PENINGTON INSTITUTE

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anex Bulletin

CHEMSEX: THE 'PERFECT STORM' OF RISKS AND STIGMA

Popular among a select percentage of the gay male population, chemsex parties can see a dozen or more participants smoke drugs or inject themselves with illegal drugs before partying hard, including intense sexual activity, often with multiple partners, often without condom protection.

A significant number of chemsex participants are HIV-positive men while hepatitis C (HCV) is an ever-present danger.

The illicit drugs being used are led by crystal methamphetamine – most commonly called 'ice' but also known as 'Tina' in the gay community. GHB (gamma-hydroxybutyrate), GBL (gamma-butyrolactone), MDMA, mephedrone, 'poppers' (amyl nitrite) and erectile dysfunction drugs are all known to be involved to varying degrees...

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IN BRIEF

Update: NSW opioid inquest

Over the last few weeks there has been media coverage of the New South Wales joint coronial inquest before Deputy State Coroner Harriet Grahame, which is examining six opioid overdose deaths that occurred in May 2016.

This inquest is different to most in that it is allowing solutions to opioid deaths to be aired and discussed in a public setting. This includes looking at a range of public health measures including the purity testing of heroin and fentanyl. Council assisting the coroner, Peggy Dwyer, has said the results of the successful pill testing trial at the recent Groovin' the Moo festival could prove useful. If a person buying heroin could test the product to see if it contained fentanyl they could obtain the knowledge needed to potentially save their life.

The inquest is also taking a close look at naloxone particularly the fact that naloxone nasal spray is not available in Australia. Ms Dwyer has told the inquest that naloxone may have been of assistance in at least two of the deaths being examined.

Fentanyl: What do you know? Seminar video online

Fentanyl is a potent synthetic opioid with an important role in the treatment of pain. However, at approximately 100 times as powerful as morphine, it's a dangerous drug that carries the risk of fatal opioid overdose if used inappropriately.

Some medicinal fentanyl is diverted into illicit use, while there are also reports of fentanyl being illegally imported into Australia and then cut with other drugs such as heroin. Fentanyl is a key driver of the opioid overdose crisis in the US and it is implicated in a growing number of overdose deaths in Australia – as identified in *Australia's Annual Overdose Report 2017* – a Penington Institute publication.

In February 2018 Penington Institute hosted a seminar about fentanyl with speakers including emergency paramedic Alan Eade, clinical toxicologist and emergency physician Dr Shaun Green and Penington Institute project lead Crios O'Mahony. To view the videos see:
http://www.penington.org.au/programs-and-campaigns/conferences-and-seminars/

PENINGTON INSTITUTE

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

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THE NICOTINE CONUNDRUM

A tobacco treatment specialist has advised frontline workers to help their clients quit smoking and withdraw from their use of other drugs at the same time.

Historically, frontline workers have not always encouraged clients to simultaneously withdraw from tobacco and other drugs.

The belief was that trying to stop tobacco use might interfere with the process of withdrawing from a primary drug of dependence.

What's more, for NSP workers, who also have a high rate of smoking, smoking with clients has sometimes been a useful way to build trust.

Associate Professor Colin Mendelsohn, a tobacco treatment specialist from the School of Public Health and Community Medicine at the University of New South Wales, says people who use substances have higher health risks from smoking than other groups because they begin smoking earlier and smoke more cigarettes.

"In a study following people who use heroin over 24 years, those who smoked had a mortality rate four times higher than those who didn't smoke", he says. "Substance users who smoke are more likely to die from a smoking-related disease than their primary drug use."

"Many people with alcohol and other drug problems overcome their primary addiction, only to then die from a tobacco-related illness."

Why are smoking rates higher in people who use drugs?

Colin says several reasons have been suggested for the high rates of smoking. Some suggest smoking is a 'gateway' to illicit drugs and is part of the culture of drug-taking. Another possibility is a shared genetic predisposition for dependence on tobacco and other drugs.

"The use of addictive drugs also releases a brain chemical (dopamine) creating a sense of pleasure and this could enhance enjoyment of tobacco when used together. Another possibility is that some people might use tobacco to relieve mental health symptoms," Colin says.

He points out that smokers who use drugs and have infections can add to their disease burden.

For example, now that HIV infection can be managed with treatment, people living with HIV lose more years of life from smoking than from HIV.

"The harmful effects of smoking are magnified in patients with HIV. People living with HIV lose more years of life from smoking-related disease than from HIV/AIDs," he says.

People with hepatitis C related to drug use also have high rates of smoking. Now that hepatitis C can be cured, Colin anticipates smokers will lose more years of life to tobacco-related illness.

Why is tobacco harm reduction important for people who use other drugs?

Tobacco harm reduction is especially important for smokers who use other drugs because they have very low quit rates. Colin says switching to a safer alternative source of nicotine substantially delivers far fewer toxins and reduces the risk of smoking-related disease.

He says the focus is best kept on preventing harm and not on preventing the use of nicotine. Nicotine alone, at doses found in smoking cigarettes and in using e-cigarettes (vaping) is relatively benign, except in pregnancy and perhaps in adolescence.

Harm reduction for smoking is no different to other harm reduction strategies widely used in addiction medicine, such as methadone for people who use heroin, NSP/needle exchange and medically supervised injecting rooms.

"Providing adequate low-risk nicotine can both help people quit cigarettes and help with their other drug withdrawal strategies," Colin says.

People who are withdrawing from heroin can have difficulty quitting for a range of reasons:

- Methadone can produce more intense tobacco cravings and withdrawal symptoms.
- Smoking can be used to decrease anxiety and depression in people who also have mental illness and high levels of stress.
- Ongoing nicotine use can improve brain function in people with mental illness, especially schizophrenia.
- A strong culture of smoking exists among people who use other drugs.
- People with low levels of self-efficacy have more difficulty refusing nicotine.

"Providing adequate low-risk nicotine can both help people quit cigarettes and help with their other drug withdrawal strategies,"

– Associate Professor Colin Mendelsohn

Colin says that providing access to low-risk sources of nicotine, such as e-cigarettes, would help to alleviate these problems. In addition, e-cigarettes are much cheaper than smoking, which would assist people who use other drugs and are often on low incomes.

What about e-cigarettes?

An Australian Government parliamentary committee has recently stated that the ban on e-cigarettes containing nicotine should remain in place (see the Report on the Inquiry into the Use and Marketing of Electronic Cigarettes and Personal Vaporisers in Australia).

Colin does not agree with the ban.

"Electronic cigarettes with nicotine should be made legally available in Australia as consumer products for adult smokers who are unable to quit with conventional treatments.

"It is illegal to possess or use nicotine liquid for vaping in Australia without a prescription, but most doctors will not write nicotine prescriptions," he says.

He points out that e-cigarettes have helped millions of smokers overseas to quit and smoking rates are falling in countries where vaping is widely available, whereas smoking rates have stalled in Australia for the last few years.

He says studies of people who use drugs show they have high rates of interest in, and use of, e-cigarettes compared with the general population.

"Quit rates are very low in this group, so e-cigarettes could have a useful role for people who use drugs.

