CHAPTER TEN

PREVENTING THE TRANSMISSION OF HEPATITIS C

The Terms of Reference received by the Committee specifically asked it to give ”particular attention to strategies for prevention”. The following discussion provides a detailed account of current preventative strategies in place for specific ‘at risk’ population groups including injecting drug users, inmates in the state’s correctional service, recipients of infected blood, health care workers and their patients and those involved in the skin penetration industry. A range of proposed preventative measures proposed to Committee Members during the course of the Inquiry are also reviewed and recommendations forwarded.

The National Hepatitis C Action Plan prepared for the Australian Health Ministers Advisory Council noted the important role to be played by prevention:

> *in the absence of a cure or preventive vaccine for Hepatitis C, education and prevention strategies remain the most important mechanism for controlling the disease in our community* (AHMAC, 1994:22).

The Action Plan considered the issue of a co-ordinated national education and prevention approach. The Plan made three recommendations in the area of prevention:

i. the development of a coordinated national education approach to Hepatitis C;
ii. a review by all states and territories and the Commonwealth of all current Hepatitis C education strategies for youth, injecting drug users, people with Hepatitis C and health service providers; and
iii. the increased availability of sterile injecting equipment (AHMAC, 1994:29-30).

The report proposed a national reference group comprising State and Commonwealth, community and professional representatives be convened to determine the details of a national education approach including priorities, respective roles and responsibilities, detailed strategies including time frames and costings.

Accordingly, an AHMAC Hepatitis C Education and Prevention Reference Group was formed. The Group’s report, *The Nationally Coordinated Hepatitis C Education and Prevention Approach*, was endorsed by the Australian Health Ministers’ Advisory Council on 20 October 1995.

The Reference Group recognised that a national education and prevention program must address both education for prevention (including the provision of the means of prevention), and education for treatment and care. It therefore developed priority lists of target groups for each of these categories. The priority groups for preventative education included:

1. People who inject drugs;
2. People who provide tattooing services and/or skin penetration services;

3. Key decision and policy makers;
4. Health service providers;
5. Correctional services; and
6. General community (AHMAC, 1995:9).

The following discussion will consider preventative strategies for five of these six groups. Strategies directed at key decision and policy makers will be considered in Section 11.1.

As has been discussed in Chapter One, 1995 also saw the release of the Report of the NSW Hepatitis C Taskforce. Unlike the AHMAC report which took a very broad brush approach to prevention, the recommendations in this report are very specific. Many of the recommendations will be discussed in the relevant sections throughout this chapter.

The issue of preventing the transmission of Hepatitis C was raised with representatives from NSW Health. Those appearing on behalf of the Department identified a range of programs in place to limit Hepatitis C transmission. They were not able, however, to identify the Department's policy to limit Hepatitis C transmission (for example, to reduce the transmission of Hepatitis C in the target populations by X% by a certain year) or identify the strategic direction used to fund and implement this policy. It would appear that the preventative strategies in place have been introduced in a somewhat *ad hoc* manner or are merely an extension of programs introduced in response to the HIV/AIDS epidemic a number of years ago (for example, methadone maintenance therapy, the needle and syringe program and peer based education).

The Department's submission also failed to identify current prevention policy and strategic direction. It merely stated that:

> *the Department has identified preventive strategies among those members of the injecting drug use community who initiate others to injecting drug use and for high risk youth as being a high priority for development* (NSW Health submission).

Despite such strategies being a "high priority for development" the submission falls short of identifying them, leaving the Committee to question whether any strategies have actually been developed.

Appended to the Department's submission was the results of a mapping exercise of Hepatitis C education, prevention and training initiatives provided by Area Health Services and other relevant agencies such as CEIDA, the Hepatitis C Council of NSW, HepCare, Kirketon Road Centre and the HIV and Health Promotion Unit of the Department of Corrective Services. This document does identify preventative programs being introduced and implemented at the local health area level. Such initiatives are commendable as they meet local needs. The Committee is concerned however, that overall strategic direction is not forthcoming from the Central Agency.

The Committee was not able to ascertain the overall direction NSW Health is taking to limit the transmission of Hepatitis C. Given the magnitude of the Hepatitis C epidemic, the lack of policy guidelines and strategic direction is of great concern to the Committee.

It is not surprising then that expert witnesses appearing before the Committee commented on the inadequacies of current preventative policies and strategies. Professor Batey, for example, told the Committee that:

> *I feel [policies] are not adequate for a disease which is transmitted by blood contamination of individuals through broken skin or venous system directly. I think that has got to be hit head on. If we are serious about Hepatitis C rather than serious about stopping drug use in the community by increasing the war strategy, then I think much more needs to be done* (Batey evidence, 27 October 1997).

Professor Batey pragmatically warned that prevention solutions have to be found unless governments:

> *want to be paying out a billion or two [dollars] in the new millennium treating end stage liver disease from this disease* (Batey evidence, 27 October 1997).

The Committee considers it imperative that policy and strategic direction be provided by NSW Health to address the issue of Hepatitis C prevention. It therefore wishes to see both the NSW Hepatitis C Policy Statement and Strategic Plan (proposed in Recommendations 28 and 31) address this issue.

RECOMMENDATION 88:

That the NSW Hepatitis C Policy Statement proposed in Recommendation 28 clearly state the Department's policy to prevent the transmission of Hepatitis C amongst target populations. The Committee further recommends that the NSW Hepatitis C Strategic Plan proposed in Recommendation 31 clearly identify the direction to be taken to prevent the transmission of Hepatitis C amongst target populations. The Plan should identify existing preventative strategies, include a range of new preventative measures that are innovative and effective and be the basis for funding and evaluation.

10.1 PREVENTING THE TRANSMISSION OF HEPATITIS C AMONGST INJECTING DRUG USERS

Numerous witnesses spoke of the need for preventative strategies to target injecting drug users. Farrell, for example, stated that:

> *my top priority would be primary prevention of injecting drug use, because injecting drug use is not the only risk factor, but it is certainly the remaining 95% plus risk factor* (Farrell evidence, 28 November 1997).

Similarly, Batey informed the Committee that:

> *I think our strategies for prevention . . . are not adequately addressing the fact that the biggest group of newly infected people are injecting users and we have to ask why that has to continue as such. People are wrestling with it. I think we need to wrestle a bit harder and come up with different policies fairly quickly* (Batey evidence, 27 October 1997);

and

> *I think the policy now has to focus on those currently using . . . The policy to stop the new cases must tackle the issue of injecting and injectable type drug using because that is where the new ones are coming. If you could stop that eight to ten thousand per annum now and just deal with the 150,000 that we have got, we would be a damn sight better off* (Batey evidence, 27 October 1997).

As has been discussed, there does not appear to be any policy and strategic direction in preventing the transmission of Hepatitis C. The same can be said for the injecting drug users population group. Given the blood borne nature of the Hepatitis C virus and the considerable risk this poses for injecting drug users, the Committee considers it imperative that the prevention of Hepatitis C amongst this group be treated as a priority.

RECOMMENDATION 89:

That the NSW Hepatitis C Policy Statement (proposed in Recommendation 28) clearly identify the Department's policy to prevent the transmission of Hepatitis C in the injecting drug user population. The Committee further recommends that the NSW Strategic Plan (proposed in Recommendation 31) clearly identifies strategies that will be put in place to prevent the transmission of Hepatitis C amongst the state's drug injecting population.

It was widely recognised and acknowledged by those appearing before the Committee and making submissions (eg. NSW Health submission) that the major barrier to halting the epidemic amongst injecting drug users is the illegality of the activities associated with injecting drug use.

The following discussion examines preventative strategies already in place for injecting drug users as well as discussing a number of proposed prevention measures raised by witnesses during the course of the Inquiry. The discussion also looks at a profile of

injecting drug users and the concept of harm minimisation that is the basis of most prevention strategies.

- **A Profile of Injecting Drug Users**

It is difficult to ascertain with precision the size of the injecting drug using population in New South Wales given that the activity is an illegal and highly stigmatised activity in the general community. People are reluctant to identify themselves as injecting drug users, making accurate and reliable data difficult to gather.

Results of the National Drug Strategy Household Survey suggest that a very small proportion of the Australian population (1-2%) inject drugs (Commonwealth Department of Health and Family Services, 1996).

Witnesses before the Joint Select Committee Parliamentary Inquiry into the Establishment or Trial of Safe Injecting Rooms addressed the issue of number of injecting drug users in Australia. Dr Darke, Senior Lecturer at the National Drug and Alcohol Research Centre suggested to Members that there are 80,000 to 100,000 regular heroin users across Australia while Dr Garsia, Chair of the Ministerial Advisory Committee on AIDS Strategy suggested there were 20,000 regular injecting drug users in NSW (NSW Parliament, 1998:22).

Despite the stereotypical "junkie" image, injecting drug use occurs across the community and there is no certain way to determine who will and who will not inject drugs (NSW Parliament, 1998:19). An analysis of the demographic characteristics of those taking part in the Western Australian Fitpack study (511 respondents) were described by the authors as "inconsistent with the stereotype of the drug injector held by many in the wider non-injecting community" (Lenton and Tan-Quigley, 1997:xiii). The study found that:

- the mean age of respondents was 26.2 years;

- just over two-fifths (43.4%) were women, a similar proportion (44.3%) were married or living with their sexual partner, and 41.7% had at least one child, 33.6% having a child in their care;

- just under one-quarter (23.8%) listed senior high school as their highest level of education completed, 22.4% listed trade or technical school and 6.8% had completed a university or college course;

- 46.4% of respondents were employed and of these 66.4% were in full time employment; 30.3% were unemployed;

- while the majority of respondents (59.6%) lived in rental accommodation, just over one in six (16.8%) owned or were buying their place of residence and just under one in six (15.4%) lived in their parents' home (Lenton and Tan-Quigley, 1997).

While acknowledging that their sample may not be representative of all drug injectors but rather of those who buy their needles through pharmacies, the authors nonetheless conclude that:

> *this study demonstrates that there are many injecting drug users who do not fit the negative stereotype held by some in the community who do not inject drugs. The data presented here challenge the "them and us" view which marginalises and stigmatises drug injectors. Challenging stereotypes and stigma is likely to be important in further supporting efforts to prevent the spread of blood borne viruses such as . . . Hepatitis C* (Lenton and Tan-Quigley, 1997:xvi).

- **Harm Minimisation**

Under current national policy, services which address drug use, both legal and illegal, include harm reduction, demand reduction and supply reduction.

Based on the premise that some individuals will continue to participate in illegal behaviours harm minimisation focuses on reducing the consequences of drug use. In 1985 the philosophy of harm minimisation was identified as the response to be undertaken to the problems caused by the use of alcohol and drugs. This was indicated by the launch of the National Campaign Against Drug Abuse at the 1985 Ministers' Conference (ANCARD submission to Joint Select Committee Parliamentary Inquiry into the Establishment or Trial of Safe Injecting Rooms).

A variety of harm reduction strategies appropriate to particular environments and target groups are encompassed in harm minimisation. In the case of injecting drug use strategies they include cessation, reduction of consumption, drug substitution, the provision of sterile injecting equipment, and education about safe administration. With regard to injecting drug use, the submission by NSW Health to the Joint Select Committee Parliamentary Inquiry into the Establishment or Trial of Safe Injecting Rooms noted that harm minimisation:

> *recognises that for many people who use illicit drugs, adopting less harmful behaviours is a more attainable objective in the short term than stopping drug use completely* (NSW Health submission to Joint Select Committee Parliamentary Inquiry into the Establishment or Trial of Safe Injecting Rooms).

The concept of harm minimisation is supported at the highest government levels including NSW Health and the Australian National Council on Drugs chaired by the Prime Minister's appointee, Major Brian Watters. Major Watters has publicly acknowledged the Council's support for harm minimisation as recently as June 1998 (Sydney Morning Herald, 11 June 1998).

Harm minimisation is also supported by some of the nation's most significant organisations in the field such as ANCARD, and at the state level, the Hepatitis C Council of NSW. In ANCARD's submission to the Joint Select Committee Parliamentary Inquiry into the Establishment or Trial of Safe Injecting Rooms the Council noted that:

> *by promoting harm reduction strategies, it is considered that an environment is produced where safer behaviours and changes toward safer behaviour are considered possible by people who use drugs. As a result there is likely to be fewer transmissions of HIV and other blood borne viruses including Hepatitis B and C . . . The reduction of transmission of viral infections such as Hepatitis B and C are anticipated outcomes of harm reduction strategies* (ANCARD submission to Joint Select Committee Parliamentary Inquiry into the Establishment or Trial of Safe Injecting Rooms).

As a Key Conclusion in its deliberations, the Committee fully supports the concept of harm minimisation and considers it to be the most effective underlying principle for strategies to prevent the transmission of Hepatitis C amongst injecting drug users. It will be the basis upon which the Committee frames all recommendations directed at injecting drug users (both in the general community and the state's correction system).

10.1.1 PREVENTATIVE STRATEGIES CURRENTLY IN PLACE

A number of health services are currently available to injecting drug users in New South Wales. These services can be categorised in the following way:

- availability of sterile injecting equipment:
    - the needle and syringe program

- treatment services:
    - methadone maintenance therapy
    - detoxification services
    - counselling and outpatient services
    - residential rehabilitation services (NSW Health submission to the Joint Select Committee Parliamentary Inquiry into the Establishment or Trial of Safe Injecting Rooms).

During the course of this inquiry, numerous witnesses suggested to Committee Members that at least two of these programs, methadone maintenance therapy (MMT), and needle and syringe programs, are appropriate strategies to limit the spread of the Hepatitis C virus amongst injecting drug users. In addition, there was considerable support for peer based education strategies targeting injecting drug users. Each of these three strategies will be reviewed in the following discussion.

- **Methadone Maintenance Therapy**

Methadone maintenance therapy aims at stabilising a heroin dependent person by providing daily doses of methadone which is a long acting and orally administered opioid. The treatment provides the person with an opportunity to disengage from illicit heroin use and the drug subculture and to access and utilise other rehabilitation services such as counselling.

Currently there are 11,400 people on methadone programs in NSW which equates to 4.1 per 1,000 persons aged 15-44 years (NSW Health submission to the Joint Select Committee Parliamentary Inquiry into the Establishment or Trial of Safe Injecting Rooms). The number of MMT clients has risen in recent years, yet Hall suggests there to be a substantial unmet demand (Hall, 1995). Approximately 70% of those receiving MMT are treated by private prescribers with the remaining 30% enrolled in public programs (NSW Health submission to the Joint Select Committee Parliamentary Inquiry into the Establishment or Trial of Safe Injecting Rooms).

Research data suggest that MMT results in a reduction of heroin use, crime and overdose deaths amongst treated heroin uses (Hall, 1996). In a US randomised control trial of methadone maintenance 25% of drug users who received this form of treatment had returned to prison within a one year period while 100% of untreated subjects had returned to gaol within the same time period (Dole *et al*, 1969).

In terms of cost effectiveness as a treatment option, Professor Wodak told the Committee that, in his view, the cost of MMT (and needle and syringe programs) is "fairly modest" (Wodak evidence, 2 October 1997):

> *We spend about $40 million nationally on methadone across the whole country each year, compared with $1.7 billion each year on illicit drug law enforcement - that is, one-fortieth of what we spend on law enforcement - and we spend only $10 million on needle exchange. The health, social and economic benefits of these interventions are staggeringly large, especially when compared with the modest costs involved. Even if we reduced Hepatitis C transmission by only five percent by expanding methadone clinics and needle exchange, the cost would be modest and there would be many other benefits apart from Hepatitis C* (Wodak evidence, 2 October 1997).

In 1995/96 approximately $8,950,000 was spent on MMT representing just over one-fifth (21.7%) of the state government's expenditure on all drug and alcohol treatment services in NSW (NSW Health submission to the Joint Select Committee Parliamentary Inquiry into the Establishment or Trial of Safe Injecting Rooms).

In its submission to the Joint Select Committee Parliamentary Inquiry into the Establishment or Trial of Safe Injecting Rooms, NSW Health made the following points on the methadone program:

- methadone maintenance is currently the most significant treatment program in New South Wales. It is well researched and widely recognised as an effective method for managing opioid dependence and reducing individual and social harms associated with dependence;

- a current trend is toward longer treatment duration. As of 30 June 1996, 48% of clients had been enrolled in their current treatment regime for two years or more and 20% of patients had been enrolled for less than six months.

While there is considerable research on the role of methadone in reducing HIV-risk behaviours (ie less frequent injecting, less frequent sharing, fewer sharing partners and lower HIV seroprevalence [see for example Darke]), there is, as yet, limited research addressing the question of whether MMT also reduces the risk of Hepatitis C. Crofts, Nigro *et al* (1997) reviewed the experience of a major MMT general practice with Hepatitis C infection from 1991 to 1995. Of 1741 individuals tested for HCV antibodies at least once, 66.7% were positive. Of 73 injecting drug users who were initially seronegative and were retested at least once, 19 were subsequently seropositive. The overall HCV incidence rate was 22 cases per 100 person-years. This incidence rate did not differ between those on MMT programs (continuous or interrupted) between HCV tests and those not on MMT (Crofts, Nigro *et al*, 1997). The study's results led Crofts *et al* to conclude that the role of MMT in the control of the spread of HCV infection among injecting drug users needs "further assessment" (Crofts, Nigro *et al*, 1997:999).

A major compounding factor in determining the potential of MMT to limit Hepatitis C transmission is the fact that most new entrants to methadone therapy in Australia are already infected with Hepatitis C. As the NSW Hepatitis C Taskforce report notes, methadone will only be an effective preventative measure when it is considerably expanded and has "far greater access for relatively new drug injectors" (NSW Hepatitis C Taskforce, 1995:19).

There was however, support amongst witnesses for methadone programs as a means of preventing the transmission of Hepatitis C. As the above quote from Wodak suggests, he supported an expansion of methadone clinics (Wodak evidence, 2 October 1997). The Hepatitis C Council also saw a role for methadone programs and

they recommended NSW Health not only expand but further resource methadone treatment centres to "improve education, counselling and support services" for people with HCV and that particular focus be given to private methadone prescribers (Hepatitis C Council submission).

NUAA supported the role of MMT as a preventative measure against the transmission of Hepatitis C. From their extensive experience in working with the injecting drug use population they consider methadone therapy facilities to be currently underutilised. As the Association's Coordinator informed the Committee:

> *just about everyone on methadone is Hepatitis C positive and the service is a place where you go every day, it is a place where people could potentially access a great deal of information and support, but often they do not because of the quality of those services . . . You go there to get your dose and you go. It is a shame because it is clearly an intervention point* (Madden evidence, 7 November 1997).

The Committee considers MMT to be an appropriate preventative measure to limit the transmission of the Hepatitis C virus. It therefore wishes to see NSW Health recognise and utilise more fully the role of the MMT program and to expand and further resource methadone therapy facilities throughout the state to provide education, counselling and support services to those who are Hepatitis C positive. The Committee considers it vital that special emphasis be given to injecting drug users early on in their injecting career to limit Hepatitis C transmission amongst this particularly vulnerable group.

RECOMMENDATION 90:

That NSW Health recognise and utilise more fully the role that the Methadone Maintenance Therapy Program plays in minimising the transmission of Hepatitis C amongst injecting drug users. The Committee further recommends that methadone therapy facilities be expanded and made available throughout the state. Resources should be made available to the Methadone Maintenance Therapy Program to provide initial education, counselling and support services for people who are Hepatitis C positive.

NUAA also identified a number of gaps in the current understanding of methadone as it impacts upon those with Hepatitis C. As Ms Madden informed the Committee, there is "no research" into methadone and Hepatitis C (Madden evidence, 7 November 1997). As an example of the current limited understanding of methadone and Hepatitis C Ms Madden recalled how medical specialists commonly advise HCV+ people not to consume alcohol given the load it puts upon the liver. However, methadone contains ethanol (a form of pure alcohol) but the link between this form of alcohol and liver functioning does not appear to be made. As the Committee heard:

> *the information from Glaxco Wellcome Australia Ltd, which makes methadone, is that methadone is contra-indicated for people with hepatic conditions. But there is no research whatsoever about the impact of methadone on the liver . . . There is no research on methadone and interferon and the interactions between these two. There is certainly no information on the impact of methadone and pregnancy and Hepatitis C. Pregnant women on methadone often have to have their dose significantly altered* (Madden evidence, 7 November 1997).

Given the numbers of injecting drug users with Hepatitis C and the role methadone can play in stabilising drug habits, the Committee considers it important that the impact of methadone on those taking interferon or who are pregnant be determined.

RECOMMENDATION 91:

That the Minister for Health, through the Australian Health Ministers Council, urge the National Health and Medical Research Council to commission and fund research into the interaction between methadone and interferon and the impact of methadone on pregnancy.

Given the potential impact of methadone on those undergoing interferon therapy a more appropriate health response may be heroin prescription. The prescription of heroin to registered drug dependent users is gaining acceptance in Australia. In August this year for example, a majority of delegates at the Western Australian National Party's annual state conference supported a motion for a heroin trial (Le Grand, 1998:3). The concept is also supported by the Lord Mayors in a majority of states across Australia in the Australian Capital Cities Resolution on Drugs (Council of Capital City Lord Mayors, 1998:2).

RECOMMENDATION 92:

That, given the high content level of alcohol in methadone and the impact this has upon those on methadone maintenance therapy who are also undergoing interferon therapy, the Minister for Health conduct a rigorous scientific trial of all alternative therapies for this group of people. The Committee further recommends that an independent advisory committee be established to develop the trial protocol, oversee the trial and review the trial's subsequent evaluation.

- **Needle and Syringe Programs**

The first National HIV/AIDS Strategy released by the Commonwealth Government in 1989 provided a framework for an integrated response to the HIV epidemic and a plan for action across a range of policy and program activities. Needle and syringe programs were part of the education and prevention strategy. The rationale behind the scheme was that:

- despite drug education and treatment programs, many individuals will continue to inject illicit and licit drugs for varying periods of time;

- people must be provided with knowledge and skills necessary to make informed choices about risk behaviours; and

- the community as a whole faces a greater danger from widespread HIV infection than it does from the effects of drug use itself (NSW Health, 1994:4).

The program is based on a model of voluntary exchange in which the return of used equipment is an objective rather than a requirement. The program's policy is that the supply of syringes is never denied on the grounds that used equipment is not returned (NSW Health submission to the Joint Select Committee Parliamentary Inquiry into the Establishment or Trial of Safe Injecting Rooms). The program aims to ensure that the rate of return of equipment to the program is maximised, and that equipment not returned is disposed of in other safe ways. Supply of equipment is always accompanied with a fitpack or other approved disposal container (NSW Health submission to the Joint Select Committee Parliamentary Inquiry into the Establishment or Trial of Safe Injecting Rooms).

In addition to supplying sterile injecting equipment, staff provide clients with information and education about drug use, infection control, health care and safe disposal of syringes; and referral to drug treatment and other health and associated services. NSW Health described this educational work as an "essential component" of the needle and syringe program and the "key" to much of the program's proven effectiveness (NSW Health submission to the Joint Select Committee Parliamentary Inquiry into the Establishment or Trial of Safe Injecting Rooms).

Needle and syringe programs commenced in NSW in 1988 after a trial scheme the previous year. Similar programs now operate in all other states and territories and most Western nations. In this state, two schemes provide sterile needles and syringes to injecting drug users: the public sector scheme and the pharmacy fitpack scheme. Operational responsibility for the public sector program lies with the state's 17 Area Health Services with policy direction and monitoring by the Central Office of NSW Health. Its 300 outlets are based in hospitals, community health services, drug and

alcohol services and associated non-government organisations (NSW Health submission to the Joint Select Committee Parliamentary Inquiry into the Establishment or Trial of Safe Injecting Rooms).

The public sector program distributes sterile injecting equipment in a number of ways to maximise accessibility to the diverse range of people that make up the injecting drug user population. These include:

- conventional services conducted from a fixed premise;

- outreach and mobile services, both vehicle based and on foot;

- use of generalist and specialised agencies as secondary (additional) outlets, such as community health services and youth services (NSW Health submission to the Joint Select Committee Parliamentary Inquiry into the Establishment or Trial of Safe Injecting Rooms).

In 1995/96 a total of 4,182,000 needles and syringes were distributed. The program expenditure was $5,959,093 with the average cost per syringe distributed being $1.42. The safe disposal rate was approximately 90% (NSW Health submission to the Joint Select Committee Parliamentary Inquiry into the Establishment or Trial of Safe Injecting Rooms).

