PENINGTON INSTITUTE

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anex Bulletin

A GLIMPSE INSIDE THE WORLD OF INJECTING ICE USE

I was 14-years-old the first time I injected ice. I came from a good family home, but I was an anxious young man deficient in self-esteem and confidence. Aged 13 my parents separated, and away from the bulwark of a rigid family structure, these deficiencies deteriorated into a dangerous self-loathing. Angry with the world and uncomfortable in my own skin, I sought solitude on the margins of society.

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UPDATE: MEDICALLY SUPERVISED INJECTING ROOM

Late last year, when the Andrews Government announced that North Richmond would be the home of the state's first medically supervised injecting room, it was a huge relief for many Victorians.

Just how important this announcement was become clear during the press conference itself as paramedics rushed off to attend a suspected overdose just 50 metres away. In further good news, legislation to make it all happen was introduced the very next day on 31 October and the Bill passed on 14 December without a single amendment.

So far, so good.

The initial two year trial of the facility is due to begin mid-2018. So the question naturally arises – will this target be met?

To help answer such questions the Department of Health and Human Services held a briefing session on 31 January. What we found out is that over February and March community engagement will take place, a director recruited and the licensing framework finalised. Heading in to March and April construction will get underway and between April and June the final touches will be put in place. This includes the recruitment of staff, more community engagement and a website going live.

During the question and answer session it was revealed that people under the age of 18 won't be able to access the facility and the only method of using drugs will be intravenous injection; smoking and snorting drugs won't be options.

Final decisions have not be made on some of the most important issues. Drug testing facilities have been considered, though the concern is that they are too time consuming. The legislation provides that regulations will define what drugs can be brought to the centre and the quantities allowed. An Expert Advisory Group is providing advice on the regulations and their drafting will be crucial. Advice is also being sought on whether pregnant women can use the facility.

So progress is being made and given the scale of the task it is hardly surprising that it is taking time. A lot of Victorians will be watching very closely to see what decisions are made on how the centre will be run and who can access its life saving services.

John Ronan

PENINGTON INSTITUTE

Penington Institute is a community-based, not-for-profit organisation that actively supports the adoption of approaches to drug use which promote safety and human dignity. Penington Institute connects substance use research to practical action and supports Needle and Syringe Programs (NSPs) and other evidence-based approaches to reduce drug-related harm.

Editor-in-Chief: John Ryan
Editor: Sophie Marcard
Design and layout: Green Scribble

Penington Institute
95 Drummond Street
Carlton VIC 3053

d: +61 3 9650 0699
f: +61 3 9650 1600
e: info@penington.org.au
w: www.penington.org.au
t: @peningtonnews

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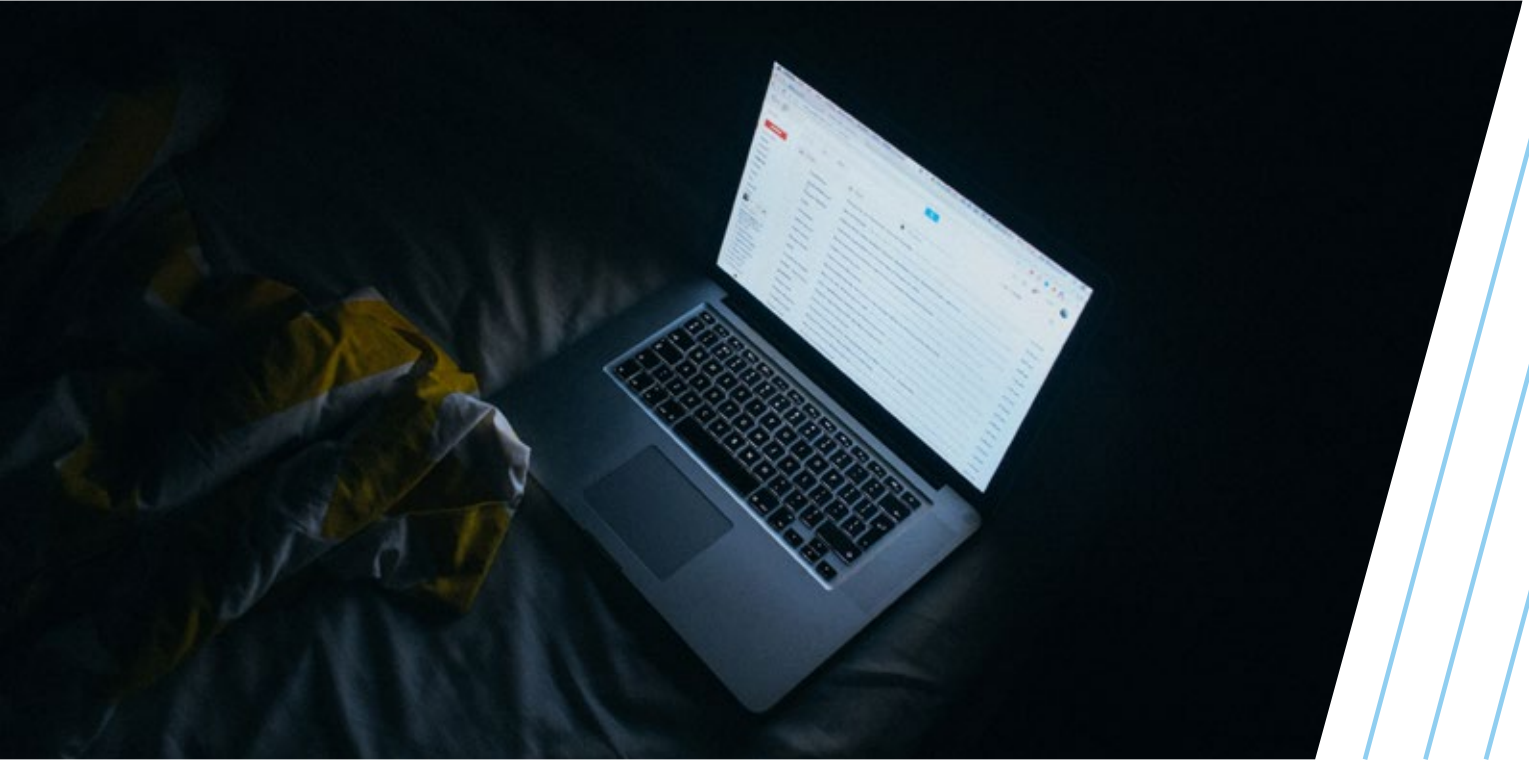


