ACT Medically Supervised Injecting Facility Feasibility Study

Final Report: 17 February 2021

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Table of acronyms used in this report

ACT	Australian Capital Territory
ACTHD	ACT Health Directorate
AMA	Australian Medical Association
BC	British Columba
AOD	alcohol and other drug
ATODA	Alcohol Tobacco and Other Drug Association ACT
BBV	blood-borne virus
CAHMA	Canberra Alliance for Harm Minimisation and Advocacy
DAA	direct-acting antiviral
DCR	drug consumption room
DH	Department of Health (Victoria)
IDRS	Illicit Drug Reporting System
MSIC	Medically Supervised Injecting Centre
MSIR	Melbourne Medically Supervised Injecting Room
NRCH	North Richmond Community Health
NDARC	National Drug and Alcohol Research Centre
NDSHS	National Drug Strategy Household Survey
NGO	non-government organisation
NSP	needle and syringe program
NSW	New South Wales
OPS	Overdose prevention site
OST	opioid agonist treatment
STI	sexually transmissible infection
SUSOS	Service Users' Satisfaction and Outcomes Survey
THN	take-home naloxone

Executive Summary

This report details findings of a feasibility study on the establishment of a drug consumption room (DCR) for the Australian Capital Territory (ACT) that was commissioned by the ACT Health Directorate and undertaken as a collaboration between the Burnet Institute and the Canberra Alliance for Harm Minimisation and Advocacy (CAHMA). The study involved four main components: (1) a desktop review of relevant literature, (2) qualitative interviews with stakeholders, (3) a quantitative survey of people who use drugs in the ACT, and (4) brief 'snapshot' surveys of needle and syringe program clients. A summary of key findings is presented in this Executive Summary.

Drug use and key drug related harms in the ACT

Primary data collected in this study coupled with other surveillance sources suggests that risky patterns of drug use among key risk groups such as people who inject drugs (people who inject drugs), including polydrug use, is prevalent in the ACT. Importantly, this work found a significant amount of public drug use was reported (between 14% and 24% of all recent drug use episodes). Key harms such as recent opioid overdose were reported by around 20% of the ACT samples of people who use drugs accessed in this study, a figure comparable to those reported in other parts of the country, including Melbourne prior to the establishment of the Melbourne Supervised Injecting Room (MSIR). Similarly, rates of heroin/opioid overdose attended by ambulances in the ACT appear comparable to those observed in Melbourne prior to the establishment of the MSIR and there has been an increase in opioid overdose deaths in the ACT over the previous decade.

The ACT service system

The ACT is home to a diverse range of services for people who use drugs. These include harm reduction and treatment services that are geographically dispersed across the region, although some are concentrated in particular areas and other areas have few services available. Treatment services are frequently used, for example the majority of the samples of people who inject drugs in the ACT report having been in treatment previously and around half report current engagement with one or more forms of treatment. Treatment statistics show that participation in treatment has increased significantly over the last decade in the ACT. In particular, over the last 10 years the proportion of people receiving opioid agonist treatment (OAT) has increased substantially and amphetamine treatment episodes have increased drastically. Evidence shows very high satisfaction with AOD services among clients in the ACT. A range of strengths were identified in the ACT system including cooperation and collaboration between service providers and the wide availability of key harm reduction responses such as Needle and Syringe Programs (NSP). A range of gaps were also identified including insufficient resourcing of services, poor access to services in some areas, and lack of specialist services for particular population groups.

Drug Consumption Rooms

Drug Consumption Rooms are spaces in which people can legally consume drugs under supervision. Evidence from Australia and internationally shows that DCRs are associated with a range of positive effects for individuals (e.g. reductions in overdose) and communities (e.g. improved public amenity). Most of the evidence derives from supervised injecting facilities that are typically established in the context of concerns around public injecting. These facilities have been shown to attract the most marginalised and vulnerable clients and economic analysis suggest that they have clear benefits to the community.

A range of DCR models exist in Australia and internationally:

- *Specialised DCRs* are fixed site and stand-alone facilities located close to drug markets. Tailored exclusively to the needs of people who use drugs, they attract the most vulnerable and marginalised populations who may not otherwise access other health services
- *Integrated DCRs* are incorporated into existing services both physically and operationally and offer a range of interlinked services
- *Mobile DCRs* are housed in vehicles which may travel to multiple sites according to need. They are limited by the number of clients able to access at any one time but are potentially suited to dynamic or geographically dispersed drug markets
- *Women-only DCRs* address specific health, social and safety concerns experienced by women who use drugs
- *Overdose prevention sites* (unique to British Columbia, Canada), involve monitoring clients for overdose, but do not require clinical supervision of drug use.

DCRs vary in terms of admission and exclusion criteria (e.g. minimum age requirements, exclusion of pregnant women or intoxicated persons), types of drug use allowed (e.g. injection versus smoking), staffing and hours of operation.

A DCR for the ACT

Converging lines of evidence presented in this report demonstrate the feasibility of establishing a DCR in the ACT. Primary and secondary data collected on patterns of drug trends and related harms indicate that overdose and public drug use are significant public health and amenity issues. Surveys of potential consumers across multiple data collections indicated a strong intention to use a DCR if established, with intentions most frequently reported among participants recruited from Civic. Sector stakeholders were strongly in support of the establishment of a DCR, and this support is echoed by the wider community, reflected in responses to the National Drug Strategy Household Survey. This support, coupled with the existence of relevant legislation and strong service structures indicates that a DCR can feasibly be implemented in the ACT.

Any DCR model in the ACT needs to reflect the ACT's relatively small population compared to other Australian cities. To this end a model in which a small DCR is established initially has been recommended. This model can be implemented through linkage to existing harm reduction service frameworks so that a range of ancillary services can be offered to clients. The service should initially focus on injection, with additional research required to determine needs and costs of providing for alternative routes of administration such as smoking. Assuming a similar per-injecting booth throughput to that seen in Melbourne, a small DCR would be expected to be able to accommodate need given the most recent estimate of the number of people who inject drugs in the ACT. Nevertheless, capacity to scale-up should be built into the facility. Monitoring and evaluation of the service should focus on process and implementation issues that would inform the development of any additional services in different locations in the ACT, should the need arise.

Service staffing should reflect the requirements of the current legislation around medical supervision but stakeholders and potential consumers also recommended the inclusion of peer workers to ensure appropriate service and system co-design, as well as to reduce stigma and facilitate service uptake. Service design may also build on the available resources for DCR design from other jurisdictions.

Although survey data suggest high levels of support for DCRs in the ACT community, further work is likely to be needed to engage the broader ACT community to build understanding of need and support for establishment of such a service, as has been the case in other Australian jurisdictions.

1.0 Introduction

This is the final report of a feasibility study on the establishment of a drug consumption room (DCR) for the Australian Capital Territory (ACT). It outlines the results of a study undertaken as a collaboration between the Burnet Institute and the Canberra Alliance for Harm Minimisation and Advocacy (CAHMA) in 2020, commissioned by the ACT Health Directorate (ACTHD).

1.1 Policy context

Australia's first supervised injecting facility (SIF), the Medically Supervised Injecting Centre (MSIC), opened in King's Cross, Sydney in 2001. A second, the Melbourne Medically Supervised Injecting Room (MSIR), opened in North Richmond, Melbourne in 2018. In June 2020 the Victorian State Government announced its intention to establish another facility in Melbourne's central business district.[1] Discussions around a SIF in the ACT can be traced back to 1998 when a Supervised Injecting Place Trial Advisory Committee was established. The following year the ACT Legislative Assembly passed the *Supervised Injecting Place Trial Act 1999*, which outlined a plan for the trial of a facility in Civic, Canberra. In July 2000, the ACT government deferred the implementation of any facility until after the 2002 election. Since then the legislation and proposed trial has remained inactive, while interest in the issue has fluctuated over the years until resurfacing recently.[2] In particular, a key commitment outlined in the current ACT Drug Strategy Action Plan (2018–21) is to 'investigate the feasibility, need, effectiveness and appropriateness of establishing a medically supervised drug consumption facility (MSIF) in the ACT'.[3] This builds upon a history of working towards reducing drug overdoses in the ACT over the past decade, including establishing Australia's first take-home naloxone (THN) program in April 2012.[4]

1.2 Project background

As part of the ACT Drug Strategy Action Plan 2018–21 (Action 18, page 21), the ACT Government committed to investigating the feasibility, need, effectiveness and appropriateness of establishing a medically supervised drug consumption facility for the ACT (the term used in tender documentation, but see discussion in 2.0 below for the preferred term, Drug Consumption Room, DCR).

The ACTHD established the Medically Supervised Injecting Facility Working Group in January 2020. The purposes of this Group are to:

- Advise on development of the feasibility study
- Advise on other strategies for reduction of overdose-related morbidity and mortality and other alcohol and other drug (AOD) related harms in the ACT
- Act as a resource for the successful consultant regarding the ACT AOD sector, appropriate stakeholder engagement and harm reduction in a local context.

The Group is chaired by ACTHD and includes representatives from Canberra Health Services, CAHMA (the ACT's drug user group), the Alcohol Tobacco and Other Drug Association ACT (ATODA, the ACT's peak body for alcohol and other drug services), Directions Health Services (NSP), Capital Health Network, ACT Policing, the Public Health Association of Australia and the ACT Drug Strategy Action Plan Advisory Group research advisor. However, for the duration of the feasibility study, CAHMA participated in Working Group meetings only in its capacity as a member of the study team.

The Working Group approved the statement of requirements for the Request for Quotation for the feasibility study in February 2020. Following executive approval, ACTHD released a request for tender in February 2020.

As successful tenderers, in April 2020 the Burnet Institute, in collaboration with CAHMA, was commissioned by ACTHD to determine the need for, and feasibility of, a DCR in the ACT and investigate potential models for such a service.

Summarised from the tender documentation, the specific aims of the study were to:

- Identify current and future drug usage patterns, risk behaviours and related issues in the ACT
- Identify gaps in current services in the ACT and services needed to address those gaps
- Describe DCR models used in Australia and internationally
- Review development processes and outcomes for similar services, including cost-benefit analyses for these services
- Assess the need and feasibility for such a service in the ACT
- Advise on an appropriate model for a service in the ACT, should one be identified as needed, and provide high-level advice on likely costs and an appropriate evaluation framework for the service.

The project was carried out during the COVID-19 pandemic, with the ACT and Australia in a state of public health emergency for much of the project. Melbourne, where the project team is largely based moved to a state of public health disaster during the latter stages of the study. This meant that all interviews for the project were conducted remotely (phone or video conference) as Melbourne-based members of the team were not able to visit the ACT.

2.0 Methods

Four research activities were undertaken for the project:

1. A desktop review of peer-reviewed and grey literature exploring:
    a. Australian and international evidence about DCR service models and design
    b. Patterns of drug use and harm in the ACT
2. Qualitative in-depth interviews with stakeholders (hereafter 'stakeholder interviews'):
    a. Organisations and individuals from the ACT including AOD, harm reduction, health and housing/homelessness service providers, government service providers and policy makers and people with lived experience (n=27), to explore support for and possible models for a DCR in the ACT (see Table A11 for detailed breakdown of those interviewed)
    b. Organisations and individuals involved in the delivery of DCR services in other jurisdictions in Australia and internationally (n=4), to examine existing DCR models and issues relating to feasibility of establishment and ongoing service provision
3. A survey of people residing in the ACT who currently use drugs (101 potential DCR service users: mean age 42 years (range: 20-67 years), 55% male, 32% Aboriginal and/or Torres Strait Islander) exploring basic demographics, drug use and service utilisation patterns and opinions about utilisation of and support for a DCR in the ACT (hereafter, 'consumer survey')
4. A brief quantitative 'snapshot' survey of clients of primary NSPs in the ACT (n=242) to identify their demographics (mean age 45 years, 69% male, 16% Aboriginal and/or Torres Strait Islander), opinions about a proposed DCR in the ACT, and drug use patterns (hereafter, 'NSP snapshot survey').

Ethics clearance was received from ACT Health Human Research Ethics Committee in May 2020 (reference number 2020.ETH.00086).

The following report synthesises the main findings of the study. It first provides:

- A brief overview of the evidence supporting the implementation of DCR services in Australia and globally
- A description of the ACT context regarding drug use patterns and the current service system for people who use drugs, including gaps and other issues, and consideration of whether there is a need for a DCR in the ACT
- An exploration of DCR models used in other jurisdictions and what may be considered suitable for the ACT.

These findings are then synthesised with the views and experiences of people in the ACT. The appendices contain detailed findings from each of the individual research activities listed above.

In this report, we use the term DCR (drug consumption room), consistent with international terminology, and to include the consideration of the consumption of drugs by means other than injection and consumption that does not necessarily involve medical supervision.

The research methods used in this study were adapted to enable work during public health emergency conditions brought about by the COVID-19 pandemic. The Melbourne-based Burnet Institute team was unable to travel to the ACT to conduct the research. All interviews were conducted using remote methods such as telephone and videoconferencing.

Potential consumer interviews were all conducted by CAHMA staff remotely. Stakeholder interviews were conducted by the Burnet Institute. NSP snapshot surveys were facilitated by staff at Civic, Phillip and Hepatitis ACT NSP sites. The CAHMA team provided input into the development of materials and interview schedules but played no role in relation to data analysis and synthesis. Stakeholders from the Medically Supervised Injecting Facility Working Group and ACT Government provided feedback on an earlier draft of this report.

3.0 Summary of evidence for Drug Consumption Rooms

KEY FINDINGS

- DCRs are spaces in which people can **legally consume drugs under supervision**.
- DCRs have been shown to **reduce a range of drug-related harms**, both for individuals who use drugs and communities through direct response to harms like overdose, advice on safer drug use practices and provision of a range of complementary services, such as those relating to blood-borne viruses.
- DCRs are typically accessed by the **most marginalised people** who use drugs and those most vulnerable to drug-related harms.
- DCRs have demonstrated a positive **return on investment**.
- DCRs have been established in other jurisdictions for **a range of reasons**, but typically in response to the presence of a street drug market, significant public injecting and discarded injecting equipment and high rates of harms, particularly overdose.
- **More than 50% of people who use drugs sampled indicated a strong intention to use a facility if available in the ACT, with highest support evident among those recruited in Civic.**
- Service providers in the ACT report **strong levels of** support for an ACT-based DCR**.**
- **A majority of ACT residents indicate support for the establishment of supervised injecting facilities.** Nevertheless, further work is likely to be needed to engage the broader ACT community to **build understanding** of need and support for establishment of such a service, as has been the case in other Australian jurisdictions.
- **Legislation** governing the operation of a trial DCR in the ACT already exists.
- Some **detailed guidelines** for operational policies and procedures from other similar services are available in the public domain.

3.1 What is a drug consumption room?

Drug consumption rooms are typically defined as spaces in which people can self-administer pre-obtained illicit drugs under trained supervision in a hygienic, safe and non-judgemental environment. Historically, DCRs operate for the supervised consumption of drugs via injection, but a small number of DCRs have been established for drug consumption through other routes of administration such as snorting, inhalation or oral administration.[5] DCRs were originally developed as a public health response to the rapid spread of HIV/AIDS among people who inject drugs in the 1980s, drug overdose and to problems posed by public drug use. The first legal supervised injecting room opened in Switzerland in 1986; as of 2019 there were at least 119 DCRs operating in 13 countries (see Table 1).[6,7] Most of these DCRs operate in Europe and Canada, and there are DCRs (medically supervised injecting facilities) in Sydney and Melbourne. There are reports of several unsanctioned DCRs in Latin America, the United States and North Africa. This review focuses on publicly available information from sanctioned sites only.

Table 1: Countries with DCRs and number of DCRs, as indicated in 2019

	n
Australia	2
Canada	49
France	2
Denmark	5
Germany	24
Luxembourg	2
Netherlands	24
Norway	2
Portugal	1
Spain	13
Switzerland	12
Ukraine	1

Although operating objectives may vary slightly, DCRs are typically established to reduce some of the individual and community harms arising from illicit drug use connected to active and open street drug markets.[8,9] DCRs aim to reduce morbidity and mortality among client populations, and to improve the public amenity of surrounding areas. DCRs may be embedded within existing health services, physically and/or operationally, providing smooth pathways for linkage to care outside of the core services offered by the DCR.[8] Importantly, evidence suggests DCRs should be low-threshold (i.e. have minimal barriers to access). DCRs are generally implemented as part of a comprehensive harm reduction strategy complementing NSPs, OAT and blood-borne virus (BBV) testing and treatment.[5]

Publicly available English-language information on the effectiveness of DCRs comes mostly from evaluations of facilities in Canada and Australia. The remainder of this section summarises the available evidence that measures the impacts of DCRs on individual and community harms related to illicit drug use. Impacts of services relate principally to:

- BBV transmission
- Overdose
- Injecting-related injury and disease
- Linkage to drug treatment
- Social and health services
- Public drug use
- Discarded drug-related litter.

3.1.2 Impacts of DCRs on people who use drugs

Evidence shows DCRs reduce drug-related harms for people who use them. Scientific evaluations show DCRs are associated with reductions in drug-related mortality,[10-14] all-cause mortality,[15] ambulance attendances at overdoses[12,16] and overdose-related hospital emergency department presentations,[17,18] at an ecological level in the areas where they have been implemented. Evidence also suggests reduced needle and syringe sharing,[19,20] reduced injecting-related injury and disease such as abscesses, septicaemia and endocarditis,[21] and positive changes in injecting practices such as not reusing needles and syringes and swabbing among clients of DCRs.[22] Further, DCR staff can

respond quickly to overdoses that occur frequently within facilities and ensure safe disposal of injecting equipment.[22-24] DCRs have also been credited with avoidance of newly acquired HIV[10,25,26] and hepatitis C infections,[18] and importantly, to date there has been no overdose fatality recorded in any DCR.[27]

There is good evidence that DCRs are accessed by those most in need – the most marginalised and vulnerable people who use drugs, including those experiencing homelessness,[12,28] mental health disorders,[18] Indigenous populations,[12,17,21] or people who engage in high-risk drug use practices.[29,30] These groups, often considered 'hidden' and 'hard-to-reach', are offered drug education[31] and linked to health[32] and social services,[12,21] drug detoxification[33,34] and treatment services[21,35] in DCRs.

3.1.3 Public amenity

Drug consumption rooms have been shown to have positive impacts on the local community through removing at least a portion of street-based and other public drug use. There is evidence that the presence of DCRs is associated with reductions in drug-related litter[17,18] and public drug use,[12,18,27,36] thus improving public amenity.[21,37] The public amenity impacts of Australian DCRs are more nuanced compared with other countries. An estimated 164,655 public injections were avoided during the first five years of the King's Cross, Sydney MSIC.[38] However, in North Richmond, Melbourne, factors including unforeseen demand, a pre-existing expansion of the local drug market, and some exclusion criteria led the panel conducting an independent review of the MSIR to conclude that the MSIR had not improved public amenity during its first 18 months of operation. The MSIR review panel noted that the trial was implemented rapidly in response to escalating public health and safety concerns surrounding public injecting in North Richmond. Data suggests that the number of people buying and/or using drugs in North Richmond was increasing before the MSIR opened. As such, the MSIR had been inundated with demand in the first 18 months of operation, and initial implementation focused primarily on establishing supervised drug consumption, with the service still being in the early stages of implementing a suite of responses to address diverse issues in the local area at the time of the review.[12]

3.1.4 Economic and societal impacts

Economic evaluations of DCRs provide estimates of the benefits accrued to the community by comparison with an alternative situation in which the facility does not exist (counterfactual).[21] Economic analyses include measures specific to the context and data available for the service being evaluated, hence there is no agreed-upon method for economic analysis. In practice, they focus on more tangible indicators, such as the costs associated with BBV infections that the facility is likely to have prevented, as well as costs associated with overdoses that occurred or were avoided in the facility that might have occurred elsewhere, and incurred costs such as ambulances and hospital treatment.[21,39]

A 2010 cost-benefit analysis of Vancouver's Insite facility found that the service prevents, on average, about 35 new cases of HIV and three deaths each year. This translates to an economic benefit of at least CAD 6million (AUD 6.3million) per year after program costs are taken into account.[10] Another cost-effectiveness analysis of Insite estimated an incremental net savings of almost CAD 14million (AUD 14.3million) and 920 life-years gained when accounting only for decreased needle/syringe sharing, increasing to CAD 20 million (AUD 21 million) in incremental net savings and 1070 life-years gained with the additional consideration of increased safe injection practices.[25]

The most recent economic evaluation of the MSIC, published by Saha International in 2008, found that the facility delivered substantial economic benefit – a saving of $658,000 over 12 months period for the New South Wales (NSW) government (compared to providing similar health outcomes through other means in the health system). Half of these savings came from the prevention of HIV and hepatitis C infections, and 25% from avoidance of overdose costs.[39] It is important to note that these economic analyses are likely to underestimate the benefits of DCRs, because some intangible costs such as deterioration in client health, reduced functionality of people affected by BBV infections and overdose, improved public amenity and decreased drug-related crime were not considered.

3.2 DCR implementation

DCRs have typically been implemented idiosyncratically in response to local demand and conditions. Moves towards establishing standards and principles for implementing and operating DCRs in the late 1990s are described mostly in publications in German. Recently, DCRs have emerged as a key response to the Canadian opioid overdose crisis, and a range of related implementation documents cover the key areas outlined in this section of the report.

Operational guidelines developed by the British Columbia Centre on Substance Use[40] state that the primary issues to consider when considering a DCR are the target client population, the existing network of services for people who use drugs, willingness to utilise a DCR, service design to meet local need, and the resources available including funding, space and staff. The authors stress the importance of including the target population (potential DCR clients) in planning and execution, as well as identifying and consulting other stakeholders. If a DCR is identified as both needed and suitable for the context, the next step is to define its goals, targets and anticipated outcomes.

3.2.1 Identification of need and suitability

Common factors which have preceded the introduction of DCRs internationally include the presence of indicators of public drug use such as a street-based drug market, inappropriately discarded injecting equipment, and high rates of overdose mortality and/or other drug-related harms such as BBV transmission. The emphasis on either public health or public order objectives differs between locations, influenced at least in part by which groups influenced DCR implementation processes.[9]

Qualitative interviews for this study found that both the MSIR and MSIC were established out of a perceived need to respond to overdose deaths, a finding reflected in the early literature on the MSIC.[41] In Sydney in the late 1990s, there was increased media and political attention on fatal overdoses in the King's Cross area. In 1997, an inquest into police corruption recommended the establishment of a sanctioned SIF (as there were several clandestine shooting galleries operating in the area at the time) to combat the problem.[41] In Melbourne, support and lobbying for an SIF followed multiple Coroner's recommendations after the fatal overdose of a woman in Richmond.[42] Support was evident across a wide spectrum including family groups, the Australian Medical Association (AMA), Ambulance Victoria, Victoria Police, the Herald Sun newspaper, and local advocacy group Residents for Victoria Street Drug Solutions. Support from politicians was also pivotal in the establishment of both Australian facilities. In the case of British Columba (BC), Canada, the key stakeholder who we interviewed for this study described an inclusive and collaborative establishment process which involved local health services, police and the local activist group, Vancouver Area Network of Drug Users.

Australian Capital Territory stakeholders were asked about whether a DCR would be appropriate for the ACT, and they generally agreed that such a service would be well received by people who use drugs and supported by other service providers. This sentiment was shared by AOD treatment providers, homelessness services, justice system representatives and ACT Police. Some recommended that multiple DCRs may be needed to service the geographically dispersed drug consumption scene of the ACT. One suggestion was to establish one primary facility, which could then be followed by other small services in areas where drug use is concentrated, and a need is identified. It was suggested that a small site could be easily integrated into existing health facilities. One stakeholder believed that a service needed to be located in close proximity to a street drug market, such as those in North Richmond and Kings Cross that have a significant concentration of drug dealing and consumption in one area, for a facility to be successful. Stakeholders noted the importance of clients being able to walk or catch public transport to the facility. Ultimately, the level of buy-in from consumers was seen as being most heavily influenced by the:

- Geographic location of the service
- Availability of other services onsite
- Confidentiality of the service.

3.2.2 Acceptability

There was strong support for the establishment of a DCR among participants in both the consumer and NSP snapshot surveys. A large majority (84%) of consumer survey participants and more than half of NSP snapshot participants (64%) indicated that they would use a DCR in the ACT if one were available (Table 2). An additional 9% of consumer survey participants and 12% of NSP snapshot study participants said they did not know or might use a DCR if one were available in the ACT.

Table 2: Intentions to use a DCR in the ACT, consumer and NSP snapshot surveys

	Consumer survey n = 98*		**NSP snapshot n = 163***	
	n	**(%)**	**n**	**(%)**
Would you use a DCR?				
No	<5	<5	39	(24)
Yes	85	(87)	104	(64)
Maybe/Don't know	9	(9)	20	(12)

*Missing: three responses from consumer survey and one from NSP snapshot survey

Support for a DCR in the ACT was consistent across age groups in both surveys (Table 3). The percentage of males and females endorsing a DCR was approximately equal for NSP snapshot participants (67% vs 57%) and consumer survey participants (84% vs 90%), but support was lower among NSP snapshot participants. Aboriginal and/or Torres Strait Islander consumer survey participants and NSP snapshot participants reported intent to use a DCR at similar rates (consumer: 87% vs 75%, NSP snapshot: 75% vs 62%). Anticipated use of a DCR exceeded 50% at all NSP sites participating in the NSP snapshot study, with the rate of anticipated use among those recruited from Civic NSP highest at 70% (n=64) (See Table A25).

Amongst consumer survey participants who said they would use a DCR, common reasons for use included reduction of overdose risk (52%), concerns about using drugs alone (52%), being away from police (49%) and needing help with and advice about injecting (30%) (Table 4). Almost half (48%) advised that they would use a DCR for 50% or more of their injections. A largely similar pattern was observed among NSP snapshot study participants who reported wanting to use a DCR: the most common reasons were concern about overdose risk (43%), concern about using alone (30%) and using away from police (27%). Individuals who did not intend to use a DCR nominated the most common reasons as already having a safe space to consume drugs (77%), preferring to consume drugs at home (69%) or preferring to keep drug use private (44%).

Table 3: Intentions to use a DCR in the ACT by age, sex and Aboriginal and/or Torres Strait Islander status

	Consumer survey		**NSP snapshot**					
	N = 101		**N = 164**					
	Yes		**No**		**Yes**		**Maybe**	
	n	**(%)**	**n**	**(%)**	**n**	**(%)**	**n**	**(%)**
Age								
18-30 years	14	(93)	7	(35)	12	(60)	<5	<5
31-40 years	29	(88)	8	(22)	25	(69)	<5	<5
41-50 years	20	(74)	12	(22)	34	(62)	9	(16)
51+ years	22	(96)	12	(23)	33	(63)	7	(13)
Sex								
Female	37	(90)	13	(28)	26	(57)	7	(15)
Male	48	(84)	26	(22)	78	(67)	13	(11)
Aboriginal and/or Torres Strait Islander								
No	58	(87)	34	(24)	89	(62)	20	(14)
Yes	27	(87)	5	(25)	15	(75)	0	(0)

Table 4: Reasons for anticipated use of a DCR in the ACT

	Consumer survey N = 101		NSP snapshot N = 164	
	n	(%)	n	(%)
Concerned about overdose risk	53	(52)	71	(43)
Concerned about using alone	53	(52)	49	(30)
To use away from police	49	(49)	44	(27)
Need support and advice to inject	30	(30)	37	(23)
Concerned about violence/standover	17	(17)	33	(20)
Curious what it would be like	6	(6)	24	(15)
Other safety related	20	(20)	-	-
Social reasons	-	-	16	(10)
Not applicable	0	(0)	<5	(<5)
Total*	228	(100)	274	(100)

*Participants could select more than one response

A strategy to engage the broader local community and foster acceptability is another important consideration. In Melbourne, the local trader's association – which had initially opposed the establishment of a SIF – ultimately played an important role in demanding a DCR to improve public amenity and reduce the impact of the street drug market on local businesses.[12] However, support for the MSIR among respondents to a community survey reduced during the first year of the trial, from 61% to 41% among residents and 48% to 41% among business owners.[12] Conversely, in Sydney the Kings Cross Chamber of Commerce attempted to thwart the opening of the MSIC by launching legal proceedings against the licensing authorities, and the Vatican intervened to prevent a Catholic group from participating in the delivery of services.[43] Despite igniting public debate, three in five residents and businesses local to the MSIC supported the establishment of the service, and this level of support was sustained over the first five years of operation.[38] A notable difference between the Melbourne and Sydney facilities is their urban location: the Sydney MSIC is a standalone facility operating from a shopfront in a commercial shopping strip, whereas the Melbourne MSIR is co-located in a community health service within close proximity to high-density public housing and a primary school.

Findings from the 2019 National Drug Strategy Household Survey (NDSHS) suggest that roughly half (47%) of the Australian population supports supervised drug consumption facilities/rooms to reduce harms associated with drug injecting. Importantly, at 56%, support was highest in the ACT of all states and territories.[44] This figure represents an important foundation for mobilising community support if needed.

3.2.3 Politicisation

Despite the broad evidence base pointing to numerous benefits – and little basis for concern about adverse effects – the implementation of policy supporting DCRs is highly politicised and often controversial.[45,46] Commonly, DCRs (along with other harm reduction programs) are perceived to be

tacit endorsement of illicit drug use, sending the 'wrong message' to the public about being 'soft on drugs'. Concerns have also variously been raised that DCRs may delay treatment initiation by drug users, and/or worsen negative local community impacts of the local drug market by attracting consumers and dealers from outside the local area (the so-called 'honeypot effect').[8] These fears have not been realised with the operation of existing DCRs: there was no evidence that the Sydney MSIC led to an increase in drug-related loitering at the front of the service after it opened, and there was no increase in the proportion of drug use or drug supply offences committed locally.[47] In Vancouver, the DCR was found to have no substantial impact on relapse into injecting drug use or stopping drug use,[20] drug trafficking or other drug-related crime in the neighbourhood.[48] In some European locations, clients of specific DCRs are subject to local residency requirements specifically to prevent attracting people who use drugs from outside the local area.[9]

Australian Capital Territory stakeholder interviews revealed no potential political or ethical objections from service providers to a DCR in the ACT. There was some concern amongst stakeholders that there would be a lack of support from government due to expected low utilisation, along with high financial investment, resulting in minimal impact and low return. This concern was also mentioned in relation to a perception of low rates of drug use and overdose in the ACT compared to some other jurisdictions, which appeared to be unfounded as we consider below in Section 4.0.

3.2.4 Legislation

Given that they generally involve the consumption of illicit drugs, DCRs typically require specific legislation or amendments to existing legislation to operate.

The implementation and operation of SIFs in NSW and Victoria involved the amendment of pre-existing legislation (the NSW *Drug Misuse and Trafficking Act 1985* and the Victorian *Drugs, Poisons and Controlled Substances Act 1981* respectively). However, these amendments included explicit objectives of each SIF that are not included in the ACT legislation. For example, the NSW legislation makes reference to reduction in the number of overdose deaths, providing a gateway to treatment and counselling, reduction in the number of discarded needles and syringes and incidence of public injecting, and reducing the spread of BBVs. The Victorian legislation incorporates these four objectives, as well as a reduction in ambulance and hospital emergency attendances due to drug overdose and the improved amenity of the neighbourhood for residents and businesses.

In Canada, DCRs require an exemption from federal drug laws (*Controlled Drugs and Substances Act*) to operate.[49] This ultimately gives the federal government in Canada the responsibility of approving any new facilities. Conditions in the exemption (under Section 56) of the federal legislation range from a requirement that the facility does not contribute to an increase in crime, identification of the need for support from local police, and prohibition of assisted injection. This level of regulation has led to the introduction of Overdose Prevention Sites (OPSs) in BC (described further in section 6.6) as a means of circumventing federal drug laws.

In the ACT, existing legislation (*The Supervised Injecting Place Trial Act 1999*, 'the Act') allows for the trial of a supervised injecting place. Briefly, the Act outlines the minimum legal requirements for the operation of the facility, as well as broadly establishing a law enforcement and internal management protocol, criteria for accessing the facility, exemptions from criminal proceedings for staff and other persons, and guidelines around provision of injecting equipment and excluding people from the service. The Act specifies that injection of a substance at a trial facility must be directly supervised by

a doctor or a nurse. The legislation also mandates that any trial facility must contain (or provide satisfactory access to) primary health care services (including medical), AOD counselling services, health education services, AOD detoxification and rehabilitation services, and BBV testing. Exemption from prosecution under the *Drugs and Dependence Act 1989* or the *Medicines, Poisons and Therapeutic Goods Act 2003* applies to possession of a maximum of 0.5g of a substance.

Criteria for scientific evaluation of a trial supervised injecting place in the ACT are not currently specified under the Act; these are to be determined by the Minister with input from an appointed Advisory Group whose membership represents key ACT stakeholders. Operational objectives are also specifically not defined in the legislation.

A further legislative consideration is the ACT *Human Rights Act 2004*, most of which reflects Australia's international human rights obligations under the International Covenant on Civil and Political Rights. Specific rights of relevance include:

- The right to life – by which there is positive onus on governments to take reasonable steps to protect people
- The right to equality (specifically the right to enjoy other human rights free from discrimination).

3.2.5 Policies and procedures

The British Columbia Centre on Substance Use published *Supervised Consumption Services: Operational Guidance* in 2018.[40] This document recommends several steps to be undertaken prior to the implementation of a DCR and describes key policies and procedures that should be considered. They include overdose response protocols, documentation procedures, referral pathways, code of conduct/rights and responsibilities for clients and staff, eligibility criteria and intake procedures, criteria and protocol for refusal of service, procedures for contacting police in the event of aggression, biohazard disposal procedures, staffing and regulatory structure, screening and informing clients, community engagement and support, and a detailed description of the services on offer. Templates are provided for many of these policies and procedures.

