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Cover image: Bunbury NSEP worker Kevin Winder (see page 16) Picture by Ben Yew

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Welcome back to the Anex Bulletin

After a two-year hiatus, we are thrilled to once again connect Australia's Needle and Syringe Program frontline workers.

For a long time, the *Anex Bulletin* was an essential information resource for NSP staff and a forum to share stories of people and places from across Australia. We intend to continue that tradition.

The *Anex Bulletin* aims to canvas a range of NSP-related issues and keep harm reduction workers up-to-date with new information and research findings. It has been funded by the Federal Department of Health for four editions over the next year. For the first time, it is being distributed in an electronic format but print-friendly, so please print for your colleagues and forward.

My ambition is to build on the *Anex Bulletin's* rich history of nurturing connections within a community of workers that is disparate in terms of geographical location, but one with shared aspirations.

The *Bulletin* has a long history: it was funded by successive Australian Governments from the publication's launch in 2002 until August 2014. During that time, it was the only regular publication researched and written specifically for people working in NSPs in Australia.

Likewise, Penington Institute has a rich background. An independent drug research, training and education organisation officially launched in 2014, it grew out of the vibrant work of Anex (Association of Needle Exchanges), a body that forged close to 20 years' experience working with people directly affected by problematic drug use.

Our thanks to the many people who advocated for continued funding of the *Anex Bulletin*.

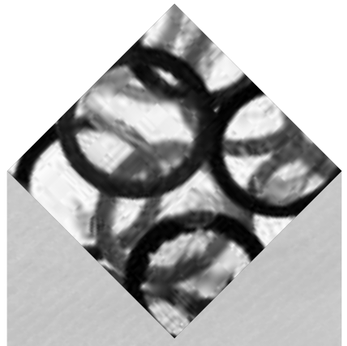
John Ryan,
Chief Executive Officer,
Penington Institute
Editor-in-Chief, Anex Bulletin

PENINGTON INSTITUTE

Penington Institute advances health and community safety by connecting substance-use research to practical action. We strive for a supported and effectively resourced NSP sector that is perceived as being part of the solution to drug-related issues.

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. With over 20 years experience, we not only help individuals, but also the wider community through our research analysis, promotion of effective strategies, workforce development and public awareness activities.

Penington Institute promotes and supports Needle and Syringe Programs (NSPs) and other evidence-based approaches.



In brief

Australian NSPs need priority, says report

Services such as Needle and Syringe Programs need priority to help meet national prevention and treatment targets, says a new report.

The National Blood-borne Viruses and Sexually Transmissible Infections Surveillance and Monitoring Report, 2015, produced by the Kirby Institute, found that Australia has not met government-set targets on hepatitis C prevention and treatment.

The report said that, overall, the data emphasises the "continued need to prioritise prevention programs such as needle and syringe programs, and opioid substitution treatment, as well as the need to increase the proportion of people accessing treatment, in order to reduce HCV-related burden of disease and deaths".

According to the report, a greater number of needles and syringes was distributed in 2014 than in the previous year. In 2014, the proportion of people who inject drugs attending needle and syringe programs who reported re-using another person's used needle and syringe (receptive syringe sharing) in the previous month was 16 per cent, similar to the 15 per cent proportion reported in 2013, and over the past 10 years.

The per capita number of needles and syringes distributed annually remained steady between 2013 and 2014 at 2.8 per capita among those aged 15 – 64 years. This equates to 44 million needles and syringes distributed, an increase of 12 per cent from 2.5 per capita in 2005 when 34 million needles and syringes were distributed

The incidence rate of hepatitis C, based on repeat testing from participants in the Australian Needle and Syringe Program Survey, declined annually between 2005 and 2009 from 14.3 to 4.0 per 100 person years, but has been increasing since 2011, to 21.4 per 100 person years in 2013. Data for 2014 are not available due to the method used to calculate incidence.

In June 2014, Australia's federal, state and territory health ministers endorsed five new National Strategies for hepatitis B, hepatitis C, sexually transmissible infections (STIs), and human immunodeficiency virus (HIV) together with a *National Aboriginal and Torres Strait Islander BBV and STI Strategy*.

The strategies set targets to improve testing, treatment and uptake of preventative measures and to reduce the impacts these infections cause.

http://kirby.unsw.edu.au/sites/default/files/hiv/resources/NBBVSTI%20Surveillance%20and%20Monitoring%20Report%202015.pdf

Russian HIV rates skyrocket

The Kremlin is continuing to reject preventative approaches to curb Russia's spiralling HIV epidemic. According to the *Canadian Medical Association Journal*, there were 93,000 new HIV cases in Russia in 2015, with most new infections coming from injecting drug use and heterosexual sex. A million people in Russia have HIV, including almost one per cent of pregnant women, which is the threshold for a generalised epidemic in the country of 143 million people.

According to the *Journal*, harm-reduction approaches such as needle exchanges, methadone replacement therapy and promoting condom use have reduced rates of HIV infection in bordering countries, including Ukraine, which has a longstanding HIV epidemic.

