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IN BRIEF

FUNDING TO WIDEN ACCESS TO NALOXONE

In February 2017, Victorian Minister for Mental Health the Hon Martin Foley MP announced initiatives to improve access naloxone and strengthen support for overdose survivors.

The Victorian Government allocated $1.3 million to subsidise the cost of naloxone to drug users or families struggling to afford it and fund an outreach service to follow up drug users who have survived an overdose.

People who have survived an overdose are at higher risk of having another overdose, so the outreach service is potentially life-saving.

The outreach service will run in Victoria's overdose "hotspots" – Yarra, Melbourne, Port Phillip, Geelong, Dandenong and Brimbank/Maribyrnong.

DR INGRID VAN BEEK AM RETIRES

In April this year, Dr Ingrid van Beek AM retired after spending three decades working at the coalface of the heroin, HIV/AIDS and hepatitis C crises. Her farewell event was attended by a wide range of people – from NSP workers to former premiers – recognising the impact her career and work had across many spheres.

Dr van Beek's contribution to supporting 'at risk' young people, sex workers and people who inject drugs will have a lasting impact in Australia and internationally.

Dr van Beek started as a doctor at the Kirketon Road Centre in Sydney's King's Cross in 1987, offering sexual health screenings, sex worker "check-ups", as well as assessment and treatment of sexually transmitted infections - a role she describes as her "first real job". She went on to become Director in 1989, and was also the founding Medical Director of Australia's first Medically Supervised Injecting Centre from 2000 until 2008.

Dr van Beek was awarded a Doctor in Medicine (MD) in 2010 in recognition of her body of published scholarly work in the international field of harm reduction. Her contribution to improving the health of socially marginalised populations was recognised in 2010 when she was made a Member of the Order of Australia.

Dr van Beek's approach is best captured in the following statement, "harm reduction is a humane and compassionate approach that recognises the importance of extending dignity and respect to people regardless of their social circumstances."

We acknowledge and thank Dr van Beek for her contribution and wish her the best in her retirement.

PENINGTON INSTITUTE

Penington Institute advances health and community safety by connecting substance-use research to practical action. 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 promotes and supports Needle and Syringe Programs (NSPs) and other evidence-based approaches.

Fiona Vanhalen

VOLUNTARY WORK SPARKS CAREERS DEDICATED TO HELPING COMMUNITY

Shayne Kilford and Fiona Vanhalen volunteered at the Northern Territory AIDS and Hepatitis Council (NTAHC) as a way of giving back for the help they received.

Their good deeds turned into full-time jobs that both love and find rewarding. Between them they have notched up more than two decades of dedication and service to the local community.

"I'll do this for the rest of my life. It's a great job, I really enjoy it. I've done a lot of different work - labouring in the building industry, a pest controller, a storeman at five star hotels – but this has been the best and definitely most rewarding," Shayne says.

Fiona agrees: "It can be trying and upsetting sometimes, but when a client comes in looking miserable to be able to help them and see them leave walking a bit taller and with a smile on their face gives me great satisfaction.

"The clients are wonderful and very appreciative. I like that we are able to see the difference we make in people's lives by offering a safe, comfortable space and giving clean injecting equipment without any stigma. When I used there were no NSPs around. I most likely wouldn't have contracted hepatitis if there were."

FIONA

Fiona is a Needle and Syringe Program worker with NTAHC and its only peer educator. Apart from the usual duties of a NSP worker including dispensing needles, syringes and harm reduction information, she sits on several committees representing consumers as a peer educator.

"It's hard to get injectors on these committees but as a previous injector, I'm their representative and voice," she says.

The committees, including pharmacotherapy and harm reduction committees, meet regularly at NTAHC, the NT Department of Health, and the Sexual Health and Blood Borne Virus Unit at Royal Darwin Hospital. They discuss issues and push for legislative and other change to reduce harms.

Successes include recent legislative change enabling needles and syringes previously only allowed to be dispensed by a NSP to now be given out by nurses and other staff in hospitals and community health centres. This also reduces crime in remote areas where, due to no access to NSPs, people were breaking in to health centres to steal syringes and needles. Another proposal is outreach services for remote areas in the NT.

"I like that we are able to see the difference we make in people's lives..."

Fiona says the committees worked for several years to provide much needed after-hours sterile dispensing units (SDUs) and a 12-month trial funded by the NT Government is now underway and proving popular. SDUs provide 24 hour access at NTAHC'S three offices in Darwin, Palmerston and Alice Springs, and dispense syringes in disposable containers via tokens. There are hopes to extend this service to remote areas.

Continued overleaf

VOLUNTARY WORK SPARKS CAREERS DEDICATED TO HELPING COMMUNITY

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Another suggestion is for a register of disabled clients who cannot get out to access NSPs. This would enable a mobile outreach service to deliver sterile equipment and collect used equipment from them. Also on the agenda are outreach programs for itinerant 'long grasses' Indigenous people with limited NSP access.

Fiona has worked at NTAHC for eight years after her initial contact as a single mum with a history of injecting.

"I got to know the workers and they encouraged me to do some volunteer work. I really fitted in, and then they put me forward for full-time work," she says.

Fiona was hepatitis C positive for 23 years after contracting the virus from her partner but successfully completed interferon treatment five years ago and is now virus free.

"The therapy was gruelling but I encourage clients to take up the new hepatitis C treatments by saying they are lucky because these treatments are much better. I can relate as I have that lived experience of being a poly-user of drugs and having had hepatitis," she says.

Fiona has featured in news stories and government literature telling her story to reduce stigma, to tell a positive story and promote services and treatment. She does public speaking and has educated businesses, for example casino staff, on handling of spills and sharps.

SHAYNE

Shayne started as a volunteer in 2001. He was questioning his sexuality and had been visiting NTAHC since 1998.

"Everyone was supportive and I got to know the staff who suggested I do some volunteer work because I'd lost my job," he says. "I wanted to give back to the community so volunteered as a NSP worker and in the sex worker outreach program. I found it very rewarding and felt like I was giving something back to the community, a community I knew quite a bit about."

A job became available and in November 2004 he started full time work as a NSP officer. Shayne works mainly at NTAHC'S Darwin and Palmerston offices, although he has done one stint at its Alice Springs office.

"I supply sterile needles and syringes to people who inject drugs so they don't catch or spread blood-borne viruses among themselves or to the general community," Shayne says. "It's a community service and is really important work. The government supports us with funds and if it wasn't for us, people who inject drugs would have a lot more HIV, hepatitis and be sicker.

"Our work also helps prevent spread of blood-borne viruses to the wider community. I provide education to businesses, clinic 34s (blood-borne virus clinics) and Aboriginal health services, and educate clients about safe injecting.

FIONA'S TIPS FOR FELLOW NSP WORKERS:

- Opening up about your story can help clients feel more relaxed. Letting them know what you have been through can open the door for them to talk and seek help.
- "It's a great reward being able to help people turn their lives around. One client was very timid and I picked up on it and that she was feeling scared and stigmatised. Because I opened up and let her know what I had been through, she started talking to me and eventually started her own treatment. She is no longer injecting and is hepatitis free."
- It can be challenging. People can be struggling with hepatitis, their drug use may be out of control and they might be beating themselves up over it. "My approach is to say don't beat yourself up and I draw on my story and how long it took for me to get on top of it."
- Be patient. "I've had clients on ice talk for an hour without taking a breath. Just bear with it."
- Don't take offence, no matter what they say.
- Try to put a positive spin on things, have a laugh with clients, always put a smile on your face and ask how their day has been, and 'How can I help you today?'
- "I like interacting with clients and making them feel normal and comfortable," she says.
- Engage clients in any way you can. Encourage them to sit down and have a drink of water and a chat if they want. Get to know them, ask how their kids are, which helps normalise things and reduces stigma. This helps you establish a relationship which may facilitate them asking for help.
- Never ask if they want rehabilitation because this is a suggestion from you that they should have it. Always wait for them to ask for rehabilitation.
- Sometimes it's hard to turn off at night at home but leave work at work because if you toss and turn all night worrying about a client, you can't do your job properly the next day.

