

Access to needles and syringes by intravenous drug users

Report No. 5

Standing Committee on Health

August 2003

Legislative Assembly for the Australian Capital Territory



Committee membership

Ms Kerrie Tucker MLA, Chair

Ms Karin MacDonald MLA, Deputy Chair

Mrs Jacqui Burke MLA

Secretary: Ms Siobhán Leyne (Acting Secretary: Mr Derek Abbott)

Research Officer: Ms Lesley Wheeler

Administration: Mrs Judy Moutia

Resolution of appointment

To examine matters related to hospitals, community, public and mental health, health promotion and disease prevention, disability services, drug and substance abuse and targeted health programs.

Terms of reference

The Committee will inquire into and report on access to syringes by intravenous drug users with particular regard to:

- after-hours access;
- prisons and remand centres; and
- indigenous peoples.

Table of contents

Terms of reference	ii
Summary of recommendations.....	iv
1. INTRODUCTION.....	1
Conduct of inquiry	1
2. INJECTING EQUIPMENT EXCHANGE PROGRAMS	3
Background	3
The need to focus on hepatitis C	4
Ongoing issues	6
Disposal of injecting equipment.....	7
Access to injecting equipment by young people	10
3. ACCESS TO INJECTING EQUIPMENT	15
Overview	15
After hours access	16
Reinforcements for current injecting equipment exchange models	18
4. PRISONS AND REMAND CENTRES.....	25
Overview	25
Can injecting equipment exchange work in a corrections setting?	27
Government views.....	30
Potential liability	31
Corrections officers	31
Belconnen Remand Centre	33
5. ACCESS BY INDIGENOUS PEOPLES	35
6. CONCLUSION	41
APPENDIX 1 – SUBMISSIONS.....	43
APPENDIX 2 – NEEDLE AND SYRINGE OUTLETS IN CANBERRA.....	45
APPENDIX 3 – BIBLIOGRAPHY	49
APPENDIX 4 – EXCERPT FROM <i>DRUGS OF DEPENDENCE ACT 1989</i>.....	51

Summary of recommendations

RECOMMENDATION 1

2.22. The Committee recommends that the Government work with the States and Northern Territory to apply consistent standards where possible in relation to the supply and disposal of injecting equipment.

RECOMMENDATION 2

2.39. The Committee recommends that the Government undertake a comprehensive education campaign on the safe disposal of used injecting equipment.

RECOMMENDATION 3

2.44. The Committee recommends that the Government, in consultation with peer intravenous drug user groups, increase the number and location of injecting equipment disposal units across the ACT, and work on methods to decrease other barriers to safe disposal as identified by intravenous drug users.

RECOMMENDATION 4

3.19. The Committee recommends that the Government undertake a needs analysis on the locations, hours and service model that injecting equipment exchange programs should operate in the ACT and following the outcomes of that analysis, ensure that services are enhanced in areas of need.

RECOMMENDATION 5

3.20. The Committee recommends that a primary outlet be established in each town centre.

RECOMMENDATION 6

3.30. The Committee recommends that the Government work with the Pharmacy Guild of Australia to enhance the current needle and syringe program in community pharmacies based on successful programs in other States.

RECOMMENDATION 7

3.59. The Committee recommends that the Government install injecting equipment vending machines across the while of the ACT.

3.60. The Committee further recommends that the locations of vending machines be trialled in consultation with key stakeholders.

RECOMMENDATION 8

4.63. The Committee recommends that the Government, in line with its harm minimisation approach, adopt the policy of injecting equipment exchange in the ACT corrections system.

RECOMMENDATION 9

4.64. The Committee recommends that the Government, as a matter of urgency, initiate round-table discussions with all current corrections officers and relevant health experts to define the safest way to implement an injecting equipment exchange program in the ACT corrections setting, including the Belconnen Remand Centre, the periodic detention Centre and the Quamby Youth Detention Centre.

RECOMMENDATION 10

4.65. The Committee recommends that the Government ensure that the new prison has purpose-built facilities for an injecting equipment exchange program.

RECOMMENDATION 11

5.13. The Committee recommends that the Government ensure that culturally appropriate education campaigns regarding safe injecting practices are available to the Indigenous community.

RECOMMENDATION 12

5.18. Following the earlier recommendation to locate a primary needle and syringe exchange outlet in each town centre, the Committee recommends that one of these new outlets be specifically focussed on the needs of the Indigenous community.

5.19. Further, the Committee recommends that the Government work closely with the Indigenous community to provide a model of secondary injecting equipment exchange outlets that can be located in areas of greatest need.

RECOMMENDATION 13

5.23. The Committee recommends that should the Gugan Gulwan Aboriginal Youth Corporation outreach service prove successful that it be used as a model for outreach to other marginalised communities.

1. Introduction

1.1. The Committee resolved to undertake an inquiry into the access to syringes by intravenous drug users following concerns raised with Members by the community that clean syringes are becoming more difficult to access.

1.2. The Committee was also concerned about reports that Hepatitis C infection is increasing at an alarming rate amongst intravenous drug users, in a large part due to sharing needles, and we, as a community need to seek solutions to this problem.

1.3. This inquiry did not look to solve or enter into the debate on drug use in the community. It instead comes from the premise that Australia, and the ACT, operates within a harm-minimisation approach to drug use and that the supply of clean injecting equipment is an important part of such an approach because of the public health issues related to the spread of blood borne viruses.

1.4. Throughout the course of this inquiry, it became clear to the Committee that it was looking at the access to 'injecting equipment' which *includes* needles and syringes, but also includes spoons, filters, water, swabs, disposal bin and other paraphernalia used by intravenous drug users. This distinction is made because, while it is of the utmost importance to reduce the incidence of sharing needles and syringes, the sharing of equipment also raises the possibility of exposure to blood borne viruses.

1.5. The Committee has therefore used the term injecting equipment, wherever possible in this report, which should be read to be inclusive of needles and syringes.

1.6. Again, by undertaking this inquiry, the Committee sought to open wider public debate on the often-controversial issue of access to injecting equipment. In the words of one forum speaker:

I'm quite sure that this audience will not necessarily like everything that I've got to say but, if nothing else, I'm sure it will add to the debate.¹

Conduct of inquiry

1.7. The Committee acknowledged that effective injecting equipment exchange programs exist in the ACT and therefore decided to specifically address the major concerns raised by the community, namely: after hours access; access by Indigenous peoples; and following the continued debate in the ACT regarding the establishment of a prison, and announcement during the term of this inquiry of the funding for a prison, access in prisons and remand centres.

1.8. During the conduct of the inquiry issues were raised regarding the general access to injecting equipment during business hours and this issue is also addressed at Chapter 3.

¹ Transcript of proceedings, 1 May 2003, p. 45

1.9. The Committee received fifteen submissions and also held a public forum on this issue, inviting a range of speakers and community members to put forth their comments or ideas and to facilitate debate on this issue.

1.10. The Committee thanks those people who attended and participated in the public forum, particularly those who travelled from interstate. All the ideas and issues discussed were of great benefit to the Committee and the debate as a whole.

1.11. The Committee encourages those interested in this debate to read the transcript of the forum proceedings. This is available by phoning 6205 0127 on the Committee's website at www.legassembly.act.gov.au/committees.

2. Injecting equipment exchange programs

Background

2.1. Injecting equipment exchange programs operate in all states and territories in Australia as a public health measure to prevent against infectious diseases spreading amongst intravenous drug users. Initially the diseases of concern were the Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). While this strategy remains, the hepatitis C virus is now also a major focus.

2.2. HIV and hepatitis C are both non-vaccine-preventable diseases, without cures, and can lead to death in many cases and in all cases, the need for considerable engagement with the health system.

2.3. “HIV transmission among intravenous drug user populations is now largely preventable in developed countries”² however, the World Health Organisation estimates that 170 million persons world-wide are chronically³ infected with hepatitis C⁴ which is far more easily transmitted through drug use than HIV.

2.4. The World Health Organisation has placed hepatitis C prevalence in Australian intravenous drug users to be between sixty and eighty percent⁵, testing for hepatitis C in intravenous drug users attending injecting equipment exchange programs in Australia has found that approximately fifty percent are hepatitis C positive⁶.

2.5. Unlike HIV, hepatitis C is rarely spread through sexual transmission and therefore strategies targeting safe injecting drug use and practices are important in reducing spread of hepatitis C. hepatitis C is highly infectious, and can be transmitted through shared injecting paraphernalia including, but not limited to, syringes.

2.6. “Sharing needles and syringes is generally acknowledged as the most important means of spread between intravenous drug users, and has consistently been found to be the major association with hepatitis C transmission among intravenous drug users worldwide.”⁷ Injecting equipment exchange programs reduce the risk of infection through providing sterile equipment for each injection, therefore minimising the risk of contact with the virus.

² Rutter, S., K. Dolan, A. Wodak and H. Heilpern. Prison-based syringe exchange: A Review of international research and program development. NDARC Technical report No. 112. National Drug and Alcohol Research Centre © 2001, p. 7

³ Chronic infection indicates those who are unable to clear the hepatitis C virus, this is approximately 80% of those exposed to the virus.

⁴ World Health Organisation Fact Sheet No. 164, October 2000

⁵ World Health Organisation, Regional Office for the Western Pacific, *Hepatitis and Related Diseases Briefing paper WPR/RC50/9*, September 1999.

⁶ Rutter *et al.* 2001, p. 8

⁷ Crofts, N. Aitken, AK and Kaldor, J. *The Force of numbers: why hepatitis C is spreading among Australian injecting drug users while HIV is not*. Published online on eMJA (Medical Journal of Australia) 1999; 170: 220-221

2.7. The success of Australia's injecting equipment exchange programs to date is evident when compared to statistics in other countries. For example⁸:

In New York City, which has a population about the same size as NSW, but rampant HIV among intravenous drug users, more than 17,000 paediatric cases of AIDS have been reported, compared to 42 in NSW. These paediatric cases of AIDS in New York City were in almost all cases, the direct result of one or another parent being an intravenous drug user.⁹

2.8. The Commonwealth Government's much vaunted report, *Return on Investment in Needle and Syringe Programs in Australia*¹⁰, found the following:

- In relation to HIV, a total savings of \$7,025 million due to:
 - o "Approximately 25,000 cases of HIV avoided, who
 - o live for an average of about 24 years after infections, and who
 - o incur average treatment costs of nearly \$14,000 each year of their life after diagnosis."¹¹
- In relation to hepatitis C the estimated treatment costs avoided are estimated at \$783 million due to:
 - o Approximately 21,000 cases of hepatitis C avoided.¹²

2.9. The report also noted that internationally, "hepatitis C prevalence in cities with needle and syringe programs was 37% lower than in cities without needle and syringe programs"¹³.

The need to focus on hepatitis C

2.10. Although injecting equipment exchange programs are successful at lowering the rate of hepatitis C infection, this is a highly infectious virus which needs renewed focus on needle and syringe programs. "hepatitis C prevalence is now so high that even very occasional sharing of needles and syringes carries an extreme risk of hepatitis C infection, to which must be added the unknown but non-negligible risks due to 'environmental' contamination."¹⁴

2.11. Of the estimated 11,000 new hepatitis C infections in Australia annually, 90 percent are thought to be from injecting drug use. Sharing unclean injecting

⁸ For further references see the bibliography at Appendix 3.

