anex bulletin
volume 10
edition 4

back to basics

a guide to the ABCs of NSPs

This edition is dedicated to the hundreds of health sector staff and managers that each year are new to Needle and Syringe Programs (NSPs). It's also a useful resource for people in health services, or pharmacies, who don't do NSP work but would benefit from knowing some of the basics.

Early butterflies is a normal feeling

The overwhelming majority of NSP workers come to the role without a strong understanding of illicit drug use. We interview two staff members who describe how they have gradually confronted their own perceptions of what NSP clients would be like.

Sophia is from a private sector book-keeping background. She is now a hospital admin worker in a small country town.

When did you first start giving equipment to clients, and what sort of introduction did you have?

It was probably within the first couple of months after I started working here, about eight months ago. I didn't get much of an introduction. It was pretty basic, really. We were trained up by the other admin staff.

What did you know about drug use before you started?

You hear of it from the general media and schooling and you hear people talk about it, but you never really see it or believe it. I'm really quite naïve about it all.

How did you feel when you first started?

It was very nerve-wracking. It's not very comfortable and not really a part of the job that I like the most. I'm a bit nervous about not knowing how people are going to be – are they rational? You know, I tried not to make eye contact with them, gave them what they wanted, the quicker the better.

Have there been times where you've made conversation with clients?

Not generally, although in the past week one person has come in and they are quite comfortable with making conversation. Mostly they just come in and perhaps they are a bit nervous, too: they're looking around, seeing who's going to know them, just asking for equipment and sticking it in their pocket and leaving. Some of them are quite held back and don't ask for much. And sometimes you even have to ask them twice because they talk quietly.

Do you make any efforts to help relax clients?

I'm as polite as I can be, I say goodbye and that's about it. It's become easier as time's gone by. It has just become kind of an acceptance rather than nervousness, and maybe that's because it's become part of the job now; or maybe I'm trying to think of it in a different way, that the hospital is trying to provide a service and people are doing things in a safe manner rather than focussing on some sort of stigma of it being a dirty, horrible thing.

How have your perceptions changed?

I suppose I thought that people would be very rough, very scary and hard to approach – maybe along the lines of the city people, where you see them homeless and stoned on the streets. Most of them, you could say, are basic, everyday people. Which is kind of scary because you can look at them and you wouldn't even think they participate in that lifestyle.

What would you like to know more about?

There's a lot that I don't really know 100 per cent. I don't really know where to go to ask. To me, it's a service where they come in and get what they want and leave. It's not my business or right to get involved.

There are records of what's being picked up and whether people are male or female, etc. I'd like to know what happens with that information, where it goes to and how it is used. It's easy for me to write on a piece on a paper that a male person came in yesterday at such at time and picked up 50 needles or whatever. But where does it go from there? What happens with it after that?

Have people asked you about this element of your job?

I had a chat with my family because they didn't even know the service existed either. They were a bit taken aback that a little town had a service like this and that many participated in it. They just asked if I was scared about doing it. It was very scary in the fact that everybody knows everybody's business and maybe they think that I could identify them. Do they think I could dob them in or publically acknowledge that they had a problem or something like that?

How important is it to explain about safe disposal?

I think it's very important, actually. I didn't know it existed and my family didn't know either, so maybe it's something that needs to be discussed a bit more –encouraging safe disposal so people know it's available and to show we are trying to make it safe for participants and the community as well.

Do many women come in?

Yes, but not very often, though. Some are pregnant. When you see them pregnant, you think, what are you doing? We are being a bit judgmental, but those things run through your head straight away. Also, are they the ones participating, or are they picking them up on behalf of somebody else?

Do many come in asking for lots of needles?

I haven't come across a person asking for a large amount, but I have seen cases where they come in three or four times a week. When you get an influx of people in a day (or a couple of days), it makes you think, is there something in town that everybody's got a whiff off all of a sudden?

It shows that obviously nobody is immune to it. Whether it's city or country, it doesn't matter where you're from or who you are. It's free and available to anybody. That's the scary part. It's interesting.

Are you more of a supporter of such interventions now?

Yes. I can say that quite confidently because at least I know that if somebody is going to do it regardless, you might as well try and make it as safe for them as possible rather than endangering themselves and other members of the community.

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Anex's vision is for a society in which all individuals and communities enjoy good health and well-being, free from drug-related harm. A community-based, not for profit organisation, Anex 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 part of the solution to drug-related issues.

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Layout and Design
Kontrast Design

Production
L&R Print Services

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/new/publications/anex-bulletin

ISSN: 1447-7483

February 2012

PROFILE:
Nicola Cowling

Nicola Cowling has been part of Anex's workforce development team for three-and-a-half years. Here she discusses how she came to work in the Alcohol and Other Drugs field, the melancholic consequences of dancing the Macarena, and the uplifting effect of being immortalised by a rat.

Your early work at Anex was in the era of 'ice'. How did that come about?

I initially started working with Anex on the National Amphetamine Type Stimulant (ATS) project at the height of the so-called "ice epidemic". There was a good deal of concern, some genuine, much fear mongering, regarding the use of ATS. Two months prior to starting at Anex I remember receiving a phone call from a local MP's office. A young man who I knew from Living Room (a Primary Health Service right in the Melbourne CBD) had asked the receptionist there if he could use their phone to call us. She called on his behalf. "What should I do with him?" she asked. I suggested she give him a train ticket and send him to Living Room. Her response was one of shock and disbelief. "But I can't do that! He says he uses ICE! He'll be a danger on public transport!"

Anex received funding from the Department of Health and Ageing to deliver practical, solution focused training sessions for frontline workers engaging with people who use ATS, such as crystal methamphetamine, otherwise known as ice. This project saw me travel to all the capital cities in addition to 20 regional and rural locations.

I was mindful not to contribute to the ice storm, so went about reading and researching everything I could find on the matter. And whilst I certainly learnt a lot from this process, it was through my travels around Australia that I gained the most practical, interesting and innovative information. From the heart breaking to the hilarious, I'm always delighted when someone in the group shares a story or experience as I think it is these stories that people remember.

Since the ATS project wrapped up, I have continued in the workforce development team, delivering NSP and related training in addition to other projects such as Motherhood and Drug Use; Young People, Drug Use and Employment and, more recently, Harmaceuticals.

Where have you worked prior to Anex?