Aside from specific elements of protocols and procedures which pertain directly to evaluation criteria, examples of current operational guidelines from the MSIC and MSIR are not publicly available. However, many operational facets broadly align with the medical model adopted in Canada. The Melbourne MSIR was modelled heavily on the Sydney MSIC, with direct support provided in the development of protocols.[12] Examples of specific policies and procedures are given in further detail in Section 7.0.

4.0 Drug use, harms and the ACT service system

KEY FINDINGS

- **Quantitative data suggest an ongoing prevalence of public drug use at between 14% and 24% of recent episodes of drug use.**
- Qualitative reports of methamphetamine and alcohol as the primary drugs of concern contrast with quantitative data showing that **heroin** is still by far the most commonly reported and most used drug amongst various studies of people who inject drugs undertaken and reviewed for this report.
- Rates of use of various drugs amongst the general population have remained **stable** for several years.
- **Polydrug use is common** in the ACT amongst people who use drugs.
- Purchase and use of drugs occurs in **both private and public settings, with both types of settings carrying health risks**. Purchasing and using in dealer's homes and in public locations such as car parks and toilets is prevalent.
- **Overdose deaths and drug related hospital separations** in the ACT have **increased significantly** in recent years.
- Around a fifth of people who inject drugs in the ACT report **recent non-fatal opioid overdose, a figure comparable to that seen in Melbourne and Sydney**.
- The rate of **ambulance** attendance at calls related to heroin or other opioid use is estimated to be as **high** as that seen prior to MSIR establishment in Melbourne.
- **Polydrug use** is perceived as the most common driver of overdose in the ACT.
- **Hepatitis C** incidence and prevalence in the ACT have been **reducing** in recent years, perhaps due to increased availability and uptake of treatment for hepatitis C.
- Other injecting-related **risks and harms** such as sharing and reusing of injecting equipment and assisting others to inject have remained relatively **stable** in the last decade, although a recent drop in sharing of equipment has been reported.
- Drug-related **arrests** have recently **increased** in the ACT.

Available data on drug use trends and harms for the ACT were collated from multiple sources and reviewed for this report. The full list of data sources from published literature is described in Appendix 1, and a detailed review of ACT trends in drug use prevalence, drug-related harms, health service utilisation and drug-related crime and law enforcement is included in Appendix 2. The following section is a summary of findings from the review as well as the primary data collected through our consumer and NSP snapshot surveys of potential service users and qualitative interviews with ACT stakeholders. It is important to note that the quantitative interviews were conducted during the COVID-19 health emergency. A small number of questions were included to identify whether the pandemic had impacted behaviour. For example, participants were asked if the drug they had injected most often or the total number of injection episodes in the past month had changed due to COVID-19 (only two and 12 participants, respectively, responded in the affirmative).

More detailed reports from these interviews and surveys can be found in Appendices 5 (ACT Stakeholder data), 6 (Consumer survey and NSP Snapshot data) and 7 (DCR stakeholder data).

Notably, there was an apparent mismatch between stakeholder's perceptions and consumer's reports of the prevalence of public drug use and overdose harms. In conjunction with independent epidemiological data, overall we found clear evidence of patterns of drug use and related harms connected to public drug use in the ACT that require a considered response.

4.1 Studies of drug use in the ACT

In identifying data sources for this report, people who inject drugs were the main population considered because they were assumed to be the group most likely to use a DCR. This heterogeneous population often experiences a range of social and health disparities. The demographic profiles of ACT samples included in the studies considered were similar and are provided in Table 5 below.

The most up-to-date estimate of the number of people who recently (previous 12 months) injected drugs in the ACT is by Larney and colleagues from 2014.[50] The estimated number of people who inject drugs in the ACT was 1250 (5.1 per 1000 of population aged 15–64 years), with lower and upper uncertainty bounds of 1000–1500 (3.7–6.4 per 1000 of population aged 15–64 years).[50] This figure represents 1.3% of the estimated national total of 93,000 (with lower and upper uncertainty bounds of 68,000 and 118,000). The authors do not provide further demographic breakdowns by jurisdiction, but the ratio of males to females nationally was estimated to be 7:3, consistent with the people who inject drugs sampled for this report (Table 5), with the exception of our consumer survey which had a relatively high proportion of female participants.

Kwon and colleagues[51] estimated the annual number of people who inject drugs in Australia between 2005 and 2016. They noted that between 2012 and 2016 the number of people who inject drugs remained stable, which – considering 7% population growth in that period – means that the overall rate of people who inject drugs per population declined from 0.44% in 2012 to 0.39% in 2016.

Table 5: Participant demographics from epidemiological studies involving people who inject drugs in the ACT

	Primary data collection		Secondary data	
	Consumer survey 2020	**NSP snapshot survey 2020**	**ACT IDRS 2019[51]***	**National NSP Survey (ACT site data 2019)[52]**
Number of participants (n)	101	242	100	128
Males	55%	69%	74%	67%
Age (min.)	20	18	.	.
Age (max.)	67	67	.	.
Age (mean)	42	45	44	42 (median)
Sexuality				
Heterosexual	84%	.	89%	73%
LGBTIQA+	16%	.	7%	13%
Not reported	.	.	4%	14%
Aboriginal and/or Torres Strait Islander	32%	16%	24%	16%
Post-school qualification(s)	27%	.	54%	.
Stable housing^	83%	90%	78%	.
Unemployed	82%	.	90%	.

* Illicit Drug Reporting System (IDRS); while ACT IDRS data from 2010–19 are included in this report, the 2019 sample was similar to previous years.
^ Includes own home, rent or public housing

4.2 Drug use patterns

Stakeholders were asked to describe their understanding of current drug use patterns and trends in the ACT. Social alcohol consumption and recreational drug use were mentioned as ongoing issues in the nightlife areas of Civic. In terms of dependent drug use, there was consensus among stakeholders that alcohol and methamphetamine were the main substances of concern. Notably, there were conflicting perspectives on the prevalence and impact of heroin and prescription opioids in the ACT, with most interviewees mentioning that patterns were increasing or stable, but a few perceived a decrease in use over time.

Findings from the 2019 NDSHS show that overall, 15% of the ACT population reported use of any illicit drug in the preceding year, with prevalence of use being 14% among men and 15% among women. The most common age groups for any illicit drug use were 18–24 (37%), 25–29 (26.2%) and 30–39 years (13%). The prevalence of illicit drug use in the ACT overall was slightly lower than in other Australian jurisdictions. Cannabis was the most frequently used illicit drug (~10%), with use of heroin (<0.3%), cocaine (2–5%), methamphetamine (1–2%) and ecstasy (2–4%) reported by less than 5% of the population. These figures have remained largely stable over the past decade.

Among IDRS participants, tobacco was the drug most frequently reported as being recently used (77%), followed by opioids (54%), cannabis (51%), stimulants such as methamphetamine (33%) and alcohol (29%).[52]

The Australian NSP Survey 25-year National Data Report showed that among participating ACT NSP attendees in 2019 (n=128), heroin (46%) and methamphetamine (45%) were most frequently nominated as being last injected, an increase from 2010 (heroin 29%; methamphetamine 27%) when injecting methadone (16%) and buprenorphine (10%) were more common.[53]

4.2.1 Heroin

Although the population prevalence of heroin use is low, the frequency of its use among samples of people who inject drugs is high. Most participants in the consumer survey reported recent use of heroin (79%). Heroin was also the drug that participants typically nominated as their drug of choice (65%), the drug they had used via any route of administration most frequently in the last month (53%) and injected most in the last month (64%). Similarly, the NSP snapshot survey found that the most commonly reported last drug of injection during the snapshot period was heroin.

Most people who inject drugs who participated in the 2019 ACT IDRS were frequent users of heroin: around three quarters of those reporting recent use (past 6 months) reported at least weekly use, and 40% reported daily use. Recent heroin use prevalence decreased from a peak of 92% of IDRS participants in 2000 to 77% in 2019. All participants who reported heroin use reported injecting the drug.[52]

4.2.2 Methamphetamine

More than half (60%) of the participants in the consumer survey reported use of crystal methamphetamine (ice) in the past six months. Across other measures of recent use, crystal methamphetamine was the second most commonly nominated drug, after heroin. Twenty-six per cent of participants nominated crystal methamphetamine as their drug of choice. This was reflected in the NSP snapshot survey, where around a quarter of participants reported methamphetamine as their most recently injected drug.

Results from the 2019 NDSHS showed a decrease in the prevalence of methamphetamine use in the ACT from 1.2% in 2010 to 0.3% in 2019.[51, 55] Among ACT IDRS participants, both the percentage of the sample indicating past-six-month methamphetamine use and frequency of use have steadily increased over the past decade.[52] Two thirds of those reporting recent use reported at least weekly use and one-fifth reported at least daily use. Methamphetamine was injected by 97% and smoked by 36% of those who reported recent use of the drug.[52]

4.2.3 Cocaine

A substantial minority of participants in our consumer survey reported recent use of cocaine (19%). Among participants in the IDRS, the prevalence of recent cocaine use more than doubled over the past decade, from 6% in 2010 to 15% in 2019, with a few fluctuations over that period. However, the median frequency of use has not changed markedly, fluctuating between two and eight days in the previous six months. The most common route of cocaine administration nominated was injecting (73%) followed by snorting (40%).[52]

4.2.4 Pharmaceuticals

Substantial minorities of our consumer survey sample reported pharmaceutical drug use, with 17% reporting recent use of methadone, 26% reporting recent use of benzodiazepines and 8% reporting morphine use. Very small numbers of participants reported pharmaceuticals as their most frequently used type of drug.

One sixth (15%) of IDRS participants in the ACT reported illicit use of methadone in 2019, an overall decrease since 2010 (25%). Around a quarter of this group reported recent injection of methadone (liquid and tablets), approximately twice a week.[52]

Most IDRS participants who reported recent buprenorphine use reported non-prescribed use; the percentage of non-prescribed use decreased from 35% in 2010 to 6% in 2019, which reflects reduced availability since the introduction of buprenorphine-naloxone. Five out of six participants reporting illicit use of buprenorphine injected it, and the median frequency of use was approximately fortnightly. The prevalence of illicit use of buprenorphine-naloxone was higher at 14% in 2019, with a median of monthly use, and half of those injected it.[52]

Reports of non-prescribed morphine consumption by ACT IDRS participants have more than halved over the past decade (from 43% in 2010 to 15% in 2019), which may reflect changes in prescribing practices (Table A4). Most of those who reported morphine use in 2019 reported injecting morphine (93%).

Reports of recent oxycodone use by ACT IDRS participants remained relatively stable at 14–17% over the past 10 years, apart from a spike in 2011–14 when consumption peaked at 35% (Table A5); it was 17% in 2019. Forty-four per cent of those reporting recent oxycodone use in 2019 reported injecting the drug.

Australian Capital Territory IDRS participants are less likely to report recent fentanyl use than use of other prescription opioids, but reports of 'any fentanyl use' doubled from 8% to 14% over 2018–19, with 79% of those reporting recent use reporting injecting the drug.[52]

4.2.5 Alcohol

Eighty-one per cent of participants in the NDSHS reported any alcohol use (daily, weekly, monthly, or less than monthly). Daily consumption of alcohol was uncommon at 4.4% (5.4% in 2010; 6.6% in 2013; 3.7% in 2016). Fourteen per cent were categorised as having a lifetime risk of harm from alcohol, with males (20%) being at three times greater risk of harm than females (9%).[54]

In our consumer survey, 55% reported recent use of alcohol, with the most reported frequency being 2–4 times per month. Just over a third (38%) reported no consumption of alcohol in the past month.

Recent use of alcohol has historically been reported by 54–75% of IDRS participants. In 2019, this figure was 62%. The median frequency of use was equivalent to twice weekly (48 days; IQR 12–100), with 21% reporting daily use, a considerably higher proportion than among the general population.

4.2.6 Cannabis

Data from the NDSHS indicate that over the last decade, reports of recent (past year) cannabis use among the general population has remained stable in the ACT (9.5% in 2010; 10.1% in 2013; 8.4% in 2016; 10.5% in 2019).[44]

Just under half of the participants in our consumer survey reported use of cannabis in the past six months (44%). Twelve per cent reported cannabis being their most used drug in the last month.

Eighty per cent of IDRS participants between 2010 and 2019 reported recent use of cannabis. Of these, 90% reported at least weekly use and over half reported daily use. All participants reported smoking as their primary route of administration and one-tenth reported vaping and/or ingesting.[52]

4.2.7 Tobacco

As reported in the 2019 NDSHS, the prevalence of tobacco smoking in the ACT was 9%, the lowest of all the states and territories.[54] However, the IDRS shows that tobacco use among people who inject drugs in the ACT has consistently remained high, with 97% of the sample reporting recent use in 2019 and 91% of recent users reporting daily use.[52]

4.2.8 Polydrug use

Consumer survey respondents commonly reported polydrug use (47% identifying using heroin and crystal methamphetamine in the last six months) before COVID-19. McKetin and colleagues' 2017 study of recent (past month) methamphetamine use in the ACT (N=183) found that half of the sample had also used heroin (48%) or other opioids (50%) in the past month, with cannabis (80%) and alcohol use (62%) also being prevalent in the same time period.[55]

4.2.9 Public drug purchase and use patterns

Consumer survey participants most commonly reported scoring drugs from a dealer's home (43%), with other common responses being street dealers (16%) and friends (14%). Participants mostly commonly reported scoring drugs from Civic (33%). Participants typically reported injecting drugs in a private location (63%), including their own home, a dealer's home or another person's home. Public locations (e.g. street, public toilet, stairwell, park, car) accounted for 30% of typical injections.

The NSP snapshot survey found that home was the typical location of the last episode of drug use of participants (76%). In addition, 10% reported the last episode of drug use occurring at another person's home. A combination of public locations like parks, toilets and cars accounted for 14% of last episodes of drug use.

Amongst the 2019 ACT IDRS sample, 80% of participants reported injecting in a private home on their last occasion of use (91% in 2018). The 2020 Australian NSP survey 25-year National Data Report shows that public injecting in the last month was self-reported by 53% (n=61) of participants in 2019, and has fluctuated each year since 2010, ranging from 28% to 56%.[53]

In stakeholder interviews, there was general agreement that measures of street drug use (including public use, public overdoses, dealing and discarded drug-related paraphernalia) were low and had been decreasing over time which conflicts with reports from consumers. Apart from some parts of the Civic area, where homelessness and drug use were concentrated, hotspots in other areas of the ACT were less obvious, which some attributed to policy that dispersed public housing communities across the ACT. Additional areas frequently mentioned as drug use hotspots were Ainslie Village and parts of Belconnen. Overall, there was a general sense that the majority of drug use activity is both secluded and dispersed across the ACT.

While much drug use in the ACT is occurring in private homes, purchase and use of drugs occurs in both private and public settings. Purchasing and using in dealer's homes and in public locations such as car parks and toilets is prevalent. Both public and private settings carry risks: using drugs at home

can exacerbate risks associated with using alone, while using in public places can carry risks both for the community and for the individual, which can include rushing injections and lack of hygiene (e.g. access to clean water and sanitary spaces) and discarding used injecting equipment inappropriately.

4.3 Drug-related harms

4.3.1 Non-fatal and fatal overdose

Consumer survey participants were asked about experiences with overdose. Twenty-one people reported experiencing one or more accidental heroin overdoses in the last six months, 20 of whom reported being administered naloxone at least once in the same period. Sixteen participants said their most recent overdose occurred in a private location, with a small number reporting a recent public overdose. Most overdoses were managed with the assistance of friends (n=13), while an ambulance attendance occurred at six of the other overdoses. Nine participants reported a recent overdose involving other opioids, eight of whom reported receiving naloxone at least once in the same period. Almost all participants (93%) were aware of THN programs and 63% had received training in how to administer naloxone.

Stakeholders were asked about key drivers of overdose in the ACT. In descending order of numbers of mentions in the data, the suggested drivers of overdose were:

- Polydrug use, in particular the combination of illicit/prescription drugs and alcohol
- Varying and inconsistent purity of drugs and drugs that have been cut (e.g. fentanyl-laced heroin)
- Consuming drugs alone
- People using drugs they are not familiar with
- People overestimating their tolerance to a particular drug (e.g. after release from prison)
- Intentional overdose
- Lack of a space that supports safe drug use
- An increase in quantity of drugs consumed due to increase in welfare payments.

In addition to causal factors for overdosing mentioned, a few participants acknowledged that the implementation of naloxone programs in recent years had successfully prevented overdose deaths in the ACT. Those who could comment on overall overdose rates (both illicit and licit substances) suggested that the issue was present but the rate was not seen as dramatically higher or lower than in the past, with a decrease suggested over the past two decades which does not accord with the trends presented below.

In 2019, one-fifth (19%) of IDRS participants reported having overdosed in the previous 12 months, which was relatively consistent with recent years. Of those who reported a recent overdose, the median number of overdoses in the previous 12 months was two and the most commonly cited drug involved in participant's overdoses was heroin (14%). Of those who reported a heroin overdose, 43% received naloxone and 43% were attended by an ambulance.[52] The prevalence of self-reported overdoses in the 2019 ACT IDRS was similar to that in the national sample, with 21% reporting an overdose in the previous 12 months on a median of two occasions. Nationally, among people who reported a recent heroin overdose, 47% received naloxone, 47% were attended to by an ambulance and 28% were admitted to an emergency department.[56]

Data compiled by the National Drug and Alcohol Research Centre (NDARC) confirms that annual deaths relating to drug overdoses in the ACT have increased by 79% between 2010 and 2018, from 19 reported deaths in 2010 to 34 in 2018, the most recent year available.[57]

4.3.2 Blood-borne viruses

People who inject drugs are at high risk of infection with BBVs including hepatitis C virus, hepatitis B virus, and HIV,[58] all of which are associated with excess morbidity and mortality.

Eighty per cent of consumer survey respondents reported a negative result for hepatitis C at their most recent BBV test, and none reported being hepatitis C positive. Almost half (43%) reported having a test in the last 12 months, and 26% reported having a test more than 12 months ago. Twenty-one per cent reported having completed treatment for hepatitis C.

According to surveillance data collated from multiple sources, an estimated 2533 people in the ACT were living with hepatitis C in 2017 (range 1549–2602; 1% of national prevalence).[59] New hepatitis C infections in the ACT have been steadily decreasing, with 126 recorded in 2019 – the lowest in the past 10 years. Current evidence suggests that around 4% of people who inject drugs in Australia are living with hepatitis B virus. During 2008–17 there were 928 new hepatitis B infections in the ACT.[59] In Australia, 3% of new HIV infections are attributed to injecting drug use; in the 10 years between 2008 and 2-17 there were 138 new HIV diagnoses in the ACT.[59]

Australia's National NSP Survey revealed that among 128 NSP attendees in 2019, lifetime testing for HIV (88%) and hepatitis C (91%) was common, with 34% and 28% reporting having received a test within the last year respectively. In that same year, 50 people self-reported a hepatitis C diagnosis, 33 (66%) of whom also reported ever receiving antiviral treatment.[53]

4.3.3 Injecting risks and harms

In the 2019 ACT IDRS, 11% of participants reported distributive sharing of needles/syringes and 8% reported receptive sharing in the last month. The prevalence of people sharing other injecting equipment has been stable over the last decade, although a significant drop was observed between 2018 (27%) and 2019 (8%). Sharing other injecting equipment was reported by 6% (e.g. spoons, tourniquet, water, and filters; 27% in 2018) and reusing own syringes was reported by 44% of the sample. Nearly half (48%) reported issues such as a 'dirty hit' (24%), nerve damage (20%) and injection into an artery (15%). A third of the 2019 ACT IDRS sample reported having injected someone else after they injected themselves (in the past month), and a fifth reported that they were injected by another person who had previously injected themselves.[52]

The 2020 Australian NSP survey 25-year National Data Report shows that reuse of someone else's needle and syringe in the last month was reported by 14% of participants, and reuse of equipment (spoons, water, filter, or drug mix) after someone else in the last month was reported by 49%, with both proportions consistent since 2010.[53]

4.3.4 Ambulance attendances and hospital separations

A drug-related hospital separation refers to hospital care where the primary diagnosis is related to a substance-use disorder or harm due to substance use. NDARC reported a 79% increase in drug-related hospital separations in the ACT from 121 per 100,000 separations in 2010 to 216 per 100,000 in 2017–18[60]. Most were attributed to the use of amphetamine-type substances, opioids and prescription medications.

Data obtained from Ambulance ACT shows the number of calls in which paramedics indicate that a substance is involved in their secondary assessment, final diagnosis or case nature, or the patient received naloxone. These may include cases in which the reason for calling was unrelated to the opioid or heroin consumption. 'Other' drug-related cases refer to any drug (other than opioids/heroin or alcohol) including prescription medications. In 2019, paramedics responded to 643 'other' drug-related cases (150.4 per 100,000 people; 673 in 2018) and 219 heroin/opioid related cases (50.6 per 100,000 people; 214 in 2018).

In Victoria, in the years preceding the introduction of the MSIR, the number of any illicit drug-related cases (including heroin) attended by paramedics more than doubled from 5,376 in 2011–12 (97.1 per 100,000 people) to 12,768 cases in 2017–18 (202 per 100,000). Heroin-related attendances also increased, from 2,150 in 2011–12 (38.8 per 100,000) to 3,027 in 2017–18 (47.9 per 100,000), a rate slightly lower than observed in the ACT. Similarly, pharmaceuticals (any) saw a sharp rise from 8,466 attendances statewide (152.9 per 100,000) to 11,013 in 2017–18 (174.2 per 100,000).[61]

4.3.5 Drug-related arrests and incarcerations

In the consumer survey, participants were asked whether they had been arrested in the last six months for drug-related offences; reported rates of arrest for use/possession and dealing/trafficking were below 5%.

The Australian Criminal Intelligence Commission's Illicit Drug Data Report recorded 609 arrests of drug 'consumers' and 88 arrests of drug 'providers' in the ACT during 2017–18.[62] Over the past decade, there has been an increase in drug 'consumer' arrests in the ACT, with 2017–18 figures being almost double the 312 'consumer' offences recorded in 2009–10.[62] Prior to the *Drugs of Dependence (Personal Cannabis Use) Amendment Act 2019*, which came into effect on 31st January 2020, most drug-related offences in the ACT pertained to cannabis and Simple Cannabis Offense Notices (52%), followed by amphetamine-type stimulants (25%) and cocaine (14%).[63] The new legislation decriminalises the use, possession and cultivation of cannabis for people aged 18 years or over subject to specified quantity limits and other restrictions, although federal laws still apply and the sale and supply of cannabis remains illegal.

In 2018–19, ACT police lodged 874 persons into protective custody at the ACT Watch House (utilised for intoxicated persons when no other options for care or protection are available) for antisocial behaviour relating to drug and/or alcohol intoxication (not specified by substance type).[63]

In 2019, 32% of IDRS participants reported that they had been arrested in the last year (30% in 2018; 22% in 2010) and 27% stated that they had engaged in drug dealing (this figure fluctuated between 2010 and 2019 from 13% to 33%).[52]

Among alleged offenders proceeded against by police during 2017–18, one in seven in the ACT had a principal offence that was illicit drug related.[64] Nationally, illicit drug offences are among the top three most common offences for people incarcerated, but in the ACT, violent offences are more common.[65]

McKetin and colleagues' 2017 study of 183 ACT residents who had recently used methamphetamine found that 56% of the sample had ever been personally involved in the prison system and 28% had been arrested in the previous year (most often related to methamphetamine possession/supply, theft, assault, damage to property, or public order offences).[55]

5.0 ACT service system and the community

KEY FINDINGS

- The ACT has a **diverse range of** harm reduction and treatment **services** for people who use drugs that are **dispersed** across the region.
- The **lack of a DCR** in the ACT was identified as a key **service system gap**.
- Some areas have a **concentration of services** while others have few services available.
- **Treatment uptake** amongst people who inject drugs in the ACT is **high**, with most reporting ever having been in treatment and around half reporting current engagement with one or more forms of treatment.
- Our consumer survey showed a substantial minority of people who inject drugs were unable to access treatment despite trying to do so in recent months, but this was not reflected in the ACT IDRS survey from 2019.
- **Participation in AOD treatment has increased significantly** over the last decade. The proportion of people receiving OAT has increased substantially and amphetamine treatment episodes have increased drastically.
- There is **very high satisfaction** for AOD services among clients in the ACT.
- **Strengths** of the ACT AOD service system include cooperation and collaboration between service providers and good access to key services such as NSP, THN and counselling.
- **Gaps and challenges** include demand on and resourcing for services, geographic access and transport to services and specialist services for particular population groups.

5.1 System overview

The majority (99%) of the ACT population resides in Canberra, with a centralised 'Civic' district, several surrounding satellite towns, and a distinct north and south geographical divide. There is a range of AOD services in the ACT that are typical of Australian cities, including:

- Several rehabilitation services, with some specialising in young people, adults, and families
- Two adult detoxification facilities in Canberra (one medical and one non-medical) and one adolescent withdrawal unit (non-medical)
- Several community health services and a few general practitioners (GPs) that can provide OAT
- Two primary NSPs, four secondary NSPs, six vending machines and 31 pharmacy NSPs
- One main health promotion and advocacy organisation that provides representation and support for people who use drugs
- A newly established Drug and Alcohol Court
- Supported accommodation for women
- A community withdrawal program

- A primary healthcare service for people who use drugs
- Services for Aboriginal and/or Torres Strait Islander people (2 Aboriginal Community Controlled Organisations, 1 program within a peer-based service and several Aboriginal-identified positions).

5.2 Current service utilisation

5.2.1 Drug treatment

Consumer survey participants were asked about their use of the AOD treatment service system (Table 6). Nearly all participants reported ever having received treatment, with the most common types being methadone maintenance, detoxification/withdrawal, counselling, residential rehabilitation and self-help groups.[a] Recent treatment access was reported by more than half of the participants, with common treatments being methadone maintenance, drug counselling and self-help groups. The most common drugs for which participants had received treatment support were heroin and crystal methamphetamine. A substantial minority of participants reported trying to access treatment in the last six months but were unable to, with the most commonly reported reasons relating to waiting lists and being turned down or turned away by programs. Some participants also reported not being aware of what programs were available or how to access them. Specific data on service types that individuals were trying to access was not collected. Furthermore, the impact of the COVID-19 pandemic on these responses could not be determined.

Consistent with previous years, half of the 2019 ACT IDRS sample reported that they were currently receiving treatment for substance use, mostly methadone maintenance (30%). Eight per cent reported receiving treatment for methamphetamine use.[52] Contrasting with data from our consumer survey, 17% of ACT IDRS participants in 2019 also thought they needed drug treatment, with 'small numbers' unsuccessfully trying to access treatment.[52] Nationally, 17% (n=156) of IDRS respondents had not accessed drug treatment in the past six months despite thinking they needed it, with 33% of these people reporting that they had tried to access treatment but were unable to.[56]

The National Alcohol and other Drug Treatment Minimum Dataset report showed that in 2018–19 ACT AOD services provided 6,700 treatment episodes to 4,026 clients. Most clients were male (61%) aged 20–29 (24%), 30–39 (29%), or 40–49 (23%). Alcohol was most frequently nominated as the drug for which people accessed treatment (43%), followed by amphetamines (23%), cannabis (13%) and heroin (11%). Drug treatment episodes overall have increased significantly in the ACT over the last decade, with the increase greatest for episodes for which amphetamines are nominated as the primary drug (Table A7). Types of primary treatment offered were information and education (29%), counselling (28%), support and case management (14%), assessment (14%), withdrawal management (8%), rehabilitation (6%) and pharmacotherapy (1%).[66] While these data reflect current capacity and usage, they do not reflect the need for AOD services in the ACT. The report is also incomplete in that data from Aboriginal and/or Torres Strait Islander services, government services and the Canberra Sobering Up Shelter are not included.

Data from the 2019 National Opioid Pharmacotherapy Statistics Annual Data Collection report indicates that the number of people in the ACT receiving pharmacotherapy drug treatment increased from 811 in 2010 to 1,014 in 2018 (Figure A13). Among those being treated in 2018, 65% were male, 77% received methadone, 1% received buprenorphine and 22% received buprenorphine-

[a] Participants could nominate more than one treatment type, so percentages add to greater than 100 overall.

naloxone. Pharmacotherapy was most often dispensed in the ACT through pharmacies (73%), public clinics (15%) and correctional facilities (12%).[67]

Table 6: Drug treatment history and utilisation characteristics among people who inject drugs, consumer survey

N = 101	**n**	**(%)**
Ever received drug treatment	88	(87)
Drug treatment types ever received		
Methadone	62	(61)
Detox/withdrawal	49	(49)
Drug counselling	49	(49)
Residential rehab	47	(47)
Self-help groups	38	(38)
Suboxone	18	(18)
Subutex	9	(9)
Treatment received – past six months (multiple choice)		
Methadone	56	(55)
Drug counselling	27	(27)
Self-help groups	16	(16)
Residential rehab	13	(13)
Suboxone	7	(7)
Detox/withdrawal	6	(6)
Primary drug of concern in treatment seeking		
Heroin	66	(65)
Crystal methamphetamine	14	(14)
Other (ecstasy, oxycodone, methadone, alcohol)	8	(8)
Inability to access treatment – past six months		
No	65	(64)
Yes	34	(34)
Reason for inability to access treatment (multiple choice)		
Waiting list/lack of beds	18	(18)
Turned down/away by program	15	(15)
Don't know of any programs/how to access programs	8	(8)
No treatment program nearby	6	(6)

The 2018 Service Users' Satisfaction and Outcomes Survey (SUSOS)[68] had 621 respondents from 25 AOD services in the ACT, and found that the most common methods of transportation for service users were their own vehicles (41%), public transport (33%) or family/friends taking them where

they needed to go (9%). When asked about how easy it is for people to get around, 48% stated that 'I can easily get to the places I need to', 36% stated that 'I sometimes have difficulty getting to the places I need to', 12% stated 'I often have difficulty getting to the places I need to' and 5% stated 'I can't get to the places I need to'. The report also found high overall levels of service user satisfaction, with 92.4% reporting that they were either 'mostly satisfied' or 'very satisfied', which was consistent with the 2015 SUSOS report.

Most respondents felt that the location (80% agreed or strongly agreed) and opening hours (83% agreed or strongly agreed) of the services were convenient and appointments were available when needed (84% agreed or strongly agreed). Attitudes towards staff and services also generally scored favorably. Regarding ancillary services, the most requested support types were housing (14%), dental health (13%), mental health (12%), Centrelink or related payments (11%), employment/skills training (10%) and BBVs (10%). The most common secondary services received related to mental health (27%), Centrelink or related payments (22%) and legal issues (21%).

5.2.2 Needle and syringe programs

Needle and syringe programs are easily accessible in the ACT. In 2019 there were two primary NSP services, nine secondary NSPs, 31 pharmacy NSP outlets and six syringe dispensing machines. The 2019 NSP National Minimum Data Collection Report states that in the ACT in 2018–19 824,076 syringes were distributed by non-government organisations (NGOs) and the public sector (93% of all distributions); the remaining were distributed by pharmacies.[53]

5.2.3 Other health services

Use of other health and support services was explored in the consumer survey. Common services recently accessed by participants included GPs (for reasons other than OAT) (69%), social or welfare workers (41%), dentists (28%), specialist doctors (18%) and psychologists (14%).

5.3 Strengths, gaps and challenges

While a comprehensive assessment of the ACT AOD service system is outside the scope of this report, data on perceived gaps in services in a general sense were collected in order to provide context for any perceived need for a DCR. This was an objective of this study (see section 1.2). The specific questions asked in qualitative and quantitative interviews and surveys are included in the data collection tools in Appendix 3. While representatives from a range of services were included in stakeholder interviews, those involved were limited by time and content constraints and were not an exhaustive list of individuals who could provide perspectives on the AOD service system.

In stakeholder interviews, participants highlighted several areas of the AOD service system that were working well. Cooperation and collaboration between services was viewed as a key feature of the system in the ACT, which contributed to a high awareness of available services and the ability to easily make referrals between services. Stakeholders mentioned good access to counselling services and excellent availability of naloxone training programs and access to THN. The recently implemented drug court system was seen as a positive initiative with the potential to divert people from prison into treatment.

Service providers and people with lived experience shared similar perceptions of the ACT AOD system, describing a wide range of gaps and challenges. These needs mostly stemmed from a shortage of funding and resourcing in the sector to meet high demand from diverse clients, including specific population groups such as young people, women and Indigenous clients, along with an

increased workload. Identified gaps in the ACT AOD system included some services being difficult to access due to location, poor public transport, and concentration of some services on the south side of Canberra, which highlights the importance of ensuring easy access to services through a consideration of transport and other links. Demand for services for detoxification/withdrawal, residential rehabilitation, mental health support services and dual diagnosis was described as substantially outstripping supply. There were particular shortages for appropriate treatment/rehabilitation services for young people, Indigenous people, people who use methamphetamine and families. For example, Indigenous people in Canberra, and specifically the inner north, were identified by a stakeholder from the homelessness sector as being disproportionately affected by drug-related harms, with another stakeholder noting that only one health service in the ACT specifically targets Indigenous people.

Access to services was seen as hampered by a lack of drop-in services and an overly complicated intake for AOD services and OAT. AOD-specialist bulk-billing GPs were also difficult to access in particular areas of the ACT, restricting access to OAT for residents.

A few stakeholders mentioned that lack of a DCR was a current service gap in the ACT, but given that the focus of interviews overall was on DCR, stakeholders may have interpreted questions about service gaps or challenges being about areas of concern aside from DCRs. The NSP snapshot survey asked participants which new harm reduction services they would like introduced in the ACT. Participant responses were coded by staff, rather than staff reading out a list of possible service types. Researchers made this choice in methodology to allow participants to generate and prioritise their own responses, which is intended to identify 'real' need rather than allowing participants to say that any and all services in a provided list are needed or wanted. The most common responses were 'supervised injecting room' (44%) and 'drug consumption room' (13%), totalling 57% of responses. The other most commonly nominated new service was 'after hours mobile NSP services' (26%).

