



Needle and Syringe Programs in Australia: Peer-led Best Practice

Prepared by Dr Susan Carruthers

**for the Australian Injecting and Illicit Drug Users
League**

Acknowledgements

I acknowledge the invaluable input from those who took part in this project; the NSP staff and service users. It is your voice I am presenting here.

AIVL is the Australian national peak organisation representing the state and territory peer-based drug user organisations and issues of national relevance for people with lived experience of drug use. AIVL's purpose is to advance the health of people who use/have used illicit drugs. This includes a primary focus on reducing the transmission and impact of blood borne viruses (BBVs) including HIV and hepatitis C – including for those accessing drug treatment services - through the effective implementation of peer education, harm reduction, health promotion and policy and advocacy strategies at the national level.

© Australian Injecting and Illicit Drug Users League (AIVL) 2018

This work is copyright. Apart from any use as permitted under the Copyright Act 1968, no part may be reproduced without prior written permission from the Australian Injecting and Illicit Drug Users League (AIVL).

Carruthers, S. (2018). *Needle and Syringe Programs in Australia: Peer-led Best Practice*. Australian Injecting and Illicit Drug Users League: Canberra.

List of Abbreviations

AIVL	Australian Injecting and Illicit Drug Users League
BBV	Blood Borne Viruses
NSP	Needle and syringe program
NTAHC	Northern Territory AIDS and Hepatitis Council
QuiHN	Queensland Injectors Health Network
WASUA	WA Substance Users Association

Contents

1. Introduction and Background	1
2. Study Method	2
3. Participant Recruitment	3
4. Findings from Service Users	4
4.1 Fixed Sited NSPs	4
4.2 Pharmacy NSP Programs	5
4.3 Community health centres/hospitals	6
4.4 Syringe Dispensing Machines	7
4.5 Peer distribution of injecting equipment	7
4.6 Mobile outreach	8
4.7 Accessing equipment when no other options are available	8
4.8 Referrals to other services from NSPs	9
4.9 Being treated unfairly	9
4.10 Collecting data on site	10
4.11 Enhancing NSP service delivery	10
5. Findings from service providers	12
5.1 Peer worker experiences	12
5.2 Referring clients to other services	13
5.3 How would you improve the service?	14
6. Discussion of the findings	15
6.1 Understanding the advantages and disadvantages related to each of the NSP service models	15
6.2 Identifying gaps in current knowledge and understanding of NSP service delivery	16
7. Recommendations and Best Practice Framework Outline	18
Appendix 1	20
Appendix 2	24
Appendix 3	26
Appendix 4	27
Appendix 5	28

1. Introduction and Background

As part of its 2017-18 work plan, AIVL sought to develop a Needle and Syringe Program (NSP) Best Practice Guide that detailed the needs of people who inject drugs, service delivery models across Australia and practice considerations for service providers that are informed by peer experience and led by peer intelligence. This project built on findings from a National NSP Forum that AIVL held in Sydney in 2015 and from a 2017 literature review that detailed NSP service models and international NSP best practice.

The aim of the consultations for this project:

- Understand the key issues in the delivery of services through NSPs
- Identify gaps in current knowledge and understanding of NSP Service Delivery
- Understand the advantages and disadvantages related to each of the NSP service models (peer-based, secondary and pharmacy based NSPs)
- Establish an evidence base for the development of NSP Best Practice Guidelines for use in all states and territories of Australia
- Establish a group of key informants to support the development of Best Practice Guidelines for NSPs in Australia

In order to achieve the aims of the project as outlined above, AIVL developed a Consultation Action and timeline document. The aim of the National Consultation was to cover topics such as:

- Current service models
- Perspectives on current best practice in terms of NSP
- Barriers to implementing self-identified best practice, and
- Evidence and gaps in knowledge related to NSP practice

These consultations were to be semi-structured in nature and held as either individual interviews or focus groups, whichever was most feasible. The project aimed to have a total of twenty interviews with service users in jurisdictions where there was a funded Drug User Organisation (DUO) and a minimum of five interviews in those without a funded DUO.

In February 2017, AIVL called for Expressions of Interest from its membership interested in conducting consultations for the project. WASUA in Western Australia was successful in their EOI and a staff member commenced in the position on 27th February 2017. The seconded Project Officer tasks are listed below:

- Co-ordinate and undertake face to face consultations with people who use NSPs across multiple jurisdictions
- Undertake phone telephone consultations with peer workers in multiple jurisdictions
- Collating and analysing consultation data
- Draft and finalise the NSP Best Practice Guide in consultation with the AIVL Director of Programs and Communications as well as state and territory member representatives
- Other tasks as appropriate and relevant to the project.

2. Study Method

The specific areas of investigation to be covered within the project were drawn from the AIVL literature review and the report from the National Forum hosted by AIVL. The areas identified were as follows:

- Access to injecting equipment through primary NSPs, secondary NSPs and the Pharmacy Program
- Access to health promotion and referrals through NSP programs
- Access to harm reduction through NSPs
- Perceptions of the value of peer workers in primary NSPs
- Experiences of stigma and discrimination when accessing injecting equipment
- Regular data collection through NSPs – perceptions and understanding

Interviews were also planned with NSP workers, both peer and non-peer. The areas of investigation for the NSP workers were clustered around peer worker perceptions of support within the organisation, opportunities for career development, data collection and how NSP services could be improved.

It was stipulated in the project brief that the data collected be qualitative in nature. Accordingly, two interview schedules were created in consultation with the project manager and AIVL staff. Interview schedules were finalised in early April 2017 and interviewing commenced in May 2017. The final interview schedules for service users and service providers can be seen in Appendix One and Five. Consultations could be one-on-one interviews or focus groups, whichever caused the least disruption to the organisations involved.

3. Participant Recruitment

The Northern Territory, Tasmania, Western Australia and South Australia were initially identified as jurisdictions in which to undertake consultations. It was also later agreed that AIVL staff would conduct the interviews in Queensland. After completing consultations in Western Australia, Northern Territory, Tasmania and Queensland it was identified that the project had reached data saturation and this, combined with time and budgetary restrictions, meant that consultations were not conducted in South Australia. Additionally, as the 2015 national NSP forum was held in Sydney and there was significant representation from New South Wales and Victorian services, it was agreed that the project instead would focus on smaller capital cities and regional areas so as to decrease the risk of consulting the same services multiple times and enhance the diversity of data collected.

AIVL provided initial contacts with NSP staff in the states chosen to be involved. These were Northern Territory (NT), Tasmania, South Australia (SA) and Western Australia (WA). The project officer initially made contact with NSP managers or staff and flyers were produced to advertise the study. Service user participants were reimbursed \$25 to cover transport and other costs. The participants were recruited mostly through primary NSPs. It was beyond the remit of this project to target those who only obtained injecting equipment from pharmacies, syringe dispensing machines (SDMs) or other secondary NSPs. In order to partially correct this we probed for use of other access sites which might be being used in conjunction with primary NSPs.

A total of 41 service users and 11 service providers were interviewed, through both individual interviews or focus groups. Individual interviews were conducted with nine services users and four service providers in the NT, nine interviews and one focus group (nine participants) in Tasmania, and 14 service users and five service providers in WA. In Queensland two focus groups with service users (two and seven participants) were conducted as well as one discussion group with two service provider participants.

