Chief Magistrate
"Throughout my childhood experiences and through to my adulthood, my family life was affected by there being two alcoholics in our family - my father and my eldest brother - so I know what the effects of alcohol use are on a family. As a magistrate and lawyer in my working life, I am aware of the link between alcohol and drug abuse and criminal behaviour. I agree with programs aimed at harm reduction."



Professor David Penington AC
Eminent doctor, academic, public intellectual and former Melbourne University Vice Chancellor

"Problems associated with addiction in our society are widespread. Many dismiss it as moral failure; but the penalties for the community are huge, not only for drug users and their families, but in many other fields. Lucid programs are trying to really help. I have seen many families suffer an enormous amount. Helping people to survive and recover is hugely important. Crime occurs largely because drugs are illicit. We have to find better ways to deal with things."



Sir Gustav Nossal AC CBE
Professor Emeritus

Anex Chief Patron Sir Gustav strongly supports increasing our communities' awareness of alcohol and other drug misuse. He especially encourages measures break down stigma associated with dependencies so that more people are able to seek assistance and access it. Sir Gustav is a leading voice in the promotion of harm minimisation in prisons including controlled sterile injecting equipment provision.



Kimbra
Singer-songwriter

"I've seen how drugs and alcohol can rob people of their true selves and their greater potential as they try to medicate away the pain in their life rather than channelling it in a way that can be positive and creative. I feel strongly that music and art have the power to provide this kind of outlet, especially for the young generation."



Fiona O'Loughlin
Comedian

"Addiction is a threat not only to your life but also to your future and the security of pretty much everything and everyone you value. It's a contradictory, bastardly, selfish, hellish disease. Its only mercy is that it does have an out, where some other diseases do not. Unfortunately the out is the hard way out, but it's the only way and worth every tremulous step."

United Nations issues prison prevention guidelines

Needle and Syringe Programs (NSPs) are an essential element of HIV and hepatitis B and C prevention programs in prisons, the United Nations Office on Drugs and Crime (UNODC) has asserted in a new policy brief.

The brief, released in July during the 29th World AIDS Conference in Washington, DC, also listed as essential "protecting staff from occupational hazards", condom programs and measures to prevent blood borne virus transmission through tattooing and piercing.

According to the UNODC, the International Labour Organisation and the United Nations Development Programme (who co-authored the policy guidelines), it is aimed at "supporting decision makers in ministries of justice, authorities responsible for closed settings and ministries of health, as well as authorities responsible for workplace safety and occupational health, in planning and implementing a response to HIV in closed settings."

The UN policy guideline came shortly after a Fairfax media report that a prisoner was considering legal action against Victorian authorities because he may have contracted hepatitis C while imprisoned. Interestingly, the front-page coverage (headlined "Prisons a disease hotbed") did not generate any follow-up controversy or negative media.

The Australian Medical Association is but one peak organisation in support of prison NSPs.

"I welcome the policy brief," said Professor Kate Dolan from the National Drug and Alcohol Research Centre. "It's a comprehensive package of what should be done to prevent and treat HIV in prisons. There's a lot of guidance for governments, and in particular prison authorities, even in Australia.

"Hopefully this is the first step in improving prevention of - and response to - HIV in prisons. It's pertinent to Australia because there are still many gaps in health care behind prison walls, especially concerning HIV and hepatitis. For example, condoms are not available in every state. Methadone is still limited in many states. We don't have needle and syringe programs in prisons anywhere," said Professor Dolan.

The UN guidelines sum up the arguments in favour of prison NSPs succinctly: "The vast majority of people in prisons eventually return to their communities.

Any diseases contracted in closed settings, or made worse by poor conditions of confinement, become matters of public health. HIV, hepatitis and tuberculosis and all other aspects of physical and mental health in prisons should be the concern of health professionals on both sides of the prison walls. It is pivotal to foster and strengthen collaboration, coordination and integration among all stakeholders, including ministries of health and other ministries with responsibilities in prisons, as well as community-based service providers."

