LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON HEALTH

(Reference: Access to syringes by intravenous drug users)

Members:

MS K TUCKER (The Chair)
MS K MacDONALD (The Deputy Chair)
MRS J BURKE

TRANSCRIPT OF EVIDENCE

CANBERRA

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Secretary to the committee:
Ms S Leyne (Ph: 6205 0490)

By authority of the Legislative Assembly for the Australian Capital Territory

Submissions, answers to questions on notice and other documents relevant to this inquiry which have been authorised for publication by the committee may be obtained from the committee office of the Legislative Assembly (Ph: 6205 0127).

The committee met at 9.21 am.

Appearances:

Dr A Wodak, Australian Drug Law Reform Foundation
Mr M Levy, Corrections Health Service, New South Wales
Mr P Sketchley, Ted Noffs Foundation
Ms W Macken, Directions ACT
Mr D Coase, AIDS Action Council of the ACT
Ms K Glavimans, Canberra Alliance for Harm Minimisation and Advocacy (CAHMA)
Ms K Price, Australian National Council on Drugs
Mr A Hart, Vendafit Pty Ltd
Mr John Ryan, Association of Needle and Syringe Programs (Anex)
Mr T Millin, Canberra Alliance for Harm Minimisation and Advocacy (CAHMA)
Ms D Riddell, Directions ACT
Ms J Lampard, Southern Area Health Service
Ms A Madden, the Australian and Injecting and Illicit Drug Users' League (AIVL)
Ms J Tongs, Winnunga Nimmityjah Aboriginal Health Service
Ms K Boyd, Winnunga Nimmityjah Aboriginal Health Service
Ms J Lynch, Winnunga Nimmityjah Aboriginal Health Service
Mr D Stubbs, ACT Council of Social Service
Mr F Monaghan, Gugan Gulwan Youth Aboriginal Corporation
Ms M Delander
Ms C Hart, ACT Hepatitis C Council
Mr James Ryan, ACT Corrective Services
Mr B Bush, Families and Friends for Drug Law Reform
Ms M McConnell, Families and Friends for Drug Law Reform
Ms R Davies, The Opiate Program, ACT Division of General Practice Ltd
Mr G Vumbaca, Australian National Council on Drugs
Mr P Schwarz, Open Family Australia
Ms B McConnell, Families and Friends for Drug Law Reform

THE CHAIR: We might begin this forum. This isn't a formal hearing of the Standing Committee on Health. It's something that other committees have done in this Assembly. The idea is to have a forum to get feedback from people in the community and have key expert speakers to inform the discussion. The committee can then deliberate on the information that comes through in this particular discussion and decide what to do from there. We could actually make recommendations to government, we could decide to do some more work on it and have formal committee hearings, or whatever we think is required after this day.

I want to thank everybody for coming. It's a good turn-up. We will be recording the forum and so, when we get to the discussion periods during the day after each speaker, if you do want to make a contribution, please identify yourself.

I should indicate what it is we're talking about today, in case people aren't quite clear. We do want to look at the effectiveness of the current supply and distribution of needles, the effectiveness of current programs and any problems or benefits, and the effect of

access programs on hepatitis C and HIV/AIDS numbers. In other words, we are considering the fundamental public health issue of blood-borne disease and how the needle supply service is having an impact on blood-borne disease. We're also interested in issues related to corrections institutions and I think we have people here from that section of the government. I hope we do.

The discussion we're having is not about whether there should be a needle exchange particularly, or whether drugs are good or bad. This is about public health and harm minimisation. I know these subjects raise issues for some people. I've done media interviews this morning already and the questions I was asked implied that the biggest issue is what people do with their needles. That's obviously a concern. That comes under problems associated with needle supply so it's certainly relevant.

However, so that we keep the discussion focused, I want people to understand that, as Chair, I won't be allowing discussion to stray sideways into the whole question of drugs and society. This is actually about whether or not the needle exchange or needle supply programs are working in terms of public health impacts, and particularly with regard to hepatitis C, which is the disease that's a very big concern to the government, and governments all around Australia and the world.

We were expecting to have Dr Nick Crofts speaking first, but unfortunately he's ill and contacted us this morning to let us know he wouldn't be able to be here, which is disappointing. However, Dr Alex Wodak, who was going speak this afternoon and still will, has offered to speak first in place of Dr Nick Crofts, because he can cover the issue equally well. He'll be looking at the whole question of the adoption of harm minimisation through needle exchange or needle supply, and how the approach of harm minimisation came to be.

I think we'll start straight away. Dr Wodak be speaking for 20 minutes and then we'll have 20 minutes for discussion, after which time we will have a break. Please welcome Dr Alex Wodak.

Dr Wodak: Good morning, ladies and gentlemen, and thank you, Kerrie, for the kind introduction. I'm not sure that I agree that I can cover this as well as Nick Crofts. I'll certainly do my best. I'm very sorry that we're not going to have Nick with us today.

In a talk that's mainly going to cover the brief history of this area, I want to start off from the present and a current epidemic, Severe Acute Respiratory Syndrome—the SARS epidemic. I think the SARS epidemic does two things straight away. First, it reminds all of us in a very forceful way of how vulnerable we all are to epidemics of infectious diseases, still, in the year 2003.

When we remember how vulnerable we are to SARS, we should also remember that we are still very vulnerable to an HIV epidemic. There are new countries every year, unfortunately, that are added to the rollcall of countries in which epidemics of HIV have overrun communities. In central and eastern Europe in the last few years, we've seen a raging epidemic of HIV infection, beginning among injecting drug users and spreading to the general population. So let's not get complacent about HIV/AIDS and let's try to recall our vulnerability to HIV/AIDS when we think about the epidemic of SARS.

I think the second thing of which the SARS epidemic reminds us is of the absolutely central importance of basing policy in such critical areas firmly and squarely on science and on nothing else. Fortunately, so far in the SARS epidemic, that seems to be very much the case: the policy makers are listening to every syllable that the scientists, microbiologists, public health experts and others are saying. I hope that we continue to do that in Australia, although at times it's been worrying that we seem to be departing from the world of science into other non-evidence-based worlds.

I think it's helpful to go back to the origins of the HIV/AIDS epidemic. Some of you will remember that, on 5 June 1981, the world changed forever. A few cases of a condition that later came to be called AIDS were announced. Then the acronym AIDS was developed, and from then this drama slowly evolved and unfolded.

We learnt of particular groups that were at very high risk of developing HIV infection. Then we saw epidemics occurring around the world. One of the most frightening of these epidemics occurred in Thailand in 1987 where, in 10 months, HIV infection spread from less than 1 per cent of injecting drug users, initially, to over 40 per cent of injecting drug users. Less than 1 per cent to over 40 per cent in 10 months—that's how rapidly epidemics can spread among injecting drug users. Epidemics among injecting drug users are a serious business, as I'm going to indicate later on this afternoon.

That epidemic in Thailand, which began among injecting drug users, spread rapidly to the general population. Within five or six years, in the north-west of Thailand, one in six male military recruits—16 per cent of male military recruits—and 1 in 8 pregnant women—12 per cent—were infected with HIV. That infection began, without any question, among the injecting drug users. So epidemics among injecting drug users are well worth containing, both for the health and welfare of injecting drug users, who are members of the community, but also because of the great possibility that an epidemic which begins among injecting drug users could spread to the general population, as it did in Thailand and as it did, more recently, in the Ukraine.

Another part of our history was the establishment of the national campaign against drug abuse. That began in Australia on 2 April 1985 at the so-called special Premiers' Conference when the then Prime Minister, Bob Hawke, met with the six premiers and two chief ministers here in Canberra. It was on that day that Australia officially declared that harm minimisation was our national drug policy. It's very important that we remember that. Harm minimisation wasn't defined at the time. People thought that everybody knew what the term meant, and that's regrettable in hindsight.

In any case, that was the commitment that was made. That initiated a whole raft of reforms that has been of spectacular benefit to this country. It's important that we remember that. After each of these periods of three to five years—and there've been several since then—of policy frameworks, there's been an independent evaluation, and we're just going through that phase currently. Each of these evaluations, carried out independently, has recommended a continuation and an extension of harm minimisation. Several of these independent evaluations have provided us with an official definition of harm minimisation.

Personally, I find some of the definitions tautological and unsatisfactory in other ways, but at least we're moving in the right direction—trying to be very concrete about what we think our national drug policy should be—and at least we are evaluating it. The evaluation has shown up a number of notable successes. We've undoubtedly succeeded in drawing alcohol and tobacco into the debate about drug policy, and that's a big plus for this country.

Over the lifetime of this policy period, from 1985 to now, since we adopted harm minimisation, we've seen a continuation of great advances in the area of alcohol. Alcohol-related harm has declined significantly in Australia over that period. It was declining before. Very few people are aware of this. We've likewise seen great advances in terms of tobacco. I would still like to see greater advances in the areas of alcohol and tobacco. They are still very major public health problems in Australia and we need to put much more emphasis on them.

Undoubtedly, however, we've gone backwards in most areas of illicit drugs, despite the policy of harm minimisation. However, without any question, a crowning public health achievement was the control of HIV/AIDS in Australia. The adoption of harm minimisation played a central role in that great public health achievement.

But it didn't come easily. On 12 November 1986, a group of colleagues and myself started the first needle/syringe program in Australia. Gino Vumbaca, who's here with us today, and Kate Dolan, a researcher in Sydney, were among the dozen or so people who started that program. It was illegal and it came, actually, after I'd prepared 13 submissions, as I later found out, to the New South Wales Health Department pleading for the establishment of a pilot program. Each of these submissions was fobbed off, denied or obfuscated in some way. This is an indication of how hard people have to fight to achieve successes that, in the benefit of hindsight, we can see were absolutely necessary.

Countries have gone different ways in response to this epidemic. It's very useful to compare and contrast Australia and the United States, two countries that are very similar in many ways: similar geography, similar history, similarities in economic policy and similarities in political systems. There are many similarities. The differences are really overshadowed by the similarities. But one huge difference has been the way these two countries have responded to the AIDS epidemic, which began in both countries around about the same time. It began in the United States a few years ahead of Australia, but there was not that much difference.

If you look at the early years of the AIDS epidemic in the two countries, you'll see that the per capita figures for AIDS infection and AIDS cases in the United States were about four times as high as Australia. That increased to six times and now the difference between the two countries is even more pronounced. In the year 2001, the United States had 14.7 new AIDS cases for every 100,000 people. In the same year, Australia had just 1.1 new AIDS cases for every 100,000 people. The United States estimates that between a third and a half of its AIDS cases are directly related to illicit drug use and the sharing of needles and syringes, or very closely related, that is, involving the sex partners of an injecting drug user or the children of an injecting drug user. In Australia, the comparable figure is about 5 per cent.

There's no doubt that Australia's policies have made a large contribution to the fact that numbers of AIDS cases are increasing so much more rapidly in the United States than they are in Australia. There's no doubt, also, that the main reason we have managed to control HIV in Australia among injecting drug users, therefore also protecting the general population, is the policy of harm minimisation.

Nevertheless, in the last few years there've been some very disturbing signs. One of the disturbing signs, in my view, has been an increase in the public rhetoric supporting zero tolerance. This support has even come from the mouth of the Prime Minister speaking in parliament, who openly declared his support for zero tolerance.

Fortunately, there's been a growing gulf between the public rhetoric and private policy-making decisions. Some of the policy-making decisions have been commendable, including a decision made at about the time that the Prime Minister openly supported zero tolerance. His government also allocated an increased expenditure of $32 million to the states and territories to allow them to expand their needle and syringe programs over a four-year period. That got very little public attention and it should have got public attention. It should have got a lot of praise and should have been commended, just as the claims for zero tolerance should have been dismissed.

In the field of politics, it is realistic to expect that there's always going to be a gap between the rhetoric that is used and the policy decisions that are made behind closed doors. However, playing with zero tolerance rhetoric is very dangerous, and the risk is that sooner or later the policy making will actually reflect the rhetoric. That's a risk that I think we should try to minimise.

The same government, commendably, commissioned a very important study of the needle/syringe programs around the world—the *Return on investment* study. It's to the government's credit that this study was carried out. This study showed that Australian governments between 1988 and the year 2000 spent $122 million. There was another $28 million spent by the community, so the total expenditure was $150 million over that 12-year period.

It's estimated that that needle/syringe program in Australia resulted in 25,000 fewer HIV infections and also resulted in 21,000 fewer hepatitis C infections. It's also estimated in the same study that Australia's needle/syringe programs will prevent 4,500 AIDS deaths by the year 2010 and 90 hepatitis C deaths by the year 2010. All up, this exercise, the needle/syringe program in Australia, now with an annual throughput estimated at around 30 million needles and syringes a year, is estimated to have saved Australian treasuries between $2.5 and $7.5 billion. That's a colossal financial saving.

A word of explanation: the lower figure, about $2.5 billion, has been estimated using a standard government accounting practice where future benefits are discounted at an annual rate of 5 per cent. When that annual discounting is added in to the $7.5 billion, it comes down to about $2.5 billion.

In an editorial marking the release of this report, Professor Bob Batey and Dr Matthew Law talked about the importance of this program and argued that not to have

followed this course would have been tantamount to public health vandalism, and would have resulted in profligate expenditure of scarce taxpayers' resources. So we see here, I think, a clear linkage. In response to an AIDS epidemic, Australia went down the route of following science. It was a struggle. Unfortunately, we had to start that process with civil disobedience—there was no choice. Roughly half the needle exchanges in the world have started with civil disobedience, so it's not remarkable. It's a reminder that, in this area, in order to base policy on science, we still have to have illegal activities carried out to get policy pointed in the right direction.

Our needle/syringe programs in Australia are not secure. They continue to be sniped at and attacked despite the results that I've told you about just a few minutes ago. We lost three needle/syringe programs in New South Wales in the run-up to the recent New South Wales state election. We need to do better—and I'll talk about this more this afternoon—at distancing decisions about retention or non-retention of individual controversial needle/syringe programs. We need to do better at insulating that from the hurly-burly day-to-day activities of politics. We need to distance those from that decision-making process.

Ladies and gentlemen, I'd ask you to think, as you hear the discussions today, about the needle/syringe programs and AIDS, and I'd ask you to think about that in relation to the SARS epidemic. Let's remember how vulnerable we all are. Let's remember the central importance, in such a critical area as public health, of basing policy on science. Thank you very much.

THE CHAIR: Thank you very much, Dr Wodak. I neglected to tell you who Dr Wodak is so I'll do that now. Dr Wodak is a physician and has been a director of the alcohol and drug service at St Vincent's Hospital since 1982. He helped establish Australia's first needle/syringe program and Australia's first medically supervised injecting room before these were legal. Dr Wodak is the president of the Australian Drug Law Reform Foundation and president of the International Harm Reduction Association. He recently reviewed the evidence concerning the needle/syringe programs for the World Health Organisation. With Tim Moore, he wrote *Modernising Australia's Drug Policy*, published in February 2002. Thank you very much, Dr Wodak.

We'll now have some general discussion and question if people want to ask questions of Dr Wodak—if that's okay with you, Alex? Would anyone like to make a comment or ask a question? Yes, thanks, would you identify yourself?

Mr Levy: Michael Levy, Corrections Health Service, New South Wales. I would like to ask Alex what the tolerance for civil disobedience was in 1985 and how that may have changed in 2003, particularly from professional boards such as the medical registration board and the like.

Dr Wodak: What happened was that we weren't arrested. I was interviewed by the police. One of the major squads invited me to assist them in their inquiries. I was interviewed for about 45 minutes. There were three or four detectives present. I had spoken for about 45 minutes, without pausing for breath, about the international evidence supporting what I was doing. At the end of that process, the senior detective admitted that they hadn't wanted to interview me but they were doing so at the express direction of the then minister for police. No further action was taken.

In 1999, when we started the medically supervised injecting centre in King's Cross, we were raided three times by the police. The police behaved very properly to the people who were involved in trying to set up the injecting centre. On the third of those occasions, there were three injecting drug users present in the injecting room. They were treated pretty shabbily, and we were very unhappy about that. Charges were laid against the three people.

Interestingly enough, when they got to court, on each of the three occasions, the magistrates threw out the charges. We were delighted that that had happened. The magistrates were very contemptuous in the remarks they made that the police had pressed charges under these circumstances. Regrettably, though, the person acting as the landlord in the group that had established the injecting room—Reverend Ray Richmond—was charged and taken to court. Then, during the court proceedings, the charges were dropped. That's what happened in our case. But this continues to move on internationally.

In Vancouver, just this week, an unsanctioned injecting room has been opened by supporters of public health and advocates of injecting drug users. This occurred after an extraordinary election for mayor of Vancouver that took place a few months ago. The coroner, who ran for mayor, had completed a landmark inquiry into a spectacular increase in drug overdose deaths in Vancouver.

The coroner ran for mayor on a platform of harm reduction and with a specific promise to open an official injecting room in Vancouver. The mayor was apparently elected in a comprehensive electoral victory. Seven of his associates were elected on the same platform. That happened only a few months ago and there hasn't yet been time to establish the injecting room.

I mention this specifically because Vancouver particularly—and the whole of Canada—is going through a very similar debate to the one that we're going through. They're under intense pressure from their southern neighbour about whether or not, in the face of such fierce US opposition, Canada would be wise to consider changing its drug policy.

Those of you with an eye for history might remember that it was Canada's retention of a regulated approach to alcohol that really was the end of the last US experiment with drug prohibition. I'm speaking now of alcohol prohibition in the United States from 1920 to 1932. The US was unable to force Canada to undo that policy. It may be, now that Canada is moving so strongly in the field of harm reduction and drug law reform, that this will signal the end of, bring closer to or accelerate the demise of, America's zero tolerance approach. Let's hope so.

I am sorry for the long answer but, in a broader perspective, we can see that this fight is going on in many parts of the world right now.

THE CHAIR: Are there any other questions or comments?

Mr Sketchley: I'm Patrick from the Ted Noffs Foundation. We deal with kids from 14 to 18. 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. I'm wondering if people have any idea of what the general feel about that is in the public sector. 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. There are all the implications around a really young person venturing into that area. I was just wondering if I could throw that open for discussion.

THE CHAIR: Sure. Maybe what we can do with that, unless Dr Wodak wants to respond right now, is ask speakers through the day to address that question, if they can.

Mr Sketchley: Yes. I think it's a huge area.

THE CHAIR: Yes. It's a good question to have addressed, I'd suggest. Do you want to respond to that now?

Dr Wodak: In January 1999, one of the Sydney tabloid papers ran a story with a photograph that purported to be of an underage kid obtaining needles and syringes from a needle exchange in inner city Sydney—in Redfern, in fact.

The then New South Wales health minister, Dr Andrew Refshauge, who'd previously shown a strong commitment to public health, went through a series of public contortions. Firstly, he condemned the exercise because apparently a 12-year-old child was allowed to have a needle exchange. He claimed this contradicted the express written directions of the New South Wales Department of Health. It then emerged that the Department of Health had no such directions. It later emerged that the 12-year-old was in fact 16 years old. Then it appeared that the whole thing might have been a set-up. I think we should remember that, when we think about this area.

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. That's the approach I would take.

I believe it's very important to discuss general principles at meetings like this. I'm not sure it's all that helpful to get down to the individual program details. Often these individual details are better left to the program directors to sort out at a local level. Sometimes things that work very well in one part of the country mightn't be quite so good in another part of the country. But I hope we all remember what happened to that minister for health, who didn't come out of that very well in terms of his response at that time.

THE CHAIR: We'll be looking at local level issues today. The next speakers will be local service providers. We will have the capacity to look at some of the local responses so, hopefully, we will hear that discussed a bit more. We'll move on to the next speakers, who are service providers. Within the 20 minutes allocated, we're going to hear from two speakers—Wendy Macken from Directions ACT and Daniel Coase from the AIDS Action Council.

Wendy works for Directions ACT. She has had extensive experience working with both drug and alcohol and mental health services, as a clinician. She also worked as a senior policy officer whilst with New South Wales Health and wrote the guidelines for the management of people with dual disorders and the drug treatment services plan, following the New South Wales drug summit.

