NSW USERS & AIDS ASSOCIATION INC

NUAA DISCUSSION PAPER:

DEREGULATION OF NEEDLE AND SYRINGE PROVISION TO IMPROVE DISTRIBUTION AND ACCESS TO STERILE INJECTING EQUIPMENT IN NEW SOUTH WALES

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INTRODUCTION

The NSW Users & AIDS Association (NUAA) is the state New South Wales peer-based drug user organisation. Through our direct experience and through our close contact with communities of people who inject drugs (PWID), we are able to provide government, services, media and the broader community with a 'drug user' perspective on a range of issues in relation to illicit drug use and the prevention of the transmission of blood-borne viruses, including HIV and hepatitis C.

In addition to providing this 'user perspective' and advocating for our members NUAA is engaged in a range of programs and services that impact directly on the prevention of blood-borne virus transmission. This includes a peer-run Needle and Syringe Program (NSP) and various community development, health promotion and peer education projects with people who inject drugs. Harm reduction is an important guiding principle for NUAA's work, as are the principles of self-determination and community control over health policy for people who inject drugs.

While there are many competing issues that impact on the lives of people who use and inject drugs, in light of recent trends such as the up-scaling of some injecting equipment provision and a growing need to increase prevention activities while at the same time challenge the current prohibitive legislative frameworks, we have decide to focus this discussion paper on the illegality of anyone other than authorised needle and syringe providers passing on clean injecting equipment to people who inject.

This paper will look at the current legislation regarding needle and syringe provision in NSW and the implications of this legislation for needle and syringe programs, for people who inject and for NUAA's health promotion, community development, peer education work and blood-borne virus prevention in general.

The paper will also look at the importance of "unauthorised" equipment distribution in the lives of people who inject and the role it plays in protecting the health of this marginalised group. We will also make some recommendations for future action on this issue.

THE CURRENT LEGISLATIVE LANDSCAPE AND HOW WE GOT HERE

The provision of sterile injecting equipment in NSW has been government policy since the 1980s and was supported by the first national strategy on HIV/AIDS which was released in 1989. This document was the first in a series of national strategies that have sought to co-ordinate Australia's response to HIV/AIDS and have been

accompanied, in later years, by strategies to respond to hepatitis C, sexually transmissible infections and dedicated strategies to address Aboriginal health.

The current National Strategies continue the work that was begun in 1989 when Australia developed the first coordinated national approach to the HIV/AIDS epidemic.[1] This first National HIV Strategy in 1989 recognised, highlighted and supported the need for needle and syringe programs and also for the development and maintenance of partnerships with affected communities.

Harm minimisation, which includes supply reduction, demand reduction, and harm reduction, is set by the Australian government and provides the national framework for working with illicit drug issues. Needle and syringe programs sit within the field of *harm reduction* based approaches to health protection, as does this discussion paper.

The NSW State HIV and Hepatitis C Strategies have flowed on from the initial national strategies and in their turn support and highlight the need for effective prevention strategies, of which sterile injection equipment provision is a key aspect. The strategies recognise that the availability of sterile injecting equipment is a key component in the prevention of both HIV and hepatitis C.

The principles of the NSW and National HIV/AIDS and Hepatitis C Strategies are recognised by the NSW Department of Health as guiding principles for the NSW Needle and Syringe Program policy and guidelines document.[2]

These principles include partnership with affected communities, harm minimisation and the principles of health promotion. These health promotion principles include the following:

1. All individuals have a right to information, education and skill development that enables them to protect themselves and others from HIV infection.
2. Health promotion is most effective when developed in collaboration with affected communities.
3. Programs should be developed in a way that is relevant and appropriate to the needs and experience of the target audience.
4. HIV programs should address broader social determinants of health where there is a link with vulnerability to HIV/AIDS.[3]

[1] National HIV/AIDS Strategy 2005-2008 (Canberra, 2005) p1
[2] NSW needle and syringe program (NSP) policy and guidelines 2006 (Sydney, 2006) p1
[3] NSW HIV/AIDS Strategy 2006-2009 (Nth Sydney, 2006) p7

The Ottawa Charter (1986) for Health Promotion was formulated by the World Health Organisation (WHO) and has had a major impact on health promotion strategies in Australia and NSW. The Ottawa Charter on Health Promotion took a comprehensive view of health determinants, referring to them as pre-requisites for health. It defined the fundamental prerequisites for health as peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity. It also recognised that access to these prerequisites cannot be ensured by the health sector alone. Rather, coordinated action is required among all concerned, including governments (health and other social and economic sectors) non-governmental organisations, industry and the media.[4]

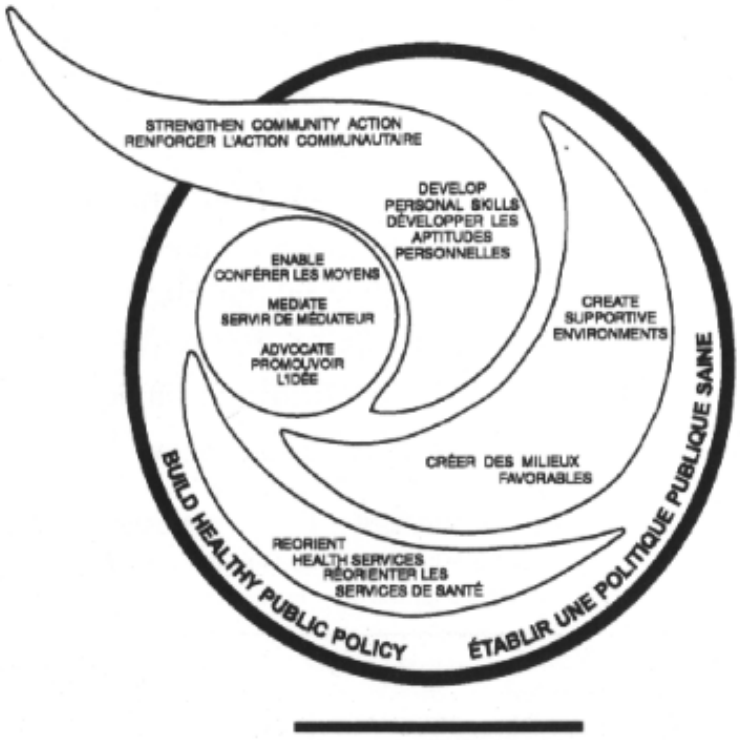

Figure 1: Ottawa Charter for Health Promotion

The Ottawa Charter is crucial in the context of this discussion as it is an internationally recognised piece of health policy that encourages policy makers to look at the broad picture of healthy living and the involvement of affected communities. It is important in the context of illicit drug use as the tension between the issue as one of the law and one of health is ever present.

[4] http://www.phac-aspc.gc.ca/ph-sp/php-psp/php2-eng.php; Public Health Agency of Canada, accessed June 2009

The NSW Needle and Syringe Program (NSP) operates within a legal framework. As most injecting drug use is illegal, the supply and possession of equipment for illicit injecting drug use is regulated and subject to a number of pieces of legislation. This has had a major impact on the way in which the needle and syringe program has developed over the years.