"In Darwin morphine pills are used because heroin is sparse and there's no continual supply. There's a lot of risk with morphine pills as fillers, colours or wax can clog the syringe so we teach how to inject only the morphine and mix it properly so they're not injecting other stuff. There's a lot of filtering involved.

"We educate about new hepatitis C treatments so clients can be treated and clear the virus, which is great."

Shayne believes the main challenge is the way the public views this valuable work. "There is still a lot of opposition and stigma. Educating the public on what we are really about - trying to stop the spread of blood-borne viruses - is needed," he says.

Media coverage that all drugs are bad and require a criminal response promotes this resistance, he says.

"Clients are very appreciative. They are never aggressive and it isn't a stressful job. Before us, they were using syringes over and over."

- Helen Carter

Shayne Kilford

SHAYNE'S TIPS FOR FELLOW NSP WORKERS:

- Attitude is everything. Be non-judgemental, kind and approachable. Treat clients with respect because they deserve it. Clients are individuals - there is no stereotypical person who injects drugs; they are from all walks of life.
- You may be the only service that clients see regularly so break down barriers and form a rapport as you then may be able to help with other health or social issues. This may include putting them in touch with health, support and mental health services if they want.
- It may take a while to build rapport until they feel comfortable and start to open up.
- Some clients might just want phone numbers of health or social services, others may want you to make the appointment while others may want you to attend with them.
- Be kind to service funders such as government.

THE LOW-DOWN ON 'DIRTY' SYRINGES

"I try not to reuse picks and I'd prefer to be more on the ball and not have to but honestly shit just happens," – Dave (62)

People who inject drugs in Australia can appear to be well provided for with regard to sterile needles and syringes. Across the country there are 3500 needle and syringe programs (NSPs) which distribute almost 50 million pieces of equipment a year. But the international best-practice for injecting drugs of a fresh needle for every injection is far from reality. People who inject drugs reuse syringes, share equipment like spoons, water and tourniquets, and a small proportion continue to share injecting equipment with others.

A 20-year survey by the Australian NSP Survey showed that the numbers of people who inject drugs who reuse and share have plateaued in recent years after steady declines since the 1990s. For instance one in three (31 per cent) injecting drug users reported that they reused syringes in 1997. Since 2011 the reuse had hovered around 21-25 per cent. The percentage of people who inject drugs who reported they shared syringes with others was also steady at 15-16 per cent from 2011-2015. And the sharing of equipment other than needles remained stable at 28-31 per cent.

For more information on these statistics see: https://kirby.unsw.edu.au/report/australian-nsp-survey-national-data-report-1995-2014 and https://kirby.unsw.edu.au/report/australian-nsp-survey-national-data-report-2011-2015

The Bulletin spoke to three people who inject drugs about their reuse of injecting equipment. All agreed that they knew it was unwise to "recycle" syringes and share paraphernalia. But they also claimed it was unavoidable under certain circumstances.

Chris* (57) a single gay man from Sydney said he used to share and reuse needles but was vehement he did not share or reuse now.

"I only ever used clean needles for myself but Tom, Dick and Harry would all show up. They've got the drugs and I've got the clean needles. What else am I going to do?"

Chris shared equipment out of social pressure and was very lucky not to have contracted any blood-borne viruses. But his arms are a vivid illustration of the damage that skin infections can wreak. Both forearms are a scarred and pitted moonscape as a consequence of bad injecting practices. Three months ago as he passed me a coffee a tiny rivulet of pus trickled across his arm and dripped onto the floor. Now the wounds are fully healed and Chris is justifiably proud of his achievement. He glows as he holds up his clean "summer" arms, as he calls them.

Chris credits his drug counsellor with encouraging him to use more safely and enable his arms to heal. He is fortunate the abscesses and other bacterial infections that caused the scarring did not develop into life-threatening conditions such as endocarditis, septicaemia or gangrene. Amputations are not unknown if infections get out of hand.

"A part of me likes to think I'm going to just stop and that using blunt needles will encourage me to quit."

He visits his local pharmacy twice a week for medication. But will not use them to get needles for fear he will be stigmatised, so he collects clean needles from the community health centre.

Dave* (62) lives in Melbourne and is in a long-term relationship. He uses regularly and says he was a "voracious" drug user. Currently though he does not use every day.

"I did share needles when I was a young fella and I do have the hep C antibodies but I didn't get it full strength. Two other mates from then got it properly and have just been on the new drugs to get clear.

"No matter how hard I try, though, I just accept now that reusing picks is a way of life for me."

He says he is planning ahead more often and thinking more often about stocking up but his timescale runs into the decades. Dave first started injecting speed in 1973.

"I know fresh picks don't grow on trees – you need to be organised."

Dave is uncomfortable with primary NSPs and prefers to pick up five-packs from reception at a local community health service or a pharmacy. He used to think data was collected to pass on to police and is generally suspicious of non-drug users.

"I had the mobile outreach drop off boxes of 100 syringes a couple of times but then you have a lot of used syringes to get rid of. You can't win really. I know how used picks bugger your veins but well..."

Sometimes impatience to use leads to reusing equipment.

"If you've picked up it doesn't make much sense to make a separate trip to an NSP for clean needles when there are picks at home that have only been used a few times.

"At the end of the day, why do I reuse? Because I'm basically too lazy to stock up. True fact."

Sasha* (32) is from northern New South Wales.

"I used to always get my boyfriend to do me up but one day it dawned on me that him using the same pick for both of us was madness. Then when I learned more about catching hep C I wouldn't even allow us both to use the same water or spoon."

Sasha has become extremely fastidious in making sure clean equipment is always on hand in the house.

"But because we live in a small town I have to be super organised because he won't. This is a nosey town around here so I'm definitely not using the NSP at the community centre so they can look down their noses at me. And I know chicks who work there too.

"I have to take the responsibility for our health – so we don't wreck our veins and all that."

But she finds the opening hours of pharmacies and some services does little to help her use only sterile syringes.

"By the time you get organised and in the car the NSP is either closed for lunch or it's after 4:30 and it's shut. That's a real bummer."