"E-cigarettes provide the nicotine and the 'smoking experience' but with only a tiny fraction of the risk and this makes vaping a far safer alternative to smoking for smokers who are unable to quit cigarettes."

He says the UK Royal College of Physicians has estimated the hazard to health arising from long-term vapour inhalation from e-cigarettes is unlikely to exceed 5 per cent of the harm from smoking tobacco.

Are there other harm reduction tools for tobacco?

Dr Alex Wodak, President of the Australian Drug Law Reform Foundation, strongly agrees that harm reduction is very important.

"Rates of smoking are not just higher in people who use drugs, they are sky high," he says. "What we also know is that not only is there a high rate of commencing smoking, but there's a very high rate of retention in smoking and a low rate of giving up smoking."

Alex says current nicotine reduction therapies – for example, chewing gums, lozenges and patches – were a big advance when introduced, but they do

not deliver enough nicotine compared with cigarettes.

"In harm reduction and in public health, there's no point in having a safer product or a safer alternative risk behaviour, if that alternative risk behaviour isn't also attractive."

Alex says devices are more attractive to smokers when they deliver more nicotine and mimic some of the ritual behaviour and physical sensations of smoking. He explains that there is a whole new array of reduced-risk products such as e-cigarettes and the "heat-not-burn" devices that heat tobacco rather than burn it.

He says these are so effective the tobacco industry views these products as "disruptive technologies".

As an example, after the recent release of a heat-not-burn device in Japan, cigarette sales have decreased 27 per cent over the last two years. Alex says there has never been such an astonishing and rapid reduction in smoking rates.

"These devices heat the tobacco and people inhale that vapour, which is much less toxic than cigarette smoke. These devices have not yet been released in Australia, but I'm sure they'll come here."

How can NSP workers help smokers who use other drugs?

Alex says that everyone working with people who use drugs should encourage their clients to quit smoking.

NSP workers should also be encouraged to quit themselves. Those who cannot quit should consider switching from cigarettes to nicotine lozenges, sprays, patches, or to lower-risk options such as e-cigarettes or heat-not-burn devices when they become available.

Colin says health professionals who smoke are less likely to offer counselling to clients to help them quit, but it is important to implement effective counselling strategies.

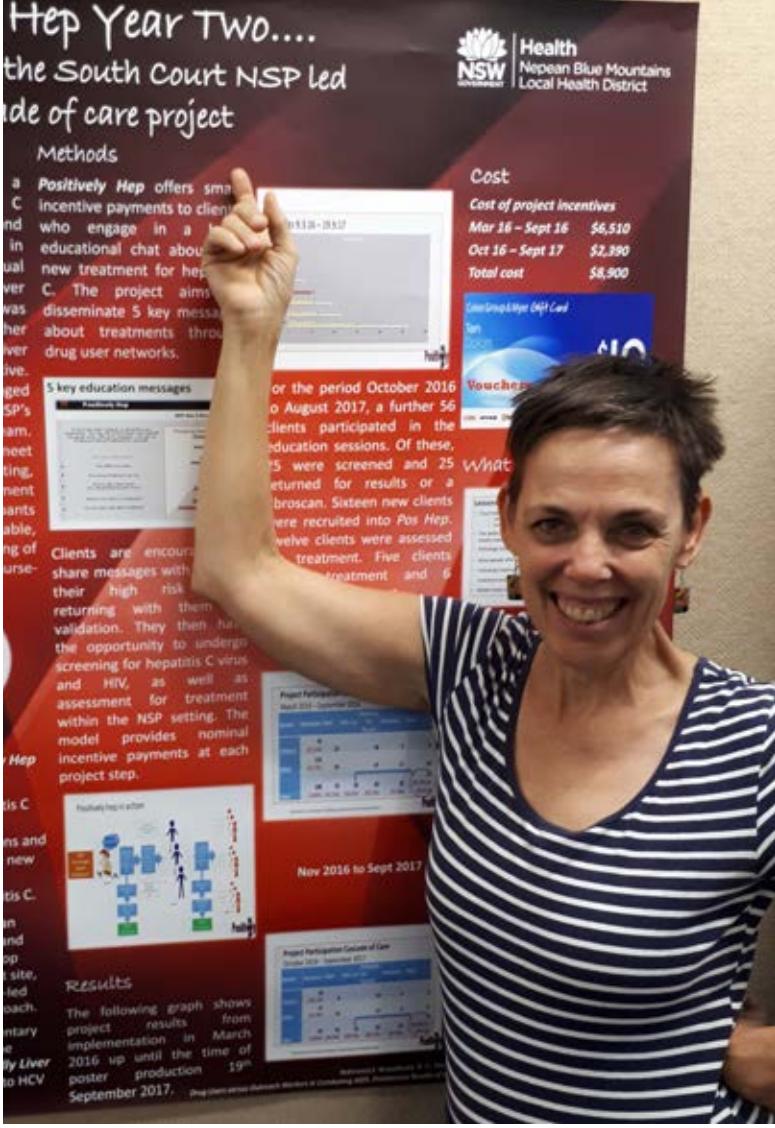
Julie Milland

Associate Professor Colin Mendelsohn

Counselling strategies to help people quit smoking include:

- Describing withdrawal symptoms and cravings and exploring ways of managing these (e.g. distraction strategies such as doing exercise).
- Agreeing on a quit date and promoting the "not-a-puff" rule (i.e. committing to not taking a single puff of a cigarette after the quit date).
- Addressing barriers to quitting and how to overcome these (e.g. weight gain or stress).
- Identifying smoking triggers and discussing strategies to cope with them (e.g. minimal or no alcohol in the early weeks of a quit attempt).
- Getting support from family and friends, support services and printed materials.
- Promoting lifestyle changes, such as exercise and avoiding high-risk situations.

SIX QUESTIONS WITH FELICITY SHEAVES



Felicity Sheaves

Anex Bulletin: Hi Felicity! What's the scope and scale of your role today?

Felicity Sheaves: I manage the HIV and Related Services within Population Health for Nepean Blue Mountains Local Health District, NSW Health.

We are a small outer metropolitan sister/brother team comprised of NSP, hepatitis health promotion and sexual health promotion. The team has approximately 7.2 full time equivalent staff.

I am responsible for the coordination of hepatitis prevention services – inclusive of needle and syringe programs. The NSP is across four local government areas – Hawkesbury, Penrith, Blue Mountains and Lithgow.

I have very recently become responsible for managing the Sexual Health Promotion Team, promoting positive sexuality and preventing HIV and STIs.

AB: What career path brought you to your current position?

FS: I was a late studier – I finished an honours degree in health communications. I was interested in health promotion and had been working as a research assistant in a centre at Western Sydney University called the Centre for Research in Healthy Futures on a healthy food project. I saw the NSP casual position come up and applied for the outreach role. In 1998 I moved into the hepatitis project officer role, thinking of ways to engage people with hepatitis C. I worked with a part-time researcher and we rolled out the Safe Injecting Cwiz project [more of this later].