Implementation of drug dependence treatment, in particular opioid substitution therapy (OST) and NSPs in prisons, should be a priority, the UNODC policy states.

Australia has approximately 30,000 people in custody at any one time, with more than 55,000 releases back into the community each year.

"The UN policy guidelines add to the debate we are having. The highest international illicit drug authority, and the organisation tasked with protection of workers' rights, has recommended these interventions for HIV and Hepatitis C in prisons. We don't have widespread treatment for hep C in prison, for example. This is not just about those developing countries where HIV is rampant among prison populations. There are important lessons and recommendations for even a country like Australia," Professor Dolan said.

Recently in Victoria a number of prison officers were arrested and charged with trafficking drugs into prisons. The main union representing prison officers, the Community and Public Sector Union (CPSU), remains opposed to prison NSPs, partly because the goal should, in their view, be to have no drugs in prisons.

The 15 recommended interventions from the UNODC are as below, with Professor Dolan's comments in brackets.

1. *Information, education and communication.*
2. *HIV testing and counselling.*
3. *Treatment, care and support.*
4. *Prevention, diagnosis and treatment of tuberculosis.*
5. *Prevention of mother-to-child transmission of HIV.*
6. *Condom programs ("not available in Queensland and NT, and only piloted in Victoria").*
7. *Prevention and treatment of sexually transmitted infections.*
8. *Prevention of sexual violence.*
9. *Drug dependence treatment ("numbers of places available in Australia are extremely limited, especially in Queensland where men are not permitted to go on methadone while in prison").*
10. *Needle and Syringe Programmes ("nowhere in Australian prisons as yet").*
11. *Vaccination, diagnosis and treatment of viral hepatitis ("is less than optimal in Australia").*
12. *Post-exposure prophylaxis.*
13. *Prevention of transmission through medical or dental services.*
14. *Prevention of transmission through tattooing, piercing and other forms of skin penetration ("WA, Tasmania and the NT do not make bleach available").*
15. *Protecting staff from occupational hazards.*

ACT closer to prison NSP 'on principles'

A "one-for-one" direct needle and syringe exchange has been nominated as the preferred model for the Australian Capital Territory's prison.

ACT Chief Minister Ms Katy Gallagher announced a consultation framework for blood borne virus prevention, which includes testing and treatment improvements, on August 15.

Ms Gallagher also announced an intention to trial a form of needle and syringe program in which sterile injecting equipment could be given to prisoners on a pure "exchange" basis.

The Chief Minister was speaking at the Justice Health Symposium in Canberra.

Principles were important in considering whether to proceed or not, said Ms Gallagher.

"Principles demand that we must see beyond the labels of 'prisoner', 'remandee', 'inmate' and 'criminal' and focus instead on the men and women who live behind those labels," she said.

"Men and women who have the right to the same health-care options and opportunities, the same culture of care, as you and I, and our children, and our friends and our neighbours do. A position of principle requires us to leave emotion and politics to one side, and concentrate on the public-health policy outcomes we seek.

"And surely the public-health outcomes we seek for members of our community who are spending a period of time in their lives in custody ought to be no different, no less, than they are for the rest of us."

The government proposed that "as a first step, detainees be given regulated access to sterile injecting equipment on a 'one-for-one' exchange basis with the medical officer having responsibility for the equipment exchange (as opposed to nursing staff)."

The Community and Public Sector Union which covers prison officers is not yet in support of needle and syringe programs in any prison. The Chief Minister said:

"Prior to introduction of this preferred model, consultation with industrial organisations on the proposed model for implementation will be undertaken to work through any concerns related to the model and to seek agreement."

The Liberal Party in the ACT is not in favour of such a program. An election in the ACT is due on October 20.

GIVING BACK

Roger Antochi was raised in Sydney's western suburbs. His dad was in and out of jail, while his mother battled alcohol and gambling addictions.

Roger was 14 years and nine months old when he decided to leave home. He had two aims: to get a job and to finish school. He couch-surfed, stayed in boarding houses and was on the streets at night; but he still attended school every day.