⁹ Penny and Crofts in Dolan, K., L. Topp and M MacDonald. *Needle and syringe programs: A Review of the evidence*. Australian National Council on AIDS, Hepatitis C and Related Diseases, 1999., p. 10

¹⁰ Commonwealth Department of Health and Ageing. *Return on investment in needle and syringe programs in Australia: Report*, © 2002, Commonwealth of Australia

¹¹ *ibid.*, p. 3

¹² *ibid.*, p. 30

¹³ *ibid.*, p. 15

¹⁴ Crofts, Aitken and Kaldor, 1999.

equipment places an intravenous drug user at a 150 to 800 times greater risk of infection with hepatitis C than HIV.¹⁵

2.12. The Government estimates that in the ACT that there are 2 500 people living with hepatitis C.¹⁶ Since 1994, a mean average of 285 cases is being notified to the Government each year. However, this belies the true figure of people living with hepatitis C as it does not take into account those who show no symptoms and are therefore not tested. The Committee heard from the Hepatitis C Council that there are an estimated 5 000 people in the ACT living with hepatitis C.¹⁷

2.13. The Council claims that this is a 45 percent increase over the past four years and at the current rate of growth, one million Australians will have hepatitis C by 2020.¹⁸

2.14. injecting equipment exchange programs have seen a significant impact on the spread of HIV amongst Australian intravenous drug users but there is evidence that they do not seem to be having the same effect on hepatitis C. This does not indicate that the programs are failing, however it does indicate that there is a need to look at reinforcing strategies in conjunction with needle and syringe programs.¹⁹

2.15. Along with improving treatment of and research into the hepatitis C, reducing the occurrence of new infections is the key challenge facing the community. A review of Australia's response to hepatitis C found that the following actions are needed to reduce the number of new hepatitis C infections:

- Provision of sterile needles and syringes, sufficient to meet demand, so as to reduce the prevalence of unsafe injecting;
- Education programs aimed at reducing illicit drug use, particularly injecting drug use;
- Provision of drug treatment programs, such as methadone maintenance, sufficient to meet demand, so as to reduce the prevalence of unsafe injecting and the prevalence of illicit drug use;
- Provision of safe injecting places to reduce the prevalence of unsafe injecting;
- Education programs targeting injecting drug users through specialist agencies (such as peer-based programs developed and undertaken by user groups) and the use of mainstream health care workers, so as to reduce the prevalence of unsafe injecting and the prevalence of injecting;
- Education programs and the provision of preventative measures in prisons;

¹⁵ Dolan, Topp and MacDonald, 1999., p. 11

¹⁶ Submission 15, ACT Government, p. 2

¹⁷ Transcript of proceedings, 1 May 2003, p. 41

¹⁸ *ibid.*

¹⁹ Crofts, Aitken and Kaldor, 1999.

- Measures that reduce the number of injecting drug users in correctional centres through the adoption of cautioning systems for first offences and diversionary sentencing;
- Removal of legal impediments to achieving a higher proportion of safer injecting amongst injecting drug users; and
- Establishment of an agreed core service structure and realistic output targets for education and prevention services.²⁰

2.16. This summarises much of what the Committee discusses in this report. There is substantial evidence published internationally, and by well-respected Australian researchers that supports this evidence, and the Committee has largely chosen not to replicate that here.

2.17. However the Committee has referred to key works, primarily by Australian researchers, and urges the Government to have the courage to support that evidence and continue to strive forward in this area, keeping in mind how past policies in relation to HIV prevention in this area that were once new and controversial have been, in the words of Dr Alex Wodak, of ‘spectacular benefit to this country’²¹.

Ongoing issues

2.18. Additional health problems facing intravenous drug users include vein damage and abscesses, caused by incorrect injection or multiple use of syringes, and a range of other physical and social problems caused not only by drugs and injecting, but community attitude and access to appropriate health care.

2.19. The Committee notes that the information leaflets currently produced by the Government are currently only available in English and welcomes the Government commitment to “broaden the range of material to include those from non-English speaking backgrounds and those who may have literacy problems”²².

2.20. Other issues were raised with the Committee, such as the need for a national understanding and consistent standards of the definitions of safe and unsafe disposal, access to different levels of injecting equipment (for example, programs in NSW are not allowed to provide barrels that contain over five millilitres, but in the ACT clients can access a whole range of equipment²³) and the need for deregulation of the supply of injecting equipment so that it can be obtained in a greater number of venues.

2.21. The Committee agrees that the inconsistencies in national standards can be confusing, and while some issues are jurisdictional, there is no reason why common standards should not be applied across other issues, such as the definitions for in/appropriate disposal as discussed below.

²⁰ Lowe, D. and Cotton, R. Hepatitis C: a review of Australia’s response. Department of Health and Aged Care, © 1999., pp. xii-xiii

²¹ Transcript of Proceedings, 1 May 2003., p. 3

²² Submission 15, ACT Government, p. 3

²³ Transcript of proceedings, 1 May 2003., p. 24

Recommendation 1

2.22. The Committee recommends that the Government work with the States and Northern Territory to apply consistent standards where possible in relation to the supply and disposal of injecting equipment.

Disposal of injecting equipment

2.23. Inappropriate disposal of injecting equipment in public places is of great concern to the community. For most people it is often the only visible sign of intravenous drug users in the community and is has a perceived high risk of danger to the community.

2.24. There is as yet no research on this type of impact of discarded equipment. For example, how long might a needle lay on the ground before being detected and disposed of? As Mr John Ryan of the Association of Needle and Syringe programs pointed out, a single needle left on the ground for a single day, and seen by one hundred people could effectively represent one hundred needles for that day and a larger problem in the perception of the community.²⁴

2.25. The Committee heard that generally, intravenous drug users want to dispose correctly and want to reduce public health dangers. Incidences of inappropriate disposal are usually due to unplanned injecting episodes and lack of access to known, readily available disposal facilities.²⁵

2.26. There is a known ‘reservoir of good will and good intention’ among intravenous drug users that should be accessed to improve disposal practices.²⁶

2.27. The Australian Intravenous League recommended changes to improve the current situation, including:

- improvement of disposal services;
- education for intravenous drug users; and
- education of the general public²⁷

2.28. There is no general profile for intravenous drug users likely to dispose ‘safely’ or ‘unsafely’. These behaviours are spread across demographics, location, ethnicity and accommodation tenure. Where the main location of use is public, ‘convenience’ is the main reason for disposal practice. Where the main location is private, there’s more likelihood that injecting equipment exchange programs are used.²⁸

²⁴ Submission 11, Australian Intravenous League. Disposal study p. 10 p. 19

²⁵ Submission 11, Australian Intravenous League, Disposal study introductory letter

²⁶ *ibid.*

²⁷ Submission 11, Australian Intravenous League. Disposal study p. 10

²⁸ *ibid.*, p. 35

“It depends on where I score or where I use to how I dispose. If I hook up on the streets, I dispose differently than if I’m at home. When I’m alone, I do things differently than when I’m with my girlfriend. It depends on how long I’ve had to wait and how I’m feeling – I’m different people at different times and they all dispose differently depending on when they had their last whack.”²⁹

2.29. In addition, displacement of activity due to increased policing strategies moves intravenous drug users from areas that are better resourced with supply and disposal facilities.³⁰

2.30. The Committee is aware that the introduction of security cameras in the Civic area in May 2001 has displaced drug use to other areas of Canberra that are not as well-resourced in terms of injecting equipment exchange programs. This is supported by the report released in August 2003, *Analysis of the needs of injecting drug users in the ACT* by James Blogg, undertaken for ACT Health. This report found that needle and syringe program “statistics for Civic dropped by over 30% in 2001-2002”.³¹

2.31. The Committee has no opinion on the use of security cameras, but feels that with their use, the resulting displaced activity must be acknowledged by the provision of appropriate supply and disposal facilities in more areas of the ACT.

‘Safe/appropriate’ and ‘unsafe/inappropriate’ disposal

2.32. Definitions of ‘safe/appropriate’ and ‘unsafe/inappropriate’ disposal, and methods of disposal which are considered safe/appropriate or unsafe/inappropriate vary from state/territory to state/territory. This creates confusion and concern for intravenous drug users³². The fact that it is unclear what constitutes ‘safe’ and ‘unsafe’ disposal practices leads to intravenous drug users coming to their own definitions which are often incompatible with official definitions and in some instances, official definitions are confusing and unclear.

2.33. The World Health Organisation incorporates safe disposal in the same context as safe injection practices in that no harm is caused to anyone as a result of an injection.

2.34. Inappropriate disposal methods include:

- public rubbish bins;
- household rubbish;
- leaving for someone else to dispose of;
- leaving equipment on the street;

²⁹ *ibid.*, p. 34.

³⁰ *ibid.*, p. 58

³¹ Blogg, James. *Analysis of the needs of injecting drug users in the ACT*. ACT Health, June 2002., p.

8

³² Submission 11, p. 7

- leaving equipment at the place of injection, which includes gutters, streets, parks, playgrounds and public toilets;
- dropping down the drain;
- flushing in the toilet;
- putting in sanitary disposal units; and
- burying³³

2.35. Practices understood by intravenous drug users of appropriate disposal include:

- breaking off the needle and disabling the needle/syringe to prevent re-use;
- re-capping used needles before disposal;
- returning used needles and syringes to needle and syringe program;
- depositing used needles and syringes in public syringe disposal units;
- burning needles and syringes.³⁴

2.36. The Australian Intravenous League considers that ‘safe’ options generally agreed to include:

- disposal in a puncture-proof container disposed of in the rubbish;
- returning needles and syringes to an injecting equipment exchange program;
- using public disposal bins; and
- returning needles and syringes to pharmacies.³⁵

2.37. It is worth noting that it is not only intravenous drug users who have difficulty understanding the differences between safe/appropriate disposal and unsafe/inappropriate methods. A 1990 survey of diabetics found that 93 percent threw them in the bin, three percent put them in the toilet, and only four percent put them in a puncture-proof container.³⁶

2.38. While the Committee hopes that this situation has improved over the past decade, it does make the point that there is a need for a general information campaign on the safe disposal of not only needles and syringes, but also other injecting and personal blood testing equipment, such as spoons and lancets.

³³ Submission 11, disposal study p. 31-32

³⁴ *ibid.*, p. 9

³⁵ *ibid.*, p. 17

³⁶ *ibid.*, p. 16, 20

Recommendation 2

2.39. The Committee recommends that the Government undertake a comprehensive education campaign on the safe disposal of used injecting equipment.

2.40. The Committee received evidence that the locations of approved disposal bins were often inaccessible.

2.41. For example, a submitter to this inquiry noted that at the Currong, Bega and Allawah housing complexes, there are only two small ‘fit bins’ available per complex and in order to use the bins, a large garbage hopper must be moved.³⁷ The submitter noted that this, and an increased police and security presence at the complexes, has led to an increase of inappropriate disposal of equipment.

2.42. The Australian Intravenous League stressed that it is important to improve disposal options, and that disposal of used equipment “ cannot be separated from the broader issue of access ... if the ACT is considering increasing access to injecting equipment, it is crucial that current options for the safe disposal of injecting equipment is reviewed at the same time”³⁸

2.43. Given the evidence received, the Committee feels that intravenous drug users are aware of the public health risks with inappropriately disposed injecting equipment and would prefer not to do so. However, the lack of appropriate and accessible disposal facilities and the fear of police reprisal³⁹ if found carrying used needles and syringes are effective barriers to safe disposal.

Recommendation 3

2.44. The Committee recommends that the Government, in consultation with peer intravenous drug user groups, increase the number and location of injecting equipment disposal units across the ACT, and work on methods to decrease other barriers to safe disposal as identified by intravenous drug users.

Access to injecting equipment by young people

2.45. The access to injecting equipment by young people was raised as a concern with the Committee during the public forum. While the Committee feels it can safely say that no one in the community, and certainly no member of this Committee wants to see young people injecting drugs intravenously, the fact remains that this is occurring.

³⁷ Submission 9

³⁸ Submission 11, p. 6

³⁹ Submission 11, Submission 9

2.46. Indeed, the Committee heard in its recent inquiry into the health of school-age children in the ACT that of the 50 per cent of secondary school students that have used substances, “five percent have used needles to inject an illicit substance”⁴⁰.

2.47. The young people that the Committee spoke to during the term of that inquiry were very clear with the Committee on the need for service providers to approach them honestly and openly and the greater need for appropriate drug education.

2.48. The Committee reiterates its recommendations on page 44 of its report, Looking at the health of school-age children in the ACT (April 2003) on the need for improved drug education.