"But, for the Kremlin, harm reduction is off the table," the *Journal* reports. A recent report from a Kremlin-backed research institute recommended a categorical refusal of harm reduction, seen as inconsistent with the "Russian model" of fighting HIV.

"One of its co-authors claimed that promoting condom use encourages people to have sex, and argued that the best form of protection against HIV was to 'be in a heterosexual family where both partners are loyal to each other'.

Sweden crisis

Drug-related deaths in Sweden have skyrocketed over the past 20 years, says a new report.

According to The Local, there were 92.9 deaths per million Swedes in 2014 compared with the European average of 19.2 deaths per million.

Local authorities say they are stumped because drug use is restricted by severe legislation and is not widespread. Some have suggested Sweden's severe criminalisation of drugs – a zero-tolerance policy introduced in 1988 - has had the adverse effect of estranging most high-risk drug-users from society. A law that formally allowed needle and syringe exchange programs wasn't drawn up until 2006 and by 2014 there were only six NSPs in Sweden.

Pride on the front line

By Andrew Stephens

Needle and Syringe Program workers should be proud of helping to address and reduce harm associated with injecting drug use, says the federal Minister for Health and Aged Care, Ms Sussan Ley.

Her message to NSP workers is one of encouragement - that their role is not just about dispensing sterile injecting equipment, but also about providing a platform for medical care, counselling and referral services to those in need.

"Frontline health-care workers, including NSP workers, face many challenges in their role and it is important to recognise this contribution," Ms Ley says. "These workers assist in prevention and harm-reduction through delivery of health promotion messages and providing access points and links to treatment services as well as providing a first contact point for many."

Appointed to the health portfolio in 2014 after 13 years in Parliament, having previously worked as a senior staff member at the Australian Tax Office, an air-traffic controller and farmer, Ms Ley says it is important that NSPs have bipartisan support at all levels of government. She describes NSPs as an evidence-based public health response to the risk of blood-borne viruses (BBV) such as hepatitis C and HIV associated with injecting drug use, and says their value is substantial.

She cites statistics showing that between 2000-2009, NSPs averted an estimated 96,667 new hepatitis C infections and 32,050 new HIV infections. There was, in that period, a health care cost saving of about $1.2 billion.

"But most importantly, this is about ensuring equitable access to a broad range of health care services, and making sure health services are responsive to the particular support needs of communities and individuals," she says.

NSP workers have a vital role to play in spreading information about the new hepatitis C direct-acting antiviral (DAA) treatments, Ms Ley says. "NSP workers, who are often the first point of contact for PWID, have an important role in providing vital information about new treatments that could benefit this population, especially with the new hepatitis C medicines."

Ms Ley and the Turnbull government have done much to bolster the introduction of new hepatitis C treatments. In March, people with hepatitis C were given access to the publicly-subsidised breakthrough, thanks to an investment of more than $1 billion. Ms Ley said at the time patients would pay just $6.20 a prescription if they were a concession-card holder or $38.30 a prescription as a general patient for the medicines, listed on the Pharmaceutical Benefits Scheme (PBS).

This would save them up to $100,000 for treatment. "The Australian Government is aware that peer education is one of the most effective ways to educate people who inject with drugs about testing and treatments, and encourage the use of NSPs for prevention and safe-injecting practices," she says.

Ms Ley says one of the priorities for improving the success of the NSP sector is ensuring NSPs are linked to the broader drug, alcohol and health system, including ensuring access to appropriate services at a local level.

Beginning in July this year, the Government is spending $298.2 million over four years to reduce the impact associated with drug and alcohol misuse to individuals, communities and families.

As well, Ms Ley says addressing stigma related to blood-borne viruses is a priority of the National Strategies for BBV and Sexually Transmissible Infections (STI). "The goals of the strategies are to reduce the transmission of, and morbidity and mortality caused by BBV and STI, and to minimise the personal and social impact of Australians living with BBV and STI."

Activities being funded under these strategies include developing national indicators for BBV- and STI-related stigma, plus a review of health-system barriers so that improvements can be made to access for people at risk of or living with BBV and STI.

"NSP workers have an important role in providing vital information about new treatments."

– SUSSAN LEY

Left: Sussan Ley is proud of the government's $1 billion investment in hepatitis C treatments.

FOR EVERY...

$1
Australia invests in NSPs

$4
is saved in health care costs and

$27
in total costs to the community.

NSPs: saving lives and money

By Andrew Stephens

The evidence is overwhelming that NSPs save lives and money, and reduce the health risks associated with sharing, says the Shadow Minister for Health and Medicare, Ms Catherine King.

"In the decade to 2010, NSPs are estimated to have prevented over 30,000 cases of HIV and around 100,000 cases of hepatitis C," she says. "As a result, NSPs averted 4500 deaths from HIV by 2010."

Ms King says the national NSP network was established in 1987 in response to the HIV epidemic. "Since then the program has grown and evolved with Labor's ongoing support. There are now around 3500 NSPs in Australia, distributing over 30 million needles and syringes a year."

NSPs are also cost-effective, she says, quoting research that for every dollar Australia invests in NSPs, it saves $4 in health care costs and $27 in total costs to the community. "NSPs saved between $2.4 billion and $7.7 billion in health expenditure over 12 years."