6.0 DCR models

KEY FINDINGS

- **Specialised** DCRs are fixed-site and stand-alone facilities located close to drug markets. Supervision of drug consumption is their primary focus, but they may provide ancillary services onsite or via established referral pathways. Tailored exclusively to the needs of people who use drugs, they attract vulnerable and marginalised populations who may not otherwise access health services.
- **Integrated** DCRs are incorporated into existing services both physically and operationally and offer a range of interlinked services. This model is popular due to the ease and low cost of implementation relative to specialised services. Integrated facilities may suit geographically dispersed drug markets and have additional capacity to provide wraparound care for clients who present with complex needs.
- **Mobile** DCRs are housed in vehicles which can travel to sites according to need, thus suiting a geographically dispersed drug market. They may operate independently or as a complement to a fixed-site facility. Mobile facilities typically face less opposition from community stakeholders. They are limited by the number of clients able to access at any one time and the lack of ability to provide ancillary services onsite.
- **Women-only** DCRs operate exclusively for women who use drugs to address specific health, social and safety concerns.
- **Overdose Prevention Sites** are unique to British Columbia, and may fit into any of the described model types. They monitor clients for overdose, but their main point of difference from DCRs is the absence of the requirement for clinical supervision of drug use. OPSs were enabled under a public health emergency declaration, exempting their implementation from the usual federal application process.

6.1 Models of DCR

Internationally, DCR operational models can be classified as specialised, integrated, embedded, outreach and women-only. While in Sydney and Melbourne a strictly clinical approach ('medical model') to the supervision of drug consumption has been adopted, not all services operate with such a high level of medical supervision. For example, in addition to DCRs, Canada has had an OPS policy since 2016, and some European DCRs operate without the clinical emphasis of the MSIC and MSIR.[69]

A description of the main types of models found internationally follows. The information on existing DCRs is sourced from secondary data (published evaluations and research), and key stakeholder interviews. Examples of DCRs operating according to each of the described models is included in Appendix 4.

6.2 Specialised model

Specialised DCRs operate as fixed-site, stand-alone facilities, separate from any other services. They are usually located in areas with a high concentration of drug market and use activity, typically with other services targeted towards people who use drugs nearby and often with referral pathways between services. Specialised DCRs vary in size, and in addition to the core role of supervising drug consumption, some larger facilities may also offer social services such as showers, meals, refreshments and laundry. They may also provide their own health and medical services such as general primary care, BBV and sexually transmissible infection (STI) testing and treatment, counselling and OAT. One of the benefits of this model is that it can reach sections of the population who use drugs who are not actively engaged in health or other social services, because of their focus on the needs of people who use drugs more broadly and (usually) a lower threshold for service than traditional medical services.[40]

An example of a specialised DCR is the Insite facility in Vancouver, Canada. Located in the city's Downtown Eastside district, it caters to the high concentration of people who inject drugs in this neighbourhood. Its clients have high rates of unstable housing, daily injection, recent non-fatal overdose, and public injecting. Insite addresses these problems by offering a low-threshold service staffed by nurses, counsellors, mental health workers and peer support workers. It also has referral pathways to local community health centres, a hospital, a rehabilitation centre and support services for women, as well as a withdrawal management facility located in the same building.[40]

Sydney's MSIC is also a specialised model, having a stand-alone building from which to operate. Organisationally, however, it is integrated into the Uniting Care service delivery framework. Like Insite, the MSIC was established as a means of responding to a high concentration of drug dealing and use associated with overdose deaths. While its primary function is to supervise injections, it also offers in-reach services for primary health care, mental health, a dental nurse, housing and legal assistance, as well as referrals to nearby services offering BBV testing and care and drug treatment.

6.3 Integrated model

Integrated DCRs operate within larger facilities offering an array of interlinked services, usually with harm reduction goals and targeting people who use drugs and local homeless populations.[70] This model is the most common worldwide, partly due to the relative ease of setting up a new service within an existing structure.[71] As the DCR is just one of many services on offer, it will only cater to a portion of clients of the broader facility, meaning the DCR may have a separate physical entry or specified area within a premises. Integrated DCRs may be more suitable for drug use environments that are more geographically dispersed, because they offer a range of social, medical and health services that can attract clientele from a wider geographic area for a diverse range of services. The inclusion of a DCR within a network of other services offered within the same facility may also help to prevent loss to care, decrease barriers in access to care, and ensure continuity of care. Thus, integrated DCRs may more easily provide wraparound care for clients who face complex health and social challenges.[40]

A key advantage of integrated DCRs is that they are less costly to implement than specialised services, because they can be 'tacked on' to existing facilities and utilise existing staff and supplies.[71] An extension of the integrated model is the 'embedded' model, which – as the name suggests – is embedded into existing services but differs from integrated DCRs with respect to the type of service

in which it is embedded. Embedded DCRs are set up within services that are not strictly harm reduction based (examples include within housing services in Luxembourg and Frankfurt).[40]

Melbourne's MSIR is an example of an integrated DCR. The MSIR is situated within the catchment of – and operated by – the local community health service (North Richmond Community Health – NRCH). Prior to the MSIR opening in 2018, NRCH had its own AOD program which included an NSP. The MSIR employs its own staffing component (along with providing BBV testing and treatment, legal services, GP services, mental healthcare coordination, drug treatment and support, oral health and housing services), which is separate from the NRCH staffing and services component.[72] This separation is not necessarily a feature of an integrated service model. For the first part of its two-year trial, the MSIR operated within the main NRCH building with its own separate entrance and exit. In 2019, it commenced operation in an adjoining purpose-built facility.

6.4 Mobile outreach model

This type of DCR is most suited to an environment where drug use and markets are more geographically dispersed, harder to reach or 'hidden'. The service involves a van or bus fitted with injecting booths that can drive to locations identified as pockets of public drug use or where there are people who inject drugs who may want to use the service. They can also complement fixed-site DCRs by offering a service to people who use drugs who may not be able to engage with a fixed-site facility. An advantage of this model, beyond the ability to cover multiple sites, is that it can be more acceptable for local stakeholders such as police, neighbourhood business organisations and policymakers. However, a smaller capacity means mobile facilities are unable to see as many clients as most fixed-site DCRs, yet require similar staffing levels as fixed facilities, so costs per client can be high.[40] Another drawback is the limited ability to offer ancillary services and spaces other than those specifically designated for drug consumption.

In Berlin, mobile DCR facilities have been in operation since 2003,[9] complementing two fixed-site DCRs. The mobile DCRs target the numerous well-established drug markets and consumption areas around the city, offering three injecting booths staffed by two nurses as well as one or two social workers.[73]

6.5 Women-only model

Women who inject drugs can experience physical and sexual violence, vulnerability to BBV transmission and a greater rate of mortality and homicide than the general population.[74,75] DCRs that cater exclusively to women provide a safe space to engage with harm reduction services, and help women overcome the barriers and dangers they may face in their homes and in public. There are two known DCRs that provide services exclusively to women, as well as one facility in Biel, Switzerland that provides a women-only service for two hours per week. The first women-only DCR was established as part of the RAGAZZA facility in Hamburg.[76] This service is part of a broader facility that provides social, medical and material support for women, completely staffed by women. SisterSpace in Vancouver opened in 2017, facilitating 16,000 visits in its first year of operation, with 65–75 women visiting each day.[77] SisterSpace is part of the Atira Women's Resource Society, which provides broad social support to women. These services not only provide women with a safer alternative to injecting in public, they give clients an alternative to injecting at home if this is not a safe environment for them.

6.6 Overdose prevention sites

Overdose Prevention Sites are low-threshold harm reduction services designed specifically to provide onsite monitoring of people at risk of overdose and allow for a rapid response when an overdose occurs.[78] Dozens of OPSs operate across BC, where they have been integrated into existing services, have their own purpose-built premises or are mobile outreach based. In practice, OPSs provide many of the same social and health interventions as DCRs (e.g. drug checking, BBV testing, naloxone training and supply, sterile injecting equipment), but do not offer medical supervision of drug consumption. The lack of supervision can create a lower-threshold environment, while still monitoring clients for overdose. The BC Minister for Health initiated OPSs to respond rapidly to a growing overdose crisis. Under a declaration of a public health emergency, the order gives BC Emergency Health Services and regional health authorities the ability to provide extraordinary overdose prevention services as necessary on an emergency basis.[79] This contrasts with a more lengthy and cumbersome procedure to establish a DCR, a federally governed process which requires an application to Health Canada for an exemption under Section 56 of the *Controlled Drugs and Substances Act* alongside requirements for feasibility studies and extensive stakeholder consultation.[80] The low resource intensity and flexible service model of OPSs mean that they can be implemented at many different service points, offering wide geographical reach.

7.0 DCRs: their clients and service specifications

KEY FINDINGS

- DCRs are accessed by the **most vulnerable and socially marginalised** people who use drugs.
- **Admission and exclusion** criteria range from personal and health attributes (e.g. minimum age requirements, pregnancy, intoxication), to social or externally sanctioned specifications (e.g. parole conditions, local residence).
- ACT stakeholders agreed that the **supervision of injection** should be a central feature of a facility and noted issues with other routes of administration (e.g. allowing **smoking** has potential harm reduction benefits but is costly to implement).
- Drug consumers were overwhelmingly in favor of **multiple routes of administration** being permitted in a DCR (injecting, smoking, snorting).
- Ancillary services offered at DCRs can be basic, practical, health oriented or support oriented. ACT stakeholders and consumers strongly supported offering a **wide range of health and support services**.
- Staff may include nurses, social workers and people with lived experience. Potential clients indicated that they would like to see **peer workers, medical staff and case managers** at a DCR.
- Local **community engagement** and education is essential for DCR site selection. interviewed experts and stakeholders considered **proximity** to local drug market/s, public transport and other health services to be vital.
- **Opening hours** should be tailored **according to local need** but include normal business hours at a minimum.
- **Implementation costs** vary considerably according to staffing profiles and operational model, including the emphasis on medical supervision.
- Most stakeholders felt a DCR would be a **worthwhile expenditure** of available funds in the ACT.
- ACT stakeholders did **not consider a medically supervised model essential**, but a governance structure could include medical oversight, alongside a range of other professionals.
- Stakeholders from existing DCRs identified that the **stigma** associated with injecting drug use hinders service delivery, but **peer workers** could help minimise this.

7.1 Service clients

Typically, DCRs are targeted towards the most vulnerable and socially marginalised people who use drugs.[27,40] DCRs in other parts of the world have generally been most utilised by populations such as people injecting drugs and/or experiencing homelessness. Stakeholders saw targeting a potential service in the ACT to those most marginalised in the community as part of an appropriate harm reduction approach.

Stakeholders from MSIR and MSIC described a high proportion of homeless or unstably housed service users, as well as 10–15% Indigenous clients, many clients with mental health comorbidities, and clients with a history of incarceration. The Victorian stakeholders described cohorts of clients that will use the service once or twice a week, those who have come almost every day since it opened, and some who do not live in the area and will use it infrequently or try it out of curiosity. They also observed that regular service users are predominantly from the local drug user community, access the local drug market and have high need for complementary services. These characteristics may mean that clients are less likely to have access to a private space to inject, such as their own home, and be more likely to experience drug-related harm.

7.2 Admission criteria

Admission criteria for DCRs vary worldwide. Most commonly, services are not available to people who are under 18 years of age, have never injected drugs, require help injecting, are occasional injectors, are pregnant or are accompanied by a child, or present as intoxicated.[81] While these conditions are designed to reduce the harms associated with injecting drug use, some DCRs have admission criteria that are aimed at regulating clientele. For example, use of a facility may be limited to clients who are registered and can prove they live in the local area; this measure is designed to prevent an influx of clients from other areas.[9] It is also common for services to require new clients to agree to a code of conduct or list of house rules before using a facility for the first time. These usually relate to client and staff rights and responsibilities, as well as what is permitted and not permitted and the consequences of breaching the rules.

The provision of an inhalation room as part of a DCR requires a different physical space to the clinical models that currently operate in Australia. Occupation health and safety considerations necessitate adequate ventilation; in Switzerland and Germany, inhalation rooms are sealed off from the rest of the facility, are kept at negative pressure, and have a ceiling extraction system leading to an external exhaust. Air quality (especially drug concentration) is monitored in the rest of the building to ensure occupational health and safety compliance for staff.[82,83]

Stakeholder interviews with providers of DCRs found that the main eligibility criteria at MSIC and MSIR are having a history of injecting drug use, being aged 18 years or over, intending to self-inject (with or without professional advice) and not being pregnant. At the MSIR, if upon entry a client's level of intoxication poses a clinical risk to themselves or to others, they will be refused access to inject further substances. The exclusion of pregnant clients was noted to be against the best available evidence and personal views of MSIC management and advice from the AMA. This sentiment was expressed in the recommendations made by MSIC management to NRCH when establishing the Melbourne facility. However, as was the case in NSW, it was determined that pregnant women are ineligible to use the service. The NSW regulatory stakeholders also identified the exclusion of pregnant people and people under the age of 18 as a service gap. They discussed strong advocacy and a statutory review on this matter finding that there was support in the community for change. Evidence and public acceptability were identified as factors in establishing a need to change the policy.

A Victorian department stakeholder listed the various reasons for refusal of MSIR use as: people with bail or parole conditions prohibiting them from using the service or being in North Richmond, pregnant people and people with accompanying children, young people (under 18), people who cannot inject themselves, people seeking to inject drugs in groups larger than two people, and

people who use drugs through routes of administration other than injecting. It was noted that refusing supervision may reduce client engagement with other health and social supports offered in drug consumption facilities.

A Victorian department stakeholder noted that there were various reasons for potential clients electing not to use the facility of their own accord. These included having a preference to inject at another location, waiting time at the MSIR, being or accompanying someone who had been sanctioned, wishing to avoid other service users or staff, and concerns about potential surveillance or perceived risk of police presence.

In BC, eligibility criteria vary across sites, but a minimum age of 16 years is universal. However, stakeholders reported that in practice people do not get turned away from services.

Australian Capital Territory-based stakeholders proposed several criteria for use of a DCR and whether there should be any specific restrictions or exclusions. Most were supportive of minimal restrictions. One topic where there was substantial consensus was the exclusion of individuals who display violent or threatening behaviour. Participants saw this as essential to maintaining a safe space, both for clients and staff.

One of the other issues discussed was the age of possible clients. Participants regarded allowing people aged under 18 to attend such a service as a complex issue, but there was general agreement that some young people would benefit from using such a service due to the potential for harm reduction. It was suggested that younger people could be separated from older clients, with physical design of the space being a key method for achieving this separation.

Some stakeholders questioned whether a service should allow visibly pregnant women to attend, including those under 18. There was no consensus: participants recognised the need to support people at a crucial time when intervention is needed, and that if they are turned away they will probably use drugs anyway. Other stakeholders suggest that pregnancy should not be a reason for excluding potential clients.

There was some discussion in relation to the exclusion of intoxicated people from DCRs in the stakeholder interviews. One stakeholder mentioned that if people were obviously intoxicated on heroin to the point of being 'on the nod', they should not be let into a service. However, this stakeholder also noted that in their experience working in a DCR, most people turned away for this reason would probably simply consume drugs elsewhere. Another stakeholder argued that excluding intoxicated, pregnant and young people was done for political reasons only, and that such eligibility criteria did not make sense otherwise. Rejected people face a higher combined risk of initial intoxication and using drugs alone.

7.3 Allowable routes of drug administration and drug types within DCRs

DCRs provide a space for clients to consume drugs in a variety of ways under supervision. The most common route of drug administration supported in DCRs worldwide is injecting,[9] and many services only allow injecting. However, some DCRs support other routes of administration, such as intranasal (snorting), inhalation (smoking) and oral (swallowing). There are different reasons for facilitating alternative routes of administration. In the Netherlands, injecting is now rare; in Switzerland and Germany, smoking was incorporated into injecting-only services to cater to the shift in local drug use

patterns as well as promote less risky forms of consumption among people who inject drugs.[9] In Canada, several DCRs offer oral as well as intranasal consumption, to address the fact that a significant proportion of overdose deaths are attributed to routes of administration other than injecting.[84]

Participants in stakeholder interviews talked about ways of consuming drugs and whether there should be restrictions related to these in the ACT. There was a broad understanding that supervised injection of drugs would be a central feature of a facility, but there was much discussion of the inclusion of smoking as a key mode of administration. In particular, this occurred in the context of smoking drugs like ice, rather than cannabis or tobacco. One stakeholder from the AOD treatment sector noted that the transition from smoking to injecting drugs is common, and by facilitating inhalation a DCR can provide valuable interventions around safer injecting practices for new injecting initiates. However, most of the discussion regarding the smoking of drugs in a DCR centred on the need to protect staff from the harms of second-hand smoke and the consequent need for proper (and costly) ventilation. It should be noted that nearly all of the participants in the consumer survey reported recent injection of drugs, so further research may be required to better understand the needs and views of smokers of drugs.

Consumer survey respondents strongly supported allowing multiple routes of administration being available in a DCR. Most participants (76%) believed that injecting, smoking and snorting routes of administration should all be permitted in a DCR in the ACT. While most (73%) reported that they would inject in a DCR, smoking and snorting were reported by 35% and 13% respectively.

Most consumer survey participants reported being primary injectors, although many also engaged in other routes of drug administration. Therefore, some further exploratory work with people who use drugs who are not primary injectors is required to scope their interest in using a DCR.

With regards to injecting, several participants talked about wanting to be able to inject with groups of people in any proposed facility. While most participants in the consumer survey (57%) said they would use a DCR to use drugs on their own, 43% said they would use the DCR to use drugs with one other person and 30% would use with a group.

When ACT-based stakeholders discussed what types of drugs should be allowed to be consumed within a DCR, there was a general understanding that any targeting or restrictions should consider which drug types offer the greatest opportunity for harm reduction if consumed in such a space, and whether other spaces currently exist where particular drug types can be safely consumed. Most participants thought that alcohol should be excluded. A few stakeholders suggested that other drugs that present minimal opportunity for harm reduction (an example suggested was magic mushrooms) could also be excluded.

7.4 Service inclusions/additions

Broadly, services offered by DCRs can fall under four categories: basic services; practical support; health care and education; and care, support and daily activities (Table 6).[69]

Table 6: Services available in DCRs internationally

Additional Services	Examples
Basic services	Tea/coffee, warm meals, needle exchange, provision of drug paraphernalia and personal care (showers and laundry)
Practical support	Phone for clients' use, support with financial and administrative affairs, lockers, a mailing address
Healthcare and education	Primary health care, drug treatment, mental health, vein care, sexual health information
Care, support, and daily activities	Referral to care and treatment facilities (e.g. OAT, dental and other medical referrals), recreational activities

The services a DCR offers will depend on its objectives, which will in turn be shaped by several social and political factors. For example, if the typical characteristics of DCR clients include unstable housing and homelessness, more social services should be considered to cater to their needs. The physical size of the service, available funding and staffing profile also limit what services may be able to be offered.

With the advent of direct-acting antiviral (DAA) treatment and point-of-care testing for hepatitis C infection, it is now much easier for DCRs to provide comprehensive onsite hepatitis C testing and treatment services. A 2017 survey of DCRs commissioned by the International Network of Drug Consumption Rooms noted that more than half of DCR clients tested positive for hepatitis C infection, creating an opportunity to treat a high concentration of people living with untreated chronic hepatitis C who might not otherwise engage with mainstream health services.[70]

There was a strong consensus amongst ACT-based stakeholders interviewed that a DCR should house a comprehensive suite of services. Conceptually, these were considered as wraparound services, capable of meeting a variety of needs (i.e. social, psychological, medical, physical). A DCR could incorporate referral into onsite provision of services if an integrated model is used. The DCR function was viewed as a platform for the delivery of a range of supports to marginalised populations who may find it difficult to access services in other contexts. Coordination of referral and service access was seen as a key professional function within the space, along with a long list of possible service types and worker disciplines (see Appendix 5).

Participants in the consumer survey strongly agreed that an ACT-based DCR should provide comprehensive information, education and advice on a range of topics relating to drug use, health and welfare. Most (75%) thought that additional services should be provided onsite. The services mentioned most commonly were AOD counselling (48%), methadone maintenance (45%), naloxone training (45%), and NSPs (40%). Participants expressed strong preferences for a comprehensive range of other health and support services spanning primary healthcare and social support, as well as physical amenities like toilets and relaxation spaces. A full list is given in Appendix 6.

The NSP snapshot survey also asked which services participants would like to see offered within an ACT-based DCR. The most popular responses were 'safe drug use education' (17%), advice and

support to access drug treatment (14%), mental health support and treatment (14%) and BBV testing and treatment (10%). A full list is shown in Appendix 6.

Services offered at other Australian-based DCRs include primary healthcare (including BBV testing and treatment), dental, housing, legal support, drug treatment referral and income support (Centrelink in-reach). Specific support related to injecting drug use is also provided onsite (e.g. injecting advice, THN training).

7.4.1 Blood-borne virus testing and treatment

Given the high prevalence and incidence of BBVs among people who inject drugs, DCRs are a logical site for testing and treatment, especially (in Australia) for hepatitis C infection.[70] Australia has enjoyed unrestricted access to new DAA treatments for hepatitis C, which require a short period of therapy and minimal follow-up, since their listing on the Pharmaceutical Benefits Scheme in March 2016. While treatment regimen barriers have been lowered in the past four years, there remain multiple barriers for people who inject drugs to access testing and treatment initiation.[85] In mainstream primary care models, attrition from the care cascade is well documented.[86] The provision of low or no-cost onsite HCV (and other BBV) care in DCRs goes some way to addressing some of these other barriers, including convenience, accessibility, reduced risk of stigma and discrimination, poor venous access for phlebotomy, travel to appointments, and cost.

The Melbourne MSIR provides a good recent example. In partnership with St Vincent's Hospital, Melbourne, MSIR offers testing, assessment, counselling, and treatment for HCV for its clients, as well as STI testing and hepatitis A and B vaccinations. The recent review of the MSIR found that the service achieved its objective of reducing the spread of BBVs, citing that in the first 18 months of operations, more than a third of people screened tested positive for HCV, and a quarter went on to be treated.[12]

In an international census of DCRs, most services indicated that they provided education to clients about HCV transmission and prevention routes (94%), information on HCV testing (78%) and HCV infection symptoms or treatment options (76%),[70] mostly through brochures and pamphlets (89%) and individual consultations (88%). Onsite testing was offered at 65% of the surveyed sites, with around two thirds of these services offering pre- (65%) and post-test (68%) counselling. Ninety-six per cent of surveyed DCRs reported referral pathways to services that provided treatment.

7.4.2 Drug checking

Drug checking is a service whereby individuals can submit samples of illicit drugs for scientific analysis of contents to determine the presence of psychoactive substances. As a harm reduction measure, drug checking offers real-time consumer-centred information that can lead to safer drug use.[87] Drug checking is available at two-thirds of DCRs and various other harm reduction services in Canada, offering consumers the opportunity to test the contents of their drugs and decide on whether and how much to consume after receiving a result. The British Columbia Centre for Substance Use publishes monthly results for its service; for example, of the 365 samples of any drug tested in March 2020, 274 matched with what the client believed the substance to be, 45 did not match and a further 46 substances were not identified.[88]

When stakeholders were asked what range of services should be offered in a DCR, drug checking was mentioned, but there was no consensus as to whether this should be a key feature of a DCR service implemented in the ACT. When asked to list services that could be included in a Canberra

DCR, 36% of participants (n=36) in the consumer survey mentioned drug checking, although this service is not currently an operational feature of other Australian DCRs. (Participants were not prompted to mention this service – they were asked an open question and researchers coded all responses provided by participants.)

The 2019 NDSHS asked respondents whether they would support allowing potential drug users to test the purity of and substances in their pills/drugs at designated sites. The harm reduction approach was supported by 70% of ACT participants, a higher proportion than in all other states and territories (57% nationally).[44]

7.5 Staffing

From their worldwide survey of DCRs, Belackova and colleagues identified 15 staff roles, although the mix of disciplines varied in each service. The most common roles were nurse (80% of DCRs) and social worker (78%). Other common roles were director/manager (57%), medical doctor (46%), technical or administrative staff (35%), security staff (33%) and peers in a paid position (24%).[70]

The composition of DCR staff will need to be considered in accordance with the overall model, as well as services offered, budget and resources, capacity, and hours of operation. However, all DCRs should have policies and procedures in place to determine minimum levels of staff, skill sets, competencies and training required for each role.[40]

For example, both the MSIC and MSIR are legally required to be supervised by a medical director with qualifications as a medical practitioner. They are also required to have four registered nurses and four counsellors on staff at any one time, all recruited for their relevant professional qualifications, training and experience.[41] At the Insite facility in Vancouver, the injection room must always have two staff members, one of whom must be a registered nurse, while the whole facility is staffed by two nurses, five program workers from the Portland Hotel Society (a non-profit community organisation), and two peer workers.[81] OPSs in BC are primarily staffed by peer workers.[89]

ACT-based stakeholders agreed that a service should be staffed by a combination of trained health and welfare professionals and people with lived experience. Consumer survey participants nominated wanting to access peer workers (88%), medical staff (82%) and support staff like case managers (67%) in a DCR, as well as counsellors (60%).

7.6 Site selection

Given the political complexity associated with establishing a DCR, experts have recommended extensive community engagement and education in their development and implementation. Site selection is particularly important: the European experience suggests that in order to be effective, the location of DCRs needs to take into account proximity to illicit drug markets, ability to be embedded in a wider network of services, compatibility with the needs of people who use drugs, and compatibility with the needs and expectations of local residents.

Stakeholder interviews with DCR providers found that the North Richmond location of MSIR was chosen because of its proximity to the main street-based drug market and being physically connected to a community health service. Issues such as discarded needles, verbal interactions, public injecting, and rarer, more serious incidents involving violence, occurred in the local area prior to the MSIR opening.[12]

In the case of Sydney's MSIC, Kings Cross was one of 39 locations considered, mainly due to the sheer volume of drug activity in the area, including a high number of fatal overdoses. Kings Cross also had a history of drug activity, and housed Australia's first NSP, which opened in 1988. After initial push-back from local community and business representatives, support has grown since evidence of a reduction in crime and fatalities in the area has mounted.

A Victorian stakeholder noted that international evidence demonstrated that in order to be effective, DCRs need to be located close to where injecting drug use and harm is most prevalent and where they can be embedded in a wider network of services. They then explained that NRCH is located near the epicentre of ambulance overdose callouts and historical drug overdose deaths in North Richmond. This stakeholder also explained that NRCH was chosen because it already operated the busiest NSP in the region, and offered naloxone and overdose response services, BBV education, health promotion and outreach in the local community.

There are dozens of DCRs and OPSs in BC, so the BC stakeholder described a variety of community responses. 'Not in my backyard' attitudes were depicted as based on lack of understanding about how DCRs can help reduce needle litter and public drug use. There was also mention of people actively working to shut down DCRs in their region. However, examples of residents no longer objecting to facilities once they had opened and the anticipated negative effects were not experienced were also outlined.

Throughout stakeholder consultations, there was a consensus that any established service should be accessible and convenient for clients, with a high coverage of public transport options. Proximity to other health services was identified as another key factor in determining service location. Stakeholders anticipated that community acceptability would be a challenge when selecting a location, especially in areas lacking existing AOD-type services.

7.7 Opening hours

Both the MSIC and MSIR are open seven days a week, with shorter operating hours on weekends: MSIR is open 7am to 9pm during the week and 8am to 7pm on weekends; MSIC is open 9am to 9.30pm during the week and 9.30am to 5.30pm on weekends. Both services began with shorter opening hours; they were extended in Melbourne after initial establishment and then again as the service moved into a purpose-built facility, and in Sydney after advice from the MSIC Consumer Committee.

The opening hours of the MSIR have been reviewed and amended over time to better meet capacity and the needs of community and clients. Client demand may be modelled by assessing a range of data including ambulance overdose response data and NSP access by time of day. It has been suggested by DCR stakeholders that current opening hours may be skewed too early (weekdays from 7am, weekends and public holidays from 8am), and that key demand occurred closer to 9am to 10am.

In Woods' 2014 survey of DCRs in Europe,[69] all DCRs were open Monday to Friday, except for one German facility which closed on Wednesdays. Sixty per cent of DCRs were open on Saturdays, and 64% on Sundays. Average opening hours varied across days of the week, with Monday having the longest average at 8.6 hours; one German DCR was open for 20 hours on weekdays, and a Swiss DCR was open for only 3 hours and 35 minutes on five of its seven operating days. In Canada, Vancouver's Insite facility is open for 18 hours a day, every day.[90] Under a pilot program in 2017,

Insite opened for 24 hours from Wednesday to Friday on weeks that social welfare cheques were distributed.[91] The aim of the pilot was to address the spike in opioid-related overdose cases in these periods but we could not locate published data on the effects.

When asked about what opening hours would make the most sense for a DCR in the ACT, stakeholder interview participants provided differing insights. Some asserted that the proposed service should be accessible as early as 7am or 8am, explaining that people who inject drugs often 'score' early in the day and many also receive OAT at these times. There was general agreement that the service should be open during normal work hours, with participants stating the importance of being open outside 9am to 5pm for those who are employed. Suggested closing times ranged from 6pm to 10pm, with most anticipating that there would be little utilisation of a service that operated overnight.

Responses to the consumer survey were consistent with the views of ACT stakeholders, suggesting that core opening hours should be normal business hours (58%), but a minority suggested the service should be open late in the evening. A substantial minority (21%) suggested the service should be open from midnight to 9am, which was also suggested by some stakeholder interviewees, who believed the service should be 24 hours a day, given that drug use happens around the clock.

Data obtained from ACT Ambulance shows that the most common time of day for opioid and heroin overdose attendances are 10am to 3pm and 8pm to 10pm. For other drugs, there is an upwards trend starting from around 10am to a peak of callouts around 8pm. Opioid and heroin overdose attendances are stable throughout the week and decrease over the weekend. Relatively more other drugs overdose responses occur on Wednesdays and weekends.

7.8 Funding and operating costs

The MSIC's budget is $4.083M per year, with fixed costs such as salaries and wages comprising 70% of the budget. Stakeholders discussed the MSIC's fixed service delivery model, which required a certain number of qualified staff on site at any one time. The lack of flexibility in this model was described as a potential issue for operations, using the example of fewer clients using the service during the current COVID-19 health emergency and the resulting overstaffing of the service.

To gauge perspectives related to funding and costs of a DCR in the ACT, stakeholders were asked for their views on what costs would need to be factored into the service, as well as on whether the funds required to operate a DCR could be better spent on other AOD services. It was noted that staffing would be the highest financial burden, which would be higher if it were going to be staffed by medical professionals (doctors, nurses) rather than people with AOD certifications. Longer opening hours were also mentioned as a factor that could drive staffing costs up.

When discussing whether the money spent on a DCR could be better spent elsewhere, opinions among stakeholders were divided. Those who thought a DCR could be a responsible investment cited that such a service could mitigate risks and harms related to drug use, as well as providing linkages to other interventions such as withdrawal and rehabilitation. Some participants suggested that even if treatment services for withdrawal and rehabilitation were better resourced, there would still be people taking drugs whose lives could be saved by a DCR. Other responses in favour of setting up a DCR also mentioned that funding for AOD services in the ACT needed to improve overall, and that it should not be a question of whether a DCR should receive funding over other services that are just as important.

Of those who did not support establishing a DCR, one stakeholder argued that the population of people that would use the service is too fractured, dispersed and small to justify funding the service. Other respondents argued that the money could be better spent on initiatives such as an NSP in the Alexander Maconochie Centre, drug checking, better diversion services for low-level offending and housing for homeless people, as well as existing services like withdrawal and rehabilitation that are known to be under-resourced and struggling to meet demand.

Victorian stakeholders suggested costing a DCR model based on a staffing profile and award requirements, rather than relying too heavily on costing data from other DCRs. This would then take into account requirements around shift length and operating hours to match up with award requirements and mandatory additional payments. Additional factors that would influence the staffing profile, and therefore costings, included the level of medical supervision, booth sizes, co-located services and whether there are services and staff funded by outside organisations. A sample budget has been generated using this approach in Appendix 5.

7.9 Governance

Sydney's MSIC does not have its own board, rather is accountable to the Uniting Care board. Frontline nursing and health education staff report to their respective manager, who reports to two operations managers, who then report to the clinical/medical director. Sydney's MSIC is run as an NGO service, and while it does follow some policy directives from the NSW state government, it is part of Uniting Care. It is also governed by legislation and licensing conditions.

In Melbourne, the MSIR is operated through NRCH, who are licensed to operate the MSIR by the Victorian Department of Health (DH). This arrangement means the facility is run under NRCH's protocols but is also overseen by the state government and governed by legislation. MSIR also has its own operations manager who reports to the clinical/medical director. The clinical/medical director reports to the CEO of NRCH, who then reports to the NRCH board. Governance also includes regular meetings between MSIR and the representatives of the Victorian DH, licence inspections and audits and community and local service engagement. Performance requirements for DH-funded services also provide a method of oversight by government.

In BC, there are various arrangements across the dozens of DCRs and OPSs. Most commonly, local health authorities run the service and governance is within their remit.

Many stakeholders discussed whether a medically supervised model with a medical director was the most appropriate form of governance for a potential ACT DCR. A majority of respondents did not see this model as necessary to ensure appropriate clinical governance and risk management for a DCR. Others mentioned that they did not believe clients of a service would want a model involving supervision by a medical practitioner, and that a non-medical model could be more cost-effective and potentially more effective in general.