4. Findings from Service Users

Area of Investigation: To understand the advantages and disadvantages related to each NSP service model (peer-based, secondary and pharmacy based NSPs) and to identify gaps in current knowledge and understanding of NSP Service Delivery

In order to identify gaps it must first be determined where people are accessing injecting equipment. The first query in the interview schedule aimed to determine where injecting equipment was being accessed and participants were asked: *'Where do you usually get your injecting equipment?' This was followed by probes to determine where else equipment was accessed. Where else do you get injecting equipment? What about syringe dispensing machines (SDMs), hospitals, pharmacies, Community Health Services and friends?*

In response to the lead *'where do you get your injecting equipment?'* participants typically mentioned primary NSPs but went on to describe other avenues by which they could, and sometimes did, access injecting equipment. These included pharmacies, SDMs, hospitals, friends and dealers.

The choice of where to go to access injecting equipment was affected by the time of day, location at the time and transport. There was a preference for primary NSPs but pharmacies and SDMs were used when transport was not available or the NSP was closed.

This section explores the experiences, positives and negatives for each service type.

4.1 Primary NSPs

Participants were asked about the relative advantages of each type of NSP they used to access injecting equipment. They expressed a preference for using a primary NSP.

'I prefer the NSP but I will use go to a pharmacy or use the machine if it's not open'

'I'd rather go into the NSP but if it's not open I'll use the machine around the corner'

Some exclusively used primary NSPs saying *'I only use here [NSP]'*, and *'always just come here [NSP] never anywhere else'*.

In areas where there were two or more primary sites available, choice depended on where they were at the time. For example,

'I always go to Rosny or Glenorchy – depends if the car is going'

'Depends which end of town I am – WASUA or HepWA'

When asked about positives and negatives of accessing injecting equipment from primary NSPs, the responses were overwhelmingly positive. Participants commented on the non-judgmental and friendly attitude of primary NSP staff saying:

'The lady here is friendly and there is no waiting. They have all the equipment I need for free and there is a disposal bin out the front'

'They are my peer group...non-judgmental and friendly. They are open until 5.30pm which is good'

'The ladies are nice and will always help you. They don't judge me and even if you have no dirties they will always give you a few for free'

'Great staff and lots of information and programs. Free fruit is good if you're homeless. Everything I need is available here'

'All the stuff is free and there's a vending machine for out of hours'

Participant comments towards primary NSPs can be summarised by the participants in the Brisbane focus groups, who described the QuIHN NSP and its staff as being 'no hassle' and 'always friendly'.

4.2 Pharmacy NSP programs

In order to understand the value of pharmacy based NSP programs, participants were asked to describe their experience when accessing injecting equipment from a pharmacy. Responses were given by those who always used the pharmacy NSPs, those who occasionally used pharmacy NSPs by necessity and those who have but no longer use the pharmacy NSPs. For some participants, particularly for those living outside of metropolitan centres that did not have primary NSP, pharmacies were a main point of access for injecting equipment.

Participants were asked: *what are the advantages of accessing injecting equipment from a pharmacy? What are the disadvantages? Probes included; What is good about pharmacies and what is not? Can you dispose at pharmacies? Do you have to pay at the pharmacy and how much, are you able to access sufficient equipment?*

The comments from a group of participants who always used pharmacies to access their equipment differed substantially from those who did not. Comments from the former reported pharmacy NSPs being a positive experience and one in which they felt respected and in which the service was non-judgmental. Comments included the following:

'The one I go to in (suburb) are OK. They get to know you and are not judgmental'

'The pharmacy I go to the staff are always polite to me'

'They're fine at the 24 hour chemist'

Pharmacies also had the advantage of being a reliable point of access for injecting equipment on public holidays.

For those who usually accessed injecting equipment from primary NSPs and used pharmacy NSPs as a back-up the comments were less positive. Participants disclosed that at some chemists they were treated '*different to a normal customer*' but went on to say '*we just don't go back there*'. They frequently talked about the 'look' they received when asking for a Fitpack and described the 'attitude' they got from those serving them. The following quotes demonstrate their experiences:

'I don't go to the pharmacy because of the way they look at you'

'They look down on you or say they don't sell them'

'It's just their attitude and the assumption that you're a junkie...you have to pay'

¹ In the NT tokens are provided for free access to the machine

'I get embarrassed asking for a Fitpack- sometimes they almost throw it at you. They are nice until you tell them what you want and then they pull back....I think there are privacy issues too'

'In pharmacies you get 'the look'. They cut you off and all of a sudden they won't touch your hands and want you to put the money on the counter rather than in their hand'

Additionally, one participant, who was diabetic, had a different experience which perhaps points to the direct discrimination against those who inject:

'Pharmacies are fine for me because I have a diabetic card'

Another also mentioned diabetes saying that *'If you say you have diabetes they are not rude'*.

Despite the reports of discrimination no participant had complained or reported such behaviour.

Experiences and perceptions of pharmacy NSPs may be also be shaped by experiences of being on opioid substitution therapy (OST) programs. Those who were on OST programs reported experiences of being made to wait for a long time for their dose, not being offered any privacy or treated as 'second class citizens' and judged in this process, which acted as a deterrent for accessing injecting equipment from any pharmacy.

In summary, there were differing views on the pharmacy NSPs, illustrating a diversity of experiences across Australia. Some appeared to have a good relationship with the pharmacy they visited and had not experienced unfair attitudes on the part of those who were serving them. Others had experienced overt discrimination which made them feel uncomfortable and may impact on their decisions to access injecting equipment.

In summary, a small group which only accessed pharmacy NSPs had generally positive experiences and did not feel discriminated against. The remainder had generally negative experiences which could be interpreted as discriminatory and impact on decisions to access injecting equipment.

4.3 Community health centres/hospitals

Community health centres and hospitals were not frequently used as access points for injecting equipment, and for those who did use these services, experiences were largely negative. Participants in the Queensland consultations discussed their experiences, with all Brisbane participants having accessed injecting equipment from a large community health centre in central CBD and all reporting negative experiences, primarily in relation to feeling judged when accessing equipment. Additionally, as the community health centre is an opioid substitution therapy (OST) provider, most chose to avoid also picking up injecting equipment there because of the potential impacts on their OST provision. Some participants noted the location of the community health centre was very close to the police headquarters, which led to a perception that police would notice who was accessing equipment and then conduct searches for drugs. This acted as an additional deterrent.

Some participants had tried to access equipment through hospital emergency departments however this was also a negative experience, with most feeling judged or being made to wait for unreasonable periods. One participant reported being told by nursing staff that the hospital did not provide injecting equipment, despite his understanding that the hospital did. Others were reluctant to access from hospitals because of negative experiences with hospitals, such as being denied pain medication when they notified staff that they were on OSTs.

4.4 Syringe Dispensing Machines

As previously mentioned participants were recruited through NSPs and it was not possible to talk with those for whom Syringe Dispensing Machines (SDMs) were their only source of injecting equipment. Participants' views on SDMs were based on their use in times when their preferred NSP service outlet was not open.