Ms Macken: I've got about 10 minutes to talk to you, so I'm going to talk very briefly about the Canberra experience—where we currently stand and what services we provide. I will talk a bit about the impact, the gaps and shortfalls, and then what we need to do or where we need to go.

In response to your question, it's a difficult situation when you get young people who may or may not be experienced IV drug users, requesting stuff like needles or butterflies. I tend to agree with Alex. If they are already using IV drugs, then it's imperative that we give them the injecting equipment to do that as safely as possible.

In the first instance, if I were to come across somebody who'd never used drugs before, who thought it might be a cool thing to do, I would go out of my way to do everything possible to dissuade them—to persuade them to put it off and look at other alternatives. It's really hard.

As to the history, NSPs were first established to basically stop the spread of HIV in the general community. This threat and the knowledge that, despite our best efforts, some people would continue to inject drugs changed government policy. NSPs are today identified as one of the first major harm minimisation strategies to be implemented across our nation.

I suspect I'm going to be repeating some of what Alex said. The first NSP started in Sydney in 1986—and then in the ACT in 1988. The total number of needles distributed in the ACT has increased fivefold in that time. Roughly, 133,000 needles were distributed in 1991. By 2000, this number had increased to over 664,000. It's a massive increase. The rationale is fairly simple. It's a preventative measure to reduce the spread of HIV and other blood-borne infections, by providing sterile injecting equipment, and education on safe injecting practices.

With regard to the impact, there were initial concerns about encouraging people who would not otherwise use drugs to use them, but that isn't so. NSPs do not increase recruitment to use, or frequency of use by users.

HIV infection amongst IV drug users in Australia is less than 3 per cent, while in the US in parts it's up to 70 per cent. Between 1991 and 2000—here I'm repeating what Alex

told you—25,000 cases of HIV and 21,000 cases of hepatitis C have been avoided. By 2010, the economic savings for an investment of $150 million is between $2.4 billion and $7.7 billion.

Directions ACT provides all the needles and syringes to the people in Canberra. Our service operates from 8.30 am until 7.00 pm, from Monday to Saturday. We've got 16 NSP outlets. The primary outlet is in Civic. Secondary outlets operate from health centres and other organisations such as CAHMA and the AIDS Council. We've got 26 pharmacies across the ACT, distributing between 50 and 3,000 packs per year.

We provide outreach services for workers within the sex industry. We have disposable safe bins, which collect more clinical waste than injecting equipment given out. We also provide a dental health program which is funded through the NSP program.

In respect of gaps and shortfalls, there are gaps and there are certainly shortfalls. Currently, there's no access to NSPs after 7 pm, or on Sundays. The exception is Friday nights, with the aboriginal youth service providing an outreach service. This restricted access increases the burden on the primary outlet in Civic. Civic sees roughly 100 people a day and there is quite a burden on that particular area. There is impact with regard to community concerns, especially from businesses around the area, which don't really like us. Prisoners in the remand centre get no access.

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. Supply of packs in suitable locations should not necessarily disrupt hospital business. This is a huge public health issue. Given that our hospitals are in the business of public health, then I think it's very much their business to be supplying injecting equipment to people who may need it.

We certainly also need to increase the number of pharmacies involved in the supply of needles and syringes. I think we need also to look at a mobile service to outreach centres. That needs to be trialled to determine cost-effectiveness—certainly outreach services targeting Aboriginal and Torres Strait Islanders, who currently don't access mainstream services. With regard to the prison population, I feel we need to look at a national strategy which aims at reducing the spread of HIV and hep C in prisons.

THE CHAIR: Thank you, Wendy. We'll ask Daniel Coase to speak now and then we'll have a discussion and questions. Daniel has been the general manager of the AIDS Action Council of the ACT since 1999. He was a volunteer with the support program of the Victorian AIDS Council from 1990 to 1996 and, as convenor of the support program, was on that council's board for three years. He is currently a member of the ACTCOSS board and its health committee. He is also a member of the ACT Ministerial Advisory Council on Sexual Health, AIDS, Hepatitis C and Related Diseases and was recently appointed to the new ACT Health Council. Thanks, Daniel.

Mr Coase: I've been asked to speak primarily from the point of view of secondary exchange. As Wendy explained, the primary exchange is Directions and we work with Directions on the secondary exchange.

Very quickly, we're involved, obviously, because we're an AIDS council and historically AIDS councils have always been involved in the injecting drug use issue. Basically, we're funded to provide community education and health promotion, but mainly targeted at men having sex with men, a community support services unit that provides support to people with HIV/AIDS, a peer-based organisation, PLWHA ACT, a sex worker outreach project and various policy functions.

I'll skim through this very quickly on the screen, but I can't resist the temptation to show how we've invoked public monuments in public health in Canberra. These are part of a series of posters and postcards and they'll also be appearing in cinema advertising. I'll quickly skim through because I note the time.

The actual exchange we operate is a secondary one. We have limited stock; we don't have the whole range of injecting paraphernalia such as butterflies and that sort of stuff. We only supply four and eight packs. These are supplied to us by Directions ACT, so there's no direct cost to our agency. We also distribute material that we get from Directions ACT, CAHMA and AIVL on safe injecting and other IDU issues. All our staff and our front desk volunteers are trained by Directions and updated regularly. The exchange is only open in business hours and certainly not on the weekends. We officially close at 5.00 pm, although people are often there later.

Who accesses that service? You may think that, because of the connection of the council with the gay community, it might be gay men, but, surprisingly, it is not, or very few that we actually recognise. There may be issues of confidentiality and anonymity. Injecting drug use in the gay community is sometimes a bit iffy for people. People may be reluctant to out themselves as a gay person with an injecting drug use habit.

There's a small group of regular clients who come there—you'll see later from the figures that it's a very small group—and we wonder why they come. It's probably because of the anonymity we provide. We're not in the middle of the city; we're located on the fringes. There is easy access, easy parking, and people can slip in very quickly. I also have to say we've had no major incidents of any kind, of overdoses or anything happening.

The sex worker outreach project we manage provides four and eight packs through the actual swap office, but again most people who come to access that exchange aren't actually sex workers; they are people who are local who know it's there and just pop in. But we do provide workers and brothels with packs during outreach visits. Each brothel is visited on a monthly basis.

The statistics for the last three years: the total out is the total number of needles distributed; the total in is of the returns; and the occasions are of how many occasions people come. You can see it's not very high but, interestingly, it has been really declining. We're not quite sure why that is so. We have had an increase in the "ins". That may be due to some of our HIV positive people who are on drug trials and who are provided, like the T20 trial where a drug is self-injected, with the equipment as part of the trial, but maybe return it to us in those bins. But it has been going down and we're currently looking at why.

Those clients are predominantly men. In that time there were 44 individuals, eight of them regularly over that three-year period and three of those are currently accessing. The number for women is much smaller and, since 2003 began, we haven't had any women accessing.

The summary is that those amounts have been distributed and we have had those returns. I have referred to the drop-off in that period and the fact that they're mainly male, mainly from the Civic area, and that heroin and speed appear to be the most common things that people are using.

Why do we do it as a council? I need to make the point that we're not funded to do that through our contract with ACT Health; we do it out of an internal commitment and also responding to external policy drivers. The internal commitment comes from the way the council was set up in the very beginning, recognising that in Australia the epidemic was facing mainly gay men, but there was also the risk of infection in needle sharing.

We also have a formal statement of policy regarding our relationship with the gay and lesbian community, wanting at the same time, as you can see down the bottom, to work with organisations representing injecting drug users and sex workers. If anybody wants copies of these afterwards, I can give them to you because I'm going very quickly. It's also written into our board structure. If we don't consider that injecting drug users are adequately represented or their issues aren't represented, we have the capacity to coopt people, and we've kept a good eye on that.

Our statement of purpose also refers to focusing our services on injecting drug users and sex workers. Our value statement in terms of non-judgmental attitudes towards all clients and respecting their choices is, I think, part of the reason we do it and how we do it. Also, in our current strategic framework which guides our individual actions in our program areas we have currently as a key focus area policy and advocacy to ensure a framework which assists the delivery of services and the prevention of HIV transmission. We've actually committed ourselves to working in partnership with those groups to promote and defend harm reduction measures for injecting drug users and advocate for appropriate law reform.

On our internal policy position, we've been participating to some extent in the ACTCOSS community coalition on corrective services. We recognise that the prevalence of HIV among people in custodial settings remains low, but note that there is a potential easily for that to get out of control. Of course, hepatitis C in prisons is a major issue.

Our position is that we believe that access to safe sex and safe injecting equipment should be available to people in custodial settings to reduce those risks and we will advocate for that in any proposed ACT prison. We do understand, of course, the issues around the fears of things being used as weapons, but we think that there should be ways explored of reducing that risk. Secondly, we believe that HIV and hepatitis C infected people in correctional facilities have the same right to care, support and treatment as people in the general community and that it should be provided without any judgment.

The external policy driver that makes us do this sort of stuff is really our commitment to the fourth national strategy which, among many other things, demonstrates that the provision of clean needles and syringes has done an awful lot to stop the spread of HIV and that even a small increase in the injecting drug use population, as Alex has said, could lead to a rapid increase in the general community.

At this point, I need to take a swipe at the feds. We are still waiting, more than six months later, for some indication of where we're going in terms of a fifth national strategy. A review of the fourth national strategy was done and completed towards the end of last year. Recommendations have been developed. We were hoping to move very quickly to a fifth national strategy, but it has been held up in the minister's office, and has been for some time. That is impacting on us locally because, without that indication, there is a reluctance to commit for funding for our organisation beyond the expiry of the strategy and also the public health funding outcome agreement, so it's a real issue.

Alex and other speakers have referred to the incredible report *Return on investment*. It is a landmark document and it should be being trumpeted internationally. It's just an amazing document, but, in the current climate, it just seems to be sitting on a shelf gathering dust and not getting much exposure. Alex has gone through that, so I'll skip through it, other than to point out, in terms of the financial analysis of the savings to government, that currently HIV has the greatest impact on financial savings and HCV to a lesser extent.

What are the positives and negatives for our agency? The positives are that it allows us to maintain links with related agencies, such as Directions and CAHMA, demonstrating the partnership approach to HIV that's trumpeted in the national strategy. It allows us to have ongoing links with individual users, particularly the regulars. There are impacts on staff volunteer time in terms of training and keeping people updated. There is a slight increase in the burden on us in terms of administration, recording and service provision. There are issues around storage—how we keep the stuff and where we put it.

A big issue is public liability insurance. Recently, we had to close the organisation briefly around public liability. Our insurance premium went from $740 a year to $7,000. I've written to the insurers to ask them whether it is possible to pull out of that figure what the bill would be if we weren't doing needle exchange, because I know CAHMA had problems with public liability exchange, and there could well be insurance issues that are really hindering people responding appropriately to national policy.

Generally, we would oppose any proposed Commonwealth spending on retractable needles—we think it would be a waste of time—and any dilution of the needle and syringe programs, including user pays, and we would oppose the one-for-one exchange requirement that Paul Osborne put up recently whereby we would only give people a needle if they brought one back.

We support NSP. We support the maintenance of access to free injecting equipment. It's essential to expand those things to after hours. We think that there is a real need to increase education on IDU around the fact that it's not just the fits; it's the whole of the

paraphernalia—the tourniquets, the spoons or whatever—in relation to hepatitis C transmission. We would support, as components of a whole range of strategies, a trial of a supervised injecting space here and a heroin trial.

THE CHAIR: Thank you, Daniel. Daniel and Wendy will take questions.

MS MacDONALD: Daniel, my name is Karin MacDonald and I'm on the committee. I'm interested to hear why the council opposes any spending on retractable needles. I don't know the issues around that and I would be interested to hear about that.

Mr Coase: I just think that it would divert funds from other areas where it's needed. They would be amazingly expensive to produce and distribute, although you referred this morning to concern about the disposal of needles. The majority of people actually want to dispose correctly and a part of the needle exchange programs is that you have that contact to talk to people about that. The packs actually do include disposable units. It's more about the provision of bins, I think, of having bins more widely available.

To introduce retractable needles would be a huge expense and I'm not even sure that it would be particularly effective. There are probably people better qualified to speak on that than I am, but the amount of money proposed is huge and I think that it could be much better spent in areas of greater need.

THE CHAIR: Do you have a comment on that issue?

Ms Macken: Yes, disposal is an issue. I don't know too much about retractables. I have heard that they are expensive and they're not perhaps as effective as they might be, but I do think we need to do research on injecting equipment that we could possibly use in prisons and around the globe and then look at providing this specialised equipment to specific populations. If that could be done, I would support that.

Mr Levy: Michael Levy, Corrections Health Service. Daniel raised the spectre of syringes being used as weapons in prison. I'm not aware of any event in a prison-based syringe exchange where a syringe was used as a weapon. In contrast, there was one tragic event that occurred in New South Wales in 1990 when a prison officer was stabbed with HIV positive blood. That occurred in the policy environment that exists today where, ostensibly, syringes are prohibited and, in fact, circulate quite dangerously.

THE CHAIR: Could you comment generally about incidents of injecting drug use in the remand centre in Canberra?

Mr Levy: I don't know specifically about the remand centre, but if ACT prisoners are in any way similar to the rest of the sentenced prisoners in New South Wales, our estimate is that 20 per cent of the inmates inject while in prison at some point and, of that 20 per cent, 10 per cent are initiated into injecting while they are in prison.

THE CHAIR: I have a question. It's a basic one, but it might be useful to get it on the record. Can you explain the difference between a secondary outlet and a primary outlet? Also, do you have any comments on insurance.

Ms Macken: I should have done my homework on this. The primary outlet is essentially the major outlet in Canberra, for instance, where people can go and can get a wide variety of injecting equipment. From that primary centre, we supply secondary outlets with, essentially, packs which are then given or sold to people if they're going to a pharmacy. We supply secondary outlets, if you like.

THE CHAIR: How many pharmacies?

Ms Macken: We have 28 pharmacies now selling packs of four or packs of eight for a charge of $2. About 18 months ago they were charging $4 and $2 of that was being returned to the government, but that has since stopped. The $2 charge goes directly to the pharmacist and there's no cost recovery.

Insurance is a huge problem and I'm not equipped to find a solution to that. In regard to our place in Civic—and this is partly what I was talking about in terms of the need to spread or dilute NSPs across the ACT rather than having a burden on Civic—we've got huge problems with our building in the sense that it is, essentially, a health hazard. We can't get contents insurance. We've got computer wires—a bit like this—all over the floor and we can't find additional buildings to lease because people get upset by our function and particularly upset by needles and syringes being supplied from our centre.

If we could just remove the white elephant kind of concept and spread it evenly and fairly across, the pressure on our organisation and our capacity to go to a real estate agent and confidently get a new building because we're from government would be much easier. That was a bit away from insurance.

THE CHAIR: Take this opportunity to raise any issue you like, Wendy.

Ms Glavimans: I'm Kathy Glavimans from CAHMA. I just wanted to comment a little further on the retractable syringes issue. The last statistics that I read indicated that, of over 30 million needles and syringes distributed in Australia, less than one per cent were reported to different reporting agencies as far as unsafe disposals are concerned; if someone sees a fit on the ground, they ring someone and say, "Hey, you really need to come and pick this up."

As far as the disposal problem in Australia is concerned, it's probably a lot more to do with a perception that there is a really large issue as opposed to there actually being a really large issue. I don't argue with the fact that needles and syringes are disposed of unsafely on occasion, but it's not as large as it might be felt that it is as far as the media and stuff like that go.

The other thing that I want to say about retractable syringes is that, apart from them being, I believe, a lot more expensive, which would put pressure on NSPs as far as operating is concerned, AIVL, which is the peak user body, have seen the different types of retractable syringes that are being trialled, so they're not necessarily working for them out there with what they're trialling, and they've actually been able to take apart every single retractable syringe after its first use and put it back together for injection again.

Obviously, that's really unsafe, but they can do it, and people will do it. Obviously, if you're taking it apart and putting it back together, you don't even have that option, while it's not a desired one, of cleaning the fit. So there are different issues with retractable syringes as far as acceptability to IV users is concerned. If retractable syringes are not acceptable to IV users, they will bring along a whole heap of different health issues and maybe even the proposal of a black market in normal fits. There's a whole heap of issues around retractable syringes. We've already got something that works fine and my opinion is that we don't really need to play with that. That's all I wanted to say.

Ms Price: My name is Karen Price. I'm from the Australian National Council on Drugs secretariat. I just wanted to follow up that comment, which I think was a useful comment, by adding that I think that one of the issues and one of the risks in relation to NSPs is the issue of unsafe disposal. That leads me to the question about access to safer disposal methods. The most simple and obvious one is bins. I've just been to the toilet in the Legislative Assembly and there's no bin in there.

My question is really to the ACT Legislative Assembly, which I know has a different role from other state governments in terms of having some local government functions as well as being a territory government in these matters. The question is about the placement of bins in public toilets, schools and other facilities. I just wanted to see if you could make a comment on the widespread availability of safer options in terms of disposal which might reduce the pressure on governments to do other things, like retractables.

THE CHAIR: I'm not the government, but the committee can certainly take that question to the government and get a detailed briefing on where they've got bins. It has certainly come up over the years; I know that I've raised it. There has been quite a bit of controversy around whether premises such as hotels should have disposal bins in toilets and so on. It is something that has come up, but I'm happy to ask the government what they see as the issues and where they are supplying bins.

I won't go on about it now, but it's certainly an issue that has come up. It is a good point and is worth bringing up again. Also, we need to get statistics, picking up the last point, on exactly how many needles are being left in the community and how big is that problem. One needle is a problem, obviously, for someone who finds it or is affected by it.

Mr Hart: Andy Hart from Vendafit. I'll just give you a bit of background. I worked in the needle and syringe program in New South Wales for the last 14 years. I resigned in November to develop products. One of the products is disposal bins; they are purpose built. Also, my company develops needle vending machines, which is one of the reasons I'm here, as this is a forum on access.

The reason I have to talk now is that the parent company is a retractable syringe company called Unitract. Just to answer some of those things, I know it's a very emotive issue, having been from inside the field. They're saying that their product will not cost more than a standard syringe. It will be autodisabled; you won't be able to take it apart.

If anybody wants any more information on that, come and see me. We have pilot stuff at the moment, but once we've got a product I'll definitely be in contact with CAHMA. I've already met with different people. If anybody has any questions, come and see me.

I think that we need to wait and see. The major fear that I'm picking up is that people assume that, even if there is a successful product, the government will force it down the back of needle exchange. I will fight against that because of the black market issue. I think that's a government decision on what equipment we're given while NSPs are issued. I don't think we need to assume that, just because there's a successful retractable, it will be the thing that you have to have.

Dr Wodak: I just want to make a few brief comments about a number of the things that have been raised. Firstly, about the retractable needles and syringes: before the most recent federal election, the federal government allocated $27 million to this subject of retractable needles and syringes. My understanding is that, without any surprise, they've come to the realisation that this is not a practical proposition in terms of injecting drug users. There's a possibility that it may be of some marginal use in occupational health and safety terms for people working in the health care industries.

I'm not surprised by that, because in the 1980s I was part of a committee that investigated this issue and at the time we started on it I had a very open mind, I was slightly positively disposed towards it, I certainly thought it was a topic well worth considering. The committee, which included some biomedical engineers, identified a number of essential and desirable criteria and we were stunned when the various applications rolled in to see that none of the applications met any of the essential criteria and most of them met very, very few of the desirable criteria. Unless the actual products meet all of the essential criteria and most of the desirable criteria, we're heading into dangerous territory. There are very strong theoretical grounds why this really cannot work in terms of injecting drug users. There may be a role for it in the occupational health and safety issue.

In terms of pharmacies, it's really time we took this issue further than pharmacies and vending machines and also considered the question of deregulating the area. Why do we in 2003 still shroud this area with so much red tape? Why don't we look at the situation in other countries where needles and syringes can be legally purchased from supermarkets, for example? I'm not against needle syringe programs. They have a very important educative role. They also refer drug users to treatment, to legal services and to many other things. I'm not in favour by any means of dismantling the system that we've built up, but I think it's time to look also at the possibility of deregulating.