There was broad agreement that the service would be best run by an NGO. With regards to a governance structure for oversight of the service, a board, governance committee and steering committee were all suggested as possible models. There was consensus that any governance structure should include a balance of professionals and people with lived experience. Some participants discussed the importance of accountability for the service to various directorates within the ACT government, including health, justice, and community services, as well as associated ministers. Broad political support for the service was perceived as central to its success. A

partnership between various services, government, and other relevant bodies was suggested as a possible approach.

7.10 Evaluations

We asked each of the DCR stakeholders how their services approached evaluations. The MSIR is still in a trial period, which has recently been recommended to be extended for another three years (after an initial two). The evaluation of the first two years of operations was based on indicators listed under the *Drugs, Poisons and Controlled Substances Act 1981*, which include reduction of fatal and non-fatal overdoses, BBV infections and discarded syringes in public, an increase in the uptake of treatment and a range of health and social services, improve amenity of the neighbourhood for residents and businesses in the vicinity, as well as reductions in use of services such as drug-related ambulance and hospital emergency department attendances.

The expert panel which reviewed the initial two-year period of the MSIR trial noted that the facility was introduced in the context of escalating drug harms for people who inject drugs. The panel regarded the objectives of the trial as ambitious, especially around improving amenity as well as saving lives and reducing harms for people who inject drugs. Despite this, the panel found that the service was meeting most of its ambitious targets, with estimates that at least 21 deaths were avoided in its first 18 months of operation and a demonstrable reduction in ambulance attendances in the vicinity and BBV spread. The panel noted that local amenity improvements were a work in progress.

The original evaluation of the MSIC was conducted by a consortium of academic organisations, and since then organisations including The Kirby Institute and the NSW Bureau of Crime Statistics and Research have completed independent evaluations. In BC, there is less formal evaluation of OPSs that involves qualitative interviews with the peer workers that staff the services.

Given the extensive body of work evaluating the effectiveness of DCRs internationally, evaluation of a DCR in the ACT should primarily focus on implementation and the experiences of service users and meeting consumer need.

7.11 Challenges and successes

The MSIR's main successes have been providing life-saving injecting supervision services, and the opportunistic provision of a growing range of health and social services onsite, which is seen as particularly important for the MSIR's client group, because they may struggle to access external services or navigate complex health and social systems. Another strength is the comprehensive suite of services offered at MSIR and NRCH and the opportunities it provides to link people with life-changing support, where and when they need it. The importance of offering long-acting pharmacotherapy (buprenorphine implants) since the beginning of the COVID-19 pandemic has been noted; it has helped people reduce the need to use illicit drugs and simultaneously maintain contact with pharmacies and other pharmacotherapy dispensers.

When asked about the most important successes of the service, aside from the lives saved by preventing fatal overdose, stakeholders cited MSIC's advocacy for the clients of the service and harm reduction in the community more broadly. This local advocacy was described as being nuanced, palatable and unique in how it engages community, police and political stakeholders. An example of

this advocacy provided was the MSIC *From the Heart* event, which exhibits art made by MSIC clients to the Kings Cross and broader local community.

When discussing challenges with DCR stakeholders, MSIR and BC representatives identified clients' common experience of stigma around drug use. The MSIR is located in Richmond, a densely populated, socio-demographically and culturally diverse area, including large areas of public and private housing, which may contribute to a lack of understanding between residents. The organisational structure of MSIR has been described as being a key matter to consider during implementation, mainly due to the MSIR being a large and complex service integrated into NRCH, which is relatively small in comparison to other community health services, which are often multi-site and employ larger numbers of staff. Indeed, part of MSIC's success was linked to the benefits of operating as part of Uniting Care, which is a much more established and diverse service with presence across NSW, making it less susceptible to media and public scrutiny.

Stakeholders suggested that the single best feature of BC's DCR and OPS services was the engagement of peers, who they described as having an important role in building trust with clients, as well as making services feel comfortable and welcoming. This peer relationship also enabled conversations with clients around types of substances being used and providing information around the strength and purity of drugs in circulation. In turn, this supportive role was an empowering experience for the peer workers.

8.0 A DCR in the ACT

Stakeholders and consumers overwhelmingly support the establishment of a DCR in the ACT, which matches broader community support. There is also a high level of understanding of and familiarity with the DCRs introduced in other contexts and jurisdictions and expectations around effectiveness in reducing drug-related harms, reflecting the strong international evidence. Our data demonstrate a strong interest in, endorsement of, and intent to use a DCR in the ACT for a high proportion of episodes of drug use amongst people who use drugs and people who inject drugs. Consumers cited health, safety and legal reasons for wanting to use a DCR.

The primary and secondary data sources analysed for this study indicate a clear need for the expansion of comprehensive harm reduction services to meet the needs of a vulnerable population of people who inject drugs. The development of a service to address these client-specific needs should also be compatible with the needs and expectations of the wider local community.

This section addresses the level of need for a DCR in the ACT, how one might operate and how much it might cost.

8.1 What is the level of need for the service?

Our analysis of drug use patterns and related trends in the ACT showed a high level of polydrug use and an underlying prevalence of harms that requires a response. These conditions are similar to those that existed when the ACT moved to establish Australia's first THN program to respond to overdose.[92] A DCR is a good fit for the documented need and is well supported by the stakeholders – especially consumers – we interviewed for this study.

Larney and colleagues estimated that the number of recent people who inject drugs in the ACT in 2014 was 1250 (range 1000–1500). An intent to use a DCR (yes/no) if there was one in the ACT was expressed by 83% of consumer survey participants and 64% of NSP snapshot survey participants. Extrapolating from these figures, we estimate that a DCR in the ACT could be utilised by 800 –1038 people who inject drugs. Fifty-seven per cent (58/101) of consumer survey participants said they would use a DCR for half or more of their injection episodes. The MSIR currently has around 5000 total clients and services around 300 clients per day from a maximum of 20 injecting booths (13 are operating at the moment to allow for physical distancing). If demand were similar in the ACT, six to eight booths would serve up to an expected 90 to 120 clients per day. It would be prudent to provide additional booths to allow easy scale-up to meet peak demands.

We found evidence of increasing or dynamic drug-related harm, particularly in relation to prevalence of recent overdose. Prevalences of reported recent non-fatal overdose amongst participants in our consumer survey (past six months: n=21, 21%) and the ACT IDRS (past 12 months: n=19, 19%) were almost identical to the prevalences of recent overdose reported in the Melbourne arm of the IDRS in 2016–17 (past 12 months: 30/150, 20% in 2016 and 29/150, 19% in 2017), immediately prior to the establishment of the MSIR. Opioid-related ambulance attendances were also higher in the ACT during 2019 than during 2016–17 in Melbourne (50.6 per 100,000 people in the ACT in 2019 vs 47.9 per 100,000 in Melbourne during 2016–17). Overdose deaths in the ACT increased by 78% from 19 in 2010 to 34 in 2018.

Other risks of drug-related harm are evident in the ACT's drug-using population from reports of sharing of injecting equipment, assisted injecting and drug use in both public and private spaces.

Consumers surveyed as part of this study indicated 30% of their injection episodes occurred in public locations (street, public toilet, stairwell, park, car). For NSP snapshot participants, public locations accounted for 14% of last episodes of drug use. This discrepancy between reports suggests public drug use in the ACT is more hidden than generally appreciated. It is well known that the criminalisation and social stigma of drug use drives clandestine drug purchase and consumption behaviours. The associated potential harms include risk of overdose, violence, arrest, and health complications from injecting in unsanitary conditions. People injecting drugs in public may also rush the process, also increasing the risk of harm.

Conversely, around half of all reported injections occurred in private settings, which carry a significant overdose risk when using alone. Around three-quarters of reported non-fatal overdoses occurred in a private home.

The increasing mean age of participants in national surveillance studies (e.g. IDRS, Australian NSP Survey), coupled with estimates that the number of people who inject drugs has remained stable Australia-wide for years, suggests that the Australian population of people who inject drugs is an ageing cohort with long-term drug use histories. Our primary data suggest prospective DCR clients have high social and health support needs (e.g. 10–17% report unstable housing and 16–19% are of Aboriginal and/or Torres Strait Islander descent). Aside from preventing overdose mortality and other injecting-related harms, a DCR would provide an essential point of contact for high-needs consumers, providing a link to the ACT's broader AOD and other health service system.

8.2 What is the best model and what are the benefits?

Given the profile of people who use drugs in the ACT and the dispersed ACT drug market and geography, the recommended model is to initially integrate a DCR with existing services, both physically and operationally. This model was well supported by stakeholders. Integration with an existing service was seen as offering benefits with regard to accessing existing staff expertise and networks with potential clients, the provision of holistic care, and a means of protecting client confidentiality (because clients would visit a site offering a range of services in addition to a DCR). The importance of ensuring low-threshold access was highlighted by many contributors and is supported by the international evidence.

The MSIR and MSIC have an explicit medical model of operation. However, an overly medical model is not recommended for the ACT. The staffing component could include full-time nurses with appropriate clinical supervision; this may be facilitated through existing health and medical services within the facility in which the DCR is integrated or provided externally. A less medicalised model than that employed in other jurisdictions could cost less and enhance client engagement and community ownership. This approach was well supported by ACT stakeholders and is already feasible within existing legislation.

On the basis of local and international views and evaluation of evidence, we recommend a service model that is integrated within a broader service that is:

- A fixed site with small but potentially expandable capacity (e.g. six injecting booths with space to expand to eight)
- Low threshold, with minimal client exclusion criteria (see section 8.4 below)
- Able to adapt to cater for drug consumption via routes of administration other than injecting in the future (see 8.4 below)
- Staffed by nurses and people with lived experience of drug use.

Keeping the service small would benefit its integration into an existing service and give the chance to evaluate the level of utilisation by the target population, scaling up or establishing additional sites elsewhere as needed. It may also help to establish local community acceptance, because the facility would already offer services to this client group.

The proposed model is feasibly implemented within existing legislation, but some amendments are recommended (see section 8.8).

Operational objectives

The operational objectives of a DCR in the ACT are not currently specified in the legislation, which allows for a trial. The MSIC is mandated to the following objectives:

- Reduction in the number of overdose deaths
- Providing a gateway to treatment and counselling
- Reduction in the number of discarded needles and syringes and incidence of public injecting
- Reducing the spread of BBVs.

The Victorian legislation incorporates these four objectives for the MSIR, with the addition of:

- A reduction in ambulance and hospital emergency attendances due to drug overdose
- The improved amenity of the neighbourhood for residents and businesses.

The MSIR Review Panel noted in its June 2020 report that, in Victoria, the specificity of the legislation made it difficult to adapt or innovate during the implementation phase of the first 18 months. Legislated operational objectives may also restrict the development of an innovative and unique DCR in the ACT. However, this needs to be balanced with community expectation and political appeal. Any objectives incorporated in legislation should therefore be carefully considered in light of the recommendation to target the most vulnerable and marginalised people who inject drugs and people who use drugs in the ACT. In this context, objectives related to service satisfaction among clients should be incorporated into operational objectives, most appropriately into service contracts.

8.3 Who should provide the service?

ACT-based stakeholder participants mentioned a range of services already equipped to provide a DCR as an extension of existing services. Suggestions predominantly included harm reduction and AOD services. Most participants mentioned more than one service that could work in partnership. There was general consensus that services would need to develop an appropriate structure for clinical governance and leadership.

Existing services in the ACT, with established reputations and relationships with the expected client group, central and accessible geographic locations, and appropriate governance structures could feasibly be adapted to provide such a service.

8.4 Who can attend the service?

Consistent with most DCRs internationally, an ACT in the DCR would likely be most relevant and useful to people who inject drugs. Broadly, the service should target the most vulnerable members of the drug-using community (e.g. people experiencing homelessness, people with complex co-occurring physical and mental health needs, recently released prisoners) because they are the most at risk of drug-related harms and the most likely to benefit from the service. Targeting vulnerable

and marginalised drug consumers is likely to achieve the greatest impact in terms of health outcomes, given fewer service users in the ACT context than in the MSIC and MSIR.

There should be strong consideration given to facilitating the consumption of drugs by routes other than injection. Consumers surveyed for this study indicated support for use of a DCR for non-injecting routes of administration, as did stakeholders in qualitative interviews. However further research with people whose primary route of drug administration is inhalation or snorting is recommended, because our consumer sample overwhelmingly represented people who primarily inject drugs. Intra-nasal consumption is a relatively straightforward inclusion, accompanied by relevant operational guidelines for monitoring clients for overdose. The inhalation of drugs presents more complex issues; a separate room with adequate ventilation is required, and this has significant cost implications during implementation.

Client entry criteria should be carefully considered with the aim of maximising the harm reduction benefits of a DCR in the ACT, balanced with occupational health and safety considerations. To this end, restricting client entry based on personal attributes which point to high vulnerability is not recommended. Some of these are discussed below.

- **Safety.** The physical safety of staff and clients is paramount and excluding clients on the basis of the threat of, or actual, violence is recommended. In addition, perceptions of safety are important in ensuring the facility is accessible to – and utilised by – other clients.
- **Age**. Strong consideration should be given to allowing entry to people aged under 18 years (e.g. 16–17 years), which may be assessed on a case-by-case basis. This may be particularly important for providing harm reduction intervention to new initiates to injecting.
- **Pregnancy**. The best available evidence supports the accommodation of pregnant clients in a DCR and is supported by the AMA. In practice, the exclusion of pregnant clients from a DCR prevents intervention in the event of overdose when the client expresses an intent to use drugs regardless of admission to the facility. Admitting pregnant clients may also provide a critical opportunity to link them with treatment and support services at a time of heightened vulnerability.
- **Intoxication.** Where a client presents to the facility already intoxicated (through the prior consumption of alcohol and/or illicit or prescription drugs), additional use of substances presents a significant risk of overdose. On this basis, strong consideration should be given to not excluding intoxicated clients from using the facility *ipso facto* but accommodated on a case-by-case basis, taking into account other factors, including expressing an intent to use drugs regardless of entry. The perceived safety of staff and other clients may also influence this assessment, as outlined above.
- **Self-administration of drugs via injection.** People who use drugs via injection but require help to do so may represent a particularly vulnerable client group. Evidence shows people who require help injecting are more likely to be women and young people, lack autonomy in their drug consumption, and experience a high risk of violence and BBV transmission. Entry to a DCR may provide these clients with a safe environment to exercise autonomy in their drug consumption, advised by experienced staff.
- **Physical injection sites.** Venous access in the forearm may be compromised for some clients including older, longer-term people who inject drugs, those who have a history of injecting substances which do not readily dissolve in water (e.g. some pharmaceutical tablets), or those who have lacked the ability to inject in hygienic environments and suffered health problems as a result. A proportion of these people who inject drugs may continue to inject in other sites,

including the femoral vein in the groin or jugular in the neck. It is recommended that clients should not be excluded on this basis. DCR staff may be able advise on how such injection can be performed as safely as possible and how to find alternative venous access.

8.5 What should be available within the service?

The core services provided in a DCR would include:

- **Safer drug use supplies** (e.g. needles/syringes, other drug using paraphernalia)
- **Supervised drug consumption**
- **Overdose response** (e.g. monitoring, oxygen, naloxone)
- **Other harm reduction supplies** (e.g. condoms, THN)
- **Harm reduction support and education** (e.g. vein care, reducing BBV risk, reducing overdose risk)
- **First aid** (e.g. wound care).

The existing legislation allowing for a trial of a DCR in the ACT also mandates the provision of – or satisfactory access to – primary health care services (including medical), AOD counselling services, health education services, AOD detoxification and rehabilitation services, and BBV testing. A DCR integrated into a larger health facility could offer some of these services onsite and establish referral pathways for others.

Stakeholders and consumers suggested a wide range of add-on services. Implementation could start with the provision of services regularly provided by DCRs internationally and be adjusted according to local need and demand. Examples of services which may be included initially are:

- Additional harm reduction services (e.g. drug checking)
- Primary health care (e.g. BBV and STI testing and treatment initiation)
- OAT and other drug treatment (external referral or in-reach clinic)
- Social services (e.g. linkage to housing and mental health support)
- Practical services (e.g. mail forwarding, telephone and internet use to access Centrelink, MyGov, Medicare online, etc.)
- Personal care services (e.g. showers, laundry, meals, tea/coffee).

8.6 When and where will the service be available?

A DCR needs to be situated in an area which is readily accessible by the target population. An initial DCR site should be centrally located and within walking distance of public transport. Additional small sites may be added in later stages, situated less centrally, and scaled according to need. Snapshot survey clients interviewed in the Civic area for this study indicated the highest level (70%) of intent to use a DCR. More than 50% of participants from all locations indicated an intent to use a DCR. A central location would also give ready access to nearby health and social support services that the DCR may not offer directly.

A DCR could initially open during normal business hours (e.g. 9am to 5pm) and adapt based on client demand after opening. Any extension to opening hours should also consider transport availability for the majority of its clients.

8.7 How much will the service cost?

A potential budget for a single small DCR, integrated into an existing service is provided in Appendix 5, based on interviews with stakeholders from existing DCRs. The provided budget (total $632,500)

assumes approximately six to eight injecting booths and service delivery during normal business hours. In addition, a base hourly rate of $320 has also been generated, which is inclusive of staff on-costs and a small infrastructure imputation but exclusive of salary loadings that may be required for after hours or weekend work.

As with all service delivery, the greatest cost component comes from staff salaries, including direct and on-costs. A more precise assessment of salary costs will depend on the desired staffing profile, which in turn is dependent on factors such as opening hours and number of booths. Under the current legislation, a nurse would always be required to be onsite. Staffing needs would also be influenced by the existing staffing profile of the service hosting the DCR, and how the DCR is integrated both physically and operationally.

Other costs would need to be considered in the context of existing infrastructure (e.g. the availability of an existing physical space to host the DCR, or the addition of a new physical space). Some capital investment in designing and constructing injecting booths would also be needed, but we have not estimated these costs as they are entirely service and site-dependent.

8.8 Feasibility assessment

The feasibility of establishing a DCR has been assessed throughout this report. This section specifically examines feasibility in the context of a range of specific criteria related to feasibility and priority setting. Across all criteria, it appears feasible to implement a DCR in the ACT.

The proposed model is likely to deliver the intended harm reduction outcomes in the context of the size and nature of need identified

International evidence suggests that a modestly sized DCR will deliver substantial drug harm reduction benefits, particularly for the most marginalised people who use drugs (e.g. homeless people, Indigenous people, people with mental health issues, young people, pregnant people), who appear concentrated in the Civic area. With appropriate site selection, targeting of services and service promotion, expected benefits include reductions in overdoses and other injecting-related harms, and enhanced consumer engagement, referral and access to complementary services, including drug treatment.

In line with international evidence, initial measures of service success would focus on assessments of quality by service users, successful referrals to other services (including those provided onsite) and numbers of drug overdoses treated within the facilities. Future evaluations could explore impact on community-reported rates of non-fatal overdose, data on fatal overdose, ambulance attendance and drug-related hospitalisation, although the expected impact would be modest, given the proposed size of the service and targeting to marginalised groups. Evaluation of implementation should be undertaken to determine lessons for potential additional sites, should a need be identified.

The proposed model is likely to be well-utilised by the target population

Data collected in this study suggest that the target population would use a DCR. Even if restricted to injecting only, it is estimated that up to 1038 clients could use the service. Actual demand for and use of a DCR would depend on factors including low-threshold access, geographic accessibility (including public transport), co-location of other services such as NSP, proximity to drug markets, flexibility in eligibility and drug consumption requirements (through allowing non-injecting routes of administration) and linkages to ancillary services (e.g. services for homeless people). Finally, peer

involvement in service design and delivery will enhance service promotion among clients and increase uptake.

Systems for measuring ongoing utilisation will need to be established alongside performance indicators. Mechanisms to allow for scale-up within any selected site (including enhanced service hours) should be established at implementation, alongside systems for measuring unmet need in other areas of the ACT that can inform future service development.

The proposed model is likely to be cost-effective

The proposed model, in which leadership and supervision can be provided by nurses rather than medical practitioners, along with substantive involvement of peers in the delivery of the service, is expected to cost less than larger-scale DCRs elsewhere in Australia. The ACT's low population density and geographic spread necessitates a smaller scale and more integrated model. This model could feasibly be implemented with some existing staffing within some services, further reducing costs.

Integrating with existing services may assist with keeping physical infrastructure costs low, but will be dependent upon the physical size of facilities and the space available in existing services. Opportunity for downstream expansion, following initial monitoring of utilisation, may be possible if capacity is too limited.

The proposed model is likely to be acceptable to the public, professionals, and decision-makers

Available data suggest stronger support for DCRs in the ACT than in the rest of Australia. Stakeholder support for a DCR was clear. Leveraging site locations already frequented by the target population through linkage with existing services means that it should be possible to minimise any concerns about so-called honeypot effects and be more acceptable to potential clients.

The proposed small size of the site may also improve acceptability. This may also mean that, subject to initial evaluation and demonstration of positive impact, expansion to other sites with identified need may be deemed appropriate and feasible.

The proposed model is likely to be legally acceptable

The existence of a specific Act centred on a DCR in the ACT enhances the feasibility of establishment and implementation. The proposed model is consistent with provisions in the Act in that it specifies nurse supervision, consistent with the ACT's requirements for supervision by a medical practitioner or a nurse. It also specifies co-location within existing services with established service provision and referral, consistent with provisions specifying that the facility must contain, or provide satisfactory access to, primary health care services (including medical), AOD counselling services, health education services, AOD detoxification and rehabilitation services, and BBV testing.

The Act allows provision for a maximum 0.5g of a substance to be carried and/or consumed onsite without potential prosecution. These amounts would need harmonisation with recent changes to ACT possession and supply laws.

However, the proposed model would require changes to the Act to provide for clearer specification of performance requirements, including the removal of the 'scientific trial' status given the evidence that DCRs are effective that has emerged since the Act was written. Any future consideration of allowing drug consumption via routes other than injecting would also require a review of the Act, which currently allows only for injecting.

These changes will require political and community support, which evidence suggests is feasible in the ACT. Recent ACT drug law changes have attracted Commonwealth interest, but given strong community support and the existence of larger services in Sydney and Melbourne, the establishment of a DCR is likely to go unchallenged by the Commonwealth.

The proposed model can be accommodated within administrative and governance frameworks

The Act currently specifies that the Minister makes decisions related to the injecting facility, but takes advice from a steering committee. Steering committee membership is dictated by the Act and includes representatives from a range of sectors (e.g. academia, peer bodies, health service providers, etc.). This is congruent with arrangements recommended by stakeholders, and would support the proposed model. Integration of the services with existing organisations which have pre-existing administrative and governance structures will provide appropriate clinical and community oversight of operations and assist with ensuring appropriate levels of community, consumer and political support.

The proposed model is scalable

The introduction of a small DCR reflects the population size and expected utilisation in the ACT. While the initial scale of the model will also be partly influenced by available physical spaces in the service site, the recommendation of establishing six, but ensuring space for up to eight, booths will allow scale-up if demand exceeds expectations. If this capacity is subsequently exceeded, it may be more appropriate to scale up to other geographic locations or to integrate with other services or sites around chosen locations. The likelihood of needing to scale down is considered low, if starting with a relatively small number of booths.

9.0 Conclusions

Converging lines of evidence in this report demonstrate the feasibility of establishing a DCR in the ACT. Primary and secondary data collected on patterns of drug trends and related harms indicate that overdose and public drug use are significant public health and amenity issues. Surveys of potential consumers across multiple data collections indicated an intention to use a DCR if established. Sector stakeholders were strongly in support of the establishment of a DCR, and this support is reflected in responses to the NDSHS.

The relatively small population of the ACT compared to other major Australian cities means we have recommended a DCR model in which a small facility be established initially. This model can be implemented through linkage to existing harm reduction service frameworks. It can not only provide a link to enhanced care but potentially reduce costs compared to other models. It can be expanded and/or enhanced if additional need becomes evident.

The ACT has an enabling policy environment for the establishment of this DCR model. Service providers are linked through engagement with relevant peak bodies. There is existing supporting legislation for a DCR that would require minimal modification to accommodate the recommended model. An advisory framework exists to support implementation through the Advisory Committee for this project that could evolve to support the establishment of the DCRs, much like the role of supporting Committees evolved in relation to the implementation of THN in the ACT. Indeed, such an Advisory Committee is required under the current provisions of the Act.

Finally, the ACT is well-served by an active illicit drug consumer group that will be able to provide support and guidance around service development and implementation, help market the services through consumer networks and facilitate uptake and use of the service once established.

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APPENDICES

List of tables and figures in appendices

Appendix 1: Secondary data sources

Table A1: Data sources for examining drug trends, drug-related harms, health service utilisation, and drug-related crime and law enforcement

Data source	Publisher/author	Source year	Publication frequency	Summary of data
National Drug Strategy Household Survey[93]	Australian Institute of Health and Welfare	2010, 2013, 2016, 2019	3-yearly	Data on alcohol, tobacco, and other drug use in Australia among the general population
ACT Illicit Drugs Reporting System (IDRS)[52]	National Drug and Alcohol Research Centre	2010 - 2019	Annual	A survey about drug use trends among people who inject drugs. The 2019 ACT sample included 100 people, mostly men with a median age of 44.
Australian NSP survey: 25-year National Data Report 1995-2019[53]	Heard S, Iversen J, Kwon JA and Maher L	2020	Special Report	Collects data on demographics, drug use, health, and health service utilisation data from NSP service users on a snapshot day each year.
Australia's Annual Overdose Report[94]	Penington Institute	2019	Annual	Describes overdose trends in Australia using data sourced from the Australian Bureau of Statistics.
ACT Policing Annual Report[63]	Australian Federal Police	2019	Annual	Reports on response to crime by ACT Police
Alcohol and other Drug Treatment Services in Australia[66]	Australian Institute of Health and Welfare	2018-19	Annual	Data on alcohol and other drug treatment services
National Opioid Pharmacotherapy Statistics Annual Data collection[67]	Australian Institute of Health and Welfare	2019	Annual	Snapshot data from pharmacotherapy clients, prescriptions, and dosing points
Service Users' Satisfaction and Outcomes Survey[68]	Alcohol Tobacco & Other Drug Association ACT	2020	3-yearly	A single day census of service users accessing ACT specialist AOD services covering satisfaction and outcomes of clients from both residential and non-residential services.

Appendix 2: The ACT context – detailed findings

Drug use trends: prevalence of alcohol and other drug use

Findings from the 2019 National Drug Strategy Household Survey show that overall, around one-seventh (15%) of the ACT population reported use of any illicit drug in the past year, with prevalence of use being 14% among men and 15% among women. The most common age groups for any illicit drug use are 18-24 (37%), 25-29 (26%) and 30-39 (13%). The prevalence of illicit drug use in the ACT overall is slightly lower than in other Australian jurisdictions. Cannabis is the most frequently used illicit drug (~10%) with use of heroin (<0.3%), cocaine (2-5%), methamphetamine (1-2%) or ecstasy (2-4%) reported by less than 5% of the population. These figures have remained largely stable over the past decade. The survey also found that 56% of ACT respondents supported supervised drug consumption facilities/rooms to reduce harms associated with injecting, the highest of any state or territory (47% Australia-wide). [44]

In 2019, the proportion of self-reported use of any category of substance listed in Table A2 was similar to those reported in previous years - with the exception of cocaine which has increased and methamphetamine which has decreased. The proportion of drug use was also similar between the ACT and Australia relative to population size.

Table A2: Recent (12 months) illicit drug use in the ACT and Australia among persons aged 14 and over, 2010-19

	ACT				Australian			
Drug type	2010 (%)	2013 (%)	2016 (%)	2019 (%)	2010 (%)	2013 (%)	2016 (%)	2019 (%)
Cannabis	9.5	10.1	8.4	10.5	10.3	10.2	10.4	11.6
Ecstasy	2.3	2.9	2.2	2.3	3	2.5	2.2	3
Methamphetamine	1.2	2.2	1.1	0.3	2.1	2.1	1.4	1.3
Heroin	**0.3	**0.3	-	-	0.2	0.1	0.2	-
Pain killers*	3.1	3.2	-	-	3.3	3.5	-	-
Cocaine	1.8	2.8	1.9	3.5	2.1	2.1	2.5	4.2
Hallucinogens	1.5	1.7	1.2	-	1.4	1.3	1	-
Any illicit drug	13.9	15.3	12.9	14.6	14.7	15	15.6	16.4

*For non-medical purposes, includes over the counter drugs; **High sampling error; - Not reported

Source: Australian Institute of Health and Welfare. *National Drug Strategy Household Survey 2019: detailed findings.* AIHW 2020

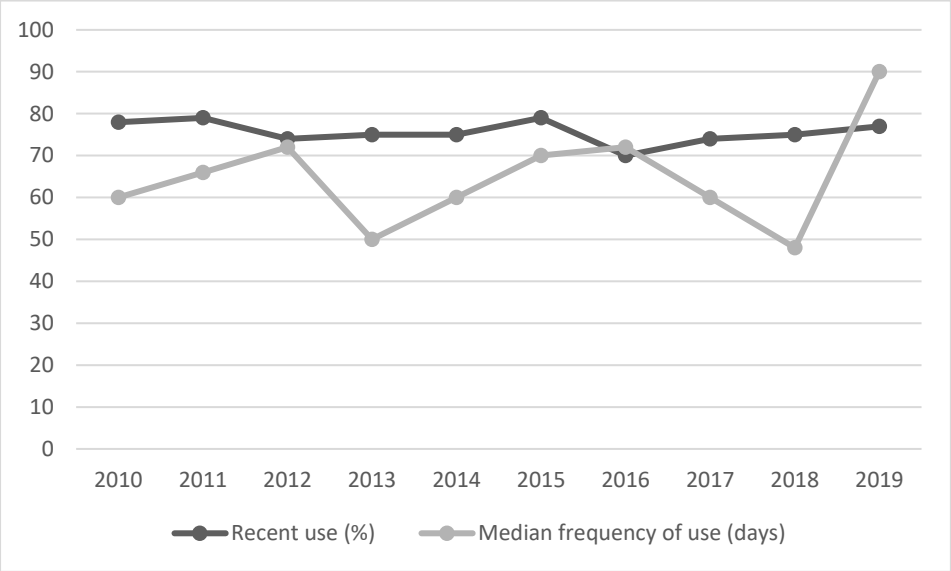
Among IDRS participants, the most used substances were tobacco (77%), opioids (54%), cannabis (51%), stimulants (33%), and alcohol (29%).[52] The Australian NSP Survey's 25 year National Data Report showed that among participating ACT NSP attendees in 2019 (n=128), the most common drugs last injected were heroin (46%) and methamphetamine (45%), an increase from 2010 (heroin

29%; methamphetamine 27%) when the prevalence of recent injecting methadone (16%) and buprenorphine (10%) was more common.[53]

Heroin

Most people who inject drugs who participated in the 2019 ACT IDRS were frequent users of heroin: around three quarters of those reporting recent use (past 6 months) reported at least weekly use, and 40% reported daily use. Recent heroin use prevalence decreased from a peak of 92% of IDRS participants in 2000 to 77% in 2019. All participants who reported heroin use reported injecting the drug.[52]

Figure A1: Recent heroin use, ACT IDRS, 2010-19

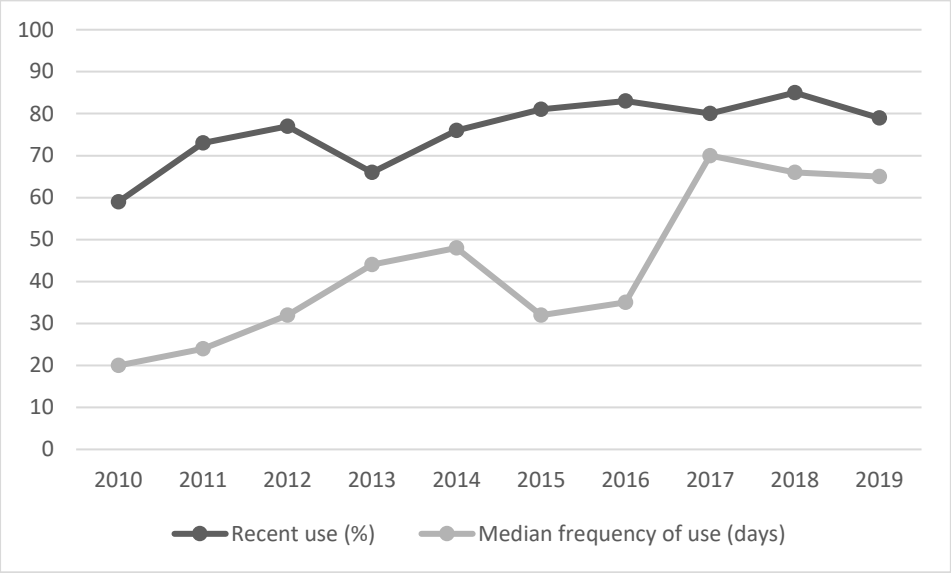


Source: Uporova J, and Peacock A. *Australian Capital Territory Drug Trends 2019: Key findings from the Illicit Drug Reporting System (IDRS) Interviews*. 2019. National Drug and Alcohol Research Centre, UNSW Sydney.