For five years I worked in a primary health care service set up to meet the physical, psychological and social needs of people who inject drugs. I absolutely loved working there. The people who used the service were many and varied and generally bloody lovely. Many were sleeping rough and the service offered them a bit of respite from being on the street. This led to clients of the original street-based program naming the fixed-site service, The Living Room.

In my last three years at Living Room, I had the good fortune of managing the service. This experience highlighted for me the many benefits of offering a more holistic, multi disciplinary service. As the service developed, staff became increasingly enthusiastic and innovative in their work with a number of creative and engaging health promotion projects and activities. Similarly, service users were far better placed to address their health and social welfare needs in a 'one stop shop' environment. If we didn't have the service they needed, we had a dedicated team of staff to assist in finding the right service for them.

Before working at The Living Room, I'd been working in a drop-in service for young people sleeping rough in Dublin. The majority of the young people who came in were using or drinking on a pretty regular basis; most were using heroin with many on the methadone program. It was not unusual to see young fellas coming in with their green methadone cordial bottles in their hand. Given the harsh weather and grim financial situation in Ireland, they had to be pretty tough and quite shrewd to get by. They were also extremely well dressed, and the fellas in particular would queue up for the ironing board.

I'd never seen teenage boys ironing their clothes. One of the regulars told me if he didn't make an effort to look clean and well presented he'd be identified as homeless and would be stigmatised – and potentially even assaulted – as a result.

I've also worked in youth and adult residential detoxes and rehabs, as a residential detox assessments worker, on outreach as an NSP and drug safety worker – and I did the obligatory waitressing work in my youth.

How did you become involved in NSP work?

I came into the sector quite by accident. I'd worked in the disability sector for years. Several of the clients I worked with would drink alcohol or smoke cannabis, sometimes recreationally, but often out of boredom or depression, as well as dependency and self medication. I often felt frustrated by the lack of respect and support granted to the people I met as clients, as well as to the people who worked in that sector.

There are a lot of similarities between the AOD and disability sectors. With mention of either job, you'll always get some well-meaning, but ill-informed, types saying "Oh, that must be such depressing work." For me, working as a waitress in an American-themed restaurant, wearing an American-themed uniform and dancing the Macarena for customers' amusement: that's depressing.

As well as that, about 15 years ago nearly everyone I knew worked at YSAS (formerly known as Youth Substance Abuse Service) – I was tired of being left out of the conversation.

What changes have you seen over time?

I guess one change has been the increasing variety of drugs used, though it's possible I've just cottoned on to the true occurrence of polydrug use as I've become older and wiser. When I was doing assessments for detox nearly 10 years ago, I did assess individuals who ticked every box for drugs used. Today, though, it seems less common to meet people who use one type of drug exclusively.

The increase in the illicit use of pharmaceutical drugs is definitely a modern phenomenon and it brings with it, I think, a greater diversity of individuals accessing services. And, as the nation becomes increasingly body conscious, there seems to be an increase in the number and diversity of people using steroids.

In terms of treatment, I've seen small changes in how residential detoxes and rehabs operate as the sector recognises and responds to some of the shortcomings of previous practices and better meets the needs of people seeking assistance for problematic drug use. Changes such as step down programs from residential rehab, which offer less intensive support in the community setting, make the transition back to the stresses of everyday life a little easier. And of course, there's the big push for more holistic care of people with a co-existing mental health issues and substance use disorder. Here's hoping the very need for a "no wrong door" policy will become a thing of the past.

Finally, I've seen an increased focus on replacement therapies and pharmaceutical drugs specifically designed to reduce diversion (is there anything naloxone can't be married to?).

What are the challenges facing the sector?

I think an ageing population of people who use drugs may pose a challenge. Many of the people who access services already have multiple and complex needs. Whilst age may bring wisdom, it also has a tendency to bring chronic disease such as diabetes, cardiovascular disease and osteoarthritis, not to mention an increased incidence of chronic pain and an increased risk of impaired cognition. Consider the impact of reduced physical, psychological or cognitive health, plus a potential increase in prescribed medication, and you have a much more complicated clinical presentation.

"The increase in the illicit use of pharmaceutical drugs is definitely a modern phenomenon and it brings with it, I think, a greater diversity of individuals accessing services."

I think meeting demand for services, particularly pharmacotherapy, is another significant challenge. This is especially the case in rural and regional areas. To still hear stories of individuals being expected to travel two or more hours a day to pick up their methadone or bupe is disheartening. And, with an ever-increasing demand for opioid substitution therapy (OST), I think it's imperative that the sector makes increased efforts to address the discrimination and stigma faced by people on OST programs and people who use drugs in general.

One other little challenge is how to attract and retain quality staff in a sector that is more renowned for staff stress and burnout than remuneration, recognition or career pathways.

Was there a particular moment where you felt that your work was especially worthwhile?

I had a client name a pet rat after me once. That was nice.

AIDS spectre sparked NSP start-up

Dr Alex Wodak AM is soon to retire as Director of the Alcohol and Drug Service at St Vincent's Hospital in Darlinghurst, Sydney. Dr Wodak is one of the pioneers of harm reduction. He shares with Bulletin readers a reflection on NSP inception alongside some conclusions drawn from decades of compassionate work with people affected by illicit drugs.

In the beginning

Dr Wodak opened his reminiscences at the period in the mid-1980s when the first needle and syringe exchange was established. That was the breakthrough that led to the establishment of what we now know as Needle and Syringe Programs across Australia.

"It was in 1984, in inner Sydney, where it was thought that possibly 3000 or 4000 people had become infected with the HIV virus.

"This was an area where there were a large number of people injecting drugs, some of whom were men who had sex with other men. So there was the potential for overlap. There were conditions for the virus to spread from the gay community into the networks of people who inject drugs (PWID) and, from there, into the broader population."

Dr Wodak searched for information about needle and syringe exchanges abroad and saw that programs had already started in the Netherlands. Alongside colleagues and some injecting drug users, he realised that they needed to start a pilot.

They put together numerous proposals for permission and funding, but, explained Dr Wodak, after numerous applications "we realised we were being stalled and that the pilot would not be supported. We then decided to go ahead. We contacted diabetes organisations and found out where to get 1ml syringes (because that was the preferred size for drug injectors), and, using our own money, we began distribution."

That was in November 1986. It was a tense period as Dr Wodak was called in for questioning by police. "I had prepared myself for this eventuality by gathering a wealth of information about HIV among drug injectors from other places, such as New York. In the event, it was a very civil conversation and the police indicated they would not be pressing charges even though technically we were in breach of the law.