"The last Labor Government funded the Penington Institute to develop Australia's first National NSP Strategic Framework. Among other priorities, the Framework called for a nationally consistent training model for NSP workers and national minimum data standards."

Above: Catherine King announcing Labor's health policies earlier this year.

Modern-day miracle
NSPs have vital role

By Gideon Warhaft

New direct-acting antiviral treatments for hepatitis C are a game-changer. What part can NSPs play in the roll-out? And is complacency now likely to become a big issue?

It was no surprise only a few thousand people a year used to sign up for the tough regime of treating hepatitis C. Notorious for harrowing side-effects including depression, weight- and hair-loss, and occasional psychosis, the treatments combining interferon and ribavirin took up to 12 gruelling months to complete. For the approximately 240,000 Australians living with the virus, the therapy also involved frequent trips to hospitals and specialist clinics – and there was a good chance of the treatment failing, anyway.

The outlook has changed dramatically. Since March 2016 new direct-acting antiviral (DAA) hepatitis C treatments have been listed on the Pharmaceutical Benefits Scheme (PBS), making these previously prohibitively expensive treatments available to everybody.

Professor Alex Thompson, director of gastroenterology at St Vincent's Hospital in Melbourne, says the new DAA drugs are a revolution in hepatitis C treatment. "It's fair to say that this is one of the most dramatic new medical interventions of the last decade or two. Previously we were treating a very small fraction of the hepatitis C population, where we were chasing our tail and could never use a treatment as prevention strategy," Professor Thompson says.

"Now we are going to be very aggressive, treat everybody, use treatment as prevention to decrease prevalence, and really focus on the elimination of hepatitis C transmission in Australia over the next decade."

So how do the new drugs compare with the old combination treatments? "For a start, they are interferon-free, so there are no injections, only between one and two tablets a day," Professor Thompson says. "There's no restriction [to qualify for treatment] - that you've got to have bad liver disease or some complication of hepatitis C. They're available for everybody."

With a success rate of between 90-95 per cent (averaged out over the different genotypes of the virus) and a treatment period of only eight to 12 weeks for most people (24 weeks for a minority of people with cirrhosis), treatment is now an attractive and viable option for almost everybody living with the disease.

Perhaps the biggest benefits of the new treatments are the near-absent side-effects. Ms Niki Parry, who runs the Pharmacotherapy Support Program at QuIHN, a non-government drug and alcohol organisation in Queensland, says: "Pretty much all of the people who have done the treatment that I've spoken with have experienced almost zero side-effects. The most I hear about is the occasional headache or dizziness. But absolutely minimal."

Ms Parry says there are few reasons to avoid treatment. "Even people who are using [illicit drugs] quite a lot – we've supported a lot of homeless people through it, a lot of people with quite complex mental-health issues. So it's opened the door for people who may not have been suitable or eligible for the old treatment."

"It's a big opportunity to work with NSPs over the next five to ten years to really make big inroads into hepatitis C in Australia."

– ALEX THOMPSON

52% prevalence of hep C among male NSP clients in 2011

54% prevalence of hep C among female NSP clients in 2011

Left: Professor Alex Thompson at St Vincents Hospital. "This is one of the most dramatic new medical interventions of the last decade or two."

Picture by Shannon Morris

The Federal Government has negotiated a deal with the drugs' manufacturers allowing almost unlimited patient access to the treatments. "In every other jurisdiction in the world there are effective restrictions on the number of people who can be treated," Professor Thompson says. "The Australian Government has negotiated a cap whereby it guarantees that X amount of money will be spent per year on hepatitis C treatment, regardless of how many people we treat. So we have a real incentive to treat as many people as we can. The more we treat, effectively the cheaper it gets. And we're not going to run out of treatment. This is an important message: people shouldn't think that treatment's going to be whisked away in the future."

As well as being a game-changer for individuals living with hepatitis C, the new treatments allow for strategies to reduce the pool of the virus among people who inject drugs, perhaps effectively eliminating its presence altogether. To achieve this, there is a vital role for NSPs to both promote and facilitate the treatment to their clients. This includes bringing treatment services into NSP settings, something that wasn't possible with the older, more clinically intensive treatments.

Continued overleaf

Modern-day miracle: NSPs have vital role

Continued from page 7

Professor Carla Treloar, director of the Centre for Social Research in Health at the University of New South Wales, says NSPs have a key role in helping to make treatment equally available to all people.

But she says fear and mistrust of services remain. “That’s not going to go away just because the drugs are really good and everybody can theoretically get them.”

QuHIN is among a handful of organisations offering hepatitis C treatment through their NSP. Their Treatment In an Injecting Drug Environment (TIDE) program operates in Brisbane, the Gold Coast and Sunshine Coast, and Townsville area.

“Basically we use the NSP as a way to engage people around their hepatitis C: a bit of peer support, a bit of awareness and education about hepatitis C,” Ms Parry says. “That wrap-around support, not having to go anywhere else, being able to get all their hep C needs met under the one roof and it not being a huge hassle like it can be at the public clinic. People can come in, catch up with the harm-reduction worker or the hep C treatment worker, anytime they’re in. So it’s not ‘we’ll see you in three months’; it’s ‘come in any time’.”