Access to a SDMs was valued by participants as they provided out-of-hours access to sterile injecting equipment. Participants described SDMs as *'convenient'*, *'still free'* (in NT only) and *'great for long weekends when pharmacies are not open'*. However, SDMs had some drawbacks. Participants identified a lack of additional equipment in the machines, such as wheel filters, as a reason not to access this service type or only access when other service types were unavailable. The location and maintenance of the machine were also raised as concerns. Participants in both Brisbane and Townsville reported that SDMs were in less than ideal locations: the machine in Brisbane was in very close proximity to the central police station which raised anxiety about police surveillance, and the machine in Townsville was located outside of the hospital and movements were recorded by a surveillance camera placed above the machine, raising concerns about anonymity and confidentiality. This was a particular concern for people in Townsville because of the small population and high risk of being 'outed' as someone who injects drugs. Other issues identified with SDMs were that machines were either broken or empty of equipment.

Important to note here that not every jurisdiction has SMDs, such as in Perth and its surrounds.

In summary, although few participants used SDMs as their most common access point for equipment, this service type provided a useful out of hours back up when preferred sites were unavailable. However the reliability of SDMs as an outlet for equipment was affected by location and security concerns, as well as the limited availability of equipment outside of needles and syringes. These factors may have some impact on the frequency of use and trust that people who inject drugs have in this service type.

4.5 Peer distribution of injecting equipment

Responses were again divided between those who did and those who did not provide sterile injecting equipment to others (termed 'peer distribution' or 'secondary supply'). The question *'do you ever pick up for others or get your equipment from friends?'* Comments such as *'I pick up for my partner and she picks up for me – never for other people...we look after each other'* were expressed while others said they never picked up for anyone else. Others regularly had sterile equipment in their home and would supply to friends or acquaintances if they did not have any. They expressed altruistic motives for doing so saying *'means no one has to share'*, and *'it makes sure that everyone has cleans'* as well as a sense that they were probably going to be asked for equipment at some point, so it's easier just to pick up extras. No-one reported providing large amounts of equipment for wider distribution.

Overall, because of the ad hoc nature by which people collected additional equipment, most did not feel this was a reliable source and thus accessed through friends only in certain circumstances, such as when using at a friend's place and not having their own equipment. This suggests that accessing through informal networks becomes a backup option when preferred sites are unavailable.

The laws applying to peer distribution of equipment vary across jurisdictions, with some jurisdictions, such as the ACT and Tasmania allowing distribution for the purposes of reducing blood borne virus transmission, with other jurisdictions outlawing provision of injecting equipment for non-medical purposes. Details of these differences across jurisdictions can be seen in Appendix Three. Consultations did not identify what role these laws played in decisions to collect or distribute but inconsistencies across jurisdictions may have potential impact on supporting more formalised secondary distribution of equipment to groups of people who may not otherwise access formal NSP outlets.

4.6 Mobile outreach

Mobile outreach services were not common across the consultation sites however one such service operated in Townsville. Participants stated that the service had been operating for around 18 months and participants had largely positive feelings towards it. Participants particularly commented on the staff as being non-judgemental and welcoming and the service offered a degree of privacy that other services did not. Participants sought to enhance their privacy by parking their car some distance away from the van and then walking across. Participants stated that, overall, the mobile service was the best site for injecting equipment in Townsville.

However, access to the service was opportunistic, rather than planned, as participants were never sure exactly where the mobile service would be at any given time. Participants suggested that the van could be in fewer locations and stay for a longer period of time, as well as advertising the service and its timetable/location in static outlets like pharmacies or SDMs.

4.7 Accessing equipment when no other options are available

While participants did not appear to have difficulty accessing injecting equipment AIVL was interested in any occasions where sterile injecting equipment could not be obtained and the outcome of such situations. The following question was asked: *If you have ever not been able to get sterile injecting what did you do?*

Participants were split between those who had never been without sterile equipment and those who had. Those who had never been caught without sterile equipment reported that they would not use, or seek drugs, if they weren't prepared with sterile equipment while others were able to plan ahead to ensure they were not put in that situation. For example, *'Never used someone else's needle. I make sure I have fits and keep an eye on what I have' and 'not ever been without cleans – I always have enough to last me', 'Never...if I haven't got cleans then I don't go looking for drugs'*. There were however, those who had been unable to get sterile equipment.

The response from these people was invariably that they would re-use their own. Historical use of someone else's needle was described by a respondent *'only a couple of times years ago. I can't remember what happened but I think I just reused one of my own'*.

There were also comments on this question from those who had been in jail in the past. Comments related to the number of times needles and syringes are re-used in the prison setting, an estimated 100 times for each piece of equipment.

In summary, there were few reports of recent receptive sharing. Re-using your own needle was the favoured action if participants found themselves without sterile injecting equipment although not using until new equipment was accessed was also mentioned. However, although participants in this consultation did not report sharing of injecting equipment, data from the latest Australia Needle and Syringe Program Survey (ANSPS) suggests that between 2012 and 2016, self-reported sharing of injecting equipment has risen from 16% to 19% of respondents as well as an increasing amount of re-use of own equipment (21% to 27%).² This suggests that needle and syringe coverage that enables at least one piece of new injecting equipment on every occasion is still challenging in some areas and among some population groups.

² Memedovic S, Iversen J, Geddes L, and Maher L. (2017). Australian Needle Syringe Program Survey National Data Report 2012-2016: Prevalence of HIV, HCV and injecting and sexual behaviour among NSP attendees. Sydney: Kirby Institute, UNSW Sydney

4.8 Referrals to other services from NSP

Staff at primary NSPs can provide referrals to other organisations for a range of services including GPs, drug treatment, BBV testing and treatment, vaccinations, and in some cases homelessness services.

There was however little evidence that participants had used such services. Comments included:

'I don't need any others services or referrals'

'I've never asked but if I needed to they should be able to refer me...Anglicare have lots of services if you needed them', and,

'I've been told WASUA can refer people to other services but I haven't needed anything'

Some recalled being given a referral to an internal service through WASUA (a nurse in the Perth office) and another to a free doctor service located close to a primary NSP.

For people living in areas without a primary NSP, there were fewer options for health advice or service referral. Experiences of stigma (detailed further in Section 4.9) in particular service types meant that, while participants used these service types to access injecting equipment, they opted to engage with the staff as little as possible. The impact of this was that these participants had lower awareness of health and social services in the local area as well as having less access to peer-developed or other health information. One participant who had recently moved to a regional area from a capital city noted the comparative lack of resources and pamphlets that were targeted toward people who inject. In these circumstances, where participants did need health information, GPs acted as the primary source of information.

4.9 Being treated unfairly

Discrimination and stigma directed towards those who inject is still commonly reported and is most often experienced when interacting with the medical profession. While there were some reports of unfair behaviour from this source the majority of comments were reserved for the manner in which participants were treated when accessing injecting equipment from a pharmacy. Participants often reiterated what they had said when asked about the negative aspects of pharmacy NSPs (see Section 4.2).

'Just at the pharmacy that couple of times I went....they look at you just like 'here's another junkie'

'At the pharmacy they like all the time treat you different. The assistant don't want to touch you. One time I asked for a Fitpack and she took me to the heat packs. When I explained what I wanted the security guard moved forward and followed me....made sure I left'

Similar concerns were expressed about unfair treatment from hospitals.