"The matter was discussed in the NSW cabinet, and when it became apparent that police would not be laying charges, it was clear that we would be able to continue with the pilot."

Other states followed very quickly, including Queensland under the then Bjelke-Peterson Government.

"So not only was I proud to have been involved with starting the first pilot, but I was also pleased that we were able to end it quickly because it became officially endorsed health policy shortly thereafter."

Know the facts and pitch emotions

Dr Wodak said that one of the lessons he learnt from those early days is still relevant to organisations considering introducing or expanding services into new sites today: this is to have sound arguments prepared when pressing a case. However, it is also important to recognise the emotional dimension of harm reduction.

"There is excellent evidence that NSPs work and save enormous public resources through disease prevention.

"But it is also important to understand and make clear that we are protecting future generations. If HIV was to spread throughout the community, as it has in many places where effective prevention has not been put in place, our children and our grandchildren would be at risk," he said.

Avoid complacency

Dr Wodak warned that Australians should not become complacent about HIV prevention merely because the country's transmission levels, as recorded in new infections, is extremely low by world standards.

He cautions against complacency partly because there will be no vaccine available in the foreseeable future.

"The HIV virus has many of the characteristics of other viruses that we have not been able to create vaccinations or cures for. It will be with us for many decades, perhaps hundreds of years, even after we have spent billions of dollars in research and applied some of the world's brightest scientific minds to create vaccines."

Coverage and scale

National hepatitis strategies and HIV prevention strategies, the National Drugs Strategy 2010-2015 and the National Needle and Syringe Program Strategic Framework 2010-2014 stress that increasing access to sterile equipment remains a core priority.

According to research, it is estimated that on average illicit drug users have access to approximately 200 sterile needles per year.

"It is important to reduce the time that any used syringe is in circulation: the longer it is, the more possibility there is for it to be shared. Therefore it's important to have enough syringes in circulation so that every episode of injection may involve a sterile needle and syringe," Dr Wodak said.

Treating NSP clients with dignity and respect

"It is important to know that many people who come into services are from very underprivileged and difficult backgrounds that have often involved trauma such as sexual, violent or verbal abuse.

"We need to remember that each person is a human being – someone's brother, sister, father, mother or cousin – and to treat them with human respect and acknowledge their dignity."

Pharmacotherapy patients as NSP clients

According to the annual Needle and Syringe Program survey, around half the people attending NSPs were on some form of pharmacotherapy while still collecting injecting equipment.

Many NSP workers can initially feel conflicted when they serve people who inject drugs, who are known to be on pharmacotherapy. It was important, said Dr Wodak, to understand that moving from regular injection toward reduced frequency (or even abstinence) is often an incremental process that involves relapse.

"Change among people usually comes gradually rather than in 'heroic' episodes. By that I mean that people tend to change behaviour over time. It could be thought of as being similar to a person who is faced with obesity," Dr Wodak said.

"I have a friend who explained that his goal was to become overweight. He was obese at the time, and he wanted to reduce his weight down to 'overweight'. If he did that, his next goal was to reduce it more to becoming 'normal' weight. We know that if people lose large amounts of weight fast, their chance for relapse is high."

Pharmacotherapy as HIV and hepatitis reduction

"Pharmacotherapy, such as when a person is prescribed methadone or buprenorphine, serves to stabilise people. It helps people either to move away from illicit drug use completely or to reduce their use substantially. Even if a person still sometimes injects while on OST, they generally do so far less frequently than if they were not."

Dr Wodak said evidence showed that needle sharing rates among regular and irregular injectors were similar, which meant that pharmacotherapy therefore had HIV reduction properties.

"If you reduce the number of instances of injection by a person, say from 50 or 60 times a month to 15, with the same sharing rates, the instances of risky sharing are reduced. There are fewer opportunities for the virus to pass between people. So pharmacotherapy has a proven HIV reduction quality."

The establishment of NSPs occurred during the atmosphere of the highly controversial grim reaper AIDS campaign.

Future challenges and new directions

When asked what he felt were some of the priority challenges for harm reduction (including NSPs) in Australia after 30 years of success, Dr Wodak began by suggesting that needle provision should undergo a form of deregulation.

"In some senses we have reached an almost saturation point in many of the health services. We should be aiming to have syringes available in commercial outlets – not just in pharmacies, but in places such as supermarkets, for example. People should be able to buy sterile equipment in the same way as they can buy other health products," he said.

Sterile fit each and every time of need

Dr Wodak believes that the policy should be that where illicit drug injection occurs, regardless of the setting, we should make it possible that it happens with sterile syringes.

He was also hopeful that more states and territories would take seriously the recommendations in national hepatitis C, HIV and blood-borne virus strategies that NSPs be trialled in correctional settings.

Promotion of in-prison NSP

"I think that there is no doubt that if HIV was to spread into injecting drug networks, and from there into the wider community, it would start within prisons," he said.

The key message is that the vast bulk of prisoners return to communities and that drug availability and injection practices in prisons were highly conducive to blood-borne virus spread.

"In contrast to prison inmates who have never used drugs, people who inject drugs generally serve more frequent and shorter sentences. About half of those who have injected drugs and are imprisoned will inject in prison at some stage, or even regularly.