Then the NSP coordinator position came up at Nepean and I put my hand up for that role. I took on that position and it was a really great time. We'd been a mobile outreach program in Nepean Blue Mountains where I'd previously worked as a casual. It was a high methadone injecting area and we were still providing winged infusion sets and 10 and 20 ml syringes (which were all later banned in NSW to 'prevent' methadone injecting). I oversaw the move to a new location and we had a support nurse – we weren't aware of any sites outside Redfern and Kirketon Road with a nurse. We handed our needles and syringes and were also able to build up a great level of trust with the clients through the nursing service.

AB: What sense of satisfaction do you get from your role?

FS: It's a constantly changing environment. With the new direct acting anti-viral treatments we've been able to build upon our partnerships. Working with your partners – that's the really satisfying part of it. What you can do with your scarce resources!

AB: What initiatives have you introduced in your work that NSPs in other jurisdictions could learn from?

FS: Our approach is to build trust and rapport through responsive service delivery and integrating health care through key partnerships. When you haven't got many resources, look around to see who you can partner with to provide the best possible levels of care.

Listen to what the punters are saying about how best to work with them and meet their needs and work as closely with the peak consumer organisation. For us, this is the New South Wales Users and AIDs Association.

I'm lucky enough to work with a super experienced team of long-term staff who've worked 15 – 20 years in this field. We've continued to grow our work over the years, learn from many mistakes and laugh at ourselves and with each other.

Whilst our teams are small we have more than one discipline – health education officers, nurses, social workers and a contract part-time Aboriginal peer support worker employed through the NSW Users and AIDs Association since 2015.

The teams provide a wealth of experience and important complementary skill sets which enables a diversity of work to occur. The NSP for example has been providing nursing care to NSP clients since 2002, which was really unusual in NSW apart from the legendary Kirketon Rd Centre.

Collaboration, cooperation and shameless self-promotion of scalable projects has been our style, so when we think that we have good projects or ideas we actively engage the sector with them.

In 2003 the NSP won the Anex NSP Program Excellence Award for the Safe Injecting Cwiz, a hepatitis C prevention project for young people under 25. This incentivised project was based on the American Sociologists work of Bob Broadhead and Doug Heckathorn from the Eastern Connecticut Health Outreach (ECHO) project.

These projects were the forerunners of the Deadly Liver Mob, Positively Hep projects and other incentivised project models in NSW. Incentives and NSP were really controversial, due to fear of shock jocks and general risk aversion at the time, so it took another ten years to get this project work up and running and embedded in core business.

To read more about the Deadly Liver Mob see: **https://harmreductionjournal.biomedcentral.com/articles/10.1186/s12954-018-0209-y**

And to find out about the Positively Hep project see: **https://www.nbmlhd.health.nsw.gov.au/news-stories/positively-hep-partnership-a-state-first.**

In 2016 the NSP partnered with Sexual Health and the Liver Clinic to enable NSP clients to receive hepatitis C treatment. The NSP used the two key multifaceted incentivised hep C projects to engage at risk clients, fostering interest and understanding about the direct acting antiviral treatments and demand for education, assessment and treatment on site in the NSP.

Through the Positively Hep project, South Court NSP has engaged over 330 NSP clients in education, screened 145, 63 were found to have chronic hepatitis C and treated 22 to date.

The Sexual Health Director/staff specialist provides medical oversight for hepatitis testing, assessment and treatment, as well as a performance and image enhancing drugs (PIEDs) clinic, and supporting a smoking cessation project within the NSP.

Rotations of medical registrars through the sexual health clinic have also provided the NSP with medical support and the opportunity to influence doctors along their medical journey.

AB: What is your most pleasing achievement?

FS: Working with colleagues in the sector to influence change is really fabulous.

The big ticket item has been the endorsement and roll out of the Deadly Liver Mob project across seven local health districts in NSW. This has been a significant collaborative effort with my hepatitis project partner Louise Maher and the Aboriginal NSP worker Kerri-Anne Smith. We worked hard to develop and propel the project as an up scalable model and great way to work with priority populations. This project is funded by a NH&MRC grant administered by the Centre for Social Research in Health. It's endorsed by the NSW Ministry for Health and local health district partners. The uptake of the project in rural, regional and metropolitan sites is really exciting and it's delivering encouraging results.

AB: If you could change one thing (practical or policy) in NSPs in Australia what would that be? Why?

FS: Provide free access for peer distribution of naloxone to save lives now.

All health facilities such as community health centres and emergency departments should be mandated as designated NSP access points with external free vending machines and internal access to a full range of equipment. We need to take away arbitrary site approvals and also fund primary health care and injecting centres in key locations with dedicated multidisciplinary teams and peer workers to address the range of health issues for people who use drugs.

AB: Thanks for your time Felicity.

Sophie Marcard

NEEDLE AND SYRINGE PROGRAMS: THE 'MISSING PIECE OF THE HEPATITIS C TREATMENT PUZZLE'

People who currently inject drugs are at the same time the largest and least-treated segment of Australians living with chronic hepatitis C and must become a priority, reported Dr Stephen McNally, Deputy CEO of Penington Institute at their recent seminar 'NSP: the missing piece of the hepatitis C treatment puzzle'.

"NSPs see people who inject drugs every day," said Stephen, "so it's time for these frontline services to be supported to play a central role in encouraging and supporting clients to get tested and treated for hepatitis C."

Attendees at the recent Penington Institute seminar heard about the importance of NSP workers in supporting their clients to get tested and treated for hepatitis C.

The seminar was attended by frontline staff from organisations including NSPs, hospitals, community health centres, research organisations, government agencies, at home nursing and universities. Speakers included specialist nurse practitioners, a prescribing doctor, an NSP manager, a person with lived experience of hepatitis C, researchers, and staff from Penington Institute. Stephen said that, for the first time, any person living with chronic hepatitis C has the opportunity to be clear of the virus for good – thanks to the introduction of new and highly effective direct acting antiviral treatments.

"People living with hepatitis C who do not currently inject drugs have been a large number of those starting treatment. However, this group – those we might describe as fairly 'easy to reach and treat' – will soon be all cured of the virus," said Stephen.

"Yes, this is a great result, but we are not even close to treating everyone who has hepatitis C if we ignore people who currently inject drugs."

Around 80 per cent of people acquire hepatitis C by sharing injecting

> "We need to better utilise the amazing network of NSPs spread across regional, rural and metropolitan Australia."

equipment, and new infections occur almost exclusively among people who inject. The Centre for Research Excellence in Injecting Drug Use estimates that approximately 50 per cent of people who currently inject drugs have hepatitis C.

NSPs are the most regular, and sometimes only, contact that people who inject drugs have with a health service.

"We need to be more creative in our response, which means thinking beyond the more traditional medical model to treat people," said Stephen.

"Investment in the capacity of NSPs to engage their clients in testing and treatment is the only way hepatitis C can be eliminated in Australia."

"Community health centres, many of which operate NSPs alongside primary health and diagnostic services, are the right venues for developing HCV testing, treatment and prevention pathways.

"We need to better utilise the amazing network of NSPs spread across regional, rural and metropolitan Australia."

Stephen proposed three activities to achieve this.

"The first thing we need to do is invest in workforce development so NSPs can increase health referrals and provide person-centred support for people who inject drugs to treat hepatitis C.