In terms of disposal, there are several papers that have been published which have demonstrated that the problem of disposal does not get worse because of needle and syringe programs. This is a common fallacy used by zero tolerance opponents of needle and syringe programs. The problem is an issue and we should be concerned about it, but it's not an issue that was caused by establishing needle syringe programs and it will not go away if the needle and syringe programs go away. And yes, we do have to do better at it.

There's actually an even bigger issue at large, that is, how we actually deal with the problem of the used needles and syringes that are generated not only by the needle and syringe programs but also by hospitals and their health care facilities. That's an even bigger issue that we don't discuss properly.

I agree very much with the comments that Michael Fromer made about the prisons issue. It is one issue that we don't discuss nearly enough. It's a significant contributor to HIV infections in Australia at the moment; that is, HIV infections occurring within correctional facilities are contributing significantly to new HIV infections in the community. Kate Dolan, I and some other authors published a review of all the existing evidence on needle and syringe programs in the several jurisdictions that have allowed them within correctional facilities. That included translating documents from Spanish into English, because a lot of this material wasn't available until now.

We've published this in *Addictions* and, to confirm what Michael said, there are no published reports of any untoward incidents from the several jurisdictions that have established needle and syringe programs within correctional facilities. There are no published reports to date. I think the fears are not unreasonable, but there's no substantiation for them. As Michael said, there are fears about not providing needle and syringe programs within correctional facilities.

THE CHAIR: I ask for further elaboration of the comment you made about the big issue of what to do with the needles and syringes once they're collected. What's the issue there?

Dr Wodak: The issue there is how well are they disposed of when they're collected from hospitals. Are the mechanisms that we've got sound from an environmental perspective? Do we really need high-temperature incineration of these? Are they all being disposed of in the right way? I'm not really the best person to discuss this issue, but I know that there are many people who feel that this issue has not really been sorted through properly.

THE CHAIR: Okay, thanks. Up the back, sir.

Mr Ryan: I am John Ryan from Anex, the Association of Needle and Syringe Programs. Following on from the comments about disposal, I agree that retractables are potentially a good idea but, the deeper you dig, the more you realise that they're a bit of a furphy. In some ways, the disposal issue is a furphy scientifically and based on evidence but, in terms of community feelings and fear and the experience of needle-stick injury, the experience of a parent whose child finds a discarded syringe, the issue is very real.

The problem is we haven't really addressed it, in any way other than the retractables initiative, in any comprehensive way. There's been no national approach. It's largely a responsibility of local governments around Australia who are reluctant for a number of reasons to become involved, particularly because of the expense. Funding hasn't been does not facilitate local governments taking on that role, particularly seeing that the program is new—street-based injecting is a relatively new phenomenon. The wheels of government have moved much slower than the dynamism of the drug market.

One of the suggestions for a way in which inappropriate disposal can be better dealt with is certainly greater access to disposal bins located in appropriate positions. The evidence about what those appropriate positions are is not collected systematically around Australia, which means that it's done using a hotchpotch approach. Some local governments do it well; others don't.

The actual evaluation of how that's done is, as far as I'm aware, absent. A systematic national evaluation is absent, which means that local government certainly feels pressure from the community about disposal. The needle and syringe program probably feels that community pressure more than any other agency. The needle and syringe program feels that pressure and is held responsible for disposal issues, even though, technically and legally, local amenity is a local government responsibility.

Mr Ryan: One recommendation has been the decriminalisation of the personal use of drugs. Drug users fear police attention and, while the possession of a syringe does not necessarily result in charges, there is a lot of fear that it will result in a charge of drug use. Police attention also results in circumstantial evidence that supports the case for further searching, which means that, if you're thinking pragmatically and are not concerned about other big issues like community perception, in the absence of good disposal facilities, the temptation to prevent police attention by inappropriate disposal is strong.

The other part of that topic is that, if there are no appropriate disposal facilities and there are discarded needles, how and when they're picked up. There's very little analysis of how long that one syringe stays on the ground. If it stays for 24 hours and 100 people walk past, it's the equivalent of 100 syringes compared to one syringe that stays on the ground for five or 10 minutes.

The failure of local government to take on that responsibility—and I appreciate that in the ACT it's slightly different—that lack of development in relation to disposal issues is part of the general problem that we've got now. After the innovation of the needle and syringe program in the mid-eighties, the changes have been dramatic. External changes have been dramatic, such as the identification of hepatitis C, but the actual program hasn't changed substantially. We've still got a structure of primary and secondary programs and, to my mind, the difference between the primary and secondary programs is that, of the 860-odd NSPs throughout Australia, less than 10 per cent are primaries.

Primaries are fundamentally funded for specialist NSP staff. Secondaries operate in organisations. Activities might include primary health care services, community health services, DNA agencies or local government. But their secondary is not funded for staff: it's funded by government for equipment, but the actual staff are not funded. This means that the financial burden of an NSP is considerable. The reason they're not funded for staff is because pouring money into NSPs is traditionally a difficult thing to do, particularly considering that most of that money is taken up by equipment purchasing, because of the explosion in injecting drug use throughout the world.

The equipment that we had in the eighties that was good for HIV prevention, and the paradigm that we had in the eighties that was good for HIV prevention—which is access

to clean injecting equipment and a change in the behaviour of injecting drug users—are not up to the current standard, including for the hepatitis C epidemic. We still don't distribute enough equipment, people are still sharing needles, but we also don't distribute other equipment that is necessary for an injecting episode, which means that people end up sharing spoons or Coke cans, or whatever they're using for injecting episodes, which are major vectors of hepatitis C transmission.

That situation is not reflected in the great numbers that come out of the *Return on investment* study. While the terms of reference of that study asked whether or not money should continue to be invested in the needle and syringe program, the study didn't actually consider whether more money needed to be invested in the needle and syringe program. This means that we have a great defensive report about the scientific evidence base for the needle and syringe program, but we don't actually have a vision for how needle and syringe programs, because of the enormous interface they have with injecting drug users, provide an opportunity for a non-discriminatory health service, which is not something that injecting drug users typically expect.

If they can receive non-discriminatory health care at an NSP that has well-trained staff who are operating on a client service model—that is, that they're not drumming their own agendas into the client and they're actually trying to facilitate a primary health response for those clients—the opportunities to get those clients into other health or welfare services—whether it is for dental work, vein care, abscesses or to deal with housing issues or whatever the clients' issues are—it has a double effect, to my mind. The potential is to improve the health outcome of that individual, but it's also been shown that, the more marginalised and disadvantaged people are, the more likely they are to involve themselves in risky practices, and therefore the more likely they are to be infected, or to be infecting others, with hepatitis C and HIV.

If we don't have a service infrastructure that's providing not five needles per visit, but as many needles as people request per visit, plus the other equipment that's necessary for their injecting, we end up with hidden populations of people who'll reuse, who will use equipment that they find on the street because they can't access equipment after 6 o'clock or 8 o'clock. We end up with the potential for a HIV explosion.

We certainly don't go anywhere near addressing the hepatitis C issues. I guess what I'm saying is that we need to look a lot more expansively at the program, rather than just thinking about the traditional paradigm.

THE CHAIR: Thank you for those points. Does anyone want to comment on that, speak against that, or say, "Yes, that's a good idea"? Some important points have been raised there. Wendy, I'd be interested to know whether you think there is a need for your sort of service to become a non-discriminatory health service generally.

Ms Macken: Yes, I think you made a number of very valid points. Directions does provide that grassroots service to our clients, so we actually operate that way. If other NSPs could be modelled on Directions, we'd go a long way towards improving the health outcomes of clients.

I do agree also that we need to be bit bigger in our thinking—as you said "expansive"—and I liked your idea, Alex, that needles and syringes or packs could be bought through supermarkets or petrol stations. I think the more we dilute and the more we mainstream, the more community acceptance will be achieved and the less negative will be the impact on those highly populated primary outlets. I like all those big ideas so thank you.

THE CHAIR: Thanks very much. You did refer to vending machines. I don't know if you can answer this, but I'm interested to know if there are vending machines at the moment. I understand there are in Sydney. Do you have any knowledge of how that works or where they are located?

Ms Macken: Alex might better to answer this. I think there are three—

THE CHAIR: Someone here knows something about it?

Mr Millin: Yes, my name's Tony Millin. First, I identify as an injecting drug user and have been so for in excess of 40 years. I'm a volunteer worker at CAHMA, which is the local user group. I might say that the manager of CAHMA is overseas at present. She was to make this presentation. Unfortunately, she couldn't make it back to Australia in time and I'm standing in at very short notice.

I have made a couple of quick phone calls over the last couple of days. I knew that there was a vending machine in Byron Bay, so that was my starting point. I managed to contact a number of people who work primarily in the Northern Rivers Health Service area, which is basically that top corner of New South Wales. The bottom line is that the result with vending machines for needles and syringes in New South Wales is exactly the same as the result we have here with barbecues in parks and washing machines and dryers in public housing facilities: when they were coin-operated and money was needed to operate a barbecue in the park or a washing machine in public housing, they were invariably being broken into every second day for the money.

Consequently, the services were down 80 to 90 per cent of the time. As soon as these services were made free, there was no trouble. I'm sure this is reflected with the barbecues: you can go and use a barbecue now free, at any time, day or night, and they always work. Likewise with the washing machines and dryers in public housing. This, indeed, was the experience of the operators of the vending machines in the northern rivers area.

I can give you some quick examples. There's one at the Lismore Base Hospital that is located outside the accident and emergency section of the hospital, so it's not actually in the hospital but it's well lit and there are people around all the time. There's no incentive to break into the thing because there's no money in it and it's being supervised by proxy, if you like, but it's available. Likewise the ones at Byron Bay and Ballina.

However, at Nimbin, where there are two vending machines that require $2 coins, the information I was given yesterday indicated that they're broken into so often that they're simply not serviceable for 15 per cent of the time. So the evidence seems to be that vending machines are viable and that if we make the stuff available free of charge then they're more than viable and more than successful.

As far as children accessing them goes, I guess the same arguments must apply to something like a cigarette machine, and kids are kids anyway. With the cigarettes, the 14-year-olds who want cigarettes invariably get the biggest kid, the oldest looking kid or one of the 16-year-olds to go and get some for them. We know what kids are like: if they want something, be it cigarettes, be it alcohol or be it a needle and syringe, they'll find a way of getting it. So I don't really have a problem with vending machines being accessible to kids. The answer seems to be make them available for free.

THE CHAIR: Okay, thank you for that. Yes sir.

Mr Hart: When I found out about the forum, I actually asked to do a presentation. I've got it there if anybody wants to see it. It takes about 20 minutes, though.

I have 14 years' experience in New South Wales. We have over 88 vending machines. They are converted cigarette machines, they're not purpose-built. But I have to dispute the advice that Tony received, because I've installed six of those myself and we've never had any of them broken into. They have a steel grille on the top and two locks. In 14 years' experience, we've had one whole machine stolen and that was because of bad placement: we put it onto a wooden door and people managed to chip away all the wood around it and take the whole machine. However, in 14 years I am not aware that they've been broken into.

It's like any machine, some of them do tend to break down, they tend to jam, but they also do work well. They're selling over 500 needles or 100 Fitpacks a week. That is the average of the machines that I used to run in the Wentworth area, which is the Penrith-Blue Mountains-Hawkesbury areas. So, yes, vending machines work well.

This is a personal opinion: I do have a problem with free vending machines because it's not really a vending machine if it's free. You might as well put a box of fits there; it's the same thing, apart from them being in a Fitpack. 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.

THE CHAIR: There are key issues here about community perceptions, particularly with regard to Alex's suggestion, which was supported here, to normalise the provision of syringes, have them in supermarkets and have vending machines. I'd be interested to know how the communities around the vending machines in Sydney responded, because there is certainly a tendency for people to be very fearful about any kind of normalisation of injecting drug use. They fear that it's going to encourage the use. That's always the predictable response to this discussion. Can you inform us about how Sydney has dealt with that?

Mr Hart: 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. I have all that data there if anyone wants to go through it.

THE CHAIR: Thank you. Regarding your offer to give a presentation, we've got the day programmed.

Mr Hart: Sure.

THE CHAIR: But your comments in this way are very useful so thanks for coming in. I'm sure we'll take advantage of your expertise.

Mr Hart: Not a problem.

Ms Riddell: Kerrie, can I just ask one question?

THE CHAIR: Yes.

Ms Riddell: When you have vending machines there, do you have a disposal bin close to it?

Mr Hart: Yes, a disposal bin has to be put next to every vending machine. Just one of the issues that John was on about earlier, and one of the main problems in needle and syringe programs in general is that we're set up, the staff are funded and off we go, but we don't have the support of the local government. People are not coming out to say that we are doing the right thing and that this works extremely well. We don't tend to have enough staff to go out and do the education.

Education for the hospital staff is imperative, especially if we're advocating free access through accident and emergency. You have to provide the education and you have to spend time and money. The only way I've ever got doctors and nurses to come to a session is to pay for relief staff, because otherwise they're too busy running the hospital to come to the session. I actually used the money from the vending machine to pay for the relief staff to get the staff there to explain why we have the system. So there are added bonuses there.

THE CHAIR: Thank you. This will be the last question before morning tea, but we'll have lots of other opportunities.

Ms Lampard: My name's Jenni Lampard. I'm the Southern Area Health Service needle syringe program coordinator and I am based at Queanbeyan. We have 25 outlets throughout the southern area. They're secondary outlets and they operate from community health centres and hospital emergency departments. Queanbeyan is the area where we have the most demand and we have a lot of stock go from Queanbeyan. Last year we had 64,000 needles and syringes go out from Queanbeyan.

At Queanbeyan, we provide the only 24-hour access, at the hospital emergency department, and we do have ACT people coming across to access that service. Likewise, we have Queanbeyan people going across to Directions.

We have a cupboard outside the emergency department at Queanbeyan Hospital. Quite often this has been fraught with difficulties regarding access and the maintenance of supply. We're going towards vending machines and we'll be installing a vending machine at Queanbeyan.

We'll be lobbying to have free access, but we believe that vending machines reach the hidden injecting drug user population, the people who don't necessarily want to be known as a person who injects drugs. That could be people who are engaged in professional work, such as accountants, lawyers, doctors and nurses. A number of professional staff inject drugs, not just the community's stereotypes—the lower socioeconomic groups or whatever. It's right across the board and I think that really should be remembered.

We're putting in our vending machine so that we can reach our hidden injecting drug user population, people who really want their drug use to remain confidential. That's going to be installed in the next couple of months. Also, across the area health service, we will be going for vending machines and this is the first initiative for southern area.

A lot of border problems arise between the ACT and Southern Area Health Service that are quite unique. Greater Murray has similar problems between Victoria and Albury-Wodonga, as do Tweed Heads and Coolangatta. Across each state and territory, there are lots of different models of the ways in which NSPs are set up and the types of equipment that's available.

I am not aware of a minimum set of standards for the way needle syringe programs operate throughout Australia. It's a very fragmented service. It's not very well integrated and, when they move from state to state, people find that they can't always access the equipment that they're used to accessing. For example, in New South Wales we're not allowed to provide barrels that contain over five millilitres—five millilitres syringes. We have to provide a limited gauge of needle and small barrels, but ACT clients can access a whole range of equipment.

THE CHAIR: Can you just explain why that's an issue?

Ms Lampard: We recognise that people are injecting higher volume substances such as methadone and pills and, particularly along our coastal areas, we have people injecting a lot of steroids and methadone. In some cases, they need the butterflies and they need

larger barrelled syringes so that, if they're going to inject it—which inevitably they will—they can do it in the safest fashion and in a way that's not going to cause abscesses, scarring and major health risks. So it's important for them to get the most appropriate equipment so that they can reduce the amount of damage they're doing to themselves.

It is an issue for us in New South Wales. I think we do have a number of people that come from the coast to the ACT to access that range of equipment. One thing that I've always wanted to see, and that I have pushed for, is a national set of standards for the way NSPs are set up. I want to have it across the board so that we don't have this fragmented type of service that we tend to have. Thank you.

THE CHAIR: Leslie, when we had the attendance sheet filled in, did we ask people for contact details? Good, because the committee may want to follow up on the comments of some of the people who have spoken.

Short adjournment

THE CHAIR: Can everyone take a seat please; we want to recommence. We'll now have a presentation from Tony Millin from the Canberra Alliance for Harm Minimisation and Advocacy, who's generously stepped in because the person who was going to speak couldn't. I'll also let you know that Andy Hart, who's spoken already this morning for Vendafit, is going to run a presentation of photographs at lunchtime. If people want to stick around and have a look at that, they're welcome to do so.

Now I'll ask Tony Millin to speak.

Mr Millin: Thank you all for coming. I've already introduced myself: Tony Millin, representing CAHMA. I am stepping in for Nicole Wiggins, who is the manager of CAHMA, the Canberra Alliance for Harm Minimisation and Advocacy. CAHMA is a peer-based, non-government organisation. By "peer based" what we mean is that the organisation is run by people who identify as either current or past injecting and illicit drug users—people who have a personal history of injecting drug use.

The information we've all seen this morning is, firstly, widely available. I was pleased to see from the documents that I've looked at that even the federal government—the Howard government—has come to see the sense in spending dollars on needles and syringes. This is best reflected in the most recent report, which Dr Wodak referred to earlier, *Return on investment*. It does seem to be that the bottom line is the dollar. It's pleasing to me to know that the number-crunchers and the bean counters have finally got the message across to the government, who have picked up and run with it, that a dollar spent today is going to save many hundreds of dollars 10, 15, 20 years down the track.

Those better informed than me will be able to provide more detail on how the problem of hepatitis C isn't so much the effect on the person who contracts it today as the long-term adverse effect on that person. Any transmission of hepatitis C that we can prevent today, any dollar that's spent today on the prevention of somebody catching hepatitis C today, is going to save the government, the community and the taxpayer many dollars 15 or 20 years down the track.

I'm going to move through this very quickly because most of the stuff has already been covered one way or another by previous speakers. I'm going to keep strictly to empirical evidence collected by researchers, academics and people who know what they're doing. I'm not giving you subjective comments or information here. The sources of the information that will, hopefully, be reflected are quite credible and, if anyone wants to go into the detail of the sources later, I'll be more than happy to provide them with it.

Let's see if we can get our heads around the visual technology here. I should also add that the views I'm expressing here are the views of the members of CAHMA. These are the views and comments expressed by the users themselves. I think it's important to bear that in mind.

An alcohol and drug task force survey was conducted in late 2002/early 2003. The question, as you can see, was: how do you, the user, rate NSP services? I hasten to add that, at that stage, if memory serves me correctly, CAHMA was unable to provide needles and syringes because of the HIH Insurance collapse and the subsequent blow-out with the insurance.

The results ranged from "excellent" to "very bad". The main thing there is that 76 per cent of the respondents ranged between "okay" and "pretty bad". The sort of reason given for that was that people who go and collect needles and syringes are chemically dependent people. They are often dual diagnosed—that is, they've been diagnosed at some stage with not only a drug and/or alcohol problem but also some psychiatric illness—and generally don't present as well as we would like to have them present. I'm starting to get a bit personal here.

Basically, when users are being attended to by other users—in other words, when somebody who needs a needle is getting that needle provided to them by somebody who is or has been a user—everything we've turned up shows that they are much more comfortable dealing with people who they know to be users or to have been users themselves. I am not attempting to denigrate or put down any of the other NSP services. I think they're great; I've always thought that. I think they do a great job. But we've shown that peer-driven, peer-based NSPs are what the users are most comfortable with.

I'll get back to the issues that we're dealing with today, starting with business hours access. That's pretty straightforward. We'll move on to this in a second and show you the breakdown of the times the different outlets are available. Before I do, I've noticed this morning that people are using acronyms. They're using terms like "primary and secondary outlets" very freely, and I'm not all that confident that people know what some of these things mean. Indeed, Kerrie asked before about the difference between a primary outlet and a secondary outlet. People talk about "fits" and "barrels" and needles and syringes, but are we really sure of what we're talking about?

