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Publication details:
Report No. NCHSR Monograph 5/2000
1875978364 (ISBN)

Publication Date:
2000

DOI:
https://doi.org/10.26190/unsworks/1200

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ISBN 1-875978-36-4

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The National Centre in HIV Social Research is funded by the Commonwealth Department of Health and Aged Care through the Australian National Council on AIDS, Hepatitis C and Related Diseases (ANCAHRD) and is affiliated with the Faculty of Arts & Social Sciences at The University of New South Wales. This study was funded by Wentworth Area Health Service.

ACKNOWLEDGMENTS

Our thanks go to the following people and organisations: the staff at St Marys Community Health Centre, the New South Wales Users and AIDS Association (NUAA), Anne-Maree Weatherall, Fiona Poeder, Maureen Steele, and the NUAA peer educators. Thanks to the service providers, residents and other stakeholders who made time to attend the focus groups. Our thanks also go to needle and syringe program clients who gave generously of their time.

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LIST OF ABBREVIATIONS

D&A: Drug and Alcohol

CBD: Central business district

CHC: Community health centre

HCV: Hepatitis C virus

HIV: Human immune deficiency virus

IDU: Injecting drug user

LGA: Local government area

NSP: Needle and syringe program

OOS: Occasions of Service

WAHS: Wentworth Area Health Service

INTRODUCTION

Background

Prior to the 30 June 1998, the primary needle and syringe program (NSP) outlet for Wentworth Area Health Service (WAHS) operated out of St Marys Community Health Centre (CHC). This primary outlet was known as St Marys NSP. The outlet had operated as an over-the-counter style of service provision, out of an office within the community health centre. St Marys NSP had been operating for some three and a half years, first as a secondary NSP before it was established as the primary NSP outlet for WAHS. The need for a primary NSP outlet grew out of increasing client numbers, with the service peaking at over 2000 occasions of service per month for April, May and June 1998.

At a meeting held in the first week of June 1998, WAHS personnel were informed that a decision had been made by the Chief Health Officer of the NSW Department of Health to close St Marys Primary NSP service. The decision to relocate NSP services was taken in response to concerted lobbying by local community members and traders who were represented by the local Member of Parliament for St Marys. WAHS were given three weeks to devise an alternative model of NSP service provision. WAHS responded by relocating St Marys NSP from its fixed site location at the CHC to a mobile service operating out of a van and a car, and by increasing the capacity of secondary NSPs. This included devising a new model of service delivery; negotiating with local government and the police on suitable parking sites; informing clients; and purchasing and outfitting the van. The last date of operation from the CHC was to be the 30 June 1998. Wentworth Area Health Service commissioned the National Centre in HIV Social Research to undertake a study on the impact of the closure and relocation of primary NSP services from fixed site to mobile van. After delays in securing ethics approval from WAHS Human Ethics and Research Committee, the study commenced in February 1999. The study aimed to assess the social and health impact of the relocation of the WAHS NSP on clients of the service, service providers and other stakeholders from the community, using qualitative research methods and a review of existing NSP data.

WAHS demographics and geography

According to the Australian Bureau of Statistics World Wide Web Information Source, the estimated resident population for WAHS in 1998 was 308,159. The WAHS population is one of the fastest growing in Australia, with the proportion of the population under 15 years of age significantly higher than the NSW average.

WAHS covers three local government areas (LGAs) including City of the Blue Mountains, City of Hawkesbury and City of Penrith. Each of these LGAs has considerable geographic and population differences. Blue Mountains LGA has long-established residential areas that primarily run alongside the Western Railway Line and Great Western Highway. Blue Mountains covers an area of approximately 1405 km^2, most of which is national park, and

has a population density of 54 residents per km². Hawkesbury LGA has large tracts of wilderness and is sparsely populated. It has two small commercial centres at Windsor and Richmond. Hawkesbury LGA covers approximately 2792 km² and has a population density of 22 residents per km². Penrith LGA has the fastest growing population in WAHS and covers approximately 406 km². Penrith LGA is the main commercial centre of WAHS and has 422 residents per km². The sheer size of WAHS is evident when considering its total geographic area of 4604 km².

Model of NSP service provision before 30 June 1998

WAHS NSP primary outlet operated out of St Marys CHC for a period of three years prior to its closure. In addition to the primary outlet, a range of secondary NSPs operated in outlying CHCs, select youth services and welfare organisations and an accident and emergencies department at a hospital. Ten secondary NSPs operated prior to 30 June 1998. These secondaries continued to operate after the relocation of the primary NSP outlet.

Model of NSP service provision after 30 June 1998

The short time frame given for relocation of primary NSP services meant that NSP management and staff had to devise a transition plan to cover all aspects of the relocation. Of particular importance was informing NSP clients of the new model of mobile service delivery. This included consulting clients on the best times and places for the van to park and appropriate hours and locations for the operation of the outreach service. Extensive negotiations with the local police and council—who influenced the decision on where the van would park—were also necessary. The short time frame gave the operators little time to consider the most suitable form for mobile service delivery, and did not allow for adequate client and community consultation processes.

The model of service delivery decided upon involved the van parking for two hours in one of two locations, five days a week. The timetable follows:

- Monday, Wednesday, Friday 10am-12pm: The van parks in an area off Forester Road, Ropes Creek.
- Tuesday and Thursday, 10am-12pm: The van parks at St Marys railway station, north side car park.

Every afternoon, except Wednesday when a staff meeting is held, is taken up with outreach services (operating out of a station wagon) and restocking of secondary NSP outlets. Staff are also expected to respond to all requests for clean-up of discarded needles and syringes. Afternoon outreach services operate in designated areas on specific days. For example, Monday afternoons the station wagon travels to the Blue Mountains; Tuesday and Thursday the van travels around St Marys and Penrith; and Friday afternoon NSP staff go to the Hawkesbury region. Afternoon operating hours are approximately 1.30-4.30 p.m. Given the geographic size of WAHS, some time is spent travelling to the Katoomba, Hawkesbury and Penrith CHCs on the designated afternoons. WAHS also runs health clinics for users, with registered nurses, at Katoomba and Hawkesbury CHCs on Monday, Tuesday and Thursday afternoons respectively. These clinics began in June 1999. Vending machines were installed in the Katoomba in May 1998 and Hawkesbury in November 1998 and have proved popular.

Changes to the above timetable were made in July 1999, with the van parking at the railway station three days a week rather than two, and at Forester Road two days per week. Operating hours have remained the same. While there were limits on the amount of injecting equipment dispensed from the NSP when it operated out of the CHC, it was decided that there would be a limit of a box of 100 needle and syringes given out from the mobile service.

Key issues

The effectiveness of Australia's needle and syringe program in limiting the spread of HIV among injecting drug users (IDUs) has been well documented (Hurley, Jolley & Kaldor, 1997). Although NSPs have been less successful in curbing the transmission of hepatitis C (HCV) amongst IDUs, with prevalence rates for HCV at about 65 per cent compared with less than 3 per cent for HIV (National Centre in HIV Epidemiology and Clinical Research, 1998), there is evidence that HCV incidence in Australia has been declining in recent years (Crofts, Jolley, Kaldor et.al., 1997; Crofts & Aitkin, 1997; MacDonald, 2000). Such a decline can, in part, be attributed to the preventative and educative role of NSPs. NSPs are widely acknowledged as providing a vital service in the delivery of information and education about the risks for transmission of blood-borne viruses. As well as supplying free condoms they also deliver information on other injecting health risks such as overdose. Importantly, NSP staff often provide timely and appropriate referrals to counselling, drug and alcohol detoxification, rehabilitation and methadone treatment services as well as legal and welfare agencies (Davies, 1998).

Given the important preventative and educative role played by NSPs, any major shift in NSP service provision, particularly within a short time frame, should be subject to evaluation. Though there are few studies that explicitly address the impact of closing NSP services, a recent study documenting the impact of the closure of a well-established needle and syringe exchange in the United States suggests that IDUs make 'substantial adjustments in reaction to the closure of the needle exchange, primarily in substantially increasing both their procurement of new syringes from unsafe sources and in their re-use of used syringes' (Broadhead, Van Hulst & Heckathorn, 1999: 58).

The social and health impact study of the closure and subsequent relocation of NSP services in Wentworth Area Health Service concentrated on building a picture of the impact of the closure and relocation of primary NSP services in the twelve months (July 1998-July 1999) following the closure the NSP outlet at the CHC. The study investigated factors such as physical access to the van for IDUs including IDUs with particular needs such as young people, single parents and those reliant on public transport. Access issues were also examined in terms of local policing practices. Other areas for investigation included the impact of the relocation on a range of service providers including St Marys NSP staff who made the transition to mobile service; service providers from secondary NSP outlets within WAHS; and service providers from NSPs outside of WAHS. The study also aimed to explore the issues and concerns of other stakeholders including local residents, traders and representatives from local council.

METHODOLOGY

Aim of study

The aim of the study was to assess the social and health impact of the relocation of WAHS primary NSP services from fixed outlet to mobile service on the following groups of people:

- clients of the service (injecting drug users)
- service providers from WAHS and outside of WAHS
- other stakeholders from the community.

Methodology

Initially, it was envisaged that rapid assessment methodology (RAM) (Vincent & Allsop, 1996) would be employed to assess the immediate impact of the relocation as it occurred. However, the study was delayed by the WAHS Human Ethics and Research Committee and did not commence until seven months after the closure and relocation of primary NSP services. The delay affected the type of data we could collect and a decision was taken to employ a number of methods to generate information to build up a retrospective picture of the initial impact of the relocation and snapshot of current impact, some eight months after the closure. The methods employed were:

Review of existing NSP data: This involved collating and analysing data collected by NSP outlets within and outside of WAHS. The finding are presented in Trends in NSP Data, p. 13.

Focus groups: This involved recruiting participants for group discussion on the impact of the relocation. Focus groups were held for injecting drug users, service providers and other stakeholders. Participants were recruited during February 1999. Focus groups were audio-taped and the tapes transcribed.

In-depth semi-structured interviews: A decision was made to conduct in-depth, semi-structured interviews with young people (under the age of 25). People in this group were considered difficult to locate and unlikely to attend a focus group. The interview schedule covered areas such as initiation and transition to injecting, current injecting practice, access to equipment before and after the relocation, and knowledge of injecting risks. Several stakeholders, including the Local Area Commander of Police, the Local Member for St Marys, and the managers of NSP and Drug and Alcohol Services in WAHS were also interviewed on the relocation issue. Interviews were conducted from February-June 1999. Interviews were audio-taped and transcribed.

Field observation: The research officer undertook 20 hours of observation in the field during March-June 1999. This included observations from the NSP van and general observations of activity surrounding the sites in which the van parks. Observations were recorded in field note form.