"Second, we need to develop community-based pathways into testing and treatment. Once people who work in NSPs are empowered to engage people in a conversation about hepatitis C and offer a pathway for their clients, NSPs need to identify the most appropriate setting to deliver testing and treatment interventions, at the local level.

"Community health centres are such a setting: they frequently offer an NSP service alongside medical, diagnostic and sometimes even pharmacy services. If properly supported, they are well placed to utilise their existing service strengths to provide a 'one stop shop' experience for current injectors," he said.

"Thirdly, to maintain the gains delivered by treatment, Australia will also need to increase efforts to prevent hepatitis C reinfection by increasing the baseline investment in NSPs."

To watch the videos of the seminar **view the playlist**.

Sophie Marcard

Bec Thatcher from St Kilda NSP responds to a question to the panel

TAMPONS, SWABS AND CIGARETTE FILTERS: THE RISKY BUSINESS OF IMPROVISED FILTERS

For Tully, improper filtering almost cost him his life.

Tully contracted endocarditis (inflammation of the heart's inner lining) after injecting heroin filtered through a cigarette filter and dissolved in what he believes was dirty tap water.

Tully became ill shortly after injecting the drugs, and initially, he attributed the illness to poor quality drugs. He didn't seek treatment for a few days but when his condition worsened Tully says he realised something was seriously wrong.

"I was in and out of hospital for months. It made me really, really sick. I knew a dirty shot could make me crook, but not that bad. I've never not used a proper filter again after that. I even tell all my mates too now. I wouldn't wish that on my worst enemy."

Many people who use drugs opt to filter using cotton wool, cigarette filters, tampons and dried swabs. These contain insoluble fibres, says Penington Institute Project Lead Crios O'Mahony, and don't properly filter out impurities from common street drugs – which can cause immediate infection and illness, and over time, can lead to major health problems.

"Filters like these have got little fibres in them. Not only are they unsterile and don't properly filter out bacteria and dirt, the fibres can also end up in your veins and congregate in your eyes, in the valves of your heart, and cause all kinds of nasty damage to blood vessels," Crios says.

"There are all sorts of things that can happen through not properly filtering: bacterial infections, dirty hits, and blocked veins. If you're doing that continually over time you're going to end up with a lot of problems including collapsed veins and serious illness. Not filtering properly is a risky business."

Commercial filters work by filtering bacteria and impurities through a permeable membrane. They are attached to the needle and used to draw up the dissolved solution. Harm Reduction WA (formerly WASUA) spokesperson Kevin Wilder says the filters act in a similar way to the plunger device on a coffee percolator – allowing liquid to pass through but blocking solid particles.

It's important to remember that the commercial filters are single use only – bacteria accumulate in a used filter. But Kevin says he is aware that cost is a deterrent for many people who inject drugs, and they are likely to reuse their filters.

Wheel filters

> "When we started giving them [wheel filters] out for free there was a huge uptake."
>
> – Craig Harvey

"It defeats the object of filtering if you're injecting accumulated bacteria. We understand people are reluctant to pay for them, and we say to people, if they do intend to use a filter more than once they should make up their shots for the day and store them in the refrigerator."

Many primary and secondary NSPs provide filters at cost price while some, like Barwon Health Clinic, provide filters for free. Barwon Health harm reduction team senior clinician Craig Harvey says the cost of injecting equipment is compensated for in preventing serious illness.

"It's counterintuitive to do anything different. When we were charging for them, very few people were collecting them and we know poor filtering has an impact on people's health."

"When we started giving them out for free there was a huge uptake and it's a greater assumed health benefit to the community," Craig says.

"As an example, if we spend $20,000 per annum on injecting equipment, if that saves one person from a case of endocarditis as a result of poor injecting, a ten-day stay in the hospital costs between $100,000 and $150,000. If we save someone from just one of those occasions, we've paid for the next five years of equipment. It's a common sense approach to overall health care. It's a no-brainer."

Commercial filters are available at primary NSPs for free or at cost price. Filters are also available from some secondary NSPs, like hospitals, pharmacies and community health centres.

The effectiveness of each type of filter is measured in units of microns. Commercial filters work to filter out particles smaller than the average vein, which is five microns wide, while makeshift filters can cause blockages and infection, says Kevin.

"The lowest rung of the filtering ladder are swabs. A swab will only filter out particles bigger than 50 microns, so if you're using these, you could be injecting particles up to 10 times the size of your vein. These aren't ideal, and we don't recommend it, but we understand that cost can be a deterrent for people who inject drugs and we do provide sterile cotton with fit-packs [at Harm Reduction WA]."

The next best and most popular option is a steri-filt, which filters out particles down to 10 microns wide, and at cost price are 30c per filter. Needle-filts filter out particles down to five microns and cost 50c per filter, while wheel

Craig Harvey

filters, says Kevin, are the best and are recommended practice.

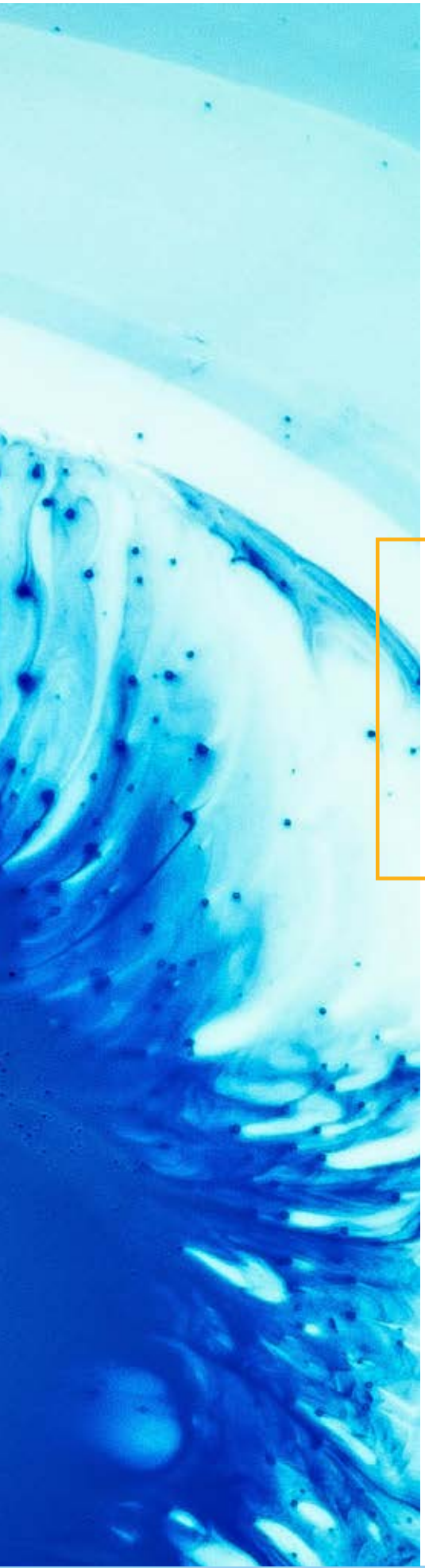
The wheel filters are available in different colours and ratings. For example, the green filter is rated at 0.8 microns and is used to filter out fillers and insoluble particles, while the blue filter is rated at 0.2 microns and is used to filter bacteria.