APPROVAL & AUTHORISATION – THE SYRINGE PROVISION LAW

The provision of needles and syringes for the purpose of administering illicit drugs occupies a legislative grey area in NSW. Legal needle and syringe provision is based on exempting certain people from prosecution. Whilst the *Drug Misuse and Trafficking Act 1985* was amended in 1985 to legalise the possession of needles and syringes, possession of other items used to administer prohibited drugs, including other items of injecting equipment remains illegal.

The legislative terrain over which this discussion ranges is subject to three pieces of legislation:

- *Drug Misuse and Trafficking Act 1985;*
- *Drug Misuse and Trafficking Regulation 2006;* and, to a lesser extent
- *Poisons and Therapeutic Goods Act 1966.*

Within these pieces of legislation two aspects of government policy begin to contradict one another: harm reduction and supply reduction are two of the three prongs of *harm minimisation,* the other being demand reduction. In theory and ideally, these three aspects complement each other. Supply reduction efforts are aimed at reducing the supply of illicit drugs and include policing and interdiction. Demand reduction is aimed at reducing demand via prevention of drug use, treatment and rehabilitation. Harm reduction is aimed at reducing immediate harms to people who are using illicit drugs and include measures such as needle and syringe provision.

It is the case however that occasionally one aspect negatively affects another. An example that particularly affects the work of NSPs is street level policing and supply reduction. Fear of being stopped and searched on suspicion of possession of or dealing in illicit drugs can impact on the quantity of clean injecting equipment a person might take from a NSP. Having a syringe found on your person during a "routine" stop-and-search makes a complete body-search more likely. NSP clients are unlikely to want to be seen carrying a box of 100 syringes for the same reason.

So while the three prongs of harm minimisation policy are intended to be complementary aspects of NSW's illicit drug use policy framework, the legislation hinders harm reduction work substantially.

Laws prohibiting the possession of equipment for the administration of prohibited drugs (*Drug Misuse and Trafficking Act 1985, 11(1))* were in existence before the need for NSPs was widely accepted.

To amend the legislation to allow needle and syringe programs to operate within the law, an exemption for authorised persons was inserted into the legislation. In addition there is an exemption for pharmacy operators to also provide needles and syringes.

Essentially it is permitted for a certain class of person to be *exempted* from the law if given approval to be so exempted by the Director-General of NSW Health (*Drug Misuse and Trafficking Regulation 2006, 4)*.

This remains the case today. Decades after the NSP in NSW was recognised and celebrated it is essentially still operating under an exemption to the law.

Practically speaking this means that an NSP needs to go through an approval process and then authorisation needs to be sought for positions or persons within the NSP to be exempted from the provision of the Act that makes equipment distribution illegal.

The authorisation itself also comes with conditions – an exempted person may not provide equipment outside the NSP's hours of operation, for example.

In addition, providing regulated goods, including injecting equipment, in a public space is restricted by Section 36 (1) of the *Poisons and Therapeutic Goods Act 1966.* Vending machines and outreach workers are exempted from the provisions of this Act by the Minister of Health, under subsections 3 and 4.[5]

Added to these restrictions mandated by legislation is a restriction that is outlined by the NSW Government and is Health Department policy which states that unpaid workers (including volunteers) are not able to distribute sterile injecting equipment:

"Under current NSW Department of Health policy, unpaid workers (including students and volunteers) are not eligible to be authorised to perform NSP duties. The provision of needles, syringes and associated equipment, and the provision of information regarding the use of injecting equipment are tasks that must not be performed by

[5] NSW needle and syringe program (NSP) policy and guidelines 2006, (Sydney, 2006) p7

students, volunteers or any other unauthorised staff. Performing these duties would leave individuals exposed to prosecution."[6]

These guidelines and legislative frameworks make it possible for people to be subjected to criminal prosecution should they engage in the provision of injecting equipment or safer injecting advice and information.

The NSW Health Department states that *"Without authorisation it would be possible for prosecution to occur for* the supply of needles and syringes, and possession and supply of associated equipment for use in the administration of a prohibited drug *(under Section 11 of the Act). Prosecution could also occur* for aiding and abetting the administration of a prohibited drug *(under Sections 19 and 20)."*[7]

The implication of this last statement is that a person not exempted is at risk of prosecution not simply for supplying syringes but for aiding a further criminal act: illicit drug injection.

Of equal concern is that should a person overdose and die when using a syringe provided by a person who is not exempted or in a position where the exemption does not apply, they (the distributor) may be at risk of being prosecuted for manslaughter.

CURRENT NSW NEEDLE & SYRINGE PROVISION MODELS

These evolutions and interactions of policy and legislation have resulted in a system of sterile needle and syringe provision that has been successful as a public health response, with HIV rates among people who inject drugs remaining low.

The Needle and Syringe Programs in NSW currently consist of a mix of outlet types and service delivery modes. (NSW Department of Health, 2006)

- **Primary outlets** are focused primarily on provision of injecting equipment to prevent the transmission of blood-borne viruses. Staff are employed specifically to provide NSP services, which include:
    - Needle and syringe provision, including 1, 3 and 5ml syringes and other injecting equipment such as alcohol swabs, cotton wool and disposable spoons
    - Disposal services

[6] *Ibid,* p7
[7] *Ibid,* p6

- Education and health promotion
- Referral to other health and community services
- Data collection
- Support to secondary outlets

- **Secondary outlets** are provided through a range of government and non-government organisations where needle and syringe provision is secondary to the main purpose or goal of the service. Usually these outlets provide only 1 ml syringes, disposal services and referral to primary NSPs.

  Some Primary NSPs provide outreach services also that aim to reach people who are unable to attend the fixed site NSP locations. Usually these will consist of either outreach from a vehicle, which will be at certain places at certain times publicised in advance, or outreach by foot, where pairs of workers will move from location to location.

  In addition, vending machines are operated in various locations across the state and are usually filled and maintained by the closest Primary NSP. These machines often charge a fee and dispense packs of syringes.

- ***Pharmacy*** distribution of syringes occurs either independently or by participation in the Pharmacy NSP Scheme. This scheme is run by the Pharmacy Guild of Australia (PGA) and generally works by selling or exchange of packs of syringes. Usually a person needs a "fitpack" to exchange for a new one for free, otherwise charges range up to $5 per 5-pack in some central Sydney chemists when purchasing without exchanges.

Independent pharmacy vendors simply purchase and on-sell needles, syringes and any other injecting equipment they wish to for whatever prices the market will withstand[8]

[8] Unlike most other states, it is not possible to obtain any syringes larger than 5ml or winged infusion sets in NSW NSPs. It is possible only to purchase them from a small number of pharmacies. The price of a 20ml barrel and a 25gauge "butterfly" can be as much as $4.50 in some chemists.

PEER PERSPECTIVES ON EQUIPMENT PROVISION

AN EARLY HISTORY OF NEEDLE & SYRINGE PROVISION

In reality, neither the government nor health care workers introduced needle and syringe provision. People who inject drugs have always helped and supported each other to obtain injecting equipment.