The Pharmacy Fitpack scheme was established in 1986 by the NSW Branch of the Pharmacy Guild of Australia. The scheme was relaunched as the Pharmacy Fitpack Scheme in 1990 with funding from NSW Health. Clients can either exchange used syringes for free new ones, or purchase required items. Approximately 530 retail pharmacies throughout the state participate in the scheme.

In 1995/96 a total of 2,141,102 syringes were distributed through this program which received a government subsidy of $1,568,404. The average cost per syringe distributed was $1.06 with the government contributing $0.82 and consumers $0.24 per syringe (NSW Health submission to the Joint Select Committee Parliamentary Inquiry into the Establishment or Trial of Safe Injecting Rooms).

Some Area Health Services such as the Hunter are utilising the needle and syringe outlets to educate clients on Hepatitis C by providing resources and encouraging them to inform others who inject (NSW Health, 1998:24).

The Committee understands that NSW Health has undertaken a state-wide review of the needle and syringe program. According to NSW Health, the first draft of the Review was completed in 1997 after "lengthy consultations" with the Injecting Drug User Working Party. It was then submitted to the Department for approval. NSW Health advised the Committee that it is anticipated the review will be released "in the near

future" (NSW Health supplementary submission). Not surprisingly a number of agencies expressed concern to the Committee at the length of time taken by NSW Health to release the results of this review.

NSW Health advised the Committee that it recurrently allocates $7,500,000 to the needle and syringe program (NSW Health submission). This figure has to be viewed within the broader context of cost-effectiveness. Estimates of the cost-effectiveness of needle and syringe programs in Australia in 1991 were developed using base case (the most plausible), best case and worst case assumptions (see Table Thirty below). An estimated 3000 cases of HIV were avoided in Australia in 1991 through the operation of needle and syringe programs. Using gross expenditure (without deducting any direct or indirect cost savings), the cost per life-year saved varied from $50 in the best case to $7000 in the worst case. The most likely cost per life-year saved was $350 (Feachem, 1995:91).

The savings in treatment costs due to prevention of HIV infection more than offset the operating costs of the program. According to Feachem, this means that the programs were cost-saving, even under the worst case assumptions (Feachem, 1995:91). His analysis underestimates the likely cost effectiveness of needle and syringe programs because the program's role in decreasing the transmission of Hepatitis B and C was not factored in. As Feachem notes, if these additional benefits were measured, both the number of years of life saved and the net direct cost savings would be increased (Feachem, 1995:91). Based upon these statistics, the Third National HIV-AIDS Strategy endorsed the ongoing use of the needle and syringe program as a cost-effective response to the spread of Hepatitis C (along with HIV and other communicable diseases) (Feachem, 1995:88).

TABLE THIRTY
COST EFFECTIVENESS OF NEEDLE AND SYRINGE PROGRAMS IN AUSTRALIA, 1991

ITEMS	BASE CASE	BEST CASE	WORST CASE
Data and assumptions [a]			
Cost per needle distributed ($)	1.40	0.70	2.80
No of IDUs per 1000 population	5	10	3
Annual reduction in rate of increase of seroprevalence attributed to program (%)	3.4	6.1	0.6
Effectiveness			
No of cases prevented	2,900	10,300	300
No of life-years saved	24,100	86,300	2,500
Cost effectiveness			
Expenditure per life-year saved ($)	350	50	7000
Net direct cost ($m)	-266.7	-984.3	-11.5

[a] Additional assumptions for all analyses:
- number of needles distributed in Australia was 6.3 million
- lifetime treatment costs is $96,200
- average age of infection of IDUs is 24 years
- average time from HIV infection to death is 12 years

Source: Hurley, Jollley and Kaldor, cited in Feachem, 1995:91.

Findings of numerous studies conducted both in Australia and overseas suggest that needle and syringe programs have been effective in controlling the spread of HIV infection. Overseas studies have shown that the average annual HIV seroprevalence is 11% lower in cities with needle and syringe programs than cities without the programs (Hurley *et al*, 1997).

Results from the Australian Needle Exchange Survey suggest that needle and syringe programs are also having an effect on limiting the transmission of Hepatitis C. The Survey's longitudinal study has found HCV antibody prevalence was significantly lower amongst injecting drug users in selected needle and syringe programs in 1997 than in 1995 and 1996 (63% and 65% vs 50%, $p<0.001$) (MacDonald, Wodak and Kaldor, unpublished). HCV prevalence was also significantly lower in 1997 than in 1995 and 1996 among respondents new to injecting (22% and 34% in 1995 and 1996 vs. 13% in 1996; 1995 vs 1997 $p<0.01$) (MacDonald, Wodak and Kaldor, draft). The study concludes that:

> *the first three years of monitoring HCV antibody among injecting drug users attending selected needle and syringe programs throughout Australia indicates that HCV prevalence is declining among this population . . . The reduction was also observed among respondents new to injecting* (MacDonald, Wodak and Kaldor, draft).

A range of studies have documented the fall in rates of needle and syringe sharing across Australia. When asked if they had shared injecting equipment in the previous month, respondents' responses ranged from 13% (Loxley *et al*, 1997:55) and 28% (Lenton, 1995) to 31% (MacDonald 1995). The Australian Needle Exchange Survey conducted in 1995, 1996 and 1997 has also found significant reductions over the three year period of 30% (1995), 28% (1996) and 17% (1997) (MacDonald, Wodak and Kaldor, draft).

In reviewing these findings Loxley cautions that the findings suggest that, because recruitment strategies determine the sub-population tapped, caution should be exercised in drawing too many inferences from a single study (Loxley, 1997:55). She concludes that:

> *despite a wide variety of needle distribution schemes around the country, some needle sharing continues, and clearly at a high enough level to maintain the Hepatitis C epidemic . . . If we are to minimise needle*

> *sharing we have to look at more than just the provision of sterile injecting equipment . . . Our investigations must consider the nature of the social relationships within which sharing takes place, and what injecting drug users believe and understand about these relationships* (Loxley, 1997:55).

Despite the success of needle and syringe programs in limiting the spread of HIV, the program continues to be criticised. Those against the program claim that it results in increasing drug use. The final report from the Joint Select Committee Parliamentary Inquiry into the Establishment or Trial of Safe Injecting Rooms notes however that as "a person who intends to inject drugs will do so whether a new needle is provided or not, it is unlikely that NSEPs have led to an increase in drug usage" (NSW Parliament, 1998:44). The Committee's claim is backed up by US and local research, with the US findings concluding that:

> *there is no evidence that needle exchange programs increase the amount of drug use by needle exchange clients or change overall community levels of non-injecting or injecting drug use* (Lurie and Reingold, 1993).

Similar findings from a Sydney based study concluded that:

> *an increase in the availability of sterile needles and syringes does not appear to lead to an increase in the frequency of intravenous drug use* (Wolk et al, 1990).

Evidence received by the Committee supported these research findings. Sladden, for example, told the Committee that:

> *I do not believe that you could say that [the needle and syringe program] is encouraging drug use. It is a pragmatic harm-minimisation strategy. It is not condoning drug use; it is merely trying to raise awareness and prevent routes of infection* (Sladden evidence, 30 March 1998).

The Committee received evidence of difficulties experienced by injecting drug users visiting needle and syringe outlets:

> *Users have told us many times that often they feel too scared to return used equipment to needle exchanges because they are afraid they will be busted by police on their way to or from the needle exchange . . . police are putting pressure on the users to tell them what the new equipment will be used for. If they admit that they are going to use it for illegal drug use, the police can harass them and make their life difficult. Users need to have only one of these experiences on the way to or from a needle exchange to make it unlikely that they go back to that exchange.*

> *Unfortunately we are hearing those stories in the areas that we can least afford people to stay away from needle exchanges - for example, western Sydney* (Madden evidence, 7 November 1997).

The Committee heard that it is NSW Police Service policy for police not to operate within the parameters of needle and syringe outlets and that police officers on the beat "generally respect and enforce" that policy (Madden evidence, 7 November 1997). However, NUAA told that Committee that:

> *we are increasingly hearing that police are sitting just outside the limit of the parameters of that area and they are coming up to drug users knowing that they have come out of the needle exchange* (Madden evidence, 7 November 1997).

Conscious of such harassment, the Hepatitis C Council recommended to the Committee that cooperation be sought from NSW Police Service to ensure that access to services for people who inject drugs is unhindered and that clients can use needle and syringe outlets without fear of intimidation or arrest (Hepatitis C Council submission).

RECOMMENDATION 93:

That the Minister for Police review the instructions concerning police patrols within the proximity of needle and syringe outlets and that the instructions clearly state that:

i) maximum and effective use of needle and syringe outlets is an effective preventative measure against the transmission of Hepatitis C and other blood borne diseases; and

ii) clients' access to needle and syringe outlets is to be unhindered and without fear of intimidation or arrest.

During the course of this Inquiry, Committee Members visited three needle and syringe outlets. The visited outlets were attached to the Albion Street Centre at Darlinghurst, the Kirketon Road Clinic at Kings Cross and the NUAA headquarters at Bondi. This latter outlet distributes approximately 80,000 needles and syringes each year to injecting drug users across the state with a return rate of 82 per cent. With reference to the NUAA outlet the Committee heard in evidence that:

> *over the past two years, the demand of the needle exchange has increased by 100 per cent each year, which is putting quite a strain on our needle exchange budget. However, we have a commitment to harm reduction and that means that we do not put limits on the equipment we give people because we believe to put limits on the amount of equipment*

> *people can have access to would say to them that we are encouraging them to reuse needles and syringes and we would not do that* (Madden evidence, 7 November 1997).

The Committee received considerable support by witnesses for the continuing use and expansion of needle and syringe programs. Crofts, for example, stated that:

> *My highest [prevention] priority would be stopping the current epidemic and my highest priority within stopping the current epidemic would be to do our utmost to eradicate the sharing of contaminated needles and syringes which means support for needle exchange programs and other ways of distributing needles and syringes* (Crofts evidence, 28 November 1997).

Gold considered needle and syringe programs to be "the major preventative strategy . . . any other strategy is a far second to that" (Gold evidence, 26 February 1998).

Sladden identified expansion of the needle and syringe program as one of the most important preventative strategies in limiting the spread of Hepatitis C. He considered there to be scope within the program to "incorporate further education into the target group injecting drug users to ensure their raised awareness" (Sladden evidence, 30 March 1998).

The Hepatitis C Council's submission stated that needle and syringe programs have a "significant role to play" in the provision of information and education to those at high risk of HCV. Further, the Council's Executive Officer identified needle and syringe programs as the Council's top preventative priority. As Loveday informed the Committee,

> *we strongly suggest that the Standing Committee on Social Issues strongly recommends support for needle exchange expansion and continues to debate and make recommendations for areas where people who choose to inject can do so as safely as possible* (Loveday evidence, 30 March 1998).

Like Sladden, the Council envisaged an expanded role for needle and syringe programs. In their submission to the Inquiry, they called for the program to be expanded to include primary health care, counselling services and safe, supervised injecting areas (Hepatitis C Council submission). The Council's submission noted that in city locations, needle and syringe outlets are "generally isolated" from other health programs and it "may be useful" for the programs to "link" with other community health programs and to become part of a range of services provided for people at risk of, or with HCV (Hepatitis C Council submission).

During the course of evidence, the Council representative suggested needle and syringe outlets to be appropriate venues to target young people who are starting to inject (Loveday evidence, 3 October 1997).

NUAA similarly recommended the expansion of the needle and syringe program to enable primary exchanges to play a more significant role in assessment, referral and general health information provision to injecting drug users. NUAA noted that needle and syringe outlets are currently unable to meet the level of demand for new injecting equipment. As a result,

> *the "new fit every hit" initiative has not been entirely successul in preventing the spread of the [Hepatitis C] virus because the supply of clean injecting equipment including water, swabs, tourniquets and spoons, has not been made readily available to everyone who has chosen to inject drugs . . . It is not possible for drug users to use a "new fit every hit" because needle exchanges cannot presently meet this demand* (NUAA submission).

Given this situation, the Association recommended resourcing levels be expanded to "more adequately" meet the needs of the injecting drug users population (NUAA submission).

Similar recommendations were made by the NSW Hepatitis C Taskforce which identified a "critical goal" of needle and syringe programs to be the provision of sterile injecting equipment throughout the state at all times of day and night while minimising costs and other disincentives to utilisation (NSW Hepatitis C Taskforce, 1995:20). Accordingly, the Taskforce recommended increasing the throughput of the needle and syringe program in NSW to reach a target of 9 million per year by the year 2000 and the identification of "blackspots" in the availability of sterile injecting equipment and the development of strategies to rectify the situation (NSW Hepatitis C Taskforce, 1995:5).

Incorporated into its submission to this Inquiry, ANCARD attached the submission they made to the Joint Select Committee Parliamentary Inquiry into the Establishment or Trial of Safe Injecting Rooms. That submission noted that, while needle and syringe programs have been successful in reducing the spread of HIV, the program alone is "not enough" to address Hepatitis C due to the highly infectious nature of the disease:

> *it should be noted that needle and syringe programs are only one component of a harm minimisation strategy, but as there appears to be a continuing unacceptably high rate of transmission of Hepatitis C amongst injecting drug users it is evident that additional and preventative measures are still required* (ANCARD submission to the Joint Select Committee Parliamentary Inquiry into the Establishment or Trial of Safe Injecting Rooms).

Professor McCaughan also supported an expansion of the needle and syringe programs. He noted that:

> *when we talked about this matter [role of needle and syringe programs in reducing the spread of Hepatitis C] two or three years ago there was general consensus that, although needle exchange was effectively controlling HIV, it was not controlling Hepatitis C. It still is not controlling Hepatitis C but when it is done properly it may have the potential to do so. So I should have thought that the number one priority in containing the spread of this infection is to expand the use of very effective needle exchange programs* (McCaughan evidence, 23 March 1998).

Given that the majority of injecting drug users have already been exposed to the Hepatitis C virus by the time they utilise needle and syringe programs some witnesses expressed a degree of ambivalence, even negativity, toward the program. Hall, for example, stated that:

> *the exchange program has probably hindered the spread of Hepatitis C but has not stopped it . . . the needle exchange program is certainly not the solution that it was for HIV. But I cannot imagine what it would be like without needle exchange and whether it would be much worse. I do not know; it is hard to tell* (Hall evidence, 6 November 1997).

Professor Farrell did not support the use of needle and syringe programs as a means of limiting the spread of Hepatitis C. He noted that:

> *needle exchange has been very successful we think with HIV and that is a triumph. It has been a miserable failure with Hepatitis C* (Farrell evidence, 28 November 1997).

As he noted, the Kirketon Road Clinic data (see Section 3.1.2) show that 89 per cent of under 20 year olds surveyed have Hepatitis C:

> *so we have reasonably good - they may not be perfect - needle exchange programs, but they are not touching Hepatitis C, so I just do not see the efficiency of that approach* (Farrell evidence, 28 November 1997).

Despite Farrell's concerns, the Committee supports the role the needle and syringe program plays in preventing Hepatitis C transmission amongst injecting drug users and wishes to see the Program further developed and extended in its reach and range of services so that outlets throughout the state provide:

- education and information (including available treatment options), counselling and support services to people who are Hepatitis C positive;

- increased after-hours service;
- access to sterile water, alcohol swabs and cotton wool filters; and
- for integrated services in conjunction with other community health programs.

RECOMMENDATION 94:

That the Minister for Health recognise the role of the Needle and Syringe Program in minimising the transmission of Hepatitis C amongst injecting drug users. The Committee further recommends that the Program be further developed and extended in its reach and range of services so that outlets throughout the state provide:

- education and information (including available treatment options), counselling and support services to people who are Hepatitis C positive;
- increased after-hours service;
- access to sterile water, alcohol swabs and cotton wool filters; and
- for integrated services in conjunction with other community health programs.

RECOMMENDATION 95:

That the Minister for Health ensure the Needle and Syringe Program is adequately resourced to take on the additional functions proposed in Recommendation 94.

As with the MMT program, the Committee particularly wishes to see the needle and syringe program target injecting drug users early on in their injecting careers to limit the transmission of Hepatitis C within this particularly vulnerable group. It therefore wishes to see needle and syringe outlets specifically target injecting initiates particularly young people.

RECOMMENDATION 96:

That NSW Health design strategies targeting those who have just commenced injecting practices to warn them of the inherent dangers of contracting Hepatitis C from unhygienic equipment and to encourage them to utilise fully the services offered by needle and syringe outlets. The Committee further recommends that the Needle and Syringe Program be resourced to implement the proposed strategies.

Given these additional functions assigned to needle and syringe outlets, the Committee recognises that those working in the outlets will need to be skilled and trained to provide HCV specific information.

RECOMMENDATION 97:
That NSW Health ensure workers at needle and syringe outlets are adequately skilled and trained to provide HCV specific information.

- **Peer Based Education Amongst Injecting Drug Users**

The development of peer based education strategies has been used successfully in many areas, most notably HIV. The aim of peer based education is to increase the level of accurate information communicated within the marginalised youth population by young people. The Hepatitis C Council suggested to the Committee that the use of these strategies in the prevention of Hepatitis C may reach a greater number of people at risk of infection and develop more appropriate interventions which take account of the specific cultural and social practices that occur around risk related behaviour (Hepatitis C Council submission).

While the Committee is aware of a number of peer education projects targeting injecting drug users such as those sponsored by the Cellblock Youth Health Service, the agency primarily responsible for peer education amongst injecting drug users appears to be NUAA. Much of the education material prepared and distributed by NUAA now provides information on the Hepatitis C virus and ways to prevent its transmission.

One of NUAA's main peer education and community development projects is known as Tribes. The Tribes project centres on Hepatitis C and drug use (Madden evidence, 7 November 1997). Through this project NUAA directly funds eight to twelve individual projects each year. As the Committee was informed:

> *Tribes operates on the premise that people who use drugs do not always identify primarily as drug users or with mainstream health promotion campaigns* (Madden evidence, 7 November 1997).

The project funds subcultural groups, or "tribes" of drug users, in the community to develop their own health education messages. These projects utilise icons, media and language of the tribe to address harm reduction issues specific to that group.

A total of 35 separate Tribes projects have been funded since the program started in 1992. The projects cover a very diverse range of groups including "Ravers", steroid users, skateboarders in Wollongong, young Indo-Chinese heroin smokers in

Cabramatta, “Rivo Boys”, “Hip Hop Crew”, “Kooris Behind Bars”, “Tattooed Metalheads”, “Bikers”, and trade unions.

NUAA’s other principle education program is known as the Community Resource Outreach Workers (CROW) project. The project targets rural and regional areas of the state. Since 1993 CROW projects have been conducted in Bathurst, Tamworth, Lismore, Dubbo, Bowral/ Moss Vale, Albury, Gosford, Narooma, Newcastle, Armidale, Parkes/Forbes, Coffs Harbour, Nimbin, Broken Hill and Goulburn in addition to a number of metropolitan areas such as St Marys, Blacktown, Liverpool, Campbelltown, and Sutherland/Cronulla (Madden evidence, 7 November 1997).

The project employs six drug users in six different geographical areas for ten hours a week for six months to work with networks of local drug users on issues of local significance. A total of 22 individual drug users have been employed as CROW project workers since 1993 (Madden evidence, 7 November 1997).

NUAA also publishes a newsletter, *NUAA News*, which also contains Hepatitis C relevant information. With an estimated readership of between 40-60,000 per edition, the newsletter is “NUAA’s flagship publication and has a statewide and international reputation and profile” (Madden evidence, 7 November 1997).

The role of peer based education initiatives as a preventative strategy in limiting the transmission of Hepatitis C was recognised by both the Hepatitis C Council and NUAA. The Council recommended peer based education programs and community based peer support groups be extended and funded to adopt fresh approaches to help prevent Hepatitis C transmission (Hepatitis C Council submission). NUAA recommended that peer based education and community development initiatives be “actively supported and funded” by the NSW Government to support the ongoing development and implementation of Hepatitis C prevention strategies among injecting drug users (NUAA submission). NUAA also specifically recommended funding be provided for a state-wide peer based education campaign on the importance of blood awareness for injecting drug users and the development of new innovative disinfection messages.

The NSW Hepatitis C Taskforce “strongly” supported the use of peer based education strategies with active non-tokenistic involvement of injecting drug users in all phases of design and implementation of education strategies (NSW Health, 1995:21).

Crofts and his colleagues suggest that peer education programs are likely to be “the most effective” harm reduction approach among new injectors (Crofts, Louie, Rosenthal and Jolley, 1996:1187).

RECOMMENDATION 98:
That NSW Health provide funding for a state-wide peer based education campaign on the importance of blood awareness amongst injecting drug users. The Committee further recommends that representatives from the Hepatitis C community and other appropriate interest groups be involved in the development and implementation of the proposed education strategies to ensure the strategies are practical and effective and appropriate.

10.1.2 PROPOSED MEASURES TO PREVENT OR DELAY INITIAL INJECTING

Loxley has noted that there is only a "narrow window of opportunity" for preventing Hepatitis C among injecting drug users (Loxley, 1997:54). This limitation has "fuelled" a research interest in people in the early stages of their injecting careers and the first transition to injecting (Loxley, 1997:54). Studies conducted by both Croft, Louie, Rosenthan and Jolley (1996) and Loxley (1997) have found the average age of first injecting in Australia to be around 16 years of age. The desire for the "rush" and curiosity about injecting were given as reasons for injecting in both studies. Respondents also said that injecting was the most cost effective way of using drugs (Loxley, 1997:55).

There is a need to reduce the incidence of new infections among people commencing to inject drugs in order to reduce the long term prevalence of HCV infection in the community. Adolescents are the primary target group. However, the Director of Kirketon Road Clinic, Dr van Beek noted in evidence that there are no specific services targeting people when they start injecting or even before that (van Beek evidence, 6 November 1997).

Adolescents who are beginning to experiment with injecting drugs may not have any knowledge of, or access to, needle and syringe programs, not would they necessarily identify themselves at that stage as injecting drug users who use such programs.

For these reasons, the Committee considers it imperative that the basic message of all preventative strategies to prevent or delay initial injecting behaviour in adolescents is a very clear one that encourages young people not to take drugs.

RECOMMENDATION 99:
That NSW Health and the Department of Education and Training ensure the basic message of all preventative strategies to prevent or delay initial injecting behaviour in adolescents is a very clear one that encourages young people not to take drugs.

The Committee considers it imperative that appropriate measures be put in place to prevent or delay initial injecting. During the course of the Inquiry, witnesses identified two measures they considered appropriate to target this group of young people.

- **Education**

A number of expert witnesses identified school based education programs as a preventative strategy to limit the spread of Hepatitis C. Farrell considered educational programs to be an "investment" (Farrell evidence, 28 November 1997) while McCaughan saw education as an important strategy in limiting the spread of Hepatitis C. He envisaged such education as commencing with 10-12 year old students (McCaughan evidence, 23 March 1998).

Dr Gold regarded school education as "one of the most important prevention strategies" (Gold evidence, 26 February 1998). Sladden considered school education to be "crucial" to enable young people to make informed choices, know what services are available and what risks they are taking before they experiment with drugs. As he told the Committee:

> *We need to look at adolescents and awareness raising in school children prior to any experimental drug-taking behaviour. That is the group we have to raise the awareness of because once they start to inject it is only a matter of time before they become infected. So we have to work with the schools to ensure that children are aware of this issue prior to any experimental behaviours* (Sladden evidence, 30 March 1998).

The Hepatitis C Council suggested education should target:

> *schools at an early age focussing initially on blood awareness and then moving on at older ages to more explicit education about the facts of drug use; accurate information and education for people who are enhanced risk of Hepatitis C infection; and education in establishments other than schools, for example, TAFE and university* (Loveday evidence, 30 March 1998).

The NSW Hepatitis C Taskforce recommended school based education programs provide objective information about risks of injecting drug use and appropriate measures for harm minimisation (NSW Health, 1995:4-5).

NUAA recommended that further funding be provided for the ongoing development of school-based education programs in relation to the prevention of Hepatitis C (and other blood borne viruses) (NUAA submission). Similarly the Hepatitis C Council recommended that NSW Health and NSW Department of Education and Training provide "greater support" and funding to school based education programs in the areas

of alcohol and other drug awareness and harm reduction strategies and that access to schools to achieve this be improved (Hepatitis C Council submission).