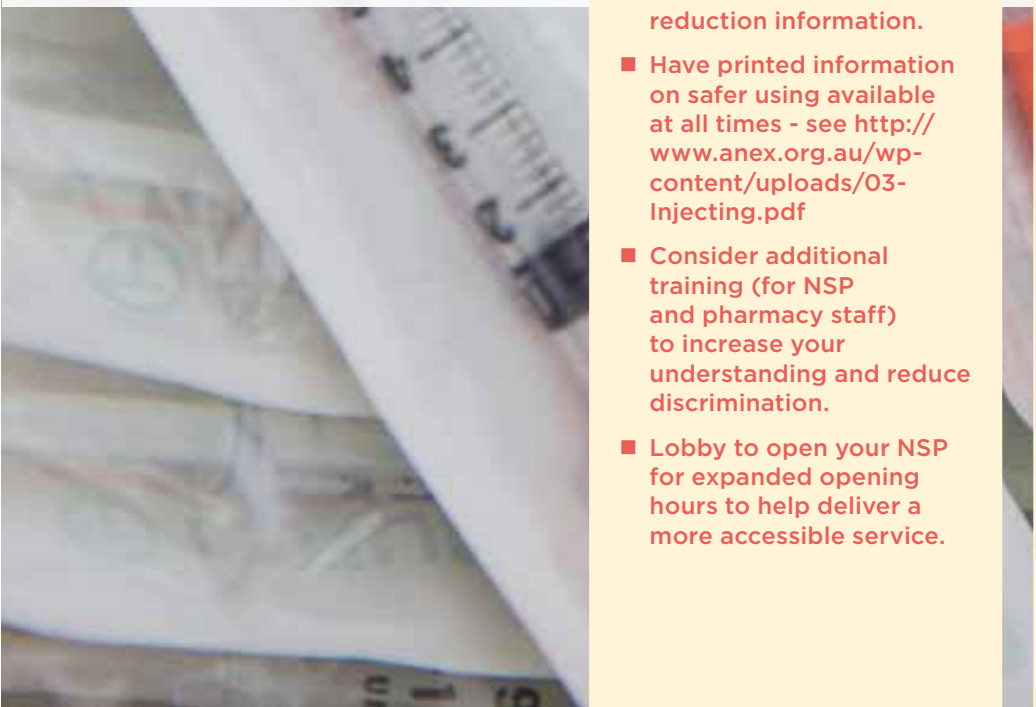
*Names have been changed.

- Royal Abbott

For a longer study of this issue see AIVL: A study into the re-use of injecting equipment in Australia (2015) - http://www.aivl.org.au/wp-content/uploads/No-one-likes-using-the-dirties.pdf

WHAT CAN NSPs DO TO HELP?

- Encourage clients to stock up. If someone just wants one five-pack at least see if they will take two.
- Equip yourself to provide informal verbal harm reduction information.
- Have printed information on safer using available at all times - see http://www.anex.org.au/wp-content/uploads/03-Injecting.pdf
- Consider additional training (for NSP and pharmacy staff) to increase your understanding and reduce discrimination.
- Lobby to open your NSP for expanded opening hours to help deliver a more accessible service.



WHY DO PEOPLE REUSE INJECTING EQUIPMENT?

- Lack of knowledge of safer using practices.
- Social circumstances, peer pressure. A group of friends gathers to use drugs and there is insufficient injecting equipment to go around.
- No money to buy equipment from Secure Dispensing Units (vending machines) or buy petrol to travel to an NSP.
- Impatience to use.
- Opening hours for NSP are too restrictive and unsuitable for people who inject drugs.
- Limits on how much equipment can be collected.
- Disorganisation, poor planning. A lack of confidence that health services hosting NSPs will protect privacy, especially in rural and regional areas.
- Shame and stigma associated with injecting drug use.
- Prisons ban detainees from possessing syringes in custody. Former prison inmates tell of five or six prisoners at a time taking turns to inject with a well-used cut-down syringe which they sharpen on a match-box striker or concrete surface.
- Suspicion that data collected at NSP is compiled at the behest of the police.
- Judgemental attitudes on the part of NSP staff. A look that may be interpreted as condescending can deter a person who injects drugs from ever returning to a particular NSP.

NSPs TO DISPENSE NALOXONE IN NSW PILOT

Amid concerns Australia is about to be caught up in the worldwide increase in opioid deaths, the NSW Health Department has funded a pilot project on the feasibility of Needle and Syringe Program workers dispensing the overdose antidote drug naloxone.

Naloxone is literally a life-saver. It temporarily reverses the effects of an opioid overdose, preventing death or acquired brain injury that can result from depressed respiratory functioning.

Naloxone is safe, non-addictive and experts want it to be more available within the community to prevent unnecessary deaths.

Sydney University Addiction Medicine Specialist Professor Nick Lintzeris says several barriers to obtaining naloxone need to be overcome, "particularly for the more difficult to reach or more marginalised populations".

Naloxone is available on prescription in Australia, and from pharmacists without a prescription since February last year as part of the Take Home Naloxone (THN) program. Unfortunately, soon after the introduction of THN, production ceased of syringes preloaded with naloxone, called minijets. Glass ampoules of naloxone replaced the minijets but many found them harder to use. Additionally, whilst naloxone is available on the PBS for only $6 for five doses, purchasing it without a prescription at a pharmacy costs a prohibitive $60. "You need to access a doctor to get a prescription and that needs to be done on Medicare to reduce costs, so they need to find one who bulk bills and then find a pharmacy that stocks (naloxone)," Nick says.

"In many parts of Australia, in regional and even metropolitan cities, it can be hard to find a GP as often there are shortages - particularly of GPs that are knowledgeable and work with people who inject drugs."

To try to overcome those barriers, Nick is working on a pilot project investigating the delivery of naloxone through NSPs and Drug and Alcohol Services. The pilot will use a newly-approved UK product, Prenoxad, which is a pre-loaded syringe containing five dose of naloxone.

Prenoxad has been fast tracked for use in Australia and it is anticipated it will be available on the PBS in coming months. Nick says the syringes are much easier to use in the high-stress environment of assisting someone who is overdosing.

Harnessing NSPs to distribute Prenoxad makes sense, Nick says.

"You have a skilled workforce; they know how to talk to people who inject drugs, they are very effective at doing education, this is just adding in the naloxone supply so, in effect, it becomes a one-stop shop."Five Local Health Districts have enrolled in the pilot, three in metropolitan Sydney and two in rural and regional NSW, encompassing up to 25 services that have NSPs and Drug and Alcohol Programs.

The first distribution of naloxone as part of this project is slated to begin within weeks.

Nick says whilst this is only one approach to increasing the use of THN, initial feedback has been positive.

"Workers, and consumers themselves, have been very keen to look at more effective ways to increase the take-up of naloxone.

"If this model works, and it's cost efficient, then I think there will be a lot interest from around Australia to replicate this in other states," he says.

"There is a lot of science around the world suggesting that opioid use may well be having a resurgence, certainly in the US it's taken off again, and I think we need to be prepared and have strategies up and running."

The pilot is being led by the University of Sydney and the South East Sydney Local Health District and involves collaboration with a range of academics, researchers and consumer groups across Australia.

Details of the pilot are still being finalised. Future editions of the *Anex Bulletin* will provide an update on the model, authorisation, logistics and other issues related to the project.

- Kate Robertson

Prenoxad (photo courtesy of Phebra)

THERE'S NEVER BEEN A BETTER TIME TO HAVE HEPATITIS C

The new direct-acting antiviral (DAA) hepatitis C treatments have been touted as a miracle cure for people living with hepatitis C. But it will be NSPs – and NSP workers – who will do the heavy lifting in educating people about the new treatments, providing encouragement and support for those reticent to get treatment, and making access to treatment as easy as possible.

Stuart Loveday, CEO of Hepatitis NSW, recalls a senior nurse at Sydney's Royal Prince Alfred Hospital liver clinic describing the effects of the new DAA hepatitis C treatments: "It's so fantastic! Everybody in the liver clinic is in a good mood these days. It's a much better work environment because everyone is getting cured! And where they exist, treatment side effects are minimal." He also recounts Hepatitis NSW peer worker Grenville Rose telling a group of health care workers that "there's never been a better time to have hepatitis C... because cure is so easy!"