While filters remove microscopic particles from a liquid mixture, they can't prevent the transmission of blood-borne disease like HIV or hepatitis C, and must be used alongside safe injecting practices.

Tom de Souza

More information:

- Why filter your mix? http://harmreductionwa.org//wp-content/uploads/2017/11/Which-Filter-Guide-WASUA-PDF.pdf
- http://www.drugsproject.co.nz/drugs/equipment/filters



HEPATITIS C AND PEOPLE WHO INJECT DRUGS:

WHAT'S HAPPENING AROUND AUSTRALIA? PART 2

In Australia around 190,000 to 200,000 people live with hepatitis C, a disease that causes around 800 deaths across the country every year. New direct-acting antiviral treatments can cure around 95 per cent of hepatitis C cases - all people have to do is take a few tablets which have minimal side effects.

However, just because new treatments exist doesn't mean that people who are living with hepatitis C are accessing these treatments. In fact, the uptake of these ground-breaking treatments has slowed in Australia and the high incidence of this virus amongst people who inject drugs makes hepatitis C a major public health challenge.

Some people who inject drugs have minimal contact with the health care system and experience feelings of marginalisation. They may not even be aware that new hepatitis C treatments are available and that they are more effective (and with fewer side effects) than old versions. These are all major obstacles to encouraging more people with hepatitis C to undergo testing and treatment.

To address these issues and eliminate hepatitis C, states and territories around Australia are acting decisively. As you may recall, in the February 2018 edition of the *Anex Bulletin* we provided a snapshot of programs in place around Australia that are making a difference in tackling hepatitis C rates for people who inject drugs.

Now it's time for part two, which takes us to Queensland and the Australian Capital Territory.

The ACT is making strong headway in encouraging people to access hepatitis C treatment. In 2016, it had the highest proportion of treatment uptake rates in Australia with 30 per cent of people living with hepatitis C starting direct-acting antiviral therapy during the period March 2016 to June 2017.

ACT

- Estimated number of people living with hepatitis C in 2015: 3591 (Source: The Kirby Institute. Hepatitis B and C in Australia Annual Surveillance Report Supplement 2016.)
- Uptake of DAA treatment in (March 2016 to June 2017): 1130 (30 per cent) (Source: The Kirby Institute. Monitoring hepatitis C treatment uptake in Australia (Issue 8) December 2017)

Queensland

- Estimated number of people living with hepatitis C in 2015: 47,356 (Source: The Kirby Institute. Hepatitis B and C in Australia Annual Surveillance Report Supplement 2016.)
- Uptake of DAA treatment in (March 2016 to June 2017): 8400 (18 per cent) (Source: The Kirby Institute. Monitoring hepatitis C treatment uptake in Australia (Issue 8) December 2017)

The Barr Government has set ambitious targets to reduce the incidence of new hepatitis C infections by 50 per cent by 2020 and increase the number of people who receive the new treatments by that same rate during the period. To achieve this, hepatitis C treatment is available not only at the Canberra Hospital Liver Clinic and via the territory's GPs, but also at the ACT prison the Alexander Maconochie Centre (AMC). Between March 2016 and March 2017 58 AMC detainees commenced new treatments and 55 of them experienced effective treatment outcomes, which highlights how successful the new treatments can be.

A key component of eliminating hepatitis C is preventing people contracting it in the first place – a high risk for people who engage in risky injecting practices. There are 10 needle and syringe outlets across the territory and 30 community pharmacies that distribute sterile injecting equipment as well as six needle and syringe vending machines accessible 24 hours a day, seven days a week. Legislation has also been passed decriminalising the peer distribution of sterile injecting equipment to prevent the spread of blood-borne diseases.

Queensland is a large state covering more than 1.8 million square kilometres so ensuring sterile injecting equipment is available in all communities is a colossal task. Many Australians outside of Queensland don't realise that the distance between Brisbane in the south east of the state and Cairns in the far north is the same distance as Melbourne to Brisbane.

Also, unlike other states with highly centralised populations Queensland has a large number of regional cities right up and down the coast. With such a highly dispersed population, the Government sees GPs are crucial to winning the hepatitis C battle. The new hepatitis C treatments are so straightforward and effective that no specialist skills are required, meaning that GPs across Queensland can play a significant role in curing people carrying the disease.

When it comes to preventing hepatitis C, there are 120 secondary and 24 primary NSP sites in Queensland with all primary sites offering treatment or referral into local treatment pathways. The Government also funds QuIHN, a non-government organisation that runs three large NSPs. In addition to providing sterile injecting equipment and disposal options, QuIHN is also responsible for referring people to health services as well as peer education and workforce development.

Queensland's remote communities, which feature high numbers of Aboriginal and Torres Strait Islander people, aren't experiencing high rates of hepatitis C (unlike hepatitis B). However, people who identify as Aboriginal or Torres Strait Islander living in the state's cities do have higher rates of the hepatitis C. In some of Queensland's NSPs in locations such as south Brisbane, the proportion of clients identifying as Indigenous is as high as 20 per cent. The good news is that they are getting treated at roughly the same rate as everyone else.

The Australian Government has a target of eliminating hepatitis C Australia-wide by 2030. We have the right treatments available to cure the clear majority of people with hepatitis C. The challenge lies in reaching those people who have the disease but don't have strong contact with the health system.

John Ronan

THE TALE TOLD BY OUR WASTEWATER

The poo doesn't lie.

Australia's increasingly sophisticated wastewater drug monitoring shows that ice (crystal methamphetamine) remains the most consumed illicit drug in Australia and its usage is increasing.

That's one of the major findings of the most recent National Wastewater Drug Monitoring Program report, from March 2018. According to the content of our sewers, alcohol and nicotine remain Australia's drugs of choice while ice, fentanyl and oxycodone are more prevalent than heroin. People who use drugs and live in regional areas are using more of those drugs than city dwellers, proportionally, and New South Wales prefers cocaine while Victorians are more likely to use heroin. Western Australia and South Australia have the strongest ice usage.

Wastewater testing is a relatively recent development but has had a major impact on drug-related health services and policing around the world. It was first used in Italy less than a decade ago and was pioneered in Victoria in 2014 by Penington Institute (publisher of the *Anex Bulletin*) to prove that ice use was a serious issue in Victoria.

Since then, wastewater testing has expanded across the nation, to the extent that at least 45 sites are now monitored across Australia, covering about 12.7 million people, more than half of Australia's total population. Scientists sample wastewater from the sites about six times a year and test for a range of drugs and substances, including ice (crystal methamphetamine), amphetamine, cocaine, MDMA (3,4-methylenedioxymethylamphetamine), MDA (3,4-methylenedioxyamphetamine), heroin, mephedrone, methylone, oxycodone, fentanyl, nicotine and alcohol.

The mass spectrometer used to test wastewater

"It's like urine testing the whole population," explains a pioneer of the testing, Adjunct Professor Jason White, Head of the School of Pharmacy and Medical Sciences at the University of South Australia. He says it is a game changer in terms of understanding drug usage.