2.49. Service providers are put into a moral dilemma when faced with particularly young people who request injecting equipment, for example, the Ted Noffs Foundation reports:

With the harm minimisation approach we take, I guess the only concerns we sometimes come up against are 14-year-old kids who want access to needles and syringes. ... If a 14-year-old or someone younger comes up and says, “Can I have a Fitpack?” in the middle of the night, you know they’re going to use. On the other hand, it may be their first time.⁴¹

2.50. However, as Dr Alex Wodak pointed out:

Undoubtedly, there are many moral and difficult ethical dilemmas in this debate. But when you think about what we should do, you should also think about what we shouldn’t do. No-one wants a 14-year-old to be injecting drugs. But, if they have started down that process, do we want them to get HIV and pass that on to other people because we’re too squeamish about giving them something that will protect them? Let’s hope their period of injecting drug use will be very short and that, when they stop their period of injecting drug use, they will be HIV negative rather than HIV positive.⁴²

2.51. The Committee agrees with Dr Wodak that while every measure should be taken to dissuade young people from acquiring a drug injecting habit, it is imperative that young people who are using be given every opportunity to use as safely as possible.

2.52. The Committee is aware that service providers in the ACT attempt to work closely with young people when they disclose that they are using or thinking about using, and will provide them with injecting equipment if needed. The Committee commends these efforts and believes that young people have no lesser right to access safe health care as than any other member of the community.

⁴⁰ Standing Committee on Health for the Fifth Legislative Assembly for the ACT. Looking at the health of school-age children, April 2003., p. 41

⁴¹ Transcript of proceedings, 1 May 2003, p. 7-8

⁴² *ibid.*, p. 8

Legality of the supply of injecting equipment

2.53. There does not appear to be a legal impediment to the supply of injecting equipment to young people. Part 7 of the *Drugs of Dependence Act 1989* (replicated at Appendix 4) states that an approved person supplying syringes may do so if they believe that it may prevent the spread of disease. There is no limitation stated under this Act as to the age of recipients of syringes.

2.54. Further, an approved supplier of syringes is exempt from prosecution under Part 9 of the *Crimes Act 1900*.⁴³

2.55. Generally, by the age of ten, young people can be charged with a crime, by fourteen see a doctor without parental approval (although a parent/guardian may have access to medical records) by fifteen leave school and by sixteen see a doctor with a guarantee of privacy and have consensual sex, and by seventeen, obtain a drivers licence⁴⁴.

2.56. While again, there is no defined age for consent to medical treatment, a young person can give consent if the doctor is sure that they understand the procedure.

2.57. Given this, the Committee feels that service providers should have no limitations place on them as to a minimum age of access to injecting equipment. However, when the service provider believes a client to be under the age of sixteen, then specific effort should be made to delay the injecting episode and refer the client to appropriate drug treatment programs, and other services as needed.

2.58. The immediate concern of these service providers should be of disease prevention.

2.59. The Government tacitly acknowledges drug use in young people through the use of diversionary programs for young people charged with drug offences.

2.60. Abstinence and relapse prevention programs are in place in Quamby Youth Detention Centre, and the Government has expressed concern about the provision of injecting equipment to minors in juvenile detention.⁴⁵

2.61. The Committee commends the use of outside agencies in the programs offered at Quamby, however is concerned that, as in adult facilities, detainees are forced to compromise their health through lack of injecting equipment. This issue is further discussed in Chapter 4.

2.62. Later in this report, the Committee discusses the use of vending machines and is aware that members of the community have concerns about the accessibility of these machines to young people.

⁴³ *Drugs of Dependence Act 1989*, Part 7.

⁴⁴ Legal Aid Office of the ACT. When can I? A Legal information handbook for young people. © 2000, p. 6-7

⁴⁵ Submission 15, ACT Government, p. 8

2.63. The Committee acknowledges these concerns, however it feels that they do not outweigh the need of the community as a whole, including young people, to have the right to disease prevention through safe, clean injecting equipment.

3. Access to injecting equipment

Overview

3.1. Needles and syringes are available free of charge from primary or secondary outlets, some medical centres and hospital emergency rooms. Primary outlets have a greater range of equipment, and secondary outlets have basic equipment such as *Fitpacks*®⁴⁶. The main primary outlet in the ACT is Directions ACT, in Canberra City. The six secondary outlets are as follows:

- AIDS Action Council (Acton)
- Alcohol and Drug Service (City)
- Belconnen Health Centre (Belconnen)
- Narrabundah Health Centre (Narrabundah)
- Phillip Health Centre (Woden)
- Tuggeranong Health Centre (Tuggeranong)

3.2. The Canberra Alliance for Harm Minimisation and Advocacy (CAHMA) is also considered to operate as a primary outlet, and it is also in the city area.

3.3. Primary outlets distribute a wide range of injecting equipment and paraphernalia to users and also supply secondary outlets with basic equipment such as *Fitpacks*®. The Committee is concerned that the two primary outlets are both located in the City area.



3.4. Twenty-eight pharmacies⁴⁷ in the ACT sell 'Pharmacy Packs' at a cost of \$2. Unlike the primary and secondary outlets, which accept used equipment in a 'needle exchange' program, the pharmacy outlets have no expressed capacity to accept disposals.

3.5. Twenty-four hour access to injecting equipment in the ACT is unavailable.

3.6. Directions ACT is open until 6:30pm Mondays to Thursdays, until 9pm Fridays and Saturdays (opening at 1pm on Saturdays). None of the secondary outlets are open after 5pm on weekdays. There is no free access to injecting equipment on Sundays.

3.7. Nine pharmacy outlets are open after 6pm on weekdays, six closing at 7pm and the remainder closing at 8pm. However on weekends all twenty-seven are open

⁴⁶ A *Fitpack*® consists of a number of syringes with needle; water for injecting; swabs; cotton balls; plastic spoon; mini disposal bin.

⁴⁷ See Appendix 2

for at least some period on Saturdays (generally mornings) and sixteen are open for some period on Sundays, again, generally in the morning.

3.8. The pharmacy outlets are distributed equally over the ACT although because of operating hours, large parts of Tuggeranong, Gungahlin and inner-Belconnen have no after hours access and limited weekend access.

3.9. The Committee is also aware that 'silent' outlets operate in the ACT. These are 'silent' in order to directly target a client group, such as sex workers or Aboriginal people. Remaining 'silent', they allow targeted information and referral to particular client groups, and the services have found them to be very effective to date.⁴⁸ The Committee supports the continuation of the services.

3.10. The Gungan Gulwan Aboriginal Youth Corporation operates an outreach bus service on Friday nights, which includes an injecting equipment exchange in an attempt to provide information and to prevent further spread of hepatitis C within the Indigenous community⁴⁹.

3.11. The Committee notes that the Government submission lists this service as an after-hours access point⁵⁰, however the Committee does not want to see this service in any way put forth as a resource to be used by the wider community as it would derogate from its aims and effectiveness within the Indigenous community.

After hours access

3.12. There are a multitude of problems resulting from there being limited hours of access to injecting equipment exchange programs. The current provision of services does not necessarily service the needs of clients who cannot plan their using habits, it makes clean needles and other injecting paraphernalia potentially inaccessible to people who work full time particularly given the proximity of the two primary outlets to each other, and it prohibits effective service provision, education and referral.

3.13. For example, after the replacement of a full-time injecting equipment exchange clinic with a part-time injecting equipment exchange bus in the Wentworth Area Health Service (NSW), access to needles reduced dramatically. This was because of several reasons, including the greater visibility of the bus to police and the general public and the inflexibility of the timetable. In addition, because intravenous drug users tend not to have predictability in their using habits, due to work and family or other lifestyle commitments, it was difficult for them to obtain clean needles in the four hours the bus was available to them. Clients were also unable to pre-plan when they were going to inject and were therefore reluctant to obtain supplies early for fear of attracting police attention. Clients reported:

See I don't know about anybody else, but with my lifestyle, I don't just wake up in the morning and think, 'oh I'm going to have a shot at this time of the day.' Like it just depends on the circumstances. Like I might run into someone...that owes me

⁴⁸ Transcript of proceedings, 1 May 2003, p. 39-40

⁴⁹ *ibid.*, p. 39

⁵⁰ Submission 15, ACT Government, p. 4

money or something. Right, so then if I'm organising to get on...it's easier for me to just rock on up to somewhere. Like I don't think, 'Oh well the bus is there at 12.00 so that's when I'm going to get on.'⁵¹

3.14. The lack of after-hours access to injecting equipment also placed users in the position of sharing needles:

...this situation meant that they had to buy equipment from acquaintances and strangers for a dollar a needle without knowing if the needle was new or used. Buying equipment this way was considered expensive; some users preferring to re-use their own equipment rather than pay for equipment on the black market. Given that many users considered themselves 'night owls', lack of after-hours needle and syringe program access meant that late night expeditions for needles were not uncommon:

Getting the needles, that's the main thing. It's bad, mate. I've got people comin' knockin' on my door 3-4.00 o'clock in the morning asking for needles, mate. Just for needles. It's a joke.⁵²

3.15. Due to this after-hours nature of use, there is limited or no opportunity for referral to other organisations and health services and education.

3.16. The Committee is concerned that given the after-hours nature of use, combined with the limited availability of primary outlets in the ACT, that this may lead to increased sharing of injecting paraphernalia, which carries a risk of hepatitis C transmission.

3.17. The Committee is not advocating a complete change in the way that injecting equipment exchange programs in the ACT currently operate, but feels that there is a need to complement these programs with after-hours service to better serve the needs of clients. In short, provision of a service centred on the client's needs.

3.18. While there is strong anecdotal evidence, and evidence coming through studies being undertaken by the Australian Intravenous League regarding the need for greater after-hour access, there has been no formal needs analysis undertaken in the ACT. The Committee supports the ACT Hepatitis C Council call for such analysis to form the basis of the other programs and ideas discussed in this report.

Recommendation 4

3.19. The Committee recommends that the Government undertake a needs analysis on the locations, hours and service model that injecting equipment exchange programs should operate in the ACT and following the outcomes of that analysis, ensure that services are enhanced in areas of need.

⁵¹ Southgate, E., C. Blair and M. Hopwood. Social and Health Impact Study: The Closure & relocation of the St Marys needle and syringe program. National Centre in HIV Social Research © 2000., p. 24

⁵² *ibid.*, p. 25

Recommendation 5

3.20. The Committee recommends that a primary outlet be established in each town centre.

Reinforcements for current injecting equipment exchange models

3.21. There are a number of options that can run concurrently as reinforcements to existing programs.

3.22. During the term of this inquiry, the Committee was made aware of a study being undertaken by the South East Sydney Area Health Service in partnership with the National Centre in HIV Social Research and the National Centre in HIV Epidemiology and Clinical Research. This project consists of a needs analysis of injecting drug users who do not access injecting equipment exchange programs on a regular basis with a particular focus on youth, culturally and linguistically diverse communities and Indigenous peoples.⁵³

3.23. The Committee urges the Government to consider the outcomes of this study closely, in addition to undertaking its own needs analysis as outlined above.

Increased pharmacy outlets

3.24. While there are limitations to the services that can be offered at pharmacy outlets, the Committee received a submission from the Pharmacy Guild of Australia, ACT Branch advocating greater use of this option.

3.25. Some of the current limitations with pharmacy outlets are:

- Hours of operation
- Cost –if intravenous drug users have to pay to buy fresh injecting equipment they may prolong re-use of equipment;
- Stigmatisation – the local pharmacy is frequented by neighbours, friends colleagues, who an individual may not want to know that they are using, and travel to another pharmacy creates a burden of cost in terms of transport; and
- Judgement – the Committee heard that the reactions of pharmacy staff can prevent users obtaining clean fits -

can you imagine how I, a man of 58 years of age, feel going into a chemist attended by a 16-year-old young lady who's just started work in her first job? Okay ... I might walk in on a day I'm not feeling too good, haven't had a shave for a couple of days and have a hole in my T-shirt and say, "I need a fit and I want it fast."

⁵³ Submission 1, Ms Gillian Booth, South East Sydney Area Health Service

Unfortunately, that's the way some clients behave, and the reaction they're going to get from the young girl is going to be everything we expect: shock, horror. You get this attitudinal thing happening right from the start. I'm not going to go and put myself in that position, because it makes me feel uncomfortable. So what am I going to do?