NSW Health officers advised the Committee that their department annually gives the Department of Education and Training $1million from the National Drug Strategy for drug education in primary and secondary schools. This allocation was confirmed by a representative from the Department of Education and Training who informed Committee Members that such funding had been provided to the Department since 1985-86. The funding “addresses the range of risks to the health of young people associated with drug use” (Kerr-Roubicek evidence, 30 March 1998). As Ms Kerr-Roubicek informed Members:

> *there is an expectation that the Department of School Education will use the funding to address priorities within schools which are consistent with directions established within national and state drug strategies . . . Current priorities relate to the provision of age-appropriate effective education about tobacco, alcohol and cannabis for all students as components of ongoing personal development, health and physical education programs* (Kerr-Roubicek evidence, 30 March 1998).

Ms Kerr-Roubicek also informed Members that current funding is being used to conduct extensive teacher training on drug education and issues associated with the management of drug-related incidents in schools. The funding from NSW Health is also used for ten field-based drug education officers who work directly with schools, providing advice and training on policy, teaching programs and resource for drug education (Kerr-Roubicek evidence, 30 March 1998).

Representatives from NSW Health informed the Committee that the school based education programs includes HCV transmission, prevention and harm reduction (Wilson evidence, 3 October 1997). However, when specifically asked about Hepatitis C educational initiatives and the risks of needle sharing, Ms Kerr-Roubicek informed Members that such information forms a “very small component” of drug education (Kerr-Roubicek evidence, 30 March 1998).

In responding to the evidence received concerning school based drug education, a representative from the Hepatitis C Council told the Committee that he was:

> *a little bemused when NSW Health mentioned that there was a definite school education program. Recently I spoke with a key researcher in Sydney . . [she] said that she was not aware of any planned, co-ordinate Hepatitis C educational program in schools, one about harm minimisation or simply suggesting that people should not inject or take drugs* (Harvey evidence, 3 October 1997).

It would appear that there are discrepancies between the NSW Health's expectations of what is included in drug education and what the Department of Education and Training actually provides. NSW Health appears to assume that Hepatitis C, its prevalence and modes of transmission are being taught to school children. Evidence provided by Education and Training suggests otherwise. The Committee would like to see the current misunderstanding between the two departments clarified.

The Committee also considers it important that agreement be reached between these two Ministers on the aims for Hepatitis C education within the school system. Appropriate aims would be:

- to prevent infection with HCV by discouraging young people from engaging in risk behaviours; and
- to promote harm minimisation for young people who already inject.

RECOMMENDATION 100:

That the Minister for Health and the Minister for Education and Training meet and reach an agreement on the role to be played by the Department of Education and Training in providing Hepatitis C education to children and young people in the state's school system. The Committee further recommends that the two Ministers give consideration to the following aims for Hepatitis C education within the school system:

- to prevent infection with HCV by discouraging young people from engaging in risk behaviours; and
- to provide information on harm minimisation for young people who may have already become involved in drug use.

The aims of Hepatitis C education will give direction to specific strategies to be put in place. The Victorian Hepatitis C strategy document identifies a number of relevant strategies for school-based education programs designed to raise about:

- the nature of HCV, including epidemiology, transmission and risk behaviours;
- a range of strategies to assist students to adopt prevention options or reduce the harm associated with specific behaviours;
- potential behavioural, social and environmental risk factors; and
- appropriate sources of information, support and advice, including testing and treatment information and services (Victorian Department of Health and Community Services, 1995:26-27).

The Committee would like to see similar strategies addressing these issues available to high school students throughout NSW.

RECOMMENDATION 101:
That the Department of Education and Training develop school-based education programs to raise student awareness on issues including:
- the nature of Hepatitis C, including epidemiology, transmission and risk behaviours;
- a range of strategies to assist students to avoid injecting drug use;
- potential behavioural, social and environmental risk factors; and
- accessing appropriate sources of information, support and advice, including testing and treatment information and services.

- **Provision of Youth Services**

Professor Farrell was the only witness appearing before the Committee to take a very broad approach to preventing the transmission of Hepatitis C amongst young people. He saw the:

> *investment in both educational programs and indeed youth services in general as being a very important part of Hepatitis C prevention* (Farrell evidence, 28 November 1997).

In his opinion,

> *We need a supportive society in which kids have proper peer support and have people that they can turn to . . . If people are not putting their hand up and becoming scout masters, maybe we need programs whereby we have better youth support activities and I think we really need to look at all those things* (Farrell evidence, 28 November 1997)

and

> *maybe funding scout masters would make more impact on Hepatitis C than needle exchange programs* (Farrell evidence, 28 November 1997).

Farrell considers it vital that we “really grapple” with the reasons behind the nation’s current high levels of dangerous drug experimentation and drug abuse and why youth turn to drugs in the first place (Farrell evidence, 28 November 1997).

The Committee fully supports Farrell and the claims he made. His concerns echo many of those issues raised during the course of the Committee's Inquiry into Youth Violence. The final report of that Inquiry made recommendations including:

> *that the Minister for Education encourage the extension of the use of schools for community-based programs and services, especially for initiatives providing support, training and leisure activities for young people (Recommendation 59);*
>
> *that the Minister for Education encourage education regions to consider the involvement of outside experts in the areas of youth programs, youth education and violence prevention in the development of programs addressing youth violence (Recommendation 63); and*
>
> *that the Ministers for Community Services, Sport and Recreation and Education collaborate on the expansion of outside school hours programs specifically designed to meet the needs of 12 to 15 year olds (Recommendation 11)* (Standing Committee on Social Issues, 1995).

10.1.3 PROPOSED PREVENTATIVE MEASURES TARGETING INJECTING DRUG USERS

Four preventative measures targeting injecting drug users were proposed to the Committee. Three of these measures would be considered to be harm minimisation strategies while the fourth, increased availability of treatment options would be considered to be a demand reduction strategy. Subsequent to making their submission and appearing before the Committee, NSW Health provided the Committee with a copy of briefing paper prepared for the National Drug Strategy Committee considering Hepatitis B vaccinations for (amongst others) injecting drug users. This issue, along with the other four already identified will be reviewed in the following discussion.

- **Hepatitis B Vaccinations for Injecting Drug Users**

Co-infection with Hepatitis B and C is associated with more severe hepatic fibrosis and cirrhosis than chronic Hepatitis C infection alone and those with both forms of hepatitis have a higher risk of cancer than those with only one form (NSW Health, 1998:2). The poor prognosis of people who acquire a second hepatitis virus while still infected with the first has led to a generally accepted recommendation that people with Hepatitis C should, where possible, be vaccinated against Hepatitis A and B.

A pilot Hepatitis B vaccination program for methadone clients was presented to the National Drug Strategy Committee Meeting in March 1998. The proposal was subsequently forwarded to the National Centre for Disease Control for consideration but as of mid August 1998, NSW Health advised that no funding had been forthcoming from this source. NSW Health also informed the Committee that a scaled-down project

proposal was forwarded to the Commonwealth Department of Health and Family Services to consideration under the Public Health Outcomes Funding Agreement Incentives Program (NSW Health supplementary submission). Advice on the success of this proposal was not available at the time of tabling this report.

Despite difficulties in securing funding for a pilot of Hepatitis B vaccination program for methadone clients, the Committee considers the proposal to have considerable merit and urges the Department to continue applying pressure to the Commonwealth Department of Health and Family Services to provide funding under the Public Health Outcomes Funding Agreement Incentives Program to pilot a Hepatitis B vaccination program for methadone clients in New South Wales.

RECOMMENDATION 102:
That NSW Health continue to urge the Commonwealth Department of Health and Family Services to provide funding under the Public Health Outcomes Funding Agreement Incentives Program for a pilot Hepatitis B vaccination program for methadone clients in New South Wales.

- **Treatment Options**

The Hepatitis C Council suggested reducing the demand for drugs by improving and increasing the resourcing for appropriate treatment facilities to be an appropriate Hepatitis C preventative strategy (Loveday evidence, 30 March 1998). Their submission recommended that NSW Health provide and fund a greater range of alcohol and other drug treatment programs to provide greater options for improved detoxification, rehabilitation, counselling and support services, both to help prevent Hepatitis C transmission and to support those already with HCV (Hepatitis C Council submission). A similar recommendation was made by NUAA who called for a range of treatment options for opioid and psychostimulant dependent users be developed and/or expanded as such services have been shown to have clear harm reduction and disease prevention implications. NUAA saw these options as including the establishment and development of LAAM, Buprenorphine, Naltrexone, slow-release oral morphine and heroin maintenance initiatives for opioid dependent users (NUAA submission).

NUAA also recommended existing drug treatment service providers play a “more direct and active role” in the provision of education and information to injecting drug users as it relates to the education and prevention of Hepatitis C (NUAA submission).

RECOMMENDATION 103:
That the Minister for Health ensure drug treatment services funded by NSW Health play a more direct and active role in providing information on the prevention of Hepatitis C to injecting drug users.

The results of a survey conducted between May and July of this year by the Network of Alcohol and Drug Agencies showed that drug treatment centres in NSW are overwhelmed with requests for treatment. As a result of this demand only 28% of those seeking admission are able to access rehabilitation programs (Bernoth, 1998). According to the Network the government "must double the available service if it is serious about taking the burgeoning drug problem" (Bernoth, 1998). To meet demand, NSW would need 3,064 additional places on top of the 2,321 places currently available. Clearly there is a need for services to be expanded to keep up with the increasing demand for rehabilitation.

RECOMMENDATION 104:
That NSW Health increase the provision of drug treatment and rehabilitation programs as an effective Hepatitis C preventative strategy.

- **Non-Injecting Routes of Administration**

Wodak strongly supports measures to encourage injecting drug users to take the drugs by methods which are "less damaging" to both themselves and the community in general. As he informed Members:

> *This means they would sniff, snort, smoke or swallow the drugs. This does not condone illicit drug use: this is simply to say that these methods are less damaging than plunging a needle in one's arm. If we managed to get people to move from injecting to these other routes of administration there would be other benefits and there would be other risks* (Wodak evidence, 2 October 1997).

Wodak identified the major benefit to be a "sustained" reduction in the overdose death rate, while the major risk would be lung damage (Wodak evidence, 2 October 1997).

In proposing this strategy, Wodak was very aware of its inherent difficulties:

> *How would we facilitate such a transition? It would be very difficult, very awkward in the extreme for Health Ministers or Premiers or Members of Parliament to exhort Australia's drug users to do the right thing by the*

country and flag and start taking drugs by these other routes of administration, and I recognise that (Wodak evidence, 2 October 1997).

He made a similar comment in his submission:

one obvious obstacle is the difficulty many political leaders and parties will have embracing such a policy. Another difficulty is how one could actually facilitate such change. The inevitable policy conflict between discouraging tobacco smoking and appearing to encourage heroin smoking is another ground for concern (Wodak submission).

Support for Wodak's proposal came from the Hepatitis C Council and ANCARD. The Hepatitis C Council recommended NSW Health, in conjunction with the Commonwealth Department of Health and Family Services, oversee and fund the development of strategies to move to alternative routes of drug administration that do not involve the blood contact risks of injecting (Hepatitis C Council submission).

ANCARD's submission to this Inquiry noted that:

we need to encourage other ways of using illegal drugs such as inhaling, swallowing or smoking . . . we must couch any program that relates to other routes of drug use on the basis that drug use of any sort carries risks and we are not suggesting that snorting or inhaling is a safe exercise, but it is safer than injecting (ANCARD submission).

In evidence before the Committee, ANCARD Chair added that:

there are non-injecting routes of administration of illegal substances which, if people are determined to take illegal substances, should be considered as a preference over injecting. It is a matter of saying that public policy is in the first instance ***do not do drugs****. But if you are going to do drugs then look at the way which is least likely to have long-term damaging effect, and that is by non-injecting routes of administration rather than by injecting drug use* (Puplick evidence, 7 November 1997).

When questioned on ways to make such a suggestion politically acceptable, Puplick replied:

I do not believe there is any political way of packaging that to make it look particularly attractive but that is part of the larger issue of addressing the fact that a simple "just say no" strategy cannot work (Puplick evidence, 7 November 1997).

ANCARD's submission to the Joint Select Committee Parliamentary Inquiry into the Establishment or Trial of Safe Injecting Rooms noted, however, that the threat of

Hepatitis C or HIV "may not be sufficient to support a complete shift away from injecting*"* (ANCARD submission to the Joint Select Committee Parliamentary Inquiry into the Establishment or Trial of Safe Injecting Rooms).

The NSW Hepatitis C Taskforce considered there to be an "inherent plausibility" in encouraging a transition to non-injecting routes of administration. However the Taskforce's report points out that the strategy carries a "theoretical" risk of increasing the numbers using potentially injectable substances, some of whom might subsequently transfer from non-injecting to injecting routes of administration (NSW Health, 1995:22).

The Committee learnt that a major obstacle to Wodak's proposal is the type of heroin available in Australia. As Members heard in evidence:

> *historically, injecting has been the preferred way of taking substances in Australia . . . One of the main reasons for that is that Australia mostly gets its heroin from the Chinese - white no. 4 - and it is not suitable for smoking. You can smoke it - of course there are ways to smoke it - but you lose most of the quality of the drug in the process. It burns too quickly. . . In Europe and the United States, the Chinese white No. 3 which is the more smokeable form, is more available . . It is more available than the No. 4. In places such as Holland, statistics show that two-thirds of people smoke and one-third inject . . . When you are spending your last $50 on a hit of heroin, you are not going to use it in a way that is not very useful to you . . . you are going to use it in the most efficient way possible. Injecting the No. 4 is that way. That is one of the major reasons we see a tendency toward injecting* (Madden evidence, 7 November 1997).

Ms Madden elaborated further that:

> *the issue is that injecting is an efficient way of using drugs - to be a bit crude: you get more bang for your buck. That is what users say about that - you get more effect for your money if you shoot it rather than smoke or swallow it. . . Users get used to injecting, they enjoy the rush that comes from injecting. You do not always get the same feeling from smoking drugs. . . There are also rituals tied up with injecting: the whole process of scoring the illicit drugs, the anticipation and the mixing of those drugs. . . some people prefer to inject drugs, which is hard to understand if you are not an injector* (Madden evidence, 7 November 1997).

Available research suggests that any transition between routes of administration that is occurring in Australia tends to be toward injecting rather than from injecting (Loxley, 1997:56).

- **Drug Policy and Law Reform**

In 1989 the National HIV/AIDS Strategy made recommendations covering multiple aspects of the Australian response to HIV/AIDS including the need for legislative reform. That Strategy did not offer detailed guidance on the majority of legal issues identified. Rather, it recommended the establishment of a Legal Working Party to report through the Intergovernmental Committee on AIDS (IGCA) to the Australian Health Ministers' Advisory Council. ANCARD's submission to the Joint Select Committee Parliamentary Inquiry into the Establishment or Trial of Safe Injecting Rooms summarised the recommendations of the Legal Working Party. They included:

- jurisdictions should repeal existing self-administering offences;

- if this does not occur, then at least the operation of self-administration laws should be limited. A directive should be issued to police that self-administration offences are normally to be dealt with not by laying charges, but by a referral for treatment etc. and specifying that police need approval by prosecuting authorities before laying self-administering charges; and

- all jurisdictions would undertake further work to examine how laws relating to prohibited drugs can best be revised to serve as effective instruments of health policy and to support public health objectives designed to limit the spread of HIV/AIDS. The role of the law in facilitating safer drug use by occasional or recreational drug users, and prison inmates should be particularly considered (ANCARD's submission to the Joint Select Committee Parliamentary Inquiry into the Establishment or Trial of Safe Injecting Rooms).

The Working Party also made a number of specific recommendations concerning the operation of needle and syringe programs and the safe disposal of used equipment.

Puplick considers the Legal Working Party's recommendations to be "an important initiative" (Puplick evidence, 7 November 1997). In commenting on the reforms proposed by the Legal Working Party, Puplick noted that a number had already been implemented. However a few, and he specifically identified the law on self-administration, are yet to be reformed (Puplick evidence, 7 November 1997).

In 1993 the NSW Ministerial Review HIV/AIDS Legal Working Party examined the recommendations made by the IGCA and proposed changes to the laws of NSW to bring them into line with the recommendations of the Second National HIV/AIDS Strategy. This report, *The Courage of Our Convictions,* was delivered to the NSW Minister for Health in 1993.

The Third National HIV/AIDS Strategy also proposed that a supportive legislative environment is integral to Australia's success in responding to HIV, HCV and other related communicable diseases. The Strategy states that:

> *the Commonwealth and the States and Territories should regularly assess policies and legislation to ensure the impediments to the prevention of HIV/AIDS and related communicable diseases continue to be reviewed and removed and that discrimination connected with HIV/AIDS and related communicable diseases is effectively combatted* (Commonwealth of Australia, 1996:67).

Both the Wood Royal Commission and the NSW Police Commissioner have canvassed law reform in relation to minor drug offences and greater concentration of harm minimisation measures in the interest of the community as a whole.

The NSW Hepatitis C Taskforce considered the issue of drug law reform and proposed that a NSW Intersectoral Advisory Committee the following recommendations:

- a review of the current emphasis on law enforcement measures which restrict drug supplies and increase the likelihood of drug use by injection with the aim of facilitating the transition from injecting to non-parenteral drug use;

- including injecting paraphernalia in exemptions for legislation which covers needle and syringe programs;

- self-administration (*Drugs Misuse and Trafficking Act*); and

- reducing the size of prison populations by making drug policy more flexible and improving non-custodial sentencing options for injecting drug users (NSW Health, 1995:5).

In commenting on the implementation of the Taskforce recommendations, NSW Health noted that the recommendations are in the area of responsibility for the Attorney General and the Minister for Police. The Department also noted that similar recommendations were made in the *Prisons and Blood Borne Communicable Diseases, the Community Policy* document (1995) and the Puplick Report entitled *The Courage of Our Convictions. HIV/AIDS: The National Strategy and the Laws of NSW* (1993).

During the course of this Inquiry, a number of witnesses raised the issue of drug policy and law reform as a preventative strategy to limit the transmission of Hepatitis C. The Hepatitis C Council, for example, considered drug policy and law reform to be "vitally important" preventative strategies which can improve the contexts in which HCV is transmitted (Hepatitis C Council submission). The Hepatitis C Council's Executive Officer, Mr Loveday, elaborated further in evidence before the Committee:

> *if there is one single issue standing in the way of effective reduction of HCV transmission it is the fact that the risk behaviour that leads to the vast majority of new Hepatitis C infections, the injection of illicit drugs,*

> *remains an illegal activity. . . the enormous economic, personal and social cost of Hepatitis C infection will continue to grow year by year until a fresh approach to the way governments and broader society treat people who choose to use drugs illicitly, and to how they view those drugs in the first place. These are drugs which are never going to go away* (Loveday evidence, 30 March 1998).

NUAA also believes current laws "contribute to the transmission of Hepatitis C" (Madden evidence, 7 November 1997). During the course of their evidence the agency tabled their *Drug Law Reform Policy Statement* (NUAA, 1997) which considers how the current drug laws are affecting drug users, why the current drug laws need to change, potential benefits of drug law reform and ten principles for change.

ANCARD's submission suggested that:

> *every effort must be made to alter drug laws, as our present set of laws acts to increase HCV exposure in our community . . . The Committee should address the whole process of drug reform and suggest that whilst drugs remain illegal, we will continue to have a problem in this community with diseases such as HCV, HBV and HIV* (ANCARD submission).

As ANCARD notes, it is "pointless" suggesting an increase in expenditure of money on the drug war as "this will never be able to outstrip the monies that will be poured into making sure the drugs enter the country" (ANCARD submission).

In appearing before the Committee, ANCARD Chair commented that:

> *The most important legislative reform that could take place in some of these areas is the change in drug laws to enable drugs to be dealt with as a health problem rather than as a criminal problem. That would keep people out of prison for relatively minor drug offences. We have a hierarchy of drug offences in which people who self-abuse in terms of barbiturate and amphetamines are far less likely . . . to end up doing prison sentences than "self-abuse" injecting drug users. We would not send somebody to prison for chronic self-abuse of certain other illegal substances . . . but we send people to gaol for relatively minor drug offences. That exposes them to a far greater public health risk than any public health risk they are exposed to outside prison* (Puplick evidence, 7 November 1997).

Three specific examples of drug policy and law reform were proposed to the Committee. Submissions from NUAA, the Community Working Group on Prisons and Blood Borne Communicable Diseases and the Hepatitis C Council suggested repealing the self-administration and paraphernalia offences detailed in the *Drug Misuse and*

Trafficking Act, 1985. If such a change was made, Mr Loveday suggested that "immediately there would be an easing of the situation in prisons" (Loveday evidence, 30 March 1998).

The Community Working Group on Prisons and Blood Borne Communicable Diseases' submission noted that Australia's success in minimising HIV transmission among injecting drug users resulted from the general moratorium on the enforcement of prohibitions against the possession of equipment for drug use and the establishment of needle and syringe programs. However, both NUAA and the Community Working Group referred to legislative anomalies that impact upon injecting drug users utilising needle and syringe programs. The Community Working Group suggested that the legislation "hampers" the ability of clients of needle and syringe programs to access clean injecting equipment and dispose of used equipment safely (Cregan, DeMarchi, Bond and Selvanera, 1997:4).

Section 11(1A) of the *Drug Misuse and Trafficking Act, 1985* provides that the current offence of having in one's possession "any item of equipment for use in the administration of a prohibited drug": s 11(1) "does not apply to or in respect of a hypodermic syringe or hypodermic needle". According to the Community Working Group this means that "it is legal to possess equipment for self-administration but it is illegal to use that equipment to self-administer". The Group concludes that such a situation is "anomalous" (Cregan, DeMarchi, Bond and Selvanera, 1997:4). If the offence of possession remains, police can prosecute people found in the act of self-administration.

In their submission to the Inquiry, NUAA recommended legislative barriers be removed to lessen the likelihood of people taking risks for fear of arrest and to facilitate users accessing needle exchanges. Similarly, the Community Working Group on Prisons and Blood Borne Communicable Diseases suggested that:

> *Repealing self-administration offences will maximise the effectiveness of the needle and syringe program by allowing people to carry clean injecting equipment and to dispose safely of used injecting equipment* (Cregan, DeMarchi, Bond and Selvanera, 1997:4).

The Hepatitis C Council, NUAA and the Community Working Group on Prisons and Blood Borne Communicable Diseases proposed amending the provision as they relate to the use and possession of small amounts of drugs to remove a criminal offence for these amounts.

The Community Working Group on Prisons and Blood Borne Communicable Diseases also proposed abolishing prison sentences for summary offences for drug use or possession and the sale of drugs not undertaken for commercial gain (the Prisons and Blood Borne Communicable Diseases Community Working Group submission). Mr

Selvanera from the Community Working Group suggested that this change would give effect to the Australian Royal Commission into Drugs undertaken in 1980 which recommended that a distinction be drawn between those people who undertake the sale of drugs for commercial gain and those who undertake the sale of drugs to support their own habits (Selvanera evidence, 23 March 1998).

- **Safe Injecting Rooms**

The term "injecting room" has been defined as a legally sanctioned indoor facility where injecting drug use occurs under the supervision of appropriately trained personnel who could provide access to medical equipment in the event of an overdose. As a harm reduction strategy, sterile injecting equipment is supplied and provision made for the safe disposal of used injecting equipment. Education and information on safe drug use is available and opportunity provided for injecting drug users attending such facilities to consider treatment and rehabilitation (NSW Parliament, 1998:5).

The issue of trialing or establishing safe injecting rooms was examined by a recent Joint Select Committee of the NSW Parliament. The reference was a direct result of a recommendation made by the Royal Commission into the NSW Police Service in which Commissioner Wood concluded that the Commission favoured the establishment of safe injecting rooms. He said:

> *at present, publicly funded programs operate to provide syringes and needles to injecting drug users with the clear understanding they will be used to administer prohibited drugs. In these circumstances, to shrink from the provision of safe, sanitary premises where users can safely inject is somewhat short-sighted. The health and public safety benefits outweigh the policy considerations against condoning otherwise unlawful behaviour . . . For these reasons the Commission favours the establishment of premises approved for this purpose and invites consideration of an amendment of the Drug Misuse and Trafficking Act to provide for the same* (Wood, 1997:226).

During the course of that Inquiry, support for the trial or establishment of safe injecting rooms was given by the NSW Law Society, the NSW Bar Association as well as parents who had suffered the death of a child through drug overdose. There was considerable apprehension in some sections of the community.

