anex bulletin
volume 12
edition 5

NSPs essential as hep C drug revolution looms

Needle and Syringe Programs will be critical links in encouraging people who inject drugs to access revolutionary and highly expensive 'new wave' hepatitis C treatments that have the potential to 'eliminate' the virus in many areas [1-3].

Globally, it is estimated that more than 185 million people around the world have been infected with the hepatitis C virus (HCV), of whom 350,000 die each year [3]. An estimated 230,000 people are currently living in Australia with chronic hepatitis C, including 58,000 with moderate to severe liver disease [4].

The 2013 national NSP survey, which includes HIV and hepatitis C testing, found that, overall, 54 per cent of injecting drug users who participated had hepatitis C anti-bodies [5].

Currently, treatment for hepatitis C involves a combination of pegylated interferon and ribavarin, as well as the option of two other drugs, boceprevir or telapravir. There are a number of barriers to commencing current treatments for hepatitis C, including:

- strong side-effects involving nausea, fever, depression, flu-like symptoms and the chance of birth defects if a female patient, or female partner of a patient falls pregnant during or six months after treatment;
- weekly self-administered injections and taking capsules twice a day; and
- a treatment period of 24 to 48 weeks with a cure rate of less than 75 per cent.

The Kirby Institute estimates that only 2360 Australians received hepatitis C treatment in 2012, down from a peak of almost 4400 in 2009. This may be partly due to people delaying treatment uptake until the 'new generation' drugs become available [4].

The new treatments for HCV are known as direct-acting antiviral (DAA) therapies. They have cure rates of more than 90 per cent, require just six to 12 weeks of treatment, have few side effects and only require people to take a tablet once or twice a day [6].

Leading Australian hepatitis C expert, Professor Greg Dore, believes DAA-based drugs have the "potential to provide one of the great advances in clinical medicine" and have "raised the prospect of HCV treatment as prevention" in Australia and possibly globally.

Two of the new drugs are simeprevir, which was approved by the United States Food and Drug Administration in November last year, and sofosbuvir, which was approved shortly afterwards. Sofosbuvir, with the brand name Sovaldi® in the United States, was approved by the European Medicines Agency in January this year [6].

Sofosbuvir has already been approved by Australia's Therapeutical Goods Administration. The Pharmaceutical Benefits Advisory Committee is tasked with assessing whether or not drugs should be listed on the Pharmaceutical Benefits Scheme, and recommending medicines and medicinal preparations to the Minister for Health. It is anticipated that other DAA drugs will be released internationally, and considered for Australia, in the near future.

In the United States, the cost of sofosbuvir is around $1000 a pill, meaning a treatment course may be around $70-80,000 [6]. Market analysts are foreseeing enormous drug business growth in hepatitis C treatment in key developed markets. Recent forecasting for just eight countries, which does not include Australia, predicts possible growth from the 2012 figure of $5.8 billion, to $18.6 billion in 2019 [7].

> *'The NSP workforce already saves millions of dollars each year through hepatitis and HIV prevention.*

There are no published estimates as to how much it may cost Australians if these new wave drugs are listed on the PBS, but it is clear that the price tag on these drugs presents significant health budget implications.

Penington Institute Chief Executive Officer, John Ryan, said if treatment costs were to soar as the new drugs became available, the financial benefits of Needle and Syringe Programs would be even higher.

"The NSP workforce already saves millions of dollars each year through hepatitis and HIV prevention. If the new medicines are made widely available, each hepatitis C case prevented in future will represent even more return on investment that NSPs provide taxpayers," John said.

Head of the Centre for Population Health at the Burnet Institute, Professor Margaret Hellard, recently told a seminar the new drugs were "fabulous" if used as part of a broader and well-maintained harm minimisation approach.

Professor Hellard said using DAAs, combined with effective harm reduction strategies such as needle and syringe and methadone programs, could markedly reduce hepatitis C prevalence over the next 15 years and eventually eliminate the virus.

'Elimination' means that HCV infection could be reduced to zero in defined geographical areas, while 'eradication' refers to a complete and permanent worldwide reduction to zero [2].

The new Australian hepatitis C strategy notes that even with super drugs on the horizon, increasing access to NSPs and the use of safe injecting equipment must be a priority. It states that NSPs need to be continued and strengthened [8].

Outside Australia, controversy is beginning to rage about the high cost of the new drugs.

The Lancet journal editorialised this year that the "main drawback of these new agents is the huge price tag" [9].

Some United States Congress members recently wrote to the manufacturer of sofosbuvir, arguing that its high cost would put it out of reach of thousands of people with hepatitis C [10].

Professor Hellard said there was much to be learned from HIV/AIDS advocates who, faced with high anti-retroviral drug prices, worked hard to have prices lowered and to open up access on a global scale.

"Think of HIV, have a look at how they did it; got drugs through faster etcetera. The example of HIV is that it has become, or is becoming, treatment as prevention. We should not be shy in hepatitis C of using HIV as an example," Professor Hellard said.

"Put simply, if someone with hepatitis C is treated and cured the individual benefits by avoiding chronic liver disease, and the broader community benefits because the patient can no longer transmit the virus to another person," she said.

"If we want to stop hepatitis C transmission, we have to ask who is spreading it? Who transmits the virus, and can we in some way work with that group, and what do we need to do to stop transmission of the virus?"

The World Health Organisation (WHO) has also promised to work towards making the treatments more accessible, which means less expensive.

"A concerted effort is needed to reduce the price of HCV medicines," the WHO said.

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PENINGTON INSTITUTE

Anex is a program of the Penington Institute.

Penington Institute advances health and community safety by connecting substance use research to practical action. A community-based, not-for-profit organisation, Penington Institute's Anex program promotes and supports Needle and Syringe Programs (NSPs) and the evidence-based approach of harm reduction. We strive for a supported and effectively resourced NSP sector that is perceived as being part of the solution to drug-related issues.

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Layout and design
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Production
L&R Print Services

An Editorial Reference Group provides advice on the content and issues that the *Bulletin* includes.

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

Citations for the edition are available online at http://www.anex.org.au/publications/anex-bulletin

ISSN: 1447 - 7483
August 2014

Briefs

A thoroughly professional approach

As many NSP workers understand, dealing with behaviour and concepts that challenge your sense of what is appropriate can be difficult. Paramedics routinely encounter people who pose challenges. We spoke to Alan Morrison, Director of Education for NSW Ambulance, and asked him how paramedics develop an even-handed approach to patients. There is much we can learn from their capacity to put judgement aside.