If I can't get clean equipment elsewhere, I know at home I've got a plastic container with used fits in it. I know I can go home, get a hammer, smash the thing, break it open, get a fit that I've used once. I know I'm the only one that's used it, but nevertheless I'm using a fit that's second-hand property, damaged goods, and I'm putting myself at risk of vein damage or abscesses just because of my feelings. It might be a bit quaint, but that's the way it is.⁵⁴

3.26. Currently in the ACT, 49 percent of pharmacies participate in the needle and syringe program. The Pharmacy Guild submitted to the Committee that this was undertaken as a community service and as part of the pharmacist's duty of care.⁵⁵

3.27. However the Guild further submitted that the models currently implemented in Tasmania and Queensland would enhance the current service provided in the ACT. Those models have three clear objectives:

- Diversification of the needle availability program;
- Creating a safe environment; and
- Investigate options for the collection of data on clients accessing pharmacy based NAP (Needle Availability Program) outlet.⁵⁶

3.28. The model emphasised appropriate staff training for the health and safety of staff as well as clients.

3.29. The Pharmacy Guild made a strong submission to the Committee about the need to enhance the current community pharmacy needle and syringe program, and the Committee agrees with the Guild's recommendations on this matter.

Recommendation 6

3.30. The Committee recommends that the Government work with the Pharmacy Guild of Australia to enhance the current needle and syringe program in community pharmacies based on successful programs in other States.

Medically supervised injecting places

3.31. Supervised injecting places are widespread in The Netherlands, Switzerland and Germany, some for over three decades. Supervised injecting places in Switzerland evolved from the development of cafés "to cater for intravenous drug

⁵⁴ Transcript of proceedings, 1 May 2003, p. 30

⁵⁵ Submission 13, Pharmacy Guild of Australia, ACT Branch, p. 3

⁵⁶ Submission 13, Pharmacy Guild of Australia, ACT Branch, p. 4-6

users who did not utilise health services”⁵⁷. Health workers were able to use this “opportunity to monitor and modify intravenous drug users risk behaviour and reduce harms associated with injecting”⁵⁸.

3.32. The opportunity for referral has also been found in Australian trials of the supervised injecting place in NSW. “Six hundred and ten referrals were provided to the 1503 [medically supervised injecting centre] clients [Kings Cross, NSW] in the first six months of operation.”⁵⁹ The most frequent referrals were for drug treatment (42 percent), followed by primary health-care (33 percent) and social welfare services (25 percent).⁶⁰

3.33. Studies of the supervised injecting places in Europe found that:

“while there is no direct epidemiological evidence to show reduced incidence of blood-borne virus (BBV) transmission among clients, observed reductions in needle sharing and increased condom use reported by clients indicate a reduction in BBV risk behaviours.”⁶¹

3.34. The Supervised Injecting Centre in Sydney has been declared a success and will be continued. Evidence of this success includes:

- one in four client visits occasioned in a health care service;
- hepatitis C and hepatitis B notifications remained stable in the Kings Cross Area, but increased in the rest of Sydney;
- half of all clients reported less risky practices;
- the frequency of public injections lessened, and were less noticeable to businesses and the community;
- clients were more likely to be tested for a blood borne virus and were more likely to start drug treatment; and
- the incidence of inappropriately discarded syringes was lower.⁶²

3.35. Although supervised injecting places are surrounded by a considerable degree of controversy, this option must be considered in the package of service delivery to intravenous drug users in Canberra.

3.36. The Committee is supportive of the concept of a safe injecting place, but acknowledges that it will only serve the needs of the people who already utilise the

⁵⁷ Dolan, K. J. *et al.* *Drug consumption facilities in Europe and the establishment of supervised injecting centres in Australia*. In *Drug and Alcohol Review* (2000) 19:337-46 Australian Professional Society and Alcohol and Other Drugs © 2000, p. 339

⁵⁸ *ibid.*

⁵⁹ Mattick *et al* *Six-month process evaluation report on the medically supervised injecting centre (MSIC)*, NDARC Technical Report No. 124. © 2001 National Drug and Alcohol Centre., p. 7

⁶⁰ *ibid.*, p. vii

⁶¹ Dolan *et al*, 2000., p. 341

⁶² MSIC Evaluation Committee. *Final report of the evaluation of the Sydney medically supervised injecting centre*. © 2003., pp. xi-xvi

area where it is located. The Committee was told that “somebody purchasing heroin in Belconnen isn’t going to get on a bus to travel to Civic to use a safe injecting place.”⁶³

3.37. The ACT has the legal mechanisms to put in place a supervised injecting place trial under the *Supervised Injecting Place Trial Act 1999* and the Committee is aware that there is a committee established under this Act looking at the detail of a trial.

3.38. Further to this, the Government released a report on 20 August 2003 entitled *Analysis of the needs of injecting drug users in the ACT* by Mr James Blogg (the Blogg report).

3.39. The Blogg report specifically looks at the issues surrounding the establishment of a supervised injecting place in the ACT. The Committee notes a decision on a supervised injecting place is under consideration by the Government.

Vending machines

3.40. Syringe vending machines work in a similar manner to an ordinary vending machine, whereby the machine may accept a contaminated syringe and issues a new one, or they may also be coin, or otherwise, operated.

3.41. A study undertaken in Marseille, France following the introduction of needle exchange programs (NEP), legal pharmacy sales and vending machines found that “compared to NEP users, vending machine users were younger, had a significantly shorter history of injection drug use, injected less frequently and were less frequently enrolled in a methadone program...”⁶⁴.

3.42. The study also found that the machines “were able to regularly attract a segment of the injection drug-using population that was hardly reached by the other syringe programs” and who had characteristics of those “reported to be at [high] risk ... for HIV infection”.⁶⁵



3.43. Submitters to this inquiry largely proposed vending machines as a good and viable addition to current injecting equipment exchange programs, but stressed that they are a back-up to current services, not a replacement.

3.44. Certainly those present at the public forum agreed with the installation of free vending machines. Ms Wendy Macken of Directions ACT said:

⁶³ Transcript of proceedings, 1 May 2003., p. 28

⁶⁴ Moatti, JP., et al., *Multiple Access to Sterile syringes for Injection Drug Users: Vending Machine, Needle Exchange Programs and Legal Pharmacy Sales in Marseille, France* in *European Addiction Research* 2001; 7:40-45, p. 43

⁶⁵ Obadia et al., *Syringe vending machines for injection drug users: An Experiment in Marseille, France*. In *American Journal of Public Health* 1999; Vol. 89, No. 12:1852-1854., p. 1853

I think it's going to be vital to look seriously at the installation of vending machines in prime locations across the ACT. We need free 24-hour access to needles and syringes at Canberra and Calvary hospitals. I'm amazed that, everywhere in New South Wales, hospitals take it for granted that they give out needles and syringes, but in Canberra it's a no-no.⁶⁶

3.45. There are already several locations across Australia, (including Lismore, Ballina, Byron Bay and Nimbin in NSW) that have installed vending machines. The Committee heard from Mr Andy Hart, a representative of a company that installs syringe vending machines that his company had over 88 vending machines in NSW.⁶⁷

3.46. A participant at the forum reported that these vending machines were found to be more viable when free of charge as they tend not to be broken into for money⁶⁸.

3.47. However, Mr Hart, had found little incidence of this occurring when the machines were installed in an appropriate manner, for example, with steel grills, such as the machine at Napean Hospital, as seen below⁶⁹. Indeed, Mr Hart felt that free vending machines increased inappropriate disposal and therefore public perception of drug use:

Even if it's a very low fee, such as \$1, you're less likely to get people taking the Fitpacks and playing with them, which has been the experience when vending machines first go in. People tend to play with the contents to see what they are and there's a lot of inappropriate disposal. Nursing staff are often responsible. When we've put them in the hospitals, the nursing staff want to know what the box is, they play with it, and then it's thrown straight into the bin. The incidence of that goes down after a short period of time but, when they have to pay for it, they tend to leave them alone.⁷⁰



3.48. The cost of injecting equipment can also act as a deterrent. The Committee was told by a self-identified intravenous drug user:

The immediate question that comes to mind is: your junkie's got his \$100 to buy his heroin, so how come he can't find \$2 for the chemist and \$1.30 for the bus or \$5 to put petrol in the car? I don't know how all that works, but I've been there myself. The bottom line is: if you are an opiate dependent person, the first thing you do is get your heroin. You work out the details later. This is where personal morality comes into it. I'm not going to pinch a car to drive to Woden, because that's where the only open chemist is. I'm not going to do that, but others may. We worry about the

⁶⁶ Transcript of proceedings, 1 May 2003, p. 10

⁶⁷ *ibid.*, p. 21-22

⁶⁸ *ibid.*, p. 21

⁶⁹ Submission 10, Vendafit NSW.

⁷⁰ Transcript of Proceedings, 1 May 2003., p. 22

bus fares, the \$2 and lunch later, and we spend our \$100 now. It's crazy, but that's the way it works.⁷¹

3.49. The Committee believes that both free and low-fee vending machines should be trialled in the ACT to determine the most effective model, which may well be a combination of both, depending on location.

3.50. Mr Hart also reported having undertaken a study on whether the vending machines increased inappropriate disposal, and found that they did not.

Every time you put in a vending machine, the local community thinks it is the first vending machine ever. As I said, there are over 80 of them. A typical example is that, when I put a machine in at Windsor Hospital, which is a semirural area, the local police commander—he had no right to do this—came out and said that the syringe crime rate would soar, there would be more disposal issues and so on.

What I did is put a coloured sticker saying how to dispose of syringes safely on every Fitpack that went out of that machine. I do this on every machine I put up, using a different colour so that I know, if any are found, where they come from. I worked with the local council and, in a six-month trial, there was not one Fitpack found. The police commander had to come out and say that it was a success, that there was no change in the crime rate.⁷²

3.51. Two essential components to the installation of vending machines were found to be the co-location of a disposal bin and education of staff in areas where the machines were located if the machines were in any way to affect them.



3.52. As previously discussed, the Committee is aware that members of the community hold concerns about these machines being accessible to young people, particularly non-drug using youth who may access the needles and syringes and use and dispose of them inappropriately.

3.53. However the Committee feels that once a young person makes a decision to start injecting drugs that they will access injecting equipment in whatever form and the Committee would rather they be able to access clean, safe equipment. The key to prevention of drug use is not to prevent access to clean, safe injecting equipment, but rather, early and appropriate drug education strategies.

3.54. The Committee has made recommendations regarding the use of vending machines but makes it clear that the locations of injecting equipment vending machines must be considered carefully with these issues in mind.

⁷¹ *ibid.*, p. 31

⁷² *ibid.*, p. 23

Late night service centres

3.55. Submitters also raised the possibility of all- and late-night petrol stations and convenience stores providing injecting equipment through the use of vending machines.

3.56. The Committee is interested in this model of service delivery, however is concerned about the duty of care and subsequent liability issues potentially placed on non health-care providers and can understand that these businesses would have serious concerns about providing this service.

3.57. However, the Committee is supportive of the use of vending machines as a method to support existing injecting equipment exchange programs.

3.58. The aforementioned Blogg report also identifies that “improved after hours NSP [needle and syringe program] access can be simply achieved by installation of vending machines”⁷³.

Recommendation 7

3.59. The Committee recommends that the Government install injecting equipment vending machines across the while of the ACT.

3.60. The Committee further recommends that the locations of vending machines be trialled in consultation with key stakeholders.

⁷³ Blogg, J., p. 6

4. Prisons and remand centres

Overview

4.1. In light of the ongoing debate regarding the establishment of an ACT prison, and as residents are held in remand and youth detention in the ACT, the Committee decided to address the issue of the availability of needles and syringes in prisons in this report. During the term of this inquiry, the Government announced plans to build an ACT prison.

4.2. The Committee believes that the design and construction of the proposed prison should take into account facilities to address substance misuse, based on national and international experiences.