"Wastewater testing provides an objective indicator of drug use when before we relied on surveys. Surveys are limited and people don't always give accurate information for a range of reasons. This [wastewater testing] gives a more accurate estimation of total usage and the tests can be far more frequent, so it's near to real-time data," he says.

"Health workers can use the data in their planning and evaluate if what they are doing is working. In South Australia, we've been doing the program for a number of years and we regularly report back to the health department, and the police also get that information."

Wastewater testing does not come without its challenges. Jason calls the raw waste a 'chemical soup' of all kinds of refuse and says scientists need to take

Water treatment plant (photo courtesy of Melbourne Water)

into account how the drugs being monitored react with other chemicals, bacteria or waste products. "Cocaine, for example, in itself rapidly disintegrates but a metabolite, benzoylecgonine that it causes in urine is quite stable, so we can search for that."

Another issue is that the remnants of drugs are only a fraction of the sample. "It's a dilution of 400 to one, so we use a lot of water," Jason says. "You have to have pretty sophisticated equipment."

The data sourced has a number of uses. Jason says it provided a genuine snapshot of drug use across Australia, as well as specific local variations. For example, in the last six months, the data found that MDMA use in Adelaide was about 90 per cent higher in December than in other months, while cannabis use dropped by 45 per cent in February. Variations like these sometimes need to be explored with experts while other dips in some drugs are expected, because of recent seizures or the closure of drug labs. While general results are provided to the public, more specific details are only offered to health and law enforcement officials.

"The police love the data because it provides objective information about the impact of their work," Jason says. "We recently contacted the police because there was an unexplained huge change in a particular drug in a particular location and they were thrilled because they had predicted it was going to occur."

Regional drug use is a huge concern, going by the data, but Jason says testers were careful not to reveal specific town names when discussing results. "You don't want a small town or regional centre getting a reputation as a drug capital," he says. However, such information did mean measures could be put in place to try and address the issue in that locality.

"It's really about resource allocation for the health workers and police," he says. "In Adelaide, when we started, people had views on the availability of different drugs in certain suburbs and a lot of those turned out to be true." Resources could then be allocated on evidence instead of hunches.

Jason says there had been very little opposition to wastewater testing, possibly because it is too anonymous to be threatening individual privacy concerns. He believes the testing will become more sophisticated and 'smarter' as other researchers cross reference the data or layer their findings on top of the wastewater information, to create ever more detailed results. He also thinks more drugs will be added to those being tested for, possibly in the near future.

Nick Place

The mass spectrometer used to test wastewater

CHEMSEX: THE 'PERFECT STORM' OF RISKS AND STIGMA

Popular among a select percentage of the gay male population, chemsex parties can see a dozen or more participants smoke drugs or inject themselves with illegal drugs before partying hard, including intense sexual activity, often with multiple partners, often without condom protection.

A significant number of chemsex participants are HIV-positive men while hepatitis C (HCV) is an ever-present danger.

The illicit drugs being used are led by crystal methamphetamine – most commonly called 'ice' but also known as 'Tina' in the gay community. GHB (gamma-hydroxybutyrate), GBL (gamma-butyrolactone), MDMA, mephedrone, 'poppers' (amyl nitrite) and erectile dysfunction drugs are all known to be involved to varying degrees.

A report by a London clinic, 56 Dean Street, titled 'The art of ART (anti-retroviral therapy)' described chemsex as 'the perfect storm' of a highly sexual population, high HCV/HIV prevalence and high-risk sex practices. The men using drugs, especially those new to the scene, were sometimes naïve about drug use and the parties didn't always have 'care pathways' to assist those who needed it, the report adds.

In Australia, chemsex parties are part of the 'Party and Play' (or PnP) scene, held in private homes or sex venues and enjoyed by a small but significant proportion of the male gay population, according to experts.

"I would say chemsex is a significant thing but I don't know how major it is," says Dr Beng Eu, from the Prahran Clinic in Melbourne. "It's a very particular group and practice, and only a certain percentage would be involved in it, but it's there."

Professor Martin Holt from the University of NSW has been periodically surveying the gay community for more

> "It's important they don't feel judged for being gay, for using crystal, for injecting or having sex when they use drugs."
>
> – Professor Martin Holt

than a decade on behaviours relating to sex and drugs and whether sections of the community need support for their health and well-being. He worries that gay men struggling to handle the after-effects of chemsex might feel stigmatised and be reluctant to ask for help.

While some of the more experienced Party and Play enthusiasts are quite adept at managing their drug use and sex risks, he says, others may not be and that's where doctors and NSPs need to be ready with gay-friendly, non-judgemental and non-stigmatising support. It's not only about the usual harm reduction messages relating to injecting and sex, it's also about being aware the client may be feeling ashamed and unsupported.

In fact, those struggling may feel a sense of double-failure, he says. "Talking to counsellors, these men might feel like: 'I fell in with these people, my peers, my friends, and everybody seems to be having a really good time but I'm not. What have I done wrong?'"

"It's important they don't feel judged for being gay, for using crystal, for injecting or having sex when they use drugs … it's a lot of things for someone to have to admit to," Martin says.

Martin says figures suggest that between 10 and 20 per cent of gay men have undertaken chemsex, which is a high number when put against the percentage of the heterosexual general population that would use a drug like crystal meth. However Martin points out that party drug use is much more normalised in gay culture.

"If you're going clubbing or going to parties, it's not seen as particularly unusual to take something to help you dance and that may feed on into having sex later, if you're awake and stimulated. People's entry into it [chemsex] may be that way.

"With the Party and Play scene, it might be curiosity, because norms about drugs and sex are more accepted in the inner city. You may know someone who has done it, so there are your peer-based networks who you can ask about it, get an introduction, find out how to score and so on," he says.