Sample–qualitative arm

Injecting drug users: A total of 36 IDUs participated in the study. Thirty-two IDUs participated in focus groups, with four young people interviewed individually or in pairs. An equal number of men and women were recruited for focus groups and interviews.

Service providers: Fourteen service providers participated in focus groups or interviews: six from secondary NSPs operating within WAHS; three from NSP and other services operating in an adjacent area health service; and three staff from WAHS mobile service itself. The co-ordinator of WAHS NSP and HIV Area Program Manager were interviewed individually.

Other stakeholders: Twelve other stakeholders participated either in focus groups or face-to-face interviews. A focus group was held for representatives of local government, local traders and members of the Community Consultative Committee, a group established by WAHS as a community liaison group on drug and alcohol issues. Six people attended this group. Another focus group was open to the residents of St Marys—four people attended. Face-to-face interviews were conducted with the Local Area Commander of Police and the Local Member of Parliament for St Marys.

Recruitment

A variety of techniques were used to recruit participants for IDU focus groups, including fliers and posters, stickers on fitpacks and 'snowballing' through key informants. Service providers were invited to participate in the study through a letter, which was followed up by a phone call. Other stakeholders were recruited through a letter inviting participation. A brief column inviting community participation was published over three weeks in the community forum section of the local press. All participants were offered $20 to reimburse travel and other expenses; most accepted.

Data analysis

NSP quantitative data were collated and analysed for trends (see Method, p.14). Focus group and interview transcripts were analysed for key themes and issues, the analytic process guided by a 'grounded theory' approach (Glaser & Strauss, 1967; Strauss, 1987).

Time frame

The empirical arm of the study was undertaken over a six-month period starting from early February 1999. NSP data was reviewed for at least the period 6 month prior to and after the relocation of NSP services.

Ethical considerations

Permission was sought from The University of New South Wales and Wentworth Area Health Service institutional ethics committees before recruiting for interviews or focus groups commenced. The confidentiality of participants in focus groups and interviews was assured. Upon transcription of the tapes all personal and place names were changed to ensure anonymity.

TRENDS IN NEEDLE AND SYRINGE PROGRAM DATA

Introduction

This chapter reports on data collected by primary and secondary NSP outlets within and outside of WAHS. They were analysed to identify possible trends in client access to NSPs within and outside of WAHS prior to and after the relocation of NSP services from fixed site to mobile service.

These data describe a range of NSP client demographics and NSP service variables. They are collected by staff at WAHS NSP outlets, Blacktown NSP and Cabramatta NSP. An analysis of WAHS data collected between 1996 and 1998 was undertaken.

Methodology

NSP data are collected on a daily record sheet that is standard at most NSPs in NSW. NSP staff record client's sex (Male/Transgender/Female) and nominate an age category (1=Under 16, 2=16-19, 3=20-24 etc) at the conclusion of each occasion of service (OOS). Staff are also required to record whether a client is a new or a repeat attendee to that particular outlet. Records of equipment given out, equipment returned, clients' methods of disposing of equipment, referrals to other agencies, number of condoms given out and other services provided are also collated by staff on this form.

The raw data from the daily record sheets were collated and used to create a descriptive statistical profile of trends regarding NSP services.

Issues in analysing NSP data

We originally intended to examine variables such as occasions of service, equipment given out and numbers of new clients in relation to both primary and secondary NSP service delivery, but a number of factors confounded the analysis of the data on 'occasions of service' and 'equipment given out'. The main factor was a change in policy on limits of equipment. When the WAHS primary NSP operated out of St Marys CHC, there were limits on the amount of injecting equipment to be given out per occasion of service (e.g. 25 1ml needles per visit). This meant that many clients made a number of visits per week to pick up adequate amounts of equipment. With the closure and relocation of primary NSP services, this limit was raised to 100 1mls per visit. As clients could pick up bulk equipment per visit, they visited the NSP less frequently. This substantial rise in the amount of equipment given out per visit made it impossible to compare the figures for occasions of service and equipment out prior to and after the relocation to a mobile service. The only variable suitable for comparison, pre and post relocation,

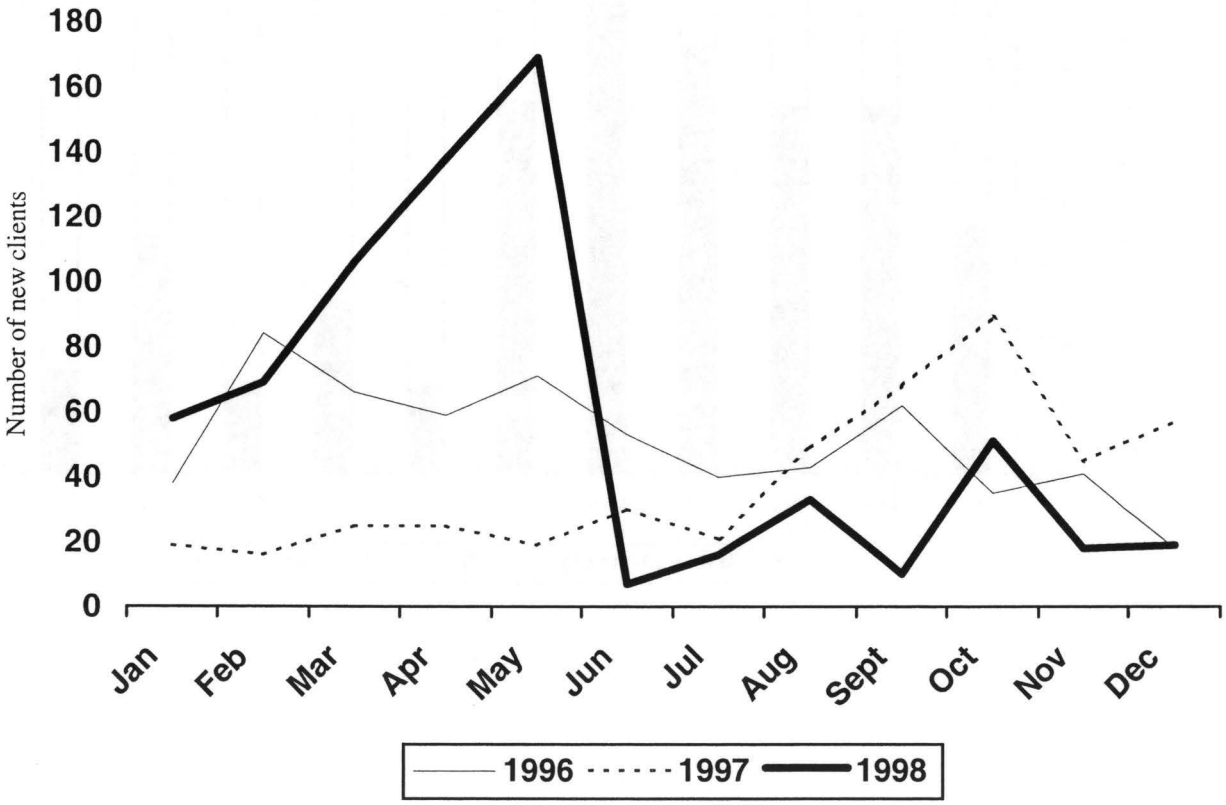
was that of new clients (see Graphs 1 and 2). It should be noted that the recording of data at secondary NSPs is often haphazard. We restricted our focus on data from WAHS primary and secondary NSPs to December 1998 in order not to confound the results with the withdrawal of big barrel syringes and winged infusion sets (butterflies) which occurred from 1 January 1999.

Data from two NSPs outside of WAHS were collected to see if there had been a 'flow-on effect' after the relocation of primary NSP outlet from fixed site to mobile service. It was decided to collect data from Blacktown NSP in Western Sydney Area Health, as it is the nearest NSP to St Marys. Data from Cabramatta NSP were collected as anecdotal evidence suggested that many clients of St Marys NSP travel to that area to buy drugs. Blacktown NSP does not collect postcode information while Cabramatta NSP does. It is therefore necessary to treat the Blacktown data with caution (see Graph 3).

Results

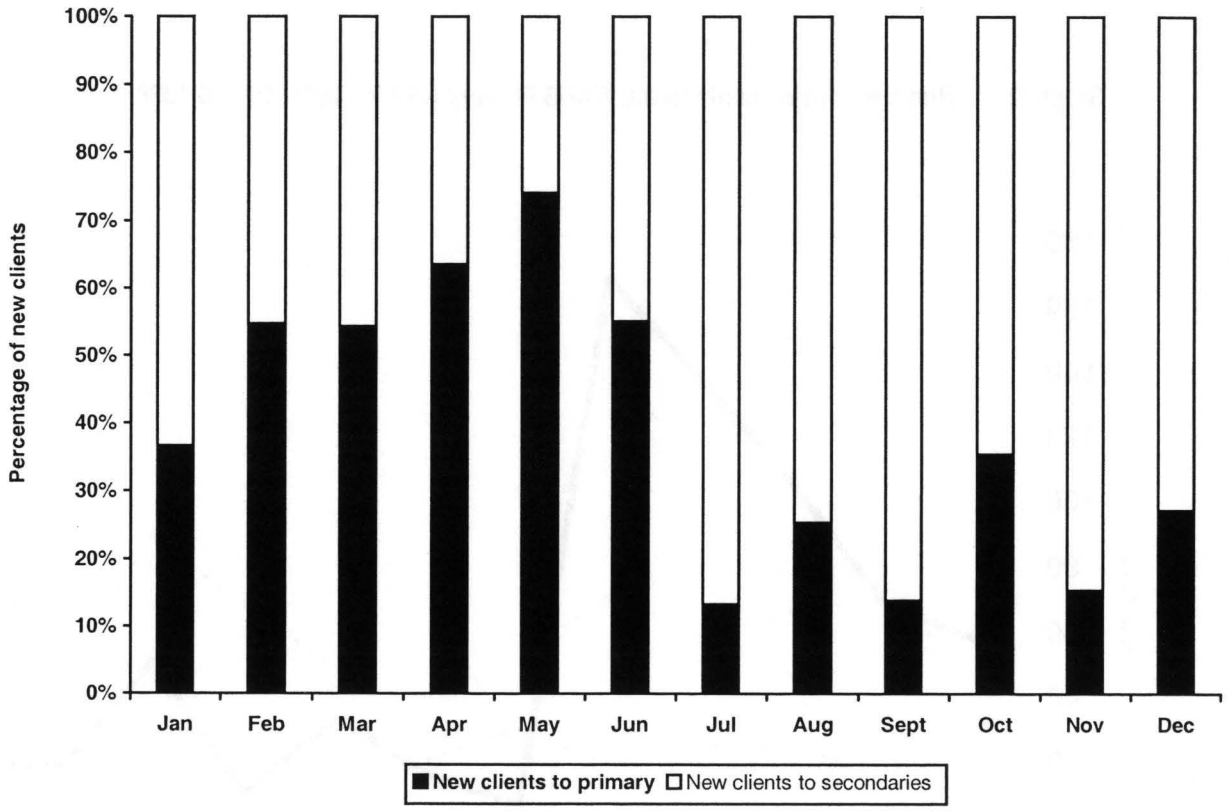
Graph 1 illustrates the decline in numbers of new clients attending WAHS primary NSP services. This primary fixed outlet ceased to operate after 30 June. In the months prior to closure, this NSP had experienced a rapid increase in new clients compared with the previous two years. After primary NSP services became mobile, the numbers of new clients fell dramatically.