4.3. The Committee would like to note its appreciation for the submission from the NSW Corrections Health Service, given the close relationship the ACT has with the NSW prison setting. The Committee particularly thanks Professor Michael Levy of the Service, who travelled to Canberra twice, not only to attend the public forum, but to also later meet with the Committee. The Committee thanks Professor Levy for his insights.

4.4. The Standing Committee on Justice and Community Safety for the Fourth Legislative Assembly for the ACT also addressed this issue in its October 1999 report *The Proposed ACT prison facility: Philosophy and principles*. The Committee urges the Government to revisit the issues raised in this report in the policy development for the ACT prison.

4.5. The Committee understands that there are additional difficulties in the consideration of an injecting equipment exchange in the Quamby Youth Detention Centre as discussed previously.

4.6. However, the Committee understands that there are young people detained at Quamby who inject drugs intravenously, and any discussion of prison needle and syringe exchange programs should equally include Quamby. Having said this, the Committee believes that the abstinence and relapse prevention philosophy currently undertaken at Quamby should continue and every effort should be made to support young offenders when released into the community so they have the option to remain free of drug use.

4.7. Further, the Committee is aware that a current inquiry of the Standing Committee on Community Services and Social Equity is addressing the issue of support for young people on release from custody at Quamby, and hopes that that inquiry can further address the issue of support regarding substance misuse treatment post release.

4.8. It should therefore be understood that where the Committee refers to corrections settings, it includes the Quamby Youth Detention Centre, the Belconnen Remand Centre, the Periodic Detention Centre and the planned prison.

4.9. The Committee recognises that the provision of access to injecting equipment in corrections settings raises a number of paradoxical issues, particularly in terms of imprisoning individuals for drug-related offences, and then, in practice, condoning behaviour through providing the means to inject illicit drugs.

4.10. However, prisoners and remandees do have certain human rights, namely the right to adequate health care, and to not be forced into practices that may put them unduly at risk of hepatitis C, HIV or other infection.

4.11. It is also important to note that remandees are innocent⁷⁴ of the crimes they are charged with, and being held in custody on the grounds of their own or community safety until released or convicted and sentenced.

4.12. Persons in corrections settings are an ideal audience for targeted reduction of hepatitis C infection. Although providing safe injecting equipment and lesser sanctions for ‘soft’ drug use may be seen as condoning drug use, such changes in policies would allow for a significant reduction in the amount of hepatitis C entering the general community *from* the prison population.

4.13. However, sanctions for drug use is a debate which is not appropriate for this report and although it needs to run concurrently with a debate on access to injecting equipment, the Committee shall not enter into it at this time.

4.14. Studies have found that “about half of the general prison population in New South Wales has a history of injecting drugs” and in a separate study undertaken in several Australian cities, 38 percent of intravenous drug users had “served a prison sentence; one third of those had injected drugs while in prison; and 60 percent of those who had injected shared needles”.⁷⁵

4.15. The Australian Hepatitis Council submitted to the Committee that the ACT “has the opportunity to ensure that an ACT prison is not regarded as an incubator of hepatitis C infection, as prisons in other jurisdictions are rightly described”⁷⁶.

4.16. Indeed, hepatitis C prevalence amongst the general prison population is estimated to be at a rate of 40 percent, and closer to 65 percent amongst female prisoners.⁷⁷ Data obtained in South Australian prisons indicates that female inmates had “156 times the risk of acquiring hepatitis C in prison compared with the broader community”⁷⁸.

4.17. This figure is particularly concerning when applied to the number of Indigenous Australians in incarceration. Although Indigenous Australians make up less than two percent of the Australian population, they are over-represented in the

⁷⁴ Proof transcript of evidence, 8 August 2003., p. 19

⁷⁵ Cregan, J. *Hepatitis C, prisons, and public health* in Australian and New Zealand Journal of Public Health: 1998: vol 22 no. 1: p. 5-7, p. 5

⁷⁶ Submission 3, Australian Hepatitis Council, p. 2

⁷⁷ Submission 15, ACT Government., p. 6

⁷⁸ *ibid.*

prison population. “In NSW for example, fourteen percent of the total prison population were Indigenous in the 1998 inmate census.”⁷⁹

4.18. Therefore, “given the high rate of incarceration reported by Indigenous intravenous drug users, prison may be an ideal opportunity to promote treatment and blood-borne virus testing and to address some of the barriers identified by Indigenous intravenous drug users.”⁸⁰

4.19. Intravenous drug use, and consequent infection spread with shared equipment is rife in corrections settings. “Intravenous drug users may inject less frequently while in prison than they do outside jail, but when they do inject they are likely to be forced into equipment sharing networks, among whom the majority of members are likely to be already hepatitis C-positive.”⁸¹

Can injecting equipment exchange work in a corrections setting?

4.20. The Committee would like to make it clear that injecting equipment exchange in the corrections setting must encompass the full range injecting equipment, including the syringe and needle, but also including sterile water, tourniquet, swabs, spoon, mixing bowls and all else that is required. The Committee has heard repeatedly that hepatitis C is so infectious that the injecting equipment must also be exchanged.

4.21. Trials overseas have found that there is little correlation between injecting equipment availability and increased drug use. A syringe exchange trial (through use of one-for-one vending machines) in Hindelbank, Switzerland found that “drug intake in prison is influenced by the availability of drugs and money. It was evident that access to syringes did not encourage drug use or injection [and] there was no increase in drug use or injection”⁸² over the course of the trial.

4.22. However, when drugs were available “high levels of syringe exchange were observed”⁸³ indicating that, given the opportunity, drug-using inmates will choose not to share equipment.

4.23. The trial also found that while drug intake decreased immediately following imprisonment, it soon returned to pre-incarceration levels. The authors suggested that this was due to an adaptation process immediately following incarceration and proposed that “a well-implemented drug and HIV programme may discourage drug using prisoners from recommencing drug use after being incarcerated”.⁸⁴

⁷⁹ Day, C. and K. Dolan *Characteristics of Indigenous injecting drug users in Sydney: Gender, prison history and treatment experiences*. Conference paper, Best Practice Interventions in Corrections for Indigenous People Conference: Australian Institute of Criminology, October 2001., p. 2

⁸⁰ *ibid.*, p. 5

⁸¹ Cregan, J. 1998., p. 5-7

⁸² Nelles, J. A. Fuhrer and H.P. Hirsbrunner, *How does syringe distribution in prison affect consumption of illegal drugs by prisoners?* In *Drug and Alcohol Review* (1999) 18:133-138. Australian Professional Society and Alcohol and Other Drugs © 1999., p. 138

⁸³ *ibid.*

⁸⁴ *ibid.*

4.24. Interestingly, it has been found that diabetics in corrections settings have a lower level of hepatitis C infection. This is the result of a number of factors, including an understanding of injecting practice, but also because they have access to clean syringes.⁸⁵ However, the Committee is concerned that this can lead to these individuals becoming a secondary needle exchange, and participate in corrupting the system as discussed below.

4.25. Corrections settings have a semi-permeable barrier. This means that while custodial officers can control who leaves the prison, they do not have full control over what enters the prison.

4.26. To expect this control places a hard burden on correctional staff. As it was pointed out to the Committee, if as a society we cannot prevent drugs entering the community, how can we expect corrections officers to prevent them entering the confines of the corrections setting? It is a community responsibility to control drug use, not an additional responsibility mandated to corrections officials.⁸⁶ We cannot have higher expectations of corrections settings than we have of the community as a whole.

4.27. Indeed, currently in the ACT, drugs can enter the corrections settings as easily as throwing them over the wall of the Belconnen Remand Centre.

4.28. The expectation that corrections officers can control what drugs and injecting paraphernalia enters the system lends itself to corruption of the system. By not providing injecting equipment, the corrections system is providing an item to be used as a currency for corruption with the system. Drugs and injecting paraphernalia are hard currency in correctional settings, introducing injecting paraphernalia as a standard part of each prisoners 'kit' removes one layer of potential corruption.

4.29. For example, the Committee was informed of a group of twelve prisoners at a maximum-security prison in Cessnock (NSW) who had a supply of heroin to last three weeks and were therefore actively injecting. Their equipment wore out and they were able to send an order through the prison transport system (via prisoners) and within three days had fresh injecting equipment from Sydney.⁸⁷

4.30. The Committee was informed of a prison governor in Spain who successfully ran an injecting equipment exchange in the prison. He saw his first responsibility to be that no one left the prison until his or her release date. His second responsibility was to ensure that his staff were professional and to ensure that he removed anything that may potentially corrupt his staff.⁸⁸

4.31. The Committee is also concerned that the need for clean injecting equipment places a burden on the families and friends of inmates. Visitors who otherwise may not condone an individual's drug use may consider that the risk and stress associated

⁸⁵ Proof transcript of evidence, 8 August 2003., p. 17

⁸⁶ *ibid.*, p. 13

⁸⁷ *ibid.*, p. 12

⁸⁸ *ibid.*, p. 11

with smuggling clean injecting equipment to their loved ones, outweighs the risk of that person contracting a blood borne virus.

4.32. So how can an injecting equipment exchange work in corrections settings? There are a number models already working in other jurisdictions, including:

- inclusion of basic injecting equipment in every new inmates 'kit';
- one-for-one vending machines;
- supervised injecting rooms (includes prescription); and
- outside organisations providing counselling plus injecting equipment exchange.

4.33. Each of these systems has its limitations, for example:

- vending machines can be tampered with by either inmates or officers;
- supervised injecting rooms require substantial physical resources; and
- the use of outside organisations require inmates to disclose drug use and those who are unwilling to disclose will therefore be more likely to reuse equipment.

4.34. However, from evidence received, the Committee believes that a combination of systems can be effective. Primarily, one-for-one vending machines and a clinic arrangement that offers education, counselling and equipment exchange.

4.35. There are several steps to making injecting equipment exchange viable in the corrections setting⁸⁹:

1. Acknowledge that injecting equipment is already being exchanged, in dangerous circumstances, with no control over distribution or collection.
2. Obtain control by implementing a one-for-one exchange. The exchange must clearly have a distribution and collection role, otherwise there is no way to control the used equipment in the system.
3. Regulate carefully. The operation of the exchange must have clear rules on how it is to operate. For example, an inmate is allowed to have one syringe which must be displayed, used or unused in a clear container in their cell. However the rules must not be so restrictive that they lend themselves to corruption. For example, requiring the aforementioned container to be displayed in an exact location so that if it is moved slightly to one side the inmate can be punished, is counterproductive.

⁸⁹ *ibid.*, p. 14

4. Ensure that the philosophy runs the policy of the prison, rather than the culture of the prison dictating the philosophy.

4.36. Because the current system in the ACT does not acknowledge the presence of injecting equipment, it does not allow for appropriate disposal, and the Committee has grave concerns that this opens up an additional hazard for inmates *and* corrections officers.

Government views

4.37. In its submission, the Government expressed the view that it is unfeasible to conduct trials of injecting equipment exchange programs in ACT correctional facilities because “there is no evidence of ongoing injecting drug use, probably due to the short-term nature of incarceration” in the remand and periodic detention centres⁹⁰.

4.38. The Committee disagrees with this claim given all the evidence of drug use in corrections settings laid before it.

4.39. Indeed, the lack of access to injecting equipment, and the lack of proper withdrawal services in the Periodic Detention Centre is identified by staff at the centre to be problematic and cause additional problems for inmates:

While a lot of the detainees might come in juiced up on Friday night, they’re very often not well by Saturday and Sunday and they don’t have any facility to help them through their withdrawal and make it to Sunday afternoon at 4 o’clock, so they are sent home and they are breached and they then fulfil this dreadful vicious cycle where they are constantly breached and they end up being in big jail, as they call it, going up to Goulburn.⁹¹

4.40. The fact remains that regardless of what a trial in another jurisdiction shows, it would still need to be re-trialled in the ACT context to ensure success.

4.41. The Committee notes that the Government says later in its submission that it would be supportive of a trial occurring in another jurisdiction, and should this prove successful then the ACT should consider injecting equipment exchange programs in the remand setting.⁹²

4.42. In light of evidence received, the Committee does not agree with the Government that injecting equipment exchange “may not achieve harm minimisation outcomes”⁹³. In its submission, the Government further goes on to argue that “there may be better ways of addressing blood borne virus transmission in correctional settings”⁹⁴.