Indeed, Stuart makes a point of always describing the new treatments as "hepatitis C treatment and cure," such is his confidence in the new drugs. "These new treatments are all oral, they are short duration, they have minimal or no side effects," Stuart enthuses. "But above all, they have a 95 per cent plus overall cure rate." But as good as these treatments currently are, they are about to become even better. Right now there are five different available combinations of direct-acting antivirals, depending on which genotype of the virus a person has. "Soon we hope we'll get a pan-genotypic treatment, one pill a day no matter what the genotype. And how great that's going to be."

"It's a much better work environment because everybody is getting cured!"

Stuart Loveday

But Stuart cautions that these great new treatments are only part of the story: educating people about them and creating conditions where people can be easily tested and treated is central to the goal of ridding Australia of the virus within 10 to 15 years. For many thousands of people with hepatitis C, it will be NSPs and NSP workers, who Loveday describes as "a fantastic bunch of people," who will kick-start and help guide their road to treatment and cure. And while a few primary NSPs can act almost as a one-stop-shop for hepatitis C treatment, with access to fibroscan machines and a complement of nurses and other health professionals attached to them, the bulk of NSPs (as well as pharmacies that distribute injecting equipment), rely on the knowledge and encouragement of their staff, as well as partnerships with services that can help deliver the treatments.

Stuart argues that NSP workers are exceptionally well placed to play a major role by emphasising a few basic things about the new treatments, the most important of which is that they are nothing like the old interferon-based treatments, "which were horrible

Continued overleaf

THERE'S NEVER BEEN A BETTER TIME TO HAVE HEPATITIS C

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and made any illness or health condition you had that much worse." The new treatments are simple to take, the process usually lasts just two or three months, and the side effects for most people are negligible. "They might create a bit of nausea, a bit of listlessness or forgetfulness," says Stuart, "but nothing like the major depression and anxiety of the interferon treatments. People breeze through the new treatment and can't believe how easy it is."

Stuart believes NSP workers can play a major role in helping end the hepatitis C epidemic by providing education, encouragement and momentum. "Have opportunistic or planned conversations with NSP clients, have resources available, fit pack stickers, posters on walls, education sessions. Resources are really key to have on hand," he says. "By engaging people, by supporting people into hep C treatment, by telling people the right places to go to, which websites to go to, which numbers to call. It's such an exciting time and we really need to capitalise on it."

Stuart suggests that there are three waves of people going into treatment, ranging from the early adopters to those who don't know they have the virus. Of course there will be some overlap between these three waves.

The First Wave comprises about 33,000 people in Australia who are generally articulate, health literate and have been proactive in managing their hepatitis C. The people in this wave have largely already taken up the new treatments in the first 12 months of their availability.

The Second Wave comprises about 70,000 people and is where particular attention is being paid by health departments and drug and alcohol services, and where NSPs will be pivotal.

"These are people who are already accessing health services, but for reasons other than for their hepatitis C," explains Stuart. "They are people attending methadone clinics or other OST services, people attending NSPs, people in prison and people accessing homelessness and mental health services."

Stuart points out that although prevalence rate in the general community of people living with hepatitis C is just over 1 per cent (or 230,000 people), the rate jumps to 32 per cent for people in NSW prisons. And the rates for Aboriginal people living with hepatitis C (and hepatitis B) are much higher than in the general community, making community controlled health services as well as mainstream health services an important part of the Second Wave of treatment. By treating the people in this Second Wave, HCV treatment and cure can effectively be seen as "treatment as prevention" of transmission of HCV. "But of course it is vital that we maintain and grow existing primary prevention services such as NSPs," Stuart emphasises.

The Third Wave comprises everyone else with hep C: around 127,000 people who received their hepatitis C diagnosis many years ago or who aren't diagnosed at all (perhaps 18 percent of people living with the virus). This group, in Stuart's view, is perhaps the most difficult to reach and we need to find new ways of mobilising and reaching people where liver disease will be advancing. Many people come from countries with a high prevalence of the virus or shared injecting equipment many years ago, and their experience of shame and guilt around having contracted hepatitis C can be an obstacle to getting treatment. In Stuart's view it will be GPs and other primary health doctors rather than NSPs or specialist clinics who are in the best position to get them into treatment.

The other important virtues of the new treatments are the cure rate, which is about 95 per cent, compared to the 50-80% success rate when taking the old interferon-based treatments, and that these new treatments are available to everybody who has hepatitis C. Any adult in Australia can access the treatment for a small monthly prescription charge, whether they currently inject drugs or not. "Australia truly has equal treatment access for all people with hep C," says Stuart, "and there is no cap to the number of people who can be treated."

Ultimately what Stuart and Hepatitis NSW would like to see is the treatment and cure of all people with hepatitis C. "We've got 10 to 15 years to do it – 10 years is the aim set by the Kirby Institute in Sydney and the Burnet Institute in Melbourne. The World Health Organization has a target of elimination of hepatitis C by 2030. We want it by 2026. And I think we may be able to achieve that," he argues. "But there is a view out there at senior levels that because we've got these new treatments and cures that the hep C epidemic is over. It's not. There's an aim to eliminate hep C in 10 years but there's a huge amount of work to do. Because whatever you do in terms of biomedical advances and treatments and cures, and whatever you do in terms of funding and system reorientation, two things always remain the same: the human behaviour of people providing health services, and the human behaviour of people in the community."

"There are so many barriers in people's lives to taking effective health care, to approaching a doctor, to approaching a health service, to approaching a nurse, and doing something about their hep C, because there are other priorities going on. But this is the first time in history we can turn around an existing disease and eliminate it in 10 years."

"Tragically there are still around 800 deaths per year from hep C-related liver disease and liver cancer is on the rise. We can turn these figures around by rapidly increasing the numbers of people accessing treatment and cure," says Stuart.

"NSPs and their staff can and should be the drivers of information and the cheerleaders of the new treatments for the many thousands of people with hep C who use their services."

- Gideon Warhaft

NSP CLIENT INPUT SHAPES WESTERN SYDNEY LIVER CLINIC

The Western Sydney Local Health District has been running a liver clinic service at its Mount Druitt and Blacktown Needle and Syringe Programs (NSPs) since May last year.

Ashley Ubrihien, HIV and Related Programs Unit Manager for the Western Sydney Local Health District, says that the service is designed to be as easy to access as possible.

"When we initially set up the clinic we did a short survey of NSP clients, asking them where they would prefer to access treatment," explains Ashley. "There was an overwhelming indication from clients that they wanted to access treatment in the same spot as they were accessing their NSP equipment. We took that feedback on board."

Aimed at marginalised populations who often find accessing traditional health services difficult, the service is built around a specialist nurse who attends the clinics three days a week, a consultant gastroenterologist one day each month, and several fibroscan machines that are shared across the district.

"There's no rigid booking system or anything like that. People come in and are assessed when they arrive. The nurse will conduct a fibroscan on the spot and refer them to a pathology provider that's just across the road," describes Ashley.

"The gastroenterologist sees each patient before they get their script, talks through any issues that might have come up through any of the tests that have been ordered, and writes them their script. She'll see them again in 12 weeks once they've finished treatment."