Professor Thompson also says NSPs are vital for the wider hepatitis C reduction strategy. “We know that if we can treat people who are injecting and are at high risk of transmission then at a public-health level we’re making a much bigger impact on the prevalence of hep C in the country. It’s a big opportunity to work with NSPs over the next five to 10 years to really make big inroads into hepatitis C in Australia.”

The first steps towards treatment typically involve testing for hepatitis C and ascertaining liver damage using a FibroScan or abdominal ultrasound. “A client would see one of the harm-reduction workers to do an initial screening: around their drug use, around their health, around their social supports,” Ms Parry says. “From there we give them some information, we explain the project, and then the next step is to link them in with our medical team to get testing.”

Of course, treating people who currently inject drugs doesn’t prevent them from being re-infected once treatment has been completed. “There’s a risk of that,” Professor Thompson says. “We’ve certainly seen this in other diseases. But the PBS doesn’t prevent us from re-treating. The basic strategy is that as the pool of treated people gets larger, the risk of reinfection is reduced.

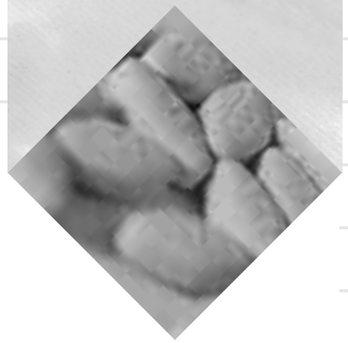
“We want to be targeting high-risk people to interrupt transmission, so we expect to see some re-infections – the cost of re-infection is not an issue because we can just re-treat them. So if we’re not seeing re-infections, we’re not treating the right populations in terms of decreasing that pool, decreasing transmission.”

There is also the threat that such successful treatments might cause complacency within NSPs or among policy-makers who support them.

“It is a danger because people love this idea of the silver bullet, the magic cure-all,” Professor Treloar says. “So much money will have been spent on these new medicines, I think that we need to inoculate ourselves against the idea that NSPs become far less important. Because NSPs do so many things – blood-borne viruses is obviously a key thing but there are many others essential for the health of people who may be very marginalised and disadvantaged in our community.

“Pretty much all of the people who have done the treatment that I’ve spoken with have experienced almost zero side-effects.”

– NIKI PARRY



“The theme in HIV is that you can never assume the job is done. The fact that HIV is low now and has been for a while, that’s because NSPs have been working so well. If you de-invest from that, what might happen? The same remains for hepatitis C.”

Hepatitis C treatments: what NSPs can do

NSP workers can have a huge impact on hepatitis C rates among people who inject drugs.

According to the Kirby Institute’s *Annual Surveillance Report* on HIV, viral hepatitis and sexually transmissible infections in Australia (2012), hepatitis C prevalence among people attending needle and syringe programs was at high levels in 2002–2011. It found hepatitis C prevalence in 2011 was 52 per cent among men and 54 per cent among women.

- **Prevention:** NSPs are the principal hepatitis C prevention tool in Australia, according to the Fourth National Hepatitis C Strategy 2014-2017. NSP workers provide sterile injecting equipment and information about harm minimisation.
- **Referral:** They can offer pathways to medical care, counselling and other services.
- **Education:** NSP workers can let clients know about the new hepatitis C treatments. They can discuss high rates of success at clearing the virus, the relatively short treatment periods and the low incidence of side-effects.
- **Reducing stigma:** Talking with clients in a non-judgmental way, NSP workers can help reduce feelings of shame around hepatitis C infection.
- **Peer support:** Peers are credible, trusted sources of information. They can connect with hard-to-reach groups to share prevention messages and education.

THE MEDICATIONS

- Harvoni® (sofosbuvir + ledipasvir) For genotype 1
- Sovaldi® (sofosbuvir) and Daklinza® (daclatasvir) For genotype 1 and 3
- Sovaldi® (sofosbuvir) and Ibavyr® (ribavirin) For genotype 2
- Viekira Pak® (paritaprevir + ritonavir + ombitasvir + dasabuvir) [sometimes with ribavirin] For genotype 1

Source: Hepatitis Australia

“NSPs have been working so well. If you de-invest from that, what might happen?”

– PROFESSOR CARLA TRELOAR

Right: Professor Carla Treloar

Getting clear of a deadly virus

Pam's story

In the year since she completed treatment to clear her system of the hepatitis C virus, Pam says the most significant changes have been psychological. "I had no future," she says. "And now I have a life to look forward to and it is still unbelievable."

Pam lived with hepatitis C for almost 20 years before being diagnosed. One of the first Australians to be successfully treated with the new drugs, she now says that "just knowing it's gone," has had an incredible effect. "You didn't realise how much it sat in the back of your mind and what a burden it was. Plus the whole infectious thing and that fear of infecting your family, the people you most care about."

Before treatment, Pam's liver was badly damaged. At this time the new direct-acting antivirals (DAAs) were not on the Pharmaceutical Benefits Schedule (PBS) so her specialists recommended she be granted access to the expensive medications on compassionate grounds. After 24 weeks, Pam was cleared of hepatitis C.