⁹⁰ Submission 15, ACT Government., p. 7

⁹¹ Transcript of proceedings, 1 May 2003., p. 54

⁹² Submission 15, ACT Government., p. 7

⁹³ *ibid.*, p. 7

⁹⁴ *ibid.*

4.43. The Government offered no evidence to support this claim, certainly the Committee heard no other real solutions to address blood borne virus transmission, and the Committee is concerned that the Government appears to be dismissing the convincing evidence from overseas correctional settings without real justification.

4.44. The Committee also does not accept the Governments claim⁹⁵ that the lack of support for these programs in Canada, New Zealand and the United Kingdom as a reasonable rationale for dismissing them in an Australian setting.

4.45. Yes, there are differences to an Australian correctional setting to those overseas, and yes, trials need to be conducted in an Australian setting. But, as the Committee has noted, there is a very concerning problem regarding the rate of hepatitis C transmission in corrections facilities, and no Australian government has the luxury of waiting for another jurisdiction to make the first move on this issue.

Potential liability

4.46. The Committee urges the ACT Government to take this opportunity to properly implement an injecting equipment exchange program in the ACT correctional setting *before* the legality of refusing to provide the duty of care that allows prisoners and detainees the same level of protection from blood borne viruses as the wider community is challenged.

4.47. The Committee notes that it was following a class action suit by a group of prisoners against the State of New South Wales⁹⁶ that condoms were introduced into NSW prisons.

4.48. The group claimed, amongst other things that the state had breached its duty of care by the failure to provide condoms. The Court found on appeal that

“individual prisoners might be entitled to injunctive or other relief if they could show that the refusal of the Department to permit them to use condoms constituted a breach of the duty of care it owed them”.⁹⁷

4.49. It was proposed to the Committee⁹⁸ that it is only a matter of time before a similar case was brought forward by an individual who had effectively accessed an injecting equipment exchange program and protected themselves from contracting a blood borne virus and, for whatever reason, found themselves incarcerated with no ability to continue to take steps to prevent a blood borne virus transmission.

Corrections officers

4.50. Corrections officers have understandable concerns regarding the availability of needles and syringes in correctional facilities and the availability of injecting equipment does raise occupational health and safety risks, namely:

⁹⁵ *ibid.*, p. 6

⁹⁶ PRISONERS A-XX INCLUSIVE v STATE OF NEW SOUTH WALES CA40614/94

⁹⁷ PRISONERS A-XX INCLUSIVE v STATE OF NEW SOUTH WALES CA40614/94; ALD 30079/93 – Appeal judgement, 29 June 1995

⁹⁸ Proof transcript of evidence, 8 August 2003., p. 19

- suffering a needlestick injury whilst carrying out cell searches;
- being assaulted with a syringe, contaminated or otherwise;
- being taken hostage⁹⁹; and
- the ability to provide a safe facility for visitors, staff and inmates.¹⁰⁰

4.51. A review of correctional injecting equipment exchange programs overseas found that there is only one reported instance of an inmate being injured by a discarded syringe¹⁰¹, however there has been an instance in NSW of an attack by a prisoner against a prison officer with a blood-filled syringe, resulting in the officer contracting HIV and later dying of an AIDS related condition.¹⁰²

4.52. It is worth noting that this attack occurred in a prison without a needle and syringe program, and in a policy environment which did not support the availability of injecting equipment in correctional facilities. The Committee is of the opinion that there is currently injecting equipment available in correctional settings in an unknown quantity and it would be better for the corrective service to have control of the distribution and collection of this equipment.

4.53. The Committee acknowledges the concerns of custodial staff and notes their opposition to needle and syringe exchange programs¹⁰³. For any trial to succeed, the Committee believes that there must be participation of corrections staff in the design and implementation of such programs.

4.54. The Committee spoke with representatives of custodial staff, who echoed the concerns raised above. From this discussion, the Committee felt that custodial staff would be open to changes, if they believed that their safety was not further compromised. However the Committee feels that, given evidence of trials in Europe that adequate measures can be put in place to ensure that the risks are no greater, and in fact less, than those in the current system.

4.55. The Committee also makes the point that an appropriately administered injecting equipment distribution and *collection* program would lead to less, rather than more injecting equipment in the prison environment, and in time, hopefully less risk of contamination with a blood borne virus due to less infected individuals sharing paraphernalia.

4.56. The Government submission notes that Corrective Services accepts that “it cannot completely prevent needles and illicit drugs from entering its facilities”¹⁰⁴. The Committee is therefore concerned that injecting equipment exchange is a necessary part of a harm minimisation policy for the protection of both staff and inmates.

⁹⁹ Doyle, J. *Management issues – A Prison officers union perspective*. Conference paper, National Conference on HIV/AIDS and Prisons: Australian Institute of Criminology, 1992

¹⁰⁰ Proof transcript of evidence, 7 August 2003

¹⁰¹ Rutter, S. *et al.* 2001, p. 1

¹⁰² *ibid.*, p. 28

¹⁰³ Submission 15, ACT Government, p. 8

¹⁰⁴ *ibid.*

4.57. Studies have shown that there would need to be clear conditions put in place prior to any injecting equipment exchange program being implemented in ACT corrections settings including, but not limited to:

- A specialist drug treatment wing;
- Staff should be adequately trained and supported;
- A joint committee of stakeholders, including inmates, should consider the appropriate model;
- Syringe exchange should be strictly one-for-one; and
- Participants should be given health monitoring and treatment, including drug treatment such as methadone maintenance, and education by both staff and peers.¹⁰⁵

4.58. The Joint United Nations Programme on HIV/AIDS has said: “prisoners are the community. They come from the community, they return to it. Protection of prisoners is protection of our communities.”¹⁰⁶

4.59. The Committee notes that there are a range of drug treatment programs already available for ACT prisoners and remandees, including “assistance with drug withdrawal, counselling and education” and methadone maintenance programs¹⁰⁷. The Committee notes that not all jurisdictions offer a methadone maintenance program. However, given the evidence received about the rate of hepatitis C infection alone, the Committee is concerned about the effectiveness of these programs as a standalone measure.

Belconnen Remand Centre

4.60. The Committee is acutely aware that the physical premises of the Belconnen Remand Centre are unacceptable from any point of view and present constraints and challenges to implementing an injecting equipment exchange program.

4.61. However, as already stated, it is relatively easy to get contraband into the facility, and while as previously discussed, it has been seen that levels of injecting tend to reduce on incarceration, the Committee was also told that because of the instability and movement in the remand setting that there are increased injecting practices¹⁰⁸.

4.62. The Committee is of the view that the matter of provision of safe injecting equipment in the Belconnen Remand Centre deserves serious and rigorous investigation and believes that the Government has a duty of care to do so.

¹⁰⁵ Rutter, S. *et al.* 2001, p. 40-41

¹⁰⁶ Joint United Nations Programme on HIV/AIDS, 1996 in Rutter, S. *et al.*, p. 7

¹⁰⁷ Transcript of proceedings, 1 May 2003, p. 46

¹⁰⁸ *ibid.* (17)

Recommendation 8

4.63. The Committee recommends that the Government, in line with its harm minimisation approach, adopt the policy of injecting equipment exchange in the ACT corrections system.

Recommendation 9

4.64. The Committee recommends that the Government, as a matter of urgency, initiate round-table discussions with all current corrections officers and relevant health experts to define the safest way to implement an injecting equipment exchange program in the ACT corrections setting, including the Belconnen Remand Centre, the periodic detention Centre and the Quamby Youth Detention Centre.

Recommendation 10

4.65. The Committee recommends that the Government ensure that the new prison has purpose-built facilities for an injecting equipment exchange program.

5. Access by Indigenous peoples

5.1. There are a range of reasons why access to injecting equipment exchange programs is more difficult for Indigenous peoples than the general mainstream community. Much of this is cultural relating to family and community structures, drug education strategies, and models of Indigenous health care provision.

5.2. The primary health care service specifically for Indigenous peoples in the ACT is Winnunga Nimmityjah Aboriginal Health Service. The model of health care provided by Winnunga, is intensive. As Ms Julie Tongs pointed out:

... we have become a one-stop shop for a lot of people and in a lot of ways we are their lifeline. We become their carers; we are the support people. If we know somebody is using and we haven't seen them around for a couple of days, we will ask the doctors if they have seen them in BRC [Belconnen Remand Centre] or we will ask the Aboriginal health workers to go out to BRC and Quamby and we'll do a head count. We go looking for our people. We know who they are, we know where they hang out and we go looking so that we know that they are safe. Particularly when we know that there is some hot heroin or hot drugs on the street, we are even more pedantic about knowing where our people are, and particularly our young people.¹⁰⁹

5.3. But with this model of health care, there are inherent barriers to the provision of an injecting equipment exchange program. Winnunga does not operate a needle exchange program for several reasons. Firstly, the current physical location and infrastructure does not allow Winnunga to dedicate a space for a program, and secondly:

there is a lot of parkland, there are public toilets—there is already a lot of action around where we are. The old people would never cope with that. We need to respect that; they are our elders and we need to respect that. That is probably another reason why we don't. They would be horrified, and then they wouldn't come there. So then we would lose people.

When we were at the Griffin Centre we found ourselves in a real dilemma because we had two little rooms at the back of the Griffin Centre and a lot of people were using around the back and they were dropping their fits and doing all that stuff. We had little kids running up and down. We only had one way in and one way out. And what we found was a lot of our old people didn't come and people didn't come as families. Since we have moved to Ainslie we have got a lot more families coming—not just the adults because they work in Civic or something, but they are coming there as a family. They know what is happening in our community; it is happening in their families. But it is still hard for them to come to terms with the fact that we are going to be giving out syringes. So we would have to be discreet in how we did that. We just don't have the infrastructure at the moment to be able to do that.¹¹⁰

¹⁰⁹ Transcript of proceedings, 1 May 2003, p. 36

¹¹⁰ *ibid.*, p. 38

5.4. The Committee has been previously told that mainstream medical services in Canberra have very little ability to cope with marginalised Indigenous clients¹¹¹. This is particularly concerning given a “study of South Australian Indigenous intravenous drug users that found that 40% of respondents were too ashamed to attend either mainstream or Aboriginal services”¹¹².

5.5. The Committee is concerned that despite the excellent work undertaken by Winnunga, and other Indigenous health services in the ACT, many Indigenous peoples may not be receiving any medical care or education for substance use.