'I went to RPH once and asked for a fit because mine was blocked. They wouldn't give me one and then security rocked up and followed me...made sure I left'

'A&E [Accident and Emergency] is bullshit. I went to A&E once and told them I smoked ganja and after that they marked my file with drug addict – wrote it in the notes! I've been denied care because they marked me as a drug user – it's pretty humiliating especially with the hep C'

When asked if they had ever complained about the treatment they considered unfair, comments were dismissive of their ability to achieve anything. The following quotes demonstrate this:

'I didn't follow it up...I just stopped going there. I can use the machine now'

'I didn't complain 'cause they might have taken the service away'

'I haven't bothered to complain...they wouldn't listen to me'

In summary, unfair treatment is still arising from within the medical professions in hospitals and from pharmacies when accessing injecting equipment. Service users did not feel empowered to complain about this behaviour believing that no one would listen to them.

4.10 Collecting data on site

A concern raised in the National Forum related to the collection of consumer information during NSP interactions. The information collected varies from state to state (see Appendix Four for details) and not all jurisdictions directly ask clients for information.

Participants were asked if they had been asked for personal information when accessing injecting equipment from NSPs, how they felt about being asked and their understanding of why such information was collected.

In WA where personal information (age, gender, regular or new client and residence³) is estimated by services rather than explicitly asking clients, participants did not recall being asked for information but invariably stated that, if they had been asked, it was not a major concern. There was a general understanding that information was collected to ensure accountability and for 'stats'. Participants in other jurisdictions had similar opinions saying *'it doesn't worry me, I know what it's for...it's all confidential so it doesn't matter'*, *'no problems'*, and *'I don't object. They explained why when I asked so no problems'*. A minority of participants, however, did express some concerns about their privacy and confidentiality in relation to data collection. Some remained unsure of what the data would be used for and stated they intentionally provided misleading responses. There was also a perception that providing personal information was compulsory and led to injecting equipment being withheld if responses were not given.

There were some who were more concerned. For example, one NT participant felt uncomfortable being asked for personal information saying *'I don't like it...I'm a bit paranoid about info so I don't answer but that's fine...they (the workers) respect that'*.

4.11 Enhancing NSP service delivery

AIVL was also interested in what improvements service users would like to see implemented to cater for their needs.

As participants for these consultations were largely recruited through primary NSPs, responses were divided between those who felt their primary NSP already provided for their needs and those who had some minor requests. The former described their NSP as *'it's good as it is'*, *'It's fine as it is it has everything I need'*, *'I think they're great and wouldn't change anything'*. A call for longer operating hours was made especially in terms of one NSP that only opened from 12.30pm to 5pm. It was suggested that it would benefit the community if this NSP opened one or two mornings a week.

³ Residence is classified as metropolitan, rural or central

Others had some suggestions for services that the NSP could provide. These included shower facilities, access to services for parents who use, legal advice and housing services. WA participants appreciated the presence of the nurse clinic to which some had been referred for STI and BBV testing. A need for a service for sex workers, especially those who were also using, and services for women in pregnancy was also voiced. The latter stressed the importance of the level confidentiality offered by their NSP.

It was also suggested that a NSP could develop into a 'health hub' for users, including access to mental health and advocacy services.

In summary, participants were mostly happy with the service received from their local primary NSP. There were some suggestions for minor additions such as shower facilities, food banks, more SDMs in the suburbs and longer hours for some NSPs.

This indicates that primary NSPs are, for the most part, responding to and supporting the needs of their clients and is likely the reason why primary NSPs are the overwhelmingly preferred place to access injecting equipment. However, as noted in other sections, other service types are characterised by significant disadvantages and drawbacks, creating the potential to discourage access.

5. Findings from service providers

The aim of the second group of discussion/staff consultations was to record views on the current services, focussing on what services are being provided and how services could be improved to provide for the needs of those who inject drugs.

Views were sought from NSP staff at a variety of levels and positions, including peer staff, non-peer staff and volunteers.

The specific questions for discussion can be seen in Appendix Four. Eleven peer and non-peer NSP workers were interviewed one-on-one and their responses are summarised below.

5.1 Peer worker experiences

The majority of staff participants considered themselves peers, having experience with drug use, drug use lifestyles and injecting. Working as a volunteer and then transitioning into a paid position was the most common pathway into working within a NSP. Workers described various tasks that they undertook within their role. All spent some time working on the NSP. Some had additional roles including managing specific programs within the organisation, doing outreach and youth outreach, delivering a mobile NSP service or filling fitpacks for distribution to pharmacies or to use in syringe dispensing machines.

Participants were asked if they felt supported and valued as a peer worker. The general consensus was that they felt valued and supported and that if they felt challenged in any way they could approach a supervisor or other worker for assistance. They felt there was an understanding by management of their abilities and credibility with the service users although in one state, some internal challenges within the organisation meant peer workers did not feel supported by management. Nevertheless, at a personal level they felt valued and supported by other peer and non-peer workers.

There were two schools of thought when participants were asked about the importance of having peers working in NSPs. One group felt it was critical as demonstrated in the following comments:

'Absolutely it's important...I understand their drug use and injection issues. The consumers appreciate a peer's background – and being a peer helps with delivering brief interventions'

'Very important...when a person asks you a question or talks about injecting a peer understands where they are coming from. Someone recently asked me about sterifilts and I could show them how they worked and what they were good for.'

Other participants, both peers and non-peers, offered different perspectives on peer NSP workers. For example:

'Experience is important but I don't think it is critical. There are pros and cons. I think it's up to an individual to make the most of their role whether they are a peer or not.'

'It's quite important but just being a peer is not enough. It's got to be the right person who can be welcoming and encourage them to talk.'

Overall, there was support for the employment of peer workers in NSPs.

The level of training NSP workers received when they started working in an NSP varied. Most had been involved with the NSP as volunteers before they became employees and thus went through volunteer training. Others had completed essential training such as training provided through NUAA and the NSP On-line training course

offered by the Health Department in WA. They also spoke about having an induction into the policies and procedures of the organisation they currently worked for. Most also mentioned learning on the job and watching what others did, especially in terms of demonstrating equipment.

Participants described how the training they received aligned quite closely with their own experience as people who injected. Others were less clear saying *'it did and it didn't. Training was about best practice and best practice falls behind sometimes when you are using'*. There were however no problems with the training peers and non-peers had received.

Being a peer worker sometimes presented challenges when working in the NSP. One peer said *'not really not anymore but it makes me itch every now and then'*. He went on to describe how he could approach his manager and talk about any issues that might arise. Another described how he sometimes bumped into people with whom he used to associate in past years. He talked about how he set boundaries for himself and could always approach his supervisor if it presented a problem for him.

Participants were asked about how they felt when asking routine data questions of service users when picking up injecting equipment. Those from WA described how they did not ask the questions per se but estimated the responses. In WA the NSP records gender, age group, residence (rural, metropolitan, inner city) and whether it was a new or a regular service user. In other states more detailed information is collected and service users are asked each time they visit the NSP.

Participants from states other than WA did not have any issues with asking the questions of service users.

5.2 Referring clients to other services

The frequency with which this occurred varied *'pretty much never. I can usually answer questions on the spot...if not usually there is someone to ask'*. This worker went on to describe how she would respond to someone asking about drug treatment.

'if they are wanting to know about treatment I will ask which drug they are using – how much –and do you want to stop or have a break? What do you want out of treatment? Their aims. Then I will research what is available and tell them'.

In one jurisdiction there was a government funded sexual health clinic to which workers referred service users for free BBV and STI testing. This clinic was frequently mentioned by service users in the same jurisdiction as a service they were happy to take up describing it as *'a good service'* and one they felt comfortable using.