> *"In spite of a popular image that would suggest...drug users "ignore risks and social responsibility," drug injectors in New York (and, indeed, throughout the world) have acted both to protect themselves and to protect others against the AIDS epidemic. Thus, by 1984, before there were any programs other than the mass media to inform them about AIDS or to help them protect themselves, drug injectors were engaged in widespread risk reduction."* ***– Sam Friedman***[9]

Indeed any successes that needle and syringe provision have had rely fundamentally on the bravery of people who inject to talk about this and to even walk into needle and syringe services in the face of real and perceived legal, social and practical barriers.

The act of injection, the understanding of the issues and pleasure around this act has always formed a bond, to one degree or another, between people who inject. One manifestation of this bond is the understanding of the central need and importance of being able to obtain injecting equipment.

As Friedman notes in the previously mentioned quote, communities of people who inject drugs where already used to acting to protect their own health and that of their peers even before HIV was recognised and understood.

Friedman says that, in particular; following the initial outbreaks of HIV that affected drug user communities, these communities mobilised in response, began distributing sterile equipment amongst their peers in a concerted manner[10]. This caring response by many people who inject drugs was not necessarily expected by people outside these communities.

[9] Friedman, Samuel R., Social networks, drug injectors' lives & HIV/AIDS (NY, 1999)
[10] Coady, Steve; The end of the beginning; *Users News #31* (Sydney, 1999)

The views of many and the understanding of injecting drug users were of a universally selfish and uncaring mass.

Apart from continuing to share knowledge with one another about where sterile equipment could be obtained – usually illicitly – a number of users volunteered in 1986 to begin illegally distributing sterile needles and syringes from premises at St. Vincent's hospital organised by Dr Alex Wodak[11].

In time NSP would become mostly legitimised by legislation, although, as we have seen, needle and syringe distribution to people who use illicit drugs has never been entirely legal.

At the same time that NSPs were being initiated, there was also support from governments to meet the affected communities' demands to be involved in the planning and strategising around HIV prevention. Some health care workers, politicians and bureaucrats understood the need for people who inject to be part of the solution. A group of activists including Steve Coady, Julie Bates, Alan Winchester, Gray Sattler and Alex Wodak put together a funding proposal for a drug user organisation to be formally established. Eventually in about 1989, NSW had its very first drug user organisation.[12] Prior to this funding, people who inject, their supporters and their allies had already self-organised into groups that undertook advocacy and NSP activities. Again, the government built on the success and experience of people who inject drugs.

At the time, establishing an NSP program was a brave and important step for a government department to take. However, the simple step of decriminalising the possession and distribution of injecting equipment by members of the public was not undertaken.

It seems incredible, particularly in light of recent evidence of the pressing need to upscale NSP activities in light of hepatitis C prevention needs that this step has still not been taken 25 years later.

A number of reports and research documents have shown the efficacy and importance of needle and syringe provision[13], peer education and drug user organisations in

[11] Wodak, Dr Alex; Why deal with users?; *Users News #31* (Sydney, 1999)
[12] Coady, Steve; The end of the beginning; *Users News #31* (Sydney, 1999)

[13] *Return on investment in NSP in Australia.* Canberra: Commonwealth Dept health and Ageing. (2002).

keeping people free from blood-borne viruses[14] yet needle and syringe programs are still seen as controversial[15] and still need to justify their existence.

People who inject drugs can be justifiably proud of the influence we have had on blood-borne virus prevention over the years in NSW and across Australia.

Regardless of officially sanctioned NSP provision, people who inject drugs and people close to them continue to confront a nonsensical and anomalous law to provide sterile injecting equipment and peer education to ensure their peers, family and friends are able to use as safely as possible and protect their health.

This tradition continues as a deep-rooted and responsible aspect of the lives of many people who inject drugs. This responsibility for the welfare of themselves and others needs to be matched by the government.

TRADITION OF PEER DISTRIBUTION

The centrality of the syringe to injecting drug use and the pleasure of this mode of ingestion is well understood by people who inject drugs. This understanding usually extends to empathy for another user who is, for whatever reason, unable to procure a sterile syringe to use with.

If at all possible most peers would happily provide a sterile syringe to another user whether known to one or not.

Some people go as far as to consciously pick up more syringes than needed for personal use so that there are always enough available for visitors or friends:

> *Usually I get about five or six six-packs and keep them under the sink, just in case they're needed. Quite often they get bummed by my neighbours as well. I'm known as the central fit depository actually [laughs]. (Male, 42)*[16]

Some peers will be known in their networks as someone who will supply sterile equipment upon request and provide disposal facilities for used equipment.

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[14] Treloar, C. (2005). Information exchange among injecting drug users : a role for an expanded peer education workforce. . *International Journal of Drug Policy; 16 (1)* , 46-53.

[15] *"Fury at needle sales near school"*; http://www.dailytelegraph.com.au/news/fury-at-syringe-sales-near-primary-school/story-e6freuy9-1225757593013; August 4, 2009

[16] Joanne Bryant & Max Hopwood, "Secondary exchange of sterile injecting equipment in a high distribution environment: A mixed method analysis in south east Sydney, Australia," *International Journal of Drug Policy* 20, (2009): p324-328

The majority of NSPs in NSW operate during office hours only, so being able to obtain a syringe late at night when an opportunity for use has unexpectedly arisen is often a challenge. Overwhelmingly these peer distributors hold and dispense equipment out of care for their peers, not for financial or in-kind gain and are meeting the gaps in the currently sanctioned NSP program.

While this type of activity has always been known by peers to occur, the phenomenon of peer to peer distribution has also been evidenced extensively through research.

Often this type of distribution is known as 'secondary exchange'. Although the term is not ideal for the NSW context, where "*Secondary outlet*" means something different, we will use it for the sake of expediency here.

Data has been collected in Vancouver and California showing that peer to peer distribution is common, with 64-75% of people accessing needle exchanges reporting passing on or receiving new syringes outside of the formal needle exchange setting[17].

In the more local setting of South East Sydney, 54% of respondents to a recent survey reported being involved in secondary exchange. These respondents reported passing on around 20% of their equipment to other users.[18]

Research also corroborates the anecdotal evidence that NUAA has collected through its extensive contact with networks of peers, that much secondary exchange or peer distribution is motivated by care and altruism.[19]

Reasons for accessing peer distribution rather than formal NSPs for equipment are varied.

> *I mean . . . it's 10:00 at night and the [NSP's] are closed . . (but) houses are open basically as long as somebody knock on the*

[17] Kuyper, L., Kerr, T., Li, K., Hogg, R., Tyndall, M., Montaner, J., et al. (2006). Factors associated with buying and selling syringes among injection drug users in a setting of one of North America's largest syringe exchange programs. *Substance Use and Misuse 41* , 883-899.

Lorvick, J., Bluthenthal, R. N., Scott, A., Gilbert, M. L., Riehman, K. S., L.Anderson, R., et al. (2006). Secondary Syringe Exchange Among Users of 23 California Syringe Exchange Programs. *Substance Use and Misuse 41* , 865-882.

