PENINGTON INSTITUTE

Volume 16 Edition 2

anex Bulletin

DRUGS AND TEETH: "IT'S A BIG ISSUE"

Gum and dental disease are the most common diseases in the world and are especially prevalent among people who use drugs.

Associate Professor Rachel Martin, manager of the oral health service at North Richmond Community Health, which hosts one of Australia's busiest NSPs, says that issues with teeth and gums also have broader implications.

"People come to us for pain relief [due to teeth problems] and, if not for that, then to get their teeth fixed so they can smile, so they can get a job, and so that people don't identify them as a drug user. They are aware that their teeth are an outward sign that they are using drugs. They are very aware of it. It is a big issue for them," says Rachel.

"Drugs like heroin, methadone, and methamphetamine (and many pharmaceutical medications) reduce saliva, which serves as a natural protective mechanism in the mouth. Crystal methamphetamine can also cause teeth clenching and grinding.

"Consequent damage is often compounded by poor lifestyle choices and the significant cost and stigma of seeking care," she says.

Story continued on page 2

Shush! Confidentiality and anonymity in the NSP/CNP
Story on page 5

'Done', 'bupe' and 'subby' – what?!?
Page 8

Pharmacotherapy key to effective hepatitis C treatment
Page 11

DRUGS AND TEETH: "IT'S A BIG ISSUE"

Gum and dental disease are the most common diseases in the world and are especially prevalent among people who use drugs.

Continued from page 1

Needle and syringe program workers are some of the few people who have the access and rapport to improve poor oral health in people who use illicit drugs.

Rachel says NSP workers on the front line can use clear messaging to help prevent poor oral health before it becomes a major concern.

"Most definitely, there are effects of particular drugs that are very detrimental to the mouth, but it's also about managing diet and sugars too – constant sugar will increase the opportunity for bacteria to wreak havoc in the mouth and cause decay.

"It's also about directing clients to the appropriate health care services – finding out what services are available in that particular area and directing people to those services."

While free or subsidised oral health care is available to those who hold a government concession card, it often involves numerous appointments and two to three years on a waiting list. What's more, the stigma of being identified as a person who uses drugs acts a significant deterrent to most.

As a result, people who use drugs often neglect treatment for oral health issues, which can have untold ramifications on their psychological health.

"We see a direct link between poor psychological health and poor oral health," says Rachel.

"Oral disease develops over time, it's not necessarily seen as a priority and we often only see people who are seeking emergency care," she says.

"It's as easy as offering simple messages: 'make sure you stay hydrated with water' and 'use fluoride toothpaste'," says Associate Professor Rachel Martin.

Leah is a volunteer for the NSW Users and Aids Association (NUAA) and has been on the methadone program for over 17 years. She has experienced many of the psychological consequences of poor oral health. Leah lost a tooth while on the nod almost 20 years ago, and the problem quickly spread through her mouth when she was unable to seek the appropriate care.

"I just didn't have the money to go to the dentist. I support a family, as well as my drug use, there is nothing left over when you do all that. I don't get public benefits, so I can't get it fixed through public health," Leah says.

"You sort of have to get it dealt with, and I haven't dealt with it. It should be a priority, but it's just kinda not," she says.

"It's really hard to make it [your teeth and oral health] a financial priority when your money is being sucked into something else. If you don't get it done straight away then it becomes this huge problem, and the bigger the problem the more its gunna cost, and the harder it is to deal with. It just keeps building."

Leah says there is definite stigma related to bad teeth.

"Now my teeth are all rotten and crooked, and people definitely treat me differently," she says."

"It was quite hard at the beginning of my time at NUAA. I was doing a lot of presenting, and for a while I didn't do any of it because I didn't look good.

"Even now, I do try not to open my mouth very much, I don't get photographed, I don't smile very much."

Around 15 years ago, Leah received $2000 to get her teeth fixed as part of a government primary health program, which she says gave a great boost to her self-esteem. But the program disappeared with a change of government.

Today, people who use drugs are limited in their treatment options, says Rachel.

"There is not a lot of choice in Australia, it depends on people's circumstances - what their access to resources and hygiene and food is. A lot of it depends on what the situation is, what their lifestyle is," Rachel says.