Some jurisdictions had access to medical and allied health facilities (such as doctors and counselling) in close proximity to the NSP which assisted them to make direct referrals. This was described by one worker as:

I make maybe 5 to 6 referrals a month here...to detox, HCV testing and treatment...I just have to refer them next door – just down the corridor...I can walk them down...I can also refer for mental health counselling in the same building'.

Participants that referred clients to other services were confident the services to which they referred were professional but also were disappointed they could not always follow-up to see any outcomes. All service providers indicated that referring to other agencies was part of their role as an NSP worker.

In summary, NSPs were referring service users to both internal and external services although the frequency with which this occurred varied. It appeared to be easier in some jurisdictions to refer due to the proximity of external services, such as NSPs located close to or within Community Health Services.

5.3 How would you improve the service?

The final query put to service providers centred on what their ideal NSP would look like. Responses varied with comments such as 'nothing really...it's fine as it is' to more concrete examples such as:

'We need more funding to support the staff and volunteers. Some external clinical support... maybe more professionalism. We need client and staff feedback – a consultative process which goes both ways. Funding is the limitation and people's own limitations'.

'I'd like to have more interactions with nurses in the clinic next door – I feel a bit isolated here, tucked away around the corner with a separate entrance. The hours could be longer too and it's a nuisance that we have to close at lunch time. Machines would be good but none of the businesses around here wanted them'.

The cost of equipment and having to charge service users in some jurisdictions was seen as an issue with workers feeling this limited services users' ability to inject safely.

The establishment of satellite services and mobile services to target the outer suburbs was also suggested.

In summary, participants were modest in their ideas of an improved service and what they considered should be available to service users. Some opinions were related directly to conditions in specific jurisdictions. Overall more funding was called for along with extended services for outer suburbs where there are no primary NSPs.

6. Discussion of the findings

Specific areas of investigation were developed following the aims drawn from the NSP Literature Review and the National Consultation Forums.

The aims were:

- To understand the key issues in the delivery of services through Needle and Syringe Programs
- To identify current gaps in knowledge and understanding of NSP delivery
- To understand the advantages and disadvantages related to each of the NSP service models (peer-based, secondary and pharmacy based NSPs)
- To establish an evidence base for the development of NSP Best Practice Guidelines

The following discussion presents the findings to satisfy the above aims.

The jurisdictions in which this investigation took place varied in the services they offered with some providing free injecting equipment and others a cost recovery model for some equipment and a one for one exchange. These variations are summarised in Table One. The NSPs where staff and service users opinions were sought also varied and included primary peer-based NSPs (WA and QLD) and peer-based NSPs which operated from within other organisations (NT and Tasmania). During the interview process participants described their interaction with pharmacy NSP programs (all jurisdictions), SDMs (NT, QLD and Tasmania), community health centres and hospitals (QLD) and mobile outreach (QLD).

6.1 Understanding the advantages and disadvantages related to each of the NSP service models

The advantages for service users associated with primary peer-based NSPs were clearly expressed with all commenting favourably on the friendly, knowledgeable and non-judgmental nature of the service they regularly attended. They were appreciative of the experience peer workers possessed and how that peer experience enhanced their interactions when accessing injecting equipment. The need for peer workers in the delivery of NSP was strongly expressed. This opinion was also expressed by service workers who commented on the mix of peers and non-peers in primary NSPs in which they worked as being an advantage. Service users voiced few criticisms of the primary NSPs they utilised. Those that were verbalised were seen to be minor and were centred on longer or different opening hours and the practice of closing at lunchtimes.

SDMs provided significant value through providing out-of-hours access to injecting equipment, yet these also had some notable drawback. The machines meant service users had 24 hour access to sterile injecting equipment and the need to use the pharmacy program was reduced, however the machines were sometimes placed in locations that created anxiety about community or police surveillance, had a limited range of equipment and occasionally were vandalised, which all limited their reliability as a source of injecting equipment.

The comments on the pharmacy based NSP were less favourable although the fact that they were available was seen as positive in that they provided another avenue to access injecting equipment. Service users encountered varying levels of discrimination and stigma when using the pharmacy NSPs although this was mostly subtle rather than overt and most often was referred to as 'the look'. Nevertheless, it made service users feel uncomfortable and could deter access to injecting equipment. Once again this observation was not universal. A small group from one jurisdiction, who had only recently come into contact with a primary NSP, appeared

to have developed more favourable relationships with the pharmacies from which they obtained all of their injecting equipment. This positive experience was also voiced by others who sometimes used the pharmacy NSP when primary NSPs were not open. This however was not the norm. It does however suggest that accessing equipment through pharmacy NSPs need not be a negative experience.

The negative experiences of those who had to rely on the pharmacy NSPs for out-of-hours access to injecting equipment could be considered a key issue in the delivery of the pharmacy NSP program.

6.2 Identifying gaps in current knowledge and understanding of NSP service delivery

Primary and peer based NSP services provide far more than just sterile injecting equipment. They can and do provide a range of other services including access to on-site clinical services, demonstrations of injecting equipment, a point of social contact in particular among those who are homeless, and referrals to other services that may be needed. Other services include, but are not limited to, drug treatment, assistance with housing, mental health and drug counselling, legal advice and advocacy.

Referrals to internal and external services occurred relatively frequently. More frequent referrals occurred where external services required were in close proximity to the primary NSPs. Referrals were regularly made to internal services as well where those services were available. For instance, a nurse practitioner service was available at one primary NSP and referrals to that service for BBV and STI testing, hepatitis C treatment and for general nurse services were common. One issue raised by service providers was the lack of follow-up or feedback when referring to external services, which has potential to impact on the ability of all service providers to provide holistic care for these clients. Unless the service user returned to the primary NSPs and reported what had occurred few outcomes were apparent. More communication with the external organisations to which service users were referred would be an advantage. This area could be seen as a gap in knowledge and understanding of NSP service delivery.

Another gap in knowledge and understanding of NSP delivery is the extent to which peer distribution is occurring. In some states and territories, peer distribution of injecting equipment is now legal and where that was the case in this investigation routine questions were asked of service users, such as *'who else are you picking up for?'* In other states and territories peer distribution remains illegal. In these jurisdictions data on how many service users were picking up for others was not asked although workers were aware that it occurred. The practice of peer distribution has been reported in the literature as it pertains to Sydney in NSW and appears to be confined to the distribution of small amounts of injecting equipment for use by friends and partners. The authors of that study concluded that '[Peer distribution] is a common activity in south east Sydney but does not appear to be highly organised, usually taking place in small networks of friends and/or partners for altruistic reasons. Harm reduction programs could capitalise on the prevalence of peer distribution to reach injecting drug users who do not use formal distribution services'.⁴

The lack of information on the extent of secondary distribution could be viewed as a gap in knowledge of NSP practice.

⁴ Bryant, J. and Hopwood, M. (2009) Secondary exchange of sterile injecting equipment in a high distribution environment: a mixed methods analysis in Sydney, NSW. *International Journal of Drug Policy* 20(4): 324 – 328.