5.6. Concerns about confidentiality when attending Indigenous health services staffed by local community members compounds in a reluctance to also attend local injecting equipment exchange programs.¹¹³

“families often showed a lack of acceptance or understanding of a family member’s drug use. Some consultants [study interviewees] mentioned that a family offering support may be seen to be supporting a family member’s drug use/addiction through their behaviour (for example by looking after children or giving money/food/shelter etc), and some people in the community believed that families offering such support were not bringing about behaviour changes.”¹¹⁴

5.7. The Government noted this applies in the case of Winnunga Nimmityjah Aboriginal Health Service, which has concerns about being able to maintain confidentiality while operating an injecting equipment exchange program.¹¹⁵

5.8. Education and harm minimisation approaches need to be taken recognising the holistic nature of Indigenous peoples health care “based on strengthening culture” and taking into account “the nature of the community, languages spoken and the significance of men’s and women’s business”.¹¹⁶

5.9. Drug education strategies have major cultural barriers to overcome within the Indigenous community.

One of the major cultural barriers to illicit drug education with Indigenous communities is the perception within these communities that illicit drug use is not happening. The community may determine that education about safe using is culturally in-appropriate as they perceive that it serves only to promote drug use. The Report on the Aboriginal and Torres Strait Islander Forum on Sexual Health (1996) found that this need for cultural appropriateness may have to be compromised in order for education around these issues to take place.¹¹⁷

¹¹¹ Briefing by Winnunga Nimmityjah Aboriginal Health Service, 21 February 2003

¹¹² Meyerhoff, G. Injecting drug use in urban Indigenous communities: A Literature review with a particular focus on the Darwin area. Danila Dilba Medical Service © 2000., p. 18

¹¹³ *ibid.*, p. 18

¹¹⁴ Holly, C. and J. Shoobridge. Investigating the impact of injecting drug use in metropolitan Adelaide, Aboriginal Drug and Alcohol Council of South Australia © 2002., p. 7

¹¹⁵ Submission 15, ACT Government, p. 12

¹¹⁶ Meyerhoff., p. 16

¹¹⁷ Meyerhoff., p. 15

5.10. The culture of sharing within families is also a major barrier to overcome.

“Indigenous injectors thought that it was okay to share needles and syringes as they would share other belongings. ... the concept of sharing, a central part of Indigenous family life has become distorted and is sometimes used as an excuse for encouraging others to use drugs.”¹¹⁸

5.11. Particularly concerning is the evidence that younger Indigenous peoples are more likely to “share injecting equipment and the prevalence of hepatitis C in the under 25s is significantly higher in Indigenous than non-Indigenous people”¹¹⁹. Studies have found “a high proportion of sharing in Indigenous young people with a figure of 50 to 60% of respondents reporting that they had shared a needle in the past twelve months”.¹²⁰

5.12. Current mainstream education campaigns are inappropriate for the Indigenous community. For example, it is not appropriate to tell Indigenous peoples ‘don’t share a fit’, but it would be appropriate to frame a campaign on ‘one hit, one fit’.

Recommendation 11

5.13. The Committee recommends that the Government ensure that culturally appropriate education campaigns regarding safe injecting practices are available to the Indigenous community.

5.14. Because of the cultural issues surrounding drug use in the Indigenous community, access to clean injecting equipment is particularly limited.

5.15. However as Mr Daniel Coase of the AIDS Action Council pointed out, adding injecting equipment exchange services on to existing targeted services does not mean that the target group is necessarily reached:

From a positive point of view, you can say, “We’ll have it at the AIDS Council because we think that’s where gay men will go, and we’ll give Winnunga needles because that’s where the indigenous people go.”

What we’re hearing is that people often, for reasons of discrimination or whatever, don’t want to out themselves within their communities on that particular issue. They need a range of places around town where they can go.¹²¹

5.16. Mr Coase supported the idea of a range of strategies as discussed in Chapter 3, but particularly, as with most forum participants, supported increasing primary outlets across the ACT.

5.17. Vending machines are not seen as a solution to the access issues facing Indigenous peoples, because in a large part it is important to get people to come into a

¹¹⁸ *ibid.*, p. 15

¹¹⁹ Submission 4, Hepatitis C Council of NSW, p. 5

¹²⁰ Meyerhoff., p. 13

¹²¹ Transcript of proceedings, 1 May 2003, p. 42

service to receive education and information to reduce the incidence of sharing. However secondary outlets were seen as an important resource for Indigenous users because they gave a layer of confidentiality, although this again does not address the issue of education and referral.

Recommendation 12

5.18. Following the earlier recommendation to locate a primary needle and syringe exchange outlet in each town centre, the Committee recommends that one of these new outlets be specifically focussed on the needs of the Indigenous community.

5.19. Further, the Committee recommends that the Government work closely with the Indigenous community to provide a model of secondary injecting equipment exchange outlets that can be located in areas of greatest need.

5.20. The Committee commends Winnunga on the research project being undertaken with National Centre for Epidemiology and Population Health at the Australian National University on illicit drug use in the ACT and region and hopes that the Government will work with Winnunga to implement the findings of this project.

5.21. The Committee further commends Gudan Gulwan Youth Aboriginal Corporation on its street outreach program. This program is a mobile service in its infancy, intended to reach young Indigenous peoples who are using.¹²²

5.22. Again the Committee expresses concern at this service being promoted as a general after-hours access point for the wider community, however if it proves continuing success, it should be used as a model for the development of other outreach services.

Recommendation 13

5.23. The Committee recommends that should the Gudan Gulwan Aboriginal Youth Corporation outreach service prove successful that it be used as a model for outreach to other marginalised communities.

5.24. The Committee has previously discussed the rate of Hepatitis C in corrections settings and the rate of Indigenous incarceration. As discussed, infection in these facilities inevitably enters the community, so consideration of the particular needs of the Indigenous community must be paramount when addressing injecting equipment use in corrections settings.

¹²² *ibid.*, p. 39

6. Conclusion

6.1. There are no easy answers to preventing blood borne viruses, however it is widely accepted that the provision of access to clean injecting equipment is a basic requirement to achieve this objective.

6.2. As Professor Levy said, *harm minimisation does not offer a perfect solution to the risk of disease, but it acknowledges that there are many choices to be made and it offers the best of choices to make.*¹²³

6.3. The Committee acknowledges that it will take a commitment of resources, time, and courage for the ACT Government to take up this challenge, but that it has a duty of care to do so.

6.4. The Committee has found that improving access to safe injecting equipment, including increased after hours access and access in the corrections settings, are key strategies to reducing the incidence of blood borne disease. It has also found that cultural factors have to be integrated into services for Indigenous peoples.

6.5. On the matter of corrections settings, we have an opportunity in designing the new ACT prison, to ensure that this important health matter is taken into account. We could be proud to lead the rest of Australia where an inmate can face 156 times the risk of contracting hepatitis C than faced in the broader community.

6.6. Tackling this issue requires a broad approach, including education, effective mental health services, and supportive rehabilitative settings as well as provision of safe injecting equipment.

6.7. This will be an ongoing discussion, which the Committee hopes that it has contributed positively to. It is very important to ensure that everyone in the community can access the best choices to protect their health.

Kerrie Tucker MLA
Chair
25 August 2003

¹²³ Proof transcript of evidence received 8 August 2003., p. 9

Appendix 1 – Submissions

1	Ms Gillian Booth	Alcohol and Other Drug Services, NSW
2	Ms Carol Hart	ACT HepC Council
3	Mr Jack Wallace	Australian Hepatitis Council, ACT
4	Mr Stuart Loveday	Hepatitis C Council of NSW
5	Dr Richard Mathews	Corrections Health Service, NSW
6	Dr Carla Treloar Dr Suzanne Frazer	National Centre in HIV Social Research, NSW
7	Mr Daniel Stubbs	ACTCOSS
8	Ms Marion Watson Ms Nicole Wiggins Ms Kathy Glavimans Ms Kim Moran	Canberra Alliance for Harm Minimisation & Advocacy
9	Mr Tony Worrall	
10	Mr Andy Hart	Vendafit, NSW
11	Ms Annie Madden	Australian Intravenous League (Australian Injecting & Illicit Drug Users League)
12	Dr Alex Wodak Dr Kate Dolan	Alcohol & Drug Service, NSW National Drug & Alcohol Research Centre
13	Ms Ann Dalton	The Pharmacy Guild of Australia, ACT Branch
14	Mr Geoff Cowan	ENSI-MED International Pty Ltd, ACT
15	ACT Government	

Appendix 2 – Needle and syringe outlets in Canberra

PRIMARY OUTLETS

Safety Packs:

27gauge Syringe, Water, Alcohol Swabs, Spoon, Cotton wool, Personal Sharps Container.

Various Medical Equipment:

Barrels & Tips 3ml,5ml,10ml,20ml and 19gauge, 21gauge, 23gauge, 25gauge, 27gauge.

SECONDARY OUTLETS

Safety Packs:

27gauge Syringe, Water, Alcohol Swabs, Spoon, Cotton wool, Personal Sharps Container.

PHARMACY OUTLETS

Pharmacy Packs (cost \$2.00):

27gauge Syringe, Water, Alcohol Swabs, Spoon, Cotton wool, Yellow Fit Container.

LOCATION AND OPERATING HOURS OF OUTLETS¹²⁴

Primary Outlets

Primary Outlets		Mon	Tue	Wed	Thu	Fri	Sat	Sun
Directions ACT 33A East Row Canberra City	Open	8:30am	8:30am	8:30am	8:30am	8:30am	9am	Closed
	Closed	6pm	6pm	6pm	6pm	6pm	5pm	Closed
CAHMA Griffith Centre, Civic	Open	10am	10am	10am	10am	10am	Closed	Closed
	Closed	5pm	5pm	5pm	5pm	5pm	Closed	Closed

¹²⁴ Taken from the DirectionsACT website: <http://www.directionsact.com/needle/access.html>

Secondary Outlets

Secondary Outlets		Mon	Tue	Wed	Thu	Fri	Sat	Sun
AIDS Action Council Westlind House 16 Gordon St., Acton	Open	9am	9am	9am	9am	9am	Closed	Closed
	Closed	5pm	5pm	5pm	5pm	5pm	Closed	Closed
Alcohol & Drug Service City Health Building Cnr Moore & Alinga St. Canberra City	Open	8:30am	8:30am	8:30am	8:30am	8:30am	Closed	Closed
	Closed	5pm	5pm	5pm	5pm	5pm	Closed	Closed
Belconnen Health Centre Swanson St & Benjamin Way Belconnen Town Centre	Open	8:30am	8:30am	8:30am	8:30am	8:30am	Closed	Closed
	Closed	4:50pm	4:50pm	4:50pm	4:50pm	4:50pm	Closed	Closed
Narrabundah Health Centre Boolimba Cres Narrabundah	Open	8:30am	8:30am	8:30am	8:30am	8:30am	Closed	Closed
	Closed	4:50pm	4:50pm	4:50pm	4:50pm	4:50pm	Closed	Closed
Phillip Health Centre Cnr. Corrina & Keltie St. Woden	Open	8:30am	8:30am	8:30am	8:30am	8:30am	Closed	Closed
	Closed	4:50pm	4:50pm	4:50pm	4:50pm	4:50pm	Closed	Closed
Tuggeranong Health Centre Cnr. Anketell & Pitman Sts. Tuggeranong	Open	8:30am	8:30am	8:30am	8:30am	8:30am	Closed	Closed
	Closed	4:50pm	4:50pm	4:50pm	4:50pm	4:50pm	Closed	Closed

Pharmacy Outlets

Pharmacy Outlets		Mon	Tue	Wed	Thu	Fri	Sat	Sun
Ainslie (Chemart)	<i>Open</i>	9am	9am	9am	9am	9am	9am	9:30am

	<i>Closed</i>	7pm	7pm	7pm	7pm	7pm	1pm	12:30pm
Campbell Blamey Pl. Campbell	<i>Open</i>	8:30am	8:30am	8:30am	8:30am	8:30am	9am	Closed
	<i>Closed</i>	6pm	6pm	6pm	6pm	6pm	12pm	Closed
Charnwood (Amcal) The Small Mall, Charnwood	<i>Open</i>	8:30am	8:30am	8:30am	8:30am	8:30am	9am	9am
	<i>Closed</i>	7pm	7pm	7pm	7pm	7pm	7pm	7pm
Chisholm - Capital Chisholm Shopping Centre	<i>Open</i>	8am	8am	8am	8am	8am	9am	10am
	<i>Closed</i>	7pm	7pm	7pm	7pm	7pm	5pm	4pm
City Markets Chemart City Markets	<i>Open</i>	8am	8am	8am	8am	8am		10am
	<i>Closed</i>	6pm	6pm	6pm	6pm	9pm	6pm	5pm
City - David Moses Canberra Arcade	<i>Open</i>	7:45am	7:45am	7:45am	7:45am	7:45am	8:30am	Closed
	<i>Closed</i>	5:45pm	5:45pm	5:45pm	5:45pm	5:45pm	12pm	Closed
City - Develins 3 Garema Place	<i>Open</i>	8:30am	8:30am	8:30am	8:30am	8:30am	9am	Closed
	<i>Closed</i>	6pm	6pm	6pm	6pm	9pm	5pm	Closed
City - Canberra Centre Pyes Pharmacy Plus	<i>Open</i>	8:30am	8:30am	8:30am	8:30am	8:30am	9pm	10:30am
	<i>Closed</i>	5:30pm	5:30pm	5:30pm	5:30pm	9pm	5pm	4pm
Curtin(Capital) Curtin Place, Curtin	<i>Open</i>	8:30am	8:30am	8:30am	8:30am	8:30am	8:30am	Closed
	<i>Closed</i>	7pm	7pm	7pm	7pm	7pm	6pm	Closed
Deakin Deakin Shopping Centre	<i>Open</i>	8:30am	8:30am	8:30am	8:30am	8:30am	9am	Closed
	<i>Closed</i>	6pm	6pm	6pm	6pm	6pm	1pm	Closed
Fyshwick Gladstone St., Fyshwick	<i>Open</i>	7:30am	7:30am	7:30am	7:30am	7:30am	8am	Closed
	<i>Closed</i>	5:45pm	5:45pm	5:45pm	5:45pm	5:45pm	12:30pm	Closed
Higgins (Guardian) Higgins Pl., Higgins	<i>Open</i>	8:30am	8:30am	8:30am	8:30am	8:30am	9:00am	Closed
	<i>Closed</i>	6pm	6pm	6pm	6pm	6pm	6pm	Closed
Holder Holder Shopping Centre	<i>Open</i>	8:30am	8:30am	8:30am	8:30am	8:30am	9am	Closed
	<i>Closed</i>	7pm	7pm	7pm	7pm	7pm	1pm	Closed
Hughes Hughes Shopping Centre	<i>Open</i>	8:30am	8:30am	8:30am	8:30am	8:30am	8:30am	9am
	<i>Closed</i>	6pm	6pm	6pm	6pm	6pm	12pm	12pm
Jamison	<i>Open</i>	9am	9am	9am	9am	9am	9am	9am