Paramedics routinely deal with people in very stressful, painful and difficult circumstances.

According to Alan, developing a balanced attitude towards taking care of people in extreme situations is integral to building a sense of professional pride.

"We train our paramedics to realise that when they wear the uniform they are serving the community and they have to serve in the context of the values that New South Wales Ambulance upholds," he said.

"We embed the concept of professionalism across the spectrum of our training, looking at the specific principles in the early stages of initial induction training for new recruits and then applying them to a variety of clinical situations.

"But there is a certain level of professionalism - of suspending your own judgement of people and what you consider to be appropriate and responsible behaviour. This is particularly so in terms of patient care and respect for each person," Alan told the Bulletin.

He said that when out on the job, paramedics can end up dealing with a range of intersecting problems and keeping one's head requires strong personal awareness and sense of oneself.

"You need strong self-awareness in understanding how your own traits and personality characteristics can have an effect on others," he explained. "This includes being aware of the personality styles of others and being aware of the sorts of behavioural indicators that could lead to an escalation of issues with difficult and challenging behaviours."

Alan said paramedics have to know how to assess the risk factors and have a range of communication techniques to deal with those situations, such as knowing when to be assertive and when to be empathetic.

"For example, knowing the difference between what is normal behaviour and what is challenging behaviour, and considering when that (behaviour) is organic and due to mental health problems, or if it's due to pain, trauma or a substance abuse problem. And then there are times you need to know how to de-escalate the situation.

"At the end of the day, you have to stay cool, calm and collected and realise that in those situations you're dealing with people who are in difficult circumstances, so don't take it personally," Alan said.

"But at the same time, you don't put yourself in situations where you are at risk of harm or danger. For our paramedics, if they are in any danger of being assaulted or hurt we'll withdraw from the interaction, and we might need to call on the police. That's not our first option though, that's at the extreme."

Keeping paramedics up to the task of suspending their personal feelings when dealing with difficult situations is an ongoing task, he said.

"We have an 18-month training program that everyone goes through and we've included dealing with challenging behaviour in this current round of training, so we're doing a bit of a refresher on it at the moment. It just has to be ongoing."

Like emergency service workers, NSP workers also have to occasionally deal with challenging behaviours from clients. Making use of your local health service training programs, or jurisdictional policies on managing challenging behaviours such as the *Needle and syringe program policy and guidelines for NSW* at http://www.wdp.org.au/pdf/NSW-Needle-Syringe-Policy-and-Guidelines.pdf is an important part of your professional development.

Another example of resources available that can help you to manage difficult behaviours, is the Australian Government resource called "Responding to challenging situations related to the use of psychostimulants" at http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/07FF9B0DE1B39D7ECA25764D0080C854/$File/chall.pdf.

Rapid HIV tests expanding for men who have sex with men, including injectors

A growing number of health services are introducing new generation point of care rapid HIV testing targeting gay men and other men who have sex with men (MSM).

Although the testing is not specifically targeting injecting drug users, the Australian Federation of AIDS Organisations (AFAO) said NSPs can help by spreading the word.

AFAO Chief Executive Officer, Rob Lake, said rapid testing is part of a major national program by HIV services to increase access to testing and make sure people know their HIV status.

Rob said it was possible that up to 20 per cent of people who actually have HIV do not yet know their status. This has obvious implications, with people continuing to have the potential to unknowingly pass the virus to others, he said.

"So, that's why testing is such a major focus of our campaign - which is aimed at ending HIV," Rob said.

"For NSP workers, particularly regarding gay men and other men who have sex with men and who inject, rapid HIV testing is something people can offer as a referral," he said.

"We would welcome NSP worker support in spreading the message that there is now rapid HIV testing for gays and MSM who also inject drugs."

A rapid point of care test can usually be completed in around 20-30 minutes. A positive result must be followed up by laboratory tests. Trained counsellors are on hand to provide support before and after testing.

At this stage, the rapid testing services are not intended for use by members of the community, including injecting drug users, who are not at risk through male-to-male sex.

The rapid tests are currently being offered at a number of services in the ACT, NSW, Queensland and Victoria. In NSW and Queensland, a number of regional health services have the testing available.

To see where the rapid testing is available, visit the AFAO website www.afao.org.au/rapid-hiv-test

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"National governments, international agencies, donors, civil-society organisations and the pharmaceutical industry will need to work together to assure that hepatitis C treatment is affordable and accessible for all those who need treatment."

The WHO hepatitis guidelines also stress the importance of NSPs in preventing new infections, even as the new treatment drugs continue to emerge. The guidelines can be downloaded at http://www.who.int/hiv/pub/hepatitis/hepatitis-c-guidelines/en/

Busy nursing life clouded judgement

The value of NSPs can never be taken for granted, but it is also important to remember that for some people in busy medical settings, the concept of bothering to treat a drug injecting client respectfully can be alien. The Bulletin *spoke with a community health nurse manager from a rural area, who has made the transition from seeing NSP clients as a burden, to now being proud to help them. Her candid thoughts, presented here in the 'first person', are a reminder that in this day and age of staff turnover, NSPs are an area that can constantly challenge social values - even amongst other health professionals.*

■ *Above: Shirley Bennets is an experienced and supportive NSP worker at cohealth in Melbourne. Shirley is NOT the subject of the story on this page.*

This is about a journey from a time when I looked upon NSP clients as a burden, to where I now value them and have integrated a NSP into our community through our small rural health service.

It is a journey from efficient, acute care clinical nurse, to a more rounded community health nurse and manager. I'm still passionate about high quality acute care, but now have a view to understanding that all that is not clinical and able to be healed is not necessarily less deserving of our skills, time or care.

My father, a farmer, taught me about trusting the people in your life, about respect and that everyone deserves respect and trust. Everyone deserves love regardless of the choices or circumstances that brought them to where they are today. He even welcomed into our home as a boarder a young man who had been to prison for drug use.

It was a clear message to me in my formative years: that everyone deserves to be treated with respect and without discrimination. I believed that every life is worth fighting for, that everyone has something unique to offer.

Sadly, somewhere between adolescence and nursing graduation in the 1980s, I allowed what I knew to be right to get lost as I strove to be the best nurse I could be. It's quite ironic looking back.