The Committee's report identified a number of arguments for and against the establishment or trial of safe injecting rooms under the broad headings of health implications, social implications, economic implications and legal implications. Arguments for establishing or trialing safe injecting rooms included:

- **Health Implications:**
  - may reduce the number of overdose fatalities
  - may reduce the transmission of blood borne viral infections such as HIV,

Hepatitis B and Hepatitis C
- may provide injecting drug users with better access to primary medical care
- may improve access to drug treatment programs
- may improve occupational health and safety conditions for health workers, police officers and ambulance officers

- **Social Implications:**
  - may lead to a reduction in the public nuisance aspects of injecting drug use
  - may provide a venue to improve the likelihood of re-integration of injecting drug users into mainstream society
  - legalising injecting rooms would reduce the opportunities for police corruption
  - allowing injecting drug users to avail themselves of an injecting room may lead to a reduction in certain criminal activities

- **Economic Implications:**
  - may reduce the costs to the community associated with the treatment of overdoses and the treatment of people who contract blood borne viral infections
  - may reduce the social and economic costs to the community of injecting drug users (if injecting room is modelled along the lines of a more general health facility)
  - may mean less time and consequently less money will need to be spent by councils on removing discarded syringes from public areas

- **Legal Implications:**
  - would clarify the role to be adopted by the police in relation to both those using and those running such establishments
  - eliminating the need to pursue self-administration offences in the courts would save police and court time.

Arguments against the establishment or trial of safe injecting rooms identified in the Committee's final report included:

- **Health Implications:**
  - may lead to an increase in drug use and/or the number of injecting drug users
  - may delay injecting drug users from entering rehabilitation
  - there are potential health and safety implications for those who use and staff an injecting room

- **Social Implications:**
  - could lead to the assumption that injecting drug use is condoned may lead to the congregation of drug users
  - areas where injecting rooms are located may become labelled as drug centres
  - may lead to an increase in drug dealing in the nearby vicinity
  - the congregation of injecting drug users where injecting rooms are located may lead to an increase in opportunistic street and property crime
  - there are moral grounds for objecting to the establishment of injecting rooms
  - areas chosen as sites for injecting rooms may feel that they are being treated as social experiments

- **Economic Implications:**
  - concern that spending money on injecting drug users is a waste of resources
  - would have a negative impact on businesses and on property values in the nearby vicinity
  - money spent on injecting rooms would be better spent on alternative drug treatment and rehabilitation programs
  - money spent on injecting rooms would be better spent on increased law enforcement

- **Legal Implications:**
  - making a distinction between behaviour which is legal in an approved injecting room but illegal elsewhere will lead to a creation of "fuzzy" law potential issues of legal liability surrounding incidents occurring in an injecting room (NSW Parliament, 1998:77-122).

The majority of Members on that Committee recommended that the establishment or trial of safe injecting rooms not proceed (NSW Parliament, 1998:188). Four members recommended that a scientific, rigorous trial of safe injecting rooms be conducted in NSW as part of an "integrated public health and safety approach to injecting drug use" (NSW Parliament, 1998:190).

During the course of this Inquiry, a number of witnesses supported the establishment or trial of safe injecting rooms as a preventative Hepatitis C measure. ANCARD supported the trial of safe sanitary injecting rooms under the licence or supervision of NSW Health or another suitable body. The Council's submission to the Joint Select Committee Parliamentary Inquiry into the Establishment or Trial of Safe Injecting Rooms, which ANCARD provided to this Committee, identified three benefits that would be provided by safe injecting rooms: significant reduction in injecting drug use risks including the transmission of Hepatitis C; reduction in the risk of overdoes; and provision of a point of interaction between support services and users, where health

information, referral and counselling can be provided and users can be made aware of available treatment options (ANCARD submission to the Joint Select Committee Parliamentary Inquiry into the Establishment or Trial of Safe Injecting Rooms).

The Hepatitis C Council urged the Committee to give “strong support” to the Joint Select Committee Parliamentary Inquiry into the Establishment or Trial of Safe Injecting Rooms which, at the time of making their submission, was still deliberating (Hepatitis C Council submission).

In their submission to this Inquiry NUAA recommended the establishment of a pilot safe injecting room project in a number of locations across the state. They anticipated such facilities would provide a role in the reduction of Hepatitis C transmission amongst injecting drug users in high risk situations as well as provide education and prevention information (NUAA submission).

Sladden informed Committee Members that:

> *I personally feel that we should seriously consider the possibility of approved injecting rooms as another strategy for reducing infection. . . injecting rooms could provide. . . the potential for a trial of injecting rooms to further provide access to those in the most at-risk drug group for harm minimisation strategies as a pragmatic public health approach to reducing new infections* (Sladden evidence, 30 March 1998).

During the course of his evidence he identified a number of benefits associated with injecting rooms: encouragement of sterile techniques; referral to other services; and reduction of public nuisance related to many aspects of injecting drug use (Sladden evidence, 30 March 1998).

- **Future Directions to Limit the Transmission of Hepatitis C amongst Injecting Drug Users**

As the above discussion demonstrates, a range of preventative measures to limit the transmission of Hepatitis C amongst injecting drug users were presented to the Committee. Support for these measures came from reputable and significant organisations actively involved in the Hepatitis C community such as the Hepatitis C Council of NSW, NUAA and ANCARD. In all instances the proposals made by these agencies were supported by research (both local and international) and other high level inquiries (such as the Wood Royal Commission, the NSW Joint Select Committee Parliamentary Inquiry into the Establishment or Trial of Safe Injecting Rooms and the NSW Hepatitis C Taskforce). In terms of drug law reform and the provision of safe injecting rooms, the Committee finds it difficult to refute the evidence put before it.

In forming its recommendations for the prevention of Hepatitis C transmission amongst injecting drug users the Committee has adopted two basic premises: the health and

safety of injecting drug users (along with the broader issue of community public health) and the principles of harm minimisation as supported by, for example, the Prime Minister's National Council on Drugs, and NSW Health.

Having deliberated upon the issue of safe injecting rooms, a majority of Committee Members concluded that an appropriate and pragmatic harm minimisation strategy to limit the transmission of Hepatitis C in the injecting drug community would be for the Minister for Health to conduct a rigorous, scientific trial of safe injecting rooms in NSW in line with the recommendations of the Wood Royal Commission. These Members wished to see the safe injecting rooms be a point of entry for injecting drug users to access services and support including detoxification services, methadone or other treatment programs, primary health care, referral and counselling.

Other Members would not agree to this proposal and considered that the findings of the Joint Parliamentary Committee Inquiry into Safe Injecting Rooms should be respected and upheld by this Committee.

In terms of drug law reform, the Committee considers the recommendations made by the NSW Hepatitis C Taskforce in 1995 to remain relevant and appropriate. The Taskforce saw a role for a state Intersectoral Advisory Committee for Health. NSW Health advised that this Advisory Committee has not yet been formally established. Given that drug policy reform necessitates a cross-portfolio approach, the Committee sees merit in establishing this Advisory Committee to consider and pursue drug law reform.

RECOMMENDATION 105:

That the Minister for Health establish a NSW Intersectoral Advisory Committee for Hepatitis C and invite the Ministers for Corrective Services and Police and the Attorney General to join him on that Committee.

The Committee would like to see the Intersectoral Advisory Committee on Health consider a number of issues including:

- consider the role of drug policy and law reform as a pragmatic measure to limit the transmission of Hepatitis C;

- assess and examine how policies and legislation relating to prohibited drugs (such as the self administration and possession offences, s10 and s12 of the *Drugs Misuse and Trafficking Act, 1985*) can best be revised to serve as effective instruments of health policy and to support public health objectives designed to limit the spread of Hepatitis C;

- encourage public debate about the public health consequences of drug policy reform; and

- examine strategies to improve non-custodial sentencing options.

RECOMMENDATION 106:

That the NSW Intersectoral Advisory Committee for Hepatitis C proposed in Recommendation 105:

- consider the role of drug policy and law reform as a pragmatic measure to limit the transmission of Hepatitis C;
- assess and examine how policies and legislation relating to prohibited drugs (such as the self administration and possession offences, s10 and s12 of the *Drugs Misuse and Trafficking Act, 1985*) can best be revised to serve as effective instruments of health policy and to support public health objectives designed to limit the spread of Hepatitis C;
- encourage public debate about the public health consequences of drug policy reform; and
- examine strategies to improve non-custodial sentencing options.

10.1.4 NEED FOR RESEARCH

The NSW Hepatitis C Taskforce identified a number of issues it considered to be "research priorities" including:

- reducing the size of the drug injecting population;
- improving the effectiveness of treatment for persons using potentially injectable illicit drugs;
- development of non-reusable injecting equipment;
- behavioural and ethnographic research into young injectors and particularly into initiation injecting and sharing of body fluids; and
- effectiveness of bleach and other agents used for decontamination of injecting equipment (NSW Health, 1995:6).

In response NSW Health assured the Committee that these issues are the "ongoing concerns" of the National Drug and Alcohol Research Centre and that the Commonwealth is the appropriate funding agency for the work of the National Centres (NSW Health submission).

The Committee fully supports the recommendation of the NSW Hepatitis C Taskforce and wishes to see its research priorities receive adequate funding. It would add one

issue to their list - factors surrounding the initiating of injecting behaviour. The Committee has included this last point as it agrees with Crofts, Louie, Rosenthal and Jolley who observe that:

> *understanding the circumstances surrounding initiation into injecting and the influences this process has on subsequent injecting behaviour may be important in allowing current harm minimisation strategies to be targeted more specifically to those at greatest risk and new approaches to be devised for the young, beginning injector* (1996:1188).

RECOMMENDATION 107:

That the Minister for Health urge his federal counterpart to fund research into issues including:

- reducing the number of injecting drug users;
- improving the effectiveness of treatment for persons using illicit drugs which can be injected;
- development of non-reusable injecting equipment;
- behavioural and ethnographic research into young injectors;
- the effectiveness of bleach and other agents used for decontamination of injecting equipment; and
- the danger of contracting Hepatitis C from the exchange of body fluids

and that the results of such research be used in devising strategies to target those at risk, particularly young injectors.

10.1.5 CONCLUSION

Sladden's published comment succinctly summarises most of the issues pertaining to the prevention of Hepatitis C amongst injecting drug users brought to the attention of Committee Members. He calls for:

> *transmission prevention and harm minimisation programs, especially targeting adolescents before any experimental drug taking. Community development and peer education of injecting drug users to promote safer injecting practices should be strengthened. The impacts of improved access to needle and syringe exchange and methadone programs, campaigns to encourage non-injecting routes of drug administration, development of non-reusable syringes, . . . provision of "safe house" injecting venues on HCV transmission all need to be investigated* (Sladden *et al*, 1997:293).

As the recommendations forwarded in the above discussion show, the Committee fully agrees with Sladden. Members have sought to forward responsible, albeit pragmatic, recommendations to prevent the transmission of Hepatitis C amongst the injecting drug community. A multi-faceted approach has been taken in line with evidence received:

> *The approach to controlling Hepatitis C must be multifaceted. One facet is to change behaviour, which will be difficult to achieve. . . It covers many topics . . There is no one answer* (Loveday evidence, 3 October 1997).

10.2 PREVENTING THE TRANSMISSION OF HEPATITIS C IN PRISONS

A number of witnesses stressed to the Committee the importance of Hepatitis C prevention within the corrections system. Crofts, for example, considers prisoners with Hepatitis C to be “doubly marginalised, doubly stigmatised” and prisons to be “the real hot spots for Hepatitis C transmission” (Crofts evidence, 28 November 1997). As a result he views prisons as a “key” to controlling the spread of HCV amongst injecting drug users (Crofts, 1997:116). In evidence before the Committee he observed that “we are not going to control Hepatitis C in the community until we control Hepatitis C in the prisons” (Crofts evidence, 28 November 1997).

ANCARD also noted that:

> *efforts must be directed to the prison system to minimise the risk associated with drug use in prison and to minimise exposure to blood in these environments* (ANCARD submission).

The Committee is also aware that:

> *while prisons represent a public health hazard for communicable disease, they also present a corresponding opportunity to deliver education and treatment programs to a group of people for whom such programs are highly relevant* (Community Working Group on Prisons and Blood Borne Communicable Diseases submission).

The Department of Corrective Services assured Committee Members that it considers Hepatitis C to be a “priority” (Vumbaca evidence, 23 March 1998). As the Committee heard,

> *We [Department of Corrective Services] recognise the sheer numbers of Hepatitis C in the system and that is a priority. Most of our educational work is now focused on Hepatitis C* (Vumbaca evidence, 23 March 1998).

In 1987 the NSW Department of Corrective Services established the AIDS Education Project to provide HIV/AIDS education and prevention programs for inmates and staff. The Project was later renamed the Prison AIDS Project, and a residential Lifestyle program for HIV positive male prisoners was established at Long Bay. In March 1996 the project became the HIV and Health Promotion Unit (HHPU) and its charter was extended to address Hepatitis C and other communicable diseases (Community Working Group on Prisons and Blood Borne Communicable Diseases submission).

As the following discussion will demonstrate, Committee Members firmly believe that a multi-faceted approach must be taken to limit the transmission of Hepatitis C amongst inmates in the state's correctional system. Efforts to prevent Hepatitis C must aim at reducing:

- the prevalence or frequency of injecting (through strategies such as methadone maintenance therapy);
- the risk of infection (utilising strategies such as ready access to bleach); or
- the population at risk (through strategies such as diversion programs and Hepatitis B vaccinations (Dolan, 1997).

- **Harm Minimisation Strategies within the Corrections System**

As has been discussed, the Committee is committed to the principles of harm minimisation in all preventative strategies relating to injecting drug users. The representative from Department of Corrective Services appearing before the Committee, Mr Gino Vumbaca told Members that:

> *The Department does have harm minimisation or harm reduction as a goal. One area in which we probably would not fit into the community definition of that is the provision of needles and syringes for various safety reasons . . . Realistically, the Department makes available to inmate many services and programs that are generally of an equitable level to those available in the community* (Vumbaca evidence, 23 March 1998).

Despite his claim, a number of witnesses appearing before the Committee were critical of the Department of Corrective Services for not providing the same range of harm minimisation measures as are available in the general community. Loveday, for example stated that:

> *The absence of harm minimisation facilities within NSW prisons means that effectively nothing can be done about ongoing transmissions* (Loveday evidence, 3 October 1997).

Cregan noted, that Department of Corrective Services:

> *vigorously pursues a policy of surveillance and prosecution with the aim of achieving drug-free prisons - arguably an impossibility, and contrary to harm minimisation approach to containing blood borne communicable diseases which has been demonstrably successful in minimising HIV infections among injecting drug users* (Cregan, 1998:5).

Representatives from NSW Health noted that their Department encourages harm minimisation but they did not consider Department of Corrective Services to have adopted such an approach (Christensen evidence, 23 March 1998). When asked to comment on the different approaches taken by these two departments that work so closely together seeking to prevent the transmission of Hepatitis C in the prisons' system, Ms Christensen admitted that there "is a conflict" (Christensen evidence, 23 March 1998).

Cregan suggested to Members that the concept of harm minimisation when viewed within the prisons' contest is "a delicate issue" and:

> *quite problematic . . . it is helpful to maintain an awareness of the distinction between drug use as an individual health problem and communicable diseases as a public health problem and to acknowledge that harm minimisation strategies as part of a total response to the drug problem are important in protecting public health. It is really important, especially when these things are debated so hotly, to maintain that focus* (Cregan evidence, 23 March 1998).

The Committee fully agrees with Cregan and in proposing the following recommendations has chosen to look at the issue from a public health perspective. This approach is in line with Loveday's suggestion to Committee Members that "drug use should be treated as a health issue within prisons" (Loveday evidence, 30 March 1998).

10.2.1 PREVENTATIVE STRATEGIES CURRENTLY IN PLACE

In terms of preventing the spread of Hepatitis C amongst prison inmates, the Department of Corrective Services informed the Committee that there is a "two-pronged strategy", namely:

> *to increase the knowledge amongst staff and inmates about Hepatitis C and the particular methods of transmission and protection. . . and to reduce the opportunity for exposure to any blood or bodily fluids or for any exposure to be handled safely and correctly* (Vumbaca evidence, 23 March 1998).

The Department currently has a number of programs in place to limit the transmission of Hepatitis C amongst prison inmates. Some of these, such as drug and alcohol counsellors and peer support programs are of a rather general nature while others specifically target those inmates at risk of contracting Hepatitis C. It is these latter programs that will be reviewed in the following discussion.

- **Education and Information**

A range of education material providing information on Hepatitis C is available to prison inmates. This material includes:

- stickers on the back of all cell doors advising inmates of the presence of Hepatitis C and HIV and encouraging inmates to avoid sharing syringes and engaging in at risk behaviours (Vumbaca evidence, 23 March 1998)

- posters (such as *Before the Take the Gee Remember the Hepatitis-C* targeting injecting drug users, and a series of instructional posters on a range of issues including needlestick injury, blood spills and universal infection control guidelines*)* and pamphlets and booklet such as *Hepatitis C Virus*, *Hepatitis C Ten Questions and Answers* (prepared by CEIDA), *Contact Hepatitis C Diagnosis* (prepared by the Hepatitis C Council of Queensland), *Hepatitis C: what you need to know* (prepared by Hepatitis C Council of NSW);

- newsletter; and

- health information sessions.

The range of resources addresses different literacy levels. As the Committee heard:

> *some [resources] are of a low literacy level, some are of a higher literacy level. We do not focus all of our attention on one particular area. We keep updating resources and putting out new things and also address areas such as cultural issues* (Vumbaca evidence, 23 March 1998).

The Department is very conscious of the role played by its education programs not just in impacting upon the transmission of Hepatitis C within the corrections system, but upon the community as a whole. As noted in their submission:

> *the education of inmates on Hepatitis C issues represents a critical intervention point for the transmission of the virus . . . A substantial number of people from the community pass through the correctional system each year. These people then have multiple contacts with a variety of family and friends in the community after release. There is an opportunity to educate people about reducing their risk of exposure to*

> *Hepatitis C if they are negative, and reducing the transmission of the virus to others if they are positive, whilst they are in custody* (Department of Corrective Services submission).

Two issues pertaining to the provision of education and information for prison inmates were raised with Committee Members during the course of this Inquiry. The first pertains to the HIV and Health Promotion Unit which is responsible for producing and disseminating educational material throughout the corrections system. The Committee understands that this Unit currently has only one dedicated worker for each region which represents approximately ten correctional centres per person, or a staff to inmate ratio of 1:200-2500 (Community Working Group on Prisons and Blood Borne Communicable Diseases submission). As the Community Working Group points out, such a staff to inmate ratio may have been adequate in the past to deal with the 20-40 known cases of HIV infection in prisons at any one time. However, it is “clearly inadequate” to provide education and support for the estimated 2,500 HCV positive inmates in full time custody. The Community Working Group recommended that the HIV and Health Promotion Unit be better resourced so that the worker to client ratio can be reduced to a more appropriate level. The Committee supported this recommendation.

RECOMMENDATION 108:

That the Minister for Corrective Services commission a review of the HIV and Health Promotion Unit to ascertain the staffing needs of the Unit and to ensure the Unit is adequately resourced to meet the information and educational needs of Hepatitis C inmates in the state’s correctional system.

The second issue raised concerned the appropriateness and adequacy of educational material provided to inmates. During the course of her evidence, Ms Cregan, a psychologist who ran a Hepatitis C positive prisoners support group in 1997, commented that:

> *the support that is supplied is based on a model that assumes that information is pretty well all that is necessary to change people’s behaviour. My professional knowledge leads me to understand that knowledge, information and facts are necessary but they are not sufficient to change people’s behaviour in regard to risk taking* (Cregan evidence, 23 March 1998).

From her experience she does not believe current educational programs are appropriate. She does not believe:

> *enough thought, preparation and establishment of the needs, methods and world views of these people have been carried out prior to developing the education program* (Cregan evidence, 23 March 1998).

The Committee is concerned with the observations raised by Ms Cregan. It is aware, for example, that the learning model she identified as being utilised is now considered inadequate:

> *In the old days health promoters talked about knowledge, attitudes and behaviours: get the knowledge right and the rest would follow. We know now that this is unrealistically simplistic but accurate knowledge is still pertinent* (Loxley, 1995:56).

The Committee considers it important that appropriate educational strategies be employed in the Department's attempts to provide information to inmates that is relevant and appropriate.

RECOMMENDATION 109:

That the HIV and Health Promotion Unit ensure all educational strategies employed reflect current health promotion practices. The Committee further recommends that representatives from the Hepatitis C community are consulted along with experts in the field of health education and health promotion in the design of educational material produced by the HIV and Health Promotion Unit.

- **Methadone Maintenance Program**

The availability of Methadone Maintenance Therapy to members of the general community was reviewed in Section 10.1. Similar programs are available within the state's correctional system. The aims of the current program are to reduce heroin injection and minimise the spread of blood borne viral infections (Dolan, Wodak and Hall, 1998:154).

Introduced in April 1986 the state's prison methadone maintenance program is the only one in Australia and one of the few such programs in the world (NSW Department of Corrective Services, 1996:51). Representatives from the Community Working Party on Prisons and Blood Borne Communicable Diseases appearing before the Committee acknowledged that NSW is in a "much better position" than most other states and territories (Selvanera evidence, 23 March 1998). As the Working Party's representative, Mr Selvanera noted "that deserves recognition, but obviously things can always be better" (Selvanera evidence, 23 March 1998).

According to a departmental publication, the program has a "high international profile and is one of the best in the world" (NSW Department of Corrective Services, 1996:51). The publication goes on to suggest that:

> *the program has kept many inmates from injecting drugs in gaol and is considered to have a significant impact in reducing the spread of communicable blood borne viruses within NSW correctional centres and thereby reducing transmission back into the community* (NSW Department of Corrective Services, 1996:51).

The Department's 1996 claims were subsequently substantiated by research published in 1998. Dolan, Wodak and Hall's study or MMT in the state's prisons provided the "first evidence" that MMT can reduce injecting risk behaviour among inmates (Dolan, Wodak and Hall, 1998:155). The study found that:

> *in order for methadone treatment to be effective, a moderately high dose of methadone was required and treatment had to be provided for the entire period of imprisonment* (Dolan, Wodak and Hall, 1998:155).

The study concluded that methadone treatment may also "have an important role in preventing HIV, hepatitis B and C in prisons" (Dolan, Wodak and Hall, 1998:156).

Given the prevalence of Hepatitis C within the corrections system discussed in Section 3.2, the Committee is not convinced that the methadone program has actually had a "significant impact" on reducing Hepatitis C transmissions as the Departmental publication suggests. However it fully supports the initiative and commends Department of Corrective Services for its introduction and continuation.

The Committee was advised that methadone programs are available in 23 of the state's 28 gaols (Vumbaca evidence, 23 March 1998). Those not offering the program include the prison camps, Mannus and Kirkconnel, and the young offenders' prison at Parklea (Vumbaca evidence, 23 March 1998). The Committee was also advised that 710 inmates are currently on methadone (Vumbaca evidence, 23 March 1998).

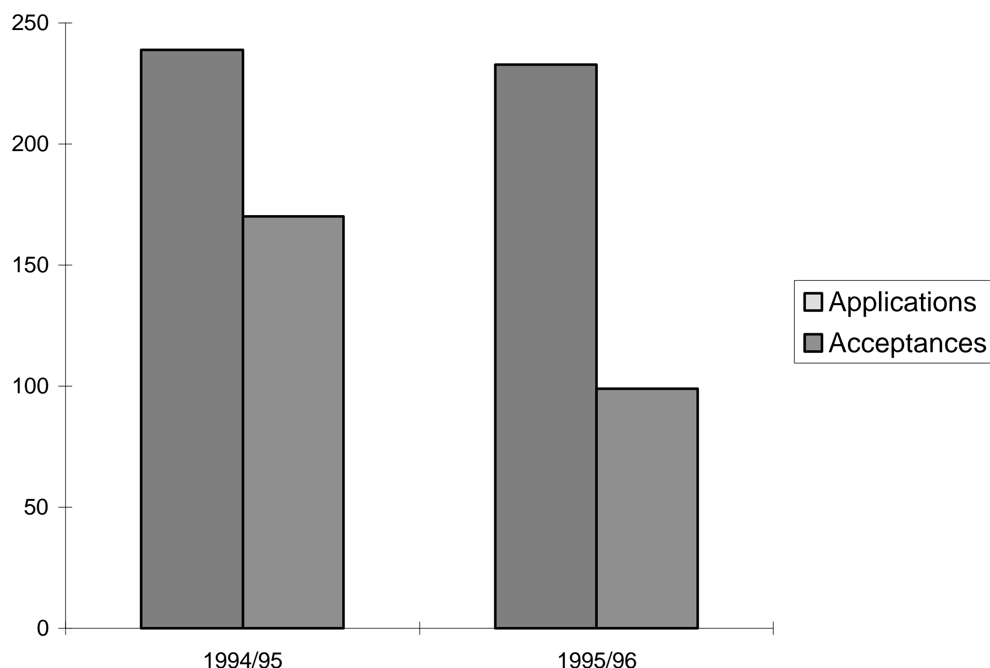
There was considerable support from witnesses for the methadone program. Harper, for example considered the program to be "excellent" (Harper evidence, 23 March 1998) while Christensen thought it to be "a very important strategy in reducing injecting in prisons" (Christensen evidence, 23 March 1998). Lloyd considered there to be a "real setting" for the methadone maintenance program as a way of reducing the likelihood of intravenous drug use in the prison (Lloyd evidence, 30 March 1998).