Let me explain to you that, when people refer to a "fit" they mean a needle; when they talk about a "four-pack" or a "six-pack", they mean a plastic container that contains either four or six one-millilitre syringes. This is typically your insulin-type syringe measured out into 100 international units. It's the one with the orange tip; I'm sure most of us are familiar with it.

Whilst it's fair to say that the majority of illicit drug users use a one-mil fit, there is a whole range of injecting possibilities that a one-mil fit simply doesn't address. A primary NSP, such as Directions or, now we've got our insurance back, CAHMA, will provide not only the one-mil fit but also the very wide range of other equipment that drug users who aren't using either heroin or amphetamines require for a safe and "successful" injecting episode.

At primary outlets we have barrels, which contain your drug, in a whole range of sizes. Somebody mentioned butterflies before. That's a tube of plastic that goes onto the end of the barrel and a needle that goes into the arm. It allows different people to use different substances in the most appropriate way. It's only the primary NSPs that have available the range of equipment. All of the other outlets are restricted to the one type of syringe: your one-mil insulin syringe. It's important that that distinction be made.

As far as access goes and the location of the primary NSPs, as Kerrie pointed out before, we've got two primary outlets in Canberra and they're both in Civic. One's in East Row; the other one's in the Griffin Centre. One of the things we pride ourselves on in Canberra

is our town planning, and we're all aware of the concept of our satellite cities. Instead of having one big city, we've got four—counting Gungahlin, going onto five—large towns. It seems to me amazing that we've got Tuggeranong, Woden, Belconnen and Civic—and Gungahlin in future years. Yet our two primary needle exchanges are within a few hundred metres of each other.

This is reflected best in the debate going on at the moment in Canberra about the location of a safe injecting place. We all agree that we've got to have one, but where on earth are we going to put it? The answer to me seems fairly obvious. One is only going to serve the needs of the people where it's located. Somebody purchasing heroin in Belconnen isn't going to get on a bus and travel to Civic to use a safe injecting place. Indeed, somebody who buys their heroin in Civic isn't going to walk past seven public toilets to get to the safe injecting place. That's the bottom line.

There was one very kind offer from a local businessman here a couple of years ago to provide at his own expense a bus to bus heroin users from here to a safe injecting place at Mitchell. Great idea, very generous and all the rest of it, but I can tell you now there'd be people mixing up their drugs in the back seat of the bus before it got past the first set of lights. That's the reality; that's what it is. Drug users, particularly those who are addicted to opiates, want their drugs, want them now and want them in their bodies the fastest way possible—instantly. That's primarily why a lot of them use needles: it produces the most immediate result.

In the analysis of data from the surveys that the alcohol and other drug task force produced, there were a whole lot of comments about staff attitudes. The bottom line, as I've already said, is that drug users feel most comfortable when they're dealing with either current or ex drug users—in other words, when they're dealing with their peers.

That could be said pretty well for all of us, no matter what walk of life we come from. There are all sorts of peer groups, and we're probably all members of more than one peer group. But we found simply that drug users invariably find themselves in an us-and-them situation. That's just the way it is. The answer? Our answer is to promote peer-based needle and syringe programs and to train drug users, be they current or ex drug users, to provide an appropriate service at a needle and syringe outlet.

I'm not saying that means that every chemist ought to employ a drug user or an ex drug user. I'm not suggesting that for one moment. To give a local example, Directions is an organisation that, looked at historically, was user driven. Over the years it's moved from being—I hope I'm not treading on anyone's toes when I say this—a primarily user-driven service to what's now been identified by a lot of Canberra drug users as just another service. It's staffed by health professionals. Those I know personally have always done a fantastic job in my eyes but, unfortunately drug users in many instances simply don't feel comfortable dealing with people who don't have a personal history of using drugs.

This leads to some difficulties. For example, if you're on a methadone program and you're picking up your methadone at a chemist and your chemist also happens to be a needle and syringe provider and you happen to need a needle and syringe, by asking your methadone dispenser—that's the chemist—for a clean needle you are putting yourself at

risk of the chemist getting in touch with the methadone program and saying, "Hey, this guy you thought was stable on his dose of methadone is getting syringes." You're then called into the methadone program to account for yourself.

So you can see the dynamic of that and the problems that it presents. There's nothing to stop the person who needs a syringe picking up their methadone at one chemist and then going to another chemist and getting their needle, if it happens to be a Sunday and none of the primary NSPs are open. That's one problem that is readily identified, certainly with some of the chemist providers.

In regard to restrictions on quantity, there was an incident recently, details of which I won't go into, where there was a restriction on the number of syringes that were to be made available from an outlet for reasons that related to a particular case. The long and the short of it was that the users were howling because they felt that this was the first move and what was going to be followed up by more restrictions in other areas. Fortunately, after some discussion around the place and a few people making some quick phone calls and getting a grip on reality again, these restrictions were changed and distribution was brought back pretty well to normal.

The Howard government itself recognises the majority of the benefits of the needle and syringe programs. In the position paper prepared by ANCD, the Australian National Council on Drugs, the recommendations are that every effort should be made to expand the availability of needles and syringes and under no circumstances should any restrictions be placed on supply. What do we mean by restrictions? Somebody might come into the NSP and say, "Can I have a box of 100?" Unless that person looks like a 14-year-old kid, it's not our place to ask, "Why do you want a box of 100?" It isn't our place to ask that.

In the peer-based user groups, because it's pretty well a small town and mostly everyone knows everyone else, we might think that the box of 100 is for somebody who lives out near Bungendore or out past the Cotter and that it's not convenient for them to come into Civic every day or every second day and they might only have to come into town once a fortnight. A box of 100 is not only for their own use but for friends who come around and have joint injecting episodes, and a box of 100 adequately meets that individual's needs. CAHMA and its members feel that under no circumstances ought there be any restrictions on the quantity of syringes made available to people on request.

I said I wasn't going to talk about staff attitudes, and I've just hit the button, haven't I? I'm not going to go into detail about that because, firstly, they were general comments. They were made not specifically about NSP staff but the whole of the alcohol and drug sector in the ACT, which includes your methadone program and some of the ancillary services that go along with that, such as counselling.

These are the users' perceptions. I'm not saying they're right or wrong; this is simply the objective data that we got back from the users who completed these surveys. It seems to be an "us and them" situation. Obviously, if people aren't comfortable using a particular NSP, they won't use it. They'll vote with their feet—likewise, the comments regarding how they feel dealing with the person across the counter in a chemist shop and, likewise, the comments on restrictions of quantity. As it says on the board there, it's self-evident.

Concerning the feelings of being uncomfortable asking for either a quantity of syringes or, for that matter, one syringe, 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'm collared and tied today, but 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."

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.

When this question was asked—and I've already said that at the time of the survey CAHMA didn't have its own needle and syringe program operating—the emphasis was on the words "any time". That brings us to the terms of reference of this inquiry, which is to do with after-hours access. Again, it's self-evident. Eighty-five per cent of the respondents said no, they couldn't get what they wanted at any time.

Let me draw you back to the points I made about what a syringe is, what a fit is and what Fitpack is. The Fitpack that comes out of a vending machine is only going to contain your one-mil, insulin-type syringe; it doesn't cater for the number of people who simply can't use a one-mil syringe. There are a lot of reasons for that. If anybody wants to know what they are, I'd be happy to discuss it with them later on.

Here's a good old pie chart, which shows the hours. I'd like my mental arithmetic to be quick enough to give you what that represents in percentages, but off the top of my head I can't. But it'll give you an idea of after-hours access on a weekday. It costs you nothing between nine and five because you can go to a primary or secondary outlet—CAHMA, Directions or health centres—and get needles for nothing. Between five and seven there are the available pharmacists, who charge a $2 handling fee. The rest of the week, from 7.00 pm until 9.00 am, nothing's available. On the 5.00 pm to 7.00 pm thing, let me go back to that point about one-mil syringes and other equipment that might be needed.

This is the story on Saturday. I have a feeling that a Directions primary outlet is open in Civic from 8.30 to 12.00.

Ms Macken: From 12.00 to 9.00 is when it's free.

Mr Millin: I meant the 8.30 to 12.00.

Ms Macken: That's when you buy it.

Mr Millin: I see. Okay, yes, fine. Righto.

Unidentified speaker: We're actually open on Saturday from 8.30 until 9 o'clock.

Mr Millin: That's what I thought: from 8.30 until 9 o'clock. That is not an accurate reflection of what is happening on Saturdays, so perhaps I'll move to Sundays and see if that's a little closer to the mark. On Sundays you can be catered for in the ACT if you need a one-mil, insulin-type syringe and you've got the $2 to pay for it and the bus fare or the transport to get to the handful of chemists. This isn't every chemist; only two or three chemists are open on a Sunday.

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

I can offer the benefit of my own experiences in custody. I've spent two periods in jail for a drug related crime: fraud that I committed in order to get money to buy heroin. It's on the public record; it was in the ACT. I make no secret of it. I'm not proud of it. I'm just a typical example of somebody who has, somewhere along the line, become addicted to heroin and kept the use together for a given number of years.

I paid for my own heroin habit for the better part of 25 years. I did that by working, in some cases, three jobs: nine to five in the public service, nights and Saturdays as a musician in rock and roll bands and I moved furniture in a furniture van on Sundays. That's what I did to get my drugs, and I wasn't a bother to anyone.

However, my circumstances changed and I found myself in a position where my drug addiction—my ever-present medical problem, as I like to call it—was dictating my lifestyle. The easiest way for me to get the money to buy heroin, to which I was addicted, was to commit fraud. So I found myself in Goulburn jail, that lovely sandstone edifice just 48 miles up the road. It is a beautiful building if you've got the time to look at it.

There I was, never got a parking ticket in my life, in jail for 32½ years—that was what the sentence was—in maximum security in a punishment jail. Goulburn jail is regarded as a punishment jail in the New South Wales system. The authorities have to have something to hold over unruly prisoners in other prisons, and Goulburn has long been the jail that you are sent to if you play up in another New South Wales jail.

Because of the arrangements the ACT has with New South Wales—we don't have our own jail here, as we all know—you do not collect $200, you go straight to jail and you go straight into maximum security in the worst jail in New South Wales, holding some of the most disgusting pieces of human filth you're ever likely to come across. I'm talking about the likes of the people who murdered Anita Cobby; I'm talking about child molesters; I'm talking about some really nasty, ugly people.

Now, here am I, collared and tied, wide-eyed and bushytailed, walking into a maximum security prison, which is where you're sent first. You're sent to the worst place first until they sort out who you are, what you're there for and what they're going to do with you. I was in maximum security in Goulburn for 14 months.

Over that period I witnessed numerous cases of people injecting. I was offered free heroin in jail, which I declined because of the injecting equipment that was being used. That was a needle that had been pinched out of the jail hospital and smuggled back into the main part of the jail. Someone had got themselves an eye-dropper from somewhere. The needle was stuck on the end of the eye-dropper with a piece of sticky tape, and that was being used and passed around in a cell between maybe seven or eight guys. It's a horror story, but it's not unique. There are heaps of them; it's happening literally every day.

People who know that they're going to jail will often get one or more syringes, cut them in half and cut the bit you put down the plunger so that a little bit remains sticking out the top. They make a bundle of maybe a dozen of these. They'll wrap them in condoms and, to use the jail expression, they'll keep them in the safe. You can work out where the safe is yourself.

Why? Not because they want clean syringes in jail but because they know that a brand new syringe in jail is currency. It's worth a lot. A lot of what? A lot of shots of heroin is what it's worth. You can exchange a brand new needle in jail for probably the equivalent of $500 worth of heroin, if you were buying it out here. So needles do have currency in jail. They're worth a lot of money.

In the eighties there was the three by three method of cleaning out syringes with bleach. However it came to pass, bleach was introduced into New South Wales jails. However, it was a good idea not executed all that well, inasmuch as the big box of bleach was placed right down the front of the wing where everybody could see who was going to the bleach bin.

Now, why would you be going to the bleach bin? Ah, to wash out a syringe. Why would you be washing out a syringe? Ah, because you've got drugs to use. What happens? People see who's using the bleach. It doesn't take them long to work out. They've got plenty of time to think about it. Who's got the drugs? The dynamics are such that you've got the violence, the standover stuff and all the rest of it.

The obvious answer to that would be, as the prisoner's coming into the jail and going through reception and being given his kit—his toothbrush, his razor—that he is given one more syringe and a little sachet of bleach. Everyone gets it. If you want, you can forget about the one more syringe, but not the sachet of bleach in with the razor and the toothbrush. If everyone's got one then it's not worth anything on the black market. These are self-evident truths. There are people better qualified than me to address these matters.

We haven't even talked about the very real damage people do to their venous systems. People, especially injecting drug users, forget that the venous system is an enclosed system. God made us so that we don't need to get into it, but humans, being the

inquisitive critters that we are, have found that, if you want to use drugs illicitly, the "best", the fastest, way to get relief for opiate dependence is to use a hypodermic syringe.

There is a poster that one of the companies puts out that shows a blown-up photo of a syringe that's been used once, twice and three or four times. Then it shows what it looks like after it's been used six times, and I can tell you it's not a pretty sight. After the first time, it starts looking like a can-opener; after the third or fourth time, it looks like the end of a Phillips head screwdriver.

I know from personal experience of one syringe being passed around and used 19 times, incredible as it may seem. There are further extremes even than that. In jail in Bangkok a prisoner took a big biro, sharpened the end of it with a razor blade, put the heroin in, put his finger over the end, added the water, chewed up a piece of newspaper into papier-mache, forced that into the end of the biro, tipped it up, let the mixture go to the papier-mache then used the internal bit of the biro to push it up, stuck the sharpened bit of the plastic biro into his vein and had a successful injecting episode. It didn't stop there; it was used by another 40 people.

Our recommendations are self-evident. We, the peer-based group in Canberra, CAHMA, support the work that's done by Directions and others in providing us, the users, with NSP outlets. But we recognise, and indeed it has been well documented, that the most effective means of educating users is through peer-based and peer-driven education programs. As we've already heard, needle and syringe programs are well positioned to draw people into the health environment.

Who better to discuss your injecting problems with, in the first instance, than somebody who knows exactly what you're talking about? They know the slang; they know the argot; they know what you're referring to when you talk about a "butterfly". They know all this. You don't get sidetracked having to explain what you're talking about. We have enough empirical evidence. We have enough privately driven research from our detractors. We know that there is enough evidence available to show that there is no increase in injecting drug use because of greater availability of syringes.

We're running out of time; I'm talking over time. I've addressed these issues. The bottom line here is: we the users consider that we own these issues. Lots of people have done heaps of hard work, but we are the ones that have driven this. It is a growth industry and, if it wasn't for us, there wouldn't be positions for a lot of you. That's not the way I look at it, but that's the way it is. I'd like to leave it at that, thanks. Should I invite questions, or are we over time?

THE CHAIR: We've got to the lunch break, but we can go a little bit over. Does anyone want to ask Tony a question? It was a very informative presentation.

Mr Millin: Sorry if I got away from it.

THE CHAIR: No, that's fine, I was chairing, and I didn't stop you either, because it was interesting and informative, so I appreciated it. Has anyone got a question?

Mr Millin: Jenni?

Ms Lampard: Yes, I wanted to make a comment, Tony, about the staff attitude of alcohol and drug services and other treatment services throughout. I agree personally with what you have to say, and I'll let it be said regarding staff attitudes that I don't think the needs of clients are met. I don't think there's strong enough advocacy for clients in terms of drug and alcohol treatment.

If clients accessing NSP services get hit with all that attitudinal stuff, they sure as hell ain't going to go to alcohol and drug treatment services if they have had that experience with attitude. I think it's really important for peer-based organisations to have an active voice in helping educate health professionals and to play a big part in establishing a service that will have good outcomes for people who inject drugs and for staff working with them.

Mr Millin: I agree with those points.

THE CHAIR: Thank you. Yes?

Ms Madden: Hello. I'm Annie Madden from the national drug users organisation. CAHMA is our member group here in the ACT. First of all, I want to thank Tony from the bottom of my heart for his presentation. It was fantastic and we need more of that. Secondly, I wanted to take the opportunity to say on behalf of CAHMA, who may not do this for themselves because it might seem inappropriate, that CAHMA desperately need more resources to do the work they are trying to do. They currently have a little more than two staff to do all of the work they do. They exist on a great deal of volunteer work done by people like Tony.

If we are to have better advocacy and treatment or better peer-based needle and syringe programs, we have to fund that properly. Drug users can't be expected to do this for nothing; they have lives to lead. As taxpayers, we deserve to have good quality health services like everyone else. We're prepared to do the work, but CAHMA need to be funded properly to play their role and can't be expected to do that voluntarily.

THE CHAIR: Thank you for that.

Luncheon adjournment

THE DEPUTY CHAIR: Good afternoon everybody. For those of you who don't know me, I am Karin MacDonald, and I am the Deputy Chair of the Health Committee.

Just before I introduce our next lot of speakers, who are sharing the time together, I just want to say that over discussion at lunch we talked about the different views around the world on a number of issues, including needle exchange-type programs and the views of people in the United States about needle exchange programs. While we all, of course, know that this is a very difficult issue to talk about and it raises a lot of emotions within society, I think one of the things that we do have to be proud of in this country is we don't bury our heads in the sand and we do take information from the experts who carry out research in this area to find out where we should be going and to inform our debate.

Without further ado, I would like to call upon Julie Tongs, Jane Lynch and Kacey Boyd from the Winnunga Nimmityjah health service, which is the Aboriginal health service here in Canberra. Dealing with drug issues is just one small part of what Winnunga Nimmityjah do. They provide an amazing service. They keep telling us they are not just catering to indigenous clients; they have a number of non-indigenous clients that come to see them. So I will let them speak for themselves. Thank you.

Ms Tongs: Thanks Karin. My name is Julie Tongs. I am the Chief Executive Officer of Winnunga. I have with me Kacey Boyd, who is the youth worker, and Jane Lynch who is our drug and alcohol nurse. Winnunga Nimmityjah health service is an Aboriginal community-controlled health service. We pride ourselves on the fact that we don't discriminate, that we run a non-judgmental service for all people who wish to access. We are a comprehensive primary health care service in the holistic sense of the word. We employ GPs, we employ a psychiatrist, we have Aboriginal counsellors, we have our drug and alcohol nurse, and we have a media person. So we are comprehensive in the way that we do our work.

In a lot of ways it is a one-stop shop and a big part of what we do is drug and alcohol. It is no secret in our community that we do have a lot of intravenous drug users and we do worry about where they get their fits, and if they are getting fits, because we do not have a needle exchange in our service.

A lot of our old people are still coming to terms with what alcohol has done to our community and it is really difficult for them to come to terms with intravenous drug use. It is people like myself and the GPs and Jane and Kacey that need to educate our old people about the use of clean fits.

We have a lot of hep C positive clients that access our service, and that is a real concern for us. Dr Sharp, our long-term GP, has been with us for 14 out of 15 years. He has got a really good handle on what has happened in this community over that time. He is now seeing third generation drug users, and this creates real concern for us.

We pride ourselves on the fact that we deliver continuity of care. We not only see our people when they access our clinic but we also see them out at Belconnen Remand Centre, in Goulburn jail and over at Quamby Youth Detention Centre.

Our population is predominantly young and so we fit with the rest of the Aboriginal population nationally. We have got 5,385 clients, and that is growing daily because of the cut to doctors not bulk-billing in the ACT and the shortage of doctors in the ACT. Therefore, a lot of the clients that are accessing Winnunga are also clients with complex needs and particularly clients with drug and alcohol and mental health problems.

So 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 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.

I never, ever thought I would see the day that I would say that I am quite relieved when I know that a lot of these young people are actually in Quamby, in the juvenile detention centre, because I know they are safe. Otherwise, they are on the street and they are using. We don't know what is going into that needle, into that syringe. It is about the substance that is actually going in there. Nobody knows. The next hit could be the last hit. But we need to know that they are safe and that they have access to clean fits if they need them, but I am not sure that that is happening at the moment.

I would also like to talk about research that we are doing with the National Centre for Epidemiology and Population Health at the ANU with Dr Phyll Dance and Dr Gabriele Bammer and others at NCEPH. The Aboriginal staff at Winnunga are co-researchers on that project and we are looking at illicit drug use in the Aboriginal and Torres Strait Islander community in the ACT and region. Some of the questions that are being asked are around where people are going and do they know about services and things like that. But I will get Kacey, who is a co-researcher on that project, to fill you in a bit more.