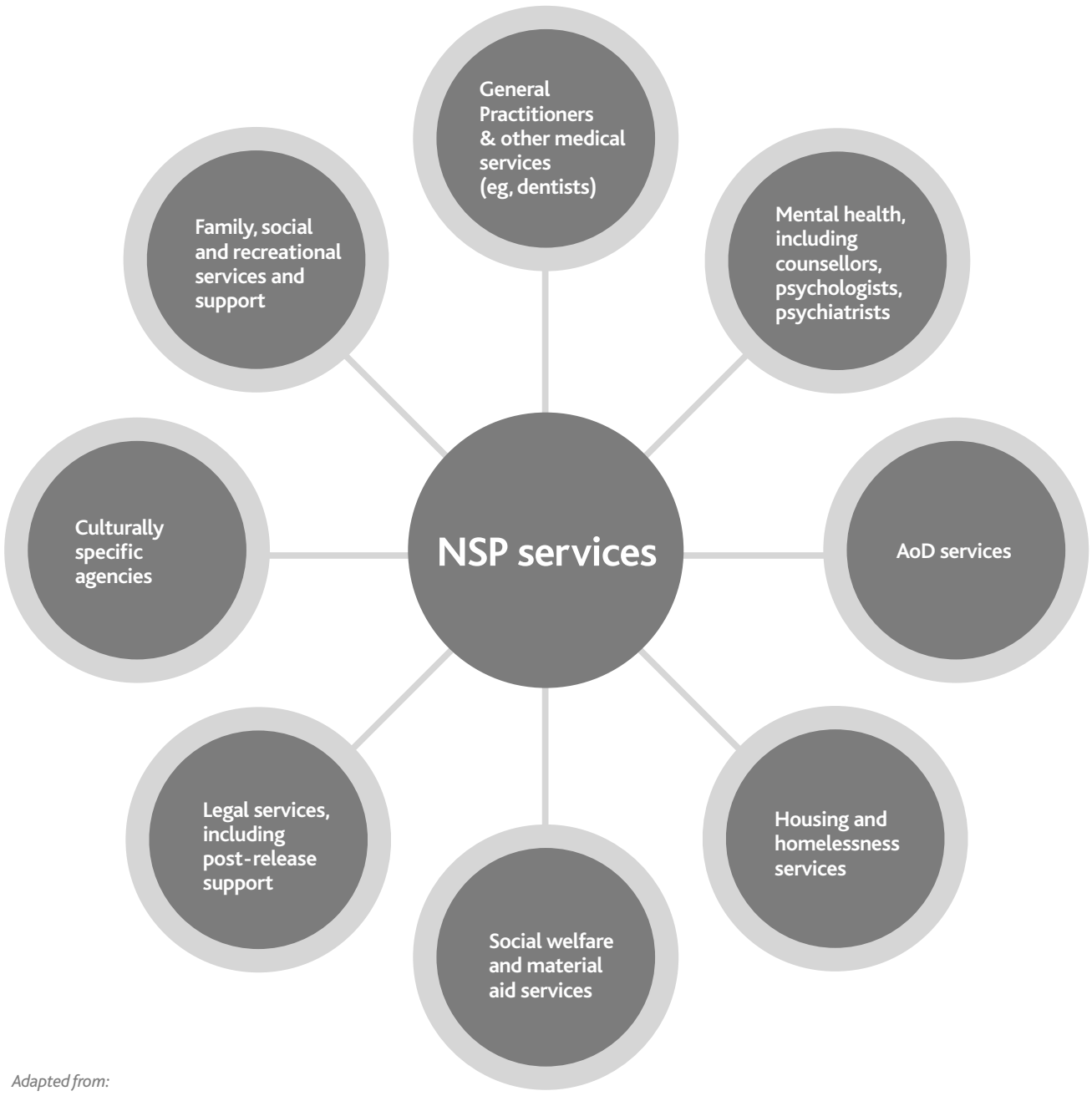
"The frequency of injecting in prison is much less than in the community, but each episode is far more dangerous for several reasons. On the outside, a person may not share at all or, if they do, it is usually with someone they know and trust, such as their partner. So their exposure to networks that potentially involve disease transmission is less.

"But prisoners tend to access and share drugs in groups. The very worn and much-repaired injecting equipment used in prison is also more conducive to HIV spread than those medical-quality syringes available in the community," he said.

Referrals

The health and welfare needs of clients can be many and varied. It is generally unrealistic for one service alone to meet the physical, psychological and social welfare needs of their client group.

Clients often require a multi-disciplinary approach to effectively address their needs. Ideally, NSP workers should have a sound understanding of effective referral steps. The following diagram shows typical referral options.



Adapted from: http://ndarc.med.unsw.edu.au/sites/all/shared_files/ndarc/resources/Ch9.pdf

Navigating the health and welfare system is difficult for anyone, but for individuals with co-occurring mental health issues, acquired brain injury or intellectual disability, assistance and support in doing this will often be necessary.

It should also be considered that many people experiencing drug or alcohol dependency may also be affected by depression, anxiety, reduced motivation and impaired cognition – all significant barriers to addressing one's own health and welfare needs.

One of the weaknesses in our systems is that it's easy for people to "fall through the gaps" once they've been referred to another service, particularly if it's external to the NSP service provider.

When working with clients who have multiple and complex needs, it is worth considering what level of support they will need to ensure they don't get lost in the system.

It is also important to remember that while some clients may benefit from a referral to an external service, they may not be ready for such intervention. Effective referral, like any other intervention, can be a gradual process and must be directed by the individual needs of the client, preferably as prioritised by them.

To force a referral is to risk alienating the client, and this should be avoided unless they pose a risk to themselves or others.

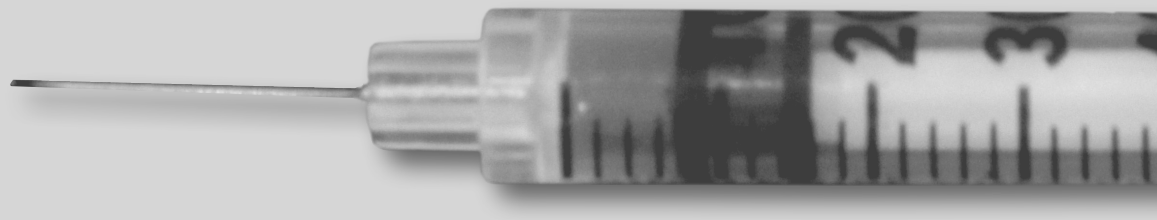
Referral tips for NSP workers

- Develop and maintain links with a range of relevant services, either within your own organisation or others in your own community and/or in other places.
- Ensure your knowledge of the service you are referring to is as accurate and up-to-date as possible. If you don't have access to lists of options, ask a manager to get one.
- Always obtain client consent before sharing any information.
- If possible, assertive follow up of any referrals should occur.
- If referring a client with multiple or complex needs, active (not passive) referral is the preferred process.
- Develop referral guidelines with services that you or your colleagues contact regularly. Guidelines developed by those who actually use them are more likely to have a positive impact on referral outcomes.
- Referral potential can be greatly improved when several services are provided on one site, either through co-location or visiting services (eg, out-reach/out-post).

Referral tips from experienced frontline workers

- "If you don't know much about the service you want to refer to, it's generally better to phone and talk to someone there rather than checking internet sites or referral directories that may be out of date. There's nothing worse than sending a client off to a service, only to find that they're not eligible or the service required is not currently available."
- "My best referrals have always been to services where I've got to know the staff there. Once you have a bit of a rapport with a few staff members, you have much better success with the referral. It means you can recommend the staff to your client, you have inside knowledge on how the service operates and you can maybe help that service out when they're looking to refer back to a service like yours."
- "Written referrals are useful but they can sometimes paint a pretty negative picture of the client. With my client's permission, I sometimes call up the service and tell them a bit about the client – about their strengths as well as their weaknesses."