A Grattan Institute report released in late March 2019 **'Filling the Gap'**, however, has recommended that all Australian's have access to free basic dental health care. In the meantime, Rachel encourages all NSP workers to advocate for people with poor oral health and direct them to the appropriate services.

"Needle and syringe program workers can be advocates for people who need oral health care. I would encourage people who work in NSP programs to raise the issue of oral health, do a quick account of what community health services are available in that area, and deliver those really simple messages," Rachel advises.

"It's the simple things that can really make the biggest difference."

Tom de Souza

Associate Professor Rachel Martin

FYI: REPORT

The cost of pain in Australia

Deloitte Access Economics for Pain Australia

This report establishes the local and Australia wide socioeconomic impact of pain, and includes a cost effectiveness analysis of health interventions that could reduce the impact of pain in Australia.

https://www2.deloitte.com/au/en/pages/economics/articles/cost-pain-australia.html

Dental health fact sheets and flyers

Dental Health Services Victoria:

Protecting your mouth - all you need to know about tobacco, alcohol, recreational drugs... (fact sheet)
https://www.dhsv.org.au/__data/assets/pdf_file/0013/2335/protecting-your-mouth-tobacco-alcohol-and-drugs.pdf

Dry mouth – what the? (flyer)
https://www.dhsv.org.au/__data/assets/pdf_file/0004/42079/DHSV_DryMouth_DL_for_web.pdf

Tobacco, alcohol and recreational drugs – how do they affect oral health? Information for people working with young people (fact sheet)
https://www.dhsv.org.au/__data/assets/pdf_file/0008/3104/tobacco-alcohol-drugs-how-do-they-affect-your-mouth.pdf

SA Dental Service:

Tobacco, alcohol and recreational drugs: How do they affect your oral health? (fact sheet)
https://www.sahealth.sa.gov.au/wps/wcm/connect/985daa004a3397b-1ba0ffa90d529bdaa/SA+Dental+-Service+drugs+and+oral+health+-fact+Sheet.pdf?MOD=AJPERES&CACHEID=ROOT-WORKSPACE-985daa004a3397b1ba0f-fa90d529bdaa-lztphTW

WA Health:

Dry mouth (fact sheet)
https://www.dental.wa.gov.au/sites/default/files/IS190%20-%20Dry%20Mouth%20Information%20v0317.pdf?v=1521536452

TIPS FOR NSP WORKERS TALKING TO CLIENTS ABOUT ORAL HEALTH:

- Find out what dental services are available locally and assist clients with a referral to those services.
- Things to let clients know:
  - It's not just the drugs that do damage. Lifestyle factors such as a diet high in sugar or frequent consumption of sugary drinks have a big impact too.
  - Make sure you stay hydrated with water – this can help to counter the dry mouth (lack of saliva) caused by some drugs.
  - Chew sugar-free gum to help produce saliva.
  - Don't forget to brush your teeth using fluoride toothpaste.

SHUSH! CONFIDENTIALITY AND ANONYMITY IN THE NSP/CNP

Maintaining confidentiality, anonymity and trust is not only good practice, it's vital to delivering a quality NSP service.

Clean needle program (CNP) worker Sue Brownbill, who works as a Hepatitis SA peer educator at Anglicare Elizabeth in South Australia, says that trust is the foundation of the CNP providing clients with a safe and respectful service.

"Trust is a major component of being a CNP worker," Sue says. "You always have people (clients) looking and listening to what and how you say things, this can put you in a 'I feel safe' space or 'I do not trust this person', which impacts on the clients in more ways than one."

Trust and confidentiality are two sides of the same coin in an NSP. To have trust, a person must have a firm belief in the reliability of their health worker. Confidentiality in this context means keeping personal and health information private and secure (e.g. locked filing cabinets) and not sharing it regardless of who is asking.

NSPs are also an anonymous service. This means that clients do not have to provide their name to receive injecting equipment. Also, the information clients do provide cannot be linked back to them.

In a CNP Sue says only basic information is collected, to better inform staff how to respond to trends and a client's needs.

"We collect date, gender, age, number of syringes provided, number of syringes returned, drug to be injected, number of people this person is collecting for, whether they identify as Aboriginal or Torres Strait Islander origin. [Plus] if applicable, whether they are a new client, referral type, and whether information/education or intensive support is provided," Sue says.