Roger lived like this for close to two years until he completed his high school certificate.

At school he fell in with the "cool kids" and at 15 began experimenting with drugs, initially marijuana and amphetamines. With no self-limits or adult supervision, Roger's relationship with drugs went from occasional use to dependency.

"It was the in-thing to do when I was younger. But at the end of the day it was my choice to use ice to escape dealing with the reality of my life issues at the time: depression, homelessness, wanting to belong, lack of

right role models, etc. Then, before I knew it, it became a raging habit," Roger says.

Roger smoked ice, and by 17 he was using day and night to avoid coming down. He recalls a time he did not sleep for 21 days straight.

Although he worked as a labourer, his habit became so expensive that he needed more money. His friends turned to crime to support their habits and Roger followed.

Roger was arrested one week before his 18th birthday for armed robbery offences and sentenced to three-and-a-half years in prison in NSW, a period he recounts as being the worst in his life. He did his time and was released six months after his 21st birthday with one bag and \$200.

He was still addicted to ice which Roger said was easily accessible inside.

Eleven months later, "the crew" called Roger back for "one more job". Desperate not to make the same mistake twice, he caught a

train to Melbourne. He tried hard to get a job, but struggled to explain the long gap in his CV. With no money and an addiction, Roger returned to crime. He was caught again and sentenced to another two-and-a-half years in Port Phillip Prison, Victoria.

Roger's first day back inside was the beginning of a series of life-changing events. Standing in the doorway of his cell, he dropped his bag on the bed. An inmate walked in and asked: "How are you travelling, mate?"

This was the first time someone had asked him how he was since he was 14. Roger was apprehensive, but soon realised that the question was genuine. He describes the "incredible" feeling that someone actually cared. By the end of their conversation, Roger wanted to be a mentor.

He completed numerous programs, training and study. While studying, he took on the role of Managing Director in the unit's Small Business Program. The program, Doin' Time, is a venture created and managed by the inmates of the Penhyn Youth Unit. The business involves t-shirt screen-printing with the designs, manufacturing, marketing, stock control and financial decisions all made by

the inmates. With much hard work (and under Roger's leadership), in 12 months Doin' Time raised \$27,000 for charity.

When Roger was released his good work continued. This time, he had the support, lifestyle and role models he needed, including rehabilitation programs, loved ones, gym/boxing and employment as the Toll Group Second Step Program National Coordinator.

This has given Roger the opportunity and capacity to help support others with addiction problems.

He is passionate about alcohol and other drug issues and says: "I strongly believe that the Federal and State Government needs to realise that a lot more work needs to be done in supporting people suffering with AOD addiction issues, as there are way too many overdoses still happening in our communities!

More action needs to be taken through extra funding and also adopting more modern practice techniques, especially from an addiction-pharmacotherapy model perspective. We are far behind compared to some other countries."

Community NSP finally gets go-ahead after opposition

SOME OF THE QUESTIONS ASKED

My mum uses your service. Can you guarantee her safety? She is 81 and quite frail. She would be a soft target for a drug user needing money. How will you guarantee her safety?

Are you going to wait until a child gets jabbed before you relocate this service? Two children, 3 children, how many?

How do you sleep at night?

Will you be checking my property to make sure it is a safe zone for my children? As we don't have fences on this rental property, will you prevent drug users from entering my property, using my property and disposing of their equipment on my property?

The newest Needle and Syringe Program (NSP) in Australia has opened after enduring a persistent one-person campaign objecting to its location near a school.

As the questions at left reveal, Knox Community Health Service (KCHS) in outer eastern Melbourne faced an, at times, irrational, emotive and stigmatising opponent.

Knox had an NSP more than 10 years ago. But it was closed when the Community Health Service (KCHS) moved to a new site following opposition from a Mrs Kelly Whaley (not her real name). Mrs Whaley objected to the NSP because the service was within 100 metres of the primary school her children attended. The school is St John the Baptist.

A decade later, in mid-2011, the service received permission to reinstate the NSP. In the meantime, the Knox local government area had developed hepatitis C transmission rates far higher than surrounding and comparable areas.