Graph 1: Number of new clients to the WAHS Primary NSP for 1996, 1997 & 1998



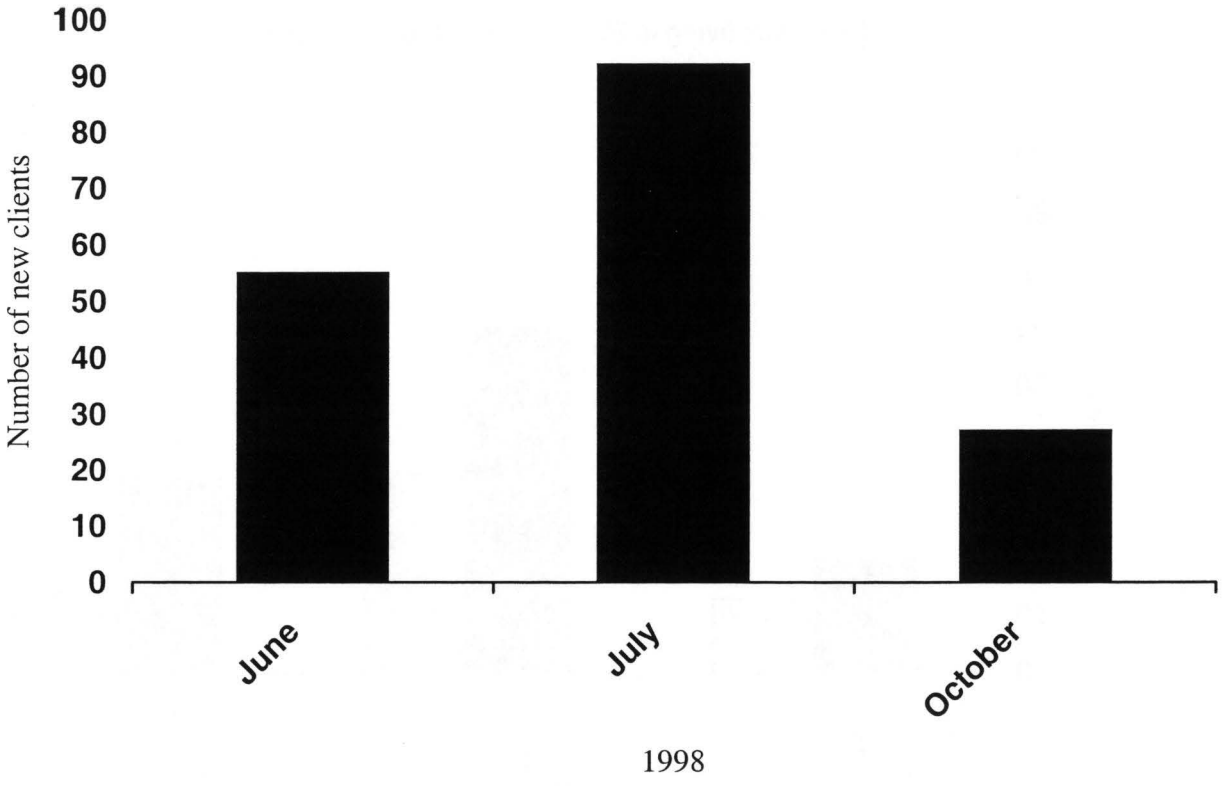
Graph 2 shows the percentage of new clients to both primary and secondary NSP sites within WAHS for 1998. An increase in clients attending secondary NSP outlets occurred from July when the primary NSP outlet at St Marys CHC closed. This graph illustrates the subsequent trend for clients to use secondaries once primary NSP services shifted into the van.

Graph 2: Percentage of new clients to the WAHS NSPs in 1998



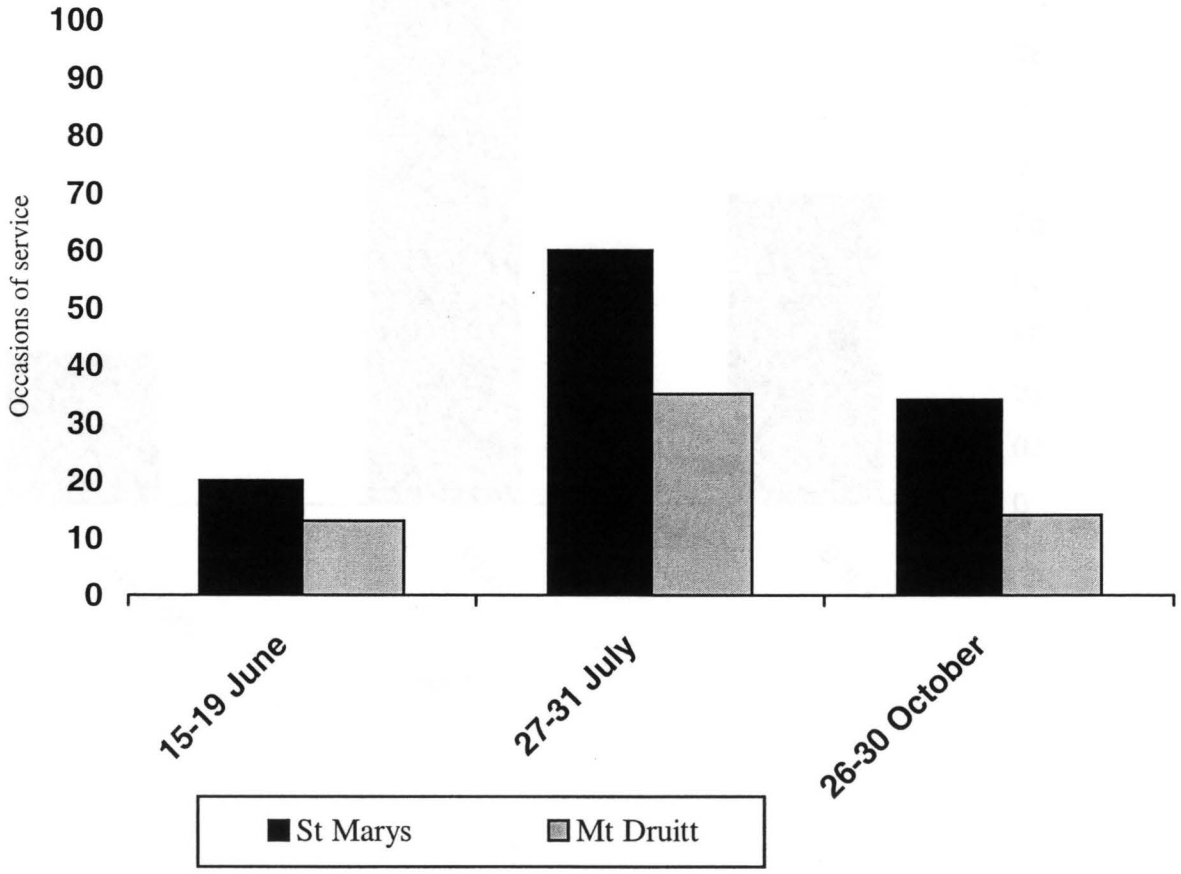
Graph 3 shows the number of new clients at Blacktown NSP located in the adjoining Western Sydney Area Health Service. While Blacktown NSP does not collect postcode data, NSP workers suggest that some of the increase in new clients can be attributed to the closure of the NSP fixed outlet at St Marys.

Graph 3: New clients to the Blacktown NSP service for the months shown in 1998



Graph 4 shows the occasions of service for the Cabramatta NSP for the weeks shown in June, July and October 1998. Coinciding with the closure of the primary NSP outlet in St Marys was a rise in occasions of service at Cabramatta NSP fuelled by St Marys and Mt Druitt clients. We collated data for Mt Druitt clients, as previous postcode surveys conducted at WAHS primary NSP had revealed that a considerable number of clients from the Mt Druitt area attended the service. By October this increase in occasions of service for Mt Druitt and St Marys clients had declined.

Graph 4: Cabramatta Needle and Syringe Program occasions of service for clients living in St Marys and Mt Druitt in 1998



Discussion

Perhaps one of the most salient issues to arise out our attempt to make sense of NSP data involves the need for reliable data collection methods to be established at NSP outlets. Staff at secondaries often feel they are too busy to record information and this affects the accuracy of data collected. In addition to this, secondary NSPs often have a number of staff members doing needle dispensing. This means that a new client could be recorded multiple times. Staff training in the collection of raw data would contribute considerably to the accuracy of data collected, and this would subsequently improve the quality of information on which to base models of NSP service delivery. Alternatively, twice-yearly 'snap-shots' might provide a more accurate and meaningful picture of client base and efficacy of service delivery than an ongoing data collection process. Snapshot surveys might also provide vital postcode information that could be used to pinpoint areas in which IDUs live for outreach and health promotion purposes.

These data offer limited insight into access issues for IDUs. Although bulk injecting equipment is being given out, it is impossible to tell if the equipment is being distributed throughout injecting networks or is being hoarded. While the data are difficult to interpret, graphs 3 and 4 do show an initial upturn in new clients for the months following the closure of St Marys primary NSP outlet. This upturn indicates a flow-on effect due to the closure. Graphs 3 and 4 also show a downturn in new clients for October. One possible explanation for this would be that it took clients several months to locate a secondary NSP outlet within WAHS. If this was the case, clients no longer needed to travel to NSPs in neighbouring area health services. Graph 2, showing increased numbers of NSP clients attending secondary NSPs in WAHS, supports this assumption.

Conclusion

It is more than likely that there was a flow-on effect created by the relocation of NSP services to a van. The impact of this flow-on effect was more sustained on secondary NSP services within WAHS than NSP services outside of WAHS. The qualitative data collected during the course of the study provides evidence in support of the flow-on effect created by the closure and relocation of NSP primary services and an insight into access issues for NSP clients.

IMPACT ON NEEDLE AND SYRINGE PROGRAM CLIENTS

Introduction

The chapter explores issues raised in focus groups and in-depth interviews conducted with injecting drug users (IDUs) who are current and former clients of WAHS primary NSP services. The chapter is arranged according to the following themes:

- Initial impact
- Access
- Policing practices
- Quality of service
- Sharing and re-using injecting equipment.