Important tip



SIZE DOES MATTER

Most NSPs provide a variety of large and small needles and syringes to cater for different types of drug use.

The choice of which needle (tips) and syringe (barrels) to use for injecting depends on a range of factors including accessibility, what drugs are being injected, how many people are going to share the drug solution, how the drugs are injected (e.g. into muscles or veins) and the condition of the veins.

The gauge of a needle refers to the diameter of the hole (bore). The higher the number, the narrower the hole in the needle. For example, a 27-gauge (27g) needle is a lot narrower than a 19 gauge, which is wide in comparison.

Ideally, people should use a narrower needle (27g to 29g) when injecting. The more narrow the needle the smaller the hole made in the vein, therefore less damage.

Many injecting drug users, especially those who have begun injecting more recently and those who still have good veins, prefer more narrow needles (such as 27g) because they are generally less painful and cause less vein damage.

People who have been injecting for longer may prefer wider-bore needles, such as a 25g, because they are less likely to bend when pushed through thick scar tissue.

While using the narrowest needle possible is generally the best option in terms of limiting vein damage, it can be more difficult to push the drug mix through the finer-gauge needles, with the possibility of the syringe becoming blocked. That is one of the reasons why it's important to carefully filter intravenous drug solutions.

There is a range of syringe (barrels) sizes available, and preference usually depends on how much water is required to dissolve the drug and what the final volume of the solution will be.

Drugs that dissolve easily in a relatively small amount of water, for example heroin, will generally require only a small barrel (e.g. 1ml), while drugs that do not dissolve easily (e.g. pills such as MS Contin®) will require a greater volume of water and therefore a larger barrel e.g. 5ml.

Steroids or hormone injections are typically injected into muscle tissue. The length and gauge of the needle will generally be bigger as steroid solutions are usually too thick to pass through narrow needles. Needles must be long enough to pass through the skin and fat layers to reach into the muscle. Steroid use often involves larger volumes of fluid and so requires larger barrels also.

Other equipment your and other NSPs may stock

Alcohol swab – Injecting drug users can use alcohol swabs to clean the injection site on the skin before injecting. Swabs may also be used to clean fingertips and injecting paraphernalia such as spoons to minimise transmission of bacteria, viruses and fungi.

By distributing these swabs to clients, NSPs can help to protect injecting drug users against abscesses and other bacterial infections.

Condoms/lube - To encourage safe sex practice.

Dental dams - These are thin latex squares held over the vaginal or anal area during oral sex. They act as a barrier to help reduce the risk of STIs that can be passed on through skin-to-skin genital contact such as genital warts and herpes.

'The choice of which needle (tips) and syringe (barrels) to use for injecting depends on a range of factors including accessibility, what drugs are being injected, how many people are going to share the drug solution, how the drugs are injected'

Hirudoid cream - This can be used to relieve pain and encourage healing in veins that have become inflamed due to repeated injections.

Sharps disposal containers - NSPs offer these containers to drug users so that they can safely store their used equipment and safely transport them to safe public disposal points or an NSP collection point.

Filters – Filters are used to reduce the risk of potentially harmful agents entering the veins. This includes:

- large particulate matter (e.g. starch, talc, wax from tablets)
- bacteria
- fungal spores

Filtering reduces the risk of vein damage and 'dirty hits' (an experience where drug users feel extremely sick rather than euphoric). Small pieces of swabs, cotton wool, and tampons, as well as roll your own cigarette filters, are often used as drug filters, but these are not sterile and don't filter all the harmful things that don't dissolve. Some NSPs provide sterile filters - these let the drug through, but reduce impurities such as fungal spores, bacteria or 'filler' from entering the blood stream. If not filtered, these impurities can lead to collapsed veins, and infections such as abscesses.

Sterile water - Some NSPs provide free or low-cost (around 50c) individual sterile water ampoules to reduce the risk of infection from bacteria, fungi, viruses and other contaminants associated with sharing water or using untreated water.

Tourniquet - If people are having difficulty finding a vein, putting a tourniquet on can help. Tourniquets are not to be applied so tightly that they restrict the flow of blood into the arm as this makes the veins thinner. They must be released as soon as a vein is reached. If not, the drug will often leak out around the needle and cause a miss.

Wheel filters - Wheel filters are small, single-use filter units designed to fit between the needle and syringe. They help to filter out impurities such as the chalk, wax and other substances added by manufacturers to bind tablets and make them easier to swallow. Different gauge filters will filter out different size particles. A larger gauge filter such as, for instance, a 5 or 1.2 micron is effective in filtering particulate matter from tablets such as binding agents. The smallest gauge available, the 0.22 micron, can filter out bacteria from the drug mix.

None are able to filter out viruses, however. While wheel filters are the most effective, other more common types that are used include cotton wool, tampons and cigarette filters (the use of filters from tailored cigarettes is not recommended as they contain numerous chemicals and, if used, bacteria too; filters bought for rolling tobacco are the preferred option).

It is important for injecting drug users to thoroughly wash their hands before handling filters to minimise the risk of bacterial and viral contamination.

Winged infusion set or "butterfly" – These have two plastic 'wings' that rest above the needle holding it in place. Attached to the needle is a long thin tube through which the drug solution passes.

These are generally used by people who are injecting large amounts. Methadone injectors often prefer to use butterflies also. Once the butterfly is inserted, the barrel can be changed without having to remove the butterfly. It enables larger solutions to be injected slowly, reducing the risk of damaging the vein.

They may also be used by individuals who have thin "rolling" veins that are difficult to access with a standard needle and syringe. The needle is held by the "butterfly wings" and placed into the vein. The wings allow the injecting drug users to grasp the needle very close to the end, ensuring greater accuracy.

Pillars of Harm Minimisation

Harm Minimisation

There is sometimes confusion about the difference between harm reduction and harm minimisation. Internationally, harm minimisation and harm reduction are generally interchangeable terms. However, in Australia the specific policy and activities of harm reduction are facets of harm minimisation.

It is easiest to view harm minimisation as an overarching or umbrella concept, comprising the following three pillars identified through successive Australian National Drugs Strategies.