My first encounter with the harm reduction model didn't come from a professor, a seminar or some up-to-date drug and alcohol worker. My first encounter, that I know of, was in the depths of the night in a rural hospital where I worked night duty as an acute care nurse for many years.

Some of my fellow community members - including people I knew - would come to the front door of the hospital under the safety afforded by the cover of darkness, to ask for a single syringe. There was no NSP at the time, even though we had a community health program on site in another part of our campus. So, clients would come at night. Many would offer stories of visiting diabetic relatives who had run out of needles.

I recall one particular nightshift that remains as a permanent entry in my mind, in a folder labelled: 'Things I wish I had done differently'.

Everything that was likely to go wrong had done so in a short period of time since the start of my shift at 10.30pm. I hadn't slept well during the day, the ward was full, the Accident and Emergency Centre was busy and, of course, we hadn't taken our break. In this situation, one-plus-one can equal a grumpy nurse, which is not a pretty situation on a day shift, and can be downright ugly at night.

A young man arrived at the front door looking to be provided with a syringe. He had to press a button to get in. I let him in and as was the usual process, retrieved a single syringe. I assumed he should be suitably grateful for it, as if I was doing him some huge favour.

At the time our hospital was yet to join the Needle and Syringe Program formally, so we *arbitrarily* charged $2 a single syringe. It was literally 'user pays'. We would use that money to provide taxis home for clients who came to the hospital and had no means of transport and no way of funding a taxi trip.

This was not the 1980s or 1990s before NSPs became commonplace. It was in the early 2000s.

It was a busy night. I was annoyed at his intrusion into my world, and I was clearly in charge with an advantage over him. He offered me the usual $2. In my bad mood I told him that the syringe was $5. He protested that he had paid $2 the previous night.

I snapped back rudely: "Last night they were on special." My stern look told him not to cross me. I saw people like him as somehow less deserving than those who were not IDU. How on earth had I suddenly become judge and jury of the community I was tasked to care for?

At that moment I just wanted to do what I had been trained to - deliver top quality, acute care nursing. But in recent years I have wondered: "How did I get through years of learning without being briefed on the concept of harm reduction?" I was a really good, compassionate, and effective nurse, but something was fundamentally wrong with my service delivery: I was narrow-minded and ignorant to the needs of the clients who came to the door under the anonymity of darkness.

How hard must it have been for them to come to the hospital, push the entrance buzzer, and have it answered by someone like myself who not only had no idea of injecting drug users and their needs, but also had no desire to know. I was too blind to even recognise the health seeking behaviour of these people who were accessing clean injecting equipment in spite of the barriers in their way, both physically and mentally.

Had I failed these people? Had the system failed me by not forcing me to consider such things during my learning? Looking back, I can't recall any learning about addiction during nursing.

However, to every imperfect situation, there is the possibility for improvement. March 2007 saw me change direction in my career from acute care to primary care. There was a bit of an informal understanding between myself and a couple of colleagues that once I left night duty and got to primary care in another part of our campus (but on the same site), I would work out a way to redirect these 'drug users' away from the hospital's front entrance.

As fate would have it, I stumbled upon a copy of the NSP Operating Policy and Guidelines in my predecessors' filing cabinet. From what I could gather, this had been on the agenda for community health nursing for many years, but it had never got off the ground.

"Aha!", I thought. "This might be just what we need around here." And I commenced my journey that was soon to change my outlook. Within a few weeks of finding out more, things started to be bathed in light. Reading the operating policy and guidelines didn't in itself bring about a miraculous change in my mindset with regards to IDU or where they fitted within the healthcare model. I struggled with my personal biases in the early days; questioning such things as did provision of syringes actually encourage drug use? I definitely wasn't instantly sold on the idea from the outset.

I persisted with the set up process largely due to two reasons. Firstly, a colleague looked me in the eye and told me to separate my personal view and professional responsibilities, and secondly, I found a copy of *NSP needle and syringe programs: your questions answered* in my filing cabinet. It is the one produced by the Department of Health and Ageing back in 2005. The discovery of this little book was a game changer. Not only did it answer my questions regarding NSP, it provided me with the information to pass on to others. It was a valuable resource with no-fuss, credible information.

Armed with the advice from my colleague, the little NSP booklet and point 2.1: The 'Aim' of Needle and Syringe Programs, from the Operating Policy and Guidelines, I was able to stay on task professionally, until eventually I came to understand and embrace the harm reduction approach.

By May 2007, approximately eight weeks after my change in career direction, I had drafted my letter to the CEO seeking support to establish an NSP.

Anex played a hands-on role by assisting us through the registration process and coming to our town to train us; teaching us a whole new way to look at NSPs and their essential role in the community.

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Eight things new NSP staff need to know

WHAT THE RETURN ON INVESTMENT STUDY HAS SHOWN*

HIV and hep C infections prevented among drug injectors due to NSPs (1999-2009).

HIV approx. 32,000	Hep C approx. 97,000

HIV or hep C among injectors with and without NSPs.

HIV current 0.1%	Hep C current 65.1%
HIV without NSPs 14%	Hep C without NSPs 87.1%

Direct healthcare cost savings due to infections prevented, only calculating direct savings.

Healthcare savings	$1.28 billion
Return on investment	$4 for each $1 spent
Average savings per syringe	$4.30

Net present 'value' of NSPs when including productivity savings due to infections prevented. Eg: costs to businesses if people get sick or die.

Value of NSPs	$5.85 billion
Return on Investment	$27 for each $1 spent
Average savings per syringe	$19

** Figures based on the Return on Investment 2 study by the National Centre in HIV Epidemiology and Clinical Research, October 2009. Read more at www.anex.org.au/reducing-harm/return-on-investment/*

Starting work in a Needle and Syringe Program (NSP) can be troubling for anyone who is unaccustomed to working in drug services. The work can challenge personal values and can lead to friction with friends and family. The Bulletin spoke with two experts in the field: Andrew Walden, an NSP coordinator in Dubbo (NSW) for Greater Western Area Health Service (Western NSW Local Health District), and Crios O'Mahony, who is a Penington Institute workforce development officer for NSPs, with almost 20 years' experience in harm reduction.

1. Who are we dealing with, who are the clients - the people behind the faces?

According to Andrew, NSP clients represent a broad cross-section of society. Some come from backgrounds with significant trauma and others may be just average workers with nine to five jobs.

He told the *Bulletin* that even experienced workers can have problems accepting that some people inject drugs. "NSP workers must be mindful of who we are working with" Andrew said.