Ms Boyd: We started this research, I think, last year. We have had over 50 participants so far—71. We have got a booklet that we go through of about 58 pages, plus we have got a separate booklet that actually goes through their recent drug use, what they have used, how they have used it, whether it has been by syringes or if it has been by smoking or what methods they are actually using.

So once you have actually established what drugs these clients or these participants are on then we actually go through the more detailed stuff of do they know about CAHMA or do they know about Directions; have they ever accessed any of these services; have they ever used Winnunga; have they ever used Gugan? This is just to get a sort of rapport with what services our drug infected people are actually using and what services they are not.

It is also about finding out how better we can assist them, what more we can do. It is also finding out about if they are aware of blood-borne viruses or diseases by sharing needles;

if they are aware of hep C, hep A, hep B; if they are aware of HIV. Also it is about asking them if they have ever had shots to prevent them from contracting these sorts of diseases. Some of them have, some of them haven't. So it is a matter of making them aware—it is not just a matter of "okay, you're using" but "how you can use safer" and making sure that they are aware of all the consequences that can go along with their drug using. So it is sort of to get feedback from them but also for us to give them something in return. Thanks.

Ms Lynch: I guess following on from that, we can probably produce some anecdotal evidence that when our clients are being interviewed there is still a lot of fear and stigma around picking up needles from mainstream needle exchange programs. When asked a little more in-depth where they were picking up from, they often went to a secondary needle exchange where they felt they were discreetly dealt with and no questions were asked.

We don't know what other non-government agencies do in terms of collection of data around accessing, but what we can say to you is when they talk to us they know that they need that discreet service but they don't want to be viewed as junkies, which is a little different I guess to Tony's group of people. Our young users, which reflect unfortunately the national data, are beginning to inject particularly opiates and then next amphetamines. Our age group is young as well. So we reflect the national trends, which is a shame. And because of that, they are at lower risk of injecting at 14 to 15.

So we have an ethical dilemma if somebody does turn up to a needle exchange program—this was touched on earlier—and you know they are injecting. I think it is a reasonable thing that if someone is picking up syringes you ask them are they injecting heroin. Then again, I think we have to consider. As a registered nurse, I would want to hand out needles. But along with that, I would also want to hand out information. This is also what the young users are saying to us: they don't just want a Fitpack; they want to know how to use safely, what to do with their syringes, and how to appropriately discard them.

A lot of how they learn is within their own peer group. Again—and the research supports this—this is where that peer group education is very important. They are not necessarily interested in a user telling them how to use. If they can come in with, say, a youth worker who has been trained in needle exchange, particularly more so for the information on what injecting is and the actual act of breaking the skin and keeping their skin clean. Things like, you know, swishing back and pumping it in, and all those sort of things become a culture of using. We have to break that down with peer support and by gentle education, and that is being around people while they are using.

That brings up issues around our elders in the community, because historically whenever health issues around substance abuse was in issue, like alcohol, health services adopted a prohibition like "Say no to alcohol". So we have embraced, and a lot of communities have embraced, a lot of education and gentle caring that it is about harm minimisation. And that needs to be explained. I think as Alex hinted this morning, "harm reduction" and "harm minimisation" have been terms that have been interposed and used politically. But correctly, harm minimisation is about keeping our clients alive. I guess they are also asking—I don't know whether I said this—that they need to know how to use, whether that is in a short pamphlet with their pack or with peer groups.

The other thing that doesn't fit well with the education are the words "Don't share". That is a really encompassing term used in Aboriginal families, that you share your community, you share everything. So to say "Don't share a fit" is really culturally inappropriate. What we almost have to say is "One hit, one fit" for our community. Because we share our beds—you know, our clients share their beds, their houses, their food.

The other aspect is that our clients who are homeless want to be regarded in terms of health, not as ID users. I guess the other thing about our access in prisons is that, because we have a continuum of care and they are visitors while they are in custody, they have often disclosed to the Winnunga health workers the use of injecting in prisons. How we as registered nurses deal with that as an ethical and a health issue is to discuss immediately blood-borne viruses and test them for that, and disclose it discreetly through their doctor. I guess the other punitive action of that is that they get branded, so they are exposed fairly quickly for their drug use in jail. I think that is probably about it.

THE DEPUTY CHAIR: Does anybody wish to ask some questions?

MS TUCKER: What is the timeframe for the study you are doing?

Ms Tongs: We hope to be finished interviewing by the end of June and then we will start analysing the data and all that. So maybe towards the middle of next year, I think.

THE DEPUTY CHAIR: Are there any other questions?

Ms Macken: Yes. Wendy Macken from Directions. I was just wondering is there a reason you don't give out packs of needles?

Ms Tongs: Yes, there is a reason and it is partly to do with the infrastructure at Winnunga where we are located. It was the old needle exchange, ironically enough, but 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.

THE DEPUTY CHAIR: We have Daniel and then—I am sorry—I've forgotten your name.

Mr Stubbs: Daniel Stubbs from ACTCOSS. That's useful information to know—about why you don't give out fits. Have you had any thoughts about how to have needles distributed where they're needed around our community? I don't know if you've had a chance to think about that at all.

Ms Tongs: That's being done discreetly at the moment on a trial basis with one of the Aboriginal corporations and Directions. It's in its very infant stage. It's to be a discreet service. It's primarily for Aboriginal clients who are younger and are not accessing. It's a mobile service.

Fred, would you like to talk about that?

THE DEPUTY CHAIR: Please come up to the microphone, Fred, and introduce yourself so we can get you in *Hansard*. What you have to say is important and we want to be able to look back through it later.

Mr Monaghan: My name's Fred Monaghan. I'm a drug and alcohol worker from Gugan Gulwan. Stanley Connors and I are drug and alcohol workers. We're working with the family planning/sexual health people and Kerry Arabena. We did the training, to get better access for our people to needles after hours.

We visit the Directions office on a regular basis on Friday nights. We then make ourselves present with our people on the streets, to fill them in on what we're doing. Basically, we're trying to get out there to stop, as Julie said earlier, the hep C concerns happening in the community, with our people.

I visit BRC and the Quamby detention centre on a regular basis. A lot of the clients I talk to are affected by hep C. There are a lot of our younger people coming up through the ranks who are out there, using. We're hoping to try to stop this—and hopefully try to stop the spread of hep C among our people.

You hand out needles to particular people and it's a case of trying to—Jane mentioned this fact—explain to them about safety and shooting drugs into the veins in their arms. They should make sure there's another person with them, to look at all the safety aspects of it. So that's what we're doing out there.

THE DEPUTY CHAIR: Thank you, Fred. Are there other questions? Does anybody wish to comment on something that's been said?

Ms Delander: I'm Marcia Delander—I was with Directions ACT. I'd like to comment further on the service Fred is working in. I also wish to comment that that was a trial of a Koori-based outreach service. That is working successfully so far, which is great. There are two youth centres in the ACT which are silent outlets—they haven't been discussed today.

There are a couple of other silent outlets that don't become public knowledge—they're not advertised. The reason is a bit like their service. They need discretion to get to their core clients, without other people accessing the service. In total, there are five of those in the ACT.

It's important that people acknowledge that there are what we call silent outlets. They may be in a brothel, they may be to do with a group of sex workers; they may be to do with Aboriginal people, or to do with youth. They're not something that can be put on a piece of paper and shown to everyone. They are documented as silent outlets.

THE DEPUTY CHAIR: Do people find out about them through word of mouth, or do they offer the services when people go in?

Ms Delander: That's correct. They only offer the service then. For argument's sake, let's pick one of the youth centres. They have the service there—the staff are all trained. What happens is that, if a client of theirs accesses them and says, "Look, I have a problem—I can't get clean needles. I don't want to go to this service or that service", they will discreetly do the exchange. They give them clean equipment; they tell them about where to dispose of it properly—and about proper vein care, and other things that may go with that.

That is not common knowledge. The reason that is done is because it enhances the services other organisations deliver to other people. It works very effectively. It's been working effectively for nearly three years. In fact, we added the Aboriginal one in late January. It is just an addition, but this has been going on for nearly three years. They need to have that quietness about them to work. The agencies that run them in parallel with other programs find it very effective to be able to not say, "Look, you have to go over to East Row or you have to go to CAHMA to get your equipment." When needed, they can give it to them.

THE DEPUTY CHAIR: In relation to that, do they operate as secondary services? We were hearing before of the difference between primary and secondary services. Primary services can give out the full range of butterflies, needles and so on. Are these silent services able to provide all of the apparatus, or do they provide only 1 millilitre syringes?

Ms Delander: There are two primary outlets in the ACT—Directions ACT and CAHMA. They provide the whole range of injecting equipment and information—whatever is needed. One thing about primaries is that they're funded positions. They're positions that are paid to be NSP workers. In major secondary outlets, which are four of the health centres in the ACT, they are not funded positions. They give out only four and eight-packs, condoms, lube and sharps containers. All the health centres have big sharps disposal bins located inside, and Phillip has one outside.

A minor secondary outlet is where Daniel is at the AIDS Action Council, where they do exactly the same thing. They're not funded either, but they're differentiated because of volume. The health centres do a phenomenal number of packs—you're talking 600, 700 or 800 packs a month. It's a huge workload for a non-funded position.

From there we have silent outlets. Silent outlets only give out packs. The only ones that give out equipment besides packs are the two primary outlets. That is a part of the system that needs fixing. We do need to fix that. We've got the majority of injecting equipment available in at least every town centre. But it will have to be a funded position. It cannot be put onto the health centres as an unfunded position.

THE DEPUTY CHAIR: We heard some of that information before, but thank you.

Mr Ryan: John Ryan from Anex. I wanted to add another perspective to the last comment. I'm not sure if the ACT's particularly different, but, if you compare it to Victoria, there are 180-odd needle and syringe programs. About 165 are secondaries and, of those 165, the vast majority provide all of the equipment that's provided through the primaries.

The access to the diversity of equipment that you can expect from a primary in Victoria is able to be accessed through the secondaries. The other issues about quality of staff, training and funding are, I think, accurate. That applies to other states as well. I think it's an idiosyncrasy of the ACT.

THE DEPUTY CHAIR: Thank you.

Ms Hart: I was looking for an opportunity with hep C, and I'm here now! Thank you for mentioning hep C.

I'm Carol Hart from the ACT Hepatitis C Council. I wanted to give you a couple of figures—I know them off by heart.

One in 100 people across Australia has hep C and 5,000 people in Canberra have hep C. It's a huge number of people. The other thing is that, as we know, it's going to get bigger. At the rate it's growing at the moment, it's increased by 45 per cent in the last four years. By 2020, almost a million Australians will have hep C, at the current rate of growth.

Forty to 60 per cent of the prison population has hep C. If they weren't using when they went in, they are very often using by the time they get out. Last year, in Canberra alone, 233 people were diagnosed with hep C. However, that's the tip of the iceberg because a lot of them won't have had any symptoms. We won't see them for 10 years, until their livers are compromised.

I also need to say that it's not only a money thing. It affects our whole community. There are flow-on effects for job prospects, employment, family and relationships. All the things we hold so dear are affected by this virus.

The ACT Hepatitis C Council believes that after-hours availability is essential for our people's health care—for all people. We believe that the availability of syringes only during office hours is discriminatory against people who work.

Availability in prisons is essential. This should be put together with a program in prisons, so they have safe injecting practices. It could be done completely within a health care environment. If people are going to inject, it's up to us to ensure they do it safely and that the ongoing effect to the community is not compromised.

Ms Tongs: Dr Sharp did the hep C training. He was disappointed because there were only two other mainstream GPs that did the hep C training—to be able to work with people with hep C, in conjunction with the liver clinic over at the Canberra Hospital. We're the service in the ACT that's working with the majority of people, and particularly the disadvantaged in this community—and there's a lot of disadvantage in this community—with limited resources. We're happy to do it, but we need resources to do it.

THE DEPUTY CHAIR: Does anybody wish to raise any comments on the indigenous issues? If there is anything else they want to talk about, we're now running about 10 minutes ahead of schedule, if we finish now.

Ms Glavimans: Kathy Glavimans, CAHMA. Although this isn't totally related to the access issue, I was interested when you were saying that a lot of indigenous people aren't reporting to the mainstream services—which I would have noticed in working at CAHMA. That's something I would agree with.

As to the whole area of safe injecting practices, they're going to secondary outlets and stuff. You were saying about putting something in the packs. Do you think that's a reasonable way to get the information out there, to people who aren't reporting to anyone who can say that this is how it works—that this may be a project we can work on?

THE DEPUTY CHAIR: I think that was answered.

Mr Coase: Daniel Coase from AIDS Action again. I suppose one of the things I tried to put in my presentation was the importance of a range of access points for needle exchange programs. 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. As several people have said, the fact that the two main primary outlets are so close together in Civic is appalling. There need to be primary outlets around town, or in the major town centres, to give people a choice of access.

THE DEPUTY CHAIR: Thank you very much.

MS TUCKER: I wondered if Julie or Fred had a comment on vending machines. Do you think that would be a useful thing to do for the indigenous community?

Ms Tongs: I don't know that that would work for our people because we're touchy-feely people—it's about having interaction with one another. Even though they might go off somewhere to get a fit, they always come back to us. We're the ones who are working on the issues around homelessness and all these other things—making sure they go for their parole—we do all those other things. The needles are one part of it—the syringe is one part of it—but I think they still need to have interaction with people. That's the way we are. It's that sharing and caring stuff.

THE DEPUTY CHAIR: Thanks, Julie. Fred, please come up to the microphone and state your name again.

Mr Monaghan: Fred Monaghan from Gugan Gulwan. The problem with the vending machines is that you could put them in some locations, but a lot of our people are running from the law, in some fashion, because of breaches. The police probably have some form of warrant for these people, and they will not come out in the open. They will stay in their own little area, shoot up and do what they've got to do with their drugs. It's a concern that a lot of these people will not access the vending machines if they're put in specific areas—the main shopping areas, like the Woden area—because of the police presence.

THE DEPUTY CHAIR: Thank you, Fred. Earlier, we were looking at the slide show. Did you want to come up and talk to us again about the location of vending machines?

Mr Hart: Yes. Andy Hart from Vendafit. You're right, Fred. In my experience with vending machines, it is very important to get the right location. You have to put a vending machine where people have a right to be. You can't have them round the back of a hospital, where security or anybody may say, "What are you doing here?" But they've also got to be where they're not going to antagonise the local community—you don't want the vending machine caught in the headlights of every passing car.

Parking is an issue, so you must find the right location where people can easily pull up, use the machine, get back into their car and go. One advantage of the vending machine is that you get 24-hour access. So it's unlikely that the police are going to stake out a vending machine for 24 hours when they can stake out an NSP that's only open from 9.00 to 5.00. We all know about police resources. I haven't heard of that happening. I don't know if this is an ACT issue. With the Aboriginal service I worked with, when I was working in NSP, we had it as a silent exchange, as Marcia explained. That worked reasonably well.

I worked in the Mount Druitt/Blacktown area, which had a fairly high Aboriginal population. A lot of people were going outside of the area because they didn't want to use the services locally. They would go to the next suburb to use their service so they weren't known or recognised by family.

THE DEPUTY CHAIR: Thanks, Andy.

Ms Madden: Annie Madden. It's important that we don't see the vending machine thing as being beyond what it's capable of being. I think it's an add-on. AIVL absolutely

supports vending machines, particularly because they give 24-hour access. I think a very important point is that you can't replace face-to-face contact with vending machines. You can give people all the injecting equipment you like but, if they don't know how to use it properly—if they don't know why they need to use safely—then it's not much good. I believe we need to keep vending machines in their context, which is an important point, but they have their place.

I wanted to make a comment about issues for indigenous users, because that's an issue which doesn't get enough attention. Having said that, I don't know how many of you saw the front page of the *Australian* this morning. I read it, over my breakfast, and I cried. There was a story there about a young indigenous drug user who had recently faced court in South Australia. During sentencing, the magistrate abused her, swore at her, said that she was a druggie and deserved to die in the gutter.

The paper said that she was visibly shaken by this, but I was kind of surprised that that needed to be said. What shocked me even more was that the South Australian Attorney-General commented on ABC radio last night that, while he thought the magistrate's comments were inappropriate, there was a double edge to this. He said he thought the majority of the Australian community would applaud the magistrate's comments.

Sadly, I think he's right. That's what I was so upset about. I suppose, for me, it highlights how far we have to go on these issues; how badly drug users are treated in our community and how sick to death we are of being everybody's whipping post. Indigenous drug users in particular cop the worst end of this deal. I think we would go a long way if we recognised that we need to get it right with indigenous injecting drug users, ensuring that their needs are met, that their health care issues are addressed, and that they are treated appropriately in society. I think that is a good yardstick for us, because that would mean we're getting somewhere.

THE DEPUTY CHAIR: Thank you for that.

Short adjournment

THE ACTING CHAIR: Thank you very much for your continued participation this afternoon. My name is Jacqui Burke. I'm one of the committee members and a Liberal member for Molonglo. It's great to see so many of you have stayed the distance. It has been a long day, so well done.

It's my great pleasure now to introduce Mr James Ryan, the Director of ACT Corrective Services. Many of you will have heard James talking before, so it may not be news to a lot of you. I think that it does us all good to be humble and teachable in these situations and to keep a mind to what's happening in other arenas.

On talking to James before we started, the one thing that came to mind straightaway was that James deals with a culture within a culture. We talked about people being transported from one set of rules to another set of rules. I, for one, am looking forward to how people are actually coping with that situation within our prison system. Without further ado, I'll hand you over to Mr James Ryan.

Mr Ryan: Thanks, Jacqui. I intend to talk about NSPs in custodial facilities in the ACT. I intend to speak about the following in general terms: the operation of our facilities so that you can put things in context; how we presently handle detainees who are intravenous drug users; the issues involved in a needle and syringe program in a custodial setting, particularly as it applies to us; and some suggestions, perhaps, for the future, things that I think are worth exploring.

On looking around the room, I know most of the faces and I also what they do. 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.

Clearly, drug addiction contributes to offending behaviour. That's a given. It certainly saddens me to see the number of offenders who keep reappearing in our system, who clearly find the challenge of defeating their drug habit simply too much for them to cope with and who appear to be caught in a vicious cycle that involves crime to feed their habit. I've been here long enough in the ACT to know many of them by name. I speak to them as they reappear in our system and often many of them approach me and their story is usually much the same: "I've been caught again. It's alleged that I've reoffended again. No, I still have not been able to overcome my addiction."

Even more tragic is the fact that I see some of them that I first encountered at Quamby in the juvenile system who have since graduated to the adult system and keep coming back. Many of them are very intelligent and talented young men and women and far too many of them are from the indigenous population. Among the older group of drug-affected offenders are some who have visibly deteriorated physically and mentally over the space of my five years here, to the point that they're no longer easily recognisable by me.

Some other general considerations just at the start: since late 2001, ACT Corrective Services is no longer responsible for juvenile offenders, but I believe that any consideration of NSPs for offenders must consider those who are under the age of 18 as well. All of our sentenced prisoners presently are transported to prisons in New South

Wales to serve their sentences and only return to our sphere of responsibility at the point of parole. You should know that we are also responsible for detainees serving periodic detention, which is served at our own centre at Symonston.

We run two remand centres and one periodic detention centre. The only other form of sentence that we supervise is home detention. Both of our remand centres lack secure perimeters which, in turn, makes the introduction of contraband much easier. It's easy for a member of the public to walk right up to the wall of either of the centres and then attempt to hoist something over the wall. We do our best to prevent that, but it's an ongoing problem that doesn't exist in a properly designed centre. Our periodic detention centre, in turn, is not a secure facility and was never meant to be.

Just some facts on our detainee population: the number of offenders that we hold in the ACT is by national standards very small indeed. As of now we're holding in both of our remand centres a combined total of about 70 remandees. We have, in recent times, peaked to numbers in the 90s. Usually at our periodic detention centre each weekend we have around 30. We have peaked in that area at around 50.