OUT OF THE DARKNESS: UNDERSTANDING DRUGS AND THE DEEP WEB

The mainstream media has now latched onto the arrival in Australia of the dangerous drug fentanyl and its even more lethal cousin, carfentantyl, but what hasn't received a lot of coverage yet is how users might be obtaining the drugs.

The dark net, sometimes called 'the deep web', is home to many shadowy and illegal trading sites. It's the world's marketplace of choice for many drugs now, including fentanyl (which appears to comprise more than 10 per cent of sales, according to recent research).

Accessible from any desktop with the right software, the dark net is the home for websites that are basically the eBay or Amazon of illegal purchasing activity, such as weapons, drugs, or codes to hack websites or cause digital disruption.

Of course, knowing how to access the dark net and make purchases requires a level of technical competence.

"You have to be reasonably confident that you can manage the 'dark arts' side of it," says Professor Roderic Broadhurst, a Professor of Criminology at the Australian National University.

"Amateurs will not survive very long on there.

"You need to know how to use a TOR (The Onion Router), and how to use cryptocurrencies to buy drugs.
I think it's often used by middle class, recreational drug users; professionals in cities who might be looking to get cocaine, for example," Roderic says.

"Street users are still probably using methamphetamines, bought on the street, but for recreational users wanting drugs, the dark web is pretty nice. DreamMarket (a major dark net marketplace) really mimics the real-world sites like eBay with vendor ratings and instructions."

Terms to know when discussing the Dark Net:

Cryptocurrencies: Digital currencies that can be traded anonymously, and digitally, avoiding traditional international currencies. Bitcoin is the most famous but there are others.

Dark Net: Also known as the dark web or the deep web. The term 'dark net' refers to networks that are not indexed by search engines such as Google, Yahoo or Bing. These networks are not available to the general internet public, and are only accessible via special authorisation, specific software and configurations. The dark net includes harmless places such as academic databases and corporate sites, as well as those with less legal topics such as black markets (for things like drugs and weapons), hacking and piracy.

DreamMarket: A leading market place on the dark net, along with Agora and AlphaBay, in the way the original Silk Road was. According to the Australian National University Cybercrime Observatory, in October 2017, 100,722 products involving 1900 vendors were listed on DreamMarket. Drugs account for half of all products sold.

TOR (The Onion Router): A torrent-based operating system that is completely encrypted and anonymous, and works in much the same way as the old Pirate Bay online audio-visual torrent site. A torrent is a communication protocol for peer-to-peer file sharing which is used to distribute data and electronic files over the internet.

Dr Monica Barratt, a research fellow at the National Drug and Alcohol Research Centre, agrees that the dark net was not a place for the naïve or the uneducated. She said her research suggested maybe one in 10 drug users have used it, or know somebody who has used it.

"People say it's just a click away but there's all the stuff you have to go through.

"There are the technological capabilities you need, and an understanding of how bitcoin works, and so on," she says.

"Do you need an anonymous operating system, maybe on a USB stick, so there's no trace on your actual computer, and then there's the question of where can the drugs be delivered? Are you going to use your own name and address, with the risks associated, or the name of an ex-housemate, who it wouldn't be unreasonable for a letter or package to arrive for? Or a fake name, which can be dangerous? But does the Post Office care if John Smith is having letters sent to your address?"

Not surprisingly, Monica said that informal research the NDARC has conducted, in surveys – there's really no way of pulling together accurate data on dark net usage or numbers – suggests that one person, who has their head around all of these aspects, tends to buy off the dark net and then distribute or sell to a wider community.

The NDARC research suggests that the convenience of having drugs delivered straight to an address or a post office box is an attraction of dark net purchasing, while other users have been enthusiastic about the wide variety of drugs available. Monica says more than 700 different varieties, classes and strands of drugs are available, covering MDMA, many kinds of cannabis, amphetamines, heroin, cocaine, LSD and other hallucinogens,

"The attraction of buying through these sites is being able to have small, subtle parcels arrive, with hard-to-detect amounts of drugs..."

and then many pharma strains, analogues and synthetics.

The dark net emerged as a source of drugs in early 2011, when Silk Road was established. Almost seven years later, several incarnations of that site have come and gone and other market sites have emerged, with vendor ratings, forums and communities to discuss the reliability of purchases and so on part of the deep web. Drug prices may be 20-50 per cent cheaper, according to a paper by Roderic and David Lord, from the ANU.

But of course, dangers remain. Roderic says sites are being constantly hit by law enforcement, competitors or exit scams, where buyers are burnt by vendors who take the cryptocurrency and vanish. Monica explains that one major marketplace was secretly taken over by Dutch police in June 2017. The police continued to run the site for a full month, with vendors and buyers unaware of what had happened, trading with all the usual information, until the arrests began.

Roderic says the really giant global dark net markets are China and South America. Australia is a minor player, with Monica saying the fact packages, even an innocuous-looking flat pack letter, must pass through Australia's custom barriers adds a degree of risk.

For that reason, a lot of the dark net drug trading in Australia is domestic, with local vendors charging higher prices for Australia Post domestic delivery, with less risk attached.