Of her initial infection, she says "it was the '70s" - a time when NSPs were unknown, injecting drug use was punished and sharing needles was rampant because equipment was difficult to source.

"We didn't have disposable syringes and certainly there was no help and support you could seek at that time," Pam says.

Later, Pam had four children and the growing weakness and fatigue she experienced was dismissed as normal for a busy parent. "The fatigue did get to me but then, I've got four children so what do you expect?"

In 1998 blood tests revealed her hepatitis C status. She had two unsuccessful rounds of the interferon/ribavirin treatment but in 2009 took part in one of the first Australian clinical trials of DAAs.

"The idea was to drop your viral load enough to return to interferon/ribavirin," she says. "I did that but that was unsuccessful, too. Then they wanted me to do 72 weeks of treatment. Each round of treatment I had the side-effects like joint pain lingered, and each time these things just got worse. Things like my mouth being dry - little things that weren't tragic but each time my body felt damaged. So I thought 72 weeks just seemed impossible."

Anticipating a future overshadowed by a slow decline to death, Pam and her husband took a "farewell to the world" overseas trip.

The virus rebounded and she became so unwell she nearly died in hospital. It was then that doctors assessed her as qualifying for treatment on compassionate grounds – and her life took a new and wonderful turn.

By Royal Abbott

Jack's story

Until recently, Jack had been living with hepatitis C for nearly 45 years. Now, he says, he is a happy man, having finished a course of the new direct-acting antiviral (DAA) treatments.

Jack completed the treatment about a month ago and is now hepatitis C-free. "I've got a young daughter, and now I don't have to strictly segregate my toothbrush, my shaving gear, and be conscious of blood all the time. And my night sweats have gone, too. Oh yeah, I'm a happy man."

When he contracted hepatitis C, the virus hadn't even been formally identified. "I knew I had something," he says. "I had an incredible tiredness, as well as night sweats and a mental fog."

In the late 1980s, after a liver biopsy, Jack spent most of a year being treated with interferon. "It was horrible. It was a kick in the guts every day," he says. "I was crawling around some days."

After completing the treatment, he felt better for a while, but symptoms soon returned and blood tests confirmed the treatment hadn't worked.

Jack first learnt of DAA treatments from people who had travelled to China to buy the drugs directly. Then his partner told him the treatments had been released on the Pharmaceutical Benefits Scheme (PBS). "I couldn't believe it," Jack says. "It was just incredible."

Even without a Health Care Card, Jack paid only $34 a month for the three-month course (those with a card pay $6.20). "You just had to take one of these pills a day," he says. "That's all you had to do."

Jack did experience a few side-effects, some of them "a bit weird", including itchy fingers and swollen earlobes - but it was a "breeze" compared with interferon.

By Gideon Warhaft

Hope for NSPs and naloxone in fighting overdose deaths

Needle and Syringe Program workers, doctors and the families and friends of people using opioids need more information and support about naloxone to help stem the grim rise in accidental overdose deaths.

So says NSP frontliner, Ms Sally Finn. Ms Finn, founder of International Overdose Awareness Day and a social worker at the Salvation Army's Crisis Service Centre NSP in St Kilda, Melbourne, says there needs to be a bigger conversation about prescription opioids.

While NSP workers have a crucial role to play at the frontline of providing information about the overdose-reversal drug naloxone, doctors, family and friends can have an important part in preventing deaths from accidental overdose, too, she says.

"My sense is that we don't want to see anybody under-medicated," she says. "That would be a tragic mistake and we don't want doctors to overreact. We want them to be clear and teach people about the properties of these drugs, that they are opioids and the risk is they shut down the respiratory system.

"My personal opinion is that every time somebody is prescribed opioids it should be suggested - or they should be given - a prescription for naloxone. I think that signals to them the kind of risk we are talking about. Even if it is never used, it is very good to have it there... they would talk to their family members or whoever is close at hand about administering the naloxone. That would glue the whole conversation together in their minds that this is a real thing, not just a warning [on a packet]."

Ms Finn has been stunned by the recent overdose report compiled by Penington Institute from Australian Bureau of Statistics data which shows deaths due to accidental overdose rose 61 per cent in the decade to 2014, from 705 to 1137.

In her work, Ms Finn says she has long been affected by the deaths-by-overdose of clients but she didn't realise the cumulative personal impact until 2008 when one particular client died. She had got to know the man well through his frequent visits to the NSP and she had filmed him for a video one year for Overdose Awareness Day. "He remains on the web in that film," she says.

Learning about his death by accidental overdose, she decided – unusually - to attend his funeral, which she describes as a celebration of his life, an event that helped his family see how much he was loved.

As she was leaving the service, Ms Finn burst into tears. Fortunately, she was with another woman who could support her. "I said 'I can't explain this, it's ridiculous'. It was uncontrollable, I couldn't contain it. I tried not to make too much noise or a scene of myself. But she was very kind and said it was completely understandable - and I said it's just that there has been so much [death] there over the years."

At the time, she had been working at the Salvation Army NSP for 10 years. "I realised just how emotional I was."