"It was clear that our community was at a disadvantage by not having the needle and syringe program," said KCHS Chief Executive Officer Mr Chris Potter.

"The Board decided unanimously to re-open it and permissions were granted. But then Mrs Whaley decided to campaign against it again. She mounted a determined email campaign to Members of Parliament, Government Ministers and the media," he said.

Anex was called in to assist in managing publicity, which had blown up in the local suburban newspaper and had spilled over to talkback radio.

"Journalists and radio hosts understood the importance of the service once it was explained to them. They responded well and it did not 'get legs' as a story," said Chris Potter.

Knox met with 73 nearby businesses. Five objected to the service, 20 expressed support and 48 were neutral. KCHS also sent an information pack to 1500 households within

a one-km radius and included a pre-paid self-addressed envelope to enable people to complain about, or support, the establishment of the NSP.

"Less than seven per cent of the 1500 households opposed the NSP," said Mr Potter. "Even fewer wrote back in support, but the fact that so few felt upset enough to write in opposition suggests that the bulk of the community were either ambivalent about it or supported it," he said.

Almost all those letters of opposition actually supported NSPs in principle. "But it was a case of NIMBYism - not in my backyard," said Mr Potter.

Mrs Whaley circulated letters of opposition to parents of students via the primary school. She also arranged a petition - albeit a misleading one - which attracted 463 signatures. (One husband and wife removed their child from the school, disappointed that it had campaigned against the NSP.)

The pressure was enough for the Department of Health to contemplate reversing the decision to approve the NSP.

"As time passed, it became clear that the opposition was from a small vocal minority. By carefully consulting stakeholders, including the local council, members of parliament and the media, it became clearer over time that the noise of the few was not representative of the broader community," said Mr Potter.

Analysis of NSP sites was conducted. It showed that dozens are located near community services such as schools, without problems.

"Our experience shows that we should never, unfortunately, take for granted the need for extensive consultation and communications planning," Mr Potter said.

The eventual decision to proceed with the service was issued by the Department on August 3rd.

IDRS report

The Illicit Drug Reporting System (IDRS) monitors and identifies emerging trends of local and national concern in illicit drug markets. It has been conducted in all states and territories of Australia since 2000 with the purpose of providing a coordinated approach to monitoring the use of illicit drugs - in particular heroin, methamphetamine, cocaine and cannabis.

The IDRS is made up of interviews with people who regularly inject drugs; interviews with key experts; interviews with people who have regular contact with illicit drug users through their work; and analysis and examination of data related to illicit drugs.

The 2011 IDRS participant survey component covered 868 participants. Their mean age was 38 years and 66 per cent were male.

Heroin was nominated by approximately half (53 per cent) of the national sample

as their drug of choice, followed by methamphetamine, morphine and cannabis.

Nearly half (42 per cent) of the participants in the national sample reported daily injecting.

Forty-nine per cent of the IDRS sample reported being currently in treatment (mainly methadone), with a median of 36 months in treatment; one-quarter reported recently injecting.

Price and availability

Heroin was typically \$50 per cap across the jurisdictions and remained stable compared to 2010. The median price for a gram varied. The majority of participants reported heroin purity as "low". Heroin was considered either "easy" or "very easy" to obtain in the last six months and this was stable. The most common source when purchasing heroin was through a known dealer or friend.

The majority of recent heroin users reported mainly using "white/off-white"-coloured heroin rather than "brown" heroin.

Pharmaceutical opioids

Around half the national sample had recently used pharmaceutical opioids such as methadone or oxycodone.

Of those who recently used pharmaceutical opioids, half reported using them for pain relief and around one-third to seek an opioid effect.

Twenty-two per cent of those who commented reported being refused pharmaceutical medications due to injecting history.

Of those who commented, three-quarters were prescribed pharmaceutical opioids by their general medical practitioner.

Needle and Syringe Programs

Needle and Syringe Programs (NSPs) were by far the most common source of needles and syringes in the preceding six months (90 per cent), followed by chemists (17 per cent).