[18] Bryant, J., & Hopwood, M. (2009). Secondary exchange of sterile injecting equipment in a high distribution environment: A mixed method analysis in south east Sydney, Australia. *International Journal of Drug Policy 20* , 324-328.

[19] Judith Snead, M. D. (2003). Secondary Syringe Exchange Among Injection Drug Users. *Journal of Urban Health* .

> *door, 24-7. It's a matter of convenience. It's like dropping in at a 7-11 to get that cup of coffee.*
>
> *Male, age 43*[20]

The hours of NSPs in NSW are generally office hours, whereas drug use, particularly spontaneous opportunistic use occurs at all hours.[21] In addition, in many areas particularly in regional and rural areas, accessing sanctioned NSP provision is difficult if not at times impossible. Issues such as confidentiality, anonymity and stigma attached to injecting are major concerns for all people who inject[22] but is particularly acute for those in smaller centres

While the legal situation does not actually preclude people from possessing injecting equipment *if it is obtained from a person exempted by the law*, this confusing caveat serves to confuse both people who inject and law enforcement officers.

Users are often afraid to carry more equipment than necessary, in case it is seen by the police either in passing or during a search. The NSW Police NSP guidelines states quite clearly that:

"*police should refrain from actions which may lead to either a reluctance to obtain sterile needles and syringes, or discourage safe disposal of used injecting equipment,*"[23]

However, the reality on the street is that the possession of injecting equipment is often used by police as a reason to conduct a body search for illicit drugs.

This threat from police, whether real or perceived, serves to make some users reluctant to access NSPs and to dispose of used equipment at NSPs. Added to this is the law which makes used syringes potential evidence of self-administration of an illicit drug.

Laws which run counter to the government's own public health initiatives and serve to confuse are one of the major barriers to more widespread

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[20]Voytek, Chelsea. Sherman, Susan G. Junge, Benjamin (2003). A matter of convenience: factors influencing secondary syringe exchange in Baltimore, Maryland, USA. International Journal of Drug Policy 14 , 466

[21] Chelsea Voytek, S. G. (2003). A matter of convenience: factors influencing secondary syringe exchange in Baltimore, Maryland, USA. *International Journal of Drug Policy 14* , 465-467.

[22] Treloar, Carla; Cao, Wendy (2005) *Barriers to use of NSP in a high drug use area of Sydney, New south Wales.* Sydney International Journal of Drug Policy 16; 308–315

[23] NSW Police. (2005). *The needle and syringe program: Guidelines for police.* Drug and Alcohol Coordination.

access to NSPs, to safe disposal of used equipment and to the lowering of hepatitis C rates amongst people who inject drugs.

This situation is also a major reason that some people rely on and only access personal networks to obtain syringes.

Peer distribution amongst networks of peers is widespread, seen as a positive by the community of people who inject drugs, and exists for a number of rational and largely altruistic reasons[24].

The practice has existed for as long as people have injected drugs and in many ways is not at all a "secondary" form of provision and access but in fact the primary form of needle and syringe provision in the sense that it is the way most people who inject are introduced to sterile equipment and how many continue.

It is also linked strongly with another naturally occurring and generally positive phenomenon that has a long history in networks of people who inject drugs: peer education.

THE TRADITION OF PEER EDUCATION

Peer education is a key strategy in the NSW Department of HIV and Hepatitis C Strategies (2006/7-2009). Peer education is also usually a naturally occurring phenomenon that people who inject drugs have always undertaken. In part this is because drug prohibition affects not only the supply of drugs but the supply of information about the drugs and about using them. Peers must share within their networks information that is otherwise not freely or easily available.

This was particularly the case until the 1980s, when the emergence of HIV demanded that knowledge about prevention of transmission, and the means to prevent that transmission, be made more readily available by the government and its health departments.

Involving people who use drugs in solving the HIV problem was a key step down the path towards the blood-borne virus strategies that prioritise peer education as a key prevention technique in NSW.

[24] Lorvick, J., Bluthenthal, R. N., Scott, A., Gilbert, M. L., Riehman, K. S., L.Anderson, R., et al. (2006). Secondary Syringe Exchange Among Users of 23 California Syringe Exchange Programs. *Substance Use and Misuse 41* , 865-882.

Drug user culture is often an oral culture. Information, stories and anecdotes are passed on from user to user. Newer users learn from other users: how to inject; how to score; how to detox; how to stay healthy.

Peer education is not an invention of health care workers and professionals. As with peers providing sterile injecting equipment for others so too has peer education in drug use settings always existed and always will.

This organic peer education often occurs during the process of preparing and injecting drugs. Drug use is often social, pleasurable and is particularly so when one is an initiate. As an initiate, one needs the assistance of others at all stages: finding/buying, preparing and injecting. It is during these processes that people learn, from their peers, how to do these things for themselves. This is not new: it is the prime assumption of peer education. What this highlights is that providing injecting equipment is a prime opportunity for people who use drugs to undertake peer education and health services and organisations need to recognise and capitalise on this tradition.

Although the process of peer education and the act of peer distribution of injecting equipment is often linked, and while drug user organisations such as NUAA have always understood this, we are prevented from capitalising on this naturally occurring phenomenon by the criminalisation of syringe distribution.

NUAA'S PEER EDUCATION AND COMMUNITY DEVELOPMENT PROJECTS

Just as individual peer educators, users and their friends and loved ones are affected negatively by the law around syringe distribution, so too is NUAA.

One of NUAA's key strengths is its close contact with networks and communities of people who inject. Through its Community Mobilisation Team, NUAA works closely with both individual people who inject and with networks of peers.

PeerLink is one of NUAA's key peer education and community development projects. PeerLink projects consist of groups of key peers being recruited and consulted around local issues and subsequently being trained as NUAA PeerLink peer educator volunteers.

While the peer educators will continue to do individual and one-on-one peer education work (as they did before NUAA training), the project fosters and supports stronger community ties within networks of peers. To this end a key aspect of the training program is the planning of a group project or set of peer education projects that the group can support each other to achieve.

An important factor in these plans is always trying to achieve the objective of reaching more peers and devising tactics and strategies to engage peers, particularly those who do not frequent services and focus on a range of issues including blood borne virus prevention.

The challenge of reaching people who do not access needle and syringe programs and other health services is raised in the PeerLink training workshops as an important activity to attempt as a group. Utilising outreach based NSP provision as a way of linking with peers outside of known networks and within more rural settings is usually suggested:

> *"let's do outreach and let people know that if they need a fit after hours or more locally they can call on one of us and from there we have the opportunity to do some peer ed."*[25]

When trainees are informed that NUAA is unable to sanction or support a project that involves peer distribution as it will put our volunteers and peer educators in jeopardy, the response is often disbelief.

Very few users are aware that it is illegal for them to pass on or receive from a non-exempted person a sterile syringe[26].

Prohibiting peer to peer equipment distribution hampers effective peer education projects. If peers were able to pass on sterile equipment, along with clear and accurate harm reduction information it is likely these projects would be more effective both in terms of harm reduction, prevention of blood borne viruses, broader health and in terms of community development.