Aside from potential detection, another danger for users is simply not receiving their package after paying for it, with posting a bad review of the vendor as their only recourse. But given vendors are anonymous and many come and go in this shadowy world, that might not mean much.

The other major risk facing dark net buyers is the potency of the product, when it arrives. The attraction of buying through these sites is being able to have small, subtle parcels arrive, with hard-to-detect amounts of drugs. Roderic calls it "ants moving house". But this means buyers tend to purchase smaller, more potent products, such as fentanyl, which can be deadly.

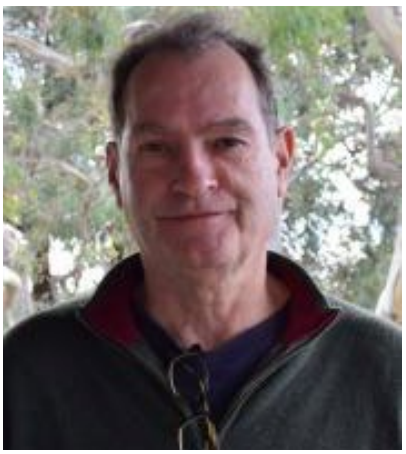
"It's a lot like the Prohibition of alcohol back in the day in the US," Monica says. "Beer was harder to transport, whereas more potent liquor could be hidden, but was more intense for the people consuming. With the dark net, people might say I'll order something small but potent, then divide it up and mix it with other things and sell it to make a lot of money."

For the purchaser, there is no way of knowing exactly what is in the drug mix as they use it, and that can have serious consequences.

Roderic advocates that injecting rooms and NSPs should definitely have systems in place and naloxone on hand, for when synthetic opioids are accidentally injected. The dark net has proven to be robust and effective as a drug market place. It's now part of the NSP world.

Nick Place

Dr Monica Barratt



Professor Roderic Broadhurst

ONLY IN TASMANIA: WHY MYF'S WORLD IS DIFFERENT

Myf Briggs suspects she inherited her deep-seated commitment to social justice from her grandmother. It's always been there; recently Myf found some school reports from when she was in Grade Six that spoke about her strong sense of social conscience.

"I started a debating team ... in Grade Six," she laughs.

Growing up in Hobart, Myf completed a degree in community development and human services, while also aware of the drug culture around her during her developmental years.

"I was growing up in a generation where drugs were widely experimented with and, while a lot of people managed to experiment and use drugs recreationally there were another bunch of people experiencing mental health issues and difficulties with addiction. I guess in a way this ignited an interest in addiction, the psychology of addiction and how often it's linked with trauma," Myf says.

Myf volunteered for the Tasmanian AIDS Council where she landed an opening at the NSP outlet. She's now been working as a Needle and Syringe

Program Support Officer for the Tasmanian Department of Health and Human Services, at the NSP on Hobart's eastern shore, for eight years and still loves it.

"I just really enjoy it," she says. "I'm passionate about the work and I love the clients. I love everything about it."

She admits it takes a certain kind of person to do her job, with the number one, non-negotiable, must-have quality, ahead of anything else, being the ability to be genuinely non-judgemental.

"It's all linked in," she says. "Not being judgemental, not discriminating, taking everybody at face value.

"Our clients face stigma and discrimination in so many areas that this [the NSP] is the one place where they can come in and talk about anything and know they're not being judged.

"They might not even talk to their doctor or health professional about things that they know they can talk about here, and so that leads to the harm reduction part of my work. It's not just the personal side but the physical aspect as well, of just focusing on trying to reduce harm."

Myf says her NSP outlet is similar to the mainland city ones, with the possible difference that most of the drugs being used in Hobart are pharmaceutical.

"It's all linked in," she says. "Not being judgemental, not discriminating, taking everybody at face value..."

"We have a unique drug culture here in Hobart. It's a little different, because pharma drugs are what most people inject," she says.

"While some drugs are made here on the Island, there is less access to other drugs that are available in most mainland states, such as heroin. Therefore many Tasmanians use other drugs, such as pharma drugs, although ice has also become more common in recent years, consistent with mainland Australia."

> Myf has her sleeves rolled up and has her head down on the challenges. She wouldn't have it any other way. It's something she can do to help.

Over the past six or seven years, Hobart has changed dramatically with the rise of MONA (the Museum of Old and New Art) and the city's gourmet reinvention as a hub for the bespoke foods and crafts coming out of the island. But Myf says the other, older Hobart, the one with high youth unemployment and other serious social issues, remains underneath.

Her outlet averages 300 or so clients per month and is one of three NSPs in Hobart City, with others in the north of the state.

The boutique, personal nature of the linked Hobart clinics means that Myf and her colleagues can take some novel approaches to their work, such as home-grown snapshot surveys that they use to gain information and data about all kinds of issues.

They conduct the surveys every six months or so, across the city, and Myf says the most recent one was about hepatitis C and awareness around new treatments for the disease.

"We do the surveys to raise awareness but also to build data," she says. "Over a four-week period, we do a quick, brief intervention with every person who walks in. We asked: 'Have you heard of the new Hep C treatments?'"

Myf says data collected looks at the status of the Hobart client base. How many are seeking, receiving or have completed treatment? Six months later, they asked again and were encouraged to find that awareness of the new Hepatitis C treatments had risen from 60 per cent to around 80 per cent of clients.

Now, of course, heading into 2018, the challenge is to uncover the other 20 per cent, who still don't know about the treatments. It might be that the snap surveys didn't capture the occasional clients, who might turn up once or twice a year, as against the everyday regular clients. Or it could be other communication issues.

Myf has her sleeves rolled up and has her head down on that challenge, along with all the others. She wouldn't have it any other way. It's something she can do to help.

Nick Place

Myf Briggs

HEPATITIS C AND PEOPLE WHO INJECT DRUGS: WHAT'S HAPPENING AROUND AUSTRALIA?