Receptive sharing ("borrowing") of needles/syringes was reported by 11 per cent

of participants in the month preceding interview, usually after a regular partner or close friend. Sixteen per cent reported that somebody had used a needle after them (the needle being "lent") in the month preceding interview.

Over half (55 per cent) of the IDRS sample experienced an injection-related problem in the preceding month, most commonly significant scarring or bruising and difficulty injecting (e.g. in finding a vein).

Mental Health

Forty-eight per cent of the IDRS sample self-reported a mental health problem in the preceding six months, most commonly depression (66 per cent of respondents) and/or anxiety (45 per cent). The majority (71 per cent) of those who experienced a problem saw a mental health professional during this period.

The report can be downloaded here: <http://ndarc.med.unsw.edu.au/resource/illicit-drug-reporting-system-idrs-national-report-2011>

HEALTH REFORMS

...a networking chance

Health funding and the division of responsibilities has been a focus of Commonwealth/State relations more or less since Federation. While the division of responsibilities is complex, the respective powers (not responsibilities, i.e. activities the different levels of government may or may not undertake) are enshrined in:

THE AUSTRALIAN CONSTITUTION

The Constitution provides for the division of powers between the Commonwealth and the States. Since amendments made by referendum in the 1940's, the practical effect of the Constitution is:

- *The Commonwealth has the major revenue collection (taxation) powers, by a wide margin, and is able to make grants to the States as the Parliament sees fit*
- *The Commonwealth and the States have had overlapping powers in relation to health*

These constitutional provisions provide considerable scope for shifts in responsibility shifting and cost shifting. It is fair to say the health funding and health services delivery have been areas of continuing tension in Commonwealth/State relations throughout the history of the Commonwealth of Australia.

With the passage of time, advances in medical treatments and demographic shifts have increased both demand for health care services and the cost of providing them. These include HIV and hepatitis treatment, and in the case of hepatitis B it also includes vaccinations.

Therefore, this historical tension has tended to intensify over the years, as health care has become a more significant social and economic, and therefore political, issue.

Broadly speaking the major divisions of responsibility in the Australian health care system have been as follows:

The Commonwealth government's major contributions to the health system include:

- two national subsidy schemes, Medicare, which subsidises payments for services provided by doctors, and the Pharmaceutical Benefits Scheme (PBS), which subsidises prescription medicines.
- shared responsibility for funding for public hospital services through the Australian Health Care Agreements (AHCA's) with the State and Territory governments.
- subsidisation of private health insurance through rebates on the cost of private health insurance premiums
- funding for a range of other health and health-related services, including public health programs, residential aged care, and programs targeted at specific populations. This includes a range of activities directed at population health in areas such as drug, alcohol and tobacco

- regulation of various aspects of the health system, including the safety and quality of pharmaceuticals and other therapeutic goods, and the private health insurance industry.

The State and Territory governments' major contributions to the health system include:

- management of, and shared responsibility for funding, public hospitals.
- funding for and management of a range of community health services.
- management of ambulance services, and regulation of various aspects of the health system, including licensing and registration of private hospitals (until recently this also extended to the registration of medical practitioners and other health professionals. but a national registration scheme for medical practitioners, and other health professionals under the aegis of the Australian Health Practitioners Regulation Agency commenced in 2010).

The bulk of the financial resources available to the States (and Territories) are provided by the Commonwealth. All Goods and Services Tax revenue is collected by the Commonwealth, but passed on to the States/Territories. The Commonwealth makes both specific purpose payments (SPP's) and general purpose payments (GPP's) to them from other taxation revenue. SPP's are to be spent by the States and Territories for the purpose for which they are provided, while they have discretion in the uses to which GPP's are put. An example was the Illicit Drugs Initiative Supporting Measures Relating to Needle and Syringe Programs.

A gradual trend is evident in these arrangements over time for "health funding" not covered by a major inter-governmental agreement. For example, a Commonwealth of Australian Governments (COAG) level Australian Health Care Agreement, moving from lower level SPP agreement to an essentially untied GPP. This includes funding for drug and alcohol services, and an effect is to leave States and Territories without any formal onus to direct resources to such services.