Methamphetamine

Results from the 2019 NDSHS showed a decrease in the prevalence of methamphetamine use in the ACT overall in the past decade.[51, 55] However, among ACT IDRS participants, both the percentage of the sample indicating past-six-month methamphetamine use and frequency of use have steadily increased over the past decade.[52] Two thirds of those reporting recent use reported at least weekly use and one-fifth reported at least daily use. Methamphetamine was injected by 97% and smoked by 36% of those who reported recent use of the drug.[52]

Figure A2: Recent methamphetamine use, ACT IDRS, 2010-19



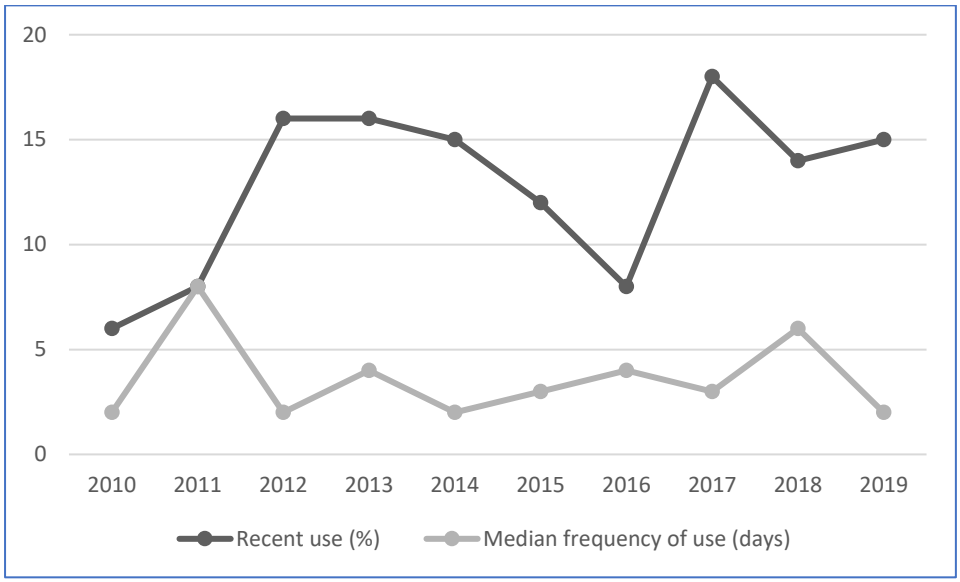
Source: Uporova J, and Peacock A. *Australian Capital Territory Drug Trends 2019: Key findings from the Illicit Drug Reporting System (IDRS) Interviews*. 2019. National Drug and Alcohol Research Centre, UNSW Sydney.

The percentage of ACT IDRS respondents who reported weekly or daily methamphetamine use was 68% and 18% respectively, with the most common form consumed being crystal methamphetamine (77%). Crystal methamphetamine was injected by 97% and smoked by 36% of those reporting recent use, with the median amount consumed on a typical day being .20 grams (IQR 0.10-0.30). The median price for one gram of crystal methamphetamine in the ACT was $325 (IQR 213-388). One-third of eligible respondents perceived crystal methamphetamine purity as 'high' (35%) or 'medium' (29%) and that it was 'very easy' (61%) to obtain.[52]

Cocaine

National Drug Strategy Household Surveys suggest that recent cocaine in the past 10 years in the ACT has risen (1.8% in 2010; 2.8% in 2013; 1.9% in 2016; 3.5% in 2019).[54] Among participants in the IDRS, the percentage reporting recent cocaine use has more than doubled over the past decade, from 6% in 2010 to 15% in 2019, with a few fluctuations in that time (Figure A3). However, the median frequency of use has not changed remarkably, fluctuating from 2–8 days. The most common route of cocaine administration was injecting (73%) followed by snorting (40%). In 2019 the median amount of cocaine consumed on a typical day was .20 grams (IQR 0.10-0.50).

Figure A3: Recent cocaine use, ACT IDRS, 2010-19



Source: Uporova J, and Peacock A. *Australian Capital Territory Drug Trends 2019: Key findings from the Illicit Drug Reporting System (IDRS) Interviews*. 2019. National Drug and Alcohol Research Centre, UNSW Sydney.

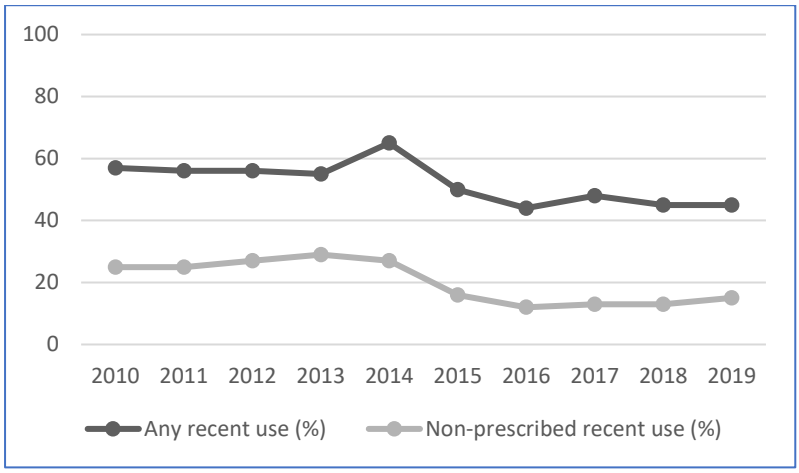
Pharmaceuticals

The 2019 National Drug Household survey found that the recent use of any pharmaceutical (excluding over the counter) in the ACT has remained somewhat stable over the last 6-7 years (3.1% in 2013; 4.6% in 2016; 3.4% in 2019).[44]

Pharmaceutical opioids

IDRS monitoring has found that since 2010, both prescribed and illicit (diverted) use of methadone decreased from 2010-2015 and has since stabilised at 45% and 15% in 2019 respectively (Figure A4). Of concern for increased overdose risk, the 2019 ACT IDRS also reported that around a quarter of those reporting recent methadone use reported injecting (liquid and tablets) on a median of nine days in the past six months.

Figure A4: Recent methadone use, ACT IDRS 2010-19



Source: Uporova J, and Peacock A. *Australian Capital Territory Drug Trends 2019: Key findings from the Illicit Drug Reporting System (IDRS) Interviews*. 2019. National Drug and Alcohol Research Centre, UNSW Sydney.

Table A3: Recent buprenorphine use, ACT IDRS, 2010-19

Year	Any recent use (%)	Median frequency of use (days)	Non-prescribed recent use (%)
2010	35	178	27
2011	28	90	21
2012	28	81	20
2013	19	90	16
2014	17	9	12
2015	16	25	11
2016	9	3	8
2017	16	19	14
2018	9	2	9
2019	6	14	.

Source: Uporova J, and Peacock A. *Australian Capital Territory Drug Trends 2019: Key findings from the Illicit Drug Reporting System (IDRS) Interviews*. 2019. National Drug and Alcohol Research Centre, UNSW Sydney.

Most IDRS participants who reported recent buprenorphine use reported non-prescribed use; the percentage of non-prescribed use decreased from 35% in 2010 to 6% in 2019, which reflects reduced availability since the introduction of buprenorphine-naloxone. Five out of six participants reporting illicit use of buprenorphine injected it, and the median frequency of use was approximately fortnightly. The prevalence of illicit use of buprenorphine-naloxone was higher at 14% in 2019, with a median of monthly use, and half of those injected it.[52]

Reports of non-prescribed morphine consumption by ACT IDRS participants have more than halved over the past decade (from 43% in 2010 to 15% in 2019), which may reflect changes in prescribing practices (Table A4). Most of those who reported morphine use in 2019 reported injecting morphine (93%).

Table A4: Recent morphine use, ACT IDRS, 2010-19

Year	Any recent use (%)	Median frequency of use (days)	Non-prescribed recent use (%)
2010	43	4	36
2011	34	5	30
2012	36	7	30
2013	29	10	23
2014	17	20	12
2015	24	4	20
2016	16	6	12
2017	27	6	21
2018	17	3	10
2019	15	5	11

Source: Uporova J, and Peacock A. *Australian Capital Territory Drug Trends 2019: Key findings from the Illicit Drug Reporting System (IDRS) Interviews*. 2019. National Drug and Alcohol Research Centre, UNSW Sydney.

Reports of recent oxycodone use by ACT IDRS participants remained relatively stable at 14–17% over the past 10 years, apart from a spike in 2011–14 when consumption peaked at 35% (Table A5); it was 17% in 2019. Forty-four per cent of those reporting recent oxycodone use in 2019 reported injecting the drug.

Table A5: Recent oxycodone use, ACT IDRS, 2010-19

Year	Any recent use (%)	Non-prescribed recent use (%)	Median frequency of use (days)
2010	14	13	3
2011	25	23	4
2012	35	34	3
2013	20	17	10
2014	21	16	6
2015	17	15	2
2016	14	12	1
2017	14	9	5
2018	15	10	30
2019	17	14	3

Source: Uporova J, and Peacock A. *Australian Capital Territory Drug Trends 2019: Key findings from the Illicit Drug Reporting System (IDRS) Interviews*. 2019. National Drug and Alcohol Research Centre, UNSW Sydney.

Australian Capital Territory IDRS participants are less likely to report recent fentanyl use than use of other prescription opioids, but reports of 'any fentanyl use' doubled from 8% to 14% over 2018–19, with 79% of those reporting recent use reporting injecting the drug.[52]

Table A6: Recent fentanyl use, ACT IDRS, 2010-19

Year	Any recent use (%)	Median frequency of use (days)	Non-prescribed recent use (%)
2013	.	5	11
2014	.	5	7
2015	.	4	10
2016	.	.	.
2017	.	4	8
2018	8	5	6
2019	14	3	10

Source: Uporova J, and Peacock A. *Australian Capital Territory Drug Trends 2019: Key findings from the Illicit Drug Reporting System (IDRS) Interviews*. 2019. National Drug and Alcohol Research Centre, UNSW Sydney.

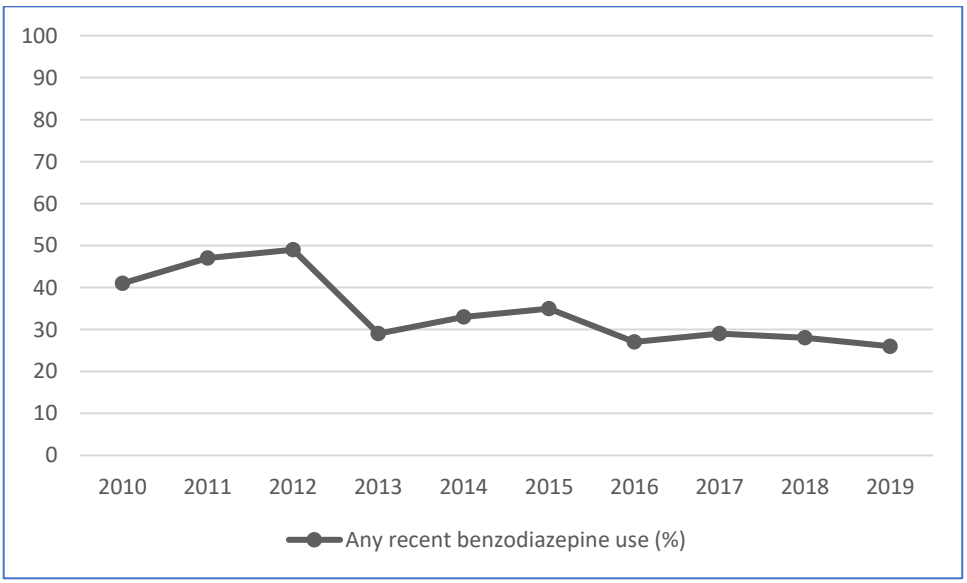
In 2019, 19% of the ACT IDRS sample reported any codeine use in the past six months on a median of seven days in that period (IQR 4-21).[52]

Non-prescribed pharmaceuticals

Benzodiazepines

In 2019, 26% of ACT IDRS participants reported recent benzodiazepine use (6% non-prescribed alprazolam and 22% non-prescribed benzodiazepines) (Figure A5). Alprazolam was reportedly used on a median of seven days (IQR 3-30) and 'other benzodiazepines' were used on a median of three days (IQR 2-45) in the past six months.

Figure A5: Recent benzodiazepine use, ACT IDRS, 2010-19



Source: Uporova J, and Peacock A. *Australian Capital Territory Drug Trends 2019: Key findings from the Illicit Drug Reporting System (IDRS) Interviews*. 2019. National Drug and Alcohol Research Centre, UNSW Sydney.

Pregabalin

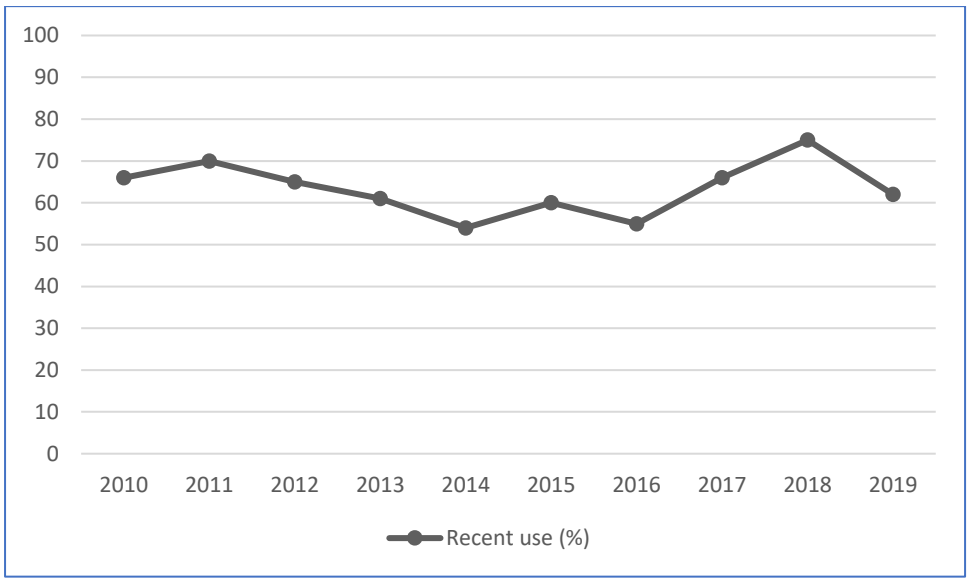
Ten percent of the ACT IDRS sample reported non-prescribed pregabalin use, for a median of 3 days in the previous month (IQR 1-9). No participants reported injecting pregabalin.[52]

Alcohol

Eighty-one per cent of participants in the NDSHS reported any alcohol use (daily, weekly, monthly or less than monthly). Daily consumption of alcohol was uncommon at 4.4% (5.4% in 2010; 6.6% in 2013; 3.7% in 2016). Fourteen per cent were categorised as having a lifetime risk of harm from alcohol, with males (20%) being at three times greater risk of harm than females (9%).[93]

Recent use of alcohol has historically been reported by 54–75% of IDRS participants. In 2019, this figure was 62%. The median frequency of use was equivalent to twice weekly (48 days; IQR 12–100), with 21% reporting daily use, a considerably higher proportion than among the general population.

Figure A6: Recent alcohol use, ACT IDRS, 2010-19



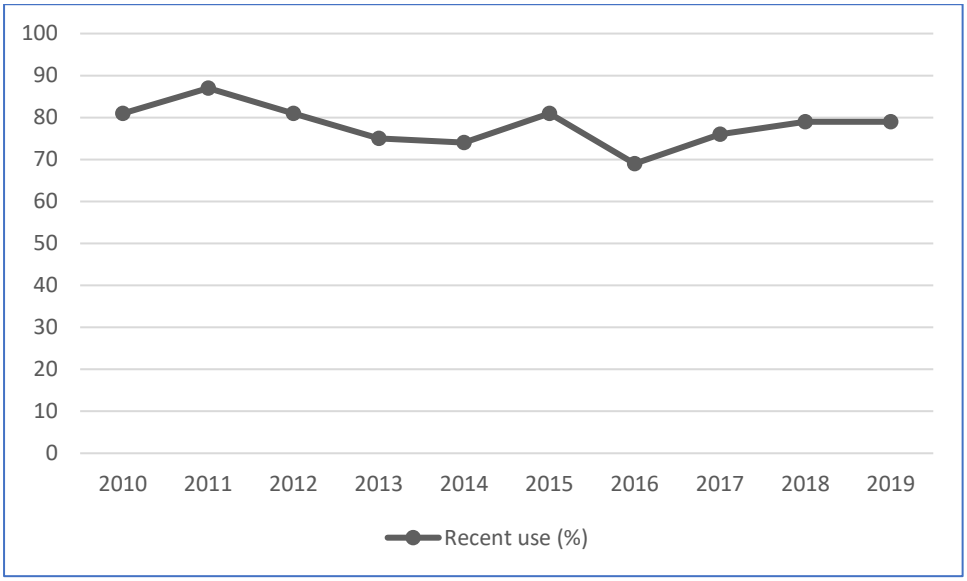
Source: Uporova J, and Peacock A. *Australian Capital Territory Drug Trends 2019: Key findings from the Illicit Drug Reporting System (IDRS) Interviews*. 2019. National Drug and Alcohol Research Centre, UNSW Sydney.

Cannabis

Data from the NDSHS indicate that over the last decade, reports of recent (past year) cannabis use among the general population has remained stable in the ACT (9.5% in 2010; 10.1% in 2013; 8.4% in 2016; 10.5% in 2019).[44]

Eighty per cent of IDRS participants between 2010 and 2019 reported recent use of cannabis. Of these, 90% reported at least weekly use and over half reported daily use. All participants reported smoking as their primary route of administration and one-tenth reported vaping and/or ingesting.[52]

Figure A7: Recent cannabis use, ACT IDRS, 2010-19



Source: Uporova J, and Peacock A. *Australian Capital Territory Drug Trends 2019: Key findings from the Illicit Drug Reporting System (IDRS) Interviews*. 2019. National Drug and Alcohol Research Centre, UNSW Sydney.

Polydrug use

Almost all of the 2019 IDRS participants reported using one or more drugs on the day before the interview (99%).[52]

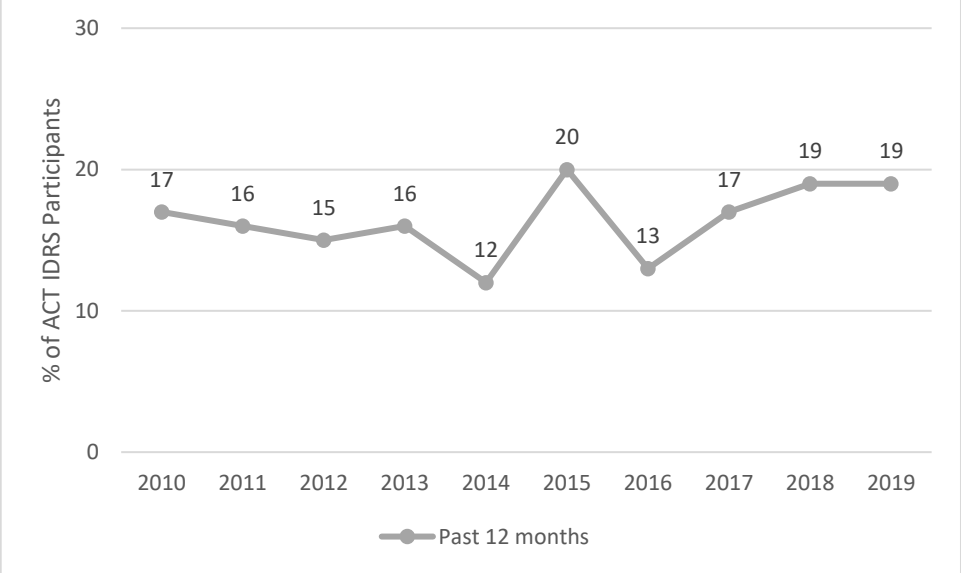
McKetin and colleagues' 2017 study of 183 recent (past month) people who use methamphetamine in the ACT found that half had also used heroin (48%) or other opioids (50%) in the past month, with cannabis (80%) and alcohol use (62%) also being prevalent in the same time period.[55]

Drug-related harms and health

Non-fatal and fatal overdose

In 2019, one-fifth (19%) of IDRS participants reported having overdosed in the previous 12 months, which was relatively consistent with recent years. Of those who reported a recent overdose, the median number of overdoses in the previous 12 months was two and the most commonly cited drug involved in participant's overdoses was heroin (14%). Of those who reported a heroin overdose, 43% received naloxone and 43% were attended by an ambulance.[52] The prevalence of self-reported overdoses in the 2019 ACT IDRS was similar to that in the national sample, with 21% reporting an overdose in the previous 12 months on a median of two occasions. Nationally, among people who reported a recent heroin overdose, 47% received naloxone, 47% were attended to by an ambulance and 28% were admitted to an emergency department.[56]

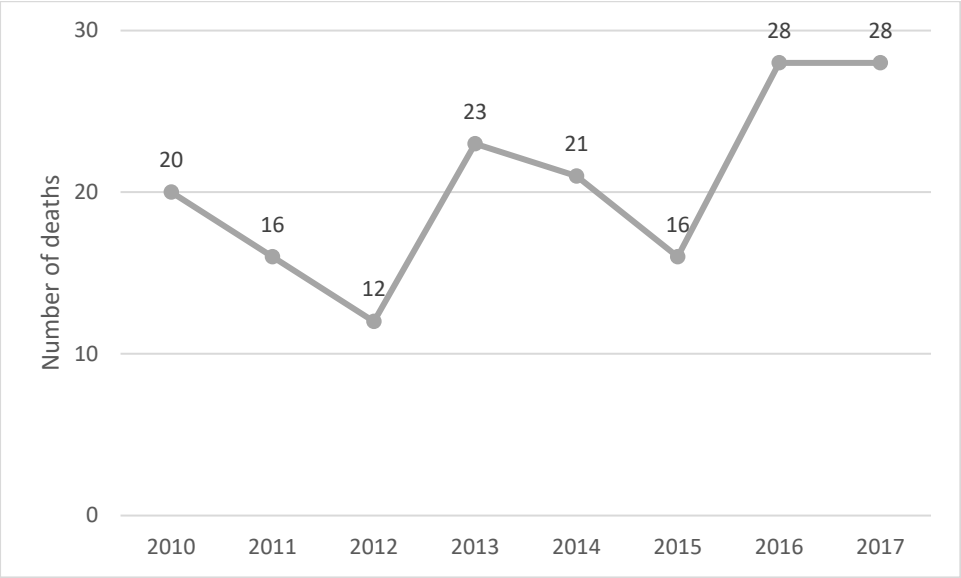
Figure A8: Non-fatal overdoses in the past 12 months, ACT IRS, 2010-19



Source: Uporova J, and Peacock A. *Australian Capital Territory Drug Trends 2019: Key findings from the Illicit Drug Reporting System (IDRS) Interviews*. 2019. National Drug and Alcohol Research Centre, UNSW Sydney.

Australia's annual Overdose Report 2019 shows that in 2017 (the most recent year with data available), 28 people in the ACT died from unintentional drug-induced causes, an increase of 40% since 2010 (Figure A5).[94]

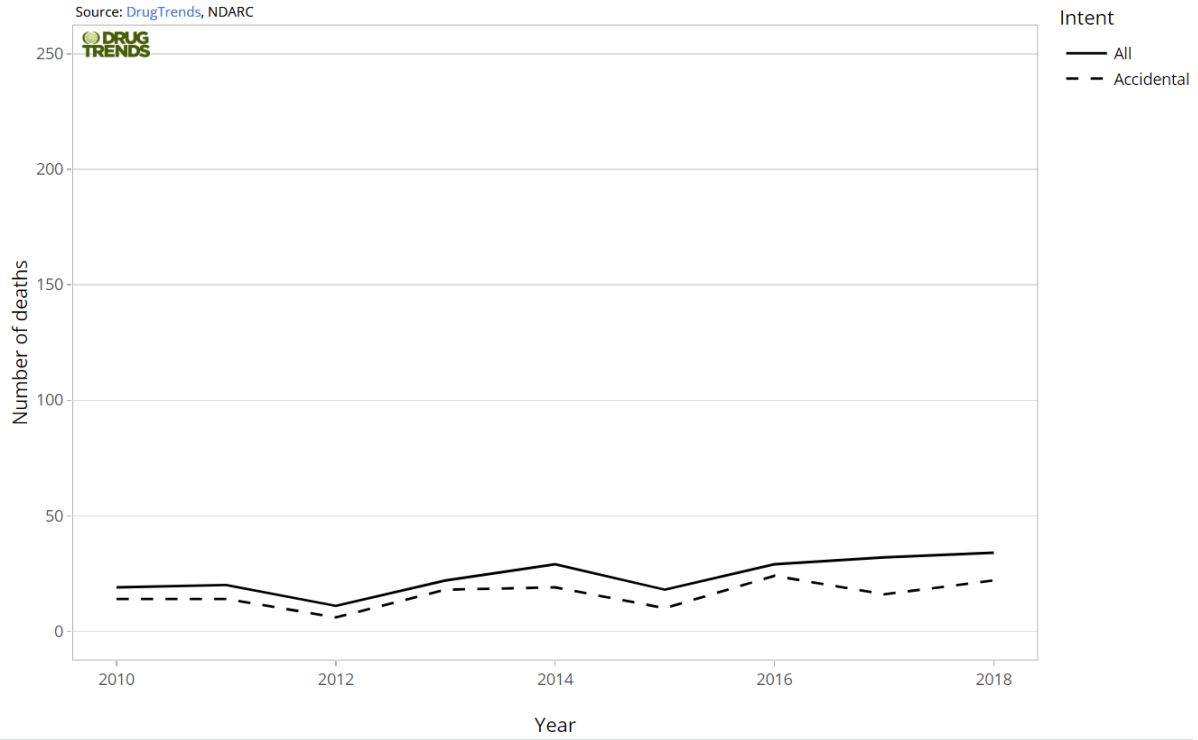
Figure A5: Unintentional drug-induced deaths, ACT, 2010-17



Source: Penington Institute. *Australia's Annual Overdose Report 2019*. 2019. Penington Institute.

Data compiled by the National Drug and Alcohol Research Centre also confirms that annual deaths relating to drug overdoses have increased, from 19 reported deaths in 2010 to 34 in 2018 (Figure A6).[57]

Figure A6: Drug induced deaths in the ACT, 2010-2018

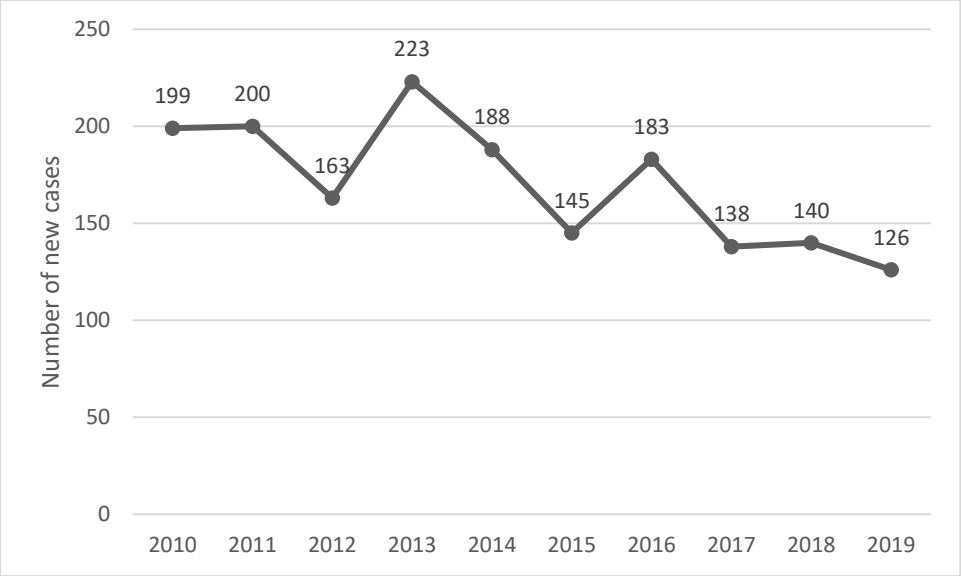


Source: National Drug and Alcohol Research Centre. *Drug-induced deaths by jurisdiction, intent, age, and sex*. 2020. University of New South Wales.

Blood-borne viruses

People who inject drugs are at a high risk of BBV infection including hepatitis C virus, hepatitis B virus, and HIV[58] that leads to excess morbidity and mortality. According to surveillance data collated from multiple sources, an estimated 2533 people in the ACT were living with hepatitis C in 2017 (range 1549–2602; 1% of national prevalence).[59] New hepatitis C infections in the ACT have been steadily decreasing, with 126 recorded in 2019 – the lowest in the past 10 years. Current evidence suggests that around 4% of people who inject drugs in Australia are living with hepatitis B virus. During 2008–17 there were 928 new hepatitis B infections in the ACT.[59] In Australia, 3% of new HIV infections are attributed to injecting drug use; in the 10 years between 2008 and 2-17 there were 138 new HIV diagnoses in the ACT.[59]

Figure A7: Unspecified or newly acquired hepatitis C infections, ACT 2010-20



Source: Australian Government Department of Health. *National Notifiable Diseases Surveillance System*. 2020.[95]

Australia's National NSP Survey revealed that among 128 NSP attendees in 2019, lifetime testing for HIV (88%) and hepatitis C (91%) was high, with 34% and 28% receiving a test within the last year respectively. In that same year, 50 people self-reported a hepatitis C diagnosis, 33 (66%) of whom also reported receiving antiviral treatment currently or in the past.[53]

Injecting behaviours and harms

In the 2019 ACT IDRS, 11% of participants reported distributive sharing of needles/syringes and 8% reported receptive sharing in the last month. The prevalence of people sharing other injecting equipment has been stable over the last decade, although a significant drop was observed between 2018 (27%) and 2019 (8%). Sharing other injecting equipment was reported by 6% (e.g. spoons, tourniquet, water, and filters; 27% in 2018) and reusing own syringes was reported by 44% of the sample. Nearly half (48%) reported issues such as a 'dirty hit' (24%), nerve damage (20%) and injection into an artery (15%). A third of the 2019 ACT IDRS sample reported having injected someone else after they injected themselves (in the past month), and a fifth reported that they were injected by another person who had previously injected themselves.[52]

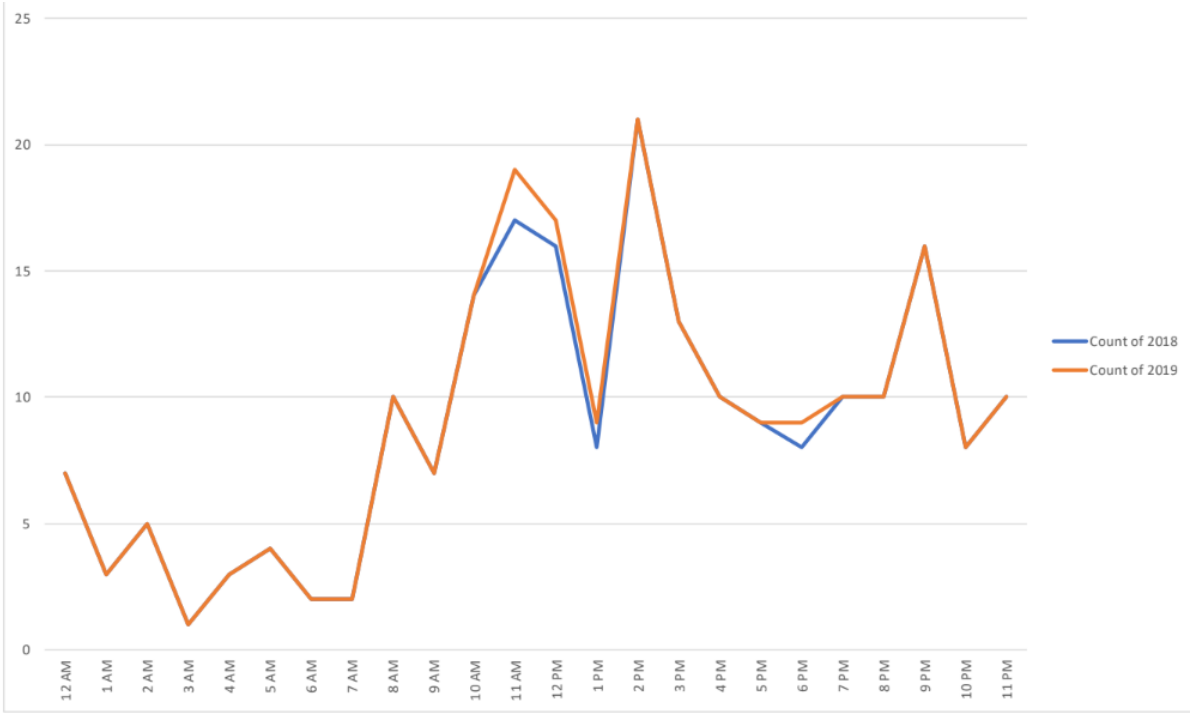
The 2020 Australian NSP survey 25-year National Data Report shows that reuse of someone else's needle and syringe in the last month was reported by 14% of participants, and reuse of equipment (spoons, water, filter, or drug mix) after someone else in the last month was reported by 49%, with both proportions consistent since 2010.[53]

Ambulance attendances and hospital separations

Data obtained from Ambulance ACT shows the number of calls in which paramedics indicate that a substance is involved in their secondary assessment, final diagnosis or case nature, or the patient received naloxone. These may include cases in which the reason for calling was unrelated to the opioid or heroin consumption. 'Other' drug-related cases refer to any drug (other than opioids/heroin or alcohol) including prescription medications. In 2019, paramedics responded to 643 'other' drug-related cases (150.4 per 100,000 people; 673 in 2018) and 219 heroin/opioid related cases (50.6 per 100,000 people; 214 in 2018).