Hepatitis C is a disease that has had serious impacts in Australia.

An estimated 800 people die from complications of the disease each year. It remains the number one reason for liver transplantation.

But in Australia we are now making strong inroads into tackling hepatitis C. Ground-breaking new direct-acting antivirals (DAA) treatments mean that the disease, if treated properly, can be cured with fewer side effects than previous treatments. Of those people who have been treated with these drugs so far around 95 per cent have been cured.

This is extremely positive news for Australians living with hepatitis C. But of course just because new treatments exist it doesn't mean the disease is no longer having an impact.

In 2015, an estimated 227,310 people were living with chronic hepatitis C infection in Australia, among whom 19 per cent commenced DAA treatment between March 2016 and June 2017. It is estimated that there are now approximately 190,000 to 200,000 people living with chronic hepatitis C in Australia. This takes into consideration new infections.

The Australian Government has set an ambitious target to eliminate hepatitis C in Australia by 2030 and we must remember that people who inject drugs are a vital piece of the hepatitis C puzzle. The prevalence of people in this group who attend NSPs and have hepatitis C is 55-70 per cent and the majority of new infections in Australia are coming from people who share injecting equipment.

NSPs reach more people who inject drugs than any other service, so there is an important opportunity to capitalise on this connection.

Around Australia there are a range of programs in place that are making a difference for people who inject drugs.

Western Australia

- Estimated number of people living with hepatitis C in 2015: 20,549
- Uptake of DAA treatment in (March 2016 to June 2017): 3320 (16 per cent)

In Western Australia, Hepatitis WA and the WA Substance Users Association provide hepatitis C treatment clinics, with target groups including people who are currently injecting drugs.

A lot of work is underway to promote testing and treatment including the clever use of videos on social media to encourage more Aboriginal people to get tested and treated. Pre-packaged needle kits such as Fitpacks and Fitsticks, which are distributed through NSPs and sold in pharmacies, feature labels with useful information such as the importance of testing and the new treatments that are available.

One of the challenges Western Australia faces is developing more NSP sites, particularly in regional and rural areas where they are few and far between. Much more also needs to be done to develop and implement strategies to increase access to NSPs for Aboriginal and Torres Strait Islander people who inject drugs as well as access to sterile injecting equipment in prisons.

The focus can't just be on just curing those who have been infected by hepatitis C, it is vital to work to help stop it spreading in the first place by reducing or preventing the sharing of injecting equipment. That also includes promoting testing and treatment and educating people who inject drugs about the disease.

Northern Territory

- Estimated number of people living with hepatitis C in 2015: 3606
- Uptake of DAA treatment (March 2016 to June 2017): 430 (12 per cent)

The task in the Northern Territory is a difficult one given that the territory has such a small population size spread over a large area. Client and staff movement and staff turnover can make it difficult to engage clients about safe injecting practices, testing, treatment and follow up.

The territory has three primary NSP outlets, which handle around 80 per cent of occasions of service. The Northern Territory AIDS and Hepatitis Council (NTAHC) raises awareness about the availability of direct-acting antivirals with clients and works with people living with hepatitis C through its care and support program and sex worker outreach programs.

A lot of work in the territory involves spreading the message of blood-borne viruses, including hepatitis C, and the importance of getting tested. Specialist sexual health service Clinic 34 promotes testing for clients who inject and remote sexual health teams do the same. The Sexual Health and Blood Born Virus Unit and NTAHC deliver education as well as needle and syringe program orientation in primary care settings as well as the broader community. Awareness of hepatitis C is also promoted through events such as World Hepatitis Day and International Overdose Awareness Day.

Victoria

- Estimated number of people living with hepatitis C in 2015: 55,261
- Uptake of DAA treatment (March 2016 to June 2017): 10,770 (19 per cent)

The Victorian Hepatitis C Strategy 2016–2020 sets targets to increase prevention, testing and treatment of hepatitis C, and to reduce stigma and discrimination.

The Victorian Hepatitis C Elimination Working Group has been established to ensure as many Victorians as possible are screened, tested and able to access the new treatments, as quickly as possible. The Government has also partnered with the Primary Health Network Alliance to build specific and local hepatitis C clinical health pathways.

The Victorian HIV and Hepatitis Integrated Training and Learning program delivers comprehensive education and training for GPs on the diagnosis, treatment and management of hepatitis B and C. Meanwhile, the Eliminate Hepatitis C Partnership, a collaboration of service providers, government departments and researchers in Victoria, is aiming to increase the uptake of treatment for hepatitis C virus infection among people who inject drugs.

John Ronan

DIRECT ACTING ANTIVIRAL (DAA) TREATMENTS FOR PEOPLE WITH HEPATITIS C

Figure 1

The estimated number of individuals DAA treatment (bar charts) and the proportion of individuals living with chronic HCV infections who initiated DAA treatment (pie charts) during March 2016 to June 2017, by jurisdiction.