During the course of the Inquiry, two specific issues related to the prison methadone maintenance program were brought to the Committee's attention. The first issue relates to waiting lists for inmates wanting to access the program.

Departmental guidelines provided to the Committee suggest that in 1996 there was an unmet demand for methadone of approximately 300 to 500 inmates. Christensen's experience substantiated this. She noted that "there are limited places and a waiting list for people who want to go on to methadone" (Christensen evidence, 23 March 1998). The Department's Annual Report documents the discrepancies between applications for the methadone program and acceptances to the program over time (Corrections Health Service, 1996a). These are reported in Figure Six.

Harper considered there to be a need for "more expansion of the methadone program so that it can be more readily available." (Harper evidence, 23 March 1998). Selvanera from the Community Working Party on Prisons and Blood Borne Communicable Diseases similarly recommended an expansion of the prison methadone program (Selvanera evidence, 23 March 1998).

FIGURE SIX
APPLICATIONS AND ACCEPTANCES TO CORRECTIONS HEALTH SERVICES' METHADONE PROGRAM, 1994/95 - 1995/96



While the Committee was not able to ascertain the current unmet demand it anticipates it to be high given the number of people entering gaol who are involved in, or who have a history of, injecting drug use. The Committee understands that the number being placed on methadone is a "small proportion of those applying" (Department of Corrective Services, 1996:52) and that the criteria for being placed on the program are the same as the community program criteria (Department of Corrective Services, 1996:52).

The submission from the Community Working Group on Prisons and Blood Borne Communicable Diseases recommended that there be no limit to the number of prisoners with a history of opiate use, having access to the prison methadone program so that all may receive a therapeutic dose for the duration of their imprisonment or as required by the prisoner (Community Working Group on Prisons and Blood Borne Communicable Diseases submission).

Wodak and Hall are currently conducting an evaluation of the state's methadone maintenance program. Professor Wodak has advised that the data collection stage of the evaluation will be completed by October-November 1998. Vumbaca advised the Committee that he anticipated the review would add 150-200 places to the methadone program (Vumbaca evidence, 23 March 1998). The Committee urges the Department of Corrective Services, in considering the results of Wodak and Hall's review, to take the current unmet demand, and the recommendation made by the Community Working Group on Prisons and Blood Borne Communicable Diseases into consideration.

RECOMMENDATION 110:
That the Minister for Health ensure any shortcomings identified in the current review of the methadone maintenance program be considered and acted upon as a matter of priority as a pragmatic public health measure to limit the transmission of Hepatitis C within the state's corrections system and, consequently, the general community.

A second issue identified related to the needs of new inmates with a history of injecting drug use who, during their first few days and weeks in prison are:

> *hanging out looking for a drug and trying to get access to an injecting apparatus and who will very likely use in a risky fashion in prison and get infected* (Lloyd evidence, 30 March 1998).

Lloyd considered it vital that these 'at-risk' inmates have access to methadone early in their imprisonment. However, as Lloyd observed,

> *one would have to take away a few of the bureaucratic hurdles to get rapid provision of methadone and expand the potential for the program* (Lloyd evidence, 30 March 1998).

RECOMMENDATION 111:
That the Minister for Health ensure methadone maintenance therapy is available to new prison inmates with a history of injecting drug use to limit the transmission of Hepatitis C within the state's corrections system and, consequently, the general community.

- **Safe Tattooing Project**

As has been discussed in Section 3.2.7 tattooing is an illegal activity in the state's corrections system. The tattooing that does occur uses guns of variable quality which are very difficult to clean. The use of such unsterile equipment poses a risk of Hepatitis C transmission. The Committee was informed that, at one stage, some of the confiscated guns were taken to consultants for advice on how they could be cleaned. The Department was told, given the nature of the makeshift guns, it would be "almost impossible" to recommend an effective cleaning method (Vumbaca evidence, 23 March 1998).

The Safe Tattooing Project arose in response to Departmental research showing inmates were unaware of the risks associated with tattooing while in prison. The Project is made up of several stages. The first stage focused on information and included the preparation of material explaining, for example, the risks of tattooing, and precautions to take (dipping the tattooing gun in bleach and wearing gloves to protect against blood splashes) (Vumbaca evidence, 23 March 1998). A booklet entitled *Gaol Ink* was prepared with advice from the Professional Tattooists' Association and endorsed by celebrities such as Angry Anderson. The Committee heard that the booklet has been circulated to "as many inmates as we could" and it is used extensively in the Department's health promotion programs (Vumbaca evidence, 23 March 1998).

The second stage of the Project will examine the feasibility of providing tattoos to inmates while they are in gaol (Vumbaca evidence, 23 March 1998). At the time of taking evidence a number of options were being explored as part of the feasibility study including holding focus groups with inmates to determine their willingness to pay for their own tattoos if they could be done professionally within the confines of gaol and linking the cost of tattooing to gaol work projects (Vumbaca evidence, 23 March 1998).

The Safe Tattooing Project was developed in 1995 with the endorsement of Corrections Health Board and the NSW Health Department. To date it has not been evaluated (Vumbaca evidence, 23 March 1998).

The Committee heard:

> *we [Department of Corrective Services] are trying to look for innovative ways to reduce [Hepatitis C transmission through tattooing], but it is not easy . . . Obviously the Department will not provide free tattoos to*

> *everybody; that is not even on the board. We have to look at other ways of either reducing the demand, which is difficult, or making it safer for people who cannot afford to get proper ones* (Vumbaca evidence, 23 March 1998).

The Committee considers it somewhat unrealistic to attempt to reduce the demand for what is an entrenched practice within the corrections system. It urges the Department to concentrate its efforts rather on sanctioning the availability of tattoos within the corrections system.

Such an approach was supported by a number of expert witnesses. The Hepatitis C Council, for example, strongly recommended its introduction as an effective preventative strategy. Butler also gave his support. He informed the Committee that:

> *I think tattooing should be made available in gaols. The popularity of it as a part of prison life dictates that it would be a good idea if there were some way of making it more hygienic* (Butler evidence, 23 March 1998).

Crofts commented to the Committee that:

> *I have never understood why tattooing is illegal in prisons or is banned in prisons and the reason I have been given when I have asked the question is security. Tattoos are part of the identification of the prisoner . . Well does it not then make sense to make the tattooing legal and above board so you know when somebody is adding a tattoo to themselves rather than keep it illegal so that people change their tattoos without anyone knowing?* (Crofts evidence, 28 November 1997).

Mr Puplick in appearing before the Committee in his capacity as Chair, Australian National Council on AIDS and Related Diseases called for a change in departmental policies on tattooing in prisons. As he noted:

> *changing prison policy about prisoners getting tattoos from reputable sources will not bring prisons to a shuddering halt in any sense, although it may have some impact in relation to health status* (Puplick evidence, 7 November 1997).

The Committee is aware that introducing tattooing in prisons will not be without its opposition. Mr Loveday from the Hepatitis C Council observed, for example, that “it seems so simple and yet we know it is so very hard, given various attitudes” (Loveday evidence, 30 March 1998).

RECOMMENDATION 112:
That, recognising the role of tattooing in the transmission of Hepatitis C, the Minister for Corrective Services enable tattoos to be available in hygienic conditions within the state's corrections system.

- **Availability of Bleach**

According to the Department of Corrective Services' policy PLY.92.197/1 bleach and disinfectant solutions are available to inmates and have been since 1992. The Committee was advised that bleach dispensers are available in "almost every gaol" (Vumbaca evidence, 23 March 1998) and that,

> *it is used for disinfecting cells and cleaning areas; if they use it for cleaning injecting equipment so be it. We cannot stop people from doing that* (Vumbaca evidence, 23 March 1998).

Corrections Health Service nurses informed the Committee that they strongly encourage inmates to clean their injecting equipment with bleach. However:

> *that was not always possible, because many times bleach was not freely available and inmates were blocked from getting it because if they went up to get bleach they were identified as drug users and they then may have been targeted for cell searches* (Christensen evidence, 23 March 1998).

There is, however, some controversy over the effectiveness of cleaning injecting equipment with bleach as its efficacy as a viricidal agent against both HBV and HCV has not yet been established (Cregan, DeMarchi, Bond and Selvanera, 1997:7). While bleach is the recommended regime to prevent the transmission of HIV, a case study presented to the Committee by Professor Lloyd suggested it may not be adequate in limiting Hepatitis C transmission (Lloyd evidence, 30 March 1998). He told Members of an inmate who injected drugs and complied with the recommended two-by-two-by-two (bleach-rinse-bleach) cleaning regime for his injecting equipment. This inmate has contracted Hepatitis C. Lloyd suggested to the Committee:

> *there is some data, this man in particular, supporting that it [bleach] is an inadequate procedure for Hepatitis C. That is a big issue in the prison because it is the recommended procedure* (Lloyd evidence, 30 March 1998).

The Committee was not able to ascertain whether the Hepatitis C transmission Lloyd reported resulted from inadequate cleaning procedures, or shared injecting paraphernalia.

The Prisons and Blood Borne Communicable Diseases policy recommends that bleach (with a minimum of 5.25% sodium hypochlorite) be freely and confidentially available to prisoners. The Policy also recommended that prisoners be supplied with up-to-date information about the efficacy of cleaning solutions against HIV, HBV and HCV and that all prisoners receive a copy of the *National Cleaning Guidelines for HIV* during induction (Cregan, DeMarchi, Bond and Selvanera, 1997).

Given that bleach is the only preventative strategy available to inmates to clean needles and syringes the Committee considers the ready availability of bleach to be an essential public health measure.

Further, the Committee finds the practice of cell searches following requests for bleach to be totally unacceptable. In many respects the practice is similar to that of police patrolling the parameters of needle and syringe outlets and harassing those seeking to obtain sterile equipment. As has been discussed the police have been directed not to operate within the parameters of needle and syringe outlets. In keeping with the Department's commitment to harm minimisation, the Committee wishes to see access to bleach to be not linked to drug surveillance in any form.

RECOMMENDATION 113:
That the Minister for Corrective Services ensure adequate bleach dispensing machines are available in all correction centres enabling inmates to access bleach freely and anonymously. This should be administered as a Hepatitis C control measure, and should not be linked to drug surveillance.

- **Availability of Toothbrushes and Razors**

In the discussion on household transmission of Hepatitis C (see Section 3.8.2) it was noted that personal grooming items such as toothbrushes and razors may contain traces of blood which may, in turn, result in the transmission of Hepatitis C. While it is relatively easy within a household setting to avoid sharing these items, the Committee was advised that such is not always the case in correctional centres. In some of the older gaols there are communal shower areas and razor blades are often left after showering or they are "put into a big bucket with inmates fishing one out the next day to shave" (Christensen evidence, 23 March 1998). The Committee also heard that a lot of bartering occurs in gaols with prisoners "swapping of razors and toothbrushes that may have blood on them" (Pritchard-Jones evidence, 2 October 1997).

The Committee was advised during the course of evidence, that prison inmates have access to razor blades and toothbrushes (Vumbaca evidence, 23 March 1998). A Disposable Razor Policy and Procedure (PLY.93.251/1) has been introduced. The policy states that:

> *a)* *all disposable razors issued to inmates will only be carried out on an exchange basis of one to one (ie old razor for new razor);*
>
> *b)* *all inmates will place their old razor in a suitable sharps container before being issued with the new razor;*
>
> *c)* *all inmates, employed within correctional centres for the purpose of cleaning wings, units and blocks (ie sweepers), will be issued with the appropriate gloves and sharps containers when they are required to clean ablution (showers and toilets) blocks. In the event that they find any discarded razors, they will then be disposed of immediately and appropriately;*
>
> *d)* *that educational material (posters and pamphlets) must be displayed and made available to all inmates regardless of classification, housed in correctional centres throughout NSW;*
>
> *e)* *if inmates continually request exchange razors without a replacement, the monetary cost of the razor be deducted from the inmates private cash* (Department of Corrective Services, 1993).

As the policy statement suggests, the HIV and Health Promotion Unit provides educational material in the form of pamphlets and posters encouraging inmates to use their own razor blade and toothbrushes (Vumbaca evidence, 23 March 1998).

The Committee is satisfied that appropriate measures are currently in place to reduce the likelihood of toothbrushes and razors being possible sources of Hepatitis C virus. The Committee would urge the Department of Corrective Services to remain vigilant in this matter. While the ready availability of toothbrushes and razors may appear to some to be an insignificant measure, the Committee considers it important given the prevalence of Hepatitis C within the corrections system. In the Committee's opinion, every measure, regardless of how small, must be taken to curb the transmission of Hepatitis C in prisons.

RECOMMENDATION 114:

That the HIV and Health Promotion Unit continue to encourage inmates not to share their razor blades and toothbrushes.

- **Diversionary Sentencing Practices**

Given the prevalence of Hepatitis C in the corrections system, considerable support was given by expert witnesses to the use of diversionary sentencing provisions as a means of diverting "at risk" or infected people from the corrections system. Crofts suggested, for example, that Hepatitis C in the community will not be controlled until we "stop locking up injecting drug users" (Crofts evidence, 28 November 1997).

Professor Batey also supported the idea and commented to the Committee that:

> *we need to keep that population out of the prison system if we possibly can. So looking at alternative centres and strategies is important* (Batey evidence, 27 October 1997).

The Hepatitis C Council suggested to the Committee that:

> *Every effort should be made to keep people out of gaols. Where people are imprisoned for drug-related offences, why should they not rather be given the option of treatment programs?. . . Changing the sentencing practices to allow magistrates to consider options other than imprisonment* (Loveday evidence, 30 March 1998).

Mr Vumbaca from Department of Corrective Services also felt that:

> *Obviously keeping people out of prison would be a major source of help for the Department of Corrective Services . . . . If we can reduce the flow into the system of people with those problems it makes it easier for us* (Vumbaca evidence, 23 March 1998).

Recognising that Hepatitis C infections contracted directly in prisons, or indirectly from released prisoners, will provide a "significant ongoing resource burden" to the health system the NSW Hepatitis C Taskforce recommended improving the non-custodial sentencing options for injecting drug users (NSW Health, 1995:19).

Further, the recommendations of the Legal Working Party to the Intergovernmental Committee on AIDS referred to in Section 10.1.2 also proposed that injecting drug users found guilty of drug offences should be kept out of the prison system and that legislation should enshrine the principle of non-custodial sentences for relevant offences and remove any mandatory sentences for minor offences (ANCARD submission to the Joint Select Committee Parliamentary Inquiry into the Establishment or Trial of Safe Injecting Rooms).

The Community Working Group on Prisons and Blood Borne Communicable Diseases submission identified the benefits to come from utilising diversionary sentencing provisions:

> *diversion of drug offenders from prisons would have the effect of reducing the prison population resulting in better and safer accommodation for those longer term prisoners for whom custodial sentences are appropriate. The presence of fewer injecting drug users in prisons would entail a corresponding decrease in the number of HCV infected inmates and thus lessen the risk of transmission among the remaining prison population* (Community Working Group on Prisons and Blood Borne Communicable Diseases submission).

The Community Working Group recommended that the Attorney General, through the Judicial Commission, undertake to bring to the attention of the magistracy and other judicial officers appropriate advice to guide their sentencing of offenders with, among other diseases, HCV (Community Working Group on Prisons and Blood Borne Communicable Diseases submission). In evidence, the Working Group representative suggested the use of non-custodial alternatives such as attendance orders or community service orders for injecting drug users who are convicted of minor offences which were committed to support their drug use (Selvanera evidence, 23 March 1998).

As the Committee is aware, his suggestion has a legislative base. The *Justices Act, 1902* s80AB provides that in summary proceedings a Justice "shall not sentence a person to full time imprisonment unless satisfied, having considered all possible alternatives, that no other course is appropriate". Selvanera pointed out to Committee Members that the current government's pre-election corrections policy "enshrined" this principle (Selvanera evidence, 23 March 1998). The Community Working Group on Prisons and Blood Borne Communicable Diseases suggest that s80 might be interpreted to apply to minor possession as well as self-administration offences (Cregan, DeMarchi, Bond and Selvanera, 1997:3). Their preference however would be to amend the *Drug Misuse and Trafficking Act, 1985* to abolish custodial sentences for all summary drug use and possession offences (Cregan, DeMarchi, Bond and Selvanera, 1997:4).

The Community Working Group on Prisons and Blood Borne Communicable Diseases' submission outlined an alternative approach to sentencing repeat minor offenders proposed by Vinson. He recommends that the judiciary be required to justify the imposition of short custodial sentences rather than community based alternatives for these offenders. Under this proposal, prisons should be reserved for more serious offenders serving longer sentences (Cregan, DeMarchi, Bond and Selvanera, 1997: 4).

A number of non-custodial sentencing options are currently available. These include:

- periodic detention which requires the offender to remain in custody for two days of each week for the duration of the sentence (NSW Law Reform Commission, 1996:212);

- home detention which permits an offender to serve part or all of a sentence in the offender's home under strict supervision and subject to conditions (NSW Law Reform Commission, 1996:144). This scheme was given a legislative base with the introduction of the *Home Detention Act, 1996*;

- Griffith bonds which place an offender on remand during which time the offender's behaviour and capacity to be rehabilitated over a period of time is assessed, before the appropriate sentence is passed; and

- community service orders which place restrictions on the time and liberty of offenders by requiring them to carry out up to 500 hours of community service (NSW Law Reform Commission, 1996:96).

The Standing Committee on Social Issues has considered the use of non custodial sentencing options in a previous Inquiry. In its final report for the Inquiry into Children of Imprisoned Parents (1997), the Committee urged that imprisonment of mothers with dependent children be a sentencing option of last resort. The Committee made it very clear in that Report that non-custodial options are not "soft". As the report states:

> *the Committee firmly believes that non-custodial penalties should not be seen or used as a "soft option". They do not mean that an offender has gotten away with an offence. Sentences such as community service orders, periodic detention and home detention are all serious penalties which curtail the liberty of an offender and the use of such options should reflect the gravity of the offence, in the level of curtailment involved* (Standing Committee on Social Issues, 1997:113).

The recommendations forwarded in the Children of Imprisoned Parents Report called for the Attorney General to:

- ensure that, through judicial education, magistrates and judges always use the option of prison as a last resort when sentencing an offender who is the parent of a dependent child (Recommendation 47). In responding to this recommendation the government advised that the Attorney General would write to the Judicial Commission suggesting the issue be considered for inclusion in the Commission's education and training programs;

- monitor the sentencing patterns of magistrates and judges to ensure prison be used as a last resort for parents of dependent children (Recommendation 48). In responding to this recommendation, the government gave "in principle" support;

- develop and implement an education program for judges and magistrates to encourage the use of non-custodial sentencing options for drug and other non-

violent offenders (Recommendation 49) and that information about the Home Detention Program (Recommendation 54), and Griffith Bonds (Recommendation 58) be included. In responding to these recommendations the government advised that the Attorney General would write to the Judicial Commission suggesting the issue be considered for inclusion in the Commission's education and training programs;

- introduce legislation to allow for the requirement of attendance at a drug and alcohol treatment centre as an alternative to imprisonment with appropriate safeguards (Recommendation 53). In responding to this recommendation, the government said that it was "under consideration".

In responding to Recommendation 53, the government identified a number of factors it considered made the implementation of a drug and alcohol treatment program in the periodic detention scheme "impractical". These factors included:

> *A program may need continuous attendance for a length of time and periodic detainees would only be available to attend two days in every seven; the length of sentence may not cover the time required for treatment; and the number of detainees at a particular centre required to attend the program may not be sufficient to make operation of the program viable* (NSW Government, 1998:24).

While recognising that the periodic detention scheme may not be the most appropriate venue for drug and alcohol treatment programs, the Committee still stands by its original recommendation for rehabilitation to be an alternative to imprisonment. It remains convinced that the objections forwarded by the government can be overcome with planning, flexibility and the will to work with drug offenders who want help. Even if counselling were available for the two days (which need not be weekends) progress would be made.

The Committee recognises the potential for non-custodial sentencing options can play in reducing the transmission of Hepatitis C in the corrections system. It wishes to see the NSW Intersectorial Advisory Committee for Hepatitis C proposed in Recommendation 105 give urgent consideration to a range of options including diversionary sentencing, drug courts, and the inappropriateness of mandatory sentences for minor offences.

RECOMMENDATION 115:
That the NSW Intersectoral Advisory Committee for Hepatitis C proposed in Recommendation 105 give urgent consideration to a range of non-custodial sentencing options such as:
- the use of diversionary sentencing;
- utilisation of drug courts; and
- the inappropriateness of mandatory sentences for minor offences

as a means of reducing the transmission of Hepatitis C in the corrections system.

- **Limit Supply of Drugs Entering Correctional Centres**

A number of expert witnesses commented on the ready availability of drugs within the prison system. The Committee heard, for example, that:

> *we know for a fact that drugs and needles and syringes come into gaol no matter how well it is policed - even with the nice new gaol - and inmate will continue to use when they go out* (Harper evidence, 23 March 1998);

and

> *Heroin is no trouble to get; there is never a shortage. There is probably more inside the prison than outside . . . there is an awful lot of use that goes on in the prison. I am sure I meet with a very biased group of prisoners but they are slightly more likely to play it straight with me and tell me the truth, and hardly none of them do not use at some time when they are inside* (Lloyd evidence, 30 March 1998).

The submission from the Community Working Group on Prisons and Blood Borne Communicable Diseases suggested that:

> *It is fallacious to expect that prisons will be drug-free, when 50% of the population are injecting drug users, and for a substantial proportion of them drug use has been a causal factor in their imprisonment* (the Prisons and Blood Borne Communicable Diseases Community Working Group submission).

Crofts was also quite realistic in his appraisal of drugs in gaols:

> *I always chuckle at the idea of the most well motivated and capable public servants sitting in their Department of Corrections or wherever and working on this problem of keeping drugs out of gaol. Even if they are*

> *working intensively, perhaps 20 hours a week, giving it their full attention, trying to devise strategies to keep drugs out of gaol, against them are hundreds and thousands or equally committed and equally intelligent people working 24 hours a day to work out how to bring them in . . . It is a losing battle . . . The drug market in prisons is just a sort of concentrated and highlighted version of the drug market elsewhere. The reasons that people use drugs in prisons are all the same sort of human reasons that they use it on the outside but made more pointed or more sharp in some ways. One of those is boredom and meaninglessness* (Crofts evidence, 28 November 1997).

Support to limit the supply of drugs in correctional centres came from Professor Lloyd who suggested that:

> *all things being equal, it would be foolish for us not to attempt to minimise the supply of drugs within the prison, and that means dealing with prisoners who go on work release and so on, who come back in and deal; as well as dealing with the custodial staff who also deal* (Lloyd evidence, 30 March 1998).

Lloyd fully recognised that such a proposition is “easier said than done, of course” (Lloyd evidence, 30 March 1998).

For drug trafficking to occur into a correctional centre its perimeter must be breached. At correctional centre with secure perimeters this is generally achieved by offenders using three main avenues including:

i. drugs or contraband passing over or under the perimeter;

ii. drugs or contraband going through a visiting section of a correctional centre; or

iii. drugs or contraband passing through vehicle and pedestrian gates by corrupt staff, civilian workers, deliveries and stores, vehicles, inmates on reception, inmates returning to a centre or in inmate mail (Department of Corrective Services supplementary submission).

The Department advised that it employs a wide range of strategies that form a comprehensive drug supply reduction program. The key components of the strategy include:

- the State Investigative and Security Group;
- the Corrective Service Investigation Unit;
- the Corrections Intelligence Group;

- Institutional Intelligence Officers;
- drug detection dogs;
- fan assisted drug detection;
- searching programs;
- video surveillance;
- toilet access for visitors;
- high profile deterrence including public notices and leaflets given to visitors;
- flagging suspect visitors;
- searching powers;
- increased penalties; and
- 1800 Drug Information Hotline (NSW Department of Corrective Services supplementary submission).