Peer-based education is a part of NSW's strategy on HIV, Hepatitis C, Sexually Transmitted Infections and is accepted as an effective aspect of blood borne virus prevention. There is evidence that peers involved in "secondary exchange" take pride in being involved in an effective public health initiative[27] and that this is undertaken out of

[25] Feedback received at Coffs Harbour PeerLink training April 2009
[26] Feedback received at Coffs Harbour PeerLink training April 2009

[27] Lenton, S., Bevan, J., & Lamond, T. (2006). Threat or Opportunity? Secondary Exchange in a Setting With Widespread Availability of Needles. *Substance Use and Misuse 41* , 845-864.

an altruistic concern for the welfare of their community[28]. The inclusion of peer to peer distribution as a legitimate act would utilise structures and traditions already firmly in place and accepted by people who inject.

Research indicates that there is a need to expand peer education activities as a means of preventing blood-borne virus transmission and that non-government organisations such as NUAA might be particularly suited to managing this expansion.[29] It would be likely that peer education would be greatly enhanced were NUAA able to encourage and resource peers to provide sterile equipment to support their peer education activities.

[28] Judith Snead, M. D. (2003). Secondary Syringe Exchange Among Injection Drug Users. *Journal of Urban Health* .

[29] Treloar, C. (2005). Information exchange among injecting drug users : a role for an expanded peer education workforce. . *International Journal of Drug Policy; 16 (1)* , 46-53.

CHALLENGES FOR NSP IN NSW TODAY

The public health response to blood-borne viruses in people who inject drugs has generally been successful. NSPs have been a major contributor to ensuring that the rate of HIV transmission amongst people who inject drugs remains low and steady at around 2.2% (2007) of people attending NSPs in NSW.

On the other hand, the prevalence of hepatitis C amongst people who inject drugs in 2007 is about 69%[30]. This is, however, a decrease from the rate of 85% in 1995.[31] Unfortunately the rate for people in prison is even higher.

The possible reasons for the disparity between the prevalence of HIV and Hepatitis C amongst people who inject drugs are complicated.

HEPATITIS C IN THE CONTEXT OF INJECTING DRUG USE

It is likely that there was already a significant pool of people living with hepatitis C before needle and syringe programs were introduced into Australia. The hepatitis C virus was only identified in 1989. This large pool essentially meant that the virus had a head start and public health initiatives such as needle and syringe programs could only hope to prevent new transmissions – a task made much harder due to the existing large pool of infection.

In addition, hepatitis C has evolved numerous genotypes or "strains" of the virus and so it is possible for people to become infected more than once. This was not known until relatively recently. Previously, people living with hepatitis C may have been inclined to believe they could not become infected again and may have taken fewer precautions for themselves as a result.

Another aspect of the hepatitis C virus that may contribute to the high prevalence of the virus in communities of people who inject drugs is the fact that the virus is relatively hardy. It appears to be able to live outside the body for some time, effectively multiplying its potential for transmission exponentially as invisible traces of blood on injecting equipment, including spoons, tourniquets and cotton wool, may pose a danger of transmission for some time.

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[30] Population Health: NSW Department of Health. (2008). *The health of the people of NSW - Report of the Chief Health Officer.* Sydney: NSW Department of Health.

[31] Population Health: NSW Department of Health. (2008). *The health of the people of NSW - Report of the Chief Health Officer.* Sydney: NSW Department of Health.

Given these circumstances, it is unlikely that the prevalence rate of hepatitis C is likely to drop quickly: it is simply too entrenched. Ensuring that the rate does not rise and working to achieve a steady decrease in prevalence and new transmission rates is a realistic aim.

PREVENTION

The NSW Health Department recognises that despite a relatively large needle and syringe program and a largely successful response to HIV/AIDS, hepatitis C prevalence and transmission amongst people who inject drugs is high and responses to this need to be more effective and new prevention strategies should be identified.[32]

Peer-based initiatives have proven effective and the NSW Department of Health is committed to supporting peer organisations to further improve them.[33] NUAA has a leading role to play in achieving this objective and various strategies are undertaken by NUAA in pursuit of this, including:

- innovative peer education;
- peer educator training;
- peer run NSP;
- peer-based outreach; and
- health promotion and community development activities.

Prevention of the transmission of blood-borne viruses is also the province of the HIV and Related Programs of the various NSW Area Health Services and the NSPs they run.

While they cannot, by definition, run peer education programs themselves, many NSPs are looking to work in partnership with NUAA and/or in partnership with the people who use their services: people who inject – to undertake innovative and effective prevention programs. However, NSPs must also look to other methods and strategies to help prevent the transmission of blood-borne viruses and to lower the prevalence percentages.

[32] NSW Department of Health. (2007). *NSW Hepatitis C Strategy 2007-2009.* Sydney: NSW Department of Health, p ii

[33] NSW Department of Health. (2007). *NSW Hepatitis C Strategy 2007-2009.* Sydney: NSW Department of Health, p ii

INCREASED EQUIPMENT PROVISION

A relatively new approach to meeting the hepatitis C prevention challenge by the NSW Department of Health has been to lift any restrictions on injecting equipment provision numbers at government-funded, Area Health Service-run NSPs. People who inject are to be encouraged to take as much, or more than enough, equipment as needed.

NSW NSPs are being directed by NSW Health to dramatically increase the number of syringes that are distributed from their outlets. This directive has been prompted by research that shows that there is still a high rate of syringe reuse among people who inject in NSW,[34] while Kwon et al., using Australian epidemiological and behavioural data, modelled that if syringe distribution was doubled then the annual incidence of hepatitis C is likely to reduce by 50%.[35]

As a result of this research the NSW Department of Health made available to NSW Area Health Service's additional funding which was tied specifically to increasing the distribution of injecting equipment.

In addition the Directors of Population Health in each of the Area Health Services were briefed on the Department's view that increasing equipment provision is critical to lessening the prevalence of hepatitis C, as were the managers of the HIV and Related Programs (HARP and Harm Minimisation Coordinators who are responsible for the NSP programs in each Area.

In this way the NSW Department of Health has very clearly indicated that increasing the amount of injecting equipment in communities of people who inject drugs need to be a high priority for the state.

The current equipment distribution laws run counter to this directive and place a serious barrier to improving access to NSPs for a group that already faces significant barriers to maintaining, let alone, improving their health outcomes.

[34]National Centre in HIV Epidemiology & Clinical Research. (2008). *HIV/AIDS, Viral Hepatitis and STI in Australia Annual Surveillance Report 2008.*

[35] Kwon, J. A., Iversen, J., Maher, L., Law, M. G., & Wilson, D. P. (2008). *The Impact of NSP on HIV and HCV transmissions in injecting drug users in Australia: A model based analysis.* NCHECR.