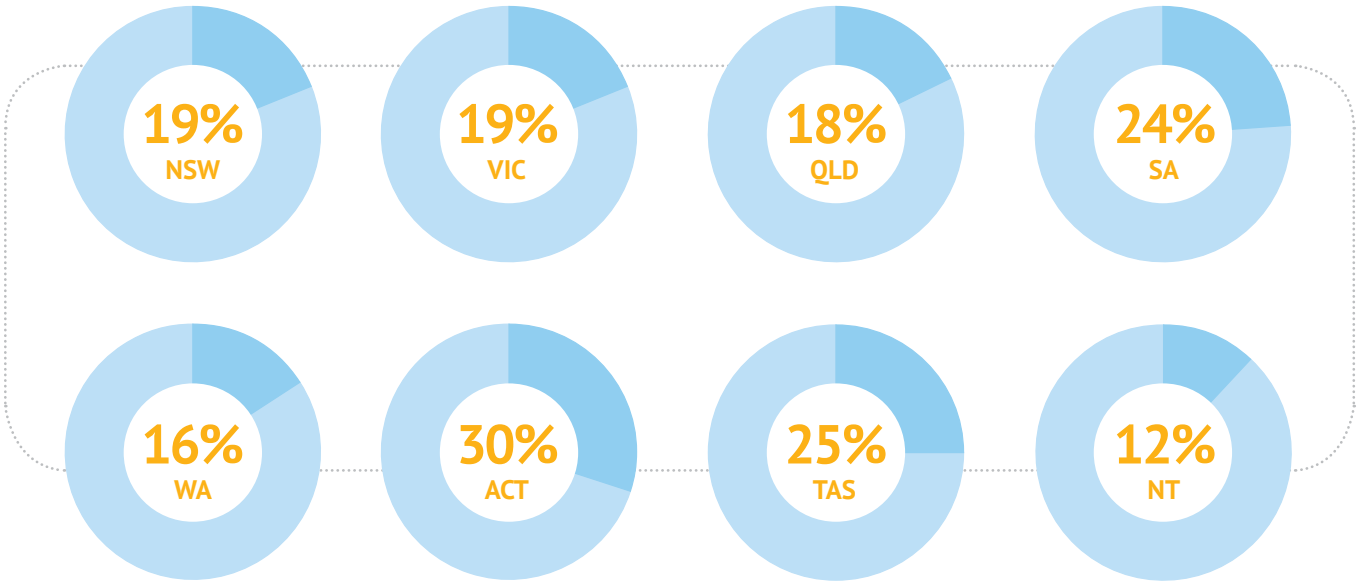
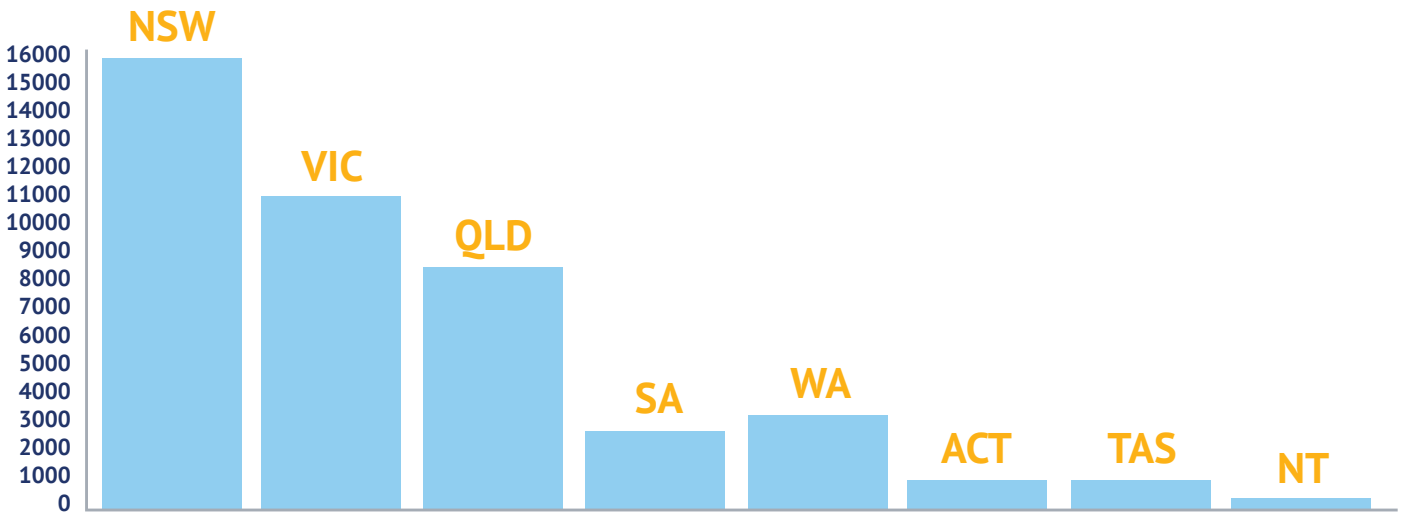


Figure 2

Estimated number of individuals initiating treatment.



Adapted from Monitoring hepatitis C treatment uptake in Australia (Issue 8). The Kirby Institute, UNSW Sydney, Sydney, NSW, Australia, December 2017.

Further reading:

https://kirby.unsw.edu.au/report/monitoring-hepatitis-c-treatment-uptake-australia-issue-8-december-2017

http://www.health.gov.au/internet/main/publishing.nsf/content/ohp-bbvs-hepc (Fourth National Hepatitis C Strategy 2014–2017)

https://theconversation.com/australia-leads-the-world-in-hepatitis-c-treatment-whats-behind-its-success-81760

https://www.hepatitisaustralia.com/inquiry-facts/

https://kirby.unsw.edu.au/sites/default/files/kirby/report/Monitoring-hep-C-treatment-uptake-in-Australia_Iss7-JUL17.pdf

https://kirby.unsw.edu.au/report/hepatitis-b-and-c-australia-annual-surveillance-report-supplement-2016

THE WHAT, WHEN AND WHY OF THE CODEINE RESCHEDULING

Misuse of prescription and over-the-counter medications is a growing issue in Australia. One particular problem is the misuse of codeine, which is found in many common over-the-counter medications for pain, colds and flu, and cough syrups. This misuse can cause opioid dependence and can be deadly, with the Australian Medical Association reporting that deaths relating to codeine more than doubled between 2000 and 2009.

Dr Suzanne Nielsen, senior research fellow at the National Drug and Alcohol Research Centre (NDARC) at the University of New South Wales has been investigating codeine misuse.

"There are an increasing number of people who are experiencing problems with codeine," Suzanne says.

"Although exact data on how many Australians are developing problems with codeine is not clear, in our convenience samples one in five codeine people who use codeine meet criteria for dependence" she says.