He gave the example of a worker who confronted an NSP client when the worker encountered the client in a social context.

"A client went to see his mate in town and this female turned up with the worker. While at work the worker had seen this fellow getting equipment (from a syringe dispensing unit), and abused the client in front of a mate and the mate didn't know the client injected."

Andrew said there's more to being an NSP worker than just giving out clean equipment.

"You might think that's easy, just giving out needles, but there's a bit more to it than that," he said. "A big thing is not pushing information on people. A lot may think they're doing the right thing by saying 'Go and talk to my mate who's an AOD counsellor', but that can put clients off and discourage them from ever returning."

2. What if our values and beliefs clash with doing our job? Can we put them aside?

"You get really challenged. Your beliefs get challenged every day," said Andrew.

"What do you think about parents who inject drugs? What do you think about pregnant mothers who walk in here and want equipment?" he said.

"Dads come in and leave their kids out the front and come in and grab stuff so the kids can't see them. There's a lot of stuff that challenges people and their values and beliefs."

Crios said NSP workers need to remember that using drugs does not necessarily make someone a bad parent or a bad person.

"Pregnant women are advised not to radically change their drug use without the help of an experienced medical professional," Crios said.

"Withdrawal from some drugs needs to be carefully managed, as it can impact on the health of both mum and baby. Pregnancy does not provide immunity from blood-borne viruses, so providing new injecting equipment can help someone stay safe.

"Once a pregnancy is confirmed, an NSP can be a good place for parents to get advice and support, and it should have details of where to find a good doctor and/or midwife to help mum and baby stay healthy," Crios said. He added that there is also the possibility a pregnant woman is collecting injecting equipment for someone other than herself.

Andrew said the importance of preserving client confidentiality must never be forgotten: "At times you feel you want to tell people, but you can't. You've got to be mindful about that. I've had people come in and tell me they've knocked stuff off. And I just tell them not to tell me that stuff.

"A lot of people starting the job [find] it's just too confronting for their values and beliefs," Andrew explained. "You can get partners of clients, mabe husbands or wives come in quizzing you. A client might have stopped the car and ducked into the NSP leaving the partner in the car. The partner, who is unaware what is going on, comes in the next day and asks what their partner was doing in the NSP, what did they get? You may feel sorry for the partner. A couple who may be husband or wife shouldn't lie to each other. You might value honesty or feel strongly that you shouldn't lie to your partner."

3. What do I tell the neighbours?

Andrew said there are a great many things for people to consider before starting NSP work.

"I don't necessarily tell people I run an NSP program. I tell them I work in blood-borne viruses or I am an Education Officer. If pushed more I might tell more, but I don't advertise what I do.

"I've had personal friends who have been quite negative about it. They say 'What are you doing helping people like that for?'

"Sometimes you're better off not to talk about it. Some of my mates, I know what they're like, so I don't even mention it.

"But if I feel the situation is right, I do tell people what I do with pride and use these situations to educate others about the NSP and the benefits for the community as a whole."

Crios urged NSP staff to bear in mind that a study on the Return on Investment by NSPs confirms it is a proven and highly efficient health service, which reduces the risks of blood-borne viruses and offers information and referral options to help drug users and others in the community stay safe.

"We should never forget that between 1999 and 2009, NSPs averted more than 32,000 HIV infections and 97,000 hepatitis C infections," Crios said. "In that time, every dollar spent on NSPs has saved $27 in costs to the health system. Helping people to look after their health is a good thing."

Even some fellow work colleagues sometimes question the value of NSP, Andrew said.

"When I go out and do presentations to other work colleagues, it can be a challenge to get them to see the program for what it is and not for who uses it," he explained. "I've had many robust discussions with fellow workers who are upset at the fact we even do the program, and sometimes they'll start attacking you as if you're the program.

"You've got to take it as not a personal thing; you've got to accept that they're not attacking you, although you might feel like it is a personal attack.

"If you're quite green at the NSP, some days you may go home in tears. That's why it is useful to get across the basics and the facts around how effective NSPs are."

The full Return on Investment 2 report and a fact-sheet with the main points can be downloaded at http://www.anex.org.au/reducing-harm/return-on-investment/

4. Am I encouraging people to use drugs?

A common complaint from sceptics is that NSP encourages people to use drugs. Crios said the community safety aspect of NSP should counter these criticisms.

"You are helping people who happen to inject drugs and other people in the community to stay safe," he said. "NSPs reduce many of the harms associated with injecting by providing new injecting equipment. They also reduce the number of used syringes discarded in the community and offer a referral point for specialist AOD services if requested. Some people call this a 'no wrong door' approach (http://www.dovetail.org.au/ insight/modules/Module%201%20Big%20Picture.pdf).

"World Health Organisation studies have found that free needle distribution does ***NOT*** lead to increased numbers of injectors or increased drug consumption. Further studies have shown that drug use can actually reduce in areas where there are NSPs, because they act as referral points for people who want to begin drug treatment, including pharmacotherapy, detox or counselling" [11, 12].

5. How do I build a relationship to help clients?

"How do we start to help clients? It's very simple, but always bears repeating," said Andrew.

"It's just being friendly, having a smile. It's not prying. The interaction has to be on their terms. If they don't want to talk, if they come in with their head down and say nothing, so be it," he said.

"If you just say 'How you goin?' Yeah good. They go away and think 'That's not too bad; he didn't ask me a thousand questions. He didn't ask who I am, where I live, what I'm doin?'

"And over time, they'll build trust with you and they might start talking about stuff or eventually say 'By the way mate do you help with rehabs or anything? And I say 'We'll sort something out for you mate'.

"It just takes time. I've had people come in for six months and say nothing. Some just never open up. Some just grab their gear and go.

"But treat everyone the same no matter what. I have a standard thing I say 'How are you going?' They'll either speak or they don't. 'Just a five-pack mate', I'll say 'Righto, have a nice day' or 'Enjoy your weekend'. And they might say 'You too', or some just walk out, but I don't think any less of them. It's just where they're at.

"If they want help, by all means do your best, but don't push it. Just whatever they want, deliver."

Andrew said he tries to let them know they can come back whenever they feel like it, 10 times a day if necessary - especially with newcomers.

"I say 'Come back and say hello'. That's what I say to the first-timers. As I get to know them, I tell them if they've got any friends who don't know the NSP is there, to tell them and help 'spread the word'.