Initial impact

Participants of focus groups and interviews were asked to describe how they found out about the closure of the St Marys primary NSP at the CHC and the introduction of the mobile service. Most participants had heard about the closure of the primary outlet by word of mouth. Some had been directly informed by NSP workers. Some found out by 'accident' after walking near the van. Other participants stated that 'casual' users, particularly young people, were the ones least likely to have been informed of the closure of the primary NSP outlet. As one young person stated:

> (A) lot of people who were actually casual users didn't know it was closing. Like, some people might have a shot here and there and actually we still got people now that come here and say, 'Where is it now?' (Some) still think it's down here (at the community health centre).

Participants were distressed that they had not been consulted about such a major change in the model of service delivery. The decision to close the NSP at the CHC came as a 'shock' to clients who had regularly used the facility over the three years it had been operating. As one participant remarked:

> Like I was saying... we had no consultation or anything that it was going to be closed. You know, all we got was... just a notice three weeks beforehand. What are we supposed to do? People have been using it for, like myself, you know over the years. What are we supposed to do? Dig a hole and crawl into it?

When asked about the initial impact of the closure on access to new injecting equipment, many participants suggested that it took several months to get used to the new model of service delivery. This included rearranging their lives in order to get to the van during its limited opening hours. Others stated that while they sometimes bought needles at the pharmacies, the expense prohibited the regular use of pharmacies as a source for new injecting equipment. Participants added that a black market grew up after the closure of the primary outlet, with people selling needles and syringes often at exorbitant prices. A hazard of this black market was that participants were unsure if the needle and syringe they were buying was new or used. Intermittent access to clean injecting equipment led some participants to re-use old injecting equipment and occasionally share their injecting equipment with partners and close friends. Participants had also witnessed IDUs picking up used injecting equipment from streets, public toilets or the garbage of known users. Many participants stated that these practices became increasingly common after the withdrawal of equipment used to inject methadone.

Access to the mobile service

The issue of access will be presented according to the following themes:

- Location and transport
- Operating hours
- Outreach services
- Access to injecting equipment through secondary and other NSPs and pharmacies

Location and transport

Prior to its closure, St Marys NSP primary outlet at the CHC opened from 8.30 a.m.–5.p.m. weekdays. The CHC which housed the NSP is located in St Marys CBD, a few minutes walk from the railway station. Participants considered that they had easy access to NSP services when they operated out of the CHC because of its proximity to public transport. They also considered that they had substantially greater privacy when attending the NSP at the CHC compared with the van, which operates in public sites. The relocation of services to a van meant greatly reduced access to the new injecting equipment with the van parking two days at the car park on the north side of St Marys railway station, and three days at a site along Forrester Road, some two kilometres from St Marys CBD. The van operates at these sites between 10 a.m.–12.p.m. Both sites were selected after negotiations with local police and after consultation with NSP clients. Afternoons are taken up with home deliveries and travel to and restocking of secondary NSP outlets (see Introduction for service delivery timetable). Changes to the above timetable were made in July 1999, with the van parking at the railways station three days a week rather than two,

and at Forester Road two days per week. Operating hours have remained the same. It should be noted, however, that the IDU focus groups and interviews for this study were conducted prior to this change in timetable. WAHS NSP also runs health clinics for IDUs with registered nurses at Katoomba, Hawkesbury and Penrith CHCs on Monday, Tuesday and Thursday afternoons, respectively.

Participants made a number of comments in regard to the railway station and Forrester Road sites and the opening hours. The railway site was considered the better site of the two due to its proximity to public transport; however it was also considered 'too open', creating a situation where IDUs were 'on show' to the general public. Users were particularly afraid that someone who was not aware of their drug use might see them going to the van at the railway car park:

> It's embarrassing if you're at the bus and someone drives past that knows you because they know what you're there for.
>
> (It's like) putting your head on show. Everybody knows your business and it's just not right... Like everyone has got a right to a private life whether you're a drug user or not.

IDUs who also attended the local methadone clinic just over the railway line were afraid that staff at the clinic would see them accessing NSP services. These feared that staff at the methadone clinic could easily watch who was going to the van and that this might jeopardise their continuing participation in the methadone maintenance program:

> You're not supposed to be on methadone and walk into the van. According to the (rules) we're not suppose to be using.

If the railway station site had problems, the Forrester Road site was generally considered to be much more inconvenient and inaccessible. As one participant remarked, the Forrester Road site was 'virtually impossible to get to unless you've got a car'. While there was a bus that went along the road, there were fears that passengers knew that the van parked in the site just off the road was there for NSP purposes and that any passenger alighting at the stop nearby would be identified as an injector. Participants also feared being recognised by people driving by:

> I'd like to see it (the van)... like where it's not so much on show. Because on Forrester Road it's right where cars are driving in and out of St Marys... and I don't want people seeing me at the (van). Especially my daughter (and my) neighbour. I don't want... their friends seein' me there. Because a lot of people, when I'm on the bus (say), 'Oh look here's the junkie bus again'.

Transport was a particularly important issue, not only in terms of getting to and from the van, but in relation to picking up new injecting equipment and returning used equipment. Although there were high limits on amounts of injecting equipment dispensed from the van, the policy only advantaged those with access to private transport, as bulk equipment was difficult to carry on foot. There was also a danger that those carrying bulk equipment on foot would attract the attention of the general public and the police.

Operating hours

For clients accustomed to having access to NSP services for eight hours every weekday, the reduction in hours proved particularly difficult to adapt to. A number of participants did not know of the van's operating hours while others discussed the difficulties of getting to the van on time in the morning. Many people had factored in a daily or regular visit to the NSP when it was located at the CHC. For these participants picking up injecting equipment became part of the shopping routine: they would pick up equipment when they went out to buy their bread and milk. Clients who worked during the day also found it difficult to get to the van during its specified hours. As one participant stated:

> I've never used the (van) because it's never there when I want... I work every day and it's hard to get to it.

While a few participants stated that they had successfully adjusted their routine to meet the morning operating hours of the van, others commented that the unpredictability of their lifestyle meant they often missed the van.

> See I don't know about anybody else, but with my lifestyle, I don't just wake up in the morning and think, 'Oh I'm going to have a shot at this time of the day'. Like it just depends on the circumstances. Like I might run into someone... that owes me money or something. Right, so then if I'm organising to get on...it's easier for me to just rock on up to somewhere. Like I don't think, 'Oh well the bus is there at 12.00 so that's when I'm going to get on'.

The issue of limited operating hours arose constantly during focus groups. The issue was summed up by a participant who remarked:

> I can only use the (van) once a week and out of that week I've got four hours... That's what it works out for me personally—four hours—10-12 Tuesdays, 10-12 Thursdays. Out of the whole week I've got four hours (to get new equipment). That's not enough. It's ridiculous.

Outreach

Every afternoon except Wednesday, the NSP workers do outreach (clients can ring the van and have equipment dropped off to them). There were mixed feelings about the efficacy of such outreach with some participants liking the 'flexibility' and the anonymity it provided, while others raised issues of access in outer areas and the strict schedule the van keeps. For example, outreach was only available on specified days and in specified areas. Participants living outside of these areas or requiring equipment on days that did not coincide with the service's schedule found it difficult to get new injecting equipment. The effect of this on users living in some suburbs was that 'it was easier to re-use than travel one hour to get a clean (needle)'.

Some participants didn't fully understand the schedule that the mobile service worked to and felt that staff had unfairly 'knocked back' their request for outreach services. As one participant explains:

> I just know that when you ring up and they say, 'Oh we're in Katoomba,' and (I'm) in somewhere else, what are you supposed to do, pick a needle up out of the gutter? (They say), 'We can't come and see you, ring back tomorrow.' Tomorrow is too late.

Other participants feared that their anonymity as injectors would be jeopardised or 'blown' if deliveries were made to their home. For young people, living at home with unsuspecting parents, outreach to the home was not considered a realistic option.

Access to other NSP services

While the IDUs we spoke to were fairly reliant on the mobile service, a few mentioned that they did access secondary NSPs and occasionally bought injecting equipment from pharmacies. Twenty-three pharmacies within WAHS were contacted early in the study and asked if they had noticed any increase in the demand for injecting equipment in the six months prior to interview. Only five stated that they had. While the vending machines at Katoomba and Hawkesbury have proven popular, there is limited after-hour access to new injecting equipment in other areas such as St Marys, where no pharmacies sell injecting equipment. Participants explained that this situation meant that they had to buy equipment from acquaintances and strangers for a dollar a needle without knowing if the needle was new or used. Buying equipment in this way was considered expensive; some users preferring to re-use their own equipment rather than pay for equipment on the black market. Given that many users considered themselves 'night owls', lack of after-hours NSP access meant that late night expeditions for needles were not uncommon:

> Getting the needles, that's the main thing. It's bad, mate. I've got people comin' knockin' on my door 3-4.00 o'clock in the morning asking for needles, mate. Just for needles. It's a joke.

Policing practices

Perhaps the single most mentioned factor related to access to the NSP services is the impact of policing practices around the railway site where the van parks. There is a widespread perception that police and railway station staff surveil the area from the top of the railway bridge for the purposes of identifying injecting drug users:

> Where (the van parks) at the railway station, there (are) police officers or railway men watching us and taking notes down who was going to the bus... So that was another thing I didn't like at all—police always seeing my face going to get needles. They pinpointed me as being a drug user and that's something I didn't want them to know.
>
> I didn't appreciate the coppers and other people taking photos because they had the advantage. They were high and could look straight down on the van.

Many stated they were unwilling to make lengthy contact with NSP workers at the van in case the police came past. Others feared being picked up by police upon leaving the van and crossing back over the railway bridge:

> Well, what's good about (the van). I mean if you're stuck, I guess you... can go there. But then like I said you're going to get rousted, you know. Like the coppers are going to be on your back... and you're going to get padded down or whatever. It's supposed to be confidential, but I mean by the time you're over the other side of the railway station, the coppers have jumped on you. They're going through your pockets and everything. If you're getting a fit they think you're going to have dope on you.

Participants stated that they were sometimes approached by police if they were in possession of the blue carry bags NSP workers used to put equipment in. This made trips to the van on foot or by public transport particularly hazardous:

Participant 1:

> They (the police) followed us all the way until we got on the bus, you know, just because you had a blue bag.

Participant 2:

> Then they started following the bus.

Participant 1:

> They know what the blue bag is, don't they?

Another participant describes a 'blue bag' incident:

> I were in the pub, now they've (the police) come over to the table (and say), 'Who owns the blue bag?' They knew straight away. Kicked us all out... I felt so small... It was really degrading. They had no right to do that.