In order to help reduce harms related to codeine, the Therapeutic Goods Administration (TGA) announced in 2016 that it would change how codeine can be accessed.

From 1 February 2018, medications that contain low doses (15mg or less per tablet) of codeine that have previously been available over-the-counter in pharmacies and supermarkets require a doctor's prescription. The change makes Australia consistent with Japan, the United States and many European countries.

Medications that are now prescription-only include:

- Nurofen Plus
- Mersyndol
- Panadeine
- Some cold and flu medicines
- Some cough syrups
- Any of the generic painkillers and pharmacy medicines that contain codeine.

Codeine belongs to the opioid family, which also includes heroin, morphine, oxycodone and fentanyl, which are powerful and addictive painkillers. Codeine is commonly used to treat pain, coughs and diarrhoea.

But despite the fact that codeine is in the company of such strong drugs, the TGA reports that the low doses of codeine that's in these common medicines has little effect on symptoms when compared to products without codeine.

For people currently misusing codeine, the change in access (rescheduling) could trigger some significant issues, says Crios O'Mahony, project lead at Penington Institute.

"The rescheduling is going to make codeine harder to get and the idea is that you have to go to a doctor to get a prescription," Crios says. "But I'm concerned that people who are misusing codeine are stockpiling it. They may alternatively move on to other drugs, which might make things more dangerous."

Crios says that there is also concern that users could switch from swallowing

Tips for NSP workers in talking to clients about the codeine rescheduling:

- Help clients to develop a plan to manage reduced access to codeine
- Refer them to a bulk billing GP for alternative medication
- Mention the dangers of doctor shopping
- If the client is injecting any tablets, talk about safer injecting including using sterile equipment and filters, and vein care
- Be prepared to talk about drug treatment including rehabilitation and/or opioid substitution therapy.

codeine to injecting it or injecting other types of medication. Injecting affects a drug's potency and the speed that it hits the system. This also brings all the risks of injecting, including vein damage and blood-borne virus transmission from sharing injecting equipment.

While the misuse of codeine may relieve pain and even provide a feeling of euphoria, there are many negative side effects. If a person begins to take more and more of the drug to achieve the same effects this brings the risk of decreased lung function and other medical complications including organ damage, coma and death.

What's more, codeine-containing medicines that are currently available over-the-counter are usually combined with either paracetamol or ibuprofen. Long term use of high doses of paracetamol can result in liver damage and the most severe adverse effects of long term ibuprofen use include serious internal bleeding, kidney failure and heart attack.

Suzanne says there is still the prospect of people accessing codeine through prescriptions. She adds that preliminary research with people who use codeine indicated that most were unlikely to use other drugs or alcohol.

"The research also said that codeine users wouldn't be turning up to emergency departments, which was a concern of ours. But what they did say was that they were likely to visit a GP to seek an alternative, so that's what we're expecting."

Crios says that NSP workers should talk to their clients who misuse codeine about the possible effects of the rescheduling change and to use it as an opportunity to discuss safer drug use and drug treatment.

"This is an opportunity to engage with clients and provide them with information. NSP workers should also talk about overdose risk and using filters to reduce the risk of harm, because if people start injecting codeine or using other drugs, then that increases the risk of overdose."

The Australian Medical Association and the Pharmacy Guild of Australia were at odds over the rescheduling decision, with reports that the Guild was lobbying in October 2017 for exemptions to be made, arguing that it would unfairly impact rural residents and place pressure on doctor's services.

But Suzanne says that the Guild and the Pharmaceutical Society of Australia are working to help implement the change and educate pharmacists and customers.

Crios believes that more funding for drug treatment should have been provided alongside restricting access to codeine.

"Some people will bear the change very well and some people will struggle. There's going to be people who misuse codeine who don't think of themselves as drug users because it comes in a nice packet and it comes from the pharmacy, and they may not have been in touch with services to provide them with the support that they need," he says.

Suzanne adds that NSP workers can help support clients manage their pain through alternative medications.

"We need to see how we can support people getting their pain managed and that's what frontline workers need to convey, that codeine is not the most effect way to manage pain and there are safer and more effective ways to do so.

"People can be reassured that there are options available."

Alana Schetzer

Dr Suzanne Nielsen

THE STATUS OF BLOOD-BORNE VIRUSES IN AUSTRALIAN PRISONS

International and Australian research has shown for decades that prisoner populations have higher rates of blood-borne viruses and sexually transmitted infections – chiefly, hepatitis B (HBV) and hepatitis C (HCV) – than the general community.

"In Australia there are about 50-60,000 people are put into prison each year. Across the country, broadly, about 25 per cent of those prisoners have chronic cases of HBV. That's at least 10,000 people. In terms of HCV, the incidence is higher again - between 30 and 40 per cent of prisoners," says Professor Andrew Lloyd, Head of the Viral Immunology Systems Program at Sydney's Kirby Institute. He's an infectious disease physician, and has provided hepatitis support to the prisons in New South Wales for decades.

Andrew says certain communities face a higher risk of hepatitis than others.

"Hepatitis in general is higher in women than men," he explains. "In the Northern Territory, where the prisoner population is heavily Indigenous, the rates of HCV are 10 to 12 per cent higher- a statistic that's fairly consistent across the country. The rates in immigrant inmates, particularly those from South East Asia, are also high."

There are a number of reasons hepatitis C rates are higher inside a typical prison environment: amateur tattooing; sexual intercourse; and blood contact as a result of violence. The biggest contributor, however, is the injection of drugs.

Heroin, methamphetamine and methadone are available; smuggled by prisoners, visitors, guards and other staff. But injecting equipment is largely unavailable; so needles and syringes are widely shared, ripe for facilitating spread of blood-borne viruses.