The type of culture developed among NSP workers is crucial to feeling supported, she says. "There is an undertow from the outside world that doesn't give much credence to these deaths," she says. "You forget about that a lot of the time and then something happens and you are reminded there is a lack of respect for the people you are helping, who are your clients."

By Andrew Stephens

Overdose: the toll

Australia's Annual Overdose Report 2016 reveals:

- Between 2008 and 2014, there was an increase in accidental overdoses from 3.1 deaths per 100,000 to 5.7 per 100,000 – an 83 per cent increase. Meanwhile, the rate per capita in metropolitan areas has moved only slightly from 4.2 per 100,000 in 2008 to 4.4 per 100,000 in 2014.
- Over the period 2008-2014 there was an 87 per cent increase in prescription opioid deaths in Australia, with the greatest increase occurring in rural/regional Australia which saw a 148 per cent increase.
- Accidental deaths due to drug overdose per capita for Aboriginal and Torres Strait Islander people grew between 2004 and 2014 with an increase of 141 per cent – from 3.9 per 100,000 in 2004 to 9.4 per 100,000 in 2014 in the five jurisdictions with data.
- Western Australia is the worst state for overdose deaths per capita with 5.8 deaths per 100,000 in 2014 followed by NSW with 5.1 deaths per 100,000.

Terumo syringe troubles NSP clients

By Andrew Stephens

Needle and Syringe Programs are expected to encounter more frustrated clients and a real threat to the program's success in preventing unsafe injecting practices.

Introduced in April, the South Korean-made Terumo equipment caused a storm of discontent among people who inject drugs.

The global medical-products manufacturer, founded in Japan, changed syringe models supplied to Australia after it shut down its US manufacturing plant earlier in the year. The US-made syringes had been well-favoured by those using them for well over a decade.

NSPs soon began receiving many complaints that the new syringes, made in South Korea, were unsatisfactory. The issues ranged from blunt and weak needles and difficult-to-use plungers, to overall quality of the product. Complaints around the new equipment causing bruising and vein damage were common. One incident reported to an NSP indicated a needle tip had snapped off in the person's arm, who then required surgery to remove it.

In Victoria, the Department of Health and Human Services (DHHS), frustrated and keen to resolve the issue, quickly tried to pursue other options soon after it became obvious that the problems arising from the new equipment were not simply an issue of people having a hard time getting used to a new product.

Terumo provided a Japanese-made product for a consumer feedback survey conducted by Penington Institute on behalf of DHHS. The survey, undertaken in consultation with five NSP sites in Melbourne, asked clients to rate the South Korean-made and Japanese-made Terumos, as well as a BD product used in other NSPs across Australia.

The results on about 5000 fits from 348 respondents to the survey clearly indicated a preference for the Japanese-made product.

"It looked like we had a clear way forward with a product that was well received by clients and overcame many of the issues people were having with the South Korean version," says John Ryan, CEO of Penington Institute.

"We're all frustrated at the Terumo decision to end the supply of the US-made syringes and those frustrations have grown since Terumo decided not to supply a Japanese-made model," Mr Ryan says.

Terumo says it had sought to introduce this "contingency option" manufactured in Japan, a product that had been going through user-acceptance trials. Only later it became apparent there would not be enough supply to meet demand.

Terumo says a worldwide drop in demand for the US-made syringes followed a shift to pen technology for injecting insulin, which has become the preferred method of uptake for that purpose. "The decision to cease the manufacturing in the USA was a global business decision," says the general manager of Terumo Australia, Ms Rebecca Cortiula

Ms Cortiula says Terumo is working to ensure quality control procedures are maintained, with an additional inspection process during the manufacture of the South Korean insulin syringe.

"We understand that some end-users still have a preference for alternatives, but the South Korean products are the only products we can currently supply."

"Had we been able to supply the Japanese syringes we would have offered that option."

– REBECCA CORTIULA

BETWEEN 2000–2009, IT WAS ESTIMATED...

96,000
new hepatitis C infections; and

32,050
new HIV infections

HAD BEEN PREVENTED AS A RESULT OF NSPS

The Japanese-made Terumo syringes provided temporarily were well received among people who inject drugs. Ms Cortiula said the decision not to supply the Japanese syringes to the Australian market was about constraints in supply, not cost. "Had we been able to supply the Japanese syringes we would have offered that option, however we subsequently found out we cannot supply this product even at a higher selling price," she says.

Ms Cortiula says the South Korean-made syringe meets the specifications of requirements for use by Australian NSPs. "However, the fact remains that they are not specifically designed to deal with excessive scar tissue from repeated use of the needle and intravenous drug injection."

Craig Harvey, outreach worker (pharmacotherapy/NSP/naloxone programs) for Barwon Health, says that when the complaints started, he thought it important consumer views be heard. He compiled a simple complaint form listing issues most frequently reported. More than 160 responses came in when the forms were distributed to Barwon Health's secondary NSPs.

"I contacted Terumo myself and explained the complaints and what we had been doing," he says. "They said they wanted the complaints sent to DHHS." He did so and also lodged a complaint with the Therapeutic Goods Administration.

Mr Harvey says some consumers were now "making do" with the new syringes while others said they would re-use older syringes. He says there is now a black market operating for old equipment.