Formation of the Medicare Locals is an opportunity for services that include NSPs, alcohol and other drug treatment programs (for example), to consider ways to engage the new networks.

The most recent attempt by governments to make this historical tension a thing of the past comes in the form of the 2011 National Health Reform Agreement. Broadly, this encompasses a number of reforms across a broad spectrum of health services under the following headings:

- prevention;
- primary and community health;
- hospital and related care;
- aged care;
- patient experience;
- social inclusion and indigenous health;
- sustainability.

At this point, the National Health Reform Agreement makes no specific reference to services directed toward the prevention, treatment or harm minimisation of drug or alcohol problems. The specific initiatives which emerge from the agreement of relevance to those working in, or needing such services, include:

Primary and Community Health

- The establishment of Medicare Locals;
- The building of some 60 General Practitioner (GP) Super Clinics;
- The trialling of new approaches to the flexible delivery of the treatment and management of diabetes through GPs;
- Increasing access to after hours services through the availability of the after hours GP helpline and by tasking Medicare Locals with a range of after hours primary care responsibilities; and
- Funding approximately 425 primary care infrastructure upgrades to general practices, primary care and community health services, and Aboriginal Medical Services to improve access to integrated GP and primary health care.

The Medicare Local initiative is of particular interest. According to the Department of Health and Ageing's website:

"Medicare Locals will be primary health care organisations established to coordinate primary health care delivery and tackle local health care needs and service gaps. They will drive improvements in primary health care and ensure that services are better tailored to meet the needs of local communities."

Their key roles are:

- They will make it easier for patients to access the services they need, by linking local GPs, nursing and other health professionals, hospitals and aged care, Aboriginal and Torres Strait Islander health organisations, and maintaining up-to-date local service directories;
- They will work closely with Local Hospital Networks so that primary health care services and hospitals work well together for patients;

- They will plan and support local after hours face-to-face GP services;
- They will identify where local communities are missing out on services they might need and coordinate services to address those gaps;
- They will support local primary care providers, such as GPs, practice nurses and allied health providers, to adopt and meet quality standards;
- They will be accountable to local communities to make sure the services are effective and of high quality.

Chance for drug issues to be part of Medicare Locals

At this point the guidelines published by the Department make no specific reference to alcohol and other drug issues. As such, the opportunity to significantly improve the overall health status of people for whom alcohol and/or other drug misuse is a problem - by ensuring better connections between the primary health system and AOD services, particularly including NSPs - is at some risk of being passed up.

Anex has raised this Australian Government Minister for Health, Hon. Tanya Plibersek, and is also in the process of engaging with Medicare Locals as they are established to encourage linkages with AOD services.

The formation of the Medicare Locals is an opportunity for services that include NSPs, alcohol and other drug treatment programs (for example), to consider ways to engage the new networks. Matters such as pharmacotherapy, referrals and information-sharing are logical matters to be put firmly on the Medicare Locals Agendas.

Hospital and Related Care

The major initiative under this heading relates to significant changes to the way public hospitals are funded and managed. Historically, while both levels of government have contributed to the funding of the public hospital system, the distribution of that funding and the management of the system have been in the hands of State and Territory governments. Amongst other things this has resulted in some degree of disparate service provision between jurisdictions. Some areas have better access to public hospital treatment than others.

Under the reforms, both levels of government will continue to contribute to the cost of the public hospital system, with the Commonwealth contribution increasing. However, the funding will be centrally distributed by a new Independent Hospital Pricing Authority, not to states and territories but to the new Local Hospital Networks. Local Hospital Networks are being established across the country to take the management of public hospitals to a more local level. The Networks will consist of groups of hospitals working together to provide hospital services and manage their own budgets. Local Hospital Networks will be:

- Run locally;
- Funded nationally; and
- Accountable for their performance against national standards.