A final gap in our knowledge of NSP practice was identified in the AIVL literature review which preceded this investigation. That gap was identified as the degree to which service users object to being asked for personal information on each occasion they access their local NSP. Concern about the use of the data that is collected was voiced by user groups and the AIVL literature review quoted Australian research which suggests that 'data collection may be perceived to be intrusive or unnecessary and can potentially discourage future use of NSP services'⁵. Service users were asked for their views on the recording of personal details such as that outlined in Table Four and service providers were asked for their opinions on having to record personal information.

The views of those canvassed for this investigation differed from that discussed in the AIVL literature review. Service users in those jurisdictions where information was regularly collected almost universally reported that the recording of certain information did not concern them. They were also aware that they did not have to answer the questions or that they could provide misinformation if they were concerned about confidentiality. In WA, where the information is estimated and questions are not specifically asked, service users were often unaware that information was being recorded. When they were then asked how they felt about service user information being recorded they remained unconcerned. Comments such as 'it's all confidential, no names are recorded' were common and it was mostly understood that such information was required for 'stats' and was necessary for funding accountability. Service providers were similarly unfazed by having to ask the questions of service users. They understood the need for such information and would explain that need to the service users if they asked. There were however a few who described themselves as '*paranoid*' about such things. Even these service users understood they were not compelled to answer and if they chose not to this didn't affect their ability to access injecting equipment and other services. The responses were markedly different from those expressed by participants in AIVL's 2015 National NSP Forum, where data collection and privacy were raised as more critical concerns.

In this context it is not clear if data collection has any significant impact on decisions to access injecting equipment from a particular site, however a best practice approach could suggest that only data that is absolutely necessary be collected and that, where possible, staff estimate these responses as is the model in WA. Additionally, the introduction of the Needle Syringe Program National Minimum Data Collection by The Kirby Institute is likely to help with consistency of data collection across jurisdictions.

Nevertheless, the concerns about privacy and confidentiality raised elsewhere deserve more investigation. It would also be advantageous for NSPs to provide a detailed explanation of how the information is utilised to inform NSP workers as part of workforce training and service users to further inform them.

⁵ Wilson, H., Brener, L., Mao, L., & Treloar, C. (2014). Perceived discrimination and injecting risk among people who inject drugs attending Needle and Syringe Programmes in Sydney, Australia. *Drug and Alcohol Dependence*, 144, 274-278.

7. Recommendations and Best Practice Framework Outline

Findings from these consultations provide some guidance towards a national best practice framework that is informed by people with lived experience of injecting drug use. What can be seen from these findings is that there exists an extensive system of access to injecting equipment across Australia, however the experience of accessing these sites is inconsistent. The inconsistencies present themselves through variable staffing attitudes, policies and practices, legislation and regulation, opening hours, workforce development, referral to services and equipment availability. At minimum, these inconsistencies created missed opportunities for people who inject drugs to engage in the health system and, at worst, may contribute to the increasing rates of injecting equipment reuse or sharing that have been recorded in the 2012-2016 Australian NSP Survey.

To achieve the goals of national and jurisdictional blood borne virus strategies, Australia's system of Needle and Syringe Programs needs to be led by and better respond to the needs of those most affected – people who inject drugs. In this context, Needle and Syringe Programs, as a core elements of Australia's health system, should be aiming for *diversity of options with consistency of experience*. Under this core principle, the following recommendations are made for the basis of a national NSP best practice framework:

- **Diversity of options with consistency of experience**
People who require NSP services should have an expectation that wherever possible and regardless of service site, a consistent range of injecting equipment is available that goes beyond basic fit packs, and that the experience is non-judgemental and creates an environment where additional health information is available when requested.
- **Ensuring that all parts of Australia's NSP system are welcoming and non-judgemental**
Experiences of stigma were identified as playing a role in decisions to use a particular service type or to engage with service staff. All parts of the NSP system should be focused on creating welcoming, non-judgemental environments, either through staff training or, in the case of syringe dispensing machines (SDMs), ensuring the location is not stigmatising with unnecessary surveillance.
- **Ensuring consistency of equipment across all service types**
AIVL's 2017 literature review on NSP service provision noted the variability of equipment availability across jurisdictions, with some types of equipment available in particular jurisdictions but not in others. Different types of injecting require different equipment, therefore a consistent range of basic equipment should be provided across all NSP service types.
- **Creating an enabling environment that maximises the widest availability of injecting equipment**
Inconsistencies in legislation and regulation, such as the varying legality of peer distribution of injecting equipment across jurisdictions, should be addressed to ensure that these barriers to injecting equipment access are removed. Legislative amendments in the ACT and Tasmania that enable provision of injecting equipment for non-medical professionals provide positive examples of leadership.
- **Position NSPs as a core part of Australia's health system**
NSPs, particularly primary NSPs, need to be recognised as a core part of Australia's health system and embedded into broader health networks in order to create service and referral pathways between NSPs and other health services. Supporting partnerships through local Primary Health Networks provides a first step towards embedding fixed site NSPs into local health systems.

- **Create pathways for employment of peers and encourage peer-employment outside of primary NSPs, and ensure that peer workers are adequately supported in the workplace**

Findings from AIVL's consultation demonstrate the benefits that peer workers in NSPs can provide, however this is largely restricted to primary NSPs in metropolitan areas. Creating pathways to employment for peers in other NSP service types and outside of metropolitan areas will support additional engagement in the health system by people who inject drugs as well as building of peer networks that play a key role in information dissemination. The role of people with lived experience of drug use is critical in Australia's response to blood borne viruses because of the trust that exists within peer networks and their reach into communities of people who may not frequently engage with the health system.

- **Ensuring funding allows for flexibility of service delivery**

Allowing for greater funding flexibility will allow NSP services to better cater for local populations, such as providing outreach services in communities with dispersed populations, establishing operating hours that align with community needs or provision of a broader range of equipment that matches the community's pattern of usage.

- **Creating greater service awareness and managing expectations**

Underpinning best practice relating to NSP service provision also requires awareness raising and management of expectations amongst people who inject drugs around service types and service availability. Developing and implementing peer-led best practice principles within the NSP service system will help service delivery match service expectations however wider promotion of service availability may also help increase service access and overall needle and syringe coverage.

- **Creating consistency in data collection with a focus on collecting what is required**

Concerns over privacy and confidentiality were raised through AIVL's 2015 National NSP Forum and by a minority of participants in these consultations. Although it is not clear if data collection has any significant impact on decisions to access injecting equipment from a particular site, a best practice approach would suggest that only data that is absolutely necessary be collected.

Appendix One: Interview Schedule for Service Users



AIVL NSP Best Practice Project: Stage Two

Interview schedule for service users

Introduction and description of the project

Hi, my name is Susan Carruthers and I currently work for the West Australian Substance User's Association in WA. I am a Community Development worker based at WASUA's South West Branch.

I have been seconded by AIVL to conduct the second stage of their *NSP Services and People who Inject Drugs Access Needs Project*. The aim of this project is to develop a *Needle and Syringe Program Best Practice Guide* that is informed by peer experience and led by peer intelligence. AIVL have conducted a Literature Review of service models and key issues and this acts as a starting point for consultation.

This stage of the project involves talking to people who use a variety of NSPs to obtain clean injecting equipment. NSPs include syringe dispensing machines, pharmacies, hospitals, peer based needle and syringe programs and others). By talking to you and getting your opinions we can record your views and experiences of the services provided, focussing on the advantages and disadvantages of each service NSP service model.