The police presence in the area meant that users were unwilling to return used needles to the van. There was a general consensus among participants that 'anyone that carries a dirty syringe around is just asking for trouble'. This was particularly so for clients who had to catch public transport or walk. Some participants were uncertain about their legal situation in regard to possession of a used fit. A lack of knowledge about the van's operating hours further compounded the disposal situation:

> I found with the van with your dirty syringes (that) you never know where they're going to be. So I don't think a lot of people are going to carry their dirty syringes... It's really scary.

An interview conducted with the Local Area Commander confirmed that the police had, for some time, 'concentrated heavily' on the area around the railway station near the methadone clinic, across the railway line from where the van parks. This increased presence involved, in the words of the Commander, 'police in uniforms, police on push bikes (and) run(ning) lots of operations, particularly on the train station and with the transit police'. Although the north side of the railway where the van parks is not specifically targeted, the presence of police across the railway line and at the railway station is noticeable. According to police statistics, the impact of such policing practices, combined with the closure of the primary NSP outlet, better public lighting and the arrest of a major car thief, had led to a reduction in stealing and theft from motor vehicle offences. Except for these two offences the crime level generally had remained the same.

Quality of service

The majority of participants commented on the general decline in the quality of service apparent since the relocation to a mobile service. For example the openness of the railway car park, the tight time frame of the van's schedule and a fear of police were factors that led to hasty contact with NSP workers. Participants were unwilling to spend time at the van to discuss health or other issues. The combination of these factors is apparent in the following focus group extract:

Participant 1:

> I've got four hours now (to pick up fits). Before I had 32 hours. Like in a nutshell.

Participant 2:

> And you just don't want to stand there and spill your guts to someone on the street.

Participant 1:

> In front of a van.

Participant 3:

> And you want to get away—you want to get away like D. said in case the cops drive past.

The van was not considered an ideal place to sit down and talk to workers about health or other issues. Participants repeatedly contrasted the 'private' and 'friendly' atmosphere of the NSP when it was located at the CHC with that of the van. As the following quote illustrates, there were numerous advantages to a fixed site operation:

> When it was here (at the CHC), it was good. You could have a shot and you could come back and drop your used syringes off and then you could go back and have a talk to the (NSP workers). We used to have some real good talks.
>
> I've been coming to (the NSP at the CHC) for years, you know, sort of it was all right, real friendly. They never made me feel like a junkie... So it's like when I come here it was nice to see the faces and they did generally give a shit. Like, if I come in and I didn't look well they'd say, 'Look J. are you all right?' Yeah, it was really sad when it shut down... I don't use the (van)... It's just too far out of my way. Too inconvenient.
>
> (When the NSP was at the CHC the staff) had time to give us lots of information, but they don't seem to have the time over (at the van) to do that... (The workers) haven't got as much time as what they did (at the CHC). They were here from 8.00 a.m. to 5.00 p.m. So they had a lot of time to talk to people and (give out) all the papers. With the bus they were only there for an hour, two hours. They haven't got time to sit down and talk to people and hand out papers.

The 'papers' this participant refers to are the various information sheets, pamphlets and referral material that NSP workers provide to clients. Participants claimed that the van was not conducive to lengthy conversations or inquiries about referrals. Some stated that they were so eager to leave the open sites where the van parks that they would not wait around for the short time it took for workers to find the health information they might require.

Single parents with small children were particularly affected by the shift to a mobile service. Whereas these parents, usually mothers, had factored a trip to the NSP into their daily shopping routine, the shorter operating hours and openness of the site near the railway station created a number of problems:

> Like you could walk (into the NSP at the CHC) with your little fella and like (it)... was discreet. You go to the bus and there's fits everywhere and the little kids know straight away they're needles, you know. They're not sort of hid like they were here... As soon as they open the side of the (van), well the whole (van) is just full of fits.
>
> When you (came to the NSP at the CHC) it was confidential, OK? Like, because the bench (counter) is really high. Most of our kids were pretty small... So (the worker) would be like, 'Hello S. and hello M.' and that and, 'How are youse going?' And while we're doing that they're getting my stuff because they know me so well and I don't even have to tell 'em what I want... You could have your kids (at the CHC).

While almost all participants agreed that the workers were friendly and willing to help, the general feeling was that the level of personalised attention each client received had substantially diminished since the move to a mobile service. Clients no longer felt comfortable sitting around talking to workers, asking workers' advice and receiving referrals and health literature. For single parents with young children, the shift to a mobile service meant a drastic loss of confidentiality. The shorter operating hours could sometimes not be accommodated into the routine of single parents, with some stating that they often re-used injecting equipment as a result of missing the van. Many single parents were without private transport. This factor and their fear of the police meant that they were unable and unwilling to pick up bulk equipment, leading to regular re-use of injecting equipment.

Re-using and sharing injecting equipment

Although the re-use of injecting equipment has been mentioned throughout this chapter, it is important to highlight the key concerns of the client group in relation to this issue. First, a number of participants stated that re-use of injecting equipment was fairly common since the closure and relocation of primary NSP services. Participants stated that they needed time to readjust their routine and familiarise themselves with the limited operating hours. It is significant that a number of participants were still unsure about operating hours, sites of operation and the existence of an outreach service.

While some participants had become accustomed to the new model of service delivery, others found it almost impossible to adjust their routine. Some of these were people with chaotic patterns of use who had relied on eight-hour, five-day-a-week access to NSP services. These clients found it impossible to pre-plan picking up clean needles or to organise their use to coincide with the mobile service's operating hours. Other clients disadvantaged by the new mode of service delivery were single parents with young children, many of whom had successfully integrated a trip to the fixed site NSP into their daily shopping expeditions. With the change in the model of service delivery, their pattern of accessing new injecting equipment shifted from routine to ad hoc. These clients stated that they regularly re-used their own equipment and occasionally shared equipment amongst partners and close friends.

For clients without private transport (many of whom were single parents and young people) picking up bulk equipment at the van was not a viable option. A lack of private transport made the Forrester Road site difficult to get to. The site at the railway station, while being the more accessible, posed its own problems. Not being able to pick up bulk equipment meant that trips to the van at the railway site would have to be made with greater frequency. For users, this meant an increased risk of attracting the attention of police, an outcome that was exceedingly undesirable. The confluence of these issues resulted in increased re-use of injecting equipment:

> (Since the NSP has moved into a van), it's just making it more difficult, you know, like the three of us have got to get around now. We've got no transport and, you know. We can only get to it two days a week... so it makes things virtually impossible. Like we're... using our dirties and that until we've got to buy new ones. It's, like, pot luck.

The lack of after-hours NSP outlets or pharmacies selling needles in the St Marys area also contributed to re-use. Even in areas where pharmacies did sell injecting equipment, some users stated that they only occasionally had enough money to buy needles. For users living beyond the specified outreach areas, access was even more of a problem, with many unwilling to travel to St Marys railway site on the specified days. For others, their erratic lifestyle precluded organising trips to the van within its specified operating hours. Put simply, for these clients the 'convenience' of knowing that the fixed site was open between 9 a.m.–5 p.m. had been replaced with the 'hassle of getting to the van'. This unpredictable access to new injecting equipment is captured in the following quote:

> You drive past and like if we see them (the van), when they're up (on Forrester Road), like we'll stop in and grab them. So like that guy said, you don't know when you're going to use or whatever.

A number of clients reported witnessing other users picking up used injecting equipment out of the gutter, from the floor of public toilets or out of the garbage of known users. As one participant explained:

> For other people... they're not going to travel a long distance to get something. If they see one (a fit) on the street... they'll just pick it up and use it and then later on think of the consequences.

While some clients had successfully adjusted to the shift from fixed site van to mobile service, others have been severely disadvantaged. The bulk distribution of injecting equipment has benefited clients with access to cars but not those who travel on foot or by public transport. Furthermore, it is difficult to assess whether users were hoarding bulk equipment or distributing it to others within their networks. Many participants were unsure of the operating hours of the mobile service and were unaware of the outreach option. Others lived outside specified outreach areas and were unable to take advantage of this mode of service delivery. For these clients re-use and sharing of fits occurred regularly. Finally, the presence of police near the railway station was a deterrent to those who accessed the van both on foot and by car. NSP clients were fearful that their car registration would be taken or that they would be identified as injecting drug users and be targeted by the police.

Conclusion

Widespread re-use and sharing of injecting equipment has implications for the spread of blood-borne viruses such as HIV and HCV. Also of concern are other injecting harms that arise from re-using injecting equipment—such as septicemia, thrombosis and long-term vein damage. The lack of privacy that clients feel when they attend the van results in hurried visits and limits the ability of staff to provide education and referrals. While clients who were aware of the weekly health clinics run in Katoomba, Penrith and Hawkesbury benefited from the service, the van was not considered a suitable site for clients to sit down and discuss personal and health issues. In summary, the quality of NSP service provision has seriously diminished since the relocation from the CHC to a mobile service.

IMPACT ON PRIMARY NEEDLE AND SYRINGE PROGRAM SERVICE PROVIDERS IN WENTWORTH AREA HEALTH SERVICE

Introduction

This chapter explores the impact of the relocation on WAHS primary NSP service providers. This includes both NSP managers and workers, with the greatest emphasis on the experiences of those working from the van. A focus group was held with the three primary NSP service providers who had made the transition from the fixed site to mobile service. Information gleaned from the focus group was supplemented by ongoing casual conversations and field observations, which were documented in the form of field notes and memos. Information collected from primary NSP workers confirmed the data collected from IDUs, with workers identifying the same problems with the mobile service as the clients. NSP workers also raised significant concerns about their ability to provide a quality health service for clients from a mobile outlet as well safety issues.

Initial impact

The decision by the NSW Department of Health to close such a long-established and popular service was completely unexpected by both management and workers. The extremely short time of three weeks given to prepare for the relocation put a considerable strain on both management and workers. Management and workers put together an action plan to facilitate the transition from fixed site to mobile service. Within three weeks they performed numerous tasks including devising a model of service delivery, purchasing and fitting out the van, informing clients about the new model of service delivery, consulting clients on the best places to park the van, liaising with local government and the police on appropriate sites to park and addressing occupational health and safety concerns for NSP workers. These tasks were undertaken on top of regular NSP duties.

The suddenness of the decision coupled with the short time frame for relocation created much stress among both NSP clients and workers. The lack of consultation around the decision produced feelings of disempowerment and anger amongst NSP workers:

The impact for the (NSP) staff... has been pretty difficult...They feel angry. They feel disempowered... (This is) what we experienced when the decision was made totally against our advice and without consultation. So they feel disempowered and they feel victimised.