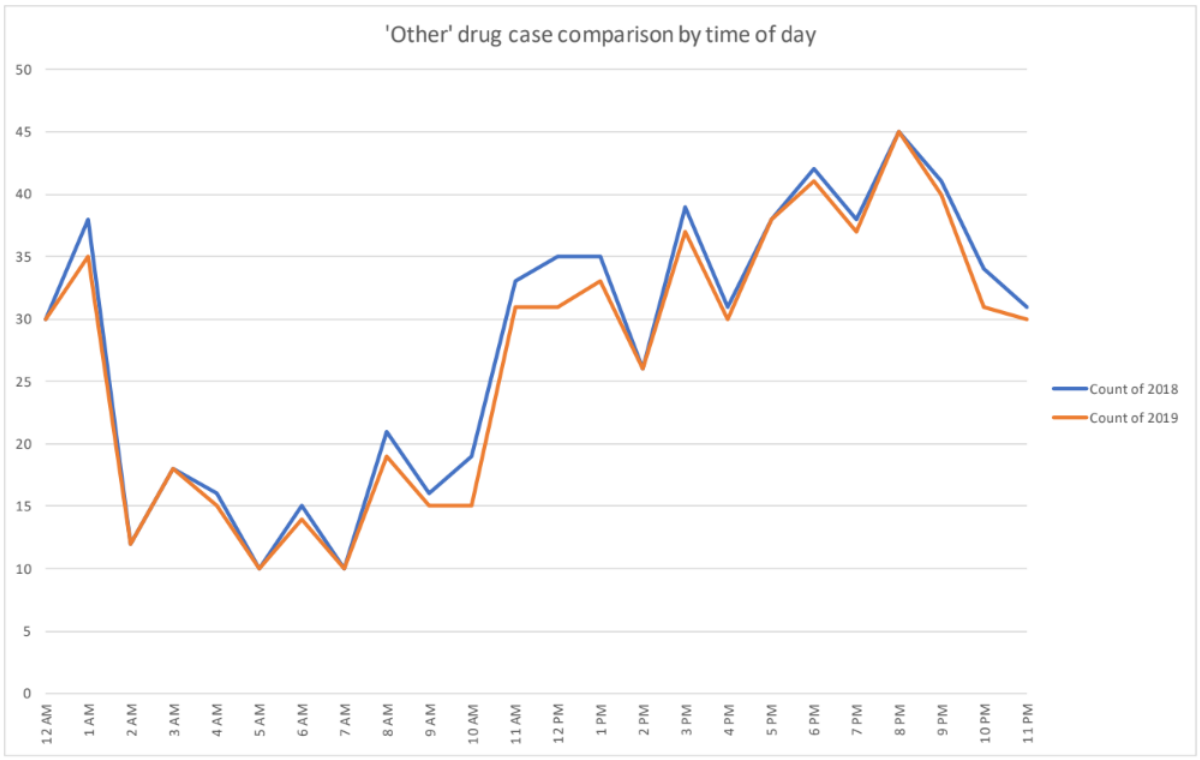
The most common time of day for opioid and heroin overdoses are between 10am-3pm and 8pm-10pm (Figure A8). For 'other drugs' there is an upwards trend starting from around 10am to a peak of callouts around 8pm (Figure A9). Regarding days of the week, opioid and heroin overdoses are stable throughout the week and decrease over the weekend (Figure A10). There is a slight variation with a higher number of 'other drugs' overdose responses occurring on Wednesdays and weekends (Figure A11).

Figure A8: Opioid and heroin related ambulance callouts by time of day



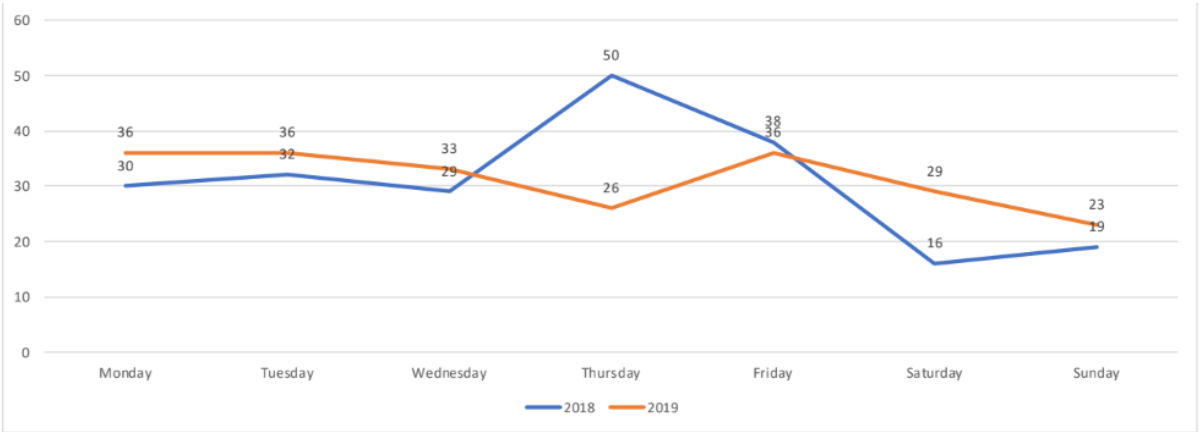
Source: Ambulance ACT, 2020, private communication

Figure A9: ‘Other’ drug related ambulance callouts by time of day



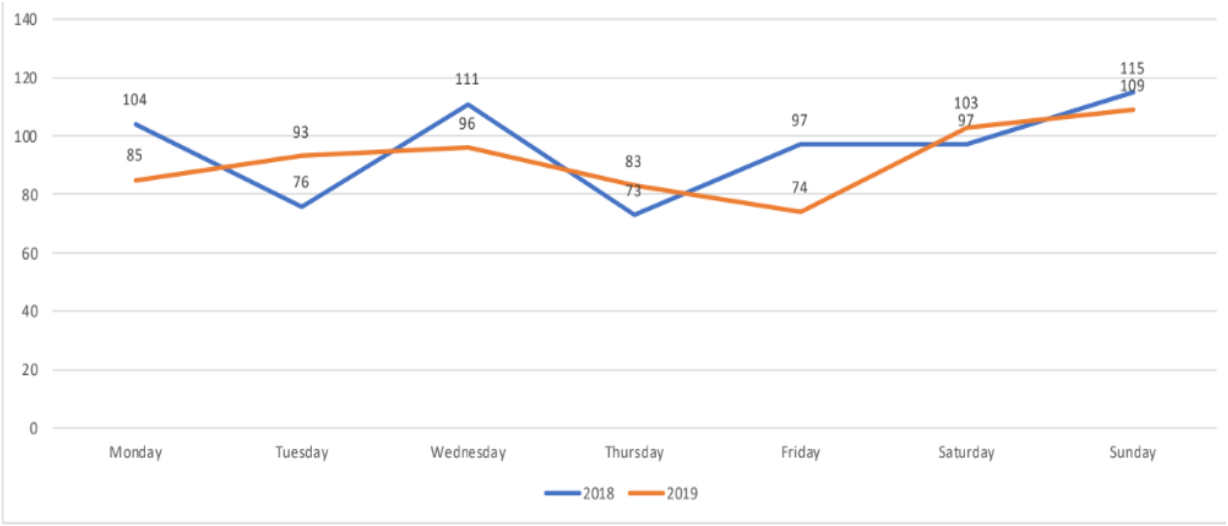
Source: Ambulance ACT, 2020, private communication

Figure A10: Opioid and heroin related ambulance callouts by day of week



Source: Ambulance ACT, 2020, private communication

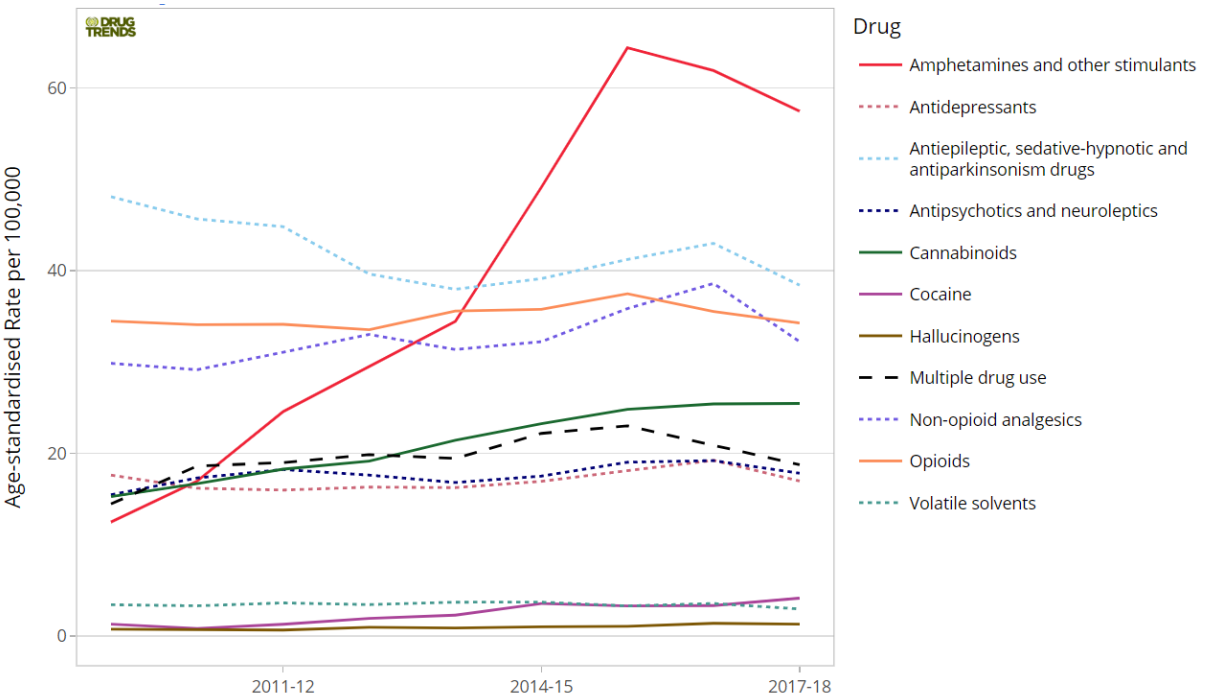
Figure A11: 'Other' drug related ambulance callouts by day of week



Source: Ambulance ACT, 2020, private communication

Analyses by NDARC found that 910 drug-related hospital separations occurred in 2017-18 in the ACT. This equates to 216 drug-related hospitalisations per 100,000 people - an increase from the rate of 121 per 100,000 people observed in 2010.[60] Most of these separations were attributed to the use of amphetamine-type substances, opioids, and prescription medications (Figure A12).

Figure A12: Drug-related hospitalisations by substance, ACT, 2010-2018



Source: National Drug and Alcohol Research Centre. *Drug-related Hospital Separations*. University of New South Wales, 2020.

Regarding emergency responses, a paper reporting on the National Ambulance Surveillance System, which found that out of 42,098 ambulance attendances in the ACT in the 2016-17 financial year, 1,130 were AOD-related (2.7%).[97]

Health service utilisation and coverage

Drug treatment

Consistent with previous years, half of the 2019 ACT IDRS sample reported that they were currently receiving treatment for substance use, mostly methadone maintenance (30%). Eight per cent reported receiving treatment for methamphetamine use.[52] Contrasting with data from our consumer survey, 17% of ACT IDRS participants in 2019 also thought they needed drug treatment, with 'small numbers' unsuccessfully trying to access treatment.[52] Nationally, 17% (n=156) of IDRS respondents had not accessed drug treatment in the past six months despite thinking they needed it, with 33% of these people reporting that they had tried to access treatment but were unable to.[56]

The National Alcohol and other Drug Treatment Minimum Dataset report showed that in 2018–19 ACT AOD services provided 6,700 treatment episodes to 4,026 clients. Most clients were male (61%) aged 20–29 (24%), 30–39 (29%), or 40–49 (23%). Alcohol was most frequently nominated as the drug for which people accessed treatment (43%), followed by amphetamines (23%), cannabis (13%) and heroin (11%). Drug treatment episodes overall have increased significantly in the ACT over the last decade, with the increase greatest for episodes for which amphetamines are nominated as the primary drug (Table A7). Types of primary treatment offered were information and education (29%), counselling (28%), support and case management (14%), assessment (14%), withdrawal management (8%), rehabilitation (6%) and pharmacotherapy (1%).[74] While these data reflect current capacity and usage, they do not reflect the need for AOD services in the ACT. The report is also incomplete in that Aboriginal and/or Torres Strait Islander services, government services, NSPs and the Canberra Sobering Up Shelter are not included (Sobering Up Shelter data were requested by authors of this report but were not available at time of report completion).

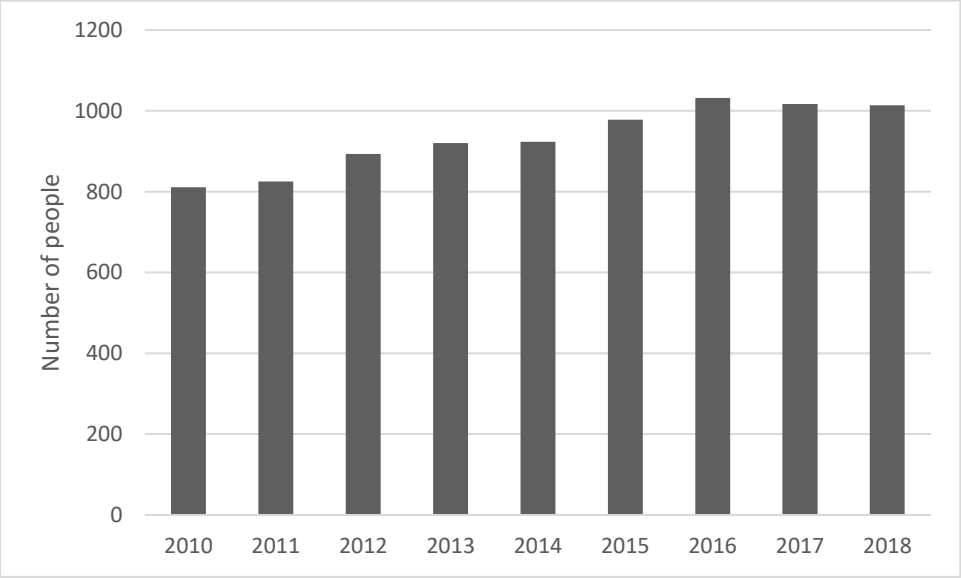
Table A7: Total closed treatment episodes, also by heroin and methamphetamine, ACT, 2009-19

Year	Total episodes (all substances)	Heroin	Methamphetamine
2009-10	3585	484	213
2010-11	3156	487	198
2011-12	4080	608	409
2012-13	4416	696	496
2013-14	4652	510	677
2014-15	5222	451	907
2015-16	5914	522	1392
2016-17	6389	502	1572
2017-18	6931	575	1626
2018-19	6700	689	1479

Source: Australian Institute of Health and Welfare. *Alcohol and Other Drug Treatment Services in Australia 2018-19. 2020*

Data from the 2019 National Opioid Pharmacotherapy Statistics Annual Data Collection report indicates that the number of people in the ACT receiving pharmacotherapy drug treatment increased from 811 in 2010 to 1,014 in 2018 (Figure A13). Among those being treated in 2018, 65% were male, 77% received methadone, 1% received buprenorphine and 22% received buprenorphine-naloxone. Pharmacotherapy was most often dispensed in the ACT through pharmacies (73%), public clinics (15%) and correctional facilities (12%).[67]

Figure A13: Clients receiving pharmacotherapy on a snapshot day, ACT, 2010-18



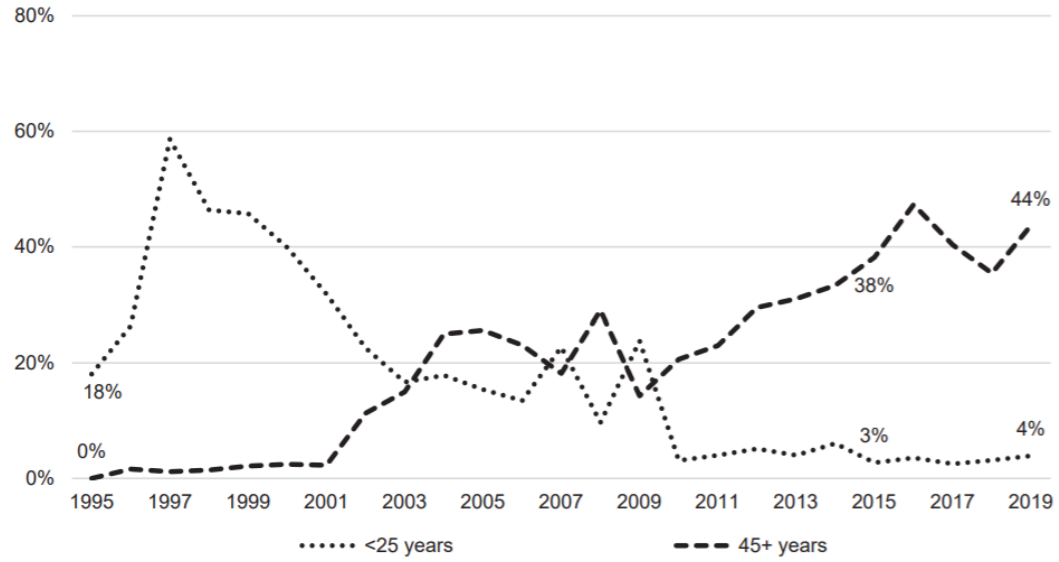
Source: Australian institute of Health and Welfare. *National Opioid Pharmacotherapy Statistics Annual Data collection 2019*. 2020

Needle and Syringe programs

Needle and syringe programs are easily accessible in the ACT. In 2019, there were two primary NSP services, nine secondary NSPs, 31 pharmacy NSP outlets and six syringe dispensing machines. The 2019 NSP National Minimum Data Collection Report states that in the ACT in 2018–19 824,076 syringes were distributed by non-government organisations (NGOs) and the public sector (93% of all distributions); the remaining were distributed by pharmacies.[53]

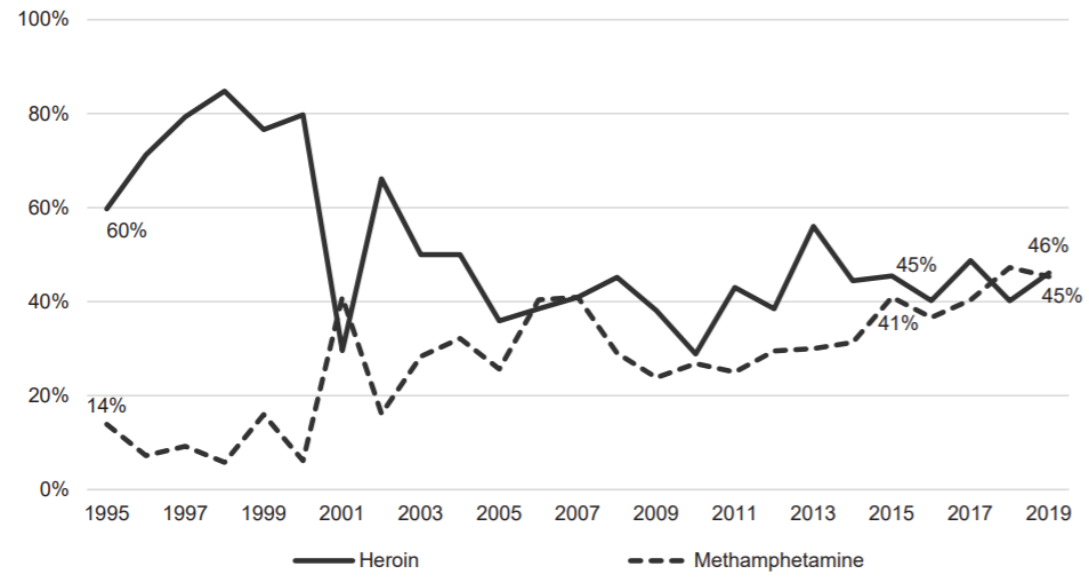
The Australian NSP survey: 25-year National Data Report 1995-2019 reported on data collected on a snapshot day in 2019 from 128 participants. The median age of service users was 42 (range 18-66), with the proportion of older service-users increasing over the years (Figure A14). The majority of respondents were male (67%) and 16% identified as Aboriginal and/or Torres Strait Islander or both. Regarding drugs most recently injected, 46% reported using heroin and 45% reported using methamphetamine; Figure A15 below shows a gradual increasing trend in the prevalence of these substances in the last decade.[53]

Figure A14: ACT proportion of younger and older NSP survey participants (%) by survey year



Source: Australian NSP survey: Prevalence of HIV, HCV and injecting and sexual behaviour among NSP attendees, 25-year National Data Report 1995-2019. 2020

Figure A15: ACT proportion of NSP survey participants (%) reporting last injecting heroin and methamphetamine



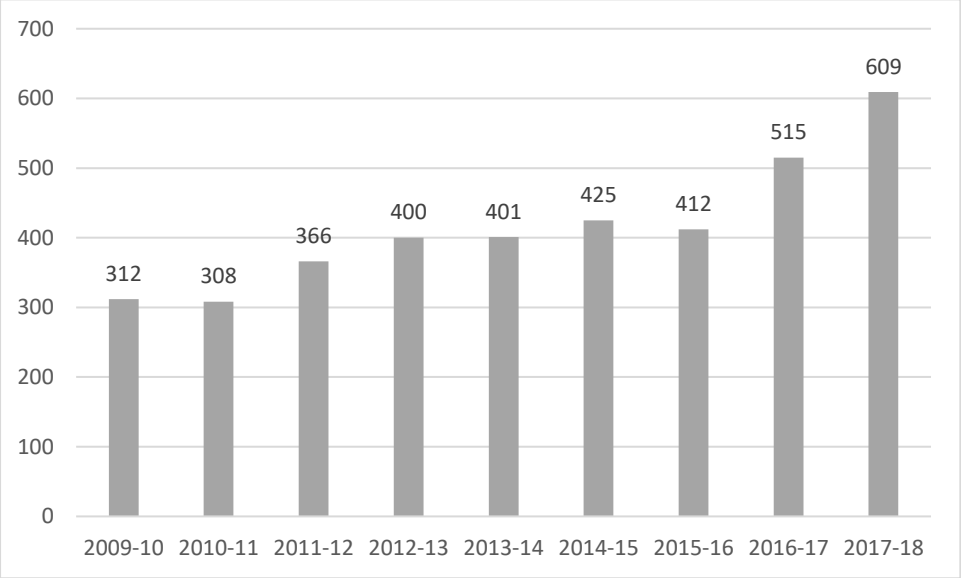
Source: Australian NSP survey: Prevalence of HIV, HCV and injecting and sexual behaviour among NSP attendees, 25-year National Data Report 1995-2019. 2020

Drug-related crime and law enforcement

Drug-related arrests

The Australian Crime Commission provides an annual report on drug-related arrests. The 2019 report found that during 2017-18 in the ACT, 609 drug 'consumers' and 88 drug 'providers' were arrested, a total of 697 offenders. Over the past decade, there has been an increase in consumer arrests in the ACT with 2018-19 figures being almost double the 312 'consumer' offences recorded in 2009-10 (Figure A16).[62]

Figure A16: Police proceedings against illicit drug consumers, ACT, 2009-18



Source: Australian Crime Intelligence Commission. *Illicit Drug Data Report 2017-18*. 2019

Prior to the Drugs of Dependence (Personal Cannabis Use) Amendment Act 2019, most drug-related offences in the ACT were related to cannabis and Simple Cannabis Offense Notices (SCON) (52%), followed by amphetamine-type stimulants (25%) and cocaine (14%) (Table A8)[63]. Most drug offences in the ACT involve possession or use of offences (82% in 2018-19) (Table A9).

Table A8: Drug arrests for consumers and providers, ACT, 2017-18

Drug	Consumers	Providers	Total
Amphetamines	157	31	188
Cannabis Arrests	295	43	338
Cannabis SCONS	52	0	52
Heroin	22	4	26
Cocaine	98	6	104
Hallucinogens	12	1	13
Steroids	4	0	4
Other Drugs	21	3	24
Total	661	88	749

Source: Australian Crime Intelligence Commission. *Illicit Drug Data Report 2017-18*. 2019.

Table A9: Drug offences by type, ACT, 2014-19

Offence type	2014-15	2015-16	2016-17	2017-18	2018-19
Possess and use drugs	550	541	638	784	507
Deal and supply drugs	69	90	71	109	68
Manufacturer drugs	41	21	18	16	15
Other drugs offences	25	30	23	44	32
Total drug offences	685	682	750	953	622

Source: Australian Federal Police. *ACT Policing Annual Report 2018-19*. 2019. Commonwealth of Australia. Canberra.

A 2017 study of 181 people who used methamphetamine found that around half (56%) had been involved in the prison system and 28% had been arrested in the past year (most often related to methamphetamine possession/supply, theft, assault, damage to property, or public order offences).[55]

People placed in custody owing to intoxication

In 2018-19, ACT police lodged 874 persons into protective custody at the ACT Watch House (utilised for intoxicated persons when no other options for care or protection are available) for antisocial behaviour relating to drug and alcohol intoxication.[63]

In 2019, one-third (32%) of IDRS participants reported that they had been arrested in the last year (30% in 2018; 22% in 2010) and 27% stated that they engaged in drug dealing (this figure has fluctuated between 2010-19 from 13-33%).[52]

Appendix 3: Interview Schedules

Consumer Survey Schedule

Section A

Administration

Interview Date

_____

Interviewer Initials

_____

Interviewer: We are going to start by asking you a few questions about yourself and your circumstances at the moment.

A1. What is your age?

A2a. What is your residential postcode?

Drop down/searchable list of postcodes

A2b. What suburb do you live in?

A3. What is your gender?

Female

Male

Transgender

Intersex

Agender/Gender non specific

Other

Don't Know

Refuse to answer

Not applicable

A3a. Specify 'other' gender

_____

A4. Which gender identity best describes you?

Male

Female

Non binary/gender fluid

Different gender identity (please specify)

Don't Know

Refuse to answer

Not applicable

A4a. Specify 'other' gender

_____

A5. What is your sexual orientation?

Heterosexual

Gay

Lesbian

Bisexual

Queer

Other

Don't Know

Refuse to answer

Not applicable

A5a. Specify 'other' sexual orientation

_____

A6. What is the highest level of education that you have completed?

None

Primary School

Year 7-9

Year 10-11

Year 12/Completed secondary school

Tertiary

Diploma/associate diploma/advanced diploma

Trade/technical qualification or TAFE qualification at certificate level

Other

Don't Know

Refuse to answer

Not applicable

A6a. Enter 'other' education?

_____

A7. How are you employed at the moment?

(Choose one)

Not employed

Full time

Part time/casual

Full time student

Home duties

Student/employed

Other

Don't know

Refuse to answer

Not applicable

A7a. Enter 'other' employment status

_____

A7b. Has your employment status changed as a result of COVID-19 restrictions or changes in COVID-19 restrictions?

No

Yes, lost my job

Yes, got a new job

Yes, other (specify)

Don't know

Refused to answer

Not applicable

A8. What was your main source of income in the last month?

(Choose one)

Wage or salary

Government pension/allowance or benefit

Criminal activity

Child support

Sex work

Parents

Other

Don't know

Refuse to answer

Not applicable

A8a. Enter 'other' main source of income

_____

A9. How much did you earn (money in the pocket) in total in the past fortnight? (Including Centrelink payments etc., wages, jobkeeper)

_____

(9997 = Don't know, 9998 = Refused, 9999 = Not applicable)

A11. Which of the following best represents your average weekly income during the past 6 months from all sources (before tax, including illicit)?

(Choose one)

$2500 +

$2,000-$2499

$1,600-$1,999

$1,300-$1,599

$1,000-$1,299

$800-$999

$600-$799

$400-$599

$250-$399

$150-$249

$1-$149

Nil income

Don't Know

Refused to answer

Not applicable

A12. Who do you currently live with?

(Choose one)

Spouse/partner

Alone with children

Spouse/partner and child/children

Parent(s)

Friend(s)

Other relative(s)

Housemate(s)

Alone

Other

Don't Know

Refuse to answer

Not Applicable

A12b. Enter "other" person live with

_____

A13. What type of accommodation do you currently live in?

(Choose one)

Owner occupied

Rental property (private)

Rental property (public)

Boarding (e.g. paying rent for accom with

family/friends)

Boarding house

Supported accommodation (crisis/medium term)

Squat

Homeless/street

Rent free (e.g. with family/friends)

Couch surfing

Community housing

Other

Don't Know

Refuse to answer

Not applicable

A13a. Enter 'other' type of accommodation

_____

A14. Is your current accommodation stable or unstable?

Stable

Unstable

Don't Know

Refuse to answer

Not applicable

A15a. Have you moved as a result of COVID-19 restrictions or changes in COVID-19 restrictions?

No

Yes, moved to be with family/partner

Yes, moved to be away from vulnerable house members

Yes, to self-isolate

Yes, couldn’t afford rent/repayments

Yes, other, please specify

A16. Are you of Aboriginal or Torres Strait Islander origin?

(Choose one)

No

Yes, Aboriginal

Yes, Torres Strait Islander

Yes, Aboriginal and Torres Strait Islander

Don't know

Refused to answer

Not applicable

Section B

B0. Have you injected any drug in the past six months?

No

Yes

Don't Know

Refuse to answer

If B0=1, Section B: Supervised Injecting Facility (for participants who have injected in past six months)

Interviewer: In this section of the survey, we are going to ask some specific questions about supervised injecting facilities and drug consumption rooms. First, we need to understand if you predominantly use drugs through injecting or other modes of administration (e.g. snorting), so that we can tailor our questions to your situation:

B1. Have you heard of medically supervised injecting rooms, like the ones in Melbourne and Sydney?

No

Yes

Don't Know

Refuse to answer

B2. Have you ever used a medically supervised injecting room?

No

Yes

Don't Know

Refuse to answer

B3. Where was that?

Sydney

Melbourne

Other

Don’t Know

Refuse to answer

B4. Why did you use it?

Being away from police

Concerned about overdose risk

Concerned about using alone

Need help and advice about injecting

Concerned about threat of violence/standover

Curious

Other

Don't know

Refused

Not applicable

B4a. Specify other reason

_____

If B2=No

B5. Do you think you would use a supervised injecting facility if one were available in the ACT?

No

Yes

Don't Know

Refuse to answer

If B5= yes

B6. Why do you think you would use it?

Being away from police

Concerned about overdose risk

Concerned about using alone

Need help and advice about injecting

Concerned about threat of violence/standover

Curious

Other

Don't know

Refused

Not applicable

B6a. Specify other reason

_____

If B5=No

B7. Why do you think you would not use it?

Already have a safe place to inject

Prefer to inject at home

Depends on where it would be located

Heard that you have to wait too long to inject

Need help injecting

Wouldn’t want to register to use site

Concerned about police near these sites

Prefer to keep drug use private

Prefer to inject alone

Don't want to inject with strangers

Poor treatment by health care professionals

They’re for heroin users only

Other

Don't know

Refused

B7.1 Already have a safe place to inject – Please provide details:

_____

B7.2 Prefer to inject at home - Please provide details:

_____

B7.3 Would depend on where it was located – Please provide details:

_____

B7.4 Heard that you have to wait too long to inject- Please provide details:

_____

B7.5 Need help injecting - Please provide details:

_____

B7.6 Wouldn’t want to register to use site – Please provide details:

_____

B7.7 Concerned about police near these sites- Please provide details:

_____

B7.8 Prefer to keep drug use private – Please provide details:

_____

B7.9 Prefer to inject alone - Please provide details:

_____

B7.10 Don't want to inject with strangers – Please provide details:

_____

B7.11 Poor treatment by health care professionals - Please provide details:

_____

B7.12 They're for heroin users only - Please provide details:

_____

B7.13 Specify other reason and detail

_____

If B6= yes

B8. How often do you think you would use it?

All injections (100%)

Most injections (more than 70%)

Half of my injections (50%)

Some of my injections (25% to 50%)

A few of my injections (less than 25%)

Hardly any of my injections (less than 10%)

Don't know

Refused

B9. Should the supervised injecting facility have access to facilities to allow people to inject only or would you like to see smoking/snorting or other types of drug use accommodated?

Injecting only

Injecting, smoking only

Injecting, smoking and snorting only

Other please specify_____

B9a Would you use the supervised injecting facility to?

Inject

Smoke (glass pipe or foil)

Snort

Other

B9b Would you like to use the supervised injecting facility

On your own

To share drugs with another (one) person (2 people share one lot of drugs)

To share drugs with a group of people (3 or more share 1 lot of drugs)

Other

B10. If a supervised injecting facility were established in the ACT, which area would be the best place to have it?

Civic

Belconnen

Gunghalin

Tuggeranong

Woden

Fyshwick

Weston Creek

Kingston, Manuka and inner south

Dickson, Watson, Mitchell and inner north

Queanbeyan

Mobile facility

Other

Multiple – if so list locations_____

B10a. Why do you think that the area/s you named would be best?

Close to my home

That's where many people pick up/access drugs

That's where most drug use occurs in the ACT

Other, specfy_____

B11. What information/education/advice do you think should be offered at a supervised injecting facility? (mark all that apply)

Injecting vein care advice

Advice on drug treatment

Drug and alcohol information

Drug checking/fentanyl testing results

Sexual health advice

BBV advice/ information

Other health education

Peer education

Advice on skin disorders

Advice on asthma/chest infection

Advice on accommodation

Advice on legal issues

Advice on finances

Quit smoking advice/information

Advice on tourniquet use

Information on safer injecting

Advice on injecting technique

No information provided

Don't know

Refused

B12. Do you think you would want to access other health or social services at a supervised injecting facility?

No

Yes

Don't Know

Refuse to answer

B12a. What additional health or social services do you think should be offered?

Drug checking/fentanyl testing service

Drug Tx - Detox program

Drug Tx - Buprenorphine treatment (implant or oral specify)

Drug Tx - Drug and alcohol counselling

Drug Tx - Methadone maintenance

Drug Tx - Residential rehabilitation

Drug Tx -Naltrexone maintenance (specify if oral or implant)

Drug Tx - Naloxone Training

Drug Tx – Counselling

Drug Tx – Case management

Drug Tx – Peer treatment support

Drug Tx – Needle and syringe program

Consumer Group

Volunteer Program/opportunities

Health Care - Medical consultation

Health Care - Health education

Health Care - BBV/STI Testing

Social Welfare - Social Welfare assistance

Social Welfare - Other counselling

Social Welfare - Legal advocacy

Social Welfare – Housing advocacy

Social Welfare – Child and Youth Protection Service (CYPS) support and advocacy

Don't know

Refused

B13. Are there any other things or services that you think should be offered at a supervised injecting facility?