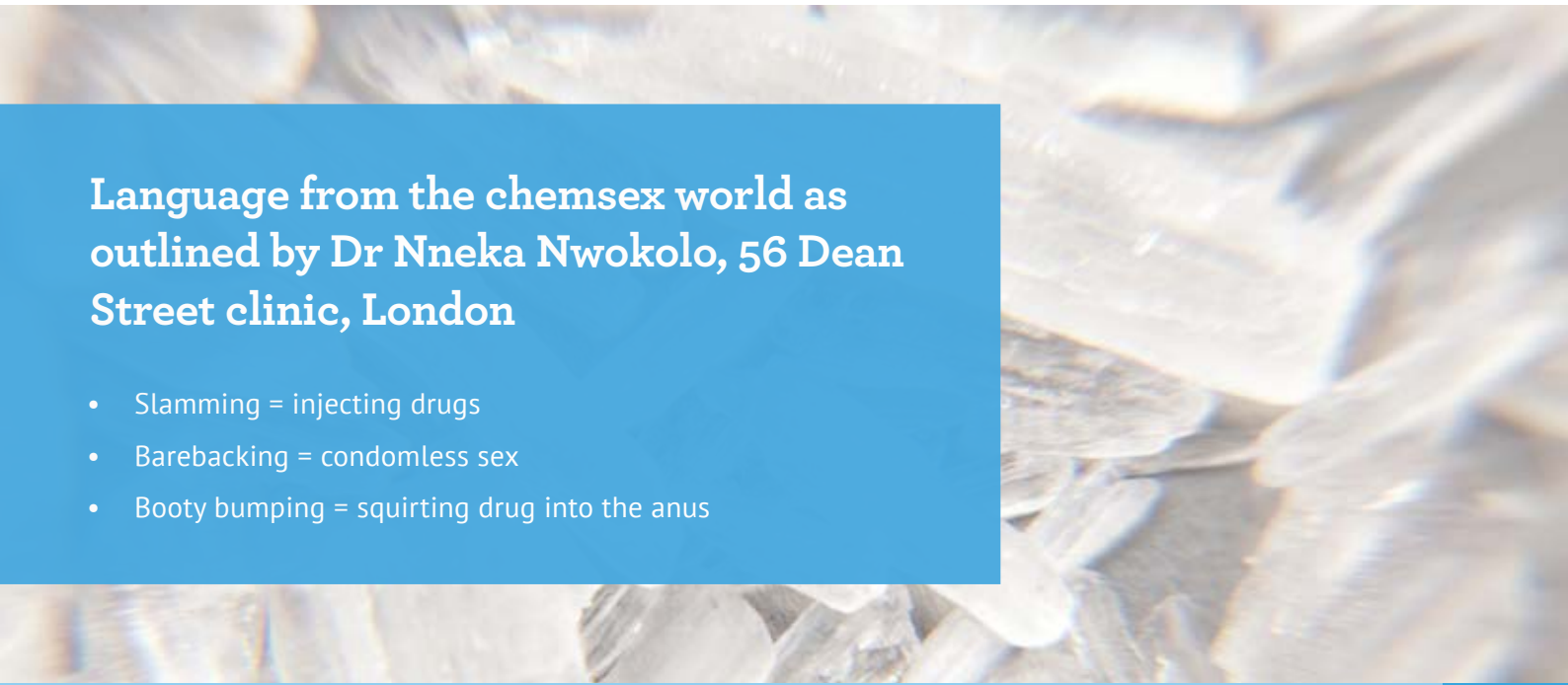
A danger for partygoers is that different rules may apply at each event. "At chemsex parties quite often people will report that the syringes are pre-loaded so there is a tray of injections that people inject," Beng says.

"It's quite different to other drug use where most people prepare their own or a friend prepares it for them. This is largely pre-prepared for use by everyone there.

"It's not only the crystal. GHB can have terrible side effects and even be fatal through respiratory suppression. The dosage to be effective is very narrow before you become overdosed," he says.

"Partygoers need to talk to the people hosting a party to make sure they are preparing the drugs safely. Then, while they're having chemsex, because they're somewhat disinhibited, they put

Crystal Methamphetamine (Kaesler Media / Shutterstock.com)



Language from the chemsex world as outlined by Dr Nneka Nwokolo, 56 Dean Street clinic, London

- Slamming = injecting drugs
- Barebacking = condomless sex
- Booty bumping = squirting drug into the anus

PrEP medication Truvada (Michael Moloney / Shutterstock.com)

themselves more at risk for HIV and hepatitis C as well, sexually as well as through the injecting practices.

"Hep C has been seen in that group a fair bit, historically."

The party scene has changed dramatically over the past decade or so. Martin says that about 10 years ago, crystal meth appeared suddenly among the gay community and caused issues, both among people who used drugs – sometimes veteran drug-takers – who couldn't cope with this highly-addictive drug and among support systems that were largely focused on HIV deterrence, rather than helping people addicted to crystal meth.

The drug disappeared for a long time but is now back in gay Party and Play circles. The core group of chemsex participants are often older men, in their forties or fifties, and Martin says men who are already diagnosed as HIV-positive "are much more likely to report injecting drug use than their HIV negative peers, and the gap is quite marked."

"Melbourne and Sydney support certain sex and drug-based networks, particularly more adventurous scenes which can feature injecting as part of the ritual and types of drugs that are taken, that may feature group sex scenes and longer sexual encounters. Positive men tend to be more represented in those scenes," he says.

"Study after study, when we look at men who are recently diagnosed with HIV – it's not the only reason but drug-based sex, particularly with more than one partner, is one of those risk factors that for more than a decade has popped up in studies," he says. "That underscores why we need effective sex- and drug-based positive action for gay men, because if they're going to participate in Party and Play chemsex, then we prefer that they are informed, have strategies in place and don't risk HIV infection."

The recent development of PrEP (pre-exposure prophylaxis) and PEP (post-exposure prophylaxis) treatments has affected both the chemsex party rules and the ability of gay men who might be exposed to HIV to seek help. PrEP is now available through the Australian Government's Pharmaceutical Benefits Scheme (PBS) and requires taking medication daily. PEP is an after-the-event treatment if a person is concerned they might have been exposed to the virus.

"It's great that people know PEP is available, if your primary strategy is condoms and then that doesn't work, or something else happens, like you negotiate around HIV status or whatever and then you realise something has gone wrong, or you misunderstood each other," Martin says.

"It's good PEP's there but I think it is a lot more stressful for people. If you're going to use PEP it's usually in less than ideal circumstances where you're a bit stressed out or very stressed, and suddenly have to talk to doctors.

"The whole planned thing about PrEP is more compatible with taking control of your sexual health and doing something proactive to reduce risk. That's why it's been so enthusiastically embraced by guys who Party and Play."

Nick Place

Professor Martin Holt

ICE, THE COMEDOWN AND OVERDOSE RISKS

Coming down from ice is 'living hell', according to Ashton from Perth. Ashton used ice intravenously for four years, and says he often relied on other drugs, like benzodiazepines, cannabis, and opioids to combat the comedown.

"After you've been awake for four, five, six, however many days, you need something to take the edge off. It's like torture; your body aches, your brain is scrambled. You need something to help you down after you've been awake for a while," he says.

Ashton isn't alone – polydrug use is common for people who use drugs, and it's a dangerous practice that significantly increases the risk of overdose, says National Drug and Alcohol Research Centre (NDARC) researcher, Professor Shane Darke.

"Polydrug use is the norm for almost all people who use drugs. It's very rare people will stick to just one drug. People who use drugs like to get the combined effects to get more and more out of the high," Shane says.

"One of the most dangerous of these combinations is mixing depressant drugs - like opiates and benzodiazepines - with methamphetamine. Depressant drugs reduce respiration, whereas when you're using a stimulant like meth, your heart needs more oxygen. So, essentially, you're sending two conflicting messages to the brain and the body doesn't know how to react."

The number of people overdosing on methamphetamine has doubled in the past seven years, an NDARC study has

found. The study looked at 1,649 ice-related deaths between 2009 and 2015 and found 43 per cent of those were caused by overdose. Almost nine of every 10 of those overdoses involved multiple drugs.

Ashton is now off ice. He admits he knew polydrug use was dangerous, but concedes it was part of the lifestyle. Benzodiazepines were the most common drug used by his peer group to combat the ice comedown, he says, and were cheaper and more accessible than opioids.