The short time frame made selection of the sites for the van to park particularly difficult, as it did not allow for adequate consultation of the client group on preferred sites. A process whereby clients would stick a drawing pin on a map in order to indicate preferred sites was devised. However as NSP staff acknowledge, this process was problematic. There was little time to assess the pros and cons of potential sites or to determine whether the most popular sites on the map were really representative of client preference. A worker sums up the impact of having to make an important decisions such as site selection without adequate time or consultation and in relation to the conflicting needs of local government and police:

> We had three weeks notice. What we did in that three weeks, we put a map on the clients' side of the counter and with drawing pins we marked where they thought would be good sites for them for access. So the clients at least had some input into where the van was going to go... So we looked at the most popular places for the van to be and the most popular place is at St Marys. At St Marys railway station, we were only allowed (by police and council) to be there two days a week. The next popular site was out (at Forresters Road). In hindsight we get a lot of reports that it's not a very popular site at all. So it was popular by, you know, the same two people probably putting two or three more drawing pins in there (when they shouldn't have).

As the inadequacies of the new model of service delivery became apparent, feelings of anger and frustration among workers mounted. As one worker remarked, there was 'huge depression (and) emotional upset at the loss of clients'. Workers contrasted their feeling of achievement when working at the busy fixed site NSP with feelings of relative ineffectualness when working from the van:

Worker 1:

> It's taken a long time to accept and I know that... it's affected me... It's devastating because results were happening. There was productiveness happening (at the NSP at St Marys CHC) and the whole team was there heart and soul, heart and soul on a professional level.

Worker 2:

> Now we're there (in the van), just not being able to provide (an adequate) service... I felt like a vending machine that just didn't offer anything.

Inadequacy of NSP services for clients living in or near St Marys

There was a general consensus among NSP management, workers, the police and users that St Marys had been a hub for drug dealing and using for at least two decades. Large numbers of people who injected drugs lived in or near the suburb. Another factor said to contribute to the concentration of IDUs in St Marys and surrounding areas

was the presence of a methadone maintenance clinic in St Marys CBD. While the mobile service was considered to be advantageous to IDUs living in outlying areas of WAHS such as the Blue Mountains and Hawkesbury regions, NSP workers felt that clients living within or near St Marys were disadvantaged by the timetable of the mobile service and its limited hours of operation. NSP workers recognised that this was particularly true for IDUs without private transport living in or near St Marys. Lack of access was exacerbated by the fact that no pharmacies in St Marys sold needles. The issue of area of greatest need and access is summed up in the following exchange between workers:

Worker 1:

> There's no real advantage in having the mobile service... Our area of need is really St Marys... I mean of all our calls out (outreach) we go back to St Marys more than we go anywhere else.

Worker 2:

> There's nowhere you can get injecting equipment from (in St Marys).

Worker 1:

> That's correct. There's no pharmacy that will sell a syringe in St Marys. The added disadvantage is that (users living in) the satellite suburbs don't have a (NSP) service. So that's one of the reasons why it's an area of greatest need.

NSP workers stated that many St Marys clients could not adjust to the limited operating hours and to the outreach timetable. If a client rang and the van was out of the area or the workers unavailable, they were directed to the nearest secondary NSP or pharmacy that sold equipment. While it was hoped that the client would make a trip to pick up new equipment, workers had heard from clients that they would rather re-use or share than travel:

> (I)f you call at the wrong time, it might be part of business hours, (but) we're not necessarily available. Wednesday afternoon... we're in meetings, the phone rings and sorry, we can direct (clients) where to go, but if you're in St Marys and you're sweating and you're hanging out and you've got the drugs in your pocket, you look for an alternative... as quickly as you can. Clients are reporting... many clients have reported the sharing of equipment. The sharps containers have been broken into, public bins, containers. (We're) hearing about needle stashes, which is quite inventive. You get some needles and stash them somewhere for when you're in St Marys. Providing they haven't been picked up or used by someone else (you put) them back in that area (after use).

In addition to the practice of 'stashing', workers had heard of an increase in shooting galleries in St Marys. They were concerned that in the area of greatest need, IDUs had invented their own systems for getting injecting equipment and that this had resulted in more re-use and sharing of needles.

Outreach

Only a small number of clients used the outreach service, either because people didn't know about the service, or because people who did not had a limited understanding of the van's timetable. This meant that staff spent most afternoons stocking secondary services and supporting the staff at secondaries rather than distributing injecting equipment:

> (The clients) haven't quite worked out our outreach service yet. We've only got a few regulars that ring up... Most of our outreach is spent stocking up secondaries. So (outreach) is not really utilised to its full potential as yet.

Education and referrals

NSP workers found that the van did not provide an environment conducive to the development and delivery of information or health promotion resources. The van was not an appropriate place to do 'project work' or develop particular educational resources or initiatives. In addition, clients were unwilling to 'hang around' the van for fear of being seen by police or other community members. Clients' preference for very quick visits meant that since the mobile service began operation, they rarely asked for information or health promotion resources. As one worker explained:

> There's no long time being spent at the (van) or any depth engaging with us (as) the worker and the client.

The speed of the visit made it difficult for workers to pass on information with adequate verbal explanation. Sitting down and talking with clients was considered vital, given the often low literacy levels of the group. This situation was contrasted with the way informal education and health promotion campaigns were run from the NSP when it was housed at St Marys CHC. Workers stated that the fixed site offered them a number of private spaces in which to conduct one-on-one education and informal counseling:

> (At the CHC) it was good being able to sit somewhere in a space when the client is in crisis or in need, and you can give them a cup of tea... and they can just have that space, five or ten minutes and go from there... I feel that the real core (of the NSP service) has gone. They'll come up (to the van), they'll have a bit of a yarn and stuff, but they're looking over their shoulder. They're looking behind (and then) they're gone.

The NSP at the CHC had a number of spaces (shop front counter and offices or intake rooms) that allowed for either quick pick-up of injecting equipment or more lengthy contact with workers. The current lack of a private, 'safe' space and the unwillingness of clients to 'hang around' the van made it difficult to give clients appropriate referrals to other health, legal and welfare services. Prior to the relocation, NSP staff regularly provided clients with referrals, particularly to drug and alcohol services such as detoxification and rehabilitation. There was also a range of services at the CHC that NSP clients could, on occasion, access without appointment. The following quote illustrates the impact of the relocation on referrals:

> (When the NSP was at the CHC) there was social workers available and there was a drug and alcohol worker by the name of Mr A. that was also available and we were able to have the support and access of (Mr A.)... (on) immediate call if a client came in (asking for help)... If Mr A's schedule was not too booked out he, would say to us, 'Yeah right oh, (send the client in) straight away.'...There were registered nurses that gave assistance.

The CHC had private spaces that allowed workers to 'build up rapport' with clients, many of whom would stop by regularly for a chat. The relaxed attitude of both workers and staff allowed for education and health promotion as well as timely referrals. Neither workers nor clients considered the van to be a 'friendly', 'confidential' or 'private' space. Another advantage of operating out of a CHC was that it allowed for staffing flexibility. According to workers, if a client sought referrals or wished to discuss an issue, then one staff member could take the client to an office, while the other serviced the counter. Staff did not feel that working the counter alone was a safety issue, as they were situated in a busy CHC with other staff around.

Loss of client contact

While NSP workers stated that they had substantially less contact with clients in general, they also identified certain client groups with whom they had lost contact. These were Aboriginal users, young people, steroid users and IDUs who were employed. Workers were aware that many clients who had previously come to the NSP when it was at the CHC, were still around the St Marys area, as they had seen these clients walking down the street during afternoon outreach trips.

Workers were unsure if the new needles they were distributing in bulk to limited numbers of clients were being distributed through networks of injectors. With limited and rushed contact at the van, it was impossible to ask clients if they were distributing or hoarding the equipment they picked up.

Safety issues

NSP workers raised a number of safety and health issues in relation to operating out of a van. First, there were limited toilet facilities at the sites where the van parks; and second, there were concerns regarding staff safety. The security the workers felt when they worked out of the CHC had been replaced with a good deal of uncertainty:

> (In the CHC) we put in an emergency buzzer... We had an alarm that made a noise if you pulled it, but also a secret button. If you pressed (the button), a doorbell would ding dong in the reception area, and then we had a protocol for staff to come in and... check what was going on. So (at the CHC we had) all those extras in terms of security and safety of staff.
>
> When the exchange operated out of the CHC it was still an open and friendly space with that extra added protection should anything happen.

The public, open nature of the railway station car park and Forrester road site meant that workers had little control over how clients might use the space. Workers felt that since moving to the van they were 'less in control' of the interaction process between client and worker. Workers also acknowledged that they could not effectively 'control' how clients used the public spaces near the van:

> (In the CHC) we had the right to control the space. (When) we're taking the van to a dirt car park, when a client wants to go behind a tree and shoot up, although we need to deter them from doing that... its not our space. So we don't have the right to control that space. So that makes things difficult.

Conclusion

In professional and personal terms, NSP workers felt disillusioned about the lack of consultation around the decision to close the primary NSP service. The short time frame allowed for the transition to a mobile service meant that staff were required to make major decisions about an alternative model of service delivery 'on the run' and without adequate client consultation. There was a consensus among NSP workers that the overall quality of NSP service had diminished since the advent of a mobile model of service delivery. The views of workers and clients on diminished quality of service were almost identical. Workers described the fixed site outlet at the CHC as 'busy, with a stable client base'. Both workers and clients like the fixed site because it was integrated into a mainstream health facility rather than isolated. The fixed site outlet was also well known among more transient clients who would 'drop in' during the course of their travels. Workers describe the atmosphere as being like a 'milk bar' where users could stop by, chat and pick up their equipment:

> (It was) like how you have a milk bar. Just in the main shopping street, you know, it was like a milk bar that people would come (to)... We've met all sorts—stewards from ships (and) other travellers—and it's just word of mouth and it was just this continual flow. All shapes, sizes, from here, there and everywhere.

Workers commented that the relocation to the van altered the atmosphere of 'comfort' and 'safety' for both workers and clients. Sitting out in the middle of a car park or paddock, with clients who feared being seen, was not conducive to effective education or referral processes. The following quote captures the change in atmosphere:

> (When we were at the CHC) we were a good first point of contact to a range of health services... It's just a seedy as a drug deal now. We're in a paddock and it's (like clients keep) looking behind, over their shoulder and (they) pick up their equipment, jump in (their) car and take off.

NSP workers stated that the shift to the van had substantially impacted on the ability of staff to give timely and appropriate referrals. It had also impacted upon the ability of staff to develop and implement education initiatives—the closure inadvertently de-skilling them. Client contact had significantly decreased, with workers seeing almost no steroid users, IDUs who are employed, youth and Aboriginal people. Workers highlighted a number of safety issues in relation to operating out of a van: these including security concerns and the inappropriate use of public space by some clients close to where the van parks.