No

Yes

Don't Know

Refuse to answer

_____

B13a. What sorts of things or services do you think should be offered?

NSP access

Drug checking/fentanyl testing service

Accessible Toilet

Client space with tea/coffee, internet, phone services, private space, chillout space

Private space for consulting with healthcare workers

Peer treatment support space and case management space

Nurse station for wound dressing etc.

Activities/training/education room (arts and crafts, safer injecting/OD prevention workshops, consumer participation groups)

Access to take home naloxone (THN)

Don't Know

Refuse to answer

_____

B14. What staff would you like to access in a supervised injecting centre? (Mark all that apply)

Medical – Doctors and nurses

Support staff – health education officers, case managers

Peer workers – peer treatment support workers, peer educators, people who are experts in injecting/using illicit drugs

Counselling staff

Other_____

Don't Know

Refuse to answer

B15 What time (hour) would you likely expect to use a supervised injecting facility?

Enter number: 24 hour clock _____

B16. What time (hour) do you think a supervised injecting facility should open?

Enter number: 24 hour clock _____

B17. What time (hour) do you think a supervised injecting facility should close?

Enter number: 24 hour clock _____

B18. Do you think a supervised injecting centre should be open on weekends?

No

Yes

Don't Know

Refuse to answer

_____

B19. How do you mostly get around at the moment?

Public transport

Own car

Friend's Car

Motorbike

Uber/taxi

Bicycle

Walk

Other

Don't know

Refused

B20a. Specify other

_____

B20b. Has this changed as a result of COVID-9 restrictions?

No

Yes

Don't Know

Refuse to answer

_____

If B20b= yes

B21. How did you usually get around before the COVID-19 restrictions?

Public transport

Own Car

Friend's car

Motorbike

Uber/taxi

Bicycle

Walk

Other

Don't know

Refused

B22. Final question: Is there anything else you would like to say about a potential medically supervised injecting facility?

(open ended)

If B0=0, Section B2: Drug Consumption Rooms (for participants who have not injected in past six months)

B1. Have you heard of drug consumption rooms, like the ones for injecting in Melbourne and Sydney?

No

Yes

Don't Know

Refuse to answer

B2. Have you ever used a drug consumption room?

No

Yes

Don't Know

Refuse to answer

B3. Where was that?

Sydney

Melbourne

Other

Don’t Know

Refuse to answer

B4. Why did you use it?

Being away from police

Concerned about overdose risk

Concerned about using alone

Need help and advice about drug use

Concerned about threat of violence/standover

Curious

Other

Don't know

Refused

Not applicable

B4a. Specify other reason

_____

If B2=No

B5. Do you think you would use a drug consumption room if one were available in the ACT?

No

Yes

Don't Know

Refuse to answer

If B5= yes

B6. Why do you think you would use it?

Being away from police

Concerned about overdose risk

Concerned about using alone

Need help and advice about drug use

Concerned about threat of violence/standover

Curious

Other

Don't know

Refused

Not applicable

B6a. Specify other reason

_____

If B5=No

B7. Why do you think you would not use it?

Already have a safe place to use drugs

Prefer to use drugs at home

Depends on where it would be located

Heard that you have to wait too long to use drugs

Wouldn’t want to register to use site

Concerned about police near these sites

Prefer to keep drug use private

Prefer to use drugs alone

Don't want to use drugs with strangers

Poor treatment by health care professionals

They’re for heroin users only

Other

Don't know

Refused

B7.1 Already have a safe place to use drugs – Please provide details:

_____

B7.2 Prefer to use drugs at home - Please provide details:

_____

B7.3 Would depend on where it was located – Please provide details:

_____

B7.4 Heard that you have to wait too long to use drugs- Please provide details:

_____

B7.5 Need help using drugs

_____

B7.6 Wouldn't want to register to use site – Please provide details:

_____

B7.7 Concerned about police near these sites- Please provide details:

_____

B7.8 Prefer to keep drug use private – Please provide details:

_____

B7.9 Prefer to use drugs alone - Please provide details:

_____

B7.10 Don't want to use drugs with strangers – Please provide details:

_____

B7.11 Poor treatment by health care professionals - Please provide details:

_____

B7.12 They're for heroin users only - Please provide details:

_____

B7.13 Specify other reason and detail

_____

If B6= yes

B8. How often do you think you would use it?

All use episodes (100%)

Most use episodes (more than 70%)

Half of my use episodes (50%)

Some of my use episodes (25% to 50%)

A few of my use episodes (less than 25%)

Hardly any of my use episodes (less than 10%)

Don't know

Refused

B9. Should the drug consumption room have access to facilities to allow people to inject only or would you like to see smoking/snorting or other types of drug use accommodated?

Injecting only

Injecting, smoking only

Injecting, smoking and snorting only

smoking and snorting only

smoking only

Other please specify_____

B9a Would you use the drug consumption room to?

Smoke (glass pipe or foil)

Snort

Other

B9b Would you like to use the drug consumption room?

On your own

To share drugs with another (one) person (2 people share one lot of drugs)

To share drugs with a group of people (3 or more share 1 lot of drugs)

Other

B10. If a drug consumption room were established in the ACT, which area would be the best place to have it?

Civic

Belconnen

Gunghalin

Tuggeranong

Woden

Fyshwick

Weston Creek

Kingston, Manuka and inner south

Dickson, Watson, Mitchell and inner north

Queanbeyan

Other

Multiple – if so list locations_____

B10a. Why do you think that the area/s you named would be best?

Close to my home

That's where most drug use occurs in the ACT

Other, specify_____

B11. What information/education/advice do you think should be offered at a drug consumption room? (mark all that apply)

Advice on drug treatment

Drug and alcohol information

Drug checking/fentanyl testing results

Sexual health advice

BBV advice/ information

Other health education

Peer education

Advice on skin disorders

Advice on asthma/chest infection

Advice on accommodation

Advice on legal issues

Advice on finances

Quit smoking advice/information

No information provided

Don't know

Refused

B12. Do you think you would want to access other health or social services at a drug consumption room?

No

Yes

Don't Know

Refuse to answer

B12a. What additional health or social services do you think should be offered?

Drug Tx - Detox program

Drug Tx - Buprenorphine treatment (implant or oral specify)

Drug Tx - Drug and alcohol counselling

Drug Tx - Methadone maintenance

Drug Tx - Residential rehabilitation

Drug Tx -Naltrexone maintenance (specify if oral or implant)

Drug Tx - Naloxone Training

Drug Tx – Counselling

Drug Tx – Case management

Drug Tx – Peer treatment support

Drug Tx – Needle and syringe program

Drug checking/fentanyl testing service

Consumer Group

Volunteer Program/opportunities

Health Care - Medical consultation

Health Care - Health education

Health Care - BBV/STI Testing

Social Welfare - Social Welfare assistance

Social Welfare - Other counselling

Social Welfare - Legal advocacy

Social Welfare – Housing advocacy

Social Welfare – Child and Youth Protection Service (CYPS) support and advocacy

Don't know

Refused

B13. Are there any other things or services that you think should be offered at a drug consumption room?

No

Yes

Don't Know

Refuse to answer

_____

B13a. What sorts of things or services do you think should be offered?

NSP access

Drug checking/fentanyl testing service

Accessible Toilet

Client space with tea/coffee, internet, phone services, private space, chillout space

Private space for consulting with healthcare workers

Peer treatment support space and case management space

Nurse station for wound dressing etc.

Activities/training/education room (arts and crafts, safer drug use/OD prevention workshops, consumer participation groups)

Don't Know

Refuse to answer

_____

B14. What staff would you like to access in a medically supervised injecting centre? (Mark all that apply)

Medical – Doctors and nurses

Support staff – health education officers, case managers

Peer workers – peer treatment support workers, peer educators, people who are experts in using illicit/using drugs

Counselling staff

Other_____

Don't Know

Refuse to answer

B15 What time (hour) would you likely expect to use a drug consumption room?

Enter number: 24 hour clock _____

B16. What time (hour) do you think a drug consumption room should open?

Enter number: 24 hour clock _____

B17. What time (hour) do you think a drug consumption room should close?

Enter number: 24 hour clock _____

B18. Do you think a drug consumption room should be open on weekends?

No

Yes

Don't Know

Refuse to answer

_____

B19. How do you get around at the moment?

Public transport

Own Car

Friend's car

Motorbike

Uber/taxi

Bicycle

Walk

Other

Don't know

Refused

B20a. Specify other

_____

B20b. Has this changed as a result of COVID-9 restrictions?

No

Yes

Don't Know

Refuse to answer

_____

If B20b= yes

B21. How did you usually get around before the COVID-19 restrictions?

Public transport

Own Car

Friend's car

Motorbike

Uber/taxi

Bicycle

Walk

Other

Don't know

Refused

Section C Drug Use

C1. What illicit or non-prescribed drugs have you used in the six months before the COVID-19 restrictions? (Note, this runs from October to March, mark all that apply)

Heroin

Speed/base/other methamphetamine

Ice/crystal meth/shard

Ecstasy

Pharmaceutical stimulants

Cocaine

Methadone

Morphine (MS Contin, Kapanol)

Buprenorphine (Subutex)

Suboxone

Benzodiazepines

Cannabis

Inhalants

Other

Don't know

Refused to answer

Not applicable

C1a. What is the name of this 'other' drug?

_____

If B0=1

C2. Which of these illicit or non-prescribed drugs did you inject in the six months before the COVID-19 restrictions? (Note, this runs from October to March, mark all that apply)

Heroin

Speed/base/other methamphetamine

Ice/crystal meth/shard

Ecstasy

Pharmaceutical stimulants

Cocaine

Methadone

Morphine (MS Contin, Kapanol)

Buprenorphine (Subutex)

Suboxone

Benzodiazepines

Cannabis

Inhalants

Other

Don't know

Refused to answer

Not applicable

C2a. What is the name of this 'other' drug?

_____

C3. What illicit or non-prescribed drugs have you used in the last month? (mark all that apply)

Heroin

Speed/base/other methamphetamine

Ice/crystal meth/shard

Ecstasy

Pharmaceutical stimulants

Cocaine

Methadone

Morphine (MS Contin, Kapanol)

Buprenorphine (Subutex)

Suboxone

Benzodiazepines

Cannabis

Inhalants

Other

Don't know

Refused to answer

Not applicable

C3a. What is the name of this 'other' drug?

_____

If B0=1

C4. Which of these illicit or non-prescribed drugs did you inject in the last month? (mark all that apply)

Heroin

Speed/base/other methamphetamine

Ice/crystal meth/shard

Ecstasy

Pharmaceutical stimulants

Cocaine

Methadone

Morphine (MS Contin, Kapanol)

Buprenorphine (Subutex)

Suboxone

Benzodiazepines

Cannabis

Inhalants

Other

Don't know

Refused to answer

Not applicable

C4a. What is the name of this 'other' drug?

_____

C5. What illicit or non-prescribed drug did you use most during the last month? (Select one response only)

Heroin

Speed/base/other methamphetamine

Ice/crystal meth/shard

Ecstasy

Pharmaceutical stimulants

Cocaine

Methadone

Morphine (MS Contin, Kapanol)

Buprenorphine (Subutex)

Suboxone

Benzodiazepines

Cannabis

Inhalants

Other

Don't know

Refused to answer

Not applicable

C5a. What is the name of this 'other' drug?

_____

C5b. Is this normally the drug you use most?

Yes

No

Don't know

Refused

Not applicable

If C5b=no

C5c. Was this unusual because of COVID-19 restrictions or changes in COVID-19 restrictions?

Yes

No

Don't know

Refused

Not applicable

If B0=1

C6. What illicit or non-prescribed drug did you inject most during the last month? (Select one response only)

Heroin

Speed/base/other methamphetamine

Ice/crystal meth/shard

Ecstasy

Pharmaceutical stimulants

Cocaine

Methadone

Morphine (MS Contin, Kapanol)

Buprenorphine (Subutex)

Suboxone

Benzodiazepines

Cannabis

Inhalants

Did not inject in the last month

Other

Don't know

Refused to answer

Not applicable

C6a. What is the name of this 'other' drug?

_____

C6b. Is this normally the drug you inject most?

Yes

No

Don't know

Refused

Not applicable

If C6b=no

C6c. Was this unusual because of COVID-19 restrictions or changes in COVID-19 restrictions?

Yes

No

Don't know

Refused

Not applicable

C7. Where did you inject most recently?

Home

Dealer's home

Other person's home

Street

Public toilet

Car

Stairwell

Disused building

Park

Supervised Injecting Facility (SIF)

Other

Don't know

Refused

Not applicable

C8. Where do you normally inject (>50% of the time)?

Home

Dealer's home

Other person's home

Street

Public toilet

Car

Stairwell

Disused building

Park

Other

Don't know

Refused

Not applicable

C9. What is your main illicit drug of choice? (i.e preferred or favourite drug) (Include illicit use of licit drugs)

Heroin

Methadone (non-prescribed)

Buprenorphine (non-prescribed)

Other opioids (morphine, oxycodone)

Methamphetamine (ice, speed)

Cocaine

Hallucinogens (LSD, peyote, mescaline, mushrooms)

Ecstasy

Benzodiazepines

Cannabis

Inhalants

Other

Suboxone (non-prescribed)

Don't know

Refused to answer

Not applicable

C9a. What is the name of this other drug?

_____

If B0=1

C10. Thinking about it overall, how many times did you inject any drug in the last month?

_____

(Injection episodes)

C11. Thinking about it overall, how many times did you inject any drug in the last week?

(Injection episodes)

_____

(9997 = Don't know, 9998 = Refused, 9999 = Not applicable)

C12. Is this normally the number of times you would inject in a month?

Yes

No

Don't know

Refused

Not applicable

If C12=no

C12a. Was this unusual because of COVID-19 restrictions or changes in COVID-19 restrictions?

Yes

No

Don't know

Refused

Not applicable

C13. When was the last time you borrowed a used needle and syringe from someone else?

(If participant answers "Never" please code as Not Applicable)

January

February

March

April

May

June

July

August

September

October

November

December

Don't know

Refused

Not applicable

Year

_____

C14. In the last month, where do you normally get your needles and syringes?

NSP

Walk-in centre (1mls)

Chemist/pharmacy

Partner/friends

Dealer

SVM

Stored supply (home/car/stash)

Mobile outreach NSP van

Other

Don't know

Refused to answer

Not applicable

C14a. Specify "other" place collected needles and syringes

_____

C15. How many times in the last two weeks did you get needles and syringes?

_____

(9997 = Don't know, 9998 = Refused, 9999 = Not applicable)

C16. In the last two weeks how many needles and syringes in total did you get?

_____

(9997 = Don't know, 9998 = Refused, 9999 = Not applicable)

C17. In the last two weeks how many needles and syringes did you give away or sell to others?

_____

(9997 = Don't know, 9998 = Refused, 9999 = Not applicable)

C18. In the last two weeks how many needles and syringes did you throw away unused (sterile needles still in wrapper)?

_____

(9997 = Don't know, 9998 = Refused, 9999 = Not applicable)

C19. At the moment how many needles and syringes do you have stored away (at home or in the car etc)?

_____

(9997 = Don't know, 9998 = Refused, 9999 = Not applicable)

C20. In the last month have you had trouble getting needles and syringes when you've needed them?

Yes

No

Don't know

Refused to answer

Not applicable

C20= yes

C20a. Was this a direct result of COVID-19 restrictions?

Yes

No

Don't know

Refused to answer

Not applicable

C21. Have you ever used a syringe vending machine (SVM)?

Yes

No

Don't know

Refused to answer

Not applicable

C22. When was the last time you used a SVM? (enter year)

_____

(9997 = Don't know, 9998 = Refused, 9999 = Not applicable)

C23. How many syringes did you obtain from the SVM the last time you used it?

_____

(9997 = Don't know, 9998 = Refused, 9999 = Not applicable)

C24. How much did it cost?

_____

(9997 = Don't know, 9998 = Refused, 9999 = Not applicable)

C25. How many syringes do you usually get from SVMs?

_____

(9997 = Don't know, 9998 = Refused, 9999 = Not applicable)

C26. About how many syringes did you get from SVMs in total over the past two weeks?

_____

C27. Have you ever used the after-hours NSP service? (walk-in centre)

Yes

No

Don't know

Refused to answer

Not applicable

C28. When was the last time? (enter year)

_____

(9997 = Don't know, 9998 = Refused, 9999 = Not applicable)

C29. How many syringes did you obtain from the after-hours service the last time you used it?

_____

(9997 = Don't know, 9998 = Refused, 9999 = Not applicable)

C30. How many syringes do you usually get from the after-hours service?

_____

(9997 = Don't know, 9998 = Refused, 9999 = Not applicable)

C31. About how many syringes did you get from the after-hours service in total over the past two weeks?

_____

(9997 = Don't know, 9998 = Refused, 9999 = Not applicable)

C32. How long ago was your last HCV test? (Enter number)

_____

(9997 = Don't know, 9998 = Refused, 9999 = Not applicable)

C33. Enter unit - days, weeks, months, years

days

weeks

months

years

Don't know

Refused to answer

Not applicable

C34 What was the result?

Positive (Ab positive/PCR positive)

Negative/naive (Ab negative/PCR negative)

Exposed/negative (Ab positive/PCR negative)

Didn't get the result

Don't know

Refused to answer

Not applicable

C35. Have you ever received HCV treatment?

On it now

Completed – cleared

Completed – didn’t clear

Never received

Don't know

Refused to answer

Not applicable

C36. How long ago was your last HIV test? (number)

_____

Enter unit

days

weeks

months

years

Don't know

Refused to answer

Not applicable

C37. What was the result?

Positive

Negative

Didn't get the result

Don't know

Refused to answer

Not applicable

C38. Have you ever been vaccinated for Hepatitis B?

Yes, completed the three courses

Yes, but have not completed the course (< 3 vaccinations)

No, not required (previous HBV exposure/immune)

No, never been vaccinated

Don't know

Refused to answer

Not applicable

C39. Have you been tested for SARS-COV-2, the virus in COVID-19?

No

Yes

Tried to get tested but not eligible

C40. When were you tested?

Day

Month

C41. What was the result?

Still waiting for result

Negative

Positive

If C41= positive

C42. How where you exposed?

Unknown

Recent overseas travel

Direct contact with infected person

Community transmission

C43. What were the consequences?

Mild, no significant symptoms

Significant symptoms managed in quarantine

Symptoms requiring hospital treatment (<=1 day)

Symptoms requiring hospital treatment (>1 day)

If C39=no or C41=negative

C44. What social isolation strategies have you engaged in because of COVID-19?

None

Avoided public transport

Avoided entertainment venues

Avoided large public gatherings

Avoided social gatherings

Working from home

Avoiding gym/group sport

Don’t know

Refuse to answer

C45. Have you been required to go into home isolation because of COVID-19?

No

Yes

C46. Why was this the case?

Awaiting test result

Believe that everyone has to

Recent overseas travel

Direct contact with infected person

Court-ordered

C47. How often do you have a (standard) drink containing alcohol in the past month?

Never

Once in the month

2-4 times a month

2-3 times per week

4 or more times per week

Don't Know

Refuse to answer

Not applicable

C47a. Has this changed since COVID-19 restrictions were implemented?

Yes

No

Don't know

Refused to answer

Not applicable

If yes…

C47b. How often would you usually have a drink containing alcohol?

Never

Monthly or less

2 to 4 times per month

2 to 3 times per week

4 or more times per week

Don't Know

Refuse to answer

Not applicable

C48. In the past month, how many (standard) drinks containing alcohol did you have on a typical day when you drink?

1 or 2

3 or 4

5 or 6

7,8 or 9

more than 9

Don't Know

Refuse to answer

Not applicable

C48a. Has this changed since COVID-19 restrictions were implemented?

Yes

No

Don't know

Refused to answer

Not applicable

If yes…

C48b. How many drinks containing alcohol would you usually have on a typical day when you are drinking?

1 or 2

3 or 4

5 or 6

7 to 9

10 or more

Don't Know

Refuse to answer

Not applicable

C49. How often did you have more than 6 (standard) drinks on one occasion in the past month.

Never

Once in the month

Once a week in the month

Every day or nearly every day

Don't know

Refuse to answer

Not applicable

C49a. Has this changed since COVID-19 restrictions were implemented?

Yes

No

Don't know

Refused to answer

Not applicable

If yes…

C49b. How often do you usually have six or more drinks on one occasion?

Never

Less than monthly

Monthly

Weekly

Daily or almost daily

Don't Know

Refuse to answer

Not applicable

C50. What is the highest number of (standard) drinks you had in one session in the past 12 months?

_____

(9997 = Don't know, 9998 = Refused, 9999 = Not applicable)

B51. On average, how many tobacco cigarettes did you smoke per day over the last month, not including use with cannabis? (If not daily smoker, enter this question as not applicable and move to reasons question)

_____

(9997 = Don't know, 9998 = Refused, 9999 = Not applicable)

C52. Enter reason not smoked per day

None smoked - former smoker

None smoked - never smoked

Smokes less than daily

Don't know

Refused to answer

Not applicable

C53. Have you vaped in the last six months?

Yes

No

Don't Know

Refuse to answer

Not applicable

C54. Did you vape using nicotine?

Yes

No

Don't know

Refused

Not applicable

C55. Did you vape using methamphetamine/ice?

Yes

No

Don't Know

Refuse to answer

Not applicable

C56. Did you vape using cannabis?

Yes

No

Don't know

Refused to answer

Not applicable

C57. Has your smoking changed as a direct result of COVID-19 restrictions or changes in COVID-19 restrictions?

Yes, I’m smoking more

Yes, I’m smoking less

No, it’s about the same

Don't Know

Refuse to answer

Not applicable

Section D Drug Purchasing

Read out: "This next section asks about the last purchase of illicit drugs you made."

D1. When did you most recently purchase illicit drugs for use/injecting?

This week

This month

More than a month ago

Not purchased in the last month (gift/exchange)

Don't Know

Refuse to answer

Not applicable

If D1 is ‘More than a month ago’ or ‘Not purchased’

D1a. Have you wanted to purchase drugs for use/injecting but were unable to in the past month??

Dealers said there was none available

Unable to get to where I needed to go to score

Scared of COVID-19 exposure

Other (and then specify)

D2. From where do you usually score drugs?

Street dealer

Dealer's home

Friend

Mobile dealer

Home delivery

Street drop off

Other

Don't Know

Refuse to answer

Not applicable

D2a. Enter 'other' location

_____

D3. From which suburb do you usually score drugs?

Civic

Belconnen

Gunghalin

Tuggeranong

Woden

Fyshwick

Weston Creek

Other_____

Specific Suburbs mentioned_____

_____

Section E: Drug Treatment

Read out: "I would now like to ask you about your use of drug treatment and other services. Please remember that all of your answers are confidential and will not affect your relationships with any services that you may be involved with."

E1. Have you ever received treatment for your drug use?

Yes

No

Don't know

Refused to answer

Not applicable

If E1= yes

E2. What types of treatment have you received for your drug use?

Methadone

Suboxone

Subutex

Sublocade

Detox/withdrawal

Residential rehab

Drug counselling

Self-help groups

Don't know

Refused to answer

Not applicable

E3. What types of treatment have you received for your drug use in the past six months?

Methadone

Suboxone

Subutex

Sublocade

Detox/withdrawal

Residential rehab

Drug counselling

Self-help groups

Don't know

Refused to answer

Not applicable

E4. What types of treatment are you currently receiving?

Methadone

Suboxone

Subutex

Sublocade

Detox/withdrawal

Residential rehab

Drug counselling

Self-help groups

Don't know

Refused to answer

Not applicable

E5. What was your primary drug of concern which led to you seeking treatment?

Heroin

Speed/base/other methamphetamine

Ice/crystal meth/shard

Ecstasy/MDMA/MDA

Pharmaceutical stimulants

Cocaine

Oxycodone (Oxycontin, Endone, Proladone)

Methadone

Morphine (Kapanol, MS Contin)

Burprenorphine (Subutex)

Suboxone

Benzodiazepines

Cannabis

Inhalants

Alcohol

Other

Don't know

Refused to answer

Not applicable

E5a. Enter 'other' drug

_____

E6. Have you tried to access treatment in the last six months but you were unable to?

Yes

No

Don't know

Refused to answer

Not applicable

E6a. What was the problem? (mark all that apply)

Waiting list/lack of beds

Don't know of any programs/how to access programs

Turned down/away by program

No treatment program nearby

Don't have the type of program I want/need

Can't afford the fees/costs

Behaviour/mental health problems

Failed too many times

OST dosage requirements (low dose/no heroin)

Lack of child friendly services

Tobacco smoking policies

No resources to call in daily/weekly

Drug of concern not treated

Service closed because of COVID-19

Other

Don't know

Refused to answer

Not applicable

E6b. Enter 'other' reason

_____

E7. Are you currently trying to get into any form of drug treatment? (including OST)

Yes

No

Don't know

Refused to answer

Not applicable

Section F: other health/social services

F1. In the last six months, have you seen a general practitioner for reasons other than OST?

Yes

No

Don't know

Refused to answer

Not applicable

F2. How regularly do you attend a GP for other reasons?

_____

F2a. Enter unit

Times per week

Times per month

Times per year

Don't know

Refused to answer

Not applicable

F3. For what other reason did you last present to a GP?

Violence related

Drug related

HCV-related/liver

Mental health

Accident

Obs.gynae (women)

Physical illness/injury

Other

Don't know

Refused to answer

Not applicable

F3a. Enter 'other' reason

_____

F4. In the last six months, have you visited a specialist doctor? (As referred by a GP, don't include psychiatrists)

Yes

No

Don't know

Refused to answer

Not applicable

F5. In the last 4 weeks, how many times have you visited a specialist doctor?

(Don't include psychiatrists/psychologists)

_____

(9997 = Don't know, 9998 = Refused, 9999 = Not applicable)

F6. For what reason was your last referral to a specialist doctor?

Drug related

Violence related

HCV related/liver

Mental Health

Accident

Obs/gynae (women)

Other

Don't know

Refused to answer

Not applicable

F6a. Enter 'other' reason

_____

Section D: Dentist Visits

F7. In the last six months, have you seen a dentist?

Yes

No

Don't know

Refused to answer

Not applicable

F8. How regularly do you see a dentist?

_____

(9997 = Don't know, 9998 = Refused, 9999 = Not applicable)

F8a. Enter unit

Times per week

Times per month

Times per year

Don't know

Refused to answer

Not applicable

F9. For what reason did you last present at a dentist?

Check-up/scale and clean

Relief of pain

Filling/s

Extraction

Other procedure (root canal etc)

Don't know

Refuse to answer

Not applicable

F10.In the last six months, have you visited other allied health professionals such as a chiropractor, nurse, physiotherapist or naturopath about a physical health problem?

Yes

No

Don't know

Refused to answer

Not applicable

F11. How regularly do you attend allied health professionals?

_____

F11a. Enter unit

Times per week

Times per month

Times per year

Don't know

Refused to answer

Not applicable

F12. For what reason did you last visit an allied health professional?

Violence related

Drug related

HCV related/liver

Mental health

Accident

Obs/gynae (women)

Other

Don't know

Refused to answer

Not applicable

F12a. Enter 'other' reason

_____

F13. In the last six months, have you visited a mental health professional like a psychiatrist, psychologist or GP for a mental health issue or problem (other than drug use)?

No

Psychiatrist

Psychologist

GP

Don't know

Refused to answer

Not applicable

F14. How regularly do you attend a mental health professional?

_____

(9997 = Don't know, 9998 = Refused, 9999 = Not applicable)

F14a. Enter unit

Times per week

Times per month

Times per year

Don't know

Refused to answer

Not applicable

F15. For what mental health conditions did you last present to a mental health professional?

No diagnosed mental health conditions

Depression

Anxiety (generalised, social)

Bipolar disorder (manic depression)

Mania

Panic attack/disorder

Post-Traumatic Stress Disorder (PTSD)

Any personality disorder (even borderline)

Schizophrenia

Other psychosis

Drug induced psychosis

Phobias

Other mental health conditions not listed

Don't know

Refused to answer

F15a. Enter 'other' mental health condition (Separate with underscore if more than one)

_____

F16. In the last six months, have you visited a social/welfare worker?

Yes

No

Don't know

Refused to answer

Not applicable

F17. How regularly do you attend a social/welfare worker?

_____

(9997 = Don't know, 9998 = Refused, 9999 = Not applicable)

F17a. Enter unit

Times per week

Times per month

Times per year

Don't know

Refused to answer

Not applicable

F18. For what reason did you last attend a social/welfare worker?

Violence related

Drug related

Housing/shelter

Mental health

Legal

Financial

Other

Don't know

Refused to answer

Not applicable

F18a. Enter 'other' reason

_____

F19. In the last six months, have you visited a parole, probation or community corrections officer?

Yes

No

Don't know

Refused to answer

Not applicable

F20. How regularly do you attend a parole, probation or corrections officer?

_____

F20a. Enter unit Times per week

Times per month

Times per year

Don't know

Refused to answer

Not applicable

F21. In the last six months, have you seen someone about employment opportunities or programs, training or education? (e.g. Centrelink, personal support program provider, job network provider)

Yes

No

Don't know

Refused to answer

Not applicable

F22. How regularly do you attend for employment, training or education programs?

_____

(9997 = Don't know, 9998 = Refused, 9999 = Not applicable)

F22a. Enter unit

Times per week

Times per month

Times per year

Don't know

Refused to answer

Not applicable

F23. In the last six months, have you seen someone regarding unemployment benefits, welfare, social security, housing or other income?

Yes

No

Don't know

Refused to answer

Not applicable

F24. How regularly do you attend for unemployment benefits, welfare, social security, housing or other income?

_____

(9997 = Don't know, 9998 = Refused, 9999 = Not applicable)

F24a. Enter unit

Times per week

Times per month

Times per year

Don't know

Refused to answer

Not applicable

Section G: Drug Overdose

G1. In the last six months, how many times have you had an accidental heroin overdose? (N/A if not applicable)

_____

G2. How many times have you had naloxone (Narcan?) administered to you for a heroin overdose in the last six months? (N/A if not applicable)

_____

G3. Who administered the naloxone (Narcan?) (Multiple responses allowed for multiple overdoses since we last saw them)

Ambulance paramedic

Doctor

ED ward staff

Spouse/partner

Other relative

Friend

Housemate

Peer trained in THN

Other

Don't know

Refused to answer

Not applicable

G3a. Specify 'other'

_____

G4. Where did your last heroin overdose occur?

Home

Dealer's home

Other person's home

Street

Public toilet

Car

Stairwell

Disused building

Park

Other

Don't know

Refused to answer

Not applicable

G4a. Specify 'other' overdose location

_____

G5. What type of care did you receive?

None - managed on own

Friends helped me out

Ambulance called

Ambulance called and naloxone

Ambulance called and taken to hospital

Taken straight to hospital

Taken to medical service (NSP, doctor’s surgery)

Taken to medical service (NSP, doctor’s surgery) and ambulance called

Taken to medical service (NSP, doctor’s surgery)

ambulance called and hospital

Other

Peer trained in THN

Don't know

Refused to answer

Not applicable

G5aa. Specify "other" type of care received

_____

G6. In the last six months, how many times have you had an accidental overdose of other opioids?

_____

(9997 = Don't know, 9998 = Refused, 9999 = Not applicable)

G7 How many times have you had naloxone (Narcan?) administered to you for overdose of other opioids in the last six months?

_____

(9997 = Don't know, 9998 = Refused, 9999 = Not applicable)

G7a. Who administered the naloxone (Narcan?) (Multiple responses allowed for multiple overdoses since we saw them last)

Ambulance paramedic

Doctor

ED ward staff

Spouse/partner

Other relative

Friend

Housemate

Peer trained in THN

Other

Don't know

Refused to answer

G7b. Specify 'other'

_____

G87. Where did your last opioid overdose occur?

Home

Dealer's home

Other person's home

Street

Public toilet

Car

Stairwell

Disused building

Park

Other

Don't know

Refused to answer

Not applicable

G8a. Enter 'other' opioid overdose location

_____

G9. What type of care did you receive?

None - managed on own

Friends helped me out

Ambulance called

Ambulance called and naloxone

Ambulance called and taken to hospital

Taken straight to hospital

Taken to medical service (NSP, doctor’s surgery)

Taken to medical service (NSP, doctor’s surgery) and ambulance called

Taken to medical service (NSP, doctor’s surgery)

Other

Peer trained in THN

Don't know

Refused to answer

G9a. Specify "other" type of care received

_____

G10. Have you heard about take home naloxone?

Yes

No

Don't know

Refused to answer

Not applicable

G11. Have you been trained in how to administer naloxone?

Yes

No

Don't know

Refused to answer

Not applicable

G11a. When was your most recent training?

_____

(enter year 9997 = Don't know, 9998 = Refused, 9999 = Not applicable)

G11b. Who provided the training?

CAHMA overdose worker

Directions Health overdose worker

Other peer worker

GP

Pharmacist

AOD/Outreach worker

Other

Don't know

Refused to answer

Not applicable

G11c. Specify 'other' person

_____

G12. Do you always carry naloxone with you?

Yes

No

Don't know

Refused to answer

Not applicable

G13. Have you resuscitated someone using naloxone?

Yes

No

Don't know

Refused to answer

Not applicable

G14. In the last six months, how many times have you had an accidental overdose of methamphetamine (methamphetamine toxicity)?

_____

(9997 = Don't know, 9998 = Refused, 9999 = Not applicable)

G15. How many times since we saw you last have you experienced an overdose of methamphetamine that required an ambulance to attend?