As of March the service has seen 44 patients across the two sites, of which 36 per cent are people from Aboriginal backgrounds.

"That's something that we're quite pleased about because we've been partnering with the local Aboriginal Community Controlled drug and alcohol service to attract some of our patients through that avenue," says Ashley.

Promotion for the liver clinic is predominately by word of mouth. "We want the word to get out there organically," explains Ashley. "Obviously we've got fliers, posters, things like that in our NSP, but we really want to get people within these networks who might have picked up hepatitis C from sharing equipment in the past. I guess we're really encouraging people to bring their friends in."

For some NSP clients the benefit of the new DAA treatments are obvious and they're happy to take up the treatment right away. For others, says Ashley, "It might be a slow burn. It will be NSP staff engaging them over a period of maybe years."

- Gideon Warhaft

FENTANYL AND CARFENTANYL: WHAT DO I NEED TO KNOW?

Its street name is "China White". Fentanyl, and its analogues (compounds that resemble fentanyl in structure) are rising, relative newcomers to the opioid market. They carry a lethal potency and are dramatically more powerful than heroin.

In the US a large percentage of overdose deaths result from heroin that has been "laced" with fentanyl analogues, or from counterfeit pharmaceutical pills containing the drug. The autopsy of musician Prince ruled that he died of an overdose resulting from counterfeit hydrocodone pills that actually contained fentanyl.

Outreach Coordinator at WASUA (The Western Australian Substance Users Association) Paul Dessauer, explains, "Fentanyl is a powerful synthetic opioid with a rapid onset and short duration of action, used widely in medicine for pain relief and as a general anaesthetic.

"When used via parenteral routes – as in subcutaneous, intramuscular or intravenous – it is 100 times more potent than morphine. This means 1 milligram of fentanyl administered by injection has roughly the same effect as 100 milligrams of injected morphine. By way of comparison, an intravenous dose of pure heroin – diacetylmorphine – is 'only' three times as potent as the same weight of IV morphine."

Paul says that fentanyl and its analogues can be injected, ingested, inhaled, taken across mucous membranes, and via transdermal (through the skin) routes. Fentanyl analogues might be purchased via dark-web vendors or research chemical suppliers, or may be 'cut' into illicit heroin. Alternatively, turning up on the black market could be the pharmaceutical products that the drugs were created for; prescription-only medicines containing fentanyl or its analogues, including trans-dermal patches, lollypops and nasal sprays, and ampoules for injecting use.

Alarmingly, Australian Customs recently intercepted a shipment of carfentanyl.

Carfentanyl (or carfentanil) is the strongest available analogue of fentanyl, roughly 10,000 times

Fatal doses compared: heroin, fentanyl and carfentanil

Image: Bruce Taylor, New Hampshire State Police Forensic Lab

more potent than morphine. If you need to anaesthetise an elephant or a whale, this is the drug for you. If somebody is looking to self-inject, not so much.

Paul says that because of Australia's geographic proximity to the primary source of high-quality salt heroin in Myanmar, and our geographic isolation from traditional North American and Latin American sources of black-market fentanyl, we've been largely protected until now. But Paul believes that could be changing.

He says the attraction to major traffickers is obvious. "Carfentanyl can be sourced more cheaply (per equivalent dose) than heroin; it is roughly one-thirty-three thousandth (1/3300th) the bulk of a dose-equivalent weight of heroin; and sniffer dogs and Ion-tracking equipment will not detect it," he says.

"Once imported it could be bulked out with poorer quality heroin, or even an inert powder, to turn an insignificant pinch of dust into thousands of street-deals. To major traffickers, the risk of interdiction or arrest are significantly lower and the potential profit margins are much higher." The major danger to users is that such tiny amounts of carfentanyl can kill. Paul says that while the drug has never been tested on humans, it is believed a lethal dose might only be 20mcg = 0.02mg (milligrams). For comparison, the lethal human dose of pharmaceutical-grade fentanyl is 2mg, and a lethal dose of morphine is usually calculated as 200mg, (although doses as low as 60mg have killed opioid naive people).

To put it more starkly, if you want to picture what 20 mcg of carfentanyl looks like, consider a single small grain of salt. Crush that into powder or mix it into water, then add to other drugs, and users could have no idea what they're about to absorb.

The only way to accurately measure fentanyl, carfentanyl or the other analogues is with highly precise scales costing upwards of $10,000. "The traditional advice we offer when someone is unsure of how strong a deal of heroin might be is to test a small sample first," Paul says.

"You know, 'two holes in the arm are better than one hole in the ground'. However, when a fentanyl analogue is mixed into heroin, only a speck or two of difference could mean that one half of the packet is tens or even hundreds of times stronger than the other.

"The best advice for individual users is to avoid using alone, and to stagger their use – that is, take it in turns and wait long enough to ensure the first person is okay before injecting their own dose – or to use in a medically-supervised setting if one is available."

- Nick Place

MINIMISING RISK TO FIRST-AIDERS:

In response to a suspected exposure to potent synthetic opioids:

- Call 000 immediately and administer first-aid as per an opioid overdose.
- Avoid handling any drug material or paraphernalia at the scene.
- Wear nitrile or latex gloves and use a face shield if available. As a last resort a simple face shield can be improvised from a piece of plastic bag with a hole in the centre.
- Ongoing ventilation and multiple doses of naloxone may be required.
- If inhalation exposure is suspected, ensure the victim has fresh air.
- If ingestion is suspected and the victim is conscious they should be encouraged to flush their mouth, eyes and nose with fresh running water.
- If contact exposure is suspected and the person is conscious, flush the area under running water. However this will probably only help within a very short time of the contact.

ICE USE IN THE COUNTRY: WORKERS SHARE THEIR EXPERIENCES IN NEW VIDEO SERIES

A new program developed by Penington Institute aims to educate workers in secondary NSPs and other health services to reduce the harms for clients who inject ice.

Injecting ice in the Country includes 10 videos and fact sheets that can be accessed from www.penington.org.au/injectingiceinthecountry. As well as building harm reduction capacity in rural and communities, the project aims to improve Aboriginal clients' access to harm reduction services through both Aboriginal and mainstream services.

The Victorian Government funded the project after the Premier's Ice Action Taskforce revealed that injecting ice was becoming an increasing concern in country areas. While targeted at rural and regional workers, the resources are relevant for anyone who has clients who inject ice. In the videos, NSP workers, doctors and other experts talk about key issues relating injecting ice, and how healthier approaches can be used to support clients to reduce the harms.

Topics include current trends in ice use, intoxication and withdrawal, psychological impacts, impacts on the body, safer injecting, harm reduction and engaging clients.

Experts explain how ice can cause heart, liver and dental problems, and that NSP workers have vital roles in educating clients to reduce these harms.

There are a range of risks that come with injecting ice that are unique; it can shrink veins, making it harder to inject, and along with tremor and blurred vision that clients experience, this can increase the risk of vein damage, missed hits and blood-borne virus transmission.

Ice use can make people feel invincible and lead to an increase in risk taking behaviours. It's also associated with poor mental health, and often contributes to clients experiencing anxiety and depression.

Bendigo Community Health Services Alcohol and Drug Community Senior Worker, Bart McGill, who is in the videos, says:

Bart McGill

"Variability and potency fluctuate wildly, and this can be a driver of harm for people who use ice.

"It's hard to gain knowledge about injecting; there's no university or education class so these videos and factsheets are really helpful.