- **Hepatitis B Vaccination Program**

The NSW correctional system currently has in place a voluntary Hepatitis B vaccination program. As the Committee heard "slowly the Corrections Health Service is warming to the fact that it is a good idea to immunise inmates against Hepatitis B" (Butler evidence, 23 March 1998).

It is Departmental policy that all correctional centre based staff in contact with inmates be provided with Hepatitis B vaccinations (Department of Corrective Services, 1996, 54). While the Committee was able to ascertain departmental policy on the vaccination program for staff, the policy as it relates to inmates was not so readily accessible.

The Committee heard that:

> *At the moment there are restrictions on length of sentence and a range of other factors come into play before a vaccination would be offered* (Vumbaca evidence, 23 March 1998).

One witness suggested this length of sentence to be six months or more. However, as the average length of sentence ranges from 3.5 to 7.5 months for females and males

respectively the Committee heard that there are "problems" and "quite a lot of people were falling through the net based on that criteria" (Butler evidence, 23 March 1998).

The Committee also heard that it is now possible for an inmate, regardless of length of sentence, to request Hepatitis B vaccinations. A 1996 Departmental publication stated that "all inmates" are entitled to free Hepatitis B vaccinations from Corrections Health Service clinics provided they are tested, screened and educated by clinic staff first (Department of Corrective Services, 1996:54). This was supported by Lloyd who told the Committee that inmates who undergo voluntary screening, are not infected and have no immunity against Hepatitis B are offered a Hepatitis B vaccination (Lloyd evidence, 30 March 1998).

From evidence taken from Corrections Health Service nurses it seems that immunisations are occurring regardless of the policy. Corrections Health Service nurses advised Committee Members that they would commence the immunisation schedule with inmates serving one month as they considered this to be a "good health prevention or health promotion activity" (Christensen evidence, 23 March 1998). As Parsons told Members:

> *We also encourage Hepatitis B vaccine in our system. Anyone who is serving a long sentence or is engaging in at-risk behaviour when we are testing . . . we offer Hepatitis B vaccine because a person with Hepatitis C is already compromised. To give another infection would involve a super infection, two viruses on the one liver, so we take that quite seriously and push the Hepatitis B vaccine, especially for the hepatitis guys and anyone who is at risk* (Parsons evidence, 23 March 1998).

However, as Christensen admitted, "I do not know whether the formal policy has actually caught up with that [practice] yet" (Christensen evidence, 23 March 1998).

Given the conflicting advice, the Committee agrees with Butler who suggested that "it was quite difficult to find out what the policy was on hepatitis B vaccinations" (Butler evidence, 23 March 1998).

Butler's survey referred to in Section 3.2.2 collected data on the Hepatitis B status of inmates. His study found:

- 33% of male inmates and 46% of females inmates were hepatitis B core antibody positive suggesting they have been exposed to the hepatitis B virus;

- 30% of male inmates and 9% of female inmates had not been exposed to the hepatitis B virus nor had they been immunised. Butler suggested that this "at-risk" group needs to be "targeted" for immunisation (Butler evidence, 23 March 1998); and

- approximately 70% of male inmates and 50% of female inmates reported completing the full course of Hepatitis B shots leaving up to 30% of males and 50% of females not receiving all three shots (Butler evidence, 23 March 1998).

There was general agreement for a Hepatitis B vaccination program amongst those witnesses with experience in the prisons system. Butler, for example, considers that "without doubt" it would be a useful policy (Butler evidence, 23 March 1998). The Prisons and Blood Borne Communicable Diseases Policy recommends that a voluntary Hepatitis B vaccination program be implemented and that participation be with the free and informed choice of each prisoner. The Department of Corrective Services representative appearing before the Committee, Mr Gino Vumbaca, also considered it an "appropriate" strategy (Vumbaca evidence, 23 March 1998):

> *Given that people are coming in for short sentences and are coming in on multiple occasions in some areas, I would think that for the cost of a vaccination any protection from Hepatitis B is better than none at the moment. . . Vaccinations should be offered to every inmate* (Vumbaca evidence, 23 March 1998).

Lloyd told Committee Members that vaccinating inmates against Hepatitis B:

> *does the whole community a good service because it captures those individuals and breaks the transmission mode of this virus* (Lloyd evidence, 30 March 1998).

The proposal made by NSW Health to the National Drug Strategy Committee for vaccinating methadone clients against Hepatitis B discussed in the preceding section also proposed that, once "teething problems" had been eliminated, the program be extended to include prison inmates. The proposal recognised that offering free HBV vaccinations to prison inmates (amongst others) could "provoke an initially negative reaction from members of the public and some clinicians" and that:

> *the soundness of preventing HBV in injecting drug users both on the grounds of this policy being a cost effective use of public funds, and which reduces risk to the general public by reducing the number of HBV carriers in the population needs to be stressed* (NSW Health supplementary submission).

A number of concerns with the current process of providing Hepatitis B vaccinations were raised during the course of evidence. One of the issues identified related to managing the immunisation process. It would seem that medical records and immunisation registers are yet to be put on a computer database enabling the records of prisoners reentering the system, or transferring to another correctional centre, to be readily accessed. The present system seems to rely on self-presentation which is not always successful. Butler observed that:

> *We need to consider other issues such as immunisation registers and access to medical records to see if somebody has already been immunised. There is no point in reimmunising people just for the sake of it but if one had access to medical records on entry, that could be determined easily* (Butler evidence, 23 March 1998).

Ms Christensen raised similar concerns:

> *because of frequency of movement inmates will often have injections . . . a card is given and a note made in the medical records, but that relies on an inmate self-presenting at the right time to have the next vaccination, which is fraught with difficulty because the medical records may not accompany the inmate. A database needs to be created that actually tracks records and alerts staff when an inmate is due for subsequent vaccination so that there can be a dual self-reporting as well as follow-up by the nursing staff in the gaol. That is a major limitation of the hepatitis B program at the moment* (Christensen evidence, 23 March 1998).

The introduction of a database for inmate's medical records has implications far beyond efficient management of the Hepatitis B vaccination program. It would appear to be a rather fundamental tool for the Corrections Health Service and clearly one requiring further consideration.

RECOMMENDATION 116:

That the Ministers for Corrective Services and Health establish a medical records database throughout the state's corrections system to facilitate the successful follow-up of inmates and management of their Hepatitis C.

Butler also expressed his concerns that current inadequacies with the Hepatitis B immunisation program could mean that when Hepatitis C or HIV vaccinations are available mechanisms and protocols will still not be in place and adequate protection will not be made available to inmates:

> *It concerns me slightly that we have moved on to Hepatitis C and now we have hepatitis G. We have a condition that is vaccine preventable and one asks whether we are doing enough to prevent it. We have a solution, which is immunisation, but are we using it effectively? I always ask the question: if we find a vaccine for HIV and Hepatitis C are we going to use it in the same haphazard way as we do with hepatitis B? If we get the hepatitis B vaccination right, then when vaccines hopefully come onboard for HIV, Hepatitis C and Hepatitis G we will be in a much better position to implement those systems* (Butler evidence, 23 March 1998).

The Committee was concerned at such a possibility and wishes to see the Hepatitis B vaccination program administered as effectively as possible.

RECOMMENDATION 117:
That the Ministers for Corrective Services and Health collaborate to ensure that the Hepatitis B vaccination program operates effectively in every prison and where possible, every alternative community sentencing program.

It was suggested to the Committee that another difficulty arises when inmates are discharged from prison before they have completed their immunisation schedule. As the Committee heard:

> *With Hepatitis B there are problems because someone to be given a course of three shots may need to receive the third one from a general practitioner on the outside* (Butler evidence, 23 March 1998).

In many instances, the third shot is not received and complete protection from the Hepatitis B virus is not achieved. Accelerated schedules of vaccination (0, 10 and 21 days) are available and one witness proposed such a schedule as an appropriate strategy ensure all three shots are obtained in as short a time as possible and before release from prison.

The cost effectiveness of the Hepatitis B vaccination program has yet to be determined. It was suggested to the Committee that:

> *We need to evaluate what is most cost effective - do we just immunise everybody at one time or do we selectively target certain groups for immunisation? We also need to know the cost implications of that . . . We need to do a study in New South Wales to ensure that we have the most cost effective vaccination policy in place* (Butler evidence, 23 March 1998).

In conducting such a cost effective exercise the Committee would like to see alternate immunisations options such as accelerated schedules included.

RECOMMENDATION 118:
That the Minister for Health commission a cost effectiveness study of the Hepatitis B vaccination program currently conducted by Corrections Health Service and that the study examine a range of immunisation options including the use of accelerated vaccination schedules.

10.2.2 HEPATITIS C PREVENTION MEASURES IMPACTING UPON ALL INMATES

Preventative strategies proposed to the Committee to limit the spread of Hepatitis C fell into two broad categories: measures impacting upon all inmates such as use of barber's shears and cleaning up blood spills; and measures directly targeting injecting drug users within the corrections system. These latter measures will be discussed in Section 10.2.3 while issues pertaining to all inmates are reviewed in the discussion below.

- **Barber's Shears**

During the course of evidence, Professor Lloyd discussed a case study involving the transmission of Hepatitis C through the use of barber's shears. One inmate incurred a laceration from barber's shears which contained blood from a laceration from the scalp of a Hepatitis C infected inmate (Lloyd evidence, 30 March 1998).

The Committee was advised that a trial of barber's shears with detachable heads that could be disinfected without using an autoclave had recently been conducted at Long Bay. In giving evidence, the Departmental officer anticipated that a recommendation would shortly be made that all correctional centres purchase and supply only these shears.

RECOMMENDATION 119:
That the Minister for Corrective Services instruct all correctional centres to purchase and supply only approved barber's shears with detachable heads that can be cleaned readily with bleach and water.

- **Contact with Blood**

The Committee heard that:

> *inmates are often asked to clean up blood spills, whether they be from an accident, an attempt at self-harm or suicide. Policies are in place to say that inmates should be given barrier methods of protection so that they do not come in contact with blood, but that does not always happen. That is something that needs to be constantly promoted and reviewed. At Public Health Services we see a number of inmates presenting after an exposure, after they have had to clean up a large blood spill without gloves or protection* (Christensen evidence, 23 March 1998).

Christensen's comments raise at least two concerns: the risk inmates are exposed to in cleaning up blood spills and attitudes of officers who insist that inmates undertake such tasks.

The Department advised the Section 2.9 of the HIV and Health Promotion Unit's *Policies and Procedures and Management Guidelines* sets out procedures relating to blood spills. The Section does not however clearly state that inmates must be provided with the necessary equipment if they are requested to clean blood spills. The Department advised that this oversight will be amended with the Guidelines are next printed (Department of Corrective Services supplementary submission).

The Committee is concerned that without adequate protection, inmates are put at risk when requested to clean up blood spills. The Committee assumes that inmates would only clean up blood spills upon direction from prison officers. Clearly the onus is upon the officers who give such directions only when adequate protection is available.

RECOMMENDATION 120:
That the Minister for Corrective Services direct that inmates required to clean up blood spills must be provided with adequate protective clothing and appropriate sterilisation solution to minimise their exposure to Hepatitis C.

10.2.3 HEPATITIS C PREVENTION MEASURES TARGETING INJECTING DRUG USERS WITHIN THE CORRECTIONS SYSTEM

A 1993 NSW study showed that injecting drug users are less likely to inject while in prison, but those who do inject are more likely to share injecting equipment than they would have prior to imprisonment (Dolan, Wodak, Hall, Gaughwin and Rae, 1996). In noting these results, the submission from the Prisons and Blood Borne Communicable Diseases Community Working Group notes that those who inject are "forced into sharing networks, among whom the majority may well be already HCV-positive".

The following discussion looks are measures proposed to the Committee to prevent the transmission of Hepatitis C amongst injecting drug users in the corrections system.

- **Education Directed to Injecting Drug Users**

Lloyd stressed to the Committee the importance of providing inmate education strategies that target the most "at risk" group of prison inmates: sero-negative inmates (ie. not yet infected with Hepatitis C) who report they are injecting drug users. As Lloyd stressed to the Committee, these men and women are, in the first few days and weeks in prison, "hanging out" for drugs (see Section 10.2.1 for Lloyd's quote). Lloyd urged

the Committee "to think laterally about how we can minimise some of those transmission events" (Lloyd evidence, 30 March 1998).

While only one witness raised this issue of education specifically directed at injecting drug users, the Committee considers it a vital factor in preventing the spread of Hepatitis C in the corrections system. The Committee is very aware of the pressure put upon new inmates during the first few days and weeks in prison and the stress this generates. It considers it vital that every effort be made to minimise the risk of transmission at this time.

RECOMMENDATION 121:

That the Minister for Corrective Services direct that appropriate educational strategies target non Hepatitis C positive inmates who are at risk of infection during their first few weeks in prison.

- **Provision of Sterile Needles and Syringes**

The *Prisons (Syringe Prohibition) Amendment Act, 1991* made it an offence for a person to introduce (or attempt to introduce) a syringe into a prison without the consent of the prison governor; or to supply (or attempt to supply) a syringe to a prisoner in custody, except when authorised to do so by a doctor, and if the prisoner is in prison, with the written consent of the prison governor. As Department of Corrective Services policy PLY.92.162/4 points out the Act includes that an offence may be committed even though only part of a syringe, such as a needle, is involved (Department of Corrective Services, 1996:66). Despite the legislation, there was, during the course of the Inquiry, considerable support given to the provision of sterile needles and syringes to prisoners within the corrections system.

In appearing before the Committee, Crofts reiterated the position he has taken in his published works in stating that "I think the provision of sterile needles and syringes in prisons would largely overcome the risk associated [with sharing]" (Crofts evidence, 28 November 1997).

In their submission to the Inquiry, the Hepatitis C Council called for the establishment of needle and syringe programs in prisons and appropriate amendments to prison regulations to enable such programs to proceed (Hepatitis C Council Submission).

Support for the provision of clean injecting equipment also came from a prison inmate who stated in his submission that:

> *I feel that the main problem in prisons today is the lack of clean needles . . . The spread of HIV/HCV is being allowed to continue due to the*

Department not wanting to be seen as condoning the use of intravenous drugs. Surely society would demand the Department of Corrective Services to be responsible for containing the spread of these viruses. . . If we lived in a perfect world then there would be no drug use or wilful spread of these viruses, unfortunately we do not and as such the Department of Corrective Services are being irresponsible for allowing the spread of these deadly viruses to continue (Lee submission).

Representatives from the Community Working Group on Prisons and Blood Borne Communicable Diseases also supported the introduction of sterile needles and syringes. In their submission to the Inquiry they argued that:

the success of needle and syringe exchange programs in the general community demands similar action within the prison system, together with comprehensive information about safe injecting procedures and vein care (Community Working Group on Prisons and Blood Borne Communicable Diseases submission).

The Working Group called for a pilot of a "strict" one-for-one needle exchange program within the prison system (Selvanera evidence, 23 March 1998).

The NSW Hepatitis C Taskforce recommended the establishment of a pilot syringe (only) exchange program in a "suitable" correctional facility (NSW Hepatitis C Taskforce, 1995:20). The Taskforce considered the trial would need to be time-limited, strictly "one-for-one" and include a careful examination of possible unintended negative consequences. It was recognised that the recommendation would be "strongly opposed" however, the Taskforce recognised the opportunities to interrupt Hepatitis C transmission in prisons to be "severely limited" (NSW Hepatitis C Taskforce, 1995:20).

Professor Lloyd informed the Committee that "in an ideal setting I would like to have a needle exchange" (Lloyd evidence, 30 March 1998). However, he was very aware of the challenges such a proposal would bring. He envisaged:

challenge on a series of levels. In a practical sense it could be dispensed in every prison by the public health nursing unit on an exchange basis. On a political level it has this huge difficulty in that the Department of Corrective Services would have to say implicitly that there are a lot of drugs available in our prisons and it is going to let that continue to be the case (Lloyd evidence, 30 March 1998).

He was also aware that:

currently there are some difficult irreconcilable stumbling blocks primarily linked to the Department of Corrective Services (Lloyd evidence, 30 March 1998).

Mr Puplick appearing in his capacity as Chair of ANCARD also gave support to the concept of needle and syringe exchange in prisons. As he informed the Committee:

> *from a public health point of view there is no reason that people who have access on the outside to a preventative health measure such as clean injecting equipment should be denied access to that same treatment simply as a result of their incarceration* (Puplick evidence, 7 November 1997).

Both Lloyd and Puplick referred the Committee back to the introduction of condoms in prisons as an example of the successful introduction of a controversial preventative strategy that, at first, received considerable opposition not only from prison officers but the general community.

As a member of the Prison Condom Committee for Corrections Health Service Lloyd reminded Members that the introduction of condoms:

> *is a good example of there being a large amount of paranoia up-front, which basically has resolved. Condoms are out there. Through careful negotiations, dealing carefully with unions, then conducting a structured trial in a set of prisons where the governors were a little more enlightened, and the realisation that there were no big crisis associated with it, we were then able to get it to fly* (Lloyd evidence, 30 March 1998).

Mr Puplick chaired the Committee that, at the request of then Attorney-General, the Hon John Hannaford, MLC, prepared a report into the possible introduction of needles and syringes and condoms in prisons. The final report recommended the introduction of condoms, but not needles and syringes. When questioned on the reasons for not supporting the introduction of needles and syringes at that stage, but his support for their introduction now, Puplick informed the Committee that:

> *our reason for not recommending . . . the availability of syringes in prisons at that stage was the specific issue of . . a syringe as an offensive weapon. . . We were not in a position to look at any overseas evidence at that stage. It is only in the past couple of years that such material, from Germany in particular, has become available. All of the material indicates that controlled self-injecting arrangements within prisons can be made to work in a way that is not in any meaningful sense dangerous to prison officers. That is either because the injecting is done in essentially a self-injecting room within the prison itself or because the control mechanisms for the issue of needles are such that only one needle is issued to a person in a prison. They are then required to be kept in a glass-fronted or perspex-fronted cabinet in their room so that the needle is kept permanently on display. There have been no instances of which I am*

aware - certainly none reported in the literature - of any of those needles being used as weapons. Prisoners are not short of significant numbers of sharp instruments of one sort of another, nor indeed are they in any sense short of dirty needles (Puplick evidence, 7 November 1997).

In his evidence he referred to "substantial overseas evidence" from Germany, Switzerland and to a lesser extent Austria and preliminary data from Spain on the extent to which the provision of clean needles has had a "significant impact" on reducing the rate of HCV infection within the prison system (Puplick evidence, 7 November 1997). Similar evidence was cited to the Committee by Mr Selvanera who informed the Committee that effective needle and syringe exchange programs are operating effectively in at least three jurisdictions: Switzerland, Germany and Spain. He provided the Committee with the following details of the Swiss pilot program:

After a 12 month pilot of one of its needle exchange programs the Swiss experience was not a single new case of HIV or Hepatitis B, no new cases of abscesses linked to injecting drug use, not a single instance in which needles were used as weapons against prison staff or other inmates and a fall in drug consumption as measured by the level of demand for new needles over the study period (Selvanera evidence, 23 March 1998).

The submission from the Community Working Group on Prisons and Blood Borne Communicable Diseases contained further detail of these pilot programs including the various models for implementing needle and syringe exchange within the prison system. Two models identified were the installation of syringe distribution machines which could be accessed anonymously and a system whereby prisoners identified themselves as current injecting drug users with the prison doctor prior to commencement on the program. Syringes are exchanged during visits to the prison health centres. The Working Group's submission notes that both models amend regulations permitting possession of syringes in the toilet area of the prisoners' cells with any syringes and drugs found outside these areas confiscated (Community Working Group on Prisons and Blood Borne Communicable Diseases submission).

In referring to these overseas models, Mr Selvanera urged the Committee that Australia does not need to "reinvent the wheel on this issue" and undertake all the policy development given that it has the experience of these countries to turn to (Selvanera evidence, 23 March 1998).

The Department of Corrective Services representative appearing before the Committee made it very clear that "the department has no plan to provide needles and syringes to inmates" (Vumbaca evidence, 23 March 1998). As he went on to elaborate:

needles and syringes in prison is an emotive issue, particularly given the recent death of a prison officer who was deliberately infected with HIV by a needle and syringe . . . . The department is not considering the option

of introducing needles and syringes in the same way that they are available through the needle exchange program (Vumbaca evidence, 23 March 1998).

In response to the evidence presented to it, Committee Members considered it appropriate for the Intersectorial Advisory Committee for Hepatitis C proposed in Recommendation 105 to investigate the appropriateness of introducing a needle and syringe exchange program into the state's correctional system. Should the Advisory Committee consider it appropriate, the Committee proposes this body then develop the guidelines to assist in the program's implementation.

RECOMMENDATION 122:
That the NSW Intersectoral Advisory Committee for Hepatitis C proposed in Recommendation 105 investigate and report on the appropriateness of introducing a needle and syringe exchange program, modelled on the successful European trials, into the state's correctional system and, if necessary, develop guidelines for the program's implementation.

The primary objection to providing needles and syringes to inmates comes from prison officers who are concerned that needles and syringes would be used as weapons. As the Committee heard from the Department of Corrective Services representative:

at the moment needles are a valuable commodity within the prison system for inmates who hold them. They are not likely to be misused or given up and they are not handed in by people . . If they were freely available in the system there is a fear amongst staff that the potential for inmates to use them will exist (Vumbaca evidence, 23 March 1998)

and

people have a number of concerns about how needles and syringes could be introduced into the system and yet maintain the safety of staff and other inmates who do not have access to needles and syringes . . . (Vumbaca evidence, 23 March 1998).

Prison officers are, however, currently put at risk of needle stick injury when conducting cell searches. The Committee was informed by the Department of Corrective Services that there is, on average, one needle stick injury a month amongst prison officers conducting searches. These injuries occur despite Procedural Order ACO:94/138 *Handling and Disposal of Needles and Syringes and Other Sharp Items* which states: "**DO NOT** place hands into areas which you cannot see" and "**DO NOT** rub fingers along or under tables, beds, mattresses etc" (Department of Corrective Services, 1994).

In addition, the Committee was advised officers receive “a lot of training” to ensure they search correctly however:

> *staff are searching incorrectly, forget to search or stick their hands somewhere where they should not and get a needle stick* (Vumbaca evidence, 23 March 1998).

As Vumbaca conceded, providing needles “would probably reduce the level of risk to staff” (Vumbaca evidence, 23 March 1998).

The submission from a prison inmate noted that:

> *I understand that needles and needle stick injuries are a problem for Officers during searches, but once again the facts are that <u>there are needles in here already</u>, and I figure that if it was me, I’d rather be stuck by a clean(er) needle than one that has been around for a long time* (Submission 63).

Both during the course of evidence and in their written submission, representatives from the Community Working Group on Prisons and Blood Borne Communicable Diseases noted that the public sector prison officers’ unions (the Prison Officers Vocational Branch and the Commissioned Officers Vocational Branch of the PSA) are opposed to harm minimisation measures in prisons (despite it being government policy). The level of support for this opposition among the rank and file is, the Committee was advised, “unknown” (Cregan evidence, 23 March 1998 and Community Working Group on Prisons and Blood Borne Communicable Diseases submission). The Working Group noted that representatives of private sector officers employed at the Junee Correctional Centre have expressed their support for harm minimisation principles on the basis that minimising the prevalence of infectious diseases among the inmate population is in their members’ own interest (Community Working Group on Prisons and Blood Borne Communicable Diseases submission).

Cregan noted in evidence that one of the features of prison officers is that they are potentially in a position to be an “incredible force for the reduction of health problems” in the corrections system (Cregan evidence, 23 March 1998). Cregan also made reference back to the introduction of condoms into prisons and informed Members that over 50 per cent of prison officers were in favour of condom distribution and non-commissioned officers were “divided about 50-50" in support of and against (Cregan evidence, 23 March 1998). As she concludes:

> *we believe that they could be a force to contributing to better health if they took a different perspective on what harm minimisation means for their own membership* (Cregan evidence, 23 March 1998).

In terms of strategies to bring about attitudinal change, the Working Group suggested that:

> *it is a matter of extreme importance to convince correctional staff of the benefit to themselves as well as to the prisoners in their care, of minimising the level of transmission risk they face in carrying out their duties and the advantage in accepting a harm minimisation approach* (Community Working Group on Prisons and Blood Borne Communicable Diseases submission).

In the course of evidence Cregan added:

> *the main thing would be to find some way of explaining to the leadership of the organisations that it is their own benefit to reduce the viral pool in prisons, to reduce the number of people who are injecting in prisons and to reduce the potential risks associated with unclean injecting equipment that is in prisons. . . . To help them see . . . that the less occurrence of Hepatitis C amongst prisoners and the safer it is in any potential situation of infection, the more it is in their own interest* (Cregan evidence, 23 March 1998).