NSP COVERAGE – ACCESSING MARGINALISED GROUPS

Even within areas with thriving needle and syringe programs, "coverage" is not absolute.[36] There are numerous groups of people who inject drugs that are not serviced adequately by current NSP arrangements in NSW or which have above average rates of sero-prevalence or blood borne virus transmission. These groups include people from culturally and linguistically diverse (CALD) backgrounds, Aboriginal people, people who inject drugs in rural settings, young women, and people who do not identify as injecting drug users – such as younger users. NUAA plays a unique role in reaching people in these settings through informal and formal networks of people who inject drugs. As a state-wide organisation with some twenty years experience, NUAA is known by many people who inject drugs and maintains close community contacts that have built up over years, particularly with people in highly marginalised communities.

These are complex issues that cannot be easily solved. For many Aboriginal people and people who inject from Asian communities there is a fear around being seen entering an NSP by someone from their close-knit community and of the subsequent stigmatisation and discrimination. For people who already suffer a degree of this due to their ethnicity, the fear of being cut-off from your own culture is serious and extreme.

On the other hand some people who inject from these groups may be less inclined to enter a service that is not staffed by people of their own culture.

Obtaining injecting equipment from peers overcomes some of these issues and when linked to effective peer education could be a powerful technique for NSP's to increase their coverage of marginalised groups.

In the Bryant & Hopwood study on secondary exchange (2009), 25.4% of "secondary exchangers" were of Aboriginal or Torres Strait Island descent.[37] This relatively high proportion suggests that at least some Aboriginal people find it easier to access equipment through social networks than through conventional services.

Maher (2004) found that, amongst other structural improvements, increasing access to sterile injecting equipment is urgently required to lower rates of hepatitis C sero-

[36] Chelsea Voytek, S. G. (2003). A matter of convenience: factors influencing secondary syringe exchange in Baltimore, Maryland, USA. *International Journal of Drug Policy 14* , 465-467.

[37] Bryant, J., & Hopwood, M. (2009). Secondary exchange of sterile injecting equipment in a high distribution environment: A mixed method analysis in south east Sydney, Australia. *International Journal of Drug Policy 20* , 324-328.

prevalence amongst people from Asian backgrounds in Cabramatta, Sydney.[38] Unfortunately, projects that involve peers providing sterile equipment along with peer education, referrals and even on-the-spot hepatitis testing are not able to be continued in these areas as it exposes the peers to prosecution under the existing distribution laws.

Given that improving access to needle and syringe programs and health services in general for marginalised communities is a priority area for action in the NSW Health blood-borne virus and Aboriginal health strategies[39], it is counter-productive that health organisations have one hand tied behind their back and are unable to develop such cost effective and successful initiatives.

SECONDARY/PEER DISTRIBUTION ELSEWHERE

INTERNATIONAL TRENDS

Networks of people who inject drugs and peer educators are utilised and supported in needle and syringe provision programs internationally and this has been shown to be an effective approach to blood-borne virus health promotion and community development.

An external evaluation of the population reached by "secondary" or peer-based syringe exchange in Vancouver in 2001-2002 showed that the program – undertaken by the peer organisation VANDU, or Vancouver Area Network of Drug Users – reached those people who inject drugs that are at highest risk of HIV transmission.[40]

Of 127 syringe programs surveyed in the US in 2000, 91% allowed peer distribution and 82% actively encouraged it as a method to expand their distribution. Only a small number discourage the practice in order to encourage contact with the program.[41] In

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[38] Maher, L., Chant, K., Jalaludin, B., & Sargent, P. (2004). Risk behaviors and antibody hepatitis B and C prevalence among injecting drug users in south-western Sydney, Australia. *Journal of Gastroenterology and Hepatology 19* , 1114-1120.

[39] NSW Department of Health. (2007). *NSW Hepatitis C Strategy 2007-2009.* Sydney: NSW Department of Health, Action Plan 1A, Objective 2;

NSW Department of Health. (2006). *NSW HIV/AIDS Strategy 2006-2009.* North Sydney: NSW Department of Health, p7

[40] Evan Wood, T. K. , et. Al, (Sept. 2003). An External Evaluation of a Peer-Run "Unsanctioned" Syringe Exchange Program. *Journal of Urban Health 80/3* .

[41] Des Jarlais, D., McKnight, C., Figo, K., & Friedmann, P. (2002). 2000 US Syringe Exchange Prgram Survey. *12th North American Syringe Exchange Conference.* Albuquerque, NM, quoted Lorvick (2006)

some cases programs rely upon peer distribution as the primary mechanism with which to access people who inject drugs.[42]

In the US, where government needle and syringe provision is not universal and often restricted, peer distribution is often seen simply as a strategy to increase distribution of equipment.

It does this[43], while acknowledging that most peer distributors:

- are motivated to provide equipment by altruism,[44]
- access people at higher risk of blood-borne virus infection[45] and
- show considerable interest in being part of a peer education project[46]

This leads to the conclusion that further supporting and encouraging peer distributors to provide valid and current blood-borne virus prevention *at the same time as providing new equipment* might contribute greatly to solving the problem of hepatitis C transmission.[47]

Despite NSW having a wider needle and syringe provision program than many states in the USA, an undertaking of this type of project in NSW is recommended by Bryant and Hopwood (2006) as an effective way to capitalise on the existence of extensive networks of people who supply other injectors with injecting equipment in NSW.[48]

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[42] Anderson, R. L, et. al, (2003). Delivering Syringe exchange services through "satellite exchangers". *International Journal of Drug Policy 14* , 461-463

[43] Chelsea Voytek, S. G. (2003). A matter of convenience: factors influencing secondary syringe exchange in Baltimore, Maryland, USA. *International Journal of Drug Policy 14* , 465-467.

[44] Judith Snead, M. D. (2003). Secondary Syringe Exchange Among Injection Drug Users. *Journal of Urban Health* .

[45] Evan Wood, T. K. , et. Al, (Sept. 2003). An External Evaluation of a Peer-Run "Unsanctioned" Syringe Exchange Program. *Journal of Urban Health 80/3* .

[46] Judith Snead, M. D. (2003). Secondary Syringe Exchange Among Injection Drug Users. *Journal of Urban Health* .

[47] Lorvick, J., Bluthenthal, R. N., Scott, A., Gilbert, M. L., Riehman, K. S., L.Anderson, R., et al. (2006). Secondary Syringe Exchange Among Users of 23 California Syringe Exchange Programs. *Substance Use and Misuse 41* , 865-882.

[48] Bryant, J., & Hopwood, M. (2009). Secondary exchange of sterile injecting equipment in a high distribution environment: A mixed method analysis in south east Sydney, Australia. *International Journal of Drug Policy 20* , 324-328.

Secondary exchange occurs as often amongst people who use NSPs as those who don't[49], so having a relatively widespread distribution of NSPs does not preclude peer-based distribution nor should it be a reason not to change the legal status of this activity.

[49] Lorvick, J., Bluthenthal, R. N., Scott, A., Gilbert, M. L., Riehman, K. S., L.Anderson, R., et al. (2006). Secondary Syringe Exchange Among Users of 23 California Syringe Exchange Programs. *Substance Use and Misuse 41* , 865-882.

ISSUES FOR CONSIDERATION

Although the introduction of officially sanctioned needle and syringe programs was a pivotal moment for the prevention of blood-borne viruses, the legislators of the time decided to allow the programs under the law in a very limited and compromised way.