PILLAR ONE	PILLAR TWO	PILLAR THREE
SUPPLY REDUCTION	DEMAND REDUCTION	HARM REDUCTION
To prevent, stop, disrupt or otherwise reduce the production and supply of illegal drugs; and control, manage and/or regulate the availability of legal drugs. Eg: customs and police agencies seize drug imports, or police bust methamphetamine labs.	To prevent the uptake and/or delay the onset of use of alcohol, tobacco, illegal and other drugs; reduce the misuse of alcohol, tobacco, illegal and other drugs in the community; and support people to recover from dependence and reintegrate with the community. Eg: drug education in schools, drug treatment.	To reduce the adverse health, social and economic consequences of the misuse of drugs. Eg: Needle and Syringe Programs that prevent disease and injection-related infections, as well as help people access other social services.

People who work in NSPs are often involved with both Demand and Harm Reduction when serving and supporting people who may be involved with drug treatment, but also use illicit drugs occasionally (or even regularly).

Drug types and their potential effects

Drug	Potential physical effects	Potential psychological effects
STIMULANTS Stimulate the central nervous system, speeding up the messages going between the brain and the body. Most effects are the result of an increased availability of dopamine and, to a lesser extent, adrenalin, noradrenalin and serotonin in the brain.		
• Amphetamine (speed)* • Methamphetamine (ice, crystal meth, base)* • Dexamphetamine* • MDMA (ecstasy)# • Paramethoxyamphetamine (PMA) • Cocaine • Phentermine (weight loss medication) • Methylphenidate (Ritalin, Concerta, Attenta)	Fight or flight symptoms* (increased heartbeat, increased temperature, increased blood pressure, increased breathing rate, increased energy, decreased appetite, wakefulness, dilated pupils) Sexual arousal Sleeping difficulties Increased sweating Dry mouth	Increased alertness and focus Euphoria Confidence Lack of inhibition Anxiety/irritability Panic attacks Jitteriness/edginess Suspicion/paranoia Increased empathy#
Nicotine	Altered heart rate (usually increased) Increased blood pressure Increased, shallow breathing Arterial constriction Increased clotting tendency Headaches Dizziness Dry mouth Sleep disturbances Increased metabolism	Relaxation Increased alertness and focus Reduced anxiety Irritability
Caffeine	Headaches Heart palpitations or increased heart rate Wakefulness Sleep disturbances Restlessness Increased urination	Increased alertness and focus Anxiety/irritability Nervousness
DEPRESSANTS Depressants relax the Central Nervous System, slowing down the messages going between the brain and the body. Their effects can vary greatly, depending on the type of drug, the amount taken and the health and tolerance of the individual taking them.		
Benzodiazepines (Valium, Xanax, Serepax etc)	Drowsiness, sedation Slurred words or stuttering Blurred or double vision Dizziness	Feeling of well being Relaxation Reduced anxiety Confusion Difficulty concentrating Mood swings Short-term memory loss and "blackouts" Impaired judgment Paradoxical stimulant effects
Opioids (heroin, morphine, oxycodone, codeine, fentanyl, methadone etc)	Reduced heartbeat Reduced breathing rate Sedation Pain relief Nausea Vomiting Pinpoint pupils Itchiness Constipation Impaired fertility	Feeling of well being Relaxation Reduced anxiety Confusion Poor concentration
Alcohol	Slowed reflexes Impaired motor control Slurred speech Nausea Vomiting	Increased confidence Relaxation Loss of inhibitions Impaired judgment Emotional volatility Memory loss and "blackouts"
Cannabis	Increased appetite Altered sensory perception Impaired coordination Low blood pressure Lower blood sugar levels Reddened eyes	Relaxation Loss of inhibition Affected thinking and memory Decreased reaction time Confusion Restlessness Hallucinations Anxiety or panic Suspicion or paranoia Detachment from reality
HALLUCINOGENS Hallucinogens cause subjective changes in perception, thought, emotion and consciousness.		
• Lysergic acid diethylamide (LSD) • Psilocybin ("magic mushrooms") • Dimethyltryptamine (DMT) • 4-bromo-2,5-dimethoxyphenethylamine (2-CB) • Phencyclidine (PCP) • Mescaline (can be synthetic or found naturally occurring in Peyote cactus) • Ketamine (a dissociative anaesthetic)	Blurred vision Increased heartbeat Increased blood pressure Increased body temperature Sweating Dizziness Impaired coordination Nausea and vomiting Some hallucinogens can cause suppressed breathing (eg, ketamine)	Euphoria Relaxation Distorted sensory processing &/or sensory hallucinations Distorted perception of time, space Confusion Poor concentration Paranoia and suspicion Agitation Anxiety or panic

The information in the tables above are compiled from Anex training materials.

NB: The effects of different drugs are subject to numerous factors, including:

- the dose
- the source
- other drugs (including prescribed) used simultaneously
- route of administration
- individual's height and weight
- individual's physical health
- individual's psychological health
- individual's tolerance
- individual's past experience of use
- setting/environment for use

Preventing needle stick injury and community safety

Transmission of blood-borne viruses

Pathogens transmitted via the blood-borne route are many and varied, but, in terms of needle stick injury, blood-borne viruses (BBV) such as Human Immunodeficiency Virus (HIV), hepatitis B (HBV) and hepatitis C (HCV) generate the greatest concern.

Unfortunately there is a common public perception that needle stick injuries in the community pose a significant risk of BBV transmission. A needle stick injury can undoubtedly cause much distress and anxiety. However, while such an incident should be taken seriously, it is important to understand that there is a very low risk of disease transmission.

To date, there is no recorded case of HIV or HBV transmission from a needle stick injury in the community setting. Indeed, there have only been three cases worldwide of HCV transmission from a discarded needle to a member of the general public in a public place.

A documented transmission is defined as: the exposed individual tests negative for the BBV immediately – or soon after – the needle stick injury but, three-to-six months later, tests positive but there have not been any other risk factors for the BBV transmission.

If the sharp involved in a needle stick injury has been in contact with dirt or soil – eg: left on the ground - the person's tetanus vaccination status should be confirmed and tetanus prophylaxis offered if required.

The administration of Post Exposure Prophylaxis (PEP) medication to reduce the risk of HIV transmission is not a trivial undertaking as the antiretroviral drugs used are associated with potentially adverse side effects.

Access to HIV post-exposure medication is currently restricted and usually limited to major hospitals.

Given the extremely low risk of BBV transmission, HIV and HBV prophylaxis are not recommended for community needle stick injuries unless there are significant contributing factors such as a deep injury from a needle/syringe that is visibly blood-stained and appears to have been only recently used.