The Working Group recommended special education modules on harm minimisation be developed and made compulsory for all staff. The Committee fully supports this proposal.

RECOMMENDATION 123:

That the Department of Corrective Services design, develop and implement an in-service training course for prison officers made up of education modules on harm minimisation and that adequate resources be made available to fund the implementation of the modules. The Committee further recommends that the Minister for Corrective Services direct all prison officers to undertake the proposed in-service training course on harm minimisation.

- **Safe Injecting Rooms**

During the course of the Inquiry support was not only given to the introduction of safe injecting rooms in the general community as has been discussed (see Section 10.1.2), but support was also given to the introduction of safe injecting rooms within the corrections system.

Harper, in her capacity as Acting Clinical Nurse Consultant with Corrections Health Service informed the Committee that:

> *I believe strongly that . . . we should have a room within the confines of the prisons for prisoners to be able to inject in a safe manner using the needle exchange program . . . I would see it as just public health under the guise of the Public Health Unit . . . That is a fairly radical viewpoint that I have but when I look at the age of the young offender who presents now and is Hepatitis C positive I have to say that alarm bells ring very loudly in terms of what we are doing about all of this* (Harper evidence, 23 March 1998).

Representatives from the Community Working Group on Prisons and Blood Borne Communicable Diseases also called for the establishment of supervised safe injecting room areas within prisons. Like Harper the Community Working Group's model saw the rooms being under the authority and supervision of the Corrections Health Service. They did not anticipate the need for legislative amendment, although there would be, they admitted, "some operational directives to be changed at the Department of Corrective Services end" (Selvanera evidence, 23 March 1998). As a Working Group representative informed the Committee:

> *we note that needles and syringes are allowed to go into the gaol premises to be used by clinic staff in the Corrections Health Service for vaccinations and treating diabetics and other medical conditions for which injections are required. As a model we propose that a safe injecting area be set up with a medical focus . . . to treat the dependency on the drug as a medical problem. A safe area could be established within the clinic area under exactly those same provisions - the exemption from the Prisons Act that covers the bringing in of injecting equipment for those other medical treatments* (Cregan evidence, 23 March 1998).

The Working Group identified two advantages in the establishment of safe injecting areas: injecting equipment would be limited to a specific area within the clinic environment so that the risk of needlestick injuries to staff searching cells would be decreased; and prison officers, currently opposed to harm minimisation measures for injecting drug users, would not be involved in running the program (Community Working Group on Prisons and Blood Borne Communicable Diseases submission). The Working Group recommended that the Commissioner for Corrective Services direct the governors of all correctional centres to designate specific areas annexed to prison clinics as safe injecting areas and authorise medical personnel to bring needle and syringes into those areas for the purposes of establishing safe injecting programs (Community Working Group on Prisons and Blood Borne Communicable Diseases submission).

The Community Working Group on Prisons and Blood Borne Communicable Diseases suggested that safe injecting rooms could help reduce the number of deaths by overdose that currently occurs in the state's corrections system. They informed the Committee that death by drug overdoes is currently the "primary cause" of death within the state's prisons system and accounts for one-third of all deaths in prisons (Selvanera evidence, 23 March 1998).

The Hepatitis C Council also called for the establishment of safe injecting rooms within the prison system (Hepatitis C Council submission). Lloyd considered a pilot injecting room in prison to be a "bold move" but admitted that he could "live with the idea". He did warn Members that "it would be a popular room, I hate to tell you" (Lloyd evidence, 30 March 1998).

In its submission to this Inquiry, ANCARD attached the submission they made to the Joint Select Committee Parliamentary Inquiry into the Establishment or Trial of Safe Injecting Rooms. In that submission ANCARD gave its support to the trial of safe injecting rooms in the prison setting. The submission notes that:

> *ANCARD would support such a trial [of safe injecting rooms] being expanded to include the prison setting . . . Regard must be given to prison officers whose safety may be compromised without ensuring adequate measures are in place. Clean injecting rooms within prisons may overcome the personal security worries of prison staff. The duty of care of prison officers must also be considered* (ANCARD submission to the Joint Select Committee Parliamentary Inquiry into the Establishment or Trial of Safe Injecting Rooms).

For obvious reasons, some departmental officers were reluctant to comment on such a sensitive issue. Others were happy to make a personal, rather than official, comment based on their experience. Mr Butler made such a personal comment when he appeared before the Committee. He noted that:

> *we need to look at options as to whether you introduce a needle exchange scheme or whether you have safe injecting rooms . . . I think that we probably need to do an evaluation of that to determine the most effective way. Safety is also an issue. It is a difficult environment, as we know about the HIV cases* (Butler evidence, 23 March 1998).

Butler envisages a safe injecting room to be run by NSW Health which could involve:

> *perhaps one needle when a prisoner goes in and one needle when the prisoner comes out* (Butler evidence, 23 March 1998)

but as he admitted:

> *one then has to consider whether prisoners would actually use that system, because it might identify them as persons using drugs* (Butler evidence, 23 March 1998).

While supporting the concept, some witnesses such as Christensen and Harper recognised inherent difficulties in the proposal:

> *The way the gaols are currently structured, I would find it quite difficult to see how safe injecting rooms or a needle and syringe exchange program could be operated. While I support that from a public health point of view because it is a valuable strategy, it would take a lot of planning, a lot of implementation and a lot of negotiation* (Christensen evidence, 23 March 1998)

and

> *I suppose you would have a security issue or problem again in that you have to work in conjunction with the Department of Corrective Services to access those inmates. We know that they would never come to the party, given the fact that an officer was stabbed and died last year. I do not believe that putting people in prison and denying them in fact works* (Harper evidence, 23 March 1998).

During the course of his evidence, the Department of Corrective Services representative pointed out to the Committee that:

> *The issue of injecting rooms that was considered in the community may have provided an opportunity for the department at least to consider that as an option for prisoners. As that has not been approved for the community it is unlikely that it will be considered by the department. . . Prisons will not lead the way in this area; they will look at what is available in the community. We are there to provide a level of service that it equitable to that in the community* (Vumbaca evidence, 23 March 1998).

The Committee noted the evidence presented to it concerning the establishment of safe injecting rooms in prisons and the calls for a time-limited safe injecting room trial to be conducted in the public health nursing unit of a carefully selected correctional centre under the authority and strict supervision of the Corrections Health Services. The Committee believed that such a trial in the correctional system would not be appropriate until a proposal for a trial in the wider community had been approved by the Government.

• **Availability of Drug Withdrawal Programs**

Another preventative strategy proposed to the Committee related to the availability of drug withdrawal programs for prison inmates. Lloyd proposed that:

> *there will be selected individuals, like those in the general community, for whom other strategies may well be useful, such as drug withdrawal programs, including long-acting narcotic antagonants such as naltrexone and so on* (Lloyd evidence, 30 March 1998).

However, when the Department was asked to provide advice on rehabilitation and treatment programs available to inmates wishing to give up drugs, the response provided made mention only of the role played by Alcohol and Other Drug Workers and group work programs. While counsellors and group work have a part to play in drug rehabilitation, they may not be appropriate for all inmates. The Committee was disappointed with the limited range of drug withdrawal strategies available to inmates which are available to those in the general community. The Committee wishes to see the Department give serious consideration to introducing a range of drug withdrawal strategies and making these available throughout the correctional system.

RECOMMENDATION 124:
That Corrections Health Service make available a range of drug withdrawal strategies to inmates seeking to give up their drug habit.

• **Abolition of Penalties Associated with Cannabis Use**

As has been discussed in Section 3.2.5 cannabis is not the drug of choice for most prison inmates for a number of reasons: it is harder to obtain than heroin because its importation into prisons is easier to detect and it is less profitable to import per unit volume; and cannabis is detectable more readily through urinalysis than heroin. As a result of these factors, prisoners are more likely to use the less preferred, but more readily available drug. As the Community Working Group on Prisons and Blood Borne Communicable Diseases noted in their submission:

> *This leads to the anomalous situation where cannabis, which is smoked and therefore safe in terms of viral transmission, is currently subject to heavier disincentives to its use than heroin and other injectable drugs, which represent the highest of all risks for HCV transmission* (Community Working Group on Prisons and Blood Borne Communicable Diseases submission).

To overcome this anomaly, the Working Group propose that:

> *the use of cannabis in prison should be preferred over injectable drugs such as heroin, and a shift in drug use patterns should be encouraged either by ceasing to test for cannabis on urinalysis, or by eliminating penalties for a positive result* (Community Working Group on Prisons and Blood Borne Communicable Diseases submission).

The Hepatitis C Council made a similar recommendation to the Committee in calling for a change in the current situation to one that encourages prisoners away from the use of powder drugs to the use of cannabis (Loveday evidence, 30 March 1998).

The Working Group made two specific recommendations to the Committee concerning cannabis in prisons. Firstly they recommended that the Department of Corrective Services cease urinalysis testing for evidence of cannabis use by prisoners and that penalties for smoking cannabis be abolished (Selvanera evidence, 23 March 1998; Community Working Group on Prisons and Blood Borne Communicable Diseases submission). Secondly that prison regulations regarding drug trafficking and use be amended so that sanctions against cannabis are lifted (the Prisons and Blood Borne Communicable Diseases Community Working Group submission).

It was suggested to the Committee that such a strategy would bring NSW prisons into line with moves toward law reform in the community and mean that:

> *transition to and from prison would no longer involve a shift for some people from less harmful substances and use practices to more harmful ones while in gaol. Any attempt to make a transition back to safer drug use after release is certain to be made more difficult if dependency has been established in prison* (Community Working Group on Prisons and Blood Borne Communicable Diseases submission).

Committee Members were not able to support the proposals forwarded by the Prisons and Blood Borne Communicable Diseases Working Group.

10.2.4 FUNDING OF HEPATITIS C PROGRAMS

The Committee is fully aware that the proposals it has recommended have costing implications. However given the prevalence of Hepatitis C within the corrections system and the implications such a high prevalence level has upon the general community, the Committee considers its proposals to be cost-effective and financially responsible.

The issue of funding was raised by the Department's representative. Mr Vumbaca noted that additional funding to finance Hepatitis C preventative initiatives has not been forthcoming and that he has to use:

> *what was dedicated HIV money to cover a whole range of issues now, including Hepatitis C. The money received from the Department of Health is still technically dedicated HIV money* (Vumbaca evidence, 23 March 1998).

Mr Vumbaca further advised that this funding arrangements between the Departments of Health and Corrective Services is “putting a strain on relationships at the moment” (Vumbaca evidence, 23 March 1998). As he noted:

> *What is probably putting a strain on the relationship at the moment is the need to use existing funds only, HIV funds, to cover a whole range of issues in the system. That is probably the main area of contention - how we keep providing all these new programs and service within the existing budget. We are taking from one area to pay for another* (Vumbaca evidence, 23 March 1998).

Utilisation of HIV funding to finance HCV preventative initiatives fails to recognise or acknowledge the extent of Hepatitis C in the prison system. In the Committee’s opinion it is inappropriate that funding allocations are not made to address Hepatitis C issues within the corrections system given the extent of the epidemic. The Committee considers it important that funding be allocated to Hepatitis C dedicated projects rather than taken from HIV allocations. The Committee therefore wishes to see all funding used in Hepatitis C programs and projects identified as such.

The absence of HCV specific funding allocations is indicative of a far greater concern of the Committee’s - the lack of policies giving direction to strategies designed to prevent the transmission of Hepatitis C in the correctional system. The Committee considers it important that the Departments of Health and Corrective Services collaborate to develop a Hepatitis C prevention policy and associated strategies and that the policy be included in the NSW Hepatitis C Policy Statement proposed in Recommendation 28 and the strategies be incorporated into the NSW Hepatitis C Strategic Plan proposed in Recommendation 31.

RECOMMENDATION 125:

That the Ministers for Health and Corrective Services direct that a policy addressing prevention of Hepatitis C within the state’s correctional system and the role played by drugs in the transmission of Hepatitis C be collaboratively developed between the two departments and that the policy be included in the NSW Hepatitis C Policy Statement proposed in Recommendation 28. The Committee further recommends that the two departments also develop strategies to prevent Hepatitis C transmission in the state’s corrections system and incorporate these strategies into the NSW Hepatitis C Strategic Plan proposed in Recommendation 31.

10.2.5 CONCLUSION

The preceding discussion proposes a wide range of strategies designed to prevent the transmission of Hepatitis C within the state's correctional system. As with the strategies adopted to prevent Hepatitis C transmission amongst injecting drug users the Committee has again chosen a multi-facets approach. This is in line with evidence received. The Committee heard, for example that:

> *I do not think any one measure that one could name is likely to do the trick and resolve the problem . . . there would be a setting for each of those components for individuals within the prison as there is in the outside community* (Lloyd evidence, 30 March 1998).

10.3 PREVENTING THE TRANSMISSION OF HEPATITIS C IN THE HEALTH CARE SETTING

In Chapter Three reference was made to Italian research which identified the risk of surgeons contracting Hepatitis C (Pietrabissa, 1997). Pietrabissa calculated the current risk over a 30 year period to be 34.8%. However, when preventative strategies were introduced, this rate could, according to his calculations, be reduced to 16.6% over the same time period (see Table Thirty-one).

TABLE THIRTY-ONE
ESTIMATED REDUCTION IN THE RISK OF HCV TRANSMISSION TO THE SURGEON BY ADOPTING PREVENTATIVE STRATEGIES

CONDITION OF 30-YEAR RISK	HVC (%)
Current	34.8
With face shields	32.6
With 50% reduction of sharp injuries	19.2
With all the above precautions	16.6

Source: Pietrabissa, 1997:575

Even if Pietrabissa's estimations are generous, as West implied during the course of his evidence, there are obviously measures that can be taken by surgeons, and other health care workers, to reduce the risk of contracting Hepatitis C from patients. In many instances incorporating such practices will also lessen the risk of health care workers passing the Hepatitis C virus on to their patients. Current and proposed preventative strategies are outlined in the following discussion.

10.3.1 PREVENTATIVE STRATEGIES CURRENTLY IN PLACE

Preventative strategies currently in place to protect both health care workers and their patients include the practice of universal precautions, hospital based Hepatitis B vaccination programs, telephone information lines, and the awareness of health care workers of their Hepatitis C status. The general practitioner education program reviewed in Section 8.4.1 also plays a major role in providing general practitioners with information on preventative strategies.

- **Universal Precautions**

Prior to an appreciation of the nature of blood borne diseases health care workers routinely undertook procedures which would be considered unacceptable today. One nurse writing to the Committee noted, for example, that:

> *many nurses in my era did the following (without gloves):*
> - *shaved open wounds ready for surgery or repair;*
> - *changed blood bottles - often the tubing was tough and the pressure needed to puncture the opening resulted in blood spurting out;*
> - *manual cleaning of theatres and manual washing of blood sponges* (Submission 19).

Universal blood and body fluid precautions ('universal precautions') were originally devised by the US Centres for Disease Control and Prevention in 1985 largely due to the HIV/AIDS epidemic and an urgent need for new strategies to protect hospital personnel from blood borne infections. The new approach placed emphasis, for the first time, on applying blood and body fluids precautions universally to all persons regardless of their infectious status or perceived risk (NHMRC, 1996:10).

Australia adopted a broader definition of Universal Precautions. Unlike the US which excluded faeces, nasal secretions, sputum, sweat, tears, urine or vomitus unless they contained visible blood, all blood and body substances were considered to be potentially infectious in Australia (NHMRC, 1996:11). However, the NHMRC have observed that the term "universal precautions" was perceived to be "ambiguous" resulting in some confusion in its interpretation and false sense of security in its application and they propose use of the terms "standard" and "additional" precautions" (NHMRC, 1996:11).

NSW Health's Infection Control Policy (95/13) recommends the adoption of the 'Standard Precautions' approach to the provision of care to all patients irrespective of their infectious status. This approach is, according to NSW Health, consistent with international best practice and encourages adoption by health care workers of a uniform, minimum level of infection control that is protective against most known hospital pathogens (NSW Health supplementary submission).

The submission received from the Royal College of Nursing, Australia expressed concerns that universal precautions alone will not be enough to prevent cross infection of blood borne viruses such as Hepatitis C between patients in haemodialysis units. The submission notes that haemodialysis has "probably the highest incidence of blood being sprayed several metres" when extra-corporeal blood lines are split or disconnected. While staff wear protective eyeware and gloves when attending patients, concern was expressed for the other patients sitting in close proximity. Hepatitis C patients are no longer required to be treated in separate rooms, only in low traffic areas. The submission questions whether such a precaution is enough to prevent cross infection within this group of patients (Royal College of Nursing, Australia submission).

The submission from the Royal College of Nursing, Australia noted that:

> *the effectiveness of universal precautions rests very much on their application in the workplace by all who are working in the clinical setting. Thus commitment on the part of all employers to staff education and occupational health and safety practices are of vital importance to success in prevention cross infection of blood borne infections.*

- **Hepatitis B Vaccination Program**

In its publication, *Infection Control in the Health Care Setting*, the NHMRC made three recommendations concerning hospital based Hepatitis B vaccination programs:

i. health care establishments should maintain immunisation programs that offer all staff, including trainees, Hepatitis B vaccinations with post-vaccination testing to identify non-responders;

ii. adequate information on the risks/benefits of vaccination should be provided to all staff to encourage participation; and

iii. hospital accreditation should require documented evidence of vaccination programs (NHMRC, 1996:3).

The guidelines also recommend that training establishments should ensure all health care worker students are adequately vaccinated to ensure protection against infections that are likely to be encountered in the course of their training (NHMRC, 1996:7).

NSW Health's policy on HBV vaccination of health care workers is consistent with the NHMRC Guidelines. The policy is spelt out in Departmental Circular 96.40 which states that:

> *it is the employer's responsibility to ensure that all susceptible health care workers whose work may involve activities with the potential for exposure to blood or other body substances are offered, free of charge, a course of Hepatitis B vaccine within ten days of commencing employment at the health care facility* (NSW Health, 1996:4).

The policy was developed in accordance with the following principles:

- employers and health care workers have a legal obligation to care for the health and safety of others in the workplace (this includes both patients and fellow workers) under the *Occupational Health and Safety Act, 1983*; and

- employers and health care workers owe a common law duty of care to their employees and patients (NSW Health, 1996:3).

It is Departmental policy that health care workers are to be offered HBV vaccine, that the offer is to be documented and that appropriate records are to be kept of the date of vaccination, vaccine batch numbers. It is also policy to offer antibody testing and vaccine free of charge to health care workers, although unless they perform exposure prone procedures, they are not obliged to be tested. Health care workers are also at liberty to be tested and vaccinated privately rather than as part of a workplace program. It is not obligatory for health care workers to inform the employer of their HBV antibody status (NSW Health supplementary submission).

The NHMRC Guidelines call for hospital accreditation to require documented evidence of HBV vaccination programs for health care workers (NHMRC, 1996:3). When asked to comment on this proposal, NSW Health noted that hospital accreditation is carried out by the Australian Council on Health Care Standards (ACHS) which looks for evidence of compliance with Infection Control Procedures in a "broad manner" (NSW Health supplementary submission). The Department informed the Committee that they do not have the resources to monitor compliance with the policy. They would "support" the notion that inspection of documentation concerning implementation of a HBV vaccination program (excluding confidential staff records) is appropriate for inclusion in ACHS accreditation procedures (NSW Health supplementary submission).

RECOMMENDATION 126:

That the Minister for Health, through the forum of the Australian Health Ministers' Council, encourage the Australian Council on Health Care Standards to include the inspection of documentation verifying implementation of a Hepatitis B vaccination program for staff (excluding confidential staff records) in the hospital accreditation procedures.

- **Needlestick Injury Hotline**

NSW Health funds a 24 hour hotline which offers expert advice to health care workers who sustain needlestick injuries. The hotline is based at the Albion Street Clinic.

- **Australian Reference Centre for Hepatitis C Information**

Health care professionals are able to access the Australian Reference Centre for Hepatitis C Information (ARCHI) for comprehensive information, reference and referral services. The Centre, which is a joint initiative of the Albion Street Centre, ANCARD and Schering-Plough, has been established to provide accessible information on the Hepatitis C virus clinical manifestations to health care professionals nationwide. A toll free 1800 telephone number (1 800 42 72 44) can be accessed Mondays to Fridays, 9:00am to 5:00pm. The Centre offers the following services:

- an up to date database providing current technical information on HCV management, treatment and policies;
- provision of infection control, transmission and prevention information;
- access to specialist referral services and HCV Centres nationally;
- technical support to health care workers;
- provision of information to researchers;
- referral to appropriate services;
- provision of legal, ethical and socially relevant information; and
- details of upcoming conferences and seminars (ARCHI, 1998).

- **Awareness of HCV Status**

It is NSW Health policy that health care workers who perform exposure prone procedures are obliged to know their status for HIV and HBV and HCV. With regard to surgeons, the Medical Board of NSW requires all surgeons to be aware of their HIV, Hepatitis B and Hepatitis C status. Similarly Dr West advised it is Royal Australian College of Surgeons' policy that surgeons regularly check their HIV, Hepatitis B and C status. In addition, surgeons susceptible to Hepatitis B should be vaccinated. The Committee was advised that any surgeon infected with any of these blood borne diseases should not perform any invasive procedures or operations (West evidence, 28 November 1997). It is possible that an infected surgeon could be accused of professional misconduct. As a result, there is, as Dr West said a "pretty stiff obligation"

on those performing exposure prone procedures to know their status (West evidence, 28 November 1997).

The NSW Medical Board has an "impairment program" to support doctors with any disability (including infection) with guidance on what duties they may safely undertake (while remaining registered and insured). There is no comparable program in place for dentists, the majority of whom operate in the private sector (NSW Health supplementary submission).

- **Professional Education**

The Committee is aware of several initiatives to provide Hepatitis C information to health care professionals. NSW Health, for example, has distributed the Hepatitis C Council produced booklet entitled *Hepatitis C: What You Need to Know*, to all medical practitioners in the state including private general practitioners and those based in hospitals. The booklet has also been lodged with the Department's Better Health Centre where it has been distributed widely. As Table Nineteen in Section 5.4.2 shows, this initiative cost $95,000.

The RACS has produced an educational video entitled *Old Dogs, New Tricks* aimed at educating surgeons and operating theatre staff. In commenting on the video Dr West noted:

> *you have to change attitudes, and that is not easy. We did manage to change attitudes of surgeons and sort of dramatise a video which they could relate to. We did manage, I think, to chance their attitudes, to change techniques in operating theatres to minimise injury, minimise splashes and contamination* (West evidence, 28 November 1997).

But as Dr West noted:

> *the problem is that in our under-staffed, over-worked hospital wards . . . this [change] is not always possible. One of the symptoms of an over-worked ward is it has got a lot of infection* (West evidence, 28 November 1997).

The submission from the Royal College of Nursing, Australia noted that there continues to be a "significant amount of misunderstanding" about the Hepatitis C virus amongst health care professionals. The College informed the Committee that they are committed to keeping nurses informed of current health issues and would be willing to assist NSW Health in providing education programs to the nursing profession.

10.3.2 PROPOSED PREVENTATIVE STRATEGIES

- **Introduction of National Infection Control Standards**

Dr West advised the Committee that each state in Australia has different infection control standards (West evidence, 28 November 1997). Such a situation is considered by the RACS to be unsatisfactory. They would like to see uniform standards set nationally (West evidence, 28 November 1997).

In 1996, the NHMRC and the Australian National Council of AIDS (ANCA) produced guidelines for the prevention of transmission of infectious diseases. The document is based on the key principles of hygiene, cleanliness and sterility. It includes implementation of Standard Precautions and Additional Precautions, design of the premises, choice and type of equipment, occupational health and safety considerations, safe disposal of clinical waste, the appropriate use of antibiotics, regular monitoring of infections and effective and ongoing education and training program for all levels of staff and incorporation of infection control into a comprehensive quality management program (NHMRC, 1996:1). The RACS considers the NHMRC infection control guidelines to be an appropriate basis for national standards (West evidence, 28 November 1997).

Infection control policies have also been produced by the RACS. The first set of policies were devised ten years ago and they are now in their fourth edition (West evidence, 28 November 1997). The document lists precautions that should be taken, particularly in operating theatres.

Dr West informed the Committee that the President of the RACS had raised the issue of infection control standards with the Federal Minister for Health. The reply received was considered by the College to be “wishy-washy” (West evidence, 28 November 1997).

The Committee supports the RACS in its quest for national infection control standards and considers the most appropriate forum for its consideration and introduction to be the Australian Health Ministers’ Council made up of federal, state and territory Health Ministers.