Unfortunately the legacy of that decision is being lived with today by the community of people who inject. Despite this fact there exist flourishing and effective unauthorised sterile injecting equipment distribution networks maintained by people who inject and those close to them.

Peer distribution, whether on a relatively organised and large scale where "network nannies" or key peers and leaders provide equipment for many in their network and set themselves up to do so, or whether on a small or ad-hoc basis is a naturally occurring and integral aspect of the community of people who inject drugs and always has been.

Rates of peer distribution at programs that actively discourage the practice are similar as the rates at programs that allow or encourage it, with around 70% of participants being involved in the practice.[50]

It is a very simple process that, like drug use itself, continues whether it is criminalised or not.[51]

It is difficult to argue that the process of one person passing on a piece of sterile injecting equipment to another who needs it in order to inject safely, is anything other than a positive, altruistic and health protective act.

One person who injects denying another person who injects a piece of clean equipment if they need it is as likely as someone denying a visitor a cup in which to drink their tea. Within drug-using networks it is *just accepted* and understood that having drugs and no sterile fit is not only frustrating but actually very hazardous to one's health.

If we accept that the provision of sterile injecting equipment is an effective blood-borne virus transmission prevention strategy and if we accept that people should be encouraged to take care of one another and if we accept that the government is responsible for protecting the health of *all* its citizens, then legitimising the very simple

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[50] Lorvick, J., Bluthenthal, R. N., Scott, A., Gilbert, M. L., Riehman, K. S., L.Anderson, R., et al. (2006). Secondary Syringe Exchange Among Users of 23 California Syringe Exchange Programs. *Substance Use and Misuse 41* , 865-882.

[51] *ibid*

process of providing sterile injecting equipment *no matter who the distributor or recipient* is absolutely crucial and long overdue.

In addition to the fact that criminalising aspects of equipment provision is dangerous and bypasses human nature, it also restricts the needle and syringe program of NSW, a major, successful public health initiative, from capitalising on its successes and improving in areas that it needs to and which will not only save money but save lives[52].

Being able to utilise the extensive networks that many people who inject already have in place for distributing equipment would assist the needle and syringe program to easily fulfil the goals of doubling the number of syringes distributed and increasing access to sterile injecting equipment as well as improving access to communities traditionally seen as "hard-to-re7ach."

At present NUAA and other organisations that operate needle and syringe programmes are prevented from being seen to know about or promote peer distribution of injecting equipment and setting up projects that utilise key peers who distribute equipment, and reporting on either the health promotion and community development outcomes or sterile equipment distribution statistics is out of the question.

This is despite the fact that whether people are aware of the law preventing them from distributing equipment or not, the practice is widespread. One of the reasons for its ongoing popularity is that many people who inject drugs are confused about the various laws around needles and syringes and are afraid of police stop and search. The confusion around the legal status of carrying either sterile or used syringes is exacerbated by the self-administration laws in NSW. Sections 11, 19 and 20 of the *Misuse of Drugs and Trafficking Act 1985* clearly state that supplying syringes and possessing syringes to inject an illicit substance is illegal. People are justifiably afraid of being caught in possession of injecting equipment whether used or not. Police have been known to get admissions of guilt from people about illicit drug use and attempt conviction because they have been in possession of injecting equipment. For some the embarrassment of this occurring in public is sufficient cause to refuse to be seen in the vicinity of an NSP, let alone enter it.

[52] *Return on investment in NSP in Australia.* Canberra: Commonwealth Dept health and Ageing. (2002).

Although the likelihood of prosecution for self-administration alone is unlikely, it is something that is used to "beef-up" charge sheets[53]. That law enforcement and health providers should run counter to one another in this way is unhelpful.

The route to legitimising peer distribution appears to be either legislative or policy-driven. Legislative reform would rely upon changing the law to deregulate the provision of injecting equipment, whilst policy change would come through the NSW Department of Health and would rely upon extending the exemption offered by the Director-General to a new, separate class of person: auxiliary NSP workers or volunteers.

Given that many people are already confused about the possession, distribution and self-administration laws in NSW and given that these in themselves cause many people to stay away from NSPs,[54] then further muddying the waters with a policy change that legitimises only volunteer or unpaid workers would not be enough to clarify the situation and provide people who inject with a clear pathway and understanding of the law.[55]

The best way to achieve this clarity is through repealing a law that brands as a criminal someone who wants to ensure their friend, their sibling, even a stranger has clean equipment if they are going to inject.

Deregulating the provision of equipment will meet the needs of both people who inject drugs and the service providers who work with them:

- people who inject will be able to carry and distribute clean equipment with less fear and confusion;
- drug user organisations will be able to work to prevent blood-borne virus transmission with their peers with one less major barrier to effective peer education and community development
- NSPs will be able to broaden their "reach", fulfil directives to double their distribution and have another strategy that they can employ legitimately to reach marginalised target groups and they will be able to record data more accurately and more effectively evaluate their practice.

[53] NUAA client, 2009

[54] Bryant, J., & Hopwood, M. (2009). Secondary exchange of sterile injecting equipment in a high distribution environment: A mixed method analysis in south east Sydney, Australia. *International Journal of Drug Policy 20* , 324-328.

[55] Please see appendix 3 for a discussion of policy change

Nearly as importantly, the government will signal that it takes the health of all the state's citizens seriously and that it does not privilege law enforcement over health care.

RECOMMENDATIONS

The NSW Users & AIDS Association makes the following recommendations based on this discussion paper:

1. Establish an electronic Advisory Committee to assist with the implementation of the recommendations and to provide expert advice where necessary.

2. Continue existing expert advisory committee to oversee and assist with meeting these recommendations.

3. Lobby NSP workforce to seek support for these recommendations.

4. Further investigate distribution models internationally in order to establish a workable model of peer distribution to recommend to NSW needle and syringe programs, should peer distribution become legitimised.

5. Work with Community Legal Centres to investigate the process necessary to repeal or change NSW legislation

6. Lobby NSW government to change the *Misuse of Drugs and Trafficking Act 1985* to allow deregulated provision of sterile injection equipment and provision of information to assist safer injection

7. Request the NSW Department of Health investigate possible policy change to allow unpaid NSP workers to be exempted from the *Misuse of Drugs and Trafficking Act 1985* under regulation 4 of *Drug Misuse and Trafficking Regulation 2006.*

8. Lobby NSW government to change the *Misuse of Drugs and Trafficking Act 1985* (Section 12) self-administration laws as a means to encourage the safe disposal of used injecting equipment.

APPENDIX 1: RELEVANT LEGISLATION

www.legislation.nsw.gov.au

DRUG MISUSE AND TRAFFICKING ACT 1985 - SECT 11

Possession of equipment for administration of prohibited drugs

11 POSSESSION OF EQUIPMENT FOR ADMINISTRATION OF PROHIBITED DRUGS

(1) A person who has in his or her possession any item of equipment for use in the administration of a prohibited drug is guilty of an offence.