Such a scenario is unusual; nevertheless, if the exposed person is not immune to hepatitis B, it may be appropriate to consider a vaccination. Even if a person has already been vaccinated they should have their immunity levels checked and a 'booster' given if required.

How to dispose of needles and syringes

1. Take the sharps container to the needle(s), not the needle(s) to the container
2. Place the container on a stable flat surface, so you don't need to hold the container steady with your hands
3. Pick the needle/syringe up from the plunger end
4. Place it into the container "needle end" first (without holding on to the container with your other hand or against your body)
5. Wash your hands following disposal

Important Points

- BBV transmission can only occur if the blood from a virus-positive individual enters the blood stream of another individual
- needles should never be recapped, bent or broken by hand, removed from disposable syringes or otherwise manipulated by hand
- exposure to intact (unbroken) skin does not pose a risk for BBV transmission

Commonly asked questions from new staff in secondary NSPs

With close to 20 years in the alcohol and other drug sector, Anex trainer Crios O'Mahony addresses some of the most commonly asked questions he fields from those who are recent additions to NSP teams. (For those wondering how to pronounce Crios, it's Irish and its equivalent is Chris.)

Is it alright to give one person a lot of needles?

Yes, it is alright. I still do NSP work and people often ask for large numbers of needles.Every time someone injects it's best that they use a new needle to prevent:

- sharing needles and increasing the risk of contracting a blood-borne virus or other infection
- reusing needles that may have blunted or gathered bacteria, increasing the risk of vein damage and infection (including abscesses and blood poisoning)
- reusing a needle that may have become mixed up with another person's needle in a group situation.

NSPs should promote the idea of planning ahead to make sure that 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 that people often get syringes and needles for other people who, for one reason or another, don't go to the NSP themselves.

When someone asks for extra syringes it's good to offer them enough disposal containers and to remind them that the NSP will take back used injecting equipment. The Western Australian system works a bit differently from elsewhere in the country. The WA Substance Users' Association Inc (WASUA) and the WA AIDS Council operate Needle and Syringe Exchange Programs (NSEP) where you can exchange used syringes for new ones. If you don't have used syringes, you can buy them and return them when they're used in exchange for new ones. The other Needle and Syringe Programs in WA aren't licensed to take back used syringes, but provide new injecting equipment to clients.

Am I encouraging people to use drugs by giving out needles?

No, you are helping people who inject drugs and other people in the community to stay safe. NSPs reduce many of the harms associated with injecting by providing new injecting equipment. 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.

Can I give needles to a pregnant woman?

Yes. Using drugs does not make someone a bad parent, and pregnant women are advised not to radically change their drug use without the help of an experienced medical professional. 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.

There is also the possibility that a pregnant woman is collecting injecting equipment for someone other than herself.

Why are some clients so impatient?

We can all be impatient sometimes. Unfortunately people who inject drugs experience a lot of stigma. 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 the doctors', dentists' and bus stops.

How do I start a conversation with someone coming into the NSP so they feel more comfortable?

The same way as you would start a conversation with anyone coming into the service. NSPs are just one of many services provided by agencies and the people who are accessing the NSP may well be accessing different services at the same site. Consider how you would like to be treated."

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

There are plenty of things you can do; 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. NSPs should have a list handy of available services or a phone number where someone can get counselling, information and referral. The Alcohol and Drug Treatment Information Network has a listing of services in each state http://www.adin.com.au/content.asp?Document_ID=38#act. Most NSPs in places like health services are staffed by admin people or receptionists who aren't expected to provide drug treatment, but are able to refer people to support agencies and provide NSP stock information and pamphlets.

How do I get different types of syringes if people ask for them?

You can order a range of different injecting equipment on the Needle and Syringe Program stock order forms. If you don't have a particular piece of equipment, you can also refer people to a primary NSP which will have a wider range of needles and syringes and may also have other injecting equipment like tourniquets, pill filters and sterile water available either free of charge or at a small cost. Primary NSPs also have workers who have knowledge of the health issues around injecting and advice on reducing injecting related risks.

How can I tell my friends that giving needles to someone isn't a bad thing?

NSPs are a proven health service that reduce the risks of blood-borne viruses and offer information and referral options to help drug users and others in the community stay safe. Between 1999 and 2009, NSPs averted more than 32,000 HIV infections and 97,000 hepatitis C infections.

In that time, every dollar spent on NSPs has saved $4 to the health system in avoided treatment costs. Helping people to look after their health is a good thing.

CLIENT FEEDBACK COMMENTS

This is about the only place I do actually feel comfortable just walking in... not judgmental as such and pretty much everywhere else I've gone has always been (judgemental) ever since I can remember.

You're doing a great job. You're all legends.

I have never met people that help you like this and make you feel welcome. I can come and talk to people in this room, it is hard to open up, but now I can break down and cry if I need.

They tell you information about what services are available and what is going, you know, like if there is a food van round the corner.

It's great. We'd have to share needles and get HIV if there were no needle exchanges.

There should be more things given out for free. Water costs money but it should be free.

I used to share fits until one of the girls working in the exchange told me about hep C. I still share them if I'm really stuck, but most of the time I don't.

I was having trouble with my kids, the staff suggested a couple of different people to talk to... lawyers and things like that so it's not just the needle program thing that they'll tell you about.

Well even though you walk in and everybody knows what you're here for they don't treat you any different. You're just treated like someone else that comes in, you know, they're always nice they're always happy.

Half of the people who I know don't use NSPs. People give them [needles and syringes] to other people. Services are not discreet enough and they (clients) do not like being labelled, this is the biggest problem.

People who live on the streets can't carry 199 needles around. I used [the service] because I have bought from chemists in the past, but they looked down on me so badly.

You can come here and get fits and condoms and help. No one ever looks at you as if you're a junkie.

The needle exchange is a life saver. I'd be dead or have a disease if it wasn't here.

Early butterflies is a normal feeling

Part 2

Jacki is a worker in a large regional health service. Before joining the sector as a family support worker, Jacki had a background in parenting programs. The NSP is part of her job.

Prior to working in the sector, what did you know about drug use, and where did you get that information from?

Before joining the team, my idea of drug use was probably illicit drug use, and a lot of what I knew was from the media. I wasn't used to thinking of my own alcohol and coffee as – I mean, I'm a drug user. I say that now, but, when I first joined, if I thought of a drug user it was someone with a problem with illegal drugs. I wasn't even aware that there are people who have problems with prescribed medications.