When clients at Sydney's Uniting Medically Supervised Injecting Centre started telling nursing unit staff about the effects of the new syringes in early May, the staff knew the fallout would be considerable. Richard Sulovsky, Uniting's health education officer, says clients said they would hoard old Terumos and sharpen old needles on matchboxes.

One of the big concerns at NSPs was that the change would lead to more needle sharing. In 2009, an Australian government assessment of needle and syringe programs found that about 32,050 HIV infections and more than 96,000 hepatitis C infections had been prevented between 2000-09 as a result of NSPs. The upshot being that spending on NSPs was considered a crucial investment in avoiding the potentially vast costs of increased infection rates and medical treatment.

Terumo syringes: From top, the US and South Korean models.

The lure of the needle

By Royal Abbott

The syringe was invented to get drugs into the body quickly and that is the primary attraction for people who use them, says Dr Matthew Frei.

"There is no more effective way of administering a drug into the circulatory system, into the brain. It is so effective and in most circumstances it reduces the waste from swallowing or even smoking."

Dr Frei, the head of clinical services at Turning Point and Eastern Health Alcohol and Drug Services, as well as an adjunct lecturer at Monash University's Department of Psychology and Psychiatry, says injecting also nurtures a ritualistic attachment. This includes the preliminary procedures of laying out the equipment and arranging the spoon, syringe, water, filter and so on.

"So there's that cultural ritual, the repeated behaviour and there's often a social aspect to it, where people often (inject) together," Dr Frei says. Thus they consider "doing it well" as a skill and "finding veins is considered a badge of honour, so the ritual becomes something of a driver".

Dr Frei says research shows injecting is especially popular in Australia. "Snorting and smoking drugs is less popular in Australia than it is in, say, the US. Possibly because the risks aren't seen to be as high. We never had HIV rates as high as some countries where half the injecting population has HIV. Plus we have good access to syringes, so Australians are less anxious about injecting.

"We have particularly good access to clean injecting equipment and the harm reduction benefits arising from that situation cannot be minimised," he said.

For Melbourne man Johnnie, injecting drugs began almost 50 years ago and he says it was because he didn't smoke cigarettes.

"My flatmates all smoked and were getting stoned off joints but I got nothing, just a cough," he says. "So I bought a syringe and some needles. It was 1970 so you had to scam a chemist to get a syringe and a set of five reusable needles."

Johnnie had read some William Burroughs and listened to Lou Reed singing about getting high on heroin. While he didn't know anyone else who shot up, it seemed cool enough to give it a go.

He says the misuse of medical technology appealed to his ideas of taking a walk "on the wild side". Mainly, though, it got him high immediately. The economies of using a syringe also appealed as it used small amounts of drugs for a stronger effect.

Some of his friends from those early days are still around and they say their interest was all about speed and efficiency. Once the health risks became apparent, they gave up. They never became addicted to injecting to the same extent as Johnnie, for whom the ritual of setting out his kit and mixing up hits had him almost completely bewitched.

He would dream of spoons, syringes and the process of injecting. In his dreams, getting high was never the point; rather it was playing with the equipment.

"Finding veins is considered a badge of honour, so the ritual becomes something of a driver."

In the blood: risky business

"I used to love the ritual, I still do," he recalls. "It calms me. I still have fresh syringes around even if I'm not actively using. Just seeing a fresh, unopened pack of five in the drawer makes me feel better.

"Quite a few people say they are addicted to needles as much as gear. It doesn't matter what is around, they will inject it."

Time and experience has changed some things: Johnnie says he balks at injecting pills now because of worries the fillers will harm him. His health is more important now than it was when he was recklessly injecting any prescription meds or illicit powders he could get his hands on.

Even so, he still puzzles at the allure injecting held for him when he was a teenager. The idea of the needle piercing the skin and entering the bloodstream made a link between him and his inner life in a tangible fashion. He feels that the link was a substitute for the lack of self-knowledge he had as a youth. He's more sanguine about injecting now. It is a delivery system - and one with substantial risk. Risk was something he'd never considered.

Now he knows more and says the kindness of NSP staff has been a great help. "Once I develop a rapport with NSP staff and know they aren't judging me I feel confident about asking them for advice sometimes," he says. "The ones who handle the transaction right, by not treating you like you're an imbecile, they can be really useful. They are worth their weight in gold."

Needle-sharing is the most efficient way to transmit a blood-borne virus, says Gabrielle Bennett, the Victorian Viral Hepatitis Educator at St Vincent's Hospital in Melbourne.

That is why the bulk of newly diagnosed hepatitis C cases each year are attributed to sharing fits.

About 230,000 Australians have hepatitis C, with about 10,000 new infections annually. Hepatitis Australia estimates about 80 per cent of new hepatitis C cases diagnosed each year can be attributed to sharing drug-injecting equipment.

HCV is transmitted blood-to-blood and is also able to survive outside the body – surfaces, equipment, hands and puncture sites contaminated with blood during the injecting process can pose a risk. The viral load in bodily fluids other than blood is considered too low for transmission.