_____

(9997 = Don't know, 9998 = Refused, 9999 = Not applicable)

G16. Where did your last methamphetamine overdose occur?

Home

Dealer's home

Other person's home

Street

Public toilet

Car

Stairwell

Disused building

Park

Other

MSIF

Don't know

Refused to answer

Not applicable

G16a. Enter 'other' methamphetamine overdose location

G17. Have you or someone else ever tested the content and/or purity of your illicit drugs?

No

Yes

Don’t know

Refuse to answer

G17a. How have you or someone else tested your illicit drugs?

Personal testing kit (e.g. colorimetric or reagent test)

Face-to-face testing service (e.g., festival pill-testing service, fixed-site service in central location)

Postal/online testing service (e.g., Energy Control, Ecstasy Data)

Testing strips (e.g. BTNX fentanyl strips or other immunoassay testing strips)

Other (specify)

Don’t know

Refuse to answer

_____

Section H: Support networks

H1. Who do you currently rely on for support/friendship? (Check all that apply)

Partners/ex-partners, spouse, lovers

Family members/relatives

Friends/neighbours

Co-workers/classmates

Health care workers

Counsellor/therapists

Medical doctor

Ministers/priests/other religious figures

Other

No one

Don't know

Refused to answer

Not applicable

H1a. Enter 'other' current social support

_____

H2. If participant nominates more than 1. "Of these, who is the most reliable, who you can turn to in a crisis or if things get really difficult for you?" If participant nominates only 1. "Is this person someone you can go to in a crisis? (Tick the same response option)

Partners/ex-partners, spouse, lovers

Family members/relatives

Friends/neighbours

Co-workers/classmates

Health care workers

Counsellor/therapists

Medical doctor

Ministers/priests/other religious

Other

No one

Don't know

Refused to answer

Not applicable

H3. Are your social supports available when you need them?

Never

Some of the time

Most of the time

All of the time

I don't seek support

Don't know

Refused to answer

Not applicable

H4. If Aboriginal or Torres Strait Islander, do you currently have contact with your community of origin?

Yes

No

Don't know

Refused to answer

Not applicable

H4a. If Aboriginal or Torres Strait Islander, do you wish to have contact with your community of origin?

Yes

No

Don't know

Refused to answer

Not applicable

H4b. If Aboriginal or Torres Strait Islander, were you or your parents a member of the stolen generation?

Yes

No

Don't know

Refused to answer

Not applicable

H4c. Do you currently have contact with your family?

Yes

No

Don't know

Refused to answer

Not applicable

H4d. Do you wish to have contact with your family?

Yes

No

Don't know

Refused to answer

Not applicable

H5. Overall, how would you rate your health during the past 4 weeks?

Excellent

Very good

Good

Fair

Poor

Very poor

Don't know

Refused to answer

Not applicable

H6. Have you had enough money to buy food in the past 4 weeks?

Yes

No

Don't know

Refused to answer

Not applicable

H7. Do you have any of the following diagnosed conditions?

No health conditions

Diabetes

Stroke

Acquired Brain Injury

Cardiovascular disease

Endocarditis

Asthma

STI's

Sleeping difficulties

Epilepsy

Other

Don't know

Refused to answer

Not applicable

(Check all that apply)

H7a. Please specify "other" condition

_____

H8. What is your weight?

_____

H8a. Enter weight unit

Kilograms

Stone

Pounds

Don't know

Refused to answer

Not applicable

H9. What is your height?

_____

H9a. Enter height unit

Centimetres

Metres

Feet

inches

Don't know

Refused to answer

Not applicable

Section I: Criminal Activity - Arrest

I1: Have you been arrested in the last six months?

Yes

No

Don't know

Refused to answer

Not applicable

I2: What have you been arrested for?

Use/possession

Dealing/trafficking

Property crime

Fraud

Violent crime

Alcohol and driving

Other drugs and driving

Other driving offence

Prostitution

Breaking COVID-19 restrictions

Other

Don't know

Refused to answer

Not applicable

I2a: Enter "other" arrested for.

_____

I3: Have you been attacked, assaulted (including sexual assault) or suffered any kind of violence in the past six months?

Yes

No

Interviewer didn't ask

Don't know

Refused to answer

Not applicable

I4: Did you seek medical attention (health care) after any of these attacks?

No

Some of the time

Most of the time

All of the time

Interviewer didn't ask

Don't know

Refused to answer

Not applicable

I5: Where did you go? (Check all that apply)

GP

IDU primary health centre

Emergency department

Other

Interviewer didn't ask

Don't know

Refused to answer

Not applicable

I6: Enter "other" place/person sought help

_____

I7: Did you seek counselling or other support?

No

Some of the time

Most of the time

All of the time

Interviewer didn't ask

Don't know

Refused to answer

Not applicable

I8: Has a drug debt put you at risk of physical violence?

Yes

No

Interviewer didn't ask

Not applicable (no drug debt)

Don't know

Refused to answer

I9: How many times have you been incarcerated in prison, on remand, in police cells or in a juvenile justice centre?

_____

Don't know

Refused to answer

Not applicable

I10: How many times have you been incarcerated in prison, on remand, in police cells or in a juvenile justice centre in the past six months?

_____

Don't know

Refused to answer

Not applicable

I11. Have you been released from custody because courts have been unable to process cases because of the COVID-19 pandemic?

No

Yes

Don't Know

Refuse to Answer

Not Applicable

K1. Final question: Is there anything else you would like to say about a potential drug consumption room?

(open ended)

End Interview

READ: That's the end of the interview. Thanks very much for your time.

NSP Snapshot Survey Schedules

Snapshot 1

1. What kind of housing are you in? (Single response)

    0. Owner occupied
    1. Public/community housing
    2. Private rental
    3. Boarding house
    4. No fixed address (inc. squat)
    5. Family member's home
    6. Other, please specify
    7. Don't know
    8. Refused to answer
    9. Not applicable
    10. Interviewer didn't ask

2. If a SIF/DCR was available in the ACT, would you use it? (Single response)

    0. No
    1. Yes
    2. Maybe
    3. Don't know
    4. Refused to answer
    5. Interviewer didn't ask

2a. If 'yes' to "2. If a SIF/DCR was available in ACT, would you use it?", why would you be interested in using it? (Multiple response)

    0. To use away from police
    1. Concerned about overdose risk
    2. Concerned about using alone
    3. Need support and advice to inject
    4. Concerned about violence/standover
    5. Curious what it would be like
    6. Social reasons
    7. Other, please specify
    8. Don't know
    9. Refused to answer
    10. Not applicable
    11. Interviewer didn't ask

2b. If 'no' to "2. If a SIF/DCR was available in Canberra, would you use it?", why don't you think you would use it? (Multiple response)

    0. Already have a safe space to consume drugs
    1. Prefer to consume drugs at home

2. Too far from where I score drugs
3. Too far from where I live
4. Have to wait too long to inject
5. Unsure if they'd let someone else inject me
6. Concerned about being seen using it
7. Wouldn't want to register to use it
8. Worried about police staking it out
9. Prefer to keep drug use private
10. Prefer to use drugs alone
11. Don't want to use drugs with strangers
12. Poor treatment by health professionals
13. Other, please specify
14. Don't know
15. Refused to answer
16. Not applicable
17. Interviewer didn't ask

Snapshot 2

1. The last time you used drugs, where did you use them?
    0. Home
    1. Dealer's home
    2. Other person's home
    3. Street
    4. Public toilet
    5. Car
    6. Stairwell
    7. Disused building
    8. Park
    9. Supervised drug consumption room
    10. Other, please specify _____
    11. Don't know
    12. Refused to answer
    13. Not applicable
    14. Interviewer didn't ask

2. What harm reduction services would you like to see introduced in the ACT? (one response)

    0. Safer smoking kits available in NSPs
    1. Supervised injecting room
    2. Drug consumption room
    3. After Hours mobile NSP services
    4. Subsidised opioid substitution therapy
    5. Increased access to harm reduction education
    6. Expanded access to take home naloxone
    7. Don't know

8. Refused to answer
9. Not applicable
10. Interviewer didn't ask

3. If a SIF/DCR was established in the ACT, what services would you like to see it offer? (3 responses)

0. Take-home naloxone training and provision
1. Safe drug use education
2. Advice and support to access drug treatment (e.g. OST, counselling)
3. Sexual health advice and testing
4. Mental health support and treatment
5. BBV testing and treatment
6. Primary care
7. Onsite drug counselling
8. Onsite social welfare support
9. Onsite legal services
10. Medication provision (inc., but not limited to, OST).
11. Don't know
12. Refused to answer
13. Not applicable
14. Interviewer didn't ask

Qualitative Stakeholder Interview Schedules

ACT Stakeholders

1. Could you please describe your role in the alcohol and other drug sector in the ACT?
2. What is your understanding of current patterns of injecting and other drug use in the ACT?
    - *Prompts: Are there any specific areas where drug use is public/visible? How does this relate to risks for drug related harms such as overdose? How does this relate to public and other amenity?*
3. In your opinion, what are the key drivers of drug overdose in the ACT?

    Prompts: Inadequate services, drug use issues
4. What are the current demands on service systems related to drug use in the ACT?
    - *Prompts: Funding, waiting lists*
5. What is the system like to navigate?
    - *Prompts: Do consumers know about available services? Do stakeholders know how to contact different services?*
6. Are there any obvious service gaps or needs?
    - *Prompts: Are linkages between services operating effectively? Do consumers fall through the gaps? Is there unmet need for treatment/harm reduction/other social services?*
7. What is your understanding of what a drug consumption room is?
    - *Prompts: Describe different models: fixed versus mobile versus pop-up. Heavily medicalised versus low threshold, service range*
8. With your knowledge of the ACT drug consumption scene, what do you think the interest would be among drug consumers for a drug consumption room? What do you think the interest would be among service providers?
9. Which model of drug consumption rooms would make most sense for the ACT?
    - *Prompts: What types of behaviours should be supervised? Injecting only? Smoking drugs?*
10. Are there any particular times of day/night during which a drug consumption room would need to operate?
11. Is there any particular location in which a drug consumption room would need to be located?
    - *Prompts: Is there an area that can best accommodate a balance between amenity for residents and convenience for consumers?*
12. Running drug consumption rooms can be expensive. In a finite budget what costs do you believe are reasonable for a drug consumption room?

13. Who should run any proposed drug consumption room?
    - *Prompts: What level of medical oversight is required? What role should there be for consumers?*
14. What services should be offered within any drug consumption room?
    - *Prompts: Harm reduction information and education? Overdose response? Primary care (including comorbidities)? Withdrawal? Pharmacotherapy and other treatment? Mental health services? Social (e.g. showers/laundry)? Please justify/explain*
15. Are there any particular consumers you think should be excluded from a drug consumption room?
16. Is there anything else that you think we should discuss to shed light on the potential of establishing a drug consumption room the ACT?

Interstate & International DCR Stakeholders

1. Could you please describe your role in relation to drug consumption rooms?
2. What was the process by which drug consumption rooms came to be established in your jurisdiction?
    - *Prompts: Were there any specific areas where drug use is public/visible? Was there a crisis in relation to drug overdose or other drug related harms? Who were the key actors involved in the establishment of the facility/ies?*
3. What are the regulations that govern the operation of the service/s?
    - *Prompts: Is the facility run purely by the health sector? Are there other governance arrangements?*
4. What are the governance mechanisms under which the drug consumption room/s currently operate?
5. Who are the clients of the service?
    - *Prompts: Are key populations unreached by the service?*
6. What services are offered in the drug consumption room/s in your jurisdiction?
    - *Prompts: Harm reduction information and education? Overdose response? Primary care (including comorbidities)? Withdrawal? Pharmacotherapy and other treatment? Mental health services? Social (e.g. showers/laundry)?*
7. Are there any major identified gaps/needs in the services you provide?
8. What burdens are there for clients of the service? Are there specific exclusions?
    - *Prompts: How much information is collected from clients? Is registration required? Why?*
9. What are the operating hours of the service?
    - *Prompts: How were they determined? Have the evolved over time?*
10. Where is the service/s located? How was this/these location/s chosen?
    - *Prompts: Is there an area that can best accommodate a balance between amenity for residents and convenience for consumers?*
11. What is the approximate budget for the service/s?
    - *Prompts: How is that budget allocated? Who pays for the service?*
12. What is the staffing profile of the service? What are the payment mechanisms?
    - *Prompts: Are all costs borne by the local jurisdiction?*
13. What is the single best feature of the service/s in your jurisdiction?
14. What is the biggest challenge for the service/s in your jurisdiction?
15. Has the service/s been evaluated? What was/is the evaluation model?
    - *Prompts: What types of behaviours should be supervised? Injecting only? Smoking drugs?*

16. The drug market in the ACT is relatively hidden with only sporadic evidence of public drug use since the turn of the century. The ACT is also very spread out geographically. Do you have any recommendations for a suitable model for a drug consumption room in such an environment?

17. Is there anything else that you think we should discuss about your experiences that may help shed light on determining the need for a drug consumption room the ACT?

Appendix 4: DCR model examples, costs, services provided, staffing, and utilisation

Table A10: DCR model examples, costs, services provided, staffing and utilisation

DCR Model	Location	Costs	Clientele and Usage	Staff profile	Services
Specialised	MSIC, Kings Cross, Sydney	Set up costs (year 2000): $1,334,041 Operating costs: first year: $1,995,784; 2005/06 financial year: $2,494,599. Current annual running cost is approximately $3.9 million (from MSIC stakeholder). Cost per client visit: $63.01 in the initial year of operation, $33.87 for the 2005/06 financial year.[17] Found to be cost effective.[21,39]	Between May 2001 and April 2010 there were 12,050 individual clients, at an average of three new clients per day; 9,500 referrals to health and social welfare services; 4,400 overdose interventions; 26% of clients were women.[81]	'Clinical service model', staffed by four registered nurses and four counsellors at any one time, overseen by a medical director.[41]	Onsite services include vein care and safer injecting advice, wound dressing, overdose management and crisis counselling. Referrals social welfare, BBV/STI testing, drug treatment and rehabilitation.[17,41] In-reach services include primary health care three days per week, therapist from St Vincent's homeless health, dental nurse, housing service, as well as occasional visits from Centrelink and Inner City Legal.
Specialised	Insite, Vancouver	Operating costs (2008): CAD $3,000,000 in 2008. Cost per client visit: CAD $14.[98] Found to be economically beneficial and cost effective.[10]	2018: 189,837 visits by 5,436 individuals; average of 337 injection room visits per day; 1,466 overdose interventions; 3,725 clinical treatment interventions (such as wound care,	Staffed by nurses, counsellors, mental health and peer workers.[81]	Services include primary healthcare, BBV testing and immunisations, addiction and housing services, education, peer-based counselling and drug checking; as well as referrals to local community health centres, a hospital,

			pregnancy tests); 28% of clients were women; 19% of clients were Indigenous.[98]		rehabilitation centre, support services for women and withdrawal management facility located in the same building. Facilitates injection, intranasal and oral consumption.[40]
Integrated	Abrigado, Luxembourg City, Luxembourg. Located in Luxembourg City centre, integrated into a low threshold emergency centre for people who use drugs in 2005.	No data available	2018: 57,926 visits to DCR; 60% heroin, 28% cocaine, 12% poly substance.[99]	Located in Luxembourg City centre, integrated into a low threshold emergency centre for people who use drugs in 2005. The service also includes counselling, drop-in centre, BBV testing, showers, laundry, lockers and night accommodation for those with unstable housing. The drug consumption room initially only facilitated injection-use, but now has a section for inhalation.[81]	The service also includes counselling, drop-in centre, BBV testing, showers, laundry, lockers and night accommodation for those with unstable housing. Initially only facilitated injection-use, but now has a section for inhalation.[81]
Integrated	MSIR, North Richmond, Melbourne. Originally operated within the NRCH building, now has its own building within the precinct.	No data available	In its first year (starting June 2018): 2,908 registered clients; 61, 823 supervised injections; 1,232 overdose interventions; 1,393 referrals; 5,082 onsite	Staffed mainly by nurses and social workers, it also has its own GP and addiction specialist doctor for prescribing and administering OAT (e.g. buprenorphine implants).	Services include oral health (both in MSIR and NRCH for further treatment), BBV testing, injecting advice, THN training. In-reach services provided include legal advice, BBV care (FibroScan®,

			services provided.[100]		treatment support), housing and emergency accommodation and linkages to detox, rehabilitation, counselling, and OAT support.
Mobile	Berlin	No data available	2010: 4082 visits (one of two vans).[73]	Two nurses with one or two social workers.[73]	Two vans NSP, THN distribution, referral to other services, BBV testing.[73]
Mobile	Barcelona	No data available	2010: 7755 visits	One nurse, two social workers.[73]	NSP, THN distribution, referral to other services, hepatitis B and tetanus vaccination.[73]

Appendix 5: Qualitative Primary Data: Stakeholder Interviews- ACT-based stakeholder data

Table A11: ACT Stakeholders Interviewed

	n
People with lived experience	9
AOD treatment providers*	6
ACT Health	1
Emergency services (police and ambulance)	2
AOD-related justice	2
Capital Health Network ACT	2
Homelessness services	3
Indigenous health	2

*Includes primary health, OAT, rehabilitation, detoxification services

Drug trends in the ACT

Stakeholders were asked to describe their understanding of current drug use patterns and trends in the ACT. Social alcohol consumption and recreational drug use were mentioned as ongoing issues in the nightlife areas of Civic. In terms of dependent substance use, there was a consensus among stakeholders that alcohol and methamphetamine were the main substances of concern. Notably there were conflicting perspectives on the prevalence and impact of heroin and prescription opioids in the ACT, while most mentioned that patterns were increasing or stable, a few perceived a decreasing trend. There was a general agreement that perceived street drug use (including public use, overdoses, dealing and discarded drug-related paraphernalia) was low and has been decreasing over time. Apart from some parts of the Civic area, where homelessness and drug use were concentrated, hotspots in other catchments of the ACT were less obvious, which some explained was due to policy that dispersed public housing communities across the ACT. Additional areas frequently identified were Ainslie Village and parts of Belconnen. Analysis revealed a general sense that the majority of drug use activity is perceived as secluded and fractured across the ACT.

Stakeholders were asked about key drivers of overdose in the ACT. In order of numbers of mentions in the data, the drivers of overdose were:

1. Poly-substance use, in particular the combination of illicit/prescription drugs and alcohol
2. Varying and inconsistent purity of drugs and drugs that have been cut (e.g. Fentanyl-laced heroin)
3. Using alone
4. People using drugs they are not familiar with
5. People overestimating their tolerance to a particular drug (e.g. after release from prison)
6. Intentional overdose
7. Lack of a safe space that supports and enables drug use
8. An increase in quantity of drugs consumed due to increase in welfare payments.

In addition to causal factors for overdosing mentioned, a few participants acknowledged that the implementation of naloxone programs in recent years has successfully prevented overdose deaths in the ACT. Given that interviews were conducted in May 2020 during the COVID-19 lockdown, anecdotal reports were also given by a couple of participants of an increase of people using alone within their own homes and subsequently overdosing, as well as a general increase in the cost of drugs.

Service system in the ACT

We also asked stakeholders to talk about the AOD service system in the ACT, including navigability, current demands, and whether there were any obvious needs for the sector. Service providers and people with lived experience shared similar perceptions of the ACT AOD system, describing a wide range of gaps and challenges. These needs mostly stemmed from a shortage of funding and resourcing in the sector to meet the high demands of diverse clients. Identified gaps in the ACT AOD system included:

- A network of AOD services that are scattered across Canberra and the ACT, creating transportation and access barriers for people who use drugs
- A clear disparity between the relatively high availability of AOD services, GPs, and specialists on the south-side of Canberra compared with the north, although ACTHD notes that an ADS service is being established in the north in 2020
- Limited beds and long waiting times for residential rehabilitation services
- A shortage of detoxification and withdrawal services, meaning people often miss out at crucial times
- Shortage of mental health support services overall, in particular dual-diagnosis services
- A lack of rehabilitation services that cater to young people, Indigenous people, and families
- A lack of drop-in and community intake services
- Long waiting times to access OAT programs
- An absence of AOD GPs that bulk bill in the Civic area
- Services are facing an increasing load of work and are stretched for funding
- Lack of treatment options to support people to overcome methamphetamine dependence
- Overly complicated intake processes for AOD services and OAT.

Stakeholders also mentioned several aspects of the ACT AOD service system that work well, such as:

- The various agencies in the AOD sector are “fairly unified” and cooperate effectively, which provides a supportive network for clients
- The recently implemented drug court system that can divert people from prison into rehabilitation and withdrawal was seen as a positive initiative
- A widespread and largely accessible network of NSPs across Canberra

- Both service providers and people who use drugs are generally aware of services available, and identifying and making referrals is relatively straightforward
- High coverage of counselling options that are easily accessible
- Naloxone availability and naloxone training programs.

Understanding of DCR service role and purpose amongst stakeholders

Participants were asked to explain their understanding of what a DCR is. Several drew comparisons from interstate and international models. Almost all stakeholders described a health service whose primary purpose was to prevent overdose and involved some level of medically trained oversight. DCRs were also outlined as being more than just a service for supervised drug consumption, and would include a range of health, social, and harm reduction services that were readily accessible for clients when needed. Most participants acknowledged that a DCR would be available for clients who wanted to use a range of different substances, with opioids and stimulants being the most mentioned. Injecting was also the most frequently mentioned route of administration, with a few participants picturing a facility that allows smoking drugs, albeit with some concern for how that would function in practice. DCRs were often described by interviewees as a space that is 'safe', 'clean' and 'supportive'. Finally, several interviewees pictured a space that was free from stigma and comfortable for clients.

Interest in and endorsement of a DCR in ACT

When asked about the level of interest expected from potential consumers of a DCR, there was a general agreement that the idea would be received positively. Reasons that consumers would find the service appealing included the perceived high number of people who inject drugs in the ACT; offering an alternative to injecting in a home or a car; as well as a more 'clean' alternative to clandestine shooting galleries that exist in public housing units in the ACT.

Several characteristics were discussed by stakeholders as being important in achieving consumer buy in. These included having a central location, having a range of social and medical supports, a high level of trust from consumers, and a discreet entrance to the service to avoid both public stigma and suspicion of police.

There were a number of barriers identified to the uptake of the service. The most common concern was the geographical distribution of drug consumption in Canberra and related logistical issues. Without a 'centralised scene' of drug use in the ACT, there was concern over whether consumers would be willing to travel across the city solely to use the service. A lack of public transport options, particularly on weekends and public holidays, was noted by multiple participants as a factor that would further deter consumers from accessing a site that was not in their own local area.

Stakeholders were also asked about whether there would be interest in the establishment of a DCR from the perspective of AOD service providers in the ACT. Most responded that service providers would be supportive of a potential DCR. The opportunity to offer medical as well as psycho-social interventions was seen as a reason for sector support, as was a DCR being part of the general harm reduction approach that is endorsed by the AOD sector and government in the ACT.

There was no mention of potential political or ethical objections from service providers to a DCR in the ACT. However, there was some concern that the relatively low rates of drug use and overdose in

the ACT would lead to a lack of government sector support for a DCR due to lack of anticipated utilisation for such a high financial investment.

Service model

When asked *'What would be the most appropriate model for a potential DCR in the ACT?'*, stakeholders often described the importance of integration with existing services, both physically and organisationally. While there was no consensus on how this could occur, or with what specific services, integration was seen as offering benefits with regards to accessing existing staff expertise, networks with potential clients, offering a holistic approach and protecting client confidentiality through clients accessing a generalist service location. Service types mentioned for possible integration included NSPs, AOD services, the hospital and homelessness services.

Stakeholders described the importance of a comfortable, clean and welcoming space which is non-stigmatising and confidential. The ability to provide such a space was seen by some as linked to whether the space is used similarly to a drop-in space, where there are limited restrictions on how long people can stay in the space, which would influence the types of clients that would be most likely to utilise the space. Client registration was raised as possibly being needed, however this was seen to be part of currently routine service provision in the ACT, so unlikely to be problematic.

There was some support amongst stakeholders for a mobile service model, with benefits including flexibility of operations generally, ability to adapt to changes in drug use patterns and drug markets, ability to engage with marginalised populations (e.g. homeless people), to counter the lack of good public transport options and to operate effectively in a jurisdiction with dispersed town centres. There were multiple mentions of the service needing to meet the needs of the most marginalised in the community as a priority. However, harm reduction more broadly was also seen as integral to whatever model could be created.

There was mention of whether there should be restrictions on what types of drugs clients are able to consume within a DCR, or whether there would be restrictions on modes of administration. This will be discussed in greater detail below, however stakeholders saw this issue requiring specific planning in relation to the physical spaces required to accommodate different types of drug use, the skills of staff, and assessment of the capacity for harm reduction related to particular substances or modes of administration.

On the question of whether a DCR in the ACT would require medical supervision (similar to those in Sydney and Melbourne), the prevailing view was that this was not essential. Some medical input and staffing was regarded as important, so that the service could be a collaborative approach between people with lived experience and those with formal training (e.g. GPs, nurses, social workers, counsellors and others). Supervision of drug use, rather than medical supervision, was seen as the key feature of the service. While overdose response training was seen as important, training in other skills such as behaviour management was also mentioned.

The importance of a low threshold service was highlighted, with discussion of perhaps needing a doctor on site for some of the time to ensure holistic service provision. A less medicalised model than that employed in other jurisdictions was seen as potentially cost-effective and beneficial for the service.

Suite of services

There was a strong consensus amongst stakeholders interviewed that the DCR should house a comprehensive suite of services. Conceptually, these were considered as wraparound services, capable of meeting a variety of needs (i.e. social, psychological, medical, physical). A DCR could incorporate referral into external services with onsite provision of services. The DCR function was viewed as a platform for the delivery of a range of supports to marginalised populations who may find it difficult to access services in other contexts.

Stakeholders suggested a long list of possible service types and worker disciplines that they would like to see offered and employed within a potential DCR in the ACT. These included:

- Housing / accommodation
- Dental
- Sexual health
- BBV screening
- Case management
- Crisis support / counselling
- Referrals / referral coordination
- Drug and alcohol treatment
- Mental health
- Domestic violence
- Community or social workers
- Opportunity to sit down to engage
- Brief assessment at reception
- Drug counselling
- Pill testing / drug checking
- Intake/referral for detoxification and rehabilitation
- GPs
- Nurses
- Pharmacists
- Brief intervention counselling
- Primary care
- NSP
- OAT / pharmacotherapy
- Injectable opioid treatments / prescription heroin
- Legal services

- Health promotion / development of health literacy
- Peer workers / peer-run initiatives
- Naloxone training
- Showers
- Toilets
- Laundry
- Drop-in space / comfortable seating
- Depot treatment administration
- Food / drinks / refreshments
- Assistance with child protection issues
- Phone
- Internet / computer access
- Television
- Financial advice
- Services targeted at young people
- Services targeted at older people
- Pre and post-natal services.

Those interviewed highlighted a few risks and issues that would likely need to be managed in the planning of a service. Interviewees discussed learnings from other SIF locations, such as issues with accessibility of basic amenities like toilets and the need to plan out the physical layout of the service to ensure appropriate throughput and to minimise potential conflicts between and amongst staff and clients. One issue discussed by several participants was issues that may arise concerning the proximity of the availability of OAT (and other treatment modes) to a drug consumption function. Discussion of managing increased risk of overdose, and generally how the services could work together, was described as needing specific planning and consideration. There was a small amount of opposition expressed to having OAT available onsite, in the context of effectively managing some clients who are working towards cessation of drug use while others are not.

There was one mention of the potential for the DCR offering services which may attract people who aren't there for the DCR function, which would require particular management. One person expressed concern about the potential for peer workers who are actively using to be at risk for getting involved in dealing drugs within the DCR.

Eligibility to use a DCR

Stakeholders raised a number of considerations on who should be able to use a DCR and whether there should be any specific restrictions or exclusions. Most were supportive of limited restrictions. One topic for which there was substantial consensus was the exclusion of individual people who display violent or threatening behaviour. Participants saw this as essential to maintaining a safe

space, both for clients and staff. Some participants discussed how the physical layout of the space could assist in reducing violent behaviour and others discussed policies that would need to be developed to manage the exclusion of particular individuals.

One of the other issues discussed was the age of potential clients. Participants discussed what they saw as the complexity of allowing young people under the age of 18 to attend such a service, however there was general agreement that there were some young people who would benefit from using such a service, especially those who are new to injecting. There was, however, a recognition that allowing young people to use the facility may introduce a different set of legal, ethical and moral issues than if the facility was restricted to adults only. It was agreed that this would need to be carefully managed to ensure that young people most at risk would be able to benefit from using the service. There was particular attention given to how younger people could perhaps be separated from older users, with physical design of the space being a key method via which this could be managed. Some mentions were also given to excluding children accompanying parents who wish to consume drugs in the space.

When discussing what types of drugs should be allowed to be consumed within a DCR, there was a general understanding that any targeting or restrictions should consider which drug types offer the greatest opportunity for harm reduction if consumed in such a space, and whether other spaces currently exist where particular drug types can be safely consumed. A significant number of participants thought that alcohol should probably be excluded, both due to associated behavioural management issues and the availability of other spaces to consume, due to its legal status. Where other drugs carry little risk of fatal overdose or other serious health problems, participants considered they should perhaps be excluded, although there wasn't firm agreement on this amongst those interviewed.

Participants also talked about different ways of consuming drugs and whether there should be restrictions related to these. There was a broad understanding that supervised injection of drugs would be a central feature of a facility. However, there was substantial discussion of the inclusion of smoking as another key mode of administration. In particular, this was described in the context of smoking drugs like ice, rather than cannabis or tobacco. With regards to injecting, a number of participants talked about having the space to facilitate groups of people to inject together, where individuals wish to share drugs or assist each other to inject.

Drug dealing within the space was mentioned as a behaviour that may need particular management, including possible exclusion. A few participants discussed whether a client presenting as quite intoxicated would require restriction or exclusion. There was no consensus on this point, however it was discussed in the context of risk management for overdose, rather than behaviour management.

There were a small number of mentions of whether a service should allow people who are visibly pregnant to attend, including those under 18. There was no consensus - participants weighed the complexity of needing to support people at a crucial time when intervention is needed and knowing that if they are turned away they will probably use drugs anyway. Discussion highlighted the difficulties with appropriate risk management within the service and management of community perceptions, as well as possible stigma or moral judgement coming from staff members within the service. Some further discussion of this matter is provided by DCR stakeholders in Appendix 6.

A small number of participants believed that a DCR in the ACT should offer comprehensive access to all in the community who may wish to use a space to consume drugs. These stakeholders considered that there should be no restrictions on any of the variables described above. There was a sense that restrictions were more politically motivated, rather than evidence-based.

Opening hours

When asked about what opening hours would make the most sense for a DCR in the ACT, participants provided differing insights. Some stakeholders acknowledged that the proposed service should be accessible in the morning from as early as 7am to 8am, with explanations given that people who inject drugs often 'score' early in the day and many also receive OAT at these times. There was general agreement that the service should be open throughout normal work hours, with participants stating the importance of having a service that was also open outside of 9am to 5pm for those who are employed. Suggested closing times typically ranged from 6pm to 10pm, with most anticipating that there would be little utilisation of a service that operated overnight. However, some respondents stated that a 24-hour facility would be necessary, explaining that "drug use happens all the time" and that overdoses are also likely to happen when people use alone overnight. While the majority gave some indication of what operating hours would be suitable, a few participants were completely unsure and stated that this would need to be determined through consultations with clients or by examining data showing the times that people in the ACT are using drugs.

Location

Throughout consultations, there was a general consensus that the Civic area of Canberra would be a suitable location for the proposed service. Interviewees explained this area would be accessible and convenient for clients, given that people from across Canberra frequent this area and that there is a high coverage of public transport options. Stakeholders explained that Civic would be ideal for DCR clients to be easily linked to the relevant health services in the area if necessary. While there was a strong preference for placing the proposed service in the Civic area, there were mentions of other localities in the ACT where a DCR could be beneficial; most notably Belconnen, due to its population of people who use drugs, public transport accessibility, proximity to a hospital and current lack of services in the area.

Stakeholders anticipated that community acceptability would be a key challenge when selecting a location especially in areas where there aren't existing AOD-type services. Participants also identified existing services where a DCR could be co-located or integrated. For example, the Civic Health Centre, the Early Morning Centre, and the Griffin Centre, where key services (such as NSPs and primary health) are already located.

Funding

Participants were asked for their views on what costs would need to be factored into the service, as well as providing an opinion on whether the funds required to operate a DCR could be better spent on other AOD services. In terms of costs discussed, it was noted that staffing would be the highest financial burden, which would be higher if it was going to be staffed by medical professionals (doctors, nurses) rather than people with other qualifications, such as AOD certifications. Longer open hours were also noted as a factor that could drive staffing costs up.

Based on suggested considerations from interviews with key AOD stakeholders in the ACT and interviewees associated with Sydney's MSIC (the participant representing the Melbourne MSIR could not comment on budgets), an estimated annual budget to establish and run a DCR in the ACT is shown in Table A12. Assumptions informing this table include that opening hours would be business hours only, size of the service could be for six to eight booths and that this would be for one site. This approach allows for a reception function (which could be integrated with existing on-site reception, leading to savings from this estimated budget), two staff to supervise drug consumption and one staff member available in the after-care area, as well as an oversight/management function combined with medical supervision, through the registered nurse role. Further security for the service is also included in this budget. This approach equates to a base hourly cost of approximately $320. Extended opening hours either into the evening or weekends would potentially require some salary loadings (dependent upon award conditions), which could be calculated following further consultation and planning. A clear consensus on specific opening hours was not reached through this study.

Table A12. Estimated annual budget for ACT DCR