"My NSP distribution has doubled in two years. That's predominantely from my relationships and people letting their friends know. They feel comfortable coming in and they're referring other people. They'll tell their mates 'He's not a bad bloke', so they spread the word and it gets bigger and bigger over time.

"But at the end of the day, just consider how you would like to be treated."

Andrew said he's had people come back to the NSP who he knows have been to a residential rehab facility, but he doesn't judge them, as drug dependence is a chronic relapsing condition for many people.

"I've assisted people get in rehab and then they return to the NSP. They think to themselves 'I don't want [to] go back and see that bloke at the NSP because he'll think I'm a loser. So I reassure them that it's OK; I don't think any the less of them.

"Some colleagues may grumble that they have not made the most of their rehab opportunity. But I tell them 'Well they're coming back aren't they? That's a positive.'

"I'll say to the clients 'The important thing is you're here. I don't care what happened at rehab. If you want to go back you come and see me and when you're ready we'll talk again'. And they'll think 'Oh well I didn't expect that. He didn't put me down or anything. Jeez, he's all right'.

"It's a big thing and even the rehabs themselves struggle with it. I've worked for them and know how frustrating it is to have someone come back three or four times. And you do start thinking 'I'm wasting my time', but that's when you have to start looking at yourself and say 'Hold on, what is it about this person that's frustrating the hell out of you if you're not helping them?' That's when you know that you have to give your clients the time and space to try treatment a few times."

6. If someone asks for help with their drug use, what can I do?

NSPs in places such as health services are often staffed by admin people or receptionists who aren't expected to provide drug treatment. But they are able to refer people to support agencies and provide NSP stock, information and pamphlets.

Crios said there are plenty of things NSP workers can do if someone specifically asks for help. Just listening to someone's concerns can be helpful.

"There may be services within your agency - such as alcohol and other drug services, doctors or nurses - that can help," he said. "NSPs should have a list handy of available services or a phone number where someone can get counselling, information and referral.

He said the Alcohol and Drug Treatment Information Network has a listing of services in each state.

A number of AOD information support services can be found on the Australian Drug Information Network (ADIN) website available at: http://www.adin.com.au/help-support-services and the National Drug and Alcohol Services Directory (NDASD) website at: http://www.ndasd.com.au/ provides information on AOD treatment services available across the country.

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Busy nursing life clouded judgement

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Seven years later it has been a radical transformation, to say the least. We are a rapidly growing NSP and our management and staff are fully supportive. We know that our community, although rural, is far from immune to heroin, misuse of pharmaceutical drugs and crystal methamphetamine.

No longer do we view NSP clients as a bother, an interruption; or as second-class citizens who get in the way of other health interventions.

Along the way I have been reminded I was not judge and jury, and people have a right to make choices about how they live their lives. People have a right to services and information to enable them to make their own decisions, in this case related to harm reduction. And that this choice is every bit as important as any other health behaviour choice.

I have re-discovered the lessons from my father many years ago, and am proud to say I respect each and every client for who they are. My life is richer, both professionally and personally, for their presence in my day.

I challenge everyone to reflect on their own journey with harm reduction. There is no time frame or well-trodden process. It is something we must come to professionally and personally. Only then can we hope to reach this same place as a society. Each individual journey that is made will add to the voice of society.

I am now proud to say that I am still a passionate nurse. I care, I work hard and I do everything in my power to help the clients achieve their goals. NSP is a successful, established program, which sits alongside all of the programs and services we proudly provide to our community, such as x-rays, physiotherapy, podiatry, dietetics, speech pathology, occupational therapy, social work, community health nursing, dentistry, optometry and drug counselling.

A couple of weeks ago, I was immunising infants. I went to the administration area to escort the next client through. It was a six-week-old babe, snuggled safely in the arms of her father.

As I took the infant's paperwork from the administration staff member, who is not formally medically trained, she apologised to me for the delay and explained that an NSP client had come in during the immunisation session. It was daytime, and the staff had paused processing my infant client and attended to the NSP client.

I stood for a moment and reflected on two things. Firstly, I loved that now - in the midst of a busy immunisation session - an NSP client can happily wander in and be served virtually straight away, demonstrating that my goal all those years ago to integrate the service had come to fruition. Secondly, here were two very powerful preventative health initiatives I am madly passionate about occurring alongside one another: infant immunisation and harm reduction through the provision of clean injecting equipment. I thought to myself: "Really, could it get any better than this?"

It is only now, in recent years since my transition from acute care to primary health care, that I am able to reflect on the degree of difficulty this group of people must have gone through to obtain clean injecting equipment.

Imagine the difficulties around arriving at a hospital entrance, knowing that the nurse greeting you not only has no idea of the harm reduction model, but also may be someone you know well due to the town's size.

I am still saddened by the fact that I was part of a system where people had to fabricate stories to justify collecting equipment that should have been freely available and encouraged, rather than locked behind the doors of my own closed mind.

It is with regret that I admit my interactions with these people were at best fleeting and, at worst, done as a means of moving them along so that I could direct my time to the priorities of providing care to the clients I was charged with for the night.

I now have three sons, aged 21, 20 and 16. I ask myself regularly: "How would I want them treated if they turned up at a hospital seeking clean injecting equipment? Would I want them respected and provided for in a caring way by a provider who understands the concept of harm reduction? Or would it be good enough for them to be simply dealt with and moved along, like I thought was okay during those late nights in acute care?"

To this day, I wish I could remember the face of the young man who I made pay $5 for a sterile needle and syringe. He is long overdue for an apology.

In recognition of the value of NSPs in all communities, the Australian Government Minister for Health, the Hon. Peter Dutton MP, recently announced $5.1 million dollars over four years to increase access to NSPs. The announcement said it was particularly supportive of NSP work in rural and regional areas. More information is available at http://medianet.com.au/releases/release-details?id=800017.

Eight things new NSP staff need to know

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The NSP sprint

Peter,[1] a long-time user, talked to the *Bulletin* about getting in and out of the NSP at speed.

"Want to know why I don't want to hang about at the NSP? Well firstly, I've usually just picked up and I'm holding (drugs), which makes me nervous. I don't want to have to deal with the cops and sometimes they snoop around outside.

"I know police aren't supposed to harass users coming out of the NSP, but I've been pulled up and turned over immediately after leaving. It's happened more than once and usually it's younger types, keen to change the world. Thankfully I've had nothing on me those times. But normally I do, so it's in-and-out.