OxyContin, morphine and heroin are drugs typically associated with overdose, but Shane says the danger of benzodiazepines (also known as benzos) are greatly underestimated and carry inherent risk, particularly when used with stimulants like ice.

"Benzos are very dangerous drugs. With benzos, there is also a greater chance that the person can become dependent on them if they are using them to treat an ice comedown. Benzo withdrawal, if you become addicted, is very dangerous and can lead to death. They are not to be taken lightly," he says.

Alcohol is another of the most popular drugs used in conjunction with methamphetamine. Unlike benzodiazepines and opioids, which are typically self-medicated to treat a comedown, alcohol is often consumed when the person is high on ice, Shane says.

"Using methamphetamine with alcohol, people may think it tones down the effect of the drug and 'takes the edge off'. What a lot of people aren't aware of, is that using alcohol with meth actually increase heart rate and blood pressure, and therefore greatly increases the effects of methamphetamine and the risk of cardiac arrest," he says

The risk of overdose from polydrug use is also greatly increased when combining stimulant drugs, which magnify the effect of the psychoactive stimulant and can cause strokes, seizures or cardiac arrest.

Treating drug overdose can be problematic if multiple drugs are involved. Barwon Health harm reduction team senior clinician Craig Harvey says when depressant and stimulant drugs are used, the symptoms of overdose are masked and it can be difficult to determine the cause of toxicity.

"When you talk about polydrug use, all the different mechanisms at play can prevent identification of the toxicity. It can be difficult to work out what you're treating," he says.

Common symptoms of opioid overdose include: vomiting, a pale or clammy face, shallow or erratic breathing, choking or gurgling, loss of consciousness, and bluish fingernails or lips.

Methamphetamine toxicity, however, can be identified by a racing heart, chest pains, seizures, and a dramatic increase in body temperature.

Some suggest that people who use methamphetamine can be naïve to naloxone. Craig advises NSP workers that including all clients when distributing information on naloxone could save a life.

The opioid medication Oxycontin (PureRadiancePhoto / Shutterstock.com)

> "When you talk about polydrug use, all the different mechanisms at play can prevent identification of the toxicity. It can be difficult to work out what you're treating."
>
> – Craig Harvey

"It's important to offer naloxone training to everyone, regardless of the substance they are using, because these people are often in an immediate position to be a lifesaver," Craig says.

"People who use substances often have a genuine care for one another, and naloxone is appropriate in their social groups. It should be distributed to anyone and everyone, not specifically targeted," he says.

Cannabis is the most common drug used in conjunction with methamphetamine, and often perceived by people who use drugs to be the safest way to navigate a comedown. However, Shane says 'getting some rest' is the least harmful way to treat the withdrawal symptoms of ice.

"There is no evidence that simultaneous use of cannabis and methamphetamine puts a user at greater risk. It's a certainly the most common combination among methamphetamine users, but the safest way to comedown is just a case of getting some rest. Putting more drugs into the body isn't going to help. My advice would be to get some sleep and not add to the chemical cocktail."

Tom de Souza

UPDATE: LAW REFORM INQUIRY

When the Victorian Parliament's Law Reform, Road and Community Safety Committee commenced its *Inquiry into Illicit and Synthetic Drugs and Prescription Medication* all the way back in November 2015 expectations were high. Committee member and key driver of the inquiry, Reason Party leader Fiona Patten, has described it is "probably the most comprehensive inquiry into drug policy ever in Australia".

This was an opportunity to conduct a wide-ranging examination into Victoria's laws, procedures and regulations relating to illicit and synthetic drugs as well as the misuse of legal pharmaceutical drugs.

The question the committee was asking was a simple one – were these laws, procedures and regulations minimising drug-related health, social and economic harm or making things worse?

To get to the heart of what was working and what could be done differently, the committee decided to look at the practice of others states and territories as well as overseas jurisdictions like Portugal. No stone would go unturned in determining what Victoria's approach to alcohol and other drugs should look like.

The inquiry was exhaustive. The committee received 231 submissions from experts and stakeholders including peak bodies, the alcohol and other drug treatment sector and legal professionals. There were nine days of public hearings in Melbourne and Sydney and the committee travelled to Geneva, Lisbon, London, Vancouver, Sacramento and Wellington to speak to experts at the forefront of drug policy and law reform.

When the 680-page report was finally released in March this year it didn't disappoint. There are 50 recommendations providing a comprehensive road map for reforming Victoria's approach to prevention, law enforcement, treatment and harm reduction. The report recommends what many experts have long been advocating – treating all drug offences for personal use and possession as a health issue, not a criminal justice issue. It also features plenty of headline-grabbing suggestions including calls for pill testing at music festivals and changes to drug-driving laws as well as exploring alternative models for drug offences including Portugal's much publicised decriminalisation model.

When it comes to helping people who inject drugs, minimising the harm of intravenous drug use and the role of NSPs this report is based on sound expert opinion.

But what did the report have to say about people who inject drugs, the state of Victoria's needle and syringe programs and where improvements could be made? Quite a lot it turns out.

Given the proven success of pharmacotherapy treatments including opioid substitution therapy (OST), it is welcome news that the committee devoted considerable time to reviewing the state's medication assisted treatments for opioid dependence. The report calls for a dedicated unit to actively manage opioid substation therapy policy and explore an OST registry where people can seek information on current prescribers and dispensers.

Even more significantly, the committee recommends the Government fund opioid substitution dispensing fees to remove a major barrier to people accessing treatment. This investment can't come soon enough. Dispensing fees for drugs such as methadone and buprenorphine can cost $1 to $10 a day – a cost that for some people will be much more than accessing pharmaceutical opioids like oxycodone.

The report also suggests expanding access to OST through financial incentives to GPs and pharmacists, enhancing the role of nurse practitioners in prescribing the drugs and exploring models for hospitals providing OST to suitable patients as part of emergency room treatment.

There is plenty of news on the needle and syringe program front too.

The report calls for a review of the state's NSP programs to consider increasing availability where there are shortfalls (including after hours) and enhancing the capacity of the workforce to educate people who inject drugs about treatment and referral options.

The report also recommends that Victoria follow the lead of the Australian Capital Territory and remove the prohibition on peer distribution.

In terms of prisons, the report suggests offering screening for prisoners on release and exploring the feasibility of compulsory screening upon entering and exiting prisons. It also recommends monitoring such screening data and international practice to consider whether we should have NSPs in the state's prisons.

Naloxone features heavily in the report, with the committee calling for more effective distribution of the drug through NSPs and other community health services. The committee also wants naloxone to be more widely available in settings such as crisis and emergency accommodation and ensure it is in the hands of first responders to overdose calls in areas with high rates of injecting heroin use. The committee also recommends providing naloxone to prisoners with a history of opioid use on their release, a model that has worked successfully overseas in countries like Canada.

When it comes to helping people who inject drugs, minimising the harm of intravenous drug use and the role of NSPs this report is based on sound expert opinion. If even some of these recommendations are acted on it would make Victoria the most progressive state or territory in Australia on alcohol and other drug policy. The ball is now in the court of the Government. It has until late September 2018 to officially respond to the report, so watch this space.

John Ronan