	<i>Closed</i>	6pm	6pm	6pm	6pm	6pm	5pm	1pm
Karabar Karabar Shopping Centre	<i>Open</i>	8am	8am	8am	8am	8am	8:30am	8:30am
	<i>Closed</i>	8pm	8pm	8pm	9pm	8pm	7pm	7pm
Kippax Fair Holt	<i>Open</i>	9am	9am	9am	9am	9am	9am	10am
	<i>Closed</i>	6:30pm	6:30pm	6:30pm	6:30pm	7pm	2pm	2pm
Lyneham(Capital) Wattle St., Lyneham	<i>Open</i>	9am	9am	9am	9am	9am	9am	9am
	<i>Closed</i>	7pm	7pm	7pm	7pm	7pm	7pm	7pm
Manuka Soul Pattinson Franklin St, Manuka	<i>Open</i>	9am	9am	9am	9am	9am	9am	9am
	<i>Closed</i>	5:30pm	5:30pm	5:30pm	5:30pm	5:30pm	2pm	2pm
Narrabundah Narrabundah Shopping Centre	<i>Open</i>	9am	9am	9am	9am	9am	9am	Closed
	<i>Closed</i>	6pm	6pm	6pm	6pm	6pm	1pm	Closed
Ngunnawal Pharmacy Ngunnawal Shopping Center,	<i>Open</i>	9am	9am	9am	9am	9am	9am	Closed
	<i>Closed</i>	6pm	6pm	6pm	6pm	6pm	1pm	Closed
Red Hill La Perouse St., Red Hill	<i>Open</i>	9am	9am	9am	9am	9am	9am	Closed
	<i>Closed</i>	6pm	6pm	6pm	6pm	6pm	1pm	Closed
Southlands(Capital) Southlands Shopping Centre,	<i>Open</i>	9am	9am	9am	9am	9am	9am	9am
	<i>Closed</i>	7pm	7pm	7pm	7pm	7pm	6pm	6pm
Tuggeranong Capital Tuggeranong Hyperdome	<i>Open</i>	8:30am	8:30am	8:30am	8:30am	8:30am	9am	10am
	<i>Closed</i>	6pm	6pm	6pm	6pm	9pm	5pm	2pm
Tuggeranong Soul Patterson Tuggeranong	<i>Open</i>	8:30am	8:30am	8:30am	8:30am	8:30am	9am	10am
	<i>Closed</i>	5:30pm	5:30pm	5:30pm	5:30pm	9pm	5:30pm	2pm
Warramanga Warramanga Shopping Centre	<i>Open</i>	9am	9am	9am	9am	9am	9am	Closed
	<i>Closed</i>	7pm	7pm	7pm	7pm	7pm	5pm	Closed
	<i>Closed</i>							

The Chemists at the University of Canberra and the Australian National University also operate a needle and syringe exchange program.

Appendix 3 – Bibliography

Blogg, James. *Analysis of the needs of injecting drug users in the ACT*. ACT Health, June 2002

Commonwealth Department of Health and Ageing. Return on investment in needle and syringe programs in Australia: Report, © 2002, Commonwealth of Australia

Crofts, N. Aitken, AK and Kaldor, J. *The Force of numbers: why hepatitis C is spreading among Australian injecting drug users while HIV is not*. Published online on eMJA (Medical Journal of Australia) 1999; 170: 220-221

Day, C. and K. Dolan *Characteristics of Indigenous injecting drug users in Sydney: Gender, prison history and treatment experiences*. Conference paper, Best Practice Interventions in Corrections for Indigenous People Conference: Australian Institute of Criminology, October 2001

Dolan, K. J., Kimber, C. Fry, J. Fitzgerald, D. McDonald and Franz Trautmann. *Drug consumption facilities in Europe and the establishment of supervised injecting centres in Australia*. In Drug and Alcohol Review (2000) 19:337-46 Australian Professional Society and Alcohol and Other Drugs © 2000

Dolan, K., L. Topp and M MacDonald. Needle and syringe programs: A Review of the evidence. Australian National Council on AIDS, Hepatitis C and Related Diseases, 1999.

Doyle, J. *Management issues – A Prison officers union perspective*. Conference paper, National Conference on HIV/AIDS and Prisons: Australian Institute of Criminology, 1992

Holly, C. and J. Shoobridge. Investigating the impact of injecting drug use in metropolitan Adelaide., Aboriginal Drug and Alcohol Council of South Australia © 2002

Jügens, R. *HIV/AIDS in Prisons: More New Developments*. In HIV/AIDS Policy and Law Review. Vol 7,1.

Lowe, D. and Cotton, R. Hepatitis C: a review of Australia's response. Department of Health and Aged Care, © 1999

Mattick, R.P., J. Kimber, J. Kaldor, M. MacDonald, D. Weatherburn, and H. Lapsley Six-month process evaluation report on the medically supervised injecting centre (MSIC)., NDARC Technical Report No. 124. National Drug and Alcohol Centre © 2001

Meyerhoff, G. Injecting drug use in urban Indigenous communities: A Literature review with a particular focus on the Darwin area. Danila Dilba Medical Service © 2000

Moatti, JP., Vlahov, D., Feroni, I., Perrin, V. and Obadia, Y. *Multiple Access to Sterile syringes for Injection Drug Users: Vending Machine, Needle Exchange*

Programs and Legal Pharmacy Sales in Marseille, France. In European Addiction Research 2001; 7:40-45

Nelles, J. A. Fuhrer and H.P. Hirsbrunner, *How does syringe distribution in prison affect consumption of illegal drugs by prisoners?* In Drug and Alcohol Review (1999) 18:133-138. Australian Professional Society and Alcohol and Other Drugs © 1999.

Obadia Y., I. Feroni, V. Perrin, Di. Vlahov and JP Moatti, *Syringe vending machines for injection drug users: An Experiment in Marseille, France.* In American Journal of Public Health 1999: Vol. 89, No. 12:1852-1854.

Rutter, S., K. Dolan, A. Wodak and H. Heilpern. Prison-based syringe exchange: A Review of international research and program development. NDARC Technical report No. 112. National Drug and Alcohol Research Centre © 2001

Southgate, E., C. Blair and M. Hopwood. Social and Health Impact Study: The Closure & relocation of the St Marys needle and syringe program. National Centre in HIV Social Research © 2000.

Appendix 4 – Excerpt from *Drugs of Dependence Act 1989*

Excerpt from *Drugs of Dependence Act 1989*

Part 7 Supply of syringes

85 Definitions for pt 7

In this part:

approval means an approval under section 86.

approved person means a person who holds a current approval.

health worker means a person who has completed a course of instruction.

course of instruction means a course approved by the Minister about appropriate health counselling and the hygienic distribution, use, collection and disposal of syringes.

86 Distribution of syringes—approval

- (1) A medical practitioner, pharmacist, nurse or health worker may apply to the chief health officer for approval to supply syringes.
- (2) An application shall—
 - (a) be in writing signed by the applicant; and
 - (b) state the full name of the applicant and his or her occupational, business or private address; and
 - (c) set out details of the applicant's occupation or business; and
 - (d) if the applicant is a health worker—set out particulars of the most recent course of instruction that the applicant has completed.
- (3) If, on an application in accordance with this section, the chief health officer is satisfied that—
 - (a) having regard to—
 - (i) the desirability of preventing the spread of disease; and
 - (ii) the number of approved persons;there is a need for an additional person to be approved; and
 - (b) the applicant has attended a course of instruction; and
 - (c) the applicant is a fit and proper person to be approved;the chief health officer shall grant an approval to the applicant.
- (4) An approval shall specify—
 - (a) the full name and address of the approved person; and

- (b) the capacity in which the person is approved; and
 - (c) an identifying number; and
 - (d) the period for which the approval is granted.
- (5) An approval granted to a health worker may be made subject to the condition that the health worker attend a further course of instruction.

87 Approval—surrender

- (1) An approved person may surrender the approval by giving written notice of surrender to the chief health officer.
- (2) The surrender of an approval takes effect on the date the notice of surrender is given, or on a later date that may be specified in the notice for that purpose.

88 Approval—cancellation

- (1) If the chief health officer believes on reasonable grounds that an approved person—
 - (a) without reasonable excuse, has not attended a course of instruction, if that attendance is a condition to which the person's approval is subject; or
 - (b) has been convicted of an offence against sections 91 or 92; or
 - (c) is no longer a fit and proper person to hold an approval; orthe chief health officer may cancel that person's approval.
- (2) The cancellation of an approval takes effect on the date the notice of cancellation is given under section 198.

89 Approval—duration

An approval shall remain in force, unless sooner cancelled, for 12 months beginning on the date the approval was granted, and may be renewed in accordance with section 90.

90 Approval—renewal

- (1) An approved person may, at any time before the end of the term of the approval, apply to the chief health officer for a renewal of the approval.
- (2) An application for the renewal of an approval shall be in writing signed by the approval holder.
- (3) On application for the renewal of an approval, the chief health officer shall renew the approval for a further 12 months, beginning on the day immediately following the day when, apart from its renewal, the approval would have ended.
- (4) A renewal of an approval of a health worker under this section may be made subject to the condition that the health worker attend a further course of instruction.

91 Approval—production to police

On request by a police officer, an approved person shall not, without reasonable excuse, fail to produce the approval for inspection by the police officer.

Maximum penalty: 10 penalty units.

92 Approval—lending to another person

An approved person shall not lend or give the approval to another person for the purpose of assisting the person to supply syringes.

Maximum penalty: 10 penalty units.

93 Offences against Crimes Act 1900

- (1) An approved person who supplies a syringe to another person shall not, only because of that supply, be taken to commit any offence under or because of a provision in the *Crimes Act 1900*, part 9 if—

(a) the supply is in the course of the professional practice or occupational duties of the approved person; and

(b) the approved person has reasonable grounds for believing that—

(i) the syringe might be used for the purpose of the administration to the other person of a drug of dependence or prohibited substance; and

(ii) the supply of the syringe might assist in preventing the spread of disease.

- (2) A person who prints or publishes a notice, announcement or advertisement in any form about the supply by approved persons of syringes in the circumstances referred to in subsection (1) shall not, only because of that printing or publishing, be taken to have committed any offence under or because of a provision in the *Crimes Act 1900*, part 9.

94 Return of approval to chief health officer

On ceasing to be an approved person, a person shall not, without reasonable excuse, fail to return the approval to the chief health officer.

Maximum penalty: 10 penalty units.