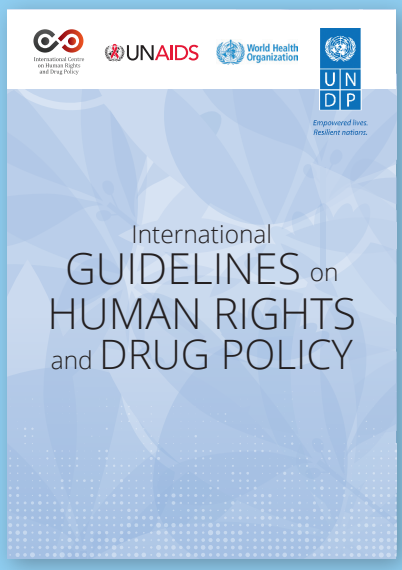
"People accessing the service trust they are anonymous, not only based on data collected, but also the setup of the CNP space and service delivery," she notes. "Unless you have the permission of a person who asks if someone comes looking for them, we do not share any information."

The importance of confidentiality

Sue believes that confidentiality is essential in the client-worker relationship.

"Clients need to know they can access the CNP with the knowledge their personal information will not be shared. This is particularly the case in the CNP as many drug users feel marginalised and most have experienced discrimination or stigma prior to walking into our service," Sue says.

FYI: REPORT



International guidelines on human rights and drug policy

By the World Health Organization, UNIADS, UNDP and the International Centre on Human Rights and Drug Policy

These guidelines are a reference tool for policy-makers, diplomats, lawyers and civil society organisations working to ensure human rights compliance in drug policy.

https://www.humanrights-drugpolicy.org/site/assets/files/1/hrdp_guidelines_2019.pdf

"Confidentiality deals with the issue of stigma and distrust of health care providers, which can include peer workers in a CNP, at times."

What happens if confidentiality is broken?

"Mayhem!" says Sue. "The impacts can include a mental health issue or domestic violence which might have the police involved. [The client] might have children taken away, might lose their housing…"

"If a client feels confidentiality is broken, it will deter them from future access of the service and how much they chose to disclose to any other CNP workers in future," she says.

"This then reduces the capacity to provide harm reduction information and increases the risk of injecting related harms."

Word also gets out on the grapevine that a service breached confidentiality. This can then affect many other clients' views of, and confidence in, the service.

The guidelines

The WA Health NSP guidelines state: "Staff will respect clients' confidentiality at all times and in all circumstances. Confidentiality must be maintained even when a client is known to be participating in other programs (e.g. pharmacotherapy) or when the client or client's relatives are known to the provider."

However, although confidentiality and anonymity are vital to NSPs, it is important to note that this confidentiality *can* be breached if the safety of a minor is at risk.

The NSW Health NSP guidelines outline this scenario: "NSP workers should be aware that respecting the confidentiality of a child or young person is not sufficient reason against making a report to child protection".

Trust in the CNP/NSP

Research fellow at the Centre for Social Research in Health at UNSW, Dr Jake Rance, whose research includes looking at trust in NSPs, says trust is essential when talking about decent health care.

"Trust has to be won, has to be maintained and it can be broken," Jake says. "It's important within health care generally but within NSPs in particular because it is so easy for those of us who are working in the field to forget that we are dealing with a criminal activity [taking illicit drugs]."

"Trust has particular meaning when you're dealing with people who are socially and structurally vulnerable," he says.

Jake believes that NSP workers have the potential to make a powerful difference in the lives of people who inject drugs.

"NSP/CNP staff occupy a unique place in the lives of people who inject drugs. It is a place where their professionalism, ('accidental therapy') skills and simple humanity can do so much more than the simple provision of injecting equipment," Jake says.

"NSP staff are the unsung heroes of harm reduction."

Remi Lih and Sophie Marcard

Dr Jake Rance

Practical tips for maintaining confidentiality and anonymity in the NSP

Myf Briggs, NSP Support Worker at the Rosny NSP in Tasmania, provides this advice for front line health workers:

- "The 'big one' is that if you see a client at the supermarket or another situation outside the NSP you must not initiate contact. This means no 'hello', no eye contact, not even a wink unless the client initiates contact with you."
- "Don't talk about one client to another client, not even their partner."
- "Don't ask for identifying information or about the client's drug use in front of other service users."
- "Don't use identifying information in worker meetings or with other workers. In meetings, be sure to use de-identified details and talk about scenarios, not specifics. This means that you can't say 'the client with tatts and a nose ring' as that identifies a service user."
- "Don't ask a client for their name. And don't be too curious or prying about their lives or drug use."
- "Remind clients of your service's commitment to confidentiality."