(1A) Subsection (1) does not apply to or in respect of a hypodermic syringe or a hypodermic needle.

(1B) Subsection (1) does not apply to or in respect of a person prescribed by the regulations, or a person who is of a class of persons prescribed by the regulations, who has in his or her possession any item of equipment that is required to minimise health risks associated with the intravenous administration of a prohibited drug.

Self-administration of prohibited drugs

12 SELF-ADMINISTRATION OF PROHIBITED DRUGS

(1) A person who administers or attempts to administer a prohibited drug to himself or herself is guilty of an offence.

(2) Nothing in this section renders unlawful the administration or attempted administration by a person to himself or herself of a prohibited drug which has been lawfully prescribed for or supplied to the person.

DRUG MISUSE AND TRAFFICKING REGULATION 2006

Director-General NSW Health approval

4 APPROVAL BY DIRECTOR-GENERAL OF DEPARTMENT OF HEALTH OF NEEDLE EXCHANGE PROGRAMS

(1) The Director-General of the Department of Health may authorise a specified person or a specified class of persons to participate in a program approved by the Director-General to facilitate:

(a) the supply to intravenous drug users of sterile hypodermic syringes and sterile hypodermic needles, and any associated equipment, to prevent the spread of contagious disease and minimise health risks associated with intravenous drug use, and

(b) the giving out of information concerning hygienic practices in the use of hypodermic syringes and hypodermic needles to prevent the spread of contagious disease.

(2) An authorisation under this clause is to be granted, and may be revoked, in the same manner as an authorisation under the Act.

APPENDIX 2: CURRENT NSW NSP POLICY

The *Drug Misuse and Trafficking Regulation 2006* provides for the Director General of the Department of Health (or his/her delegate) to approve Needle and Syringe Programs and to authorise persons or classes of persons to participate in such programs. Under the Regulation authorised persons are exempt from certain provisions of the *Drug Misuse and Trafficking Act 1985* that might otherwise prohibit them from supplying needles and syringes, possessing and supplying associated equipment, and giving out information in connection with an approved NSP.

The Regulation also exempts pharmacists and persons who act under supervision of pharmacists, from provisions of the *Drug Misuse and Trafficking Act 1985*7 that might otherwise prohibit them from possessing and supplying equipment that can be used to administer prohibited drugs. The effect of the *Drug Misuse and Trafficking Regulation 2000*,6 is that staff authorised to perform NSP duties at an approved Needle and Syringe Program may dispense needles, syringes and associated equipment, and give out information in relation to their use, without being exposed to prosecution under the *Drug Misuse and Trafficking Act 1985*..

Without authorisation it would be possible for prosecution to occur for the supply of needles and syringes, and possession and supply of associated equipment for use in the administration of a prohibited drug (under Section 11 of the Act). Prosecution could also occur for aiding and abetting the administration of a prohibited drug (under Sections 19 and 20). It should be noted that exemptions only apply for the purpose of enabling authorised persons to participate in an approved NSP within NSW. Unauthorised persons, and authorised persons providing needles and syringes outside of an approved NSP are liable for prosecution. The *Drug Misuse and Trafficking Regulation 2000*6 also specifically exempts any person from prosecution for aiding and abetting the administration of a prohibited drug (under Sections 19 and 20) for giving out information about the location or hours of an approved Needle and Syringe Program.

APPENDIX 3: EXEMPTION MODEL

An alternative to complete deregulation that may not need legislative change is available to the Health department of NSW already. Widening the base of people to be exempted under section 4 of the Misuse of Drugs Act 2006 to include volunteers and peer educators could be an important step towards legitimising peer distribution. How

might this model look and what would we need to do to make it work? What advantages might it bestow and what might be some of the problems?

WHO WOULD DO IT?

This system would rely heavily upon community members wanting and feeling safe to become peer or secondary distributors. Because the actual law will not have changed it would still not be legal to pass on injecting equipment and people would still be in jeopardy if they did so outside the context of the exemption.

The exemption would necessarily be linked to projects and programs of NSPs and services as attempting to exempt all injecting drug users, for instance, would be problematic in then extreme. In that instance, proving to a law enforcement officer that one was exempted from the laws around providing equipment would be self-incriminating in another way!

Instead feeling, and indeed officially being, an extension to the service or organisation might ensure a greater feeling of safety for the peer distributors. Safer using, harm reduction and peer education training would be given to shore up knowledge and ensure consistency across the volunteer / peer distributor base as well as contribute to the self-confidence and self-esteem of the distributors.

NSP ROLE

The role of NSPs would of course be crucial. Even if the peer distribution projects are extremely basic the NSP would at the very least need to ensure that all peer distributors are registered as volunteers and that these volunteer positions are formally exempted through the NSW Department of Health. Distributors would need identity cards to show police and perhaps to other community members and these would need to be provided by the local NSP.

Peer educators would also need training around safer using, harm reduction, and health promotion. Although NUAA would be the logical organisation to undertake this training it is unlikely, given the numbers of NSPs and PWID across NSW that NUAA would have the resources to undertake training for every volunteer in NSW. Instead NSPs would need to undertake training with defined learning outcomes. This would not be one-off either as not only would people need refreshers but attrition rates would ensure that new volunteers and peer educators would need to be recruited and trained regularly.

The initial provision of equipment to the peer distributors would also likely be the responsibility of the local primary NSP.

Without a law change the actual injecting equipment itself is also still regulated. At present equipment must therefore be owned by the Area Health Service form purchase right through distribution, usage and disposal. This would need to remain, as would the exemption granted, by the Minister, to NSPs to undertake outreach and thus supply a regulated good in public. This exemption would need to be passed on to any authorised person operating out of that NSP, paid or unpaid, during opening hours or after hours.

In short, a commitment to meaningful consultation and training would need to be made along with the associated time and funding costs.

POLICY / FUNDER ISSUES

For this initiative to go ahead Needle and Syringe Program policy will need to be modified. The main change in policy that would need to be investigated is the policy around unpaid workers which, at present, states that they may not distribute injecting equipment, or advice around the use of this equipment.

The current authorisation and approval arrangements for NSPs in NSW are outlined earlier in the document and the NSW NSP guidelines overview is in Appendix I. In addition, the various current NSP delivery modalities are illustrated. These different modalities each have different legislative problems and in each case have needed a slightly different fix to ensure the service can be undertaken. For instance outreach and vending machines both breach a law in some way but each are exempted as their value is recognised. Perhaps this is the way unpaid workers and peer educators should be understood. There is much research that points to the fact that peer distributors are a valuable source of clean equipment in the community. Given this, along with the fact that it occurs despite it being illegal, it needs to be seen as another distribution modality and authorised and exempted in a similar fashion to other distribution techniques.

Approaching the issue from this angle highlights the fact that peer or secondary distribution is a logical extension of current NSP policy and that legislative problems can be solved with a similarly logical extension of the current NSP provider approval and authorisation policy.

It is possible that political will may be raised and maintained if it is understood that secondary distribution legitimised in this way is less a change of policy than a refinement and an improvement of a distribution modality that is already largely in place, albeit illicitly.

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