"Obviously it likes to be in 37 degrees - in the blood, inside the body, in the dark," Ms Bennett says. "So it starts to break down otherwise. In lab situations where perfect conditions exist, it has lived from days up to a week. No one knows how long it can live outside the body because the conditions are so variable. So the message is: be blood aware and don't do anything where you can get someone's blood into your blood."

Other transmission risks include:

- **Unsterile body art practices, such as tattooing and piercing.** Any item used during these procedures that may contain traces of blood is a risk. Ms Bennett says single-use only equipment is used in professional settings in Australia and is generally considered safe. "I think professionally our systems here are pretty good regarding that now. But some people do it at home with friends, or overseas."
- **Personal grooming.** Items such as nail-clippers, toothbrushes or razors can also present a hazard if even small amounts of blood are involved.
- **Childbirth.** Most pregnant women are routinely tested for hepatitis C, as there is about a five per cent chance of those with the virus passing it on to their child.

As for sex, Ms Bennett says hepatitis C is not classified as a sexually transmitted infection, yet it provokes much fear in that domain. As she says, there are thousands of couples where only one has hepatitis C but has not passed it on to the other. Risky practices include rough sex or use of sex toys that might tear the skin, or any other exchange where blood is present.

Ms Bennett says one of the biggest issues working against testing and treatment is stigma and lack of information. Health professionals can also sometimes present negative and stigmatising reactions.

Once, after she had given a talk to some health workers, Ms Bennett says one person approached her having only just recalled sharing a needle once or twice many years previously.

"She'd been having all these symptoms and investigations and it had never occurred to her or anyone else. She had hep C. It was a huge relief in a way because it meant she had a diagnosis - and then she got cured."

– Andrew Stephens

"The best job in the world"

By Andrew Stephens

When workers at Bunbury's Needle and Syringe Exchange Program (NSEP) heard about an East Coast idea for a postal order service, they knew it had great potential. After all, they'd been doing it successfully in Western Australia for years – mailing out injecting and other equipment to people with limited access.

Bunbury's South West Fixed NSEP site, run by the Western Australian Substance Users Association (WASUA), not only operates a mobile service around Margaret River, Busselton and Manjimup, but also the postal-order system.

"The best way we can reach remote users is through mail order," says Mr Kevin Winder, the South West NSEP's coordinator. "We are the only ones I know of nationally who do this."

It is just one of the challenges faced by the service which, given the huge geographic area involved and the sparsity of the population, has a complex catchment quite different to those found in urban centres such as Sydney, Melbourne or Brisbane.

And Mr Winder says he has "the best job in the world".

"The part that I get the most satisfaction from is working on the needle exchange, engaging with consumers, doing brief intervention work to improve the health outcomes for our consumers and reducing the harms associated with their drug use," he says. "When a consumer returns and their health has benefited from the brief intervention work that we do, it is so rewarding and motivates me to support more consumers in the best way possible for them."

Mr Winder came to the service as a volunteer when he emigrated from Britain two years ago. "My background in the alcohol and other drugs (AOD) sector began in London while working in hostels for street-based heroin and crack cocaine users. I went on to work in rehab and then policy and service development. My work on the ground floor in hostels in London was the most rewarding part of my career." As a volunteer in Bunbury, he says he became passionate about the work that WASUA does to reduce the harms associated with drug use without judging or discriminating against consumers.

The south-west of WA has had a mobile service for about 10 years. The fixed site at Bunbury started five years ago – so now the mobile unit is less stressed, and can focus energy on meeting the needs of the areas outside the town and its immediate surroundings.

In the past year (July 2015 to June 2016), the Bunbury fixed site had 1723 client interactions, the mobile service 735 and the postal service 34.

Mr Winder coordinates both the Perth fixed site and the South West branch and says one of the great opportunities when dealing with clients is for positive interventions to help them make informed choices. The peer-based service is staffed by people with personal experience of illicit drug use: thus the workers at WASUA focus on being non-judgmental in their interactions.

"We have a unique opportunity," Mr Winder says. "There is an implied trust when clients use our service that helps them feel comfortable to open up, whereas many don't open up with mainstream health services.

"They're usually very open about what drugs they are using - so we capitalise on that unique opportunity for targeted intervention work, to tackle what is the most important issue on that day for that person. So if someone comes in in emotional distress, then we are probably going to refer them for counselling."

Likewise, if a client has abscesses or signs of bacterial infection on their arms, workers will discuss injecting practices, hygiene, how they are mixing up or how they swab to try and reduce the risk of further infection. They would also be referred to a GP for antibiotics.

Mr Winder, like many of his local and national colleagues in the field, draws encouragement from knowing that the work they are doing is also helping to dramatically reduce transmission rates of blood-borne viruses such as hepatitis C and HIV. The service employs a hepatitis C community development worker to encourage local GPs to get onboard with prescribing hepatitis C treatments for more clients. The service is hoping, too, to establish an outreach clinic to maximise client uptake of hepatitis C treatments.

Kevin Winder at the Bunbury NSEP fixed site.

Picture by Ben Yew

"There is an implied trust when clients use our service that helps them feel comfortable to open up."

– KEVIN WINDER

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1723
client interactions

735
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