IMPACT ON OTHER SERVICE PROVIDERS

Introduction

Focus groups were held with other service providers working within WAHS and in an adjoining area health service. Some of these service providers were NSP workers and youth workers; others were from secondary NSP outlets in WAHS (CHCs and youth services). Other service providers including those working within WAHS' drug and alcohol sector contributed to the discussion. A total of nine service providers participated. Six were from secondary NSPs operating within WAHS and three were from NSPs operating outside of WAHS. This chapter examines the experiences of these service providers and is organised as follows:

- Impact on secondary NSP service providers in WAHS
- Impact on other service providers in WAHS
- Impact on service providers in an adjacent area health services.

Impact on secondary NSP service providers in WAHS

Increase in numbers of NSP clients attending secondary NSP outlets

Most service providers working at secondary NSP outlets within WAHS spoke of increased numbers of IDUs attending their service since July 1998. One service provider describes this increase in IDUs presenting at her service:

> I was just looking back through figures last year. Back in June (1998) we just had 80 clients access (our) service (for new injecting equipment). In March (1999) we had 240. So over the months it gradually picked up, and also our orders for equipment have gone up too. We were placing an order once a month. Now it's up to two or three orders a month because of the numbers.

For some secondary services, the increase in client numbers increased pressures on the staff. As one service provider explains:

> I guess for us it's increased pressure to provide a replacement service, which we were never set up to really provide.

The impressions of these service providers is supported by NSP data show significant increases in the number of new clients going to secondary outlets since July 1998, the month when the WAHS primary NSP service became mobile.

Quality of service

Service providers at secondaries were concerned that they were unable to supply the same quality of service that clients received when they attended the primary NSP outlet at the CHC. Secondary service providers did not feel that the physical layout of their services provided enough anonymity for NSP clients who feared being recognised by neighbours or other members of the local community. Staff had only brief contact with NSP clients who usually wanted fast service and were unwilling to 'hang around for any length of time'. Staff at CHCs, particularly administration personnel who were required to do NSP duties, were particularly busy and had little time to provide information or education. The following quotes by an administrator and CHC health worker respectively, illustrate this point:

> I don't think we could provide as good a service as St Marys (primary NSP outlet) did... I mean, not because we're opposed to it, but realistically (NSP) exchanges are happening in reception with, like, all the other medical issues going on... There's very little education work (we) can do... I mean, if they're unsure of how to use stuff, they won't ask us.

> I think one of the biggest losses for (NSP clients) is the lack of support. There is nowhere they can go and talk. In secondary outlets mostly the admin workers are so busy...Well, even if they don't mind doing it, they're too busy anyway. The big loss (with the closure of the fixed NSP site) is that if they (IDUs) want to talk to someone, there's no-one there.

Service providers stated that some administration and other staff did not support the program. These staff were not welcoming of NSP clients, displaying negative attitudes towards them:

> (A)t X service (needle and syringe exchanges) are done by the admin staff, and some admin staff hate that part of their job. They just think that its an awful part of their job... They often have a real philosophical argument with us as to whether or not they're going to see a needle and syringe exchange (client). No-one is forced to do it and I think that users can pretty much pick up that sort of body language if (they) come to the counter. They do pick it up and... if you've got someone who is reluctant like it really shows up and it makes (NSP clients) feel uncomfortable and that's when you start having problems.

A few service providers stated that with the increase in NSP clientele came an increase in 'problems'. These problems involved 'anti-social' behaviour towards CHC staff and injecting on CHC premises. Some staff at secondaries expressed fears about their security and safety.

NSP clientele

Service providers described their client base as consisting primarily of men, under 30 years of age. They were seeing few women, and virtually no women with children. There was an absence of young mothers, who constituted a considerable proportion of clients of the primary NSP when it was located in St Marys CHC. The absence of this group from NSP clientele attending secondaries was frequently remarked upon:

Service Provider 1:

> I'd actually thought we'd (get) some of the younger women with their children, which used to happen a lot at St Marys (CHC). They'd actually buy their shopping—it was all part of the trip. That's not the case (now). Largely it's a male clientele coming in and I would say mostly young males up to the age of 30.

Service Provider 2:

> I know what J. is talking about. I haven't seen those women either. And they've just sort of disappeared.

Secondary service providers stated that the lack of anonymity at CHCs made it difficult for young people in particular to access NSP services. As one service provider pointed out:

> I mean you can be really busy in the waiting room. It's hard enough to get young people to come in and grab a handful of condoms and get out the door, let alone ask for a fitpack.

Impact on other service providers in WAHS

The impact of the closure of the fixed site on other service providers in WAHS was varied. The most significant impact had been on a drug and alcohol (D&A) worker who had worked closely with primary NSP staff. St Marys CHC had provided a confidential and comfortable space for clients to discuss their health and other needs with NSP workers. This allowed NSP workers to build up rapport with clients who subsequently requested referrals to other services. Many of these referrals were to the D&A worker who provided counseling and referrals on to detoxification, rehabilitation and treatment services. According to this worker, there had been a dramatic drop in his referrals since the shift to a mobile service:

> Prior to the closure of the needle exchange (at St Marys CHC)... last year, we actually set up a drop-in service through the needle and syringe exchange for (IDUs) and the impact that (the closure of the fixed site) has had on my referrals (to the drop-in service is) my referrals went from something like 15 per cent to something like 22-23 per cent... That was a significant increase in the number of referrals as a direct result of having that drop-in arrangement... I found that people, when they get into using drugs, particularly (injecting) drugs... their life becomes very impulsive. They do things on the spur of the moment and we took advantage of that impulsivity by having that drop-in arrangement. They could just come in and say, 'I want to talk about getting off the stuff,' and that increased the referrals dramatically. As soon as the needle exchange closed at the end of June (1998), the percentage of (IDUs) referring to me dropped from 22-23 per cent of all my referrals down to 5 per cent.

Primary NSP workers confirm this dramatic drop in the referral process, particularly to D&A services. They maintain that the van, parked in a car park or paddock, does not provide the privacy and confidentiality needed for referral processes to be undertaken.

Impact on service providers in an adjacent area health service

NSP service providers in an adjacent area health service confirm a flow-on effect, similar to that of the secondaries inside WAHS. A definite flow-on of St Marys NSP clients occurred after the fixed site closed. The flow-on effect to their services was of much shorter duration however, lasting about two or three months after St Marys fixed site closed. Initially, clients from St Marys fixed site were given cards with a phone number to contact the new mobile service. This flow-on of clients is confirmed by trends in NSP data (see Chapter 3, p. 13).

Conclusion

Many service providers working in organisations offering secondary NSP services within WAHS have been substantially affected by the relocation of primary NSP services to a van. These services have experienced a prolonged flow-on effect while other NSP services outside of WAHS experienced a much shorter flow-on of St Marys clients. Increased numbers of clients at secondaries in WAHS has put already busy staff under increased pressure. Staff at secondaries inside of WAHS do not feel that they can offer the same quality of service to NSP clients as a primary outlet. Staff at secondaries are seeing few young people who inject, Aboriginal and women IDUs. Some staff at secondaries are reluctant to provide NSP services and there are mounting concerns regarding security and safety. Referrals of IDUs to a key D&A worker within WAHS have dropped considerably.

IMPACT ON OTHER STAKEHOLDERS

Introduction

Stakeholders from local government, the traders association and the Community Consultative Committee (a liaison group established by WAHS to look at drug and alcohol issues) were invited to participate in a focus group or one-on-one interview. Six stakeholders representing these groups attended a focus group. Another focus group was arranged for residents of St Marys. Advertisements for participants for the residents' focus group were placed in the community forum section of the local press over a number of weeks. Community members were also invited to partake in one-on-one interviews if they preferred.

Four community members attended a focus group. It should be noted that there was ongoing confusion over the topic for discussion at these focus groups, with participants confusing the local methadone maintenance clinic with that of the needle and syringe program. To most focus group participants, NSP services were inextricably linked to the private methadone clinic that operated near St Marys railway station. In addition to these focus groups, the Member for St Marys and Local Area Commander of Police were interviewed individually. All participants were asked to describe what the situation was like when NSP services operated at St Marys CHC. They were then asked to describe the situation since NSP services had gone mobile. Similar themes emerged from both focus groups and interviews. This chapter examines these themes according to the following time frame:

- The impact of the fixed site NSP service (prior to 30 June 1998).
- Impact of mobile NSP service (after 30 June 1998).

The impact of the fixed site NSP service (prior to 30 June 1998)

Background

Stakeholders from local government, traders associations and the broader community cited numerous negative aspects of the fixed site NSP. Interestingly, all said that it was impossible to differentiate the impact of the NSP from that of the private methadone clinic situated close to the railway station and CHC. The methadone clinic and NSP were seen as 'intertwined'. For these stakeholders it was impossible to 'separate' the two as they were both viewed as adding to volume and visibility of drug users in St Marys CBD. There was, as one participant pointed out:

> (A) really strong belief that if the methadone clinic wasn't there in the first place then we wouldn't have a needle exchange.

There was a strong view held by participants that the 'druggies' who came to St Marys were not 'locals' and that the methadone clinic and NSP had contributed to the 'drug' problem and to crime. The combination of NSP and methadone clinic in St Marys CBD was viewed as a 'very dangerous cocktail' attracting 'undesirables' to the area.

Attitudes to IDUs and the NSP

While some participants were sympathetic to the health and other needs of IDUs, most considered this group to be 'anti-social', 'irresponsible' 'criminals' and 'parasites'. The follow commentary is indicative of participants' attitude towards IDUs and their use of NSP services:

> The trouble is the people who use these things (needles) don't have any social mores. It doesn't matter what you provide for them and it doesn't matter what you give them, they have no respect for other people or the need for them to merge into a society and be part of that society. They're very selfish sort of people who, so long as they get their fix, as long as somebody provides them with a needle... they have no responsibility after that and therein lies the whole problem. We could forever provide just those little things... and they would still abuse all those facilities that were given to them...and that begins, in the rest of the community, a degree of... separatism... where there's them and us.

There was a pervasive view that one-for-one needle exchange should be implemented and a lack of understanding about the various roles that NSP services play:

> What got me was when I went into the needle exchange (at the CHC) and I saw the people and I sat there and watched what was going on and I said to a (NSP worker), 'Do you ask them about their health when you see them at different times?' That's not our job, I was told point blank... I was deplored and surprised that they didn't.

Visibility of IDUs and fear of crime

Much of the discussion in the focus groups and interviews centred on user visibility and fear of crime. The close proximity of the methadone clinic to the NSP at the CHC was thought to have attracted large numbers of IDUs to the area. According to participants, the high visibility of IDUs at the railway station end of town made people feel uncomfortable and fearful. Business at the railway end of the CBD suffered from a lack of pedestrian traffic. A concentration of users near the railway station was considered inappropriate as it deterred the general public from using public transport and exposed school children to 'inappropriate behaviour'. The people who 'hung around' the railway station were assumed to be IDUs. The visibility of these people was offensive to local traders and shoppers:

> I'll never forget that morning we were at the station and all these blokes, it was a warm morning, and they were laying around. To be honest, they looked more like animals or dogs or something, laying around outside the place. Now the atmosphere might be OK in parts (of) Swaziland or somewhere else, but I mean we don't want to see that in St Marys.