This may raise some questions in regard to secondary NSPs which, under past arrangements are not purpose-funded (by state health authorities), but to which varying levels of resources are directed by hospital management. It is not yet clear how and to what extent this process of devolving responsibility for the distribution of hospital funding to (yet to be established) Local Hospitals Networks will ensure the continued operation of such secondary NSPs.

Seroquel® Street Market

By all accounts, the illicit use of prescription medication is on the increase in Australia. While media focus has concentrated predominantly on pharmaceutical opioids and benzodiazepines, much less attention has been paid to the emerging illicit market for antipsychotic drugs, particularly quetiapine fumarate (Seroquel®). A recent study published by the National Drug and Alcohol Research Centre (NDARC) examines data from the Illicit Drug Reporting System (IDRS) to investigate the use of quetiapine amongst people who inject drugs.

Key experts consulted in the 2010/11 Illicit Drug Report System report identified quetiapine as the primary antipsychotic used illicitly, expressing concern that it is used by individuals who have not been diagnosed with a psychiatric disorder and who are most likely ignorant of the drug's adverse effects. They spoke of apparent side effects such as antisocial behaviours describing service users who appeared "unreasonable", "agitated" and "oblivious to the world around them" (Kirwan, Reddel, Dietze, 2012).

Quetiapine is an atypical antipsychotic commonly prescribed for schizophrenia and, to a lesser extent, bipolar disorder. Since 2010 the use of quetiapine has been extended to include generalised anxiety disorder and major depressive disorders. Guidelines suggest that

it only be used as a second line treatment, where other treatment has proven ineffective or inappropriate (TGA 2010 as cited in Kirwan 2012). However, anecdotal evidence suggests this is not always the case. In light of the broadening scope of application, and an associated increase in prescription, it is perhaps no surprise then that the illicit use of quetiapine is on the rise.

Like most anti-psychotics, quetiapine has a sedative and anxiolytic (reduces anxiety) effect, adding to both its medical and illicit appeal. Despite this quetiapine has been regarded by some in the medical profession as a safe sedative alternative to benzodiazepines, particularly where there is concern regarding licit or illicit drug dependence. (Hussain, Waheed & Hussain, 2005 as cited in Kirwan, 2012). Ironically, studies suggest the illicit use of quetiapine is in many ways similar to that of benzodiazepines: used to counteract insomnia, dysphoria and other 'come down' effects of stimulant drugs such as methamphetamines (Inciardi et al., 2007 as cited in Kirwan, 2012) and used as an adjunct drug with other depressants such as heroin.

Unlike its 'typical' antipsychotic predecessors such as Largactil®, quetiapine is less likely to be associated with extrapyramidal symptoms (a group of symptoms that can occur in persons taking antipsychotic medications)

such as tremors, restlessness and shifting gait. However, it does come with its own risks. Quetiapine is associated with significant weight gain and the associated increased risk of high cholesterol, diabetes and cardiovascular disease. Of significant concern is the potential for quetiapine to interfere with the QTc interval prolongation - an effect on the heart rhythm that can result in sudden death. This is of particular relevance for individuals prescribed methadone, which is also associated with the potential to prolong the QTc interval (Paparrigopoulos, Karaikos & Liappas, 2008 as cited in Kirwan, 2012).

Given the high incidence of chronic and complex health issues amongst many people

who inject drugs, these serious cardiovascular and metabolic effects are of even greater concern (Kennedy et al., 2008 as cited in Kirwan, 2012). The other significant issue to consider is the increased risk of overdose due to polydrug use. All of these concerns are amplified by the fact that individuals engaging in illicit quetiapine use are less likely to be informed of the potential risks and side effects.

To read the report visit:
<http://ndarc.med.unsw.edu.au/resource/idrs-bulletin-july-2012-licit-and-illicit-quetiapine-use-among-idrs-participants>

Harm reduction sits with new 'recovery' policy emphasis

Valuable harm reduction measures, particularly Needle and Syringe Programs (NSPs), have remained central within the first overtly "recovery-oriented" drug and alcohol treatment strategy released by an Australian state or territory government.