Prisons and prisoner health have always been complicated and difficult areas, both in terms of policy and service provision. But work is being done towards making inroads. In Victoria, the Statewide Hepatitis Program (SHP) was developed in 2015 by Melbourne's St Vincent's Hospital in cooperation with the state government. All Victorian prisoners are now screened for hepatitis when entering prison or when relocated. Nurses and hepatologists visit each prison every 2-4 weeks to conduct clinical assessments.

As of 30 September 2017, 953 prisoners had commenced hepatitis C treatment, and of those, 364 prisoners are already considered cured. A cure is defined by a specific blood test being negative at 12 weeks post treatment completion. (reference: https://www.gayletierney.com.au/prisoner-hepatitis-treatment/)

It was in October 2017 that the Andrews' government would renew the initiative for another two years.

"The program is a great opportunity to treat people in prisons, where there's a high incarceration rate for drug-related crimes," says SHP director Professor Alex Thompson.

"Feedback from prisoners has been positive – almost universally. The engagement with the program has been very good. We hope it'll underline all the work being done to reduce hepatitis in Victoria."

As prison management and prison health falls under the jurisdiction of state governments, the St Vincent's program is unable to expand into other Australian states or territories. However, Alex attended a national workshop earlier this year – co-organised by Alex, Andrew and others – looking at prisoner health.

"There were submissions from government and community representatives from each state to discuss the different programs," Alex says. "It was a great chance to sit down and see what was working and what wasn't working. I hope that will have some positive outcomes, and that the great outcomes we're having here in Victoria can be replicated in other states."

It appears there are. In the ACT, massive inroads have been made in recent years. "The ACT has virtually eliminated HCV from the prisoner population," says Professor Michael Levy, director of the state's Justice Health Service. Figures are showing new drugs have **helped reduce** the number of HCV-positive inmates from 30 per cent of the prison population in 2010 down to just three per cent this year.

But Michael says to keep the numbers down, the **National Prison Entrants' Blood-borne Virus Survey** (NPEBBVS) – a questionnaire on risk behaviours, and a blood and urine test carried out by nurses - is going to be crucial.

"The NPEBBVS is one of only two public health data collections (the other is run by the Australian Institute of Health and Welfare) that acknowledge the integral part of public health is prisoner health," Michael explains.

"Prison entrants are the canaries in the coal mine – early warning populations for health issues of critical importance to the community. These data collections are unique internationally. If they were allowed to lapse, critical insights into the public health of Australia would be lost."

While treating prisoners is yielding positive outcomes for now, Andrew is calling for the focus to shift toward hepatitis prevention. He says developing new preventative strategies is what will ultimately beat the spread of the virus.

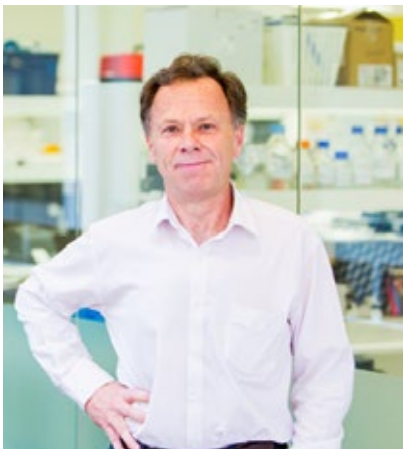
"Many inmates are coming into prisons uninfected, and leaving less than a year later infected. The small amount of research we have looking into prevention [from Andrew's own research] suggests our older prevention strategies – such as cleaning injecting devices with bleach and distributing condoms – don't work," Andrew says.

"You could theoretically implement needle exchange programs, but there isn't much political support for that issue. We need to be pushing to scale up our efforts as high as possible."

Evan Young

> "The program is a great opportunity to treat people in prisons, where there's a high incarceration rate for drug-related crimes."
>
> – Professor Alex Thompson

Professor Alex Thompson



Professor Andrew Lloyd

National Prison Entrants' Bloodborne Virus and Risk Behaviour Survey Report 2004, 2007, 2010, 2013 and 2016:
https://kirby.unsw.edu.au/sites/default/files/kirby/report/JHP_National-Prison-Entrants-Report-2004-2007-2010-2013-2016.pdf

Tom de Souza

DOWN A DARK ALLEY:

A GLIMPSE INSIDE THE WORLD OF INJECTING ICE USE

I was 14-years-old the first time I injected ice. I came from a good family home, but I was an anxious young man deficient in self-esteem and confidence. Aged 13 my parents separated, and away from the bulwark of a rigid family structure, these deficiencies deteriorated into a dangerous self-loathing. Angry with the world and uncomfortable in my own skin, I sought solitude on the margins of society.

When I found ice, I was regularly wagging school and smoking pot. I decided to sell small amounts of the drug for an easy source of income. My pursuit for a supplier led me to a man known as Mado. He was a chronic ice user, and my drug-dealing venture prospered under his guidance. I visited his flat with increasing frequency, where he advertised to me the rush of injecting ice.

Injecting wasn't new to me. I had injected opiates on a few occasions, the first of which was at a friend's house, aged 13. He was three years older than me, and I knew him as a source of drugs. He offered me a shot of OxyContin, or *hillbilly heroin*, and I reluctantly accepted. There was a small crowd there,

> "It wasn't just injecting, or even the ice I was addicted to. It was the lifestyle. Life was an emotional rollercoaster, and getting on was more about the search for innovative ways to source a buck and find some gear."
>
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many of whom were injecting. I was afraid of the purported consequences, but I was curious and yearned for the sense of belonging neglected to many young men in today's society.

I enjoyed opiates, but they didn't fill the empty void in me hollowed out by self-hatred. I was eager to experience the rush of ice and I had means of access. Friends who had revived from a cruel path of ice dependency warned me against it, but that only piqued my curiosity. It seemed an exciting drug, but it wasn't long before I discovered the true consequence of addiction.