Participants were fearful of venturing to the railway station end of town because of the presence of IDUs. They stated that they had witnessed drug dealing in the area and reported that bag snatching was commonplace. Most were afraid of being sworn at or physically assaulted. Others found it frightening to travel in the vicinity of the railway station. The following story exemplifies this fear of crime:

> This is just one thing that happened to me and I am an older resident. I'll be honest with you: I'm 53. Now I went around next door to the railway station, I bought a packet of smokes. I had to go to the chemist shop, so I had to walk past the methadone clinic, past the hotel to the zebra crossing to go through to that shop. This lady, roughly the same age as me, I don't know come up and said, 'Do you mind if I walk with you?' and she put her arm through mine. Right and I'm saying, 'Never seen you in your life. What are you doing?' I said, 'What was all this about?' She said, 'I cannot get off the train, walk up the main street of St Marys past that methadone clinic and the hotel because of the druggies and the drugs... I don't know what's going to happen to me.' Now that lady, to put it politely, was shit scared.

Participants were wary about parking their cars around the railway station as crimes against property were common. The high visibility and concentration of IDUs near the railway station and fear of crime were directly associated with the fact that the methadone clinic and the NSP at the CHC were a couple of minutes walk from each other. Their proximity was said to have created a zone of fear.

Impact on business

Representatives from traders associations and the local MP attributed the gradual demise of St Marys CBD to the methadone clinic and NSP. A fall in the number of consumers using the shopping area was linked to fear of crime, user visibility and car theft. Profits were said to be diminished by IDUs who shoplifted. The presence of 'druggies' was also linked to a drop in property value:

> I'm a self owner (of a) building... in the CBD and just after I bought it, it was valued at $700,000. Now I was refinancing it and the valuation was about the same. But then I had a letter (from the lender) saying, look the valuation was 700 but we feel it's only worth 500 because of the drug problems in St Marys... Is it any wonder that I'm a little bit upset because I just lost $200,000 overnight? That's cold hard cash.

Needle litter

Perhaps the greatest concern arising from the interviews and focus groups related to needle litter. The dumping of used injecting equipment was of grave concern to all participants who stated that this was a 'mammoth problem' prior to the relocation of the NSP from the CHC to a mobile service. The high level of concern is illustrated in the following quotes:

> The deplorable situation was the fact that everywhere you went in that CBD there were syringes... It was absolutely shocking.

> We built a new toilet block down in X. Lane and it was a super duper block. We had a change table for babies. We had to take that out because they kept finding needles in it.
>
> The needles were all around... where the swings are and the slippery dip... And they're all sticking out... and you can't see them with the (long) grass.

Lack of response from government and health authorities

Participants felt 'frustrated' and 'angry' at what they perceived as a lack of response from WAHS and government authorities. They were upset that there had been no consultation process before either the methadone clinic or NSP opened in St Marys. Indeed, they described themselves as being the government's 'guinea pigs' in regard to the locating of these two services in close proximity. Participants expressed annoyance at having attended public meetings about the methadone clinic and NSP in which their concerns were not responded to. They were particularly angry at the 'health people', this being a term for personnel from WAHS and the state government. This frustration and anger is summed up in the following quote:

> (There would) be meetings but I saw them as talkfests. Nothing really happened. It was let's have a meeting to placate the people that are complaining and we'd all talk... but you'd go away and nothing had happened. You'd have a meeting in three months time and nothing had happened... Everybody was going to do something, but this went on for many years and each one of us at this table would have been extremely frustrated with the run-around that we did get. And it was really fantastic to see finally that the needle exchange did close last year.

Participants stated that their frustration turned to intense, organised lobbying after a meeting in which issues related to the methadone clinic were discussed. This further indicates the way NSP services and the local methadone clinic were inextricably linked in the minds of participants. Indeed many saw their next task as lobbying to get the methadone clinic out of the St Marys area.

Impact of mobile NSP service (after 30 June 1998)

There were conflicting views on the impact of the relocation of NSP services from fixed site to van. While traders stated that there had been some reduction in crimes such as shoplifting, they maintained that the presence of the methadone clinic still contributed to user visibility and fear of crime. Fear of crime was a major concern for participants of the general community focus group despite the relocation of NSP services. Indeed one resident attending a focus group was unaware that NSP services had ceased to operate from the CHC, stating that he had not noticed any difference in user visibility in St Marys CBD. In general, participants attributed a fall in car thefts and property crime to an increase in police presence and new lighting down the railway end of St Marys CBD rather than the closure of the fixed NSP site. Both traders and community member felt that there had been little decrease in drug dealing.

On the issue of needle litter, it was the impression of traders and local government representatives that there was a marked decrease in dumped needles in the CBD. Alternatively, local residents thought that the shift to a mobile service meant that needle litter was no longer concentrated in the CBD but rather was becoming increasing apparent in streets, parks and paddocks away from the CBD. They suggested that the mobile service had caused a displacement effect, with needle dumping shifting to other areas in St Marys rather than ceasing:

> We're saying going mobile hasn't made this problem (needle litter) any better. It's just that it's spread it over a bigger area.

Local residents stated that the displacement effect was evidenced by an increase in the number of needles they now found in and around suburban streets and an increase in shooting galleries in derelict houses and other buildings. The other impact of the relocation of NSP services that this group highlighted was the 'offensive' nature of seeing the outreach service drop off needles to clients in the CBD.

Conclusion

The impact of the relocation of NSP services appears to be negligible in terms of user visibility and fear of crime. It is impossible to determine the extent to which the relocation impacted upon the fall in crimes against property and car theft in the CBD. As the police point out, the drop in crime is probably due to a combination of factors including increase in police presence near the railway station, better lighting, the shift in NSP services and the incarceration of a well-known car thief. While traders and local government representatives argued that needle litter has decreased in the CBD, local residents pointed to a displacement effect, with needles being dumped more frequently in suburban streets away from the CBD.

CONCLUSION

Key findings

This chapter highlights the key findings that arose from focus groups, interviews and NSP data.

- There is and has been for several decades, a concentration of people who inject drugs living in St Marys and surrounding suburbs.
- The three-week timeframe set for the transition from fixed site NSP to mobile service severely impeded the development of an effective model of service delivery. The short time frame did not allow for an adequate consultation process with the client group, police, local traders and residents. Such a consultation process is vital if an appropriate and accessible model of NSP service delivery is to be formulated.
- The rapid closure of the fixed site NSP at the CHC caused a displacement effect with IDUs traveling to secondary NSPs within WAHS and NSPs in other Area Health Services. Secondary NSPs within WAHS have been most affected by this displacement, with significantly increased numbers of IDUs continuing to visit secondary NSPs.
- Access to new injecting equipment from the van is limited by its short operating hours in fixed sites, the openness of the sites in which it parks, and users' fear of attracting police attention. Furthermore, few of the IDUs who participated in the study were aware of or fully understood the timetable for outreach services.
- There is no after-hours access to new needles in St Marys.
- While giving out bulk equipment from the van benefits IDUs with private transport, it does not advantage IDUs who must make there way to the van on foot, bicycle or by bus. It is physically difficult to carry around bulk equipment, and IDUs without private transport are reluctant to do so for fear of attracting police attention. According to participants, it is often young people, single parents and Aboriginal people who are without private transport. These injectors are reluctant to keep returning to the van to get new equipment for fear of attracting police attention.
- Single parents, particularly mothers with young children, are reluctant to go to the van. They do not want their children to know that they inject, however this is difficult given that children can see injecting equipment in the van and witness NSP workers giving this equipment to their parents.
- IDUs without private transport refuse to return used injecting equipment to the van for fear of being picked up by police patrolling the railway station end of St Marys. They also fear that they will miss the van because of its short fixed-site operating hours and will be left carrying used equipment with them in a patrolled area of the town.

- Some IDUs have moved from a pattern of routine access to injecting equipment, when the NSP operated out of the CHC, to ad hoc access to equipment. These IDUs are unable to adjust their routine to suit the van's limited fixed site hours of operation.
- IDUs who work find it difficult to access the van due to its limited hours of fixed site operation.
- Since the move to a mobile model of service delivery, there has been a considerable decrease in NSP referrals to the main D&A counselor in St Marys.
- The move to a mobile model of service delivery has substantially decreased the quality of service delivery in general. The van does not offer private or confidential space suitable for education or referrals. IDUs are reluctant to spend time at the van for fear of being recognised as an injector by local community and the police. This compromises the ability of primary NSP workers to deliver harm reduction messages.
- There is anecdotal evidence suggesting that, since the relocation to a mobile service, there has been a displacement of needle litter from St Marys CBD to surrounding streets.
- Participants stated that since the advent of the mobile NSP service, a lack of access to new injecting equipment has led to an increase in their sharing and re-use of injecting equipment.

Overview

In general, the key findings describe the impact of the closure and subsequent relocation of WAHS primary NSP to a mobile service on IDUs living in or near St Marys. Given the high population density of Penrith LGA compared to the other LGAs within WAHS, and the reported historical concentration of IDUs around St Marys, the emphasis on the needs of IDUs within this area is not unwarranted. Moreover, it is vital to call attention to the link between area of greatest need and IDU concentration, lack of access to primary NSP services and re-use and sharing of injecting equipment. The interconnection of these factors has implications for the transmission and spread of blood-borne viruses such as HIV and HCV and other harms related to the re-use of used injecting equipment, such as septicemia, thrombosis and vein damage. Significantly, participants reported sharing and re-using injecting equipment with greater frequency since the advent of the mobile service.

Qualitative data suggests that particular groups of IDUs have been significantly disadvantaged by the shift from fixed site to mobile service. These groups are single parents, especially young mothers with children, Aboriginal people, youth and IDUs who work. In general, IDUs without private transport have not benefited from bulk distribution of equipment. Users who are unable to take away bulk equipment are required to make many more trips to the van if they want to access new equipment. Put simply, for IDUs increased trips to the van meant the possibility of increased surveillance by police, which acted as a deterrent to accessing new injecting equipment.

Moreover, it is important to consider the sheer geographic size of WAHS—over 4600 kms^2—in relation to the efficacy of mobile service delivery. It is highly unlikely that a mobile model of primary NSP service delivery could cover such a vast area, particularly given the travelling time between large towns. Given the concentration of IDUs in and around St Marys, the benefits of even attempting such broad primary NSP outreach are questionable. This

is not a criticism of mobile or outreach service delivery per se. Rather, as this study illustrates, it is imperative to formulate models of NSP service delivery which adequately address the specificity of local conditions and the health needs of people who inject drugs.

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