The Australian National Council on Drugs (ANCD) held a round table on "recovery" in early June, immediately after the Victorian Government's release of a new strategy entitled New Directions for Alcohol and Drug Treatment Services – A Roadmap.

Recent "recovery-oriented systems of care" emanate from a US-born concept that is shaping drug treatment policy in the United Kingdom and is now in the early stages of being promoted in Australia. One of these systems' key points is to give additional emphasis to self-help networks where people develop hope that they can reduce or eliminate problematic drug and/or alcohol use by learning from those who have done so themselves.

Unlike in England, where recent drug treatment policy announcements seem to have put far more emphasis on goals of abstinence (including from pharmacotherapy such as methadone maintenance), the Victorian strategy clearly supports harm reduction.

Anex CEO Mr John Ryan immediately congratulated the Government for adapting the principles of recovery to the Australian context in which harm reduction is valued as much as demand reduction, of which drug treatment is but one valuable part.

The policy document, which sets the scene for significant reforms to drug treatment systems, states that harm reduction services are a critical part of the system, which "operates within a framework of harm minimisation. Every treatment intervention can help reduce the harms caused by substance misuse. The government also recognises that some people will continue to struggle with their use of alcohol or drugs at risky or harmful levels despite the harm it may cause them and their families. For this reason, Victoria supports harm reduction services that keep people safer and healthier."

It also states that "because people can take time to seek help, harm reduction services are a critical part of Victoria's system. NSPs and specialist primary health services keep people safer and healthier until they are ready to start treatment. Harm reduction services can play a critical role in helping people find their way into treatment when they are ready."

Both Anex and the Australian Injecting and Illicit Drug Users League (AIVL) have produced discussion papers concerning the emergence of recovery as a potentially over-arching framework. The revised Anex paper says that recovery-oriented systems, adapted for Australia's harm minimisation framework and multi-jurisdictional structure, could potentially "make a valuable contribution to Australian drug policy and practice, particularly when fostering community linkages to support people attempting to reduce or cease problematic alcohol or other drug consumption".

Anex undertook an extensive consultation process. Leading Australian and international drug policy experts also commented on the draft Anex discussion paper which, in its revised form, can be downloaded at www.anex.org.au/recovery

There is an emerging consensus that there should be an Australian or Australasian definition of recovery (in the context of drug treatment) and agreed set of principles. Mr Ryan said that, after wide consultation, the proposed definition (in italics) and principles are:

- Recovery is a voluntary, self-determined process toward wellbeing through minimisation or cessation of drug-related harms. This involves fostering healthy, supported connections, such as those with self, family, peers and community, and is premised upon fair access to pre-requisites for wellbeing.
- Recovery is a reflexive, change process with boundless initiating causes. It involves hope and aspirations for development, not just of individuals, but also of wider social networks, including communities.
- Recovery involves perseverance in individuals and families because setbacks are natural. Health should be protected before and throughout a recovery journey.
- Australian recovery is a non-prescriptive form of harm reduction, fostering improved health and wellbeing, with cessation of alcohol or other drug use a common aspiration and outcome.

- There are many sources and pathways of recovery. Recovery should be self-determined, rather than being imposed by others.
- Recovery empowers and develops individuals, families and communities.
- Because each individual must choose for themselves the most appropriate path and technique of recovery, there is no justification for forms of prescriptive public policy in this area.
- Recovery involves development of individuals' and communities' social capital, including access to housing, education, work and healthy relationships with others and self. It needs to be holistic and involves macro-to-micro environmental factors.
- Recovery is fostered by peers, families and allied institutions within communities, as Australian people need to have opportunities for a fair go at the essentials of life.

Mr Ryan warned against rushed wholesale changes without sufficient funding:

"If recovery was to become an agreed strategy, it should only evolve over many years at the frontline and be preceded by substantial and cautious policy development arising from widespread consultation," he said.

"Transformation toward new recovery approaches would require large-scale investments, and should not be at the expense of already under-funded harm reduction programming."

The Australian Recovery Academy will be officially launched on September 21st, when it will release its first discussion paper.