"Secondary NSP workers have many competing priorities and can be unsupported in the critical work they do as NSP workers."

Bart says there are risks associated with injecting that are unique to ice and because it's a stimulant, the body runs at an elevated rate which reduces appetite and the need for sleep.

To access the resources, visit www.penington.org.au/injectingiceinthecountry. Training sessions for staff can be booked by emailing info@penington.org.au.

- Helen Carter

TIPS FOR HELPING CLIENTS:

- Your approach is critical. It's important to build trust with clients – this is made easier when they are confident that their information is confidential and won't be shared with other staff or members of the community.
- Be welcoming, approachable and respectful as clients treated respectfully are more likely initiate conversations with NSP staff.
- Building rapport takes time. It's important to be genuine, sincere and consistent. Being friendly and professional will reassure clients that you take their privacy and health concerns seriously.
- Don't be disheartened if clients are not talkative on all occasions; don't expect or demand responses.
- Building a relationship is vital as often the NSP worker is the only contact clients will have with a health service. NSP workers who develop a relationship with the client may be able to open up a conversation about seeking further support.
- Be patient; don't ask too many questions as clients may not have slept or eaten for days – leaving them depleted and exhausted.
- For Aboriginal clients cultural sensitivity and safety is important as trust in health services may be low.
- Engaging Aboriginal clients is enhanced by understanding the cultural issues, including the impacts on family and community.

TIPS FOR SAFER INJECTING:

- Hydration is critical so drink ample water. Amphetamines constrict veins, making injecting when dehydrated difficult, but keeping hydrated boosts liquid in veins, making it easier to inject safely. Being unable to access veins and jabbing repeatedly blunts needles, resulting in greater likelihood of vein damage.
- Proper nutrition and sleep are vital to prevent bad outcomes. Inject during the day and sleep at night to keep the body as close as possible to a natural routine and give it a chance to rest.
- Avoid smoking and caffeine in the hours before injecting as they narrow veins.
- Rotate injecting sites, practise good vein care, use sterile equipment and take more needles and syringes than you need, just in case.

Injecting ice in the Country: factsheets

NSP NATIONAL MINIMUM DATA COLLECTION

In 2015, the Australian Government Department of Health engaged the Kirby Institute to develop a Needle and Syringe Program National Minimum Data Collection (NSP NMDC) to support the National Blood Borne Viruses (BBV) and Sexually Transmissible Infections (STI) Strategies 2014-2017 and to complement the annual Australian Needle and Syringe Program Survey (ANSPS) National Data Report.

Across Australia, 49.4 million needles and syringes were distributed in 2015/16. The figures also show that over the past 10 years the number of needles and syringes distributed in Australia increased by 48 per cent, with a 31 per cent increase over the past five years.

Collated national data will enable reporting against key indicators required to monitor the success of the National HIV Strategy, the National Hepatitis C Strategy and the National Aboriginal and Torres Strait Islander BBV and STI Strategy. The release of a report that collates Australia-wide demographic characteristics of NSP attendees, the number and types of NSP services and quantifies syringe distribution represents a significant development.

To read the full report visit: https://kirby.unsw.edu.au/report/needle-syringe-program-national-minimum-data-collection-report-2016

IN 2015/16, 49.4 MILLION NEEDLES AND SYRINGES WERE DISTRIBUTED IN AUSTRALIA.

AN ESTIMATED 755,000 OCCASIONS OF SERVICE TOOK PLACE IN PRIMARY AND SECONDARY NSPs.

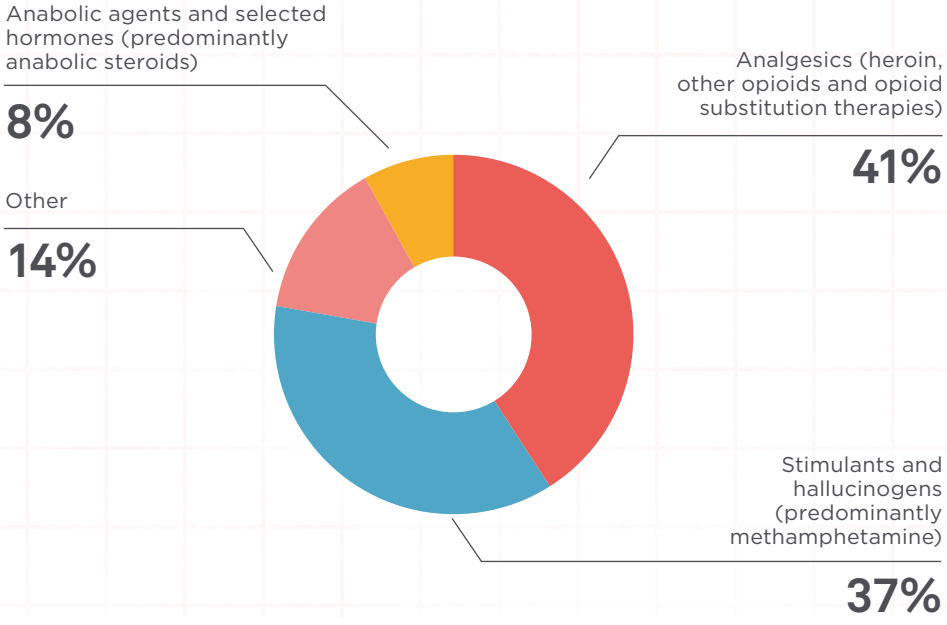
AUSTRALIA'S NETWORK OF NSP SERVICES IN 2015/16:

102 PRIMARY

786 SECONDARY

2,321 PHARMACY NSPs

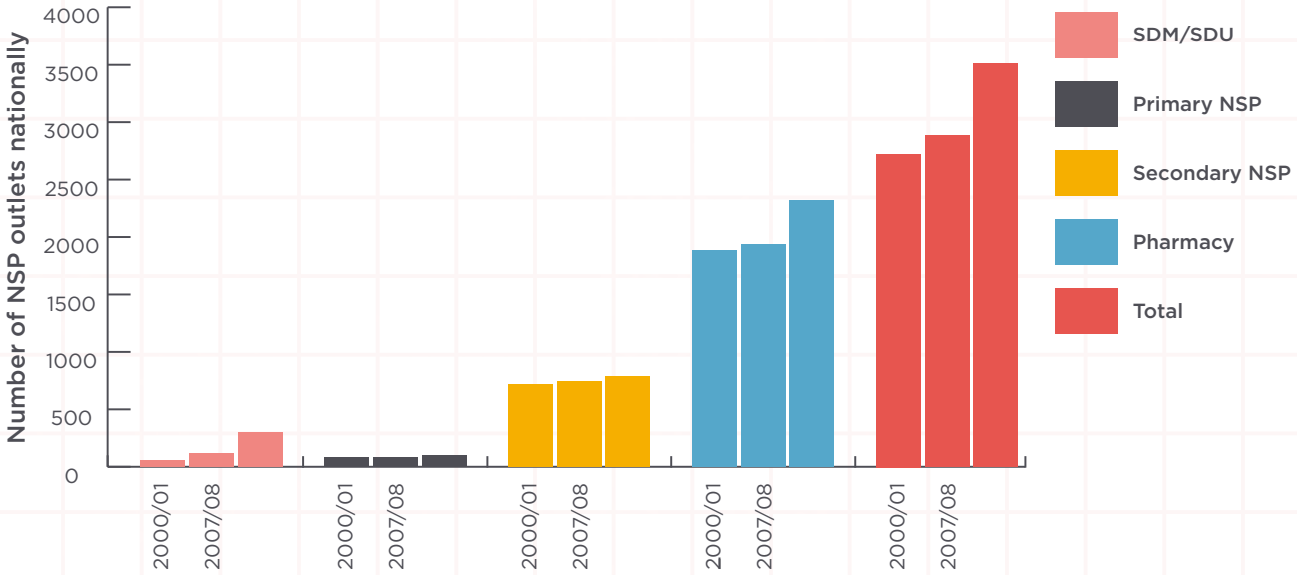
THE MOST COMMONLY REPORTED DRUGS INJECTED ON THE SNAPSHOT DAY:



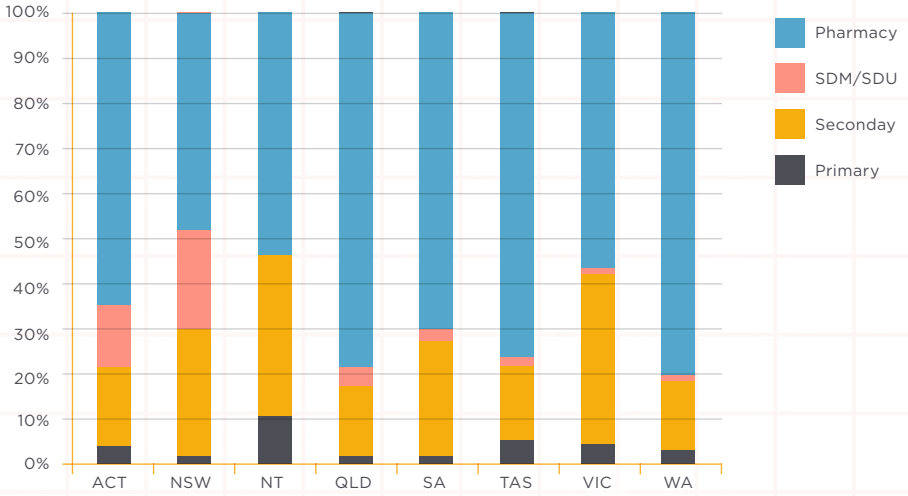
Graphs and data adapted from:

Iversen J, Linsen S, Kwon JA, and Maher L. Needle and Syringe Program National Minimum Data Collection: National Data Report 2016. Sydney: Kirby Institute, UNSW Australia; 2017.

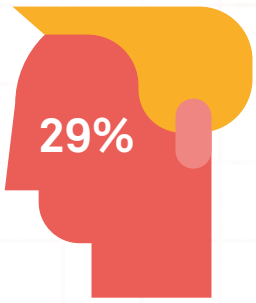
GROWTH IN NSP SERVICE PROVISION:



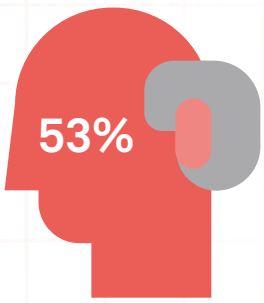
SERVICE TYPE BY STATE:



THE MOST COMMONLY REPORTED DRUGS INJECTED ON THE SNAPSHOT DAY, BY AGE:

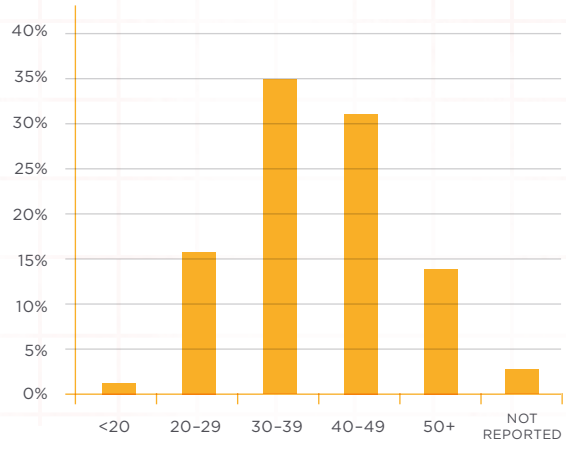


Young people (<25):
Stimulants and hallucinogens



Older people (≥50):
Analgesics

OCCASIONS OF SERVICE BY AGE:



SPOTLIGHT ON SURGE IN OVERDOSE RATES

Needle and Syringe Program staff are being urged to put their support behind International Overdose Awareness Day that takes place on 31 August, as research shows deaths from accidental overdose in Australia have soared by 61 per cent in a decade.

Australia's Annual Overdose Report 2016, complied by Penington Institute, found deaths from overdose reached 1,137 in 2014, up from 705 deaths in 2004. Most at risk are older men living in rural Australia, particularly Aboriginal men.

Rural and regional Australia has experienced an 83 per cent increase in deaths in the six years between 2008 and 2014 and Aboriginal communities have had to cope with a 141 per cent increase in the decade from 2004, compared to a 45 per cent rise in the non-Aboriginal community.

Prescription opioids, rather than illicit drugs, were responsible for most of the deaths.

Penington Institute CEO John Ryan says International Overdose Awareness Day is about tackling the stigma around drug use and raising awareness of overdose prevention."There are a whole lot of grieving families suffering in silence because they feel they can't talk about overdose, and because they don't talk about it we continue to have this clichéd view of who is impacted by drug addiction and overdose. It also means there's no natural community to push for a policy response," John says.

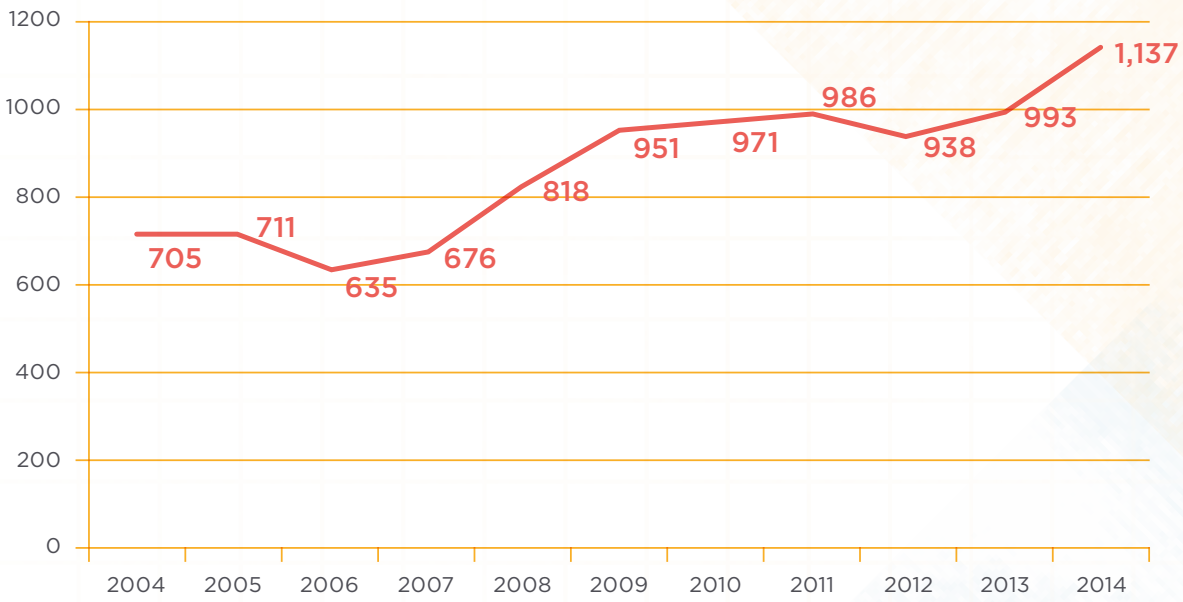
The International Overdose Awareness Day website displays heart breaking messages from people who have lost family members and friends to drug use.