"The other thing is that you go to the NSP after you've picked up (drugs) and you're in a hurry to use them. If you're a regular user, you're not about to sit around and have a coffee and a yak because you might be starting to get sick (from withdrawal) and need to have a taste.

"And then there's the public judgement part. You're taking illicit drugs and that's against the law. Now part of the reason why I might be doing that could possibly be tied into the whole illegality issue. Part of me says that shooting up drugs is what I do and bugger off anyone who doesn't like it. The world is simple: there are people like me who take drugs and there are people who don't.

"In between, there are a few stray do-gooders who will want to help out people like me. I am grateful that NSPs hand out clean fits, don't get me wrong; it's just that I'm the tiniest bit suspicious about what's going on with that.

"As I see it, I don't have a problem and I'd have a lot to say to anyone who'd try and treat me like I was a f**k-up. So I'm pretty wary about ruining the beautiful relationship I have with the crew at the NSP. I don't entirely trust them not to judge me and put me in the 'sick' or 'damaged' box and think they are going to try and get me going straight.

"So don't get too pally or call me 'mate' or 'buddy'. I'm no-one's 'buddy'. Maybe one day when I get to know you all better. Until then NSP staff are all on the nose. No offence meant."

More information on the value and importance of NSPs can be found at: http://www.health.gov.au/internet/main/publishing.nsf/Content/73934F5307F88EC7CA257BF0001E009F/$File/ques.pdf

[1] *Not his real name.*

7. How many needles are enough needles?

People often ask for large numbers of needles, Crios said.

"Every time someone injects they should use a new needle to help avoid blood borne viruses and because needles get blunt very fast and reusing them makes vein damage more likely," he explained. In addition, syringes that have sat around can incubate bacteria, increasing the risk of infection, including abscesses and blood poisoning.

"Also if you're using as part of a group, your equipment might become mixed up with another person's and you end up sharing, and that increases the risk of contracting blood-borne viruses or other infections."

He said NSPs should promote the idea of planning ahead to make sure people who inject are not caught short without a new syringe for themselves and their friends.

"It is always a good idea for people to take extra syringes, needles and sharps containers so they don't run out. We also know people often collect syringes and needles for other people who, for one reason or another, don't go to the NSP," Crios said. You also need to think about regularly offering clients other equipment such as filters, tourniquets and condoms where they are available.

8. How to handle clients who bolt in and bolt out.

No matter how much NSP staff may wish to help clients, a newcomer is going to be confronted by what may be perceived as rudeness. Someone rushes in, shouts orders, grabs the packet of equipment and bolts out the door without a word of thanks.

Andrew said this behaviour can be because of the stigma of injecting and the associated shame.

"They might be embarrassed about what they're doing and worry that you're judging them, and may also be worried you're going to ask them questions," Andrew explained.

"So they're in and out, bang, done. If it's their first time or they don't come very often, they probably come with huge anxieties. Often it's fear you might ask questions or they're shameful because they've been shamed before. So even if you do just say 'Hello', they assume you're judging them."

Crios agreed that the stigma around injecting drugs can affect people's behaviour in the NSP.

"Unfortunately people who inject drugs experience a lot of stigma." Crios said. "As a result, many are keen to get in and out of the NSP as quickly as possible to avoid being identified.

"This is even more of an issue in smaller communities where an NSP may be co-located with a local health centre. Clients may also be withdrawing and feeling pretty bad and wanting to get out.

"It's worth remembering that there are plenty of impatient people in many other services, like at the doctor's, dentist's and at bus stops," he added.

Hepatitis C treatment in prison faces serious barriers

Prisons no longer resemble the squalid and unsanitary places conveyed in the writings of 19th century authors such as Alexander Dumas, Fyodor Dostoevsky or Charles Dickens. The grim Marshalsea prison in Little Dorrit or the prison hulk from which Magwitch escapes in Great Expectations, have long been superseded by more modern, sanitary institutions.

But the connection 19th century writers made between prisons and their role as incubators of infection still resonates today. This makes the drug injection environment in prisons, and possible harm reduction measures, relevant to NSPs and their workforces.

Almost one in three Australian prisoners suffer from a chronic disease, according to a 2012 study by the Australian Institute of Health and Welfare (AIHW). Communicable diseases such as hepatitis are some of the most common, with one in five inmates testing positive for hepatitis B and C [13]. The prevalence of hepatitis C is known to be 30 times higher among prisoners than the general community [14].

Injecting drug use accounts for the majority of new infections, so it is a real concern that 44 per cent of prisoners report recent injecting drug use. Many continue to inject while in prison, and initiation to drug use including injection also occurs [15], and hepatitis C continues to spread [16, 17].

One NSW study found 34 per cent of injecting drug users continued to inject drugs in prison, with 90 per cent of those reporting that they had shared injecting equipment [17].

There are a range of measures to reduce harms from shared injection in prisons in Australia, including access to bleach [18].

Prison life compounds risks associated with injecting drug use, and for many people, it is in prison where they are introduced to it. Hepatitis C is widely transmitted in prisons, and people are at higher overdose risk upon their release. These are just another reason frontline NSP workers are well placed to serve important roles when working with people going into or having returned from prison.

To remove the need to share equipment, several countries have established programs to allow prisoners to access clean needles [19, 20].

The national NSP strategic framework notes the lack of in-prison NSP is a gap that should be addressed [24]. The Australian Capital Territory (ACT) is the first, and to date only, Australian jurisdiction to propose opening a prison NSP. The ACT proposal, however, has run into determined opposition from the Community and Public Sector Union, which represents prison guards. Negotiations are ongoing.

In March this year, the Victorian Ombudsman investigated deaths and harms in prison and noted that overcrowding was a contributing factor to hepatitis C transmission in prisons [25].

Last October, Victorian Auditor-General John Doyle delivered a report on drugs in prison in which he said the strong evidence base in favour of prison-based NSPs indicated they may be one of the most effective methods of harm reduction available [26].

"Evaluations of prison NSPs in other international jurisdictions have found that NSPs have yielded reduced rates of blood-borne viruses without corresponding negative outcomes such as increased incidences of injecting or needles being used as weapons," Doyle's report said. The report went on to encourage Corrections Victoria to investigate further.

Prison can be a useful period of stability where medical attention can pay dividends for the individual and the broader community once the inmate is released. A report on prisoner health by the AIHW last year found that more than one-third of inmates believed their health had improved in jail.