RECOMMENDATION 127:

That the Minister for Health, through the forum of the Australian Health Ministers’ Council, urge his federal, state and territory counterparts to consider the adoption of national infection control standards. The Committee further recommends that the Minister for Health propose the NHMRC’s guidelines for the prevention of transmission of infectious diseases entitled *Infection Control in the Health Care Setting* (1996) be considered as the basis for national infection control standards.

- **Awareness of Patient HCV Status**

The RACS recommends that patients should be tested pre-operatively for HIV, Hepatitis B and Hepatitis C when "it is clinically indicated" (West evidence, 28 November 1997). In evidence before the Committee, RACS representative, Dr West stated that:

> *We think it important to have a knowledge that the patient is infected. If you have knowledge you can do things in an organised way in the best possible circumstances* . . . *The College believes that it should be a two-way street, that if the surgeons are going to know their status it is not unreasonable for the patients to be aware of their status and to reveal their status if they are going to have a procedures that puts other people at risk* (West evidence, 28 November 1997).

The Committee is aware that the surgeons' position on this issue is not supported by all in the Hepatitis C community. The Hepatitis C Council considers the RACS's recommendation to be "unnecessary" stating that:

> *apart from the potential for greater discrimination practices to occur than are currently taking place in health care settings, there are enormous cost implications, as only PCR testing could give a reasonable indication of infectivity status . . . Current infection control practice recognises that any patient could have any infectious disease. With regard to preventing transmission of an infectious disease, where infection control guidelines are properly applied, it becomes irrelevant for any individual patient to warn health care workers of their status* (Loveday correspondence, 28 November 1997).

The Committee is aware that the controversy that surrounded a call by surgeons in the early 1980s for pre-operative HIV testing when it was clinically indicated has dissipated. The Committee does not believe patients should be now required to declare their Hepatitis C status prior to undergoing surgery.

- **The Obligations of Hepatitis C Infected Health Care Workers: NSW Health Policy**

NSW Health advised it is in the process of preparing a policy statement on the obligations of Hepatitis C infected health care workers. The Department included a summary of the policy in its submission. In brief it stated that:

- a health care worker with a confirmed HCV PCR positive test is not to perform exposure prone procedures. Current evidence does not support exclusion from performance of exposure prone procedures of health care workers who are HCV antibody positive but HCV PCR negative;

- to facilitate compliance with the policy, free confidential testing will be made available to health care workers undertaking exposure prone procedures. If the results of the antibody test are positive, a PCR test will be performed and the health care worker told both results together eliminating any period of time of uncertainly regarding whether the worker should continue performing exposure prone procedures. The health care worker will also be referred to a specialist for expert medical assessment and to other agencies for confidential counselling;

- There are three possible outcomes for HCV infected health care workers:

  1. they may be rendered non-infectious by treatment with interferon and able to resume normal practice of exposure prone procedures

  2. they may have a chronic infection that will not resolve in which case they will need to consider moving into a different occupation that does not required the performance of exposure prone procedures; or

  3. they may be able to modify their practice (under specialist advice) to ensure that their patients are not put at risk. For example, an infected surgeon may take extra precautions such as routinely double gloving, using kevlar glove liners and perform only those parts of operations which are low risk for glove perforation while a colleague performs the high risk parts of the operation (NSW Health submission).

An early draft of the policy proposed that the Blood Bank be involved in HCV testing. This was in response to health care worker concerns that staff health service would not offer a sufficient level of confidentiality for HCV testing. The listing of HCV PCR testing on the Medicare Benefits Schedule in July 1998 (HCV antibody testing was already listed) means that health care workers have the option of monitoring both their HCV antibody and PCR status in consultation with any medical practitioner of their choice. There is now an alternative funding option for health care workers who do not wish to take advantage of free HCV testing offered by Staff Health Services at publicly-funded health facilities.

Pending endorsement of the revised proposal by relevant health care workers organisations, NSW Health advised that the HCV Infected Health Care Worker policy will be released “as soon as possible” (NSW Health supplementary submission).

The RACS recommended a number of provisions it wishes to see made available to all health care workers (whether they are employees or working under contract) when the policy becomes available. These provisions include:

TESTING FOR HCV:

- all testing for HCV should be performed at the Department of Health's expense;

- the HCV tests should be performed with the identify of the health care workers encrypted;

- if the health care workers is anti-HCV positive in initial testing, they should not be informed of the results until their infectious status is established by PCR testing.

ASSISTANCE AND COMPENSATION FOR HCV+ HEALTH CARE WORKERS:

- health care workers found to be positive on testing should continue under their existing employment/contract arrangements during treatment which may render them non-infective, or until they are retrained for other duties if they have to cease performing exposure prone procedures;

- the cost of any treatment for infective health care workers should be at the Department of Health's expense;

- counselling and retraining should be made available through the Department of Health using such agencies as are available. The costs of counselling and retraining should be met by the Department of Health;

- no fault compensation should be available (RACS submission).

The NHMRC infection control guidelines propose a range of recommendations for Hepatitis C infected health care workers and students (NHMRC, 1996:5-6). The recommendations proposed that HCWs with Hepatitis C viraemia should not perform exposure prone procedures. Those with indeterminate Hepatitis C test results should not be excluded from performing exposure prone procedures on the basis of test results alone. If test results are positive or indeterminate, HCWs should be clinically assessed by an experienced physician, over a reasonable period of time, for any sign of current/active infection. Where there is insufficient evidence of current/active infection, the testing doctor, or the individual concerned, should seek the advice of a State/Territory health and/or professional advisory board (NHMRC, 1996:6). The guidelines also make recommendations concerning:

- counselling and treatment;
- reporting;
- confidentiality;

- assistance for HCWs who have occupationally acquired a blood borne virus;
- 'look back' investigations of patients of health care workers infected with a blood borne virus;
- compliance; and
- health care worker students and training (NHMRC, 1996:6-7).

One of the primary issues faced by Hepatitis C infected health care workers is that of retraining and compensation. Under the *Workers Compensation Act, 1987*, employers have certain obligations regarding rehabilitation of employees. The Department's policy regarding occupational rehabilitation is set out in Circular 97/89 *Policy and Guidelines for the Management of Occupational Rehabilitation in NSW Public Health Care Facilities*. NSW Health advised that, in the event of occupationally acquired HCV, employees may be provided with alternative duties and retraining where appropriate (NSW Health supplementary submission).

Dr West discussed the consequences for a health care worker of a positive HCV test result with the Committee:

> *if you are going to ask the surgeons to test themselves, there is not much incentive to be tested if the end result is that you cannot work, that is the problem. If this is going to be a public health measure in order for it to work, there has to be some pro quo, in other words, if the surgeon is positive, he then has to be given some assurance that he will be retrained. For employees and visiting medical officers there should be some sort of redeployment or retraining process . . . The place of some sort of compensation should be looked at. The only recourse at the moment is for health care workers to take common law action . . . Even workers compensation provisions are totally inadequate to cope with employees and this sort of thing* (West evidence, 28 November 1997).

He anticipated that there would probably be 40 surgeons throughout Australia who would require retraining and compensation (West evidence, 28 November 1997). He felt that if testing was going to succeed as a public health measure then:

> *some sort of mechanism should be put in place for people who become positive instead of just casting them to the wind so to speak* (West evidence, 28 November 1997).

His view is reiterated in the College's submission which stated that:

> *for [the policy] to succeed, some form of recompense for those unfortunate individuals found to be positive will need to be established to*

> *ensure health care workers are willing to make themselves aware of their* status (RACS submission).

The Department's *Policy and Guidelines for the Management of Occupational Rehabilitation in NSW Public Health Care Facilities* (Circular number 97/89) would be the appropriate document to ascertain the Department's position on retraining and compensation. The policy states that:

> *The Department of Health and each health care facility shall develop, implement and regularly review an occupational rehabilitation policy and program in accordance with the appropriate WorkCover Guidelines* (NSW Health, 1997:9).

It would appear that the policy is recommending the development of a policy rather than stating the Department's position on rehabilitation. The Committee was not able to ascertain with any certainty what measures are actually taken for Hepatitis C infected health care workers.

The issues surrounding HCV infected health care workers are similar to those faced by professional colleges and health departments in the early 1980s when protocols pertaining to HIV/AIDS infected health care professionals were developed.

- **Quality Assurance for Endoscopic Units**

As was discussed in Section 3.5.3 there have been reports of patients becoming infected with Hepatitis C during endoscopic procedures. Dr West suggested to the Committee that the problem primarily lay in the instruments not being cleaned properly:

> *[transmission] tends to occur in endoscopy units . . . And it is usually related to staff training, new staff . . . We are concerned that [patient-to-patient transmission] is a possibility* (West evidence, 28 November 1997).

The College would like to see a self-regulatory quality assurance system introduced for endoscopic unit covering regular testing of equipment (using broth cultures) and documentation of that testing. According to the RACS such procedures should be "a requirement, not a suggestion" of the Department of Health. As Dr West noted:

> *Gastroscopes are done in major institutions and day surgical units. They should have in place mechanisms to monitor it. It should be part of their accreditation process when they are accredited. All hospitals are accredited* (West evidence, 28 November 1997).

Farrell made similar recommendations. He called for:

closer regulation of day surgery and endoscopy procedures to make sure that they all come up to the high standards of sterilisation, and use of disposable medical appliances that have been recommended by responsible bodies such as the Gastrological Society of Australia (Farrell evidence, 28 November 1997).

The Committee fully supports the proposals made by West and Farrell for tighter regulation of day surgery units performing endoscopic procedures and wishes to see the Minister for Health, within the context of the Australian Health Ministers' Council, urge his federal, state and territory counterparts to consider the adoption of standard procedures for endoscopic units including sterilisation, staff training and use of disposable medical appliances as part of the hospital accreditation process.

RECOMMENDATION 128:
That, within the context of the Australian Health Ministers' Council, the Minister for Health urge his federal, state and territory counterparts to consider the adoption of standard procedures for endoscopic units including sterilisation, staff training and use of disposable medical appliances as part of the hospital accreditation process.

10.4 PREVENTING THE TRANSMISSION OF HEPATITIS C AMONGST BLOOD RECIPIENTS

When asked to identify the most important preventative measures to limit the spread of Hepatitis C Professor Farrell nominated as his first strategy, to "fix up" the blood supply, which, as he noted, as already been done (Farrell evidence, 28 November 1997).

A number of strategies are available to limit the transmission of the Hepatitis C virus through blood and blood products. The NSW Blood Bank currently employs the following strategies: potential blood donors complete a questionnaire and undertake an interview to identify "at risk" behaviours such as injecting drug use prior to donating blood; and all blood and blood products are screen for, amongst other factors, HCV antibodies. As a result of these measures, Dr Benjamin assured the Committee that:

to the best of our knowledge anybody who is infected with the [Hepatitis C] virus is excluded from donating as best as medical science can allow us to do (Benjamin evidence, 10 October 1997).

- **Identification and Exclusion of "at risk" Blood Donors**

In the mid-1980s injecting drug users were excluded from donating blood to NSW Blood Bank as a public health response to the HIV/AIDS epidemic. While it was not

appreciated at the time, this action was to have significance far greater than the possibility of transmitting HIV in that it assisted in limiting the spread of HCV through blood transfusion.

Currently two mechanisms are employed to identify those at risk of transmitting the Hepatitis C virus.

Every donor's ability to donate is reviewed at each visit. Prior to donating blood, donors are asked to complete a Donor Questionnaire, undertake an interview and sign a Declaration form.

Questions asked in the Donor Questionnaire cover a number of at risk activities including:

- contact with the HIV/AIDS virus
- male to male sexual activity
- bisexual activity
- injecting drugs not prescribed by a doctor
- sharing needles
- accidental needle stick injury
- sexual activity with male or female prostitutes
- tattoos
- history of jaundice or hepatitis.

Once the questionnaire is completed, the potential donor undertakes an interview conducted by Blood Bank staff. As the Committee heard, it is during this stage that staff ask "hard questions" if necessary:

> *if anybody has in any way erred in their questionnaire, they are put through a fairly quelling set of questions to ensure their honesty and to understand the gravity of what they are doing* (Benjamin evidence, 10 October 1997).

- **Serological Testing for HCV Antibodies**

Once the donor has completed the questionnaire and signed the declaration form blood is taken. That blood is tested and only after the blood is cleared can it be released:

> *blood cannot be released unless there is a clearance on that blood to be despatched* (Benjamin evidence, 10 October 1997).

All blood is serologically tested for Hepatitis C as well as HIV, Syphilis, Hepatitis B and HTLV-1. As with the Donor Questionnaire, all blood is tested on each occasion.

Any potential donor testing positive for any of the diseases is notified in strict confidence. Similarly if a false positive results is obtained the *Human Tissue Act* requires the donor to be notified and the blood to be discarded.

The Committee was informed that:

> *the system has never broken down . . . in all the years that it has been in operation, of a component being released before the virology results are known to have cleared the donation* (Benjamin evidence, 10 October 1997).

The processes in place to safeguard the spread of Hepatitis C and other blood borne diseases has resulted in the Blood Bank being "regarded as being the world's leading Blood Bank" (Benjamin evidence, 10 October 1997).

The Committee commends the Blood Bank for the thorough processes it has in place to limit the spread of Hepatitis C and other blood borne diseases and its commitment to ensuring that only clean blood and blood products are released.

10.5 PREVENTING THE TRANSMISSION OF HEPATITIS C IN THE SKIN PENETRATION INDUSTRY

The NSW Hepatitis C Taskforce recommended that the AIDS/Infectious Diseases Branch of NSW Health revise the skin penetration regulatons and guidelines and develop an effective implementation strategy (NSW Health, 1995:6). The Taskforce further recommended that the strategy should include prisons.

Early on in the Inquiry, NSW Health advised the Committee that a review of the Regulations and associated Skin Penetration Guidelines had commenced. In a supplementary submission received early October 1998, the Department advised that the Skin Penetration Guidelines were in the final review stage and expected to be released by December 1998 (NSW Health supplementary submission).

The National Hepatitis C Action Plan also considered the issue of skin penetration. As part of the Commonwealth's response to the Action Plan it has prepared educational material addressing infection control advice for the tattooing and skin penetration industry. The material is in the form of leaflets entitled *Tattooing and Your Health* (Commonwealth Department of Health and Family Services, undated) and *Tattoo: Hygienic Procedures for Tattooists* (Commonwealth Department of Health and Family Services, undated). Produced by the Commonwealth Department of Health and Family Services in association with the Professional Tattooing Association of Australia the leaflets identify the basic steps to hygienic and health tattooing and related preventative issues.

Infection Control Guidelines have also been produced by the Australian Acupuncture Association. The Guidelines consider a range of issues including aseptic and hygienic clinical practices, cleaning, sterilisation and disinfection procedures, storage of devices and disposal of sharps and other waste. A quick reference guide is also available in both English and Chinese languages.

The Committee is satisfied with the preventative measures currently in place for those working in the skin penetration industry.

10.6 EDUCATING AND INFORMING THE GENERAL COMMUNITY ON HEPATITIS C

According to ANCARD:

> *there are currently over 50 pamphlets relating to Hepatitis C and providing information to the general public, to patients and to health care workers* (ANCARD submission).

Despite this, ANCARD noted that:

> *It is clear that information has not flowed freely to the general community, even though there have been multiple press releases on Hepatitis C, multiple documents produced and multiple programs aired on television for patients regarding this virus* (ANCARD submission).

The issue of educating the general community on Hepatitis C related issues was a recurring theme throughout this Inquiry with considerable support coming from both expert witnesses and those with Hepatitis C who made written submissions. The Executive Officer of the Hepatitis C Council, for example, stated in evidence that:

> *Education is a vital component part of the strategy to reduce both the spread and impact of Hepatitis C transmission* (Loveday evidence, 30 March 1998).

Sladden suggested to the Committee Members that:

> *It is very important that we raise general awareness in the community about this disease and especially about how it is not transmitted and that there are no risks in normal social contact with people with Hepatitis C. That is crucial . . .* (Sladden evidence, 30 March 1998).

Wodak has stated that:

> *there is in my view, no substitute for a big-bang campaign along the lines of the Grim Reaper. Although that campaign was criticised at the time and subsequently for arousing anxiety, there is no doubt that it transformed HIV/AIDS from an issue that occasionally occupied a tiny paragraph on the inside pages to one that involved banner headlines on the front page. And without that attention, Australia would probably be struggling with an AIDS epidemic of US proportions* (Wodak, 1997b:17).

NSW Health's Chief Health Officer considered there to be "substantial benefit for the whole community" in conducting a community based media campaign (Wilson evidence, 3 October 1997).

Calls for increased public awareness and education were also made by those with Hepatitis C who made submissions to the Inquiry:

> *public awareness has to be created in any and every way possible as such a complex problem is difficult even for those who wish to understand* (Submission 70);

> *now is the time to curb the spread of this virus though . . . a comprehensive education program* (Submission 80); and

> *the matter of concern which I wish to bring to your notice is that I believe not enough is being done to educate people with regard to the transmission of this disease . . . with regard to the simple day-to-day things they would not think of* (Submission 6).

Community education has also been considered by the Nationally Coordinated Hepatitis C Education and Prevention Approach (AHMAC, 1995) (reviewed at the beginning of this chapter) and the NSW Hepatitis C Taskforce (1995). The AHMAC document recommended program of activities for the community included four strategies:

- establish a national Hepatitis C awareness week;
- inform and educate dental, medical and other appropriate journalists;
- develop strategic coalitions with key dental and medical associations and community based organisations; and
- develop public relations strategy and media kits (AHMAC, 1995:16).

The Committee was somewhat surprised (and disappointed) at the limited scope of the proposed education strategy for the general community. The activities are very low key and lack the flair and creativity that characterised the HIV campaign of the early 1980s.

The Committee is not confident that the strategies proposed by AHMAC have the impetus to reduce Hepatitis C transmission by 50% in accordance with the program's aim.

The NSW Hepatitis C Taskforce "supported" the need for mechanisms to raise and maintain high levels of awareness. It did however "question" whether "expensive high profile national education campaigns" achieve the desired outcomes at lowest cost and highest effectiveness (NSW Health, 1995:20). Accordingly, the Taskforce supported the development of less costly, but more effective methods of raising and maintaining high levels of awareness about HCV noting that this would be "required if potentially controversial measures were to gain community support" (NSW Health, 1995:20).

During the course of evidence, NSW Health was asked if consideration had been given to a broad community-based media campaign. Officers informed the Committee that the matter had been considered some 18 months previous (Taylor evidence, 3 October 1997). At that time it was considered the "infrastructure" in terms of skilled general practitioners was not available to "support a massive rush of people" seeking medical advice and testing from their general practitioner (Taylor evidence, 3 October 1997). The Committee feels that the national education project for general practitioners being coordinated by the RACGP (and discussed in Section 8.4.1) will improve the knowledge base of general practitioners enabling them to provide accurate information and advice to their patients.

The Committee was also advised that discussions were taking place with ANCARD regarding the possibility of a national campaign, but, at that time a decision had "not been made" (Fowler evidence, 3 October 1997).

- **Anticipated Outcomes of a National Community Based Education Campaign**

Witnesses identified a number of benefits that would arise from a national community education campaign which included:

- raising GP awareness: Hall, for example, considered that a national public education campaign would

  > *help with GP awareness and with patients connecting with GPs and even thinking about Hepatitis C as an issue* (Hall evidence, 6 November 1997);

- lessening discrimination and stigmatisation experienced by those with Hepatitis C: Sladden, for example, suggested that:

> *We need to raise awareness in the general community to reduce the stigma that people experience* (Sladden evidence, 30 March 1998);

- raising tolerance and compassion towards those with Hepatitis C: the Committee heard for example that:

> *I can only hope and pray that with increased knowledge and awareness, Hepatitis C sufferers will be treated with more tolerance and compassion, and less alienation* (Submission 41);

- increasing awareness of the disease and how it is transmitted: the Hepatitis C Council's submission noted that:

> *there is an urgent need to develop public education and awareness campaigns about HCV, not only to increase the general population's understanding about the virus and its transmission but also to reduce the fear and stigma associated with the disease* (Hepatitis C Council submission),

while a person with Hepatitis C who wrote to the Committee stated that,

> *If people in the community are told that they can catch Hep C from infected people only if they share razor blades, toothbrushes or needles, they won't treat them as different, as outcasts* (Submission 2);

- giving the disease a profile and putting it on the public agenda;
- reinforcing information obtained in the work setting: within the community are general practitioners and other health care workers, tattooists and acupuncturists, and prison officers. A widely disseminated education campaign would supplement and reinforce the information these people were receiving in their professional capacity;
- alerting those 'at risk' of contracting Hepatitis C such as current injecting drug users and those who may be considering experimenting with the practice; and
- alerting past injecting drug users and prisoners who may have Hepatitis C but have never been tested.

Given such a range of anticipated outcomes arising from a national community education Hepatitis C campaign the Committee fully supports such a campaign being

conducted and recommends the Minister for Health approach his federal counterpart encouraging him to support the design and introduction of such a strategy.

RECOMMENDATION 129:
That the Minister for Health encourage his federal counterpart to design and introduce a national community education Hepatitis C campaign. The Committee further recommends that NSW Health fully support the introduction of a community based Hepatitis C education campaign within NSW and provide whatever assistance may be required.

The Committee would like to see the proposed campaign inform and educate the general community on the benefits of preventative strategies in place to limit the transmission of Hepatitis C. Committee Members are aware of community misunderstandings and apprehensions about strategies such as the methadone maintenance therapy program and the needle and syringe program with, often, limited appreciation of the role these programs play in limiting the transmission of Hepatitis C. Members consider it to be beneficial if a greater community appreciation of these strategies could be gained.

RECOMMENDATION 130:
That the national community education Hepatitis C campaign proposed in Recommendation 129 include a component about the role of preventative strategies such as the methadone maintenance therapy program and the needle and syringe program in limiting the transmission of Hepatitis C.

In August 1998 the Minister for Health announced changes to the management of the state's methadone program. Included in that announcement was a commitment to provide $600,000 to Hepatitis C prevention and education programs (Refshauge, 1998). The Committee understands that this one-off allocation has been 'earmarked' to be spent on a Hepatitis C public awareness campaign. The Committee welcomes this funding allocation and the decision to conduct an awareness campaign.

10.6.1 RESEARCH

Sladden informed the Committee that, in developing a community education campaign such as that proposed in Recommendation 129:

> *we need to consider carefully how we go about doing that so that we do not create further concern. We need to do that in a way that does not blow out the situation further* (Sladden evidence, 30 March 1998).

Similar claims for the control and prevention of Hepatitis C to be based on sound research have been made by the NHMRC which has stated that "the control of Hepatitis C requires both education and research" (NHMRC, 1994:5) and the Hepatitis C Council who informed the Committee that social research needs to be undertaken to inform prevention programs (Loveday evidence, 3 October 1997).

The National Hepatitis C Action Plan proposes that:

> *social research should be undertaken during the course of the co-ordinated education response to inform the development of education programs; to establish benchmarks; and assess effectiveness of strategies. It should also be undertaken to explore the cultures and contexts in which risk behaviour occurs* (AHMAC,1994).

The Committee recognises the important role to be played by social research in the design of a successful community education campaign. It considers it imperative that this role be fully appreciated by the federal government in the design and introduction of the recommended national community education Hepatitis C campaign.

RECOMMENDATION 131:

That the Minister for Health urge his federal counterpart support and fund research into the social factors which increase the risk of contracting Hepatitis C. The Committee further recommends that the Minister for Health encourage his federal counterpart to utilise the results of sound social research in the design and introduction of the community based education Hepatitis C campaign proposed in Recommendation 129.

10.7 CONCLUSION

This chapter has canvassed a very wide range of prevention strategies aimed at reducing the transmission of the Hepatitis C virus in all segments of society. The Committee has taken such a broad approach as it is conscious that no one strategy would be appropriate or effective in combatting this pervasive disease. The Committee agrees with Mr Loveday of the Hepatitis C Council who observed that "we need a range of these [preventative strategies]. One alone is not going to work" (Loveday evidence, 30 March 1998).

In proposing this prevention strategy, the Committee is also very conscience of the accuracy of Wodak's claim that:

> *Even if effective prevention measures are adopted in Australia today and implemented vigorously, it will still take many years to bring this dreadful epidemic under control* (Wodak, 1997b:17).

The Committee can only agree with Wodak who observes that:

> *the sooner we start to get real about Hepatitis C the better - there is not a moment to be wasted* (Wodak, 1997b:17).