It is important that you know that the discussion will remain confidential and no names will be recorded.

The findings from this stage of the AIVL project will be collated into a report that creates guidelines for NSP service delivery and will be available on the AIVL website later in the year.

Do you have any questions? Are you willing to be interviewed?

I need to ask if you give will allow me to tape this interview to ensure I gather as much information as possible and understand nuances of the conversations. The tapes will be deleted when the project is finished.

NSPs include syringe dispensing machine, hospitals or community groups where you can get injecting equipment free or at a cost, a fixed site which is set up just to provide services to people who inject, and pharmacies.

Primary Areas of investigation

A: Access to Injecting Equipment (IE)

[Below is a series of questions with detailed probes. The questions and probes are designed identify the advantages and disadvantages for each IE access point]

The first thing I'd like to talk about is the places you get injecting equipment.

1. Where do you usually get your injecting equipment (IE)?

Write in response (NSP, SDM etc.)

2. So can you tell me where else you go?

(List all the places they go – and record the advantages and disadvantages of each – see probes below)

Probes: *If a SDM what are the advantages of accessing IE through the SDM? What are the disadvantages?*

Do you have to pay at the machine or is equipment free?

Are you able to access sufficient equipment so you don't have to re-use any?

How often is the machine not working or empty?

If machine is empty is there anything you can do? (e.g. are there instructions on the machine?)

If you have put your money in and you don't get the equipment, is there someone available to help you?

Can you get your money back?

Can you take used needles there and dispose of them safely?

What are the advantages of accessing IE from NSP? What are the disadvantages? Are you able to access sufficient equipment so you don't have to re-use any? Are opening hours suitable? How many hours is the NSP open? Do you have trouble getting to NSP during open hours? Are there disposal facilities attached?

If a Youth/Health Centre/hospital what are the advantages of accessing IE through this place? What are the disadvantages? Are you able to access sufficient equipment so you don't have to re-use any? Can you take your used equipment to the centre for disposal?

If a pharmacy what are the advantages of accessing IE from a pharmacy? What are the disadvantages? Are you able to access sufficient equipment so you don't have to re-use any? Are there disposal facilities attached? Do you have to pay at the pharmacy? How much? Can you take used equipment to the pharmacy for disposal?

If you access equipment through friends etc. what equipment do they have? is there always enough of what you need?

3. So you use a range of places to get your IE. What makes you choose one place over another?

(e.g. easy to get to, open when needed, cost)

Has this changed over time? If so can you describe how and why it has changed?

4. Have you ever **not** been able to access injecting equipment when you needed it?

What was the situation? Out of NSP hours, no pharmacies open, no SDMs etc.

What did you need you couldn't get?

How often does this occur?

Have you ever had problems accessing the type of equipment that you wanted?

What do you do if your preferred location or source is closed or doesn't have the equipment you need?

5. When you get your injecting equipment (SDM, NSP, pharmacy, health centre, or personal supply) is there anyone there you can talk to about health issues?

How often do you talk with staff about other health issues?

If you use SDMs, are there other sources or people that you can talk to about health issues? Who are these people? E.g. asking for BBV testing or where to go, information about safer injecting, referral non-discriminatory doctors, ORT, other drug treatments? Peer information? Written resources?

Interviewer to read out the following:

6. *NSPs are staffed by people who use drugs as well as people who don't. Are there types of helpful information that the staff who use drugs can provide that others can't? What are these? Is there ever a different in experience when you access equipment from staff who use drugs over staff who don't?*

7. *What other services are available to you from (NSP/SDM/health centre/hospital/pharmacy)*

Probe for available referrals for drug treatment/Nurse/GP clinic/STI testing/HCV treatment/Wound care for each access point.

8. *What about other referrals such as accommodation services/crisis care/counselling/mental healthcare?*

What other services not discussed above would you like to see made available?

Have you ever needed a referral to another service?

Are there ever times when you can't get a referral to the service you want?

9. *Is there anything else you would like to mention about accessing IE?*

Part Two

The next part of the discussion is about being treated differently or unfairly because you are a drug user. The literature review I mentioned at the beginning of the interview highlighted that there are continuing reports of PWID experiencing discrimination and stigma when accessing injecting equipment. The following questions are designed to detail how the discrimination occurred, in what setting and whether there were any mechanisms by which the behaviour could be addressed.

1. *Some people who inject drugs report being treated unfairly when accessing injecting equipment.*

Has this ever happened to you or someone you know?

Can you describe what happened? Where were you? Who was involved?

Were you able to report the behaviour to anyone?

How did you feel about reporting what happened? Did you feel comfortable doing so?

What happened when you reported it?

If you chose not to report it, what was the reason that stopped you?

Did the same thing happen again at the same site?

The literature review highlighted concerns about being asked personal questions for data collection saying 'the purpose and security of data collection has been highlighted as an issue for NSP clients'. The following next few questions seek to find out respondents' views on being asked to participate in surveys or interviews for external research projects, for internal (peer based) surveys or for government based statistical requirements.

2. Have you ever been asked for personal information when you access IE? e.g. age, Aboriginality, type of drugs used?

If yes, did the person explain why they needed that information?

How did you feel about being asked these questions?

3. Have you ever been asked to take part in a research project?

Did you agree to take part? Were you reimbursed?

Did you understand the purpose of the research?

Probes: How did you feel about the interview? Did you feel you were treated with respect?

Did you feel your input was valued?

Were you happy with the level of confidentiality offered

And one final question.

Overall, how could NSPs better respond to your needs? What changes could be made to make sure you can access injecting equipment anytime and every time that you need it?

Thanks for taking part in this project. It is important to us that we hear the voices of people who use NSPs so we can improve services

Background Information – for interviewer only:

Location of interview

Gender

Estimated age

Time started

Time finished

Reimbursement given

Contact details given if they wish to discuss the interview with AIVL?

Appendix Two: Consultation Actions and Timelines

Stage	Actions	Resources	Timeline
Stage One: State and territory drug user organisations (DUOs)	Develop a literature review of NSP service models and key issues that acts as a starting point for consultations with AIVL members	Staff time	By 30 January
	Plan, invite and host a national consultation with member organisations. Consultations will be a semi-structured focus group format and cover topics including: <ul style="list-style-type: none"> • jurisdictional consultations that have already taken place • current NSP service models • perspectives on current best practice • barriers to implementing self-identified best practice • evidence and gaps in knowledge related to NSP practice 	Staff time Travel costs Event costs	30-31 January
Stage Two: People who inject drugs	Building on and adapting the outcomes from Stage One, support state and territory DUOs to undertake consultations with people who inject drugs, focusing on the advantages and disadvantages of the variety of NSP services models and raising other critical issues identified in Stage One. Consultations will aim to engage 20 participants in jurisdictions with a funded DUO, and a minimum of five participants in jurisdictions without a funded DUO. Consultations will be semi-structured and DUOs will have the flexibility to decide between one-on-one interviews or focus groups, depending on time, resources and appropriateness of either format.	Funding for state and territory DUOs to undertake consultations Participation fees for key informants AIVL staff to provide support as required and requested, particularly in jurisdictions without an established DUO	February-April 2017
Expert Advisory Group	Establish an Expert Advisory Group (EAG) drawn from key informants in Stage One and Stage Two consultations to shape the development of the best practice guide. EAG will meet virtually via teleconference and peer member participation will be supported through other means if required.	Staff time Participation fees for peer members	April-June 2017