As one of the study's authors, Dr Pamela Kinnear, said: "For some prisoners, the only place they get a check-up is in the lock-up".

Prison theoretically can be a good environment for undergoing drug therapy for hepatitis C, particularly if a person's life outside prison tends to be chaotic. Although guidelines and conditions vary between jurisdictions, Opioid Replacement Therapy (ORT) is also available in prisons, either as a continuing treatment or beginning the treatment. ORT is not available for male prisoners in Queensland however. In 2009, approximately 11 per cent of all people in prison were receiving some form of ORT [27].

> *'Prison theoretically can be a good environment for undergoing drug therapy for hepatitis C.'*

But while prison might seem a perfect public health opportunity in terms of having a captive audience and the facilities needed to treat a serious illness, the Auditor-General's report showed hepatitis C treatment had achieved only limited success in Victorian prisons.

Corrections Victoria allows for 30 prisoners to undertake hepatitis C treatment a year. However uptake by prisoners has traditionally been low, with just over half of the available places typically used [26].

The low take-up of hepatitis C treatment in prison is a national phenomenon. The National Prison Entrants' Bloodborne Virus & Risk Behaviour Survey is one of the few national prisoner health projects.

The 2010 survey questioned 873 prison entrants from all states and territories and found that only seven hepatitis C antibody positive prisoners reported receiving treatment for hepatitis C, compared with one in 2007 and two in 2004. No Aboriginal or Torres Strait Islander prisoners reported receiving treatment for hepatitis C in either 2004 or 2007, and only one NSW Aboriginal or Torres Strait Islander prisoner reported receiving treatment in 2010.

The AIHW report found that while 22 per cent of prisoners tested positive for hepatitis C, less than two per cent received treatment during 2010-11.

Studies of hepatitis C treatment have shown that prisoners were often either unwilling or unable to begin treatment. For one thing prisoners often balked at beginning treatment due to the severity of the side effects and the knowledge they may not get the treatment to counter the side-effects.

But one of the main barriers to undergoing hepatitis C treatment in prison is simply timing. A course of treatment for hepatitis C takes six months to a year, and most prison sentences are not long enough to accommodate the treatment.

Another obstacle is movement between jails. Few inmates serve their entire sentence in one prison, which can make it difficult for an inmate who wants support with hep C to get sufficient continuity of care.

To have any chance of completing a course a prisoner would need to be in one facility continuously, which rarely happens unless they are serving a sentence of several years. Since most sentences are in the vicinity of six months, few prisoners would be eligible.

NSP workers vital in new strategies

The Australian Government released four key health strategies that again emphasise the critical role that Needle and Syringe Programs play in preventing HIV and hepatitis. These are the:

- *Seventh National HIV Strategy;*
- *Fourth National Hepatitis C Strategy;*
- *Second National Hepatitis B Strategy;*
- *Fourth National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy.*

These strategies can be downloaded at www.penington.org.au

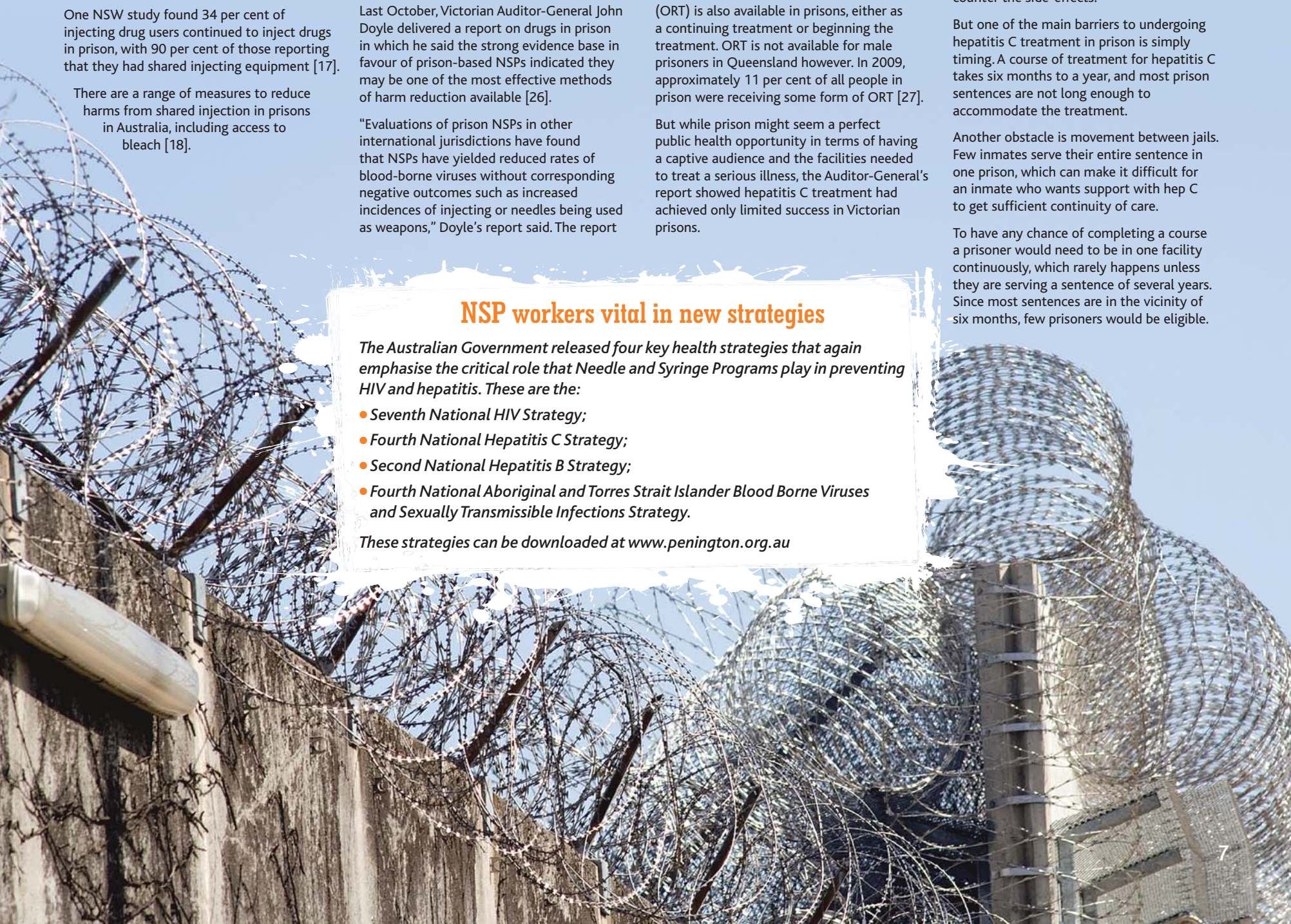


Fig tree event helps overdose prevention message take root

International Overdose Awareness Day

prevention and remembrance

Balloons being released during the 2013 event in Mt Zion, in rural Illinois, USA.