The remandee admissions are, of course, much higher than those numbers. At the two remand centres, for example, during 2001 and 2002 the admissions were considerably higher. At Belconnen, they were 666. That's an interesting number. Around 70 per cent of our remandees identify as having a history of illicit drug use and over time this apparently varies between 60 and 80 per cent. Many of those, in turn, also have associated health and mental health problems. These figures are not mine—they've been sourced from Health—and I'm not exactly sure what the definitions mean. But even if you halve them, the problem is huge.

So what do we do about the treatment of intravenous drug users? ACT Corrections Health provides a range of services for such users, including assistance with drug withdrawal, counselling and education and access to methadone. I'm not aware of any other pharmacological alternatives that they're using other than methadone. I should also at this point acknowledge the assistance that we receive from Winnunga Aboriginal health services in the delivery of our health services across-the-board.

It's worth noting that not all Australian jurisdictions offer methadone programs to remandees. Furthermore, the management of methadone for people in custody in the ACT does allow for access to the program on a priority basis. Compared to New South Wales, from what I can see, it's easier for an offender arriving into custody to enter the methadone program than they would face in the state next door. In addition to offenders on remand, those on periodic detention are eligible to receive takeaway doses of methadone from the ACT Community Care alcohol and drug program to cover the period of their periodic detention, which stretches from Friday night to Sunday night over whatever number of weekends they are required to report.

Some words on legislation and regulations. This is what makes us different. The legislation and regulations covering the operation of remand centres and the periodic detention centre allow for the confiscation of items regarded as prejudicial to the health of detainees or the security and good order of the facilities. Consumption of illicit drugs is prohibited whilst in custody at any of those facilities and, in accordance with these regulations, we consider needles and syringes to be contraband.

We have a situation where our client group includes a large number of illicit drug users, including intravenous drug users, who are locked up in an environment where illicit drugs and associated paraphernalia are regarded as illegal and who, as a group, receive by way of help from the system support and assistance from the health services, which are limited to, perhaps I could say, help in withdrawal from their drug addiction or to use methadone.

But for those offenders in custody who do not wish to avail themselves of these opportunities or find it difficult to cope with them there is, of course, the avenue to attempt to service their drug habit illegally. Under the current arrangements for the management of correctional facilities in the ACT, as with others in Australia, although this may be difficult, it's certainly possible. Nobody who knows anything about prisons would deny that in the close to 100 facilities around the country all of them, at least at some stage or other, face the problem of the illegal introduction of drugs, needles and syringes into their facilities. So they're the facts.

What about the prevention of the introduction of drugs into these facilities? Many would maintain that not only are drugs available in prison but also it is impossible to keep them out. That is not strictly true and there are measures that could be used to prevent the introduction of drugs into prison. However, these, I would contend, are not acceptable to the general community or to prison administrators for that matter.

For instance, the entry of drugs could be reduced significantly if contact visits by visitors were disallowed. Indeed, this is a measure taken often in the event that a prisoner is caught receiving contraband from a visitor. In the extreme, prisoners could be separated in a way that prevents the traffic of drugs within a prison. No visitor contact and minimised prisoner to prisoner contact would largely solve the problem. However, these are measures that are obviously draconian and are reserved for the extreme cases of prisoner behaviour. Keep in mind that these are some of the arguments that you will get trotted out when you start to talk about other alternatives to address this problem. There are things that we can do.

What about urinalysis? One of the measures of assessing the extent of drug use in prison is urine testing and our results seem to vary. For example, during 2002, of 127 urinalysis drug tests at the BRC, only five showed opiate and amphetamine use, with a further five refusing urinalysis. Those five, we imagine, probably did so because they had been using.

During the period January to March 2003, 35 urinalysis drug tests were performed at the BRC, with three positive results and a further three refusing to undergo urinalysis. It should be noted that the frequency of tests that we impose depends on the intelligence received on possible drug use within the facility and all of our tests usually are targeted as a result of that intelligence.

The story at the periodic detention centre is somewhat different and perhaps reflects the part-time nature of periodic detention. In 2002, 79 urinalysis tests were conducted at periodic detention and on 21 occasions the results did show opiate and amphetamine use. We believe this reflects the drug use behaviour outside the facility. There have been no positive results to opiate and amphetamine use at the PDC since January 2003.

In my opinion, there are too many limitations on urinalysis to use it as any accurate measure of the extent of the drug problems in our facilities in the ACT. There are too many ways available to, particularly, the old hands to thwart that test, to negate that test. But it does at least confirm that we have a problem, doesn't it?

As far as needles and syringes are concerned, although the legislation and the continual searches that we conduct make the introduction of syringes into our facilities difficult, they do make their way in. For example, since January of this year we've found four at Belconnen and two at our new temporary remand centre. We haven't in that period found any at the PDC; they seem to be a bit more relaxed. They know they're out on Sunday night, I suppose, and just steel themselves for the two days, plus they're not searched and watched in the same sort of way; there is not the same level of security.

What about needle and syringe programs in Australia and overseas? These programs, within a prison environment, have not been introduced in any Australian jurisdiction, as far as I know. I also believe it's highly unlikely that they will be in the foreseeable future. In some European countries, such as Spain, Switzerland, Germany and Italy, such programs have been introduced in prisons, but not on any large scale in comparison with the total prison population. Perhaps more significantly, certainly for me, there doesn't appear to be any wide-based official support for these programs by the correctional administrators in Canada, New Zealand and the UK, countries whose correctional philosophies are more akin to ours.

The prison NSPs already in existence seem to be provided to especially identified and targeted prisoner groups who represent a small percentage of the total prison population. I've seen one of these in operation and, in the context that it operated, it worked. But it's not also clear to me whether any existing programs operate for remandees, keeping in mind that at present in the ACT remandees are our focus. It should also be noted that in the event of an NSP for offenders in custody in the ACT, when a remandee is sentenced into New South Wales he would then go from a situation where there is a program into one where there isn't a program and in these circumstances we'd need to establish whether an NSP is appropriate merely for that remand period.

There are some other issues in relation to the operation of these programs in our setting. For many detainees, remand provides a period of calm in a life that's otherwise dictated by the demands of obtaining illicit drugs out in the streets. Remand is an opportunity for detainees to improve their health and to reflect upon their situation. Arguably an NSP might reduce the opportunity for detainees to address their substance abuse programs and may even provide an excuse not to do so. It may also promote drug use with other detainees. There are lots of assumptions there, but they're the things that I hear being put forward.

Other issues involved in the question of the feasibility of these programs in custody include public health equity, duty of care issues and occupational health and safety issues. As far as public health equity is concerned, Australian custodial organisations adopt the principle that detainees should receive health services at the same level as is available in the community. Indeed, the principle adopted in the ACT is that it should be at least equal to or better. But we know that exchange programs are operating and

generally accepted in the community and failure to provide sterile injecting equipment to injecting drug users in custodial facilities may therefore be perceived by some as a violation of detainees' rights to access health care services and treatments available in the community.

Although we agree that sharing needles and syringes presents a health problem, we don't consider that the arguments on the grounds of public health equity for access are likely to be sustained. Nor do they outweigh, in our view, the disadvantages, at this point anyway, of introducing such a program. It's also probably doubtful that such an argument could be sustained under the present legislation, which clearly recognises the importance of excluding illicit drugs, needles and syringes from correctional facilities. To my knowledge, there hasn't been any legal challenge mounted on this basis in the ACT. You could argue that all of that just requires that we go back and look again at the legislation.

What about the duty of care issues? The free access to an NSP in a custodial environment would raise, in my view, serious duty of care issues. The provision of syringes will not, of itself, reduce the dangers of overdoses or harm from injecting substances smuggled into the facility. The issues in the instance of an overdose resulting in death may include who is responsible for the substance taken and the dose, whether drugs for injection by detainees should be prescribed and distributed by health services perhaps to avoid harm caused by the injection of a substance the content of which is unknown, and the possibility of a person becoming an intravenous drug user while in detention. This already occurs, as we know, but at least not in an environment where needles and syringes are sanctioned. The final point on that issue is the responsibility to those detainees who are undergoing treatment for drug dependencies and seeking alternatives to intravenous drug use.

Clearly, it would be important to exclude any group using a needle and syringe program from the mainstream of the population. How feasible would this be for remandees in the ACT, given the small, mixed population that we have? The introduction of a program of that type also raises issues in relation to the provision of similar policies and practices for the use of non-injecting drugs and even, say, alcohol.

Occupational health and safety issues: offenders in custody are denied access to anything that could be used as a weapon—I'm talking about our offenders in custody on remand—such as a kitchen knife, until such time as they are classified worthy of trust. That's usually unlikely for our remandees and only happens after careful classification as sentenced prisoners, if they go that far. Prisoners habitually as a group seek out opportunities to obtain or manufacture objects that could be used as weapons. The use of a needle or syringe as a hold-up weapon is commonplace and very often effective, mainly because of the threat of contaminated blood being associated with them. As is the case in all other jurisdictions in Australia, custodial staff in the ACT are strongly opposed to the introduction of needle exchange services.

It is acknowledged that there may be several ways of minimising the risk, but it remains an important industrial issue in corrections. One of the reasons for this is the memory of the death from AIDS in 1999 of custodial officer Geoff Pierce, who contracted AIDS following an assault with a blood-filled syringe at Long Bay in July 1990. There's also, of course, the risk of any such implements being used as weapons against other

prisoners. Before you leap to your feet, I do understand that there is the possibility of technology that may, in large part, help to overcome that use as a weapon. I think that perhaps it is overrated as an issue, but one that industrially we would have to argue hard and long to overcome.

What alternative methods do we have of overcoming this problem? There may be, for example, scope for the health services to identify those detainees who are not treatable in any other way than by giving them needles and drugs and to manage them accordingly and, I stress, separate them from the mainstream. It should be noted, however, that the current health and correctional facilities in the ACT, in my view, don't have the capacity to separate this group from the general population. We're flat out separating the major separations that we have already by virtue of gender, protection and so on.

Given the importance of this issue, another approach could be to clearly identify and manage those in custody with blood-borne diseases. Perhaps it's a no-no as far as the medical profession is concerned, but why can't we have mandatory screening on entry into custody and at a further time thereafter to cover any incubation period to enable us to make decisions about who really is likely to spread these diseases? I also think that such screening should be undertaken on exit so that we can measure what we're trying to do.

I'm fully aware that there are many ethical objections to such an approach, but there may be other quite different ethical issues in opposition to NSPs anyway from the general community. While screening of that type may not be feasible for remandees because of their often too short period on remand, I believe that perhaps it's something we should consider for ACT-sentenced prisoners if and when they are accommodated in the ACT in the future. I should mention that the Corrections Health board has done some work at looking at this issue. The board established a subcommittee to explore the feasibility of the introduction of these programs. They commissioned a report, but it has been decided that the further consideration be left until it is considered in the context of the development of any new correctional facilities in the ACT.

Just to conclude what I have been trying to say, there is a drug problem in prisons and in that regard the ACT correctional facilities are no different. There is a risk of needle sharing, and clean needles and syringes help prevent the spread of blood-borne diseases. But we consider that the introduction of NSPs into our present custodial facilities would not be easily or sensibly run. We also contend that the introduction of such a program would lend perhaps tacit support to illegal drug use, raise duty of care and industrial issues, and be difficult to manage in our circumstances.

Further, the issue of NSPs in prison is well worthy of further consideration if and when the ACT's sentenced prisoners are returned and we have control of our total system. But, in my view at this point, any such program should be conducted with the group separate from the mainstream and I believe that it would need to involve strict control by health staff of any drugs used in the program.

THE ACTING CHAIR: Thank you very much, James. That certainly gave me some perspectives to consider. Access to syringes by intravenous drug users has many facets to it, as I think we've learnt. How do we grapple with the many cultures, particularly in correctional institutions?

Ms Lampard: Hi, James. My name is Jenni Lampard. I am from the Southern Area Health Service NSP. My question is with regard to the use of needles in the correctional setting in terms of tattooing. That's a big issue, from my understanding. From my experience working in a correctional facility previously, tattooing is something that is quite a concern and does spread blood-borne viruses rapidly throughout the prison population. Is there consideration of needles for that use?

Mr Ryan: It's not a big issue with us now, but certainly with the return of our sentenced prisoners it is a policy we would have to address. Personally, and it's only a personal view, I would be in favour or arranging for tattooing to be done on a controlled basis in such a way that you minimise any possibility of spreading disease as a result of tattooing. We know that the culture of these organisations is such that they're going to do it anyway.

Ms Madden: Annie Madden. I suppose, to lead on from what you just said, they're going to do it anyway. If we can apply that mindset to tattooing, we probably need to apply the same mindset to injecting drug use in the prisons, because it is already happening. There are already needles in the system; they're already being used.

It's my understanding of the overseas programs that are currently running prison-based needle and syringe programs that those that have been evaluated formally have shown that none of them have led to an increase in injecting drug use in the population, none of them have led to an increase in drug use generally, none of them have had a single incidence of violence against any prison staff, and none of them have had a single incidence of violence against any inmate on another inmate. However, in the Australian context, as you rightly pointed out, without the needle and syringe programs in prisons we have had the incident of an inmate attacking a prison staff member with a blood-filled syringe which, unfortunately, resulted in a HIV infection.

I suppose I'm asking for your thoughts on that, but it seems from the evidence that our environment without exchanges is much more dangerous. We currently have a system where things are really unregulated, uncontrolled. We don't know how many syringes are in the system, we don't know where they are, whereas those prisons that have exchanges have everything. Designated people have to have their syringes in a certain place, carry them in a certain way. It seems much safer.

Mr Ryan: I wouldn't argue that the systems that are in place in other countries don't work. From what I read and from what I saw, they seem to be workable. I would raise a very big question mark, though, with respect to what goes into the needle and syringe. I can't imagine that we would be doing the right thing if we didn't try and tackle both problems at the same time. I know that that, in turn, raises the bar. You've got to do that in the community first, perhaps—or do you? I don't know. But I would be very concerned about entering into such an arrangement without better control over what happens.

Keep in mind, too, that these other countries are, I think, looking at groups of people that are taken from their mainstream population, which is what I think we should do if we

ever get into it as well. I note that existing programs in Australia not involving NSPs that try and concentrate on the rehabilitation and care of drug users invariably seem to end up with a rather small group

There's a new arrangement coming in New South Wales which others here may know more about than I do. I looked at it with great joy, only to find out they're talking about 150 or 200 inmates out of their population of 8,000. In Victoria, the special drug program that is run at Bendigo is wonderful, too. It doesn't include any NSP, but it's only for a very small number of people, 200 or 300, out of the total prison population and they can't cope with being able to handle separately within that program women and indigenous offenders.

The issues of controlling the program properly, controlling all facets of it, and making sure that we can really cope with it, and I don't think we can cope with it in the mainstream, are the issues that I'd like to see satisfied before I'd be recommending to government, if asked, that we should go ahead with it.

Mr Bush: Bill Bush from Families and Friends for Drug Law Reform. Just two issues, if I could have your reactions to them. First, the duty of care, as a person with some legal training. The question of duty of care is not just limited to that. I'd suggest that there is the possibility that the sexual partners and the children of inmates have much to stand by in terms of whether the person in prison has contracted hepatitis C, HIV or something like that. What is your reaction to that?

The second issue I'd like your reaction to is harm minimisation and cannabis. Of course, cannabis is much more detectable, both in urine samples for days and by the smoke. But would an easier option and one with fewer security concerns be to permit cannabis to be more widely used in prisons?

Mr Ryan: Thanks for that, Bill! The issues you raise with the extent of duty of care are very real and I certainly don't have the answers to those. About all we can do is address what we think are the duty of care issues within the facility. I suppose you could argue that we have a duty of care to our staff, too, and it's not just an occupational health and safety thing—it's a duty of care that we have to them.

It has been interesting to hear over the years, particularly about a decade ago, the arguments that have been emerging about the possibility of prisoners zero converting, if that's a term, whilst in prison and there appeared to be a great struggle to find information to prove this. And then there was one or two. I don't know how many there are now. The point was, though, that it didn't matter if there were dozens or one or two—one or two is enough, thank you very much. But so too are one or two officers who are injured in the course of their duties because we don't handle the situation properly. What was the second question, again?

Mr Bush: Marijuana.

Mr Ryan: Marijuana. I'm not even going to go there. I don't think that it's our place in corrections to be trying to set standards for the use of a drug that is prohibited, at least to

some level, in the community and that's that. I know that in other jurisdictions, even in an unsaid way, the attention given to finding and preventing the introduction of marijuana is far less compared with that of other contraband.

Ms McConnell: Marion McConnell from Families and Friends for Drug Law Reform. I guess what I want to say is a comment rather than a question. I just feel that I have to say this, and I've said it many times before.

In your introduction you were speaking about many of the people on remand being there for drug-related issues. I think you said that between 70 and 80 per cent of people on remand are there for drug-related crime or drug-related issues. Many of these people have an addiction. We should be having more early intervention programs so that people don't end up in remand and don't end up in prison for what to me and many people in our community is a health issue.

We cannot cure a health issue like addiction through punishment. We need to give these people treatment and help. Many of them have mental illnesses, many of them come from poor backgrounds and so on—not all, but many. I guess I'm directing this more to governments. We really need to have policies whereby these people do not end up in remand or end up in prison.

THE ACTING CHAIR: Thank you. I think that's a very commonsense comment. I suppose what really is getting to me through this whole discussion, James, is the fact that we're talking today about access to syringes by intravenous drug users and they have a problem. How do you cope with that? I've no idea what happens to a person who needs a fit and who gets into prison and hasn't got this fit. Isn't that a problem in itself?

Mr Ryan: Yes, and they, first of all, are helped to the extent that they're able to be or willing to be by the health services, but far too many of them find that those options are not what they want and they seek the drug of their use by some other means, and it appears to be readily available. All we can do is keep on chipping away at the problem. It's such a problem that discussions or talks or groups such as this have to keep on talking about it.

I always feel a little bit powerless because we're right at the end of the whole problem and we can't solve the problem. We're just trying to deal with a group that have been foisted upon us because of failures elsewhere in society and we can just do our best to try and uphold the law, and that's it.

Mr Levy: Michael Levy, Corrections Health Service. First of all, I'd like to acknowledge that the points that you've brought forward at least give parameters for further discussion. My sense is that in New South Wales we haven't even acknowledged that needle and syringe exchange does exist in prisons overseas. We haven't even broached the issue of safe injecting facilities in prison and going beyond that to therapeutic prescription of drugs of addiction. You've already raised some very interesting points and that must be acknowledged.

The Corrections Health Service has made a formal submission to this inquiry and in that we note with a caveat that the New South Wales government does not support the

provision of sterile injecting equipment to prisoners at this stage, but we know that we work in an environment where methadone is now allowed and condoms have been brought in following a class action. I think it's a fair estimate that, one way or another, syringe or injecting equipment exchange will be in Australian prisons at some time in the future, whether it be by the grace of custodial authorities, by the pressure of health authorities, by the courts—a very likely possibility—or just by pressure from the community, political leadership I suppose you call that.

We're then going to be faced with the application of what is a tested strategy in a limited number of jurisdictions overseas. You've mentioned Spain, Switzerland and Germany. There are also two prisons in a country called Moldova in central Europe which have syringe exchange and each have adapted their own local needs. We're going to have to apply those lessons to the Australian environment.

You've already noted many times the Australian prison systems are violent. In anticipation, we have to address the issue of violence in prisons. We have to address the issues of officer safety, the perceptions and the real threats to safety that officers have, and the violence that is perpetrated by prisoner on prisoner. The level of violence is unacceptable. It's not acceptable in the community, less so inside where we have a duty of care. That would impact on our ability to supply syringe exchange when the time comes.

THE ACTING CHAIR: Thank you for that comment. I was just thinking of something when you said that. We tend to think that we have to reinvent the wheel. It's about working smarter, not harder, and it's about human life, it's about protecting. We do have a problem and we'd all like to see that we had no problem. I think you have raised some valid points and we need to look at world best practice. You're quite right, James, this facilitates that and I commend our Chair, Kerrie Tucker, for bringing this on today.