Table 2: Overview of NSP service delivery models in Australia with service user feedback incorporated into summary of advantages and disadvantages⁶

Outlet Type	Description/Settings	Advantages	Disadvantages
Primary	Service where the core function is NSP service delivery	<ul style="list-style-type: none"> Specialist service with focus on harm reduction Service focus on NSP means better trained staff who are motivated to work with people who inject drugs Accessibility: often distribute a diverse range of equipment, no limits, free 	<ul style="list-style-type: none"> Focus on NSP can mean that holistic health needs of service users are not prioritised Cost of running service high relative to other models
Secondary	Service outlet where NSP service delivery is done in the context of another service, most often a health service. Settings are diverse and include but are not limited to Community Health Centres, Youth Service, Emergency Departments, Women's Health Services, Aboriginal Medical Services	<ul style="list-style-type: none"> Variety of service models and locations expands access to locations where demand is not high enough to support a primary service 	<ul style="list-style-type: none"> Lack of specialist knowledge of the issues affecting people who inject drugs Can lack confidentiality/privacy for service users Staffing models may result in service users frequently experiencing stigma and discrimination
Pharmacy	Pharmacies provide NSP within a commercial pharmacy setting. They are enrolled in NSP distribution via schemes that vary across jurisdictions	<ul style="list-style-type: none"> Highly accessible with the potential to provide service delivery in any location with a pharmacy service Low cost as situated within an existing expert health service May be able to access greater variety of equipment in some services 	<ul style="list-style-type: none"> Cost of equipment can be high Service users often experience stigma and discrimination Lack of specialist knowledge of the issues affecting people who inject drugs Can lack confidentiality/privacy for service users
Syringe Dispensing Machines	Syringe dispensing offer equipment for a nominal fee (\$2 – 4) or free. Often located near health facilities or primary outlets for after hours service	<ul style="list-style-type: none"> Confidential Flexible service locations 	<ul style="list-style-type: none"> Usually only stock single unit syringes with no ancillary equipment No opportunity for health promotion or engagement Often run out of equipment on weekends/holidays

Sourced for AIVL Literature Review 2017

⁶ Based on consultation work by AIVL, NUAA,

Appendix Three: Jurisdictional differences in secondary NSP distribution

	Possession of equipment	Peer/extended distribution permitted?	Comments
NSW	Legal	No	NSW recently trialled a peer distribution scheme via the NSW Users and AIDS Association. The scheme ended in July 2016 and has not been renewed in spite of a favourable evaluation
VIC	Legal	No with exceptions	Peer distributors are registered as NSP volunteers via the Department of Health and Human Services. Harm Reduction Victoria supports a network of peer distributors (the Peer Networker Program) in partnership with NSP services. ¹
QLD	Legal	No	
WA	Legal	No	WASUA is submitting an ethics application to examine secondary distribution. Police routinely confiscate sterile equipment.
SA	Legal	No	
TAS	Legal	Yes	Peer distribution similar to ACT and NT authorised as at June 2016
NT	Legal (with defence)	See comments	Restrictions have eased to extend the number of people authorised to distribute equipment to community and other settings and authorisation has been broadened to include peer distribution. (June 2016) It's permissible to distribute large volumes.
ACT	Yes	Yes	Peer distribution has been decriminalised. Anyone, including peers, can distribute so long as the aim is to prevent blood borne viral infections (changed in 2016)

Appendix Four: Data questions asked when accessing injecting equipment

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA
Occasions of Service	✓	✓	✓	✓	✓	✓	✓	✓
Unique Individuals	✓	X	X	X	X	X	X	X
New or existing client	X	X	✓	X	✓	X	✓	X
Gender	✓	✓	✓	✓	✓	✓	✓	✓
Age (or age range)	✓	✓	✓	✓	✓	✓	✓	✓
Language at home	✓	✓	X	X	X	X	X	✓
Indigenous status	✓	✓	✓	✓	X	X	X	✓
Postcode of residence	✓	X	✓	✓	X	X	X	X
Equipment distributed	✓	✓	✓	✓	✓	✓	✓	✓
Collecting for others	X	X	✓	X	✓	✓	✓	X
If so, how many others	X	X	X	X	X	✓	✓	X
Drug injected	✓	✓	✓	✓	✓	✓	X	X
Disposal: returns to NSP	X	✓	✓	X		X	✓	X
Disposal: usual method	X	X	X	X	X	X	✓	X
Condoms distributed	X		X	X	X	X	✓	X
Shared needles and syringes since last visit	X	X	X	X	X	X	✓	X
Referral	✓	✓	✓	✓	✓	✓	✓	✓
Health education/Brief intervention	✓	✓	✓	✓	✓	✓	✓	✓

Appendix Five: Interview Schedule for Service Providers



AIVL NSP Best Practice Project: Stage Two

Interview schedule for service providers

Introduction and Preamble

Hi, my name is Susan Carruthers and I currently work for the West Australian Substance User's Association in WA. I am a community Development worker based at WASUA's South West Branch.

I have been seconded by AIVL to conduct the second stage of their *NSP Services and People who Inject Drugs Access Needs Project* the aim of which is to develop and implement a *Needle and Syringe Program Best Practice Guide* that is informed by peer experience and led by peer intelligence. AIVL have conducted a Literature Review of service models and key issues and this acts as a starting point for consultation.

The second stage of the project involves talking with and discussing, in semi-structured interviews, with people who work at NSPs (Peers, non-peers, managers and others) who are involved in providing NSP services. The aim of the discussions is to record views on the current services, focussing on what services are currently offered and how services could be improved to provide for the needs of those who inject drugs.

A short report on the findings from this stage of the AIVL project will be available on the AIVL website later in the year.

It is important that you know that the interview/discussion will remain confidential and no names will be recorded. I need to ask if you give permission for me to tape this interview to ensure I gather as much information as possible and understand nuances of the conversations.

Do you have any questions? Are you happy to continue?

Peer interview schedule

The first thing I'd like to talk about is your job/role within this NSP.

How long have you been employed here? What does your day look like? What sorts of things do you do

What is it like working here as a peer?

Probes: feeling supported; feeling valued; feeling like they fit in, given opportunities to develop,

Who showed you what to do when you first started?

Probes: on-site training; external training; on-line training

Do you think there are opportunities for you to develop?

Do you ever have to ask clients for specific information – like asking their age, or the drug they last used? How did you feel about asking the questions? Do you understand why you are asking the questions? How do the clients react?

For other workers/managers in Secondary Programs

Is there specific staff involved in handing out IE or is it part of everyone's duties?

Does staff get training?

(Describe training – in-house, on-line, external courses etc.)

Has the program changed over time? How and why?

How much interaction do the staff/you have with users of the service?

For example, are you able to offer advice to clients about safer injecting? Do you have written resources on offer? Maybe refer to other health services, social services, housing etc.?

Do you think there is a need for the service to expand?

Does the program have the resources/capacity to expand the range of services?

How could the organisation improve the service?

What would your 'gold standard' service look like?

What are the barriers to achieving this?

(Footnotes)

¹ Peer Networker Program, <http://hrvic.org.au/safer-drug-use/the-peer-networker-program/the-story-so-far>, accessed January 2016



www.aivl.org.au