Mado was reluctant to give me my first shot of ice. As I came to know, the subterranean world of drugs is ruled by a loose code of ethics and inexorable violations included dogging on someone (giving them up to the authorities); paedophilia; infecting someone with a blood-borne virus; and giving someone their first shot. I told Mado I had injected before, and he agreed to *do me up*.

Initially, I relied upon Mado and other acquaintances to inject me. Over time, my use increased in frequency and quantity and my appetite for the drug grew insatiable. I became reluctant to share, and decided to learn to inject myself. Initial attempts were unsuccessful: on one occasion I *missed*, injecting subcutaneously rather than intravenously; other times, I struggled to find a vein and *butchered* myself, poking the syringe through both walls of the vein. I'd watched others enough to understand the practicalities of injecting, but it was difficult to keep a steady hand.

My first successful self-injection was a Rubicon moment. My habit soon spiralled out of control, and the actual motions of injecting soon became equally addictive as the rush of the drug. In our argot, the syringe was known as a *weapon*, and I lusted to draw the plunger back and watch the blood creep up the barrel. I would practice on myself, shooting up all kind of drugs – Xanax, Ecstasy, other insoluble pills strained through a cigarette filter - in various veins around the body, just to satisfy the desire.

Usually, I obtained clean syringes from the local chemist. These were supplied in the form of a *FitPack*, which contained three one millilitre insulin syringes. One millilitre was known as 100 *units*, owing to the measurements on the side of the barrel. These measurements were used to determine the quality of ice; if you mixed a bag with 20 *units* of water, and it *jumped* to 40 *units*, you knew it was good *gear*.

You had two options when purchasing a FitPack: with diluted water and swabs for $7, or just syringes for $5. The cheaper option was almost always preferred. Several free syringes could be obtained from a Needle and Syringe Program in the city, but it was a 45-minute bus ride from my residence, and I seldom passed by. Mado was part of the needle exchange program, and often had a surplus of syringes he supplied me.

Reusing a dirty syringe was common practice in the drug world, but sharing needles was considered a major taboo. Nevertheless, it was prevalent. Whoever purchased the drugs was obliged to the first *taste*, and if those next in line weren't in possession of a *freshie*, or clean syringe, they confronted the predicament of sharing a needle or going without. As governed by the code, only if someone had been diagnosed with a blood-borne virus would they refuse to share, or allow another user to precede them.

Admittedly, I partook in the malpractice of sharing needles on a number of occasions. It was usually a direct result of unpreparedness, insufficient money, or inaccessibility of available syringes at the irregular hours of my drug use. There was only one 24 hour chemist in the entire city, and it was an expensive

taxi ride away. Fortunately, I avoided the indelible scourge of blood-borne virus, or other serious health concerns associated with injecting.

It wasn't just injecting, or even the ice I was addicted to. It was the lifestyle. Life was an emotional rollercoaster, and *getting on* was more about the search for innovative ways to source a buck and find some *gear*. Actually injecting the drugs was a fleeting anti-climax, a breather at the finish line of a thrilling chase.

In our subterranean world, we reproduced the values we believed society neglected us. Our addictions socially outcast us, and out here on the fringes of society we were united by a fraternal dissidence, belonging, and acceptance. In their world we were scum, but here we could be respected, *revered* even.

One year after that first shot, I was using up to $400 of ice a day. Ice is a rampageous drug, and I would stay awake on ice binges for days, even weeks at a time. Sleep deprivation is the most dangerous side effect of ice and it was a torturous state of being, but highly sought after. The longer you stayed awake, the more strung out and twisted the high became.

I realised ice was affecting my mental health after a serious psychotic episode, but it didn't concern me. It was nothing out of the ordinary. I had been awake for 12 days, and in 12 hours I'd eaten 40 Valium to try and soften the comedown. My body and mind shut down, the ice kept my eyelids open, and I became violently deluded. Arming myself with a meat cleaver, I sprinted up the street in search of an illusory figure. Eventually, I was apprehended by the police and taken to juvenile detention.

> "Drugs rob you of joy, and it has taken years of re-learning to appreciate the simple pleasures of life."

I was frequently in police custody, but it did not serve as the punishment or rehabilitation that is intended. Instead, prison was a stimulant to crime. Behind the barbed wire fence criminal behaviour was glorified, and a measure of quantifying qualities of respect and esteem. As per the criminal code, criminality often determined the social standing of prisoners. Dependent ice users were of lower status, their crimes often erratic and ill-considered.

On the street, I resorted to all kind of measures to fund my habit, but selling pot remained my primary occupation. Selling drugs was a much a social activity as it was a source of financial revenue. Often, 30-40 customers would visit in a day, and dealing was a pleasant antidote to the loneliness of drug addiction. When you had drugs, everyone was your mate.

It was only when ordered by the Court I began abstaining from drugs. I was to be sentenced for a long string of offences and given the option of jail time, or release to the care of my mother with the strict supervision of the Drug Court program. I opted for the latter. I was subjected to tri-weekly urinalysis tests but I wasn't ready to quit, and delighted in cheating the system.

I continued using intermittently, making only mild progress on the lengthy road of rehabilitation. Change only happens when it's inevitable, and only after a drastic series of events did I realise it was necessary to change my life if I wanted to live. After a relapse and consequent failed suicide attempt, my Drug Court order was breached and I was returned to prison. I was given an ultimate chance, and shortly after my release, my two closest friends were charged and convicted of murder, and sentenced to life in prison.

It took two years to get clean, but today, with the guidance of my immediate support network, I've been clean three years. I'm still confronted with the consequence of addiction on a daily basis. Repairing damaged relationships is an ongoing work in progress, but the most difficult part of rehabilitation is learning to live again. Drugs rob you of joy, and it has taken years of re-learning to appreciate the simple pleasures of life.

Tom de Souza