Ms Davies: Hello, James. My name is Robyn Davies. I work for the TOP program in the ACT Division of General Practice. I'm a member of the alcohol and other drugs task force and I'm a nurse at the periodic detention centre. There are only three of us and we only work Friday nights. You made interesting comments about the detainees and I would like from the workface to suggest to you that you do have withdrawal packs for the detainees in periodic detention.

At the moment, they don't have access to any of those facilities. 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.

There is a lack there where they don't have facility to withdrawal services in periodic detention. They do have methadone, but that is a little bit wobbly. You often get people coming in who have just started on methadone and they haven't gone through the system adequately and those people start to feel uncomfortable on the weekend, although less often.

Finally, I'd like to comment that perhaps if you were to engage with the thought of introducing a needle and syringe program in corrections in the ACT the periodic detention centre would be an appropriate place to start, because you could separate those people for their injecting at least and they are there for such a limited time that they probably wouldn't have the incentive nor the opportunity to cause the occupational health and safety issues that you're so concerned about. Perhaps you'd like to comment on that.

Mr Ryan: They are all very interesting points that I think we should look at. Certainly, it's apparent to me that a number of our periodic detainees do experience difficulties during the weekend, probably for the reasons that you say, and some of them don't even get to start their weekend because on arrival and on testing, perhaps when they see you or see some of the officers, they're sent home.

The way we run PD in the ACT is a bit different to New South Wales. At any time, if a detainee feels that he or she doesn't want to participate, they can walk away. We don't wrestle them down at the door and say that they have to stay there, but we do say to them that they are likely to finish up being breached or deemed not to have served. The opportunities for them to get out on the weekend are many, perhaps too many. In fact, we're revisiting the ability to breach, because at present they get three strikes before they're out, in addition to the ability to arrive for the weekend, just as a schoolboy might, saying, "Here's a letter from my doctor to say that I'm not going to stay here this weekend." We're perhaps a little bit too weak on it.

As far as introducing needle and syringe programs at PD, I'd acknowledge that as a starter it would be an easier place perhaps to do it than the remand centres, but a lot of the other problems I've mentioned still would need to be addressed before I'd recommend it to government, but these are the sorts of things we should be talking about and I look forward to talking to you later about the earlier suggestions in relation to the condition of these people on withdrawal and so on.

As far as the difficulties they're experiencing with methadone, we don't really have any control over that. They get their dose and they arrive. I might add that it's the only place in the ACT where prison officers actually arrange for the dose then to be delivered. At the two remand centres, the prison officers won't do it, and took us on on a previous occasion and won their case to say that that's not their job. Meanwhile, quietly they are doing it at the periodic detention centre, at least in some form.

THE ACTING CHAIR: Thank you, yes.

Mr Vumbaca: Gino Vumbaca from the National Council on Drugs. Thanks, James, for the presentation. It seems to me that, for 15 years now—probably since 1987—we've been talking about HIV prevention measures in prison, the same as in the community. The debate has centred on condoms and needles in particular. In the past, we've worked on some of those issues in New South Wales.

When the line was finally broken and they decided to trial condoms, we saw that a lot of the theoretical arguments about what the problems would be—the industrial problems in particular—didn't materialise. What we saw was that, from the three jails they were piloted in in New South Wales, they were able to extend that out to all the prisons.

I'm wondering what your view is now. Has the time come to pilot a needle and syringe exchange program within a prison, to see how real some of those problems are and, if they do exist, what can be done to deal with them—or if they can't be dealt with properly? In a way, there are valid arguments on both sides of this. You can see points of view on both sides, but the time has probably come to say, "Let's do it and see what the problems are in reality."

Mr Ryan: Thanks, Gino. I learnt much of what I know about this subject from Gino many years ago and it has stood me in good stead. No, I don't think it's time. I certainly wouldn't be saying that now is the time for the ACT to embark on a pilot program. I think we need to get a grip of our total system and talk through these issues, before we get to that point. I know you are, and have been for a long time, anxious about this. All I can say is that there's a way to go yet.

THE ACTING CHAIR: Thank you, Mr Ryan.

Mr Coase: Daniel Coase, AIDS Action Council. I'd offer a different view—that it's precisely the right time to do that sort of trial right now. We're not trying to, in the ACT perhaps with the building of a new prison, amend an existing system or cope with fears of a particular culture that's been long ingrained in prison systems elsewhere.

The reasons I've heard advocated for proposing an ACT prison is that it will be from a different culture, because people are unhappy about the way the ACT prisons are dealt with in the ACT system. I would have thought this is the time to have the discussion—at the beginning stage of the debate about what a new prison would look like, how it would operate and what programs it would offer.

THE ACTING CHAIR: Thank you, Daniel.

MS TUCKER: Firstly, you said that the Corrections Health Board looked at this issue and decided it wasn't something to be pursued until we had a prison. I'd be interested to know when the Corrections Health Board did that work, and if the committee can have a copy of whatever report they came out with. Secondly, you just said that you think we've got a way to go yet—and that there are more steps we have to go through. I'm not clear what those steps are. I'd like you to elaborate.

Mr Ryan: Thank you, Kerrie. The Corrections Health Board has not yet dealt with that report. What they've said is that they'll deal with it in the context of any new facility. They've yet to go through the process of taking the report formally and dealing with it, although it's sitting there. They haven't dealt with it at all. As far as the steps that we need to go through are concerned, I suppose you're coming from the same line as some others here who ask, "Why not start to trial this now?"

MS TUCKER: No, I want to know what the steps are that would make you satisfied that it was legitimate to have a trial. I want to understand what you think should happen.

THE ACTING CHAIR: Kerrie's asking what the steps are. You wanted to know what the steps are. Is that right, Kerrie? I am sorry. People at the back couldn't hear.

MS TUCKER: The steps Mr Ryan thinks are necessary.

Mr Ryan: Firstly, the easiest or most obvious one is to see how we can get across the very real industrial issues. For what it's worth, we received feedback from our officers some years ago in the context of their last agreement—not the one that's about to be signed—that, whilst they didn't agree in any way with this prospect, they were prepared to talk about it. We'd need to go through that with them.

In my view, we'd need to see how, in the context of the small population we have, we're going to deliver it. I'm not convinced, at this stage, that you can simply walk in there and put in place, in every cell, the sort of system we see operating overseas—where they would have a syringe on display in a prominent place so that there's some sort of control. I don't think we can do that. I don't think it's right to do that, in any shape or form, for those who are not interested in the program. I don't think that's the right thing to do.

To appreciate that, I think that those who are pushing this line need to go and look at the Belconnen Remand Centre. I don't know whether you've been there. It hasn't changed; it's perhaps got worse. It's more overcrowded than before. We have a devil of a problem, as I mentioned, just handling the separations we need to handle—much less handle the separation I'm suggesting. If the health services believe there's a group which can be handled only in this way, then it seems to me that, in turn, we have to separate them from the main stream and then address the other problem I raised, of how we control what goes into those needles and syringes.

I don't think you can simply say, "There are the needles and syringes—you're on your own—find your own stuff." I don't think that would work. There are many issues and a lot of talking would go on before we got to that point. What I'm saying is that I don't think we should, in any way, close off the prospect of somehow doing better in relation to the problem that's posed to us by the use of dirty needles in prisons.

THE ACTING CHAIR: Thank you, James.

Ms Lynch: I am Jane from Winnunga. I am the alcohol and drug nurse. I am concerned about needle exchange in a remand setting. All our customers are in remand—they've not been sentenced. If they are drug-screened prior to being sentenced, or prior to many of their court appearances, this may, in fact, put their sentencing at risk. A lot of our clients are sentenced to rehabs, rather than incarceration. That was an anecdotal point.

I have no view against syringes in prisons, where people have been sentenced to a period of time, but I do have concern that a lot of our users are young, and it will certainly impair their treatment and sentencing options, which may be a rehab. That was just a statement.

I know it's not connected to needle exchange but, in respect of Canberra, a large proportion of our clients are in BRC. To comment on the two who were caught out at Symonston, they were bored. I guess we have to work around their boredom and craving. I know they cannot get methadone out at Symonston—it's available only at Belconnen. I guess we have to work more about their desires to use, and their misbehaviour, rather than wanting to constantly use. That's a little bit of evidence. They are clients of our service as well.

THE ACTING CHAIR: Thank you, Jane.

Mr Ryan: This is only my opinion, but I think there's a long way to go before you would get the general community in the ACT to agree to such a program, particularly if such a program were accompanied by the caveats I have placed on it—namely that, if you're going to do it, you'd better watch what goes into the needles and syringes as well.

THE ACTING CHAIR: Thank you.

Mr Schwarz: My name is Peter Schwarz. I'm a street outreach worker with Open Family. I'm rather concerned at the position ACT Corrective Services is taking with this. I dealt with a young person who recently got out of BRC. He explained to me that he knew of one syringe being passed between 14 prisoners at the moment. These people are going to come back into society—a lot of them will. We have an obligation to these people to find an alternative. Obviously what's happening now isn't working.

Mr Ryan: No—and I accept the huge problems that attend the existing system. I've been through those problems in detail. That aside, there are huge problems with the solution you're suggesting, just as there are huge problems that attend any other solution, I would suggest—namely, don't have prisoners mix with prisoners, and don't have them mix with visitors. We can, sure as hell, stop it.

There are huge problems associated with other things I've mentioned such as let's take these blood samples, and keep taking them until we find out where it is—and keep them all separate. It's not easy. I accept the points you're making. However, I don't think there's a straightforward answer to the problem, especially as that straightforward answer should be that we immediately make needles and syringes available out there without some study and control of what the hell we're trying to do. That's the reason for my position. I know you don't like it. I don't like the situation we're in either, but we've got to keep trying to work our way through it.

THE ACTING CHAIR: Thank you, James. We will take one last question.

Ms Hart: Probably for my own peace of mind, I wonder whether there may be a little bit bigger picture here. We know that not only visitors supply prisoners with contraband. Perhaps the bigger picture is that maybe we have to admit that there are drugs in prisons, coming in through the guards.

Mr Ryan: I'm sorry you leave the list there. You could add that they perhaps come in with lawyers, visiting chaplains and health workers—the list is endless. I will tell you

what: I'm with you. I think it would be good if we could treat everyone who enters the facility as equal in this regard and leave them all, including staff, open to search processes that are random, or whatever they may be, in a way that gives us a better picture of what goes on.

Once again, there'd be industrial issues with that, but I think that sort of thing is something we can overcome and do in the future. It would be harder for us, though, to get to the point where we search all of those other groups I mentioned. Let there be no doubt about it: anyone who enters a prison under those circumstances, as a worker or someone assisting there, is possibly able to bring something in, just like a visitor—perhaps more easily than a visitor.

THE ACTING CHAIR: Thank you very much. Ladies and gentlemen, given that it's nearly 3.45 pm, we want to move on. I'm not sure if you're able to stay until the end of the session, or do you have to go?

Mr Ryan: No. Unfortunately, I can't stay. I must apologise that I wasn't here earlier today—and I'm missing four other staff who I know would like to be here. I did receive feedback from this morning's activities before I came across, and I'll be chasing through whatever happens later this afternoon as well. I believe this is a very important and necessary gathering, and I think we should keep talking about it.

THE ACTING CHAIR: On behalf of the committee, I'd like to thank you for coming. Ladies and gentlemen, please join with me in thanking James Ryan, Director of ACT Corrective Services. I'm sure you all know where to find James, anyway.

THE ACTING CHAIR: If we can have your forbearance for a little longer, we're now going to move to our final session. We have the pleasure of having Dr Alex Wodak here to do that for us, in his very amiable and capable way. Welcome, Dr Alex Wodak.

Dr Wodak: Firstly, thank you very much for inviting me to give this talk, and also earlier today. I have enjoyed coming along here today. It's very important that we examine this issue. The needle and syringe program in the ACT has been going for 13 years. It's important to look back at how it has been working. Also, it's timely that we look into the future and try to figure out where the gaps are and where we need to do things a little bit better, and that's really what my talk is about.

I'm going to talk about five questions. Firstly, does HIV among injecting drug users matter? Secondly, do needle and syringe programs reduce HIV infection among injecting drug users? Thirdly, are needle and syringe programs safe? Fourthly, should we be worried about HIV infection among prisoners? Fifthly, what should we be doing about HIV infection among injecting drug users in prisons?

We've already discussed the last two of those questions for a while this afternoon. Let's turn to the first question: does HIV among injecting drug users really matter? I've mentioned already this morning that we've got a number of very well documented examples around the world of countries where HIV infection has spread very rapidly among injecting drug users with devastating health, social and economic consequences and then have spread rapidly to, unfortunately, spark a generalised epidemic in the entire community. I mentioned the example of Thailand. There are many examples now and, unfortunately, from several continents in the world.

The end result of this is spectacularly higher health, social and economic cost. When we're considering this question, the policy framework that is relevant here is not what's possibly going to happen or what's probably going to happen, but I think what we have to do is to consider the worst-case scenario. We're certainly entitled to hope for the best, but policy should be based on preparing for the worst.

When we design a bridge or any civil engineering system, the whole system is overdesigned for the worst-case scenario. The bridge might be designed with the possibility that at any one stage there'll be 200 tonnes of vehicle on the bridge, but the bridge is actually then built so that it can withstand 400 tonnes just in case there's a miscalculation. So we should overdesign to give the benefit of safety to the general public.

I think that in the last discussion we had that was the quality that I've been missing out on. We're not just designing HIV/AIDS policies for this generation, although that's important. Let's not forget that we're designing our policies today for our future generations—for our children, for our grandchildren—and we mustn't ever forget that. We mustn't ever forget that HIV prevention measures among injecting drug users have been put under the microscope for 15 years and, as you'll hear later on in this talk, the evidence really is overwhelming that they are effective and also that they're safe. I'll go onto that now.

Let's turn to the second question. How good is the evidence that needle and syringe programs actually work? It was mentioned before in the introduction that recently I've been reviewing this evidence for the World Health Organisation, particularly for a project they've got running which is called evidence for action. It has caused me to systematically read the needle and syringe program literature, which is now quite extensive. I was never really confused about my enthusiasm for the evidence that needle and syringe programs work. But, having read this literature in a fairly systematic way over many months, the evidence is even more overwhelming than I thought it was in the first place. As I said, I was never in any doubt that the evidence was very strong, but it really is extraordinarily strong.

The approach that we took to examine this evidence was that we put it through a framework which was designed by an English epidemiologist called Bradford Hill. I give a warning that there's a technical phrase coming up now. Bradford Hill addressed himself to the following question: under what circumstances would it be appropriate for researchers to—here's the technical bit—draw inferences of causality from studies of association? Sorry for the jargon.

What that means is that epidemiologists often look at populations and compare the proportion of the population that has been exposed to a particular risk factor and then look to see what proportion of that population then was observed to develop a particular illness or disease. Those are called studies of association. Epidemiologists continue to point out, quite appropriately, that it is dangerous to assume, simply because two things are associated, that the connection between the two things is causal.

When I was a medical student, I remember our professor of medicine flashed up a slide showing the increase in the number of radio receivers in Australia and that was very highly correlated with the number of heart attacks in Australia. It's remarkable how close the statistical association was but, obviously, it was nonsensical to say that radios caused heart attacks. So this is where the inference of causality is wrong.

Bradford Hill designed a set of nine criteria and these are how these days we work out that lung cancer is or is not caused by tobacco smoking. In the case of lung cancer and smoking, obviously, we have drawn the inference that the connection between the two is causal, that smoking does cause lung cancer. Bradford Hill identified these nine criteria and we put this evidence for needle and syringe programs through these nine criteria. We have added another five criteria that are often used. They have been added since Bradford Hill did his work, but weren't part of the original work.

That is what I'll be running through with you today. The starting point is that the highest test that we often put questions to in public health medicine, but especially in clinical medicine, is the randomised control trial. There are certainly lots of critics of randomised control trials, but when it comes to policy makers accepting evidence, I'd have to say that that's the evidence they're often looking for and, for very good reasons, randomised control trials simply are not possible with needle and syringe programs.

In those countries where needle and syringe programs are already legal, its logistically impossible and possibly ethically questionable to try to randomise injecting drug users to

either attend or not attend needle and syringe programs. In those countries where needle and syringe programs are not yet legal, it's even more difficult to randomly allocate some injecting drug users to attend needle and syringe programs and others not to attend needle and syringe programs.

Therefore, what we're left with is a very large number of what are called observational studies. We look to see who attends needle and syringe programs and who doesn't and look to see what the rates are of infection in both of those groups and the risk behaviour in both of those groups. The problem that bedevils these kinds of studies is what's called selection bias, that these two populations may not be exactly comparable, so it may be that any differences you observe in risk behaviour or in HIV infection rates may not be due to the fact that they are attending or not attending a needle and syringe program, but due to other differences that were not measured in the first place.

We've got a real problem in that randomised control trials aren't available here, but randomised control trials are very rarely available in public health anyway. Even in a lot of clinical conditions it's very hard sometimes to actually implement a randomised control trial for a particular area. So we're left with looking at these nine criteria.

The starting point for us was looking at the biological plausibility. If you provide clean needles and syringes and also remove dirty needles and syringes from circulation, there's an inherent high biological plausibility that this should reduce the incidence of a viral infection that is carried, we know, through the needles and syringes. So that's one of the criteria that are satisfied. There's more to it than that.

We've had lots and lots of studies, as I said before, comparing people who attend needle and syringe programs and people who don't attend needle and syringe programs and the findings that come across in almost all of these studies are that where injecting drug users attend needle and syringe programs we have much lower levels of risk behaviour, we have lower HIV prevalence—that is, the number of old cases of HIV is much lower—and we also have lower HIV incidence, that is, a lower number of new cases of HIV infection. But the problem is that we can't exclude the possibility that there's a problem with selection.

There have been two or three studies that have actually found more HIV infection among people attending needle and syringe programs. These studies were done in Montreal and Vancouver in Canada and a very careful examination of those studies has found very good reasons why those findings occurred in Montreal and Vancouver. There are some lessons to be drawn from that. In the case of Montreal, it's clear that one of the problems was that community resistance to the idea of having needle and syringe programs meant that there were far too few needle and syringe programs to cover Montreal, there wasn't enough coverage, so the drug users travelled from outer Montreal into the centre of the city.

Unfortunately, there was an inadvertent mixing of populations that shouldn't really have mixed, there was a very high risk population in inner city Montreal, high rates of mental illness, high rates of homelessness, and the people travelling in from suburban outer Montreal mixed with this population and shared needles and syringes. That's almost certainly the reason there was a higher rate of HIV infection among people who attended the Montreal needle and syringe exchange.

In the case of Vancouver, there's another lesson for us, particularly now with us having this recent period of heroin shortage, which has unfortunately had an unintended consequence of increased use of psycho-stimulants by injection, that is, increased use of amphetamine and cocaine. Vancouver, the largest port in North America, with a beautiful harbour like Sydney's, is a major entry point for drugs into North America and, over a very short period of time, about 10 years ago Vancouver changed from a predominantly heroin-injecting city to a predominantly cocaine-injecting city.

Vancouver had the largest needle and syringe program in North America which, by our standards, was pretty small and had very little treatment and other services for drug users. Within a few years of that switch from heroin injecting to cocaine injecting, unfortunately, Vancouver had a major HIV epidemic with up to a quarter of the drug injectors in Vancouver infected. Unfortunately, that epidemic continues to rage at those sorts of levels. Also, unfortunately, that epidemic among injecting drug users in Vancouver has led to an HIV epidemic spreading to non-injecting drug users, to the general population of British Columbia. So there are very serious lessons to be learnt from those unfortunate events in Canada.

We've also had modelling studies. How these work is that people produce mathematical formulas or computer programs that predict the course of an HIV epidemic and they make these models up from careful observations of what we know about the factors that contribute to the spread of the epidemic. One particular modelling study was very influential. It was carried out in the town of New Haven in Connecticut, where Yale is based. Some very skilled mathematicians, computer experts and someone from the School of Business Management at Yale University, Ed Kaplan, did these studies.