Now is the time to start planning an event, either big or small, for International Overdose Awareness Day on 31 August 2014.

Needle and Syringe Programs have a key role to play in supporting the day and promoting and delivering overdose prevention programs.

Trying to talk about drug overdose in many circles can often be guaranteed to stop conversation. Starting a public conversation about drug overdose will be the main message this year.

Overdose prevention programs are growing across the developed world, and that growth is fed by information, public discussion and public awareness. Starting a conversation works in the broadest advocacy sense, to help make the community begin to recognise overdose as a human, as well as a personal, tragedy.

Services are being encouraged to think creatively about what they can do to mark this opportunity for remembrance, stimulate conversations, and highlight prevention messages. For more information on International Overdose Awareness Day, visit www.overdoseday.com or ring the Penington Institute, which includes the Anex program, on 03 9650 0699.

Patrick's story

Patrick McKenzie, who works in Townsville, was so moved by his first International Overdose Awareness Day last year, that he is already planning another even more special event for this year. He recounted his experience of the day to the Bulletin.

"I was new to Townsville. I contacted a colleague at the NSP and we and a bunch of people from one of the Salvation Army rehabs put something on," Patrick said.

"There were about a dozen people, and we met under a Moreton Bay fig tree, which just happened to have a broken limb. It was symbolic. We talked about our personal experience of surviving overdoses," he said.

"I've survived it many times, I have to say. We spoke about how easy it is to overdose, and the shame that can be involved. The shame of coming to in a park, or in a car, and you've been narcanned (administered naloxone).

"The shock, particularly when members of the public see it, when the ambulance might get called to your house, and your neighbours find out.

"People shared a lot of those stories. Mixed with gratitude for narcan, and then the trauma of going and scoring again because of that misconception that 'the dope has gone out of my system and I have to score again'.

"I had three overdoses in one day - a long time ago - because of that kind of behaviour," Patrick said.

"So all the people told brief stories, and then we attempted to light little candles, and the wind kept putting them out."

"Everyone wrote down the names of the people they knew had passed away, and between the 12 of us we had about 20 names. And 10 were mine that I knew over the years."

"It was really powerful and symbolic. And the worker from the NSP spoke about initiatives, such as trying to get naloxone publically available, the risks of fentanyl going around etcetera, so there was a psycho-education component as well," he said.

"This year I want to do something more significant. Even though I've worked in the sector for years, in the mainstream the stigma of being a user is really profound.

"I'd never been in an Overdose Day event before. It was just so moving to be able to name my friends publicly, in this special session of people who understood. To read their names aloud and have other people hear - that was very, very potent."

"That was my first one. Previously I didn't have the time or capacity. Now I do. I'll be doing it again, and we are going to make it very special."

Remembrance in our 'red heart'

The Community Education and Support Team at the Alice Springs office of Alcohol and Other Drugs Services Central Australia are also gearing up, following last year's successful information stall in a shopping mall.

Team member, Petra Yan, said it was easy to get involved and even though many people "tend to take a wide berth" when they see a colourful stall featuring drug-related information, many more were drawn to the stall.

"We set up in a shopping centre, taking resources with us such as brochures and display boards, showing the various types of drugs and their risks," Petra said. "We provide a lot of information for parents, and we steer them to where they can get more specific information if they want it."

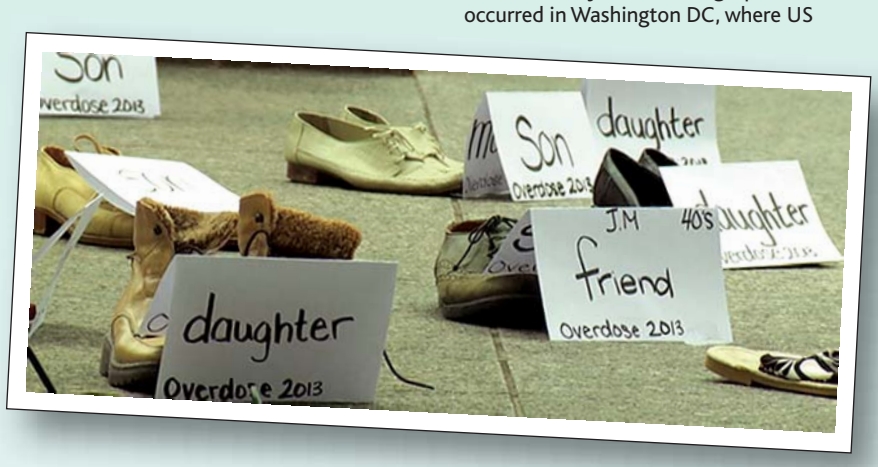
A growing movement

Events marking the day last year were held in all Australian states and territories. Outside Australia, events were staged in the United States, Canada, the United Kingdom, the Slovak Republic, India, China and Belgium.

Internationally, the most high-profile event occurred in Washington DC, where US President Barack Obama's then drugs policy chief, Gil Kerlikowske launched an overdose prevention package at a press briefing in conjunction with drug treatment agency, SAMHSA (Substance Abuse and Mental Health Services Administration).Four US jurisdictions - Illinois, Colorado, Washington State and Delaware - have officially declared 31 August as International Overdose Awareness Day,.

International Overdose Awareness Day falls on a Sunday this year, so commemorations in public places on the day are more likely to attract the general public. But, many services will hold events during the week before or after the Sunday. Marking the day need not be complex or expensive. Simplicity can be very poignant and effective.

Suggestions for organising an event for the day are available at http://www.overdoseday.com/events/event-tips/. The listings of last year's events on the website also give an indication of how other groups in Australia and around the world marked the day. Supporting materials are also being developed for groups planning an event.



Shoes serve as symbols of lives lost to overdose at the 2013 International Overdose Awareness Day event in Ottawa, Canada.