Dr Jake Rance's tips to help build trust for CNP/NSP workers

- Be genuinely non-judgmental
- "Clients can be extremely appreciative of small acts of kindness," Jake says of NSP clients.
- Be honest in the NSP/CNP
- Be honest with people, this includes telling people what they don't want to hear. "No one wants to be messed around and a little honesty can go a long way," says Jake. This might be the case with referral to treatment that has a waiting list and the client is keen to start today.
- Give practical assistance
- Be helpful where possible, whether it be as simple as charging a phone when asked. "Going the extra little step for someone who uses an NSP can mean a lot," he says.
- Be aware of the power relationship
- "There is a degree of power that NSP/CNP workers have. It is important to be careful and aware of this power relationship," Jake says.

Links:

A confidentiality poster to display in your NSP:

http://www.penington.org.au/wp-content/uploads/2017/04/NSP-poster-C08.pdf

‘DONE’, ‘BUPE’ AND NEXT ‘DEPOT’ — WHAT?!? THE TODAY AND TOMORROW OF PHARMACOTHERAPY

Called pharmacotherapy by frontline workers and ‘The Done’ and ‘subbies’ by people who inject drugs – knowing about Medication Assisted Treatment for Opioid Dependence (MATOD) is an important skill in the NSP worker’s toolkit.

Lachlan Rose, a community pharmacist and Pharmaceutical Society of Australia (PSA) NSW branch committee member, says that pharmacotherapy is important but not the only piece of the treatment puzzle.

“All addictions require intervention – they won’t just go away. It’s fortunate in the case of opioid dependence that there are effective medications that can assist,” says Lachlan.

“Of course, these medications are just one component and need to be paired with appropriate medical advice and support.”

Current options for pharmacotherapy

The National Opioid Pharmacotherapy Statistics Annual Data collection (NOPSAD) 2018 reports that, on a snapshot day in 2018, just over 50,000 clients received pharmacotherapy treatment for their opioid dependence at 2,852 dosing points across the country.

A small variety of medication assisted treatments are currently available in Australia, Lachlan explains.

“Methadone comes in two oral liquid forms – methadone syrup and a sugar-free version called Biodone,” he says.

“The ‘pros’ of methadone are that it’s easy to adjust or tailor the dose and it’s quick and easy to administer. The main ‘con’ is that it can be diverted, often restricting the number of unsupervised doses (‘takeaways’). It also has a shorter duration of action so requires daily dosing.”

FYI: REPORT

AIHW: Alcohol, tobacco and other drugs in Australia (web report)

This report brings together the most recently available information on alcohol, tobacco and other drug use in Australia, including key trends in the availability, consumption, harms and treatment.

https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/introduction

Buprenorphine is available in two forms: sub-lingual (under the tongue) or buccal (between the cheek and gums). These are Subutex® sub-lingual tablets (buprenorphine) and Suboxone® films (buprenorphine/naloxone).

"Suboxone includes naloxone to act as a deterrent to people diverting the product and injecting it. This means it's more appropriate for unsupervised 'takeaway' doses," Lachlan says.

With buprenorphine the 'pros' include a longer duration of action meaning some patients can dose every second day rather that every day.

"The 'cons' of buprenorphine include that because the films and sublingual tablets come in fixed strengths there's less flexibility with small dose adjustments. Also, supervised administration in the pharmacy can be a longer process as sublingual tablets and films can take longer to dissolve or disperse," he says.

The view from pharmacies

Lachlan finds dispensing MATOD a positive experience, as he can build a relationship with the patients.

"The patients you serve on a MATOD program are sometimes the patients you get to know the best, as you are often seeing them every day. It is very satisfying to provide a MATOD service." Lachlan says.

The price to patients is usually $5-7 per day and the price isn't regulated by government. This expense can be a major barrier to patients staying on treatment

You can read more about the cost of pharmacotherapy in the Penington Institute report 'Chronic unfairness: equal treatment for addiction medicines?'.