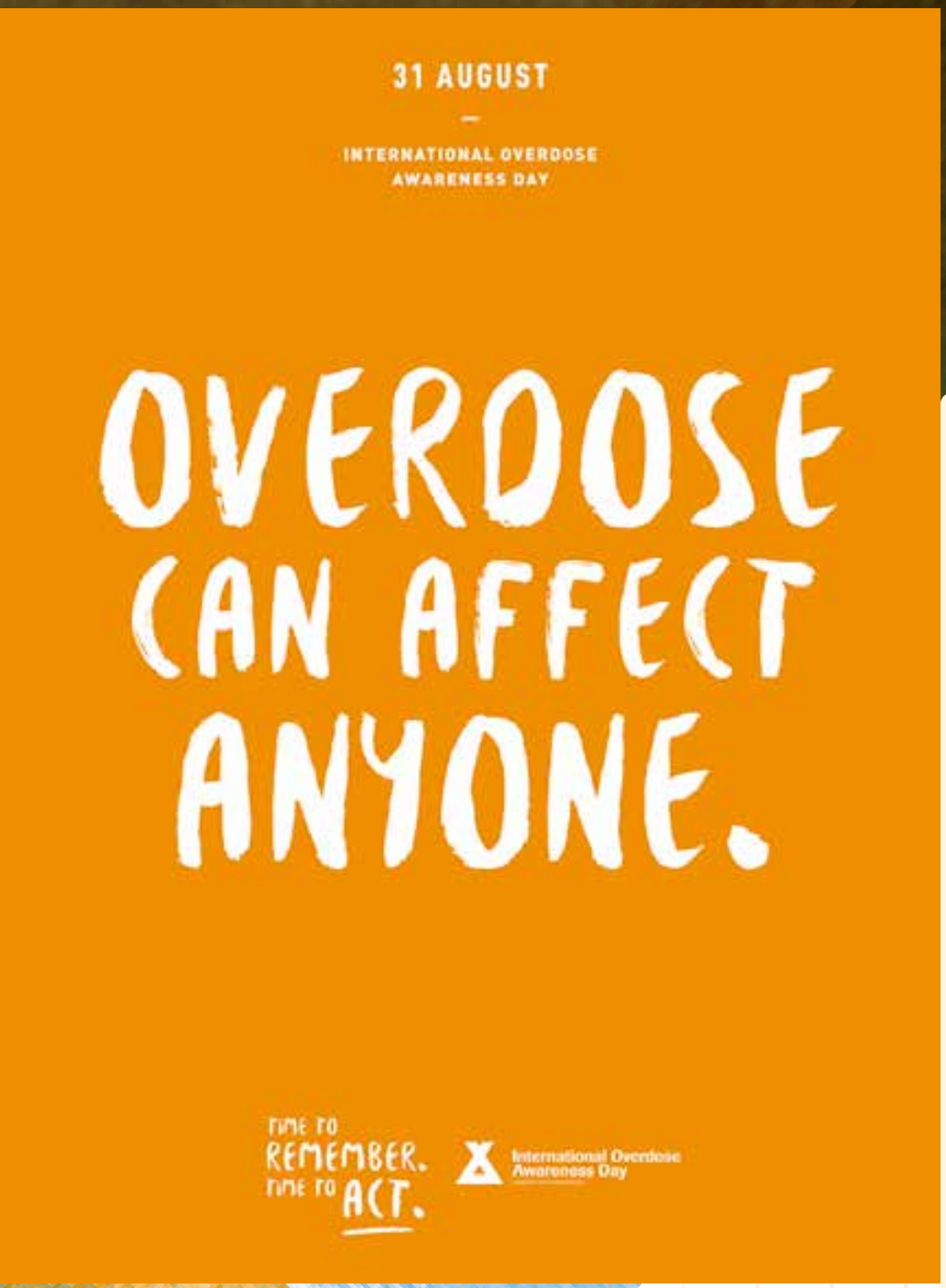
NSPs can support the message that overdose deaths are preventable by planning an event and sharing it on the International Overdose Awareness Day website. You can also advertise your event on social media with the hashtag #OverdoseAware2017 and download and display promotional materials such as factsheets and posters – available in a number of languages.

See www.overdoseday.com for details.

- Kate Robertson

THE GROWING RATE OF OVERDOSE IN AUSTRALIA





IOAD meme: Overdose can affect anyone

ORGANISING AN EVENT IN YOUR COMMUNITY

International Overdose Awareness day is a time to reflect on those lives lost through overdose. It provides an opportunity to support those left behind, share memories and provide overdose prevention training.

Each year at the Needle and Syringe Program and Primary Health clinic in Dandenong an event is held to focus on overdose prevention, education and support. We have previously held a community BBQ to share the message that overdose is preventable with the wider community. In 2016 we held an event to bring together services and clients with a focus on remembering people who we've lost to overdose. We have tree of remembrance onsite with messages from those that have lost friends, family and loved ones.

The planning is hard work, but to see communities, services and clients supporting one another, reducing the risk of overdose and generating a cohesive approach is definitely worth it.

Theresa Lewis Leevy

Team Leader, Monash Health Dandenong

THE PEOPLE BEHIND THE STATISTICS

On International Overdose Awareness Day, Narelle Hassett's thoughts will turn to three men: her brother Shane, who died of a prescription drug overdose at the age of 29, and the paramedics who saved her life when she was overdosing from heroin as a troubled 19-year-old.

Narelle is now enjoying a full life as a mum to her step children and doting aunt to Shane's six-year-old daughter. She avoids even the mildest of medication and loves her job as a disability support worker.

"Every day at work I get a chance to make someone smile. It's a way for me to give back for all of those bad years. It's nice to be on the other side."

Narelle started using heroin at the age of 16 to escape mental health issues, including crippling anxiety. At 19, she realised she had a choice — give up drugs or die.

"That was what prompted the overdose," Narelle says. "I didn't know how to go about getting clean, it seemed too overwhelming."

Luckily for Narelle, ambulance officers promptly attended the scene and administered the overdose antidote medication, naloxone. She has kept the naloxone packaging, marked with the date and time of her overdose. Soon after, with the support of the man she has since married, and her family, she enrolled in a methadone program and turned her life around.

"I think of all the good things I could have missed out on … I was given a second chance at life because of naloxone and two wonderful paramedics who I will never get to thank."

Shane was not so lucky. After years of doctor shopping for a range of opioid medications to cope with depression, he died at his parent's home. His father was in the kitchen, unaware that the sound of heavy snoring was an indicator Shane was experiencing an overdose.

Narelle was close to her brother and his death was shattering. She still keenly feels the stigma people who use drugs face and, on International Overdose Awareness Day, she hopes the community will be a little kinder to those impacted by drug use; understanding that mental health issues are often a contributing factor in their choices.

She also hopes that those with family or friends who use drugs will learn the signs of an overdose and ensure they have naloxone on hand. Take home naloxone wasn't an option when Shane was alive. She wonders if it was, would he still be.

- Kate Robertson

Narelle Hassett