What were trickiest parts to learn about?

I didn't realise people crushed up pills to inject them. The nurse in the team talks about it and we have recently introduced wheel filters because apparently it helps filter out all the crushed up bits. I had no idea about that. The different needle sizes took me a little while to get used to. If people asked me something, I would just go, "Wait, I'll go and ask somebody else." Most people had been there before and knew what they were looking for and would help themselves.

A male came in once and asked about steroids. I had to get a colleague who asked him "are you injecting?", "where are you injecting?" and "did you know you can inject in the upper part of your buttocks?" I didn't actually know that, so it was helpful for me as well.

Is conversing with clients one of or the most difficult parts of your work?

Probably, because I don't feel confident about how to do that and I don't feel fully confident about the advice I would give anyway. Once, when I asked someone "what are you injecting?", the look he gave me was quite defensive. He was kind of like "what do you want to know for?"

I didn't know where to go with that. I said, "This doesn't go anywhere, I'm not reporting it; but are you crushing up stuff? Do you need a filter?" That didn't instil confidence in me to keep on asking people what they're injecting.

How have your perceptions about drug use and users changed?

Initially I thought that they would be stereotypical 'junkies'. And while some obviously have poor dental hygiene and look like they haven't showered for days, there are equally as many people who look like your average person you'd pass in the street and would never suspect. I've even had one young woman that came in wearing nursing student uniform.

What's your approach to make clients – newish ones – feel comfortable?

Smiling, being friendly and giving them the same amount of respect as you'd give anyone. Treat them like normal people, because they are. And, trying to see that the service I give them is no different from what I provide to anyone else who comes in to our health organisation. It's fairly natural that I treat everyone with a level of respect. It has taught me that you can't make judgments about people. Well, it's not helpful to, anyway.

What about referring people to drug treatment?

A couple of people (males) have said "I really need to do something about this, cause it's getting out of control and I want to change, stop, cut down or whatever." I've replied that we can take your name down at intake and you can get in with one of the counsellors here. Both times they were open to the idea. Our process is that they have to contact the intake worker to organise it.

Perhaps at our next team meeting I could ask about that. If we do have someone at the NSP keen to link in, can we have someone at intake contact them, rather than leave it for them to contact us? That's been a point of contention recently, because one of our workers said it would be good, at the point when a person is presenting almost at crisis, to get them linked in straight away.

How do you explain this work to other people, friends or family?

That is one of the things I've noticed. Before I was doing parenting programs and now I say I work in the drug and alcohol team. The reaction is quite different, ranging from "I could never work with people like that", to a certain look on people's faces. Before, they might ask what I do, whereas often now they won't say anything.

What would you say to a person who is a recent addition to an NSP program?

To not be scared of clients: people with drug problems are still people at the end of the day. Be friendly and polite and courteous and respectful. That's the best way of engaging and developing that trust. It could be that the NSP is the only service they are using, but if they have a good contact there then it may be the foot in the door to whatever other services we can provide.

KEEP UP THE GREAT WORK

Hepatitis B prevention should become an integral part of NSP operations, according to Professor Michael Kidd AM who is Chair of the Australian Government's Ministerial Advisory Committee on Blood Borne Viruses and Sexually Transmissible Infections.

The country's first specific hepatitis B prevention strategy, which was released by the Health Minister in 2010, rates people who inject drugs as a priority target population and Prof Kidd believes that NSP services should be given opportunities to play a far greater role in carrying that strategy out.

"Hepatitis B is a serious disease and it's preventable. The work of NSPs is really important in reducing hep B transmission – as it is for reducing hepatitis C and HIV," Prof Kidd told The Bulletin.

"Their role may expand (and I hope it does) so that they become an important part of education, raising awareness and encouraging those who haven't been vaccinated to get vaccinated."

The professor's vision for the wider role of NSPs corresponds to one of the hepatitis B strategy's priority action areas, namely "to develop education on chronic viral hepatitis B for medical practitioners, nurses, pharmacists, other healthcare workers, interpreters and people working with communities most affected".

The availability of a vaccination means that NSPs can play a direct prevention role, not only by encouraging safer injection practices and continuing expanded equipment distribution, but also by promoting and even delivering (where possible) vaccinations themselves.

"An estimated 160,000 people – perhaps even more – are living with chronic hepatitis B in Australia. It is a vaccine-preventable disease. "If we had vaccine prevention working as well as it should be we would have nobody with hepatitis B. The challenge that we have is the large number of adults who have not been vaccinated (which contrasts with the very good coverage in childhood immunisation).

"So there is a need to raise awareness and to have everybody who maybe is at risk of contracting hepatitis B vaccinated," he said.

National Needle and Syringe Strategic Framework

Prof Kidd also shared his thoughts about National NSP Strategic Framework recommendations concerning workforce development.

The NSP Framework recognises that many people working directly with clients, particularly those in secondary services and pharmacies, have not had sufficient training. It states that there is "considerable workforce turnover" and that "investment in training must be constant to address the orientation and further training needs of new personnel".

When The Bulletin asked Prof Kidd if he thought it was important, as the Framework suggests, for a more standardised curriculum for NSP training to be developed, he agreed and said that he favours a "bottom-up approach" through which clients and NSP staff, including those for whom needle exchange is not a primary task, are encouraged to help identify training areas that need more attention.

"The people who are working in the sector are in the best position to say 'here's the training we need, here are the areas that do need some standardisation and here are the areas where we do need to maintain flexibility because of context-specific issues'.

As Australia is a highly urbanised nation, the bulk of NSP distribution is through metropolitan services. However, Prof Kidd suggested that there should be recognition of regional and rural drug trends and that workforce development should reflect them.

"The impetus should come from people who are working in NSPs, and, you know, Anex does this brilliantly: you bring people together. People from the grassroots need to come together to share what's happening in different sites around the country and come forward with recommendations about what needs to change. And, frankly, this has been one of the successes of the past 30 years."

Professor Michael Kidd AM

Key aims in the NSP Strategic Framework are:

To develop national standards to guide NSP practice for future implementation

To increase the availability of needle and syringe equipment by increasing NSP hours and sites

To improve data collection and reporting systems to clarify who is accessing NSPs and uncover gaps in current NSP service delivery

To strengthen the evidence base for peer education

To develop and implement a nationally consistent training model for NSP workers

To regularly assess the effectiveness of NSPs through evaluation of the direct and indirect effects of NSPs and their impact on the prevention of drug-related harms