The benefits for clients

The most obvious benefit of pharmacotherapy is that patients/clients gain more stability in their lives.

"Imagine if the daily supply of pharmacotherapy was covered by a prescription on the PBS [Pharmaceutical Benefits Scheme], in a consistent format across every state and territory!? I'd vote for that!" pharmacist Lachlan Rose says.

This can improve their mental, physical and social health.

Tony has been receiving treatment for opioid dependence since the 1970s. He praises Suboxone® for its effect on his day-to-day life.

"Subbies helps me function," he says. "They help me get up in the morning."

Suboxone® alleviates Tony's back pain while also minimising his urge to inject opioids.

"It eases the pain in my back and takes away the desire to score."

Tony recommends Suboxone® to others because of the positive impact of the treatment on his quality of life.

He much prefers Suboxone® compared to methadone, both of which he has used. He cites methadone as the reason for losing all his teeth. (For more on this topic see the article 'Teeth and oral health' in this edition of the Anex Bulletin).

The future of pharmacotherapy

With methadone and buprenorphine well-established as forms of pharmacotherapy, what else is on the immediate horizon?

At its March 2019 meeting the Pharmaceutical Benefits Advisory Committee (PBAC) was considering whether to recommend two new formats of buprenorphine for listing on the Pharmaceutical Benefits Scheme (PBS). Sublocade® is made by Indivior and Buvidal® is made by Camurus.

Dr Mark Daglish*, director of Addiction Psychiatry at the Royal Brisbane and Women's Hospital, explains the new formats:

"Buvidal and Sublocade are both slow release [depot] forms of buprenorphine," says Mark. "They are injected subcutaneously into the fatty layer of the skin such as in a patient's belly fat. The game-changer is that the slow release [of the pharmacotherapy] lasts from a week up to a month or more.

"We haven't had a change of this magnitude since buprenorphine was introduced in the 90s.

"You're going from supervised consumption in a pharmacy or clinic with a variable number of takeaways, measured in days. You'll soon be able to go to a health professional for the injection, but you're doing that once a week or once a month. And I think most people will end up on the monthly dose," Mark says.

"There are ways that this [the new pharmacotherapies] is going to change treatment that we're not even aware."
- Dr Mark Daglish

As the medication is still an opioid, the overdose risk remains – particularly if a person on the new pharmacotherapy consumes alcohol and other drugs such as benzodiazepines and/or pregabalin.

The other danger is diversion, which is why the injections have to be given by a health professional and will not be given to clients. NSP workers need to be aware that injecting the new formats into a vein or muscle will have very serious health consequences for clients.

"Both Sublocade and Buvidal and would be extremely dangerous products to put into a vein," Mark says.

"If people have managed to acquire it somehow and come into the NSP looking for injecting advice workers need to make it very clear that the products are only safe when injected subcutaneously.

"Don't put it into a muscle, don't put it into a vein. It has got nothing to do with dose."

Sublocade also requires a cold chain.

"Sublocade has to remain stored below 4 degrees [centigrade] for transit. It can be out of the fridge for up to seven days prior to administration," Mark says. "This should be invisible to clients, but has implications for clinics, pharmacies and particularly private prescribers with small numbers of clients."

On the plus side, Mark believes that the long time between doses offers major benefits and opportunities.

"There are many advantages of the new formats. If you think about people who are working or whose work hours don't match pharmacy hours or clinic hours – it will be very convenient to have a monthly dose.

"Imagine not having to go and ask your clinic for takeaway doses because you spontaneously want to do something fun and go away with your partner for a weekend. Or you get a call at 6pm with a job opportunity. You're on the bus at 6am and you don't want to tell the boss 'actually I've got to get some takeaways' and it's too late to phone your clinic. These everyday things," he says.

"What's more, for many people there is a lot of stigma [of receiving pharmacotherapy], being in line, being identified as someone on opioid replacement."

* Disclosure: Dr Mark Daglish has consulted for Indivior, the makers of Sublocade®.