These studies were done with very sophisticated techniques where they could actually track individual needles and syringes moving through the system. The needles and syringes had bar codes and they followed these things with fanatical zeal. This research study was extraordinarily influential in the United States and, as a result of this study, New York City turned around from opposition to needle and syringe programs to grudging acceptance of needle and syringe programs. That was very important in the history of this in the United States.

This particular research study has been rigorously reviewed and re-reviewed and the two things that the reviewers have said are that, firstly, the studies were very competently and very conservatively done and, secondly, that the finding from these modelling studies that needle and syringe programs in New Haven reduced HIV infection by about 30 per cent was undoubtedly too conservative, that the effectiveness of that needle and syringe program was almost certainly more than 30 per cent. But still it's better to be too conservative.

We've had a lot of studies which have looked at the replication of the findings around the world. Overall, this involves a very large number of studies. The studies have been done by different authors using different designs and have occurred in different countries with very different conditions and, very notably, at different stages of the HIV epidemic. This consistency of replication is something that epidemiologists look for; this is one of the criteria.

We've also had more recently a number of what are called ecological studies. This is where the researchers look overall at communities and look to see that they don't measure any other factors except whether they've got needle exchanges or not got needle exchanges and looked at the HIV rates. The *Return on investment* study that's been mentioned a couple of times today already looked at 103 cities around the world that had at least two surveys of HIV infection among injecting drug users and they divided the cities into those with needle and syringe programs and those without needle and syringe programs.

Overall, the HIV prevalence in cities without needle and syringe programs rose by an average of 8 per cent per annum. Overall, for cities without needle and syringe programs, an increase of 8 per cent per annum. The cities with needle and syringe programs had an overall decline of 18 per cent. For cities with needle and syringe programs a decline of 18 per cent per annum and without a rise of 8 per cent per annum.

The question here is: do you want your children, grandchildren and great grandchildren to live in a country where HIV is going to be rising among injecting drug users by 8 per cent, or do you want it to be falling by 18 per cent? I had two beautiful slides at this point comparing HIV prevalence in Songkhla province in Thailand with HIV prevalence in injecting drug users in Sydney, Australia. These two slides show HIV prevalence over the course of about 10 years in Thailand rising from about 10 per cent to 30 per cent and in New South Wales falling over 15 years from slightly above 2 per cent to under 2 per cent.

So we've got very consistent findings and in many of these findings we've got a very substantial effect. It's not just that needle and syringe programs work; they are actually also very effective and it's important that we keep on looking at the relative benefit—not just the absolute question of whether they are effective, but they are also very powerful, at least for HIV they're very powerful, but for hepatitis C they're not so powerful.

It was estimated that if the US had implemented needle and syringe programs at the same time as Australia, about 1987, and they looked at a period from 1987 to 1995, there would have been somewhere between 4,400 and 10,000 fewer HIV infections and this would have saved somewhere between $US240 million and $US540 million. This study, by Peter Lurie and Ernest Drucker, was published in the *Lancet*, a very reputable journal, and there were seven major steps in carrying out that study where each time they had to feed in some variables. They had variables of measurements estimating the extent of a particular factor.

In each case, in each of those seven steps, they fed in the most conservative value, so these are very conservative findings, very widely criticised by needle and syringe program advocates in the United States who thought they were being far too conservative, but it is much better in this case to be too conservative. That's quite a considerable saving in terms of HIV infection and financial costs, particularly when you remember that this is a very conservative estimate.

Another criterion we look at is what are called temporal effects. Did A follow B? Did the introduction of needle and syringe programs precede a change in risk behaviour and

precede a change in HIV infection rates? Even more to the point, did the removal of the needle and syringe program precede an increase in risk behaviour and an increase in HIV infection?

We've got lots of studies that show that the introduction of a needle and syringe program does get followed by a reduction in risk behaviour and does get followed by a reduction in HIV infection. There's one study—sadly, there's only one in some ways—from Connecticut where a needle and syringe program was closed and, fortunately, we had measurements before and afterwards and, as you'd expect, risk behaviour was far higher after the needle and syringe program was closed compared to when the program was still going.

There has been a number of comprehensive reviews of all of this data. In particular, I draw your attention to five comprehensive reviews that were conducted by US government agencies or commissioned by US government agencies. Following the results of those five reviews being published, there was a consensus development conference in 1997 convened by the National Institute of Health, which is roughly equivalent to our NHMRC.

All of these six comprehensive reviews reached the same two identical conclusions: needle and syringe programs are effective and needle and syringe programs do not increase illicit drug use. They don't decrease the age of initiation of illicit drug use, they don't increase the frequency of injecting drug use, and they don't increase the duration of injecting drug use. The conclusions of these six comprehensive reviews have become much more confident over time. The more the evidence comes out, the clearer it is that we're looking at something that really is very powerful.

I might mention also that there was another review, a kind of secret review. It was a US government internal document which was never meant to reach daylight and which examined all of these five reviews and said that the observations are correct, the conclusions that were drawn from the observations were right, and the recommendations that were made on the basis of the conclusions were right. This review was undertaken as part of a consideration in April 1998 for the Secretary of Health and Human Services, equivalent to our federal Minister for Health, declaring that the conditions had been fulfilled that allowed the US government to provide federal funding for the needle exchange system in the United States.

Unfortunately, it appears that President Clinton, who was president at the time, had lost so much political capital over events that had occurred in the Oval Office with one of his junior female assistants that he couldn't take more political flak on board by allowing federal funding for the needle and syringe program. In any case, this review did surface in the *Washington Post*, it was leaked by a patriot, and, as I said, it validated all the other reviews.

In addition, we've got evidence of other benefits. There has been a reduction in hepatitis B and C. That came out in that *Return on investment* study. But we still need more studies on hepatitis B and C to have a much more categorical conclusion about that. There is some evidence that needle and syringe programs reduce local and distant

bacterial infections, namely, abscesses and infections on the heart valve, bacterial endocarditis, brain abscesses and those sorts of things. There's some evidence that needle and syringe programs reduce those, but not fantastic evidence, I'd have to say.

There's better evidence that needle and syringe programs do increase referral to drug treatment and to other services. There have been several studies on this and some of the studies have increased the referral to drug treatment, but most of the studies in the United States have shown that the drug treatment was already full and couldn't take on any extra referrals. So the people got there but, unfortunately, it couldn't go further.

A number of studies have shows that needle and syringe programs are cost effective and there are at least 15 publications that show that harm reduction measures, which basically means needle and syringe programs, reduce more than 18 infections for every $US1 million spent. In the US, that threshold of 18 infections averted for every $1 million is considered to be the threshold for cost effective HIV prevention.

There are nine publications that there are over 50 infections averted for every $US1 million. The *Return on investment* study that was done here, commissioned by the Department of Health and Ageing, works out at over 200 HIV infections averted for every $A1 million, about 110 or 120 HIV infections averted for every $US1 million.

We've already talked about the *Return on investment* study. I can't emphasise enough how valuable a study that is. If there are questions about needle and syringe programs, they are really not about their effectiveness, their safety or their cost effectiveness. The questions are about the models of intervention delivery: how do you actually provide these?

One area that is most controversial but rarely gets discussed is the question of how much needle exchange we really need. There's been some talk here today that the ACT system provides, I think it was said, about 600,000 needles and syringes a year. That's terrific, but is it enough?

The way to work this out is to make a conservative estimate of how many injecting drug users you think you've got in an area like, say, the ACT, multiply that by the number of injections that you think each injecting drug user on average gets up to in a year, which gives you an estimate of the total number of injecting episodes, and then compare that with the throughput of your needle exchange system.

Remember that figure of 600,000. Let's assume that the ACT has got about 3,000 injecting drug users, and I gather that many people would consider that that's conservative. I'm being signalled that the estimate is about 5,000. Let's keep it at 3,000, but keep in mind that it might be much higher than that. Let's say that the average injecting drug user injects 60 times a month. We've got research data from Australia from 10 or 15 years ago that indicates that that is a reasonable estimate.

Let's assume that they only inject for 10 months of the year and that for two months of the year they are serving a bit of time in prison, are flat broke or the mother-in-law's visiting. Let's say that for 10 months of the year they're injecting and for two months of the year they're not injecting. That's about 600 injections per injector. That would mean

that if there were only 3,000 injectors—there might be 5,000 and we're not even counting the recreational injectors—and if they're only injecting 600 times a year, that means that the ACT has about 1.8 million injecting episodes a year, and you're providing 600,000 clean needles and syringes. That means 1.2 million of the 1.8 million injecting episodes involve a reused needle and syringe and possibly a shared needle and syringe.

That really puts this in a different light and makes us realise that if we're going to take this epidemic seriously, and keep in mind our children and our grandchildren, we will really have to ramp up our efforts. I think that there are limits to how much we can expect Joe Taxpayer to keep on forking out money for needle and syringe programs, even though they're dirt cheap—$122 million to run needle and syringe programs in Australia nationwide for 12 years.

But there are limits to how many times we can keep on going back to Peter Costello and asking for more funding for this. I think this is where we need to start looking at the deregulation side. Maybe we can get more coverage without a lot of extra dollars by deregulating some of this and having needles and syringes more available from supermarkets and other places like that.

Another of the questions that come up is: to what extent do we want fixed units and to what extent do we need mobile units? The advantage of the fixed units is that they have a lower unit cost, but the disadvantage of fixed units is that they're not quite so good at reaching vulnerable populations. Often, if you want to reach a vulnerable population, I'm afraid Mohammed has to got to the mountain; you can't expect the mountain to always come to Mohammed. I don't know the ACT well, but if you think that there are pockets of people who are particularly vulnerable in the ACT and are not getting to the needle and syringe programs, there's a good case to have mobile programs.

The populations particularly of concern are young injecting drug users, because they seem to be at higher risk, and inmates, as we said before, but we don't need a mobile unit for them. We should keep in mind gay male injecting drug users, because they're often a bridge to other populations. It's a way for HIV infection to reach from men who have sex with men through gay injecting drug users to the general population of injecting drug users, female injecting drug users and heterosexual male injecting drug users. They're a particular public health concern. Also, commercial sex workers who are injecting drug users are a particular concern.

Pharmacy outlets have the advantage of diversifying the population we're trying to reach. We have to remember that the population of injecting drug users is every bit as diverse as the population of non-injecting drug users, and we all know the population of non-injecting drug users is very diverse. We have to approach this problem as if we were trying to sell toothpaste or some other factor that we knew was of great benefit to the general population.

So we have to look at it, at least in part, as a marketing exercise. How can we saturate this population with clean needles and syringes for everybody's benefit, for their benefit and for everybody else's benefit? How can we also improve the benefits by linking people who do go to needle and syringe programs to other services—to primary health care, to drug treatment?

I think there's a very strong role for vending machines. The experience in New South Wales has been very positive. The literature on this is small, but it's very positive. I think what it tells us is that vending machines are very useful for servicing time zones that are otherwise very difficult to service. Maybe that's not an issue in the ACT; maybe it is, I don't know. They're also useful for servicing geographical parts that aren't met very well by existing fixed services and they can also be useful for servicing particular populations which are very wary of being identified.

There's the issue of whether we should be selling this equipment and, if we should be selling it, whether it should be general commercial and retail sale. I think we've reached the stage where we really do need to consider that. There are also issues about what goes along with needles and syringes. Should we be distributing or selling alcohol swabs, sterile water and tourniquets? These things increase the cost a little bit, but the cost effectiveness is very high.

There is a question about how much counselling and education is needed. I don't think we'll ever get good measures on that; we'll probably always have to make a judgment on that. I think there is a strong case to be made for having some part of the whole system which always has humans providing that service so that people who want to go and talk to somebody do have that opportunity.

Are needle and syringe program safe? The evidence is overwhelming. As I said, there's no evidence that you increase the number of injecting drug users, increase the frequency of use, or increase the duration. People have been looking hard for 15 years or more for this evidence and I think that it has to be acknowledged sooner or later that people have looked hard and that evidence doesn't exist. We have to stop policy makers saying that they have to assume that maybe these needle and syringe programs do increase illicit drug use, as maybe Mr Ryan was trying to suggest to us.

Should we be worried about HIV infection in injecting drug users in prisons? I think the arguments here really are overwhelming. They're really very much stronger than Mr Ryan suggested, but I acknowledge, as Michael Levy did, that he's obviously done some hard thinking about this. Roughly half the inmates in Australia are serving sentences for drug-related offences; that's a conservative estimate. Roughly half of those inmates will inject while they're in prison. The evidence in New South Wales is that people who go into prison inject more frequently than people who aren't going into prison and who are just average street drug users.

The average number of injections per month of people who are going to go into prison is about 100, compared to 60 for the average street drug users. Those 50 per cent of injecting drug users who will inject in prison reduce their injecting episodes from about 100 a month before they go into prison to about five a month while they're in prison.

There's a very important debate or question to be considered here and that is—Mr Ryan is probably right and others are probably right—that you can reduce the number of injecting episodes from what it is at present, but we really need to consider the benefit and the cost of doing that. By that I mean: how much of a reduction in injecting episodes do you get in prison and what sorts of things do you have to put up with in order to achieve that objective?

What's not talked about in this whole debate is the fact that the more you seem to reduce the number of injecting episodes in prison, and it's very hard to measure these things, the more you make each injecting episode even more hazardous. What's not understood by many people about those five injecting episodes per month of the inmates who do inject in prison is just how much more sharing there is in prison than outside prison. The average injecting drug user who shares outside prison these days might only share with two or three people from a very small social network, whereas the injecting drug user who shares in prison and who might spend 12 months in prison, which would be unusual, might very easily end up sharing with 100 different people and those 100 different people will come from a wide variety of different geographical and social networks that they're going to return to when they leave prison.

That is really why prisons are such dangerous places in terms of preventing an HIV epidemic in the general community. We've got a lot of evidence from lots of countries—it's indirect evidence, admittedly; Thailand is a good example—where still today if you look at HIV-infected injecting drug users in the community and ask them whether they've injected drugs in prison, it's a very strong predictor for them being HIV positive; so you can pick who's HIV positive from who has injected in prison. This is after a raging epidemic for 15 years in Thailand. There are many other countries where that finding also applies.

What can we do about HIV in prisons? I think the first point that we always have to come back to, as Marion reminded us earlier today in an indirect way, is reducing the size of the prison population. Western Australia has done this recently by eliminating sentences of less than six months duration. We have to start looking at this much more seriously and we have also to remember that the benefits are not only reduced HIV infection but also a lot of financial saving and probably many other benefits when we start looking at that carefully.

We also have to look much more seriously at non-custodial sentencing options, even for people who are serving sentences longer than six months. I think we also do have to consider providing the same prevention as in the community. Despite all the caveats that the commissioner gave us, we need much more education of inmates, officers and authorities about the real hazards that we're running with the policy that we've got at the moment. It really is a high-risk strategy.

The high-risk people in our community are not just the injecting drug users. Some of the high-risk people are also the decision makers and policy makers. We have to remind ourselves that all the evaluations that have been done of prison needle and syringe programs have had favourable evaluations and no untoward incidences have been mentioned. Part of this debate has to be to improve drug treatment in prisons. That means improving the capacity, improving the range of options and improving the quality.

Let me come to the conclusions. HIV infection among injecting drug users in the community really does matter. Secondly, there is compelling and consistent evidence that HIV infection is reduced by needle and syringe programs and there is some evidence, not nearly as good, that there are other worthwhile benefits. Thirdly, there is no convincing evidence of any serious negative consequences to date. Needle and syringe programs are safe; they do not increase injecting drug use.

Fourthly, we've got strong evidence that needle and syringe programs are cost effective. Fifthly, the magnitude of these benefits is very impressive. Sixthly, when we look round the world, in most places too little is being done too late. Despite all the praise that has been heaped on the program in the ACT, deservedly so, maybe the ACT program also needs to be increased along the ways I suggested earlier.

Seventhly, we have to remember that this is an area that needs persistent advocacy. In Australia, unfortunately, ministers for health and chief health officers have been derelict in this important duty that they have. We need the politicians to speak out on this issue, educate the community and remind the community why these programs are so necessary. The opposition to needle and syringe programs isn't just data-resistant; it really is largely data-proof, and we need community leaders who are accepted to make these arguments.

There is, though, reasonable community support. There has been questioning of this earlier today. When people have actually studied this, we do have evidence that the community does understand this reasonably well, but often the politicians, oddly enough, are way behind the community. Finally, I think we have to recognise that we need to follow the same general principles in prisons as we do for the community. Ladies and gentlemen, thank you very much.

THE CHAIR: Thank you, Alex. We don't have much time as we did say we'd finish at 4.30. If people are wanting to ask some questions of Alex or make final comments, I'm happy to stay another 10 minutes. Does anyone have something they would like to say or a question they would like to ask?

Mr McConnell: Brian McConnell, Families and Friends for Drug Law Reform. I've got some comments. I want to go a little bit further than what Alex said in terms of reducing the prison population. If I could make some suggestions for the committee on some things to look into.

Really, the issue is about the law and the consequences. If we're serious about reducing the prison population, we heard from Mr Ryan about the number of people in prison because of drug-related crimes and that's something that should be looked at, particularly the law on personal use. We heard earlier today that it can actively encourage unsafe use and unsafe practices, particularly on the disposal side. That is something the committee might like to look at.

I must say that I was a little concerned about Mr Ryan's presentation. It seemed to me that he was making an active attempt not to do anything that was going to be active opposition. The prescription that you asked him for, Kerrie, was really a prescription for finding the whole solution before we do anything about a partial solution. I thought that was a little less than satisfactory.

The other thing I'd like to comment on that wasn't mentioned today is the question of education. It seems to me that a part of the Achilles heel for the needle and syringe program is really to do with public education and, to some extent, a little bit of hysteria about finding a lost syringe or one that's been disposed of improperly.

As an anecdotal story that I mentioned earlier today, our house is on the way to a primary school and on a particular day not long after the primary school had some education program about what to do when you find a needle on the footpath or somewhere on the road the children concerned surrounded a needle that, obviously, had been thrown out of a car window as it went past our place and one of the children came in and found a responsible adult to dispose of it. That was an example of very good education for children. I think that things along those lines might help reduce some of the hysteria and remove the Achilles heel.

Ms Tongs: Julie Tongs, Winnunga. I'd just like to say that I really believe the reason why we've got so many of our people incarcerated in the ACT is because of a lack of rehabilitation services and other support services. We've got whole families that are affected by intravenous drug use. There could be six siblings in the family and they're all intravenous drug users. The mainstream model doesn't fit well with the way that we do our business.

We know that it would be expensive to try and have our own detoxes, but it would be good if we could come to some arrangement to have beds in detoxes and that we could actually visit people. Our people need a lot of support. There's that real fear of mainstream services and also there's a breakdown often because of attitudes and other things in mainstream services when our people get in. I think that people need to be supported to get through.

Another thing is that we don't just work with perpetrators, victims or whatever; we work with everybody. That's another dilemma. There might be somebody locked up in the remand centre or Goulburn jail, or even a kid in Quamby, but we're working with the whole family on the outside as well as the individuals on the inside. I don't believe that we need a prison in the ACT. I believe that we need a rehabilitation centre.

THE CHAIR: Okay. Thank you for that.

Mr Bush: Bill Bush, Families and Friends for Drug Law Reform. We have had so much focus upon drugs in prisons, but the reality is, as far as the law is concerned, that no-one is in prison because of drugs. They are there because they've committed some other crime—burglary, violence or something like that—but no-one is committed for consuming drugs, yet we seem to punish people so much in relation to their drug use. There is something crazy about this whole thing. Drugs are the thing that actually leads to the person committing these offences. They're not sentenced because of their drug use, yet in prison they're punished because of their drug use.

THE CHAIR: A good point. Okay, I think we might wrap up. It's been a long day. I thank everybody who's been here and participated. It has been very useful for the committee. We are going to have the transcript of these proceedings edited. I'll table it in the Assembly, hopefully—I need to consult with the committee, but I'm sure that they'll be happy to do so—so that it becomes a public document. Also, I should be able to arrange for copies to be made available, because I think it has been a really valuable discussion that has occurred today. Let's applaud everyone because everyone was so helpful. Some of the speakers have gone, but I thank everyone for their input.

The committee adjourned at 4.35 pm.