Rob Pfeiffer and Sophie Marcard

Lachlan Rose

MATOD: Medication Assisted Treatment for Opioid Dependence

MATOD and pharmacotherapy are also known as:

- OMT: Opioid Maintenance Therapy
- ORT: Opioid Replacement Therapy
- OST: Opioid Substitution Therapy

MATOD comes in the form of:

- Methadone and Biodone®
- Buprenorphine in Subutex ® and Suboxone®
- Naltrexone
- Sublocade®
- Buvidal®
- Hydromorphone
- Heroin, see RAND's review of the evidence here: **https://www.rand.org/content/dam/rand/pubs/working_papers/WR1200/WR1263/RAND_WR1263.pdf**

Slang:

- Sub/Subby/Subbies = Suboxone®
- Done/The Done = methadone
- Bupe = buprenorphine

Further reading:

WA Health: Opioid pharmacotherapy in the community **https://healthywa.wa.gov.au/Articles/N_R/Opioid-pharmacotherapy-in-the-community**

Department of Health and Human Service Victoria: pharmacotherapy guidelines **https://www2.health.vic.gov.au/public-health/drugs-and-poisons/pharmacotherapy/pharmacotherapy-policy-in-victoria**

PHARMACOTHERAPY KEY TO EFFECTIVE HEPATITIS C TREATMENT

Eliminating hepatitis C in Australia is now a real possibility, thanks to new direct-acting antiviral (DAA) drugs and the removal of two significant barriers to treatment according to Penington Institute Deputy CEO Dr Stephen McNally.

At the same time, the nation's NSP workers have a central role in eradicating hep C.

"The Government's decision that everyone with hepatitis C is eligible for treatment combined with no-cost access to DAA drugs is a significant step forward," Stephen says.

"Everyone, including people who are currently injecting drugs, can now receive treatment knowing that there is a better than 95 per cent chance of clearing the hepatitis C virus."

Treating hepatitis C has never been easier for health professionals or patients. But, three years on, the slow down in treatment uptake is a reality check for everyone working to make elimination a reality.

Most new hepatitis C infections (estimated at just over 10,000 each year) continue to be among people who inject drugs.

"One of our biggest challenges is finding effective ways to engage with one of the largest hepatitis C cohorts - people who inject drugs - while also strengthening existing and creating new pathways to treatment within a range of community-based settings.

"This challenge is also one of the biggest opportunities for needle and syringe program workers providing an important service to clients."

Sustained pharmacotherapy plays an important role in reducing injecting, says Stephen, resulting in minimising hepatitis C infections and reinfections.

"We still have serious hurdles to overcome, such as people not knowing about the new treatments and either not believing, or not fully understanding, that the side effects and success rate have significantly improved from the old, harsh treatment regime," Dr Stephen McNally says.

"It's likely that treatment pathways will be jeopardised because people are unable to pay dispensing fees for their pharmacotherapy treatment, which will in turn weaken an important pathway for clients to engage with a local pharmacist about hepatitis C treatment," he says.

Many people drop out of pharmacotherapy, as they cannot keep up with paying the daily dispensing fee. Between 65-75 per cent of clients have limited finances and are often on fixed incomes or government benefits with limited capacity to pay the additional costs.

A paper by Penington Institute with ASHM (Australasian Society for HIV Medicine) focuses on the current arrangements of pharmacotherapy in Australia and its implications for hepatitis C treatment. Stephen explains that the current funding arrangement for pharmacotherapy means that hepatitis C treatment costs will likely increase if steps are not taken to ensure pharmacotherapy is accessible and sustainable.

"In the paper we ask the question: what is the cost if someone gets infected or reinfected with hepatitis C because they could not maintain their pharmacotherapy?

"New arrangements need to be developed with community pharmacists and other primary health workers so that dispensing pharmacotherapy is viable and maximised for clients."

Sophie Marcard

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.

DISCLAIMER:

The *Anex Bulletin* is published by Penington Institute and funded by the Australian Government. The views expressed in this publication are not necessarily those of the Australian Government or Penington Institute.

Penington Institute takes no responsibility for loss or damage that may result from any actions taken based on materials within the Anex Bulletin and does not indemnify readers against any damage incurred.

Copyright © 2019

All rights reserved. All written material in this publication may be reproduced with the following citation: "Reprinted from vol. 16, ed. 2 of Anex Bulletin, published by Penington Institute, with credit to the author(s)."

www.penington.org.au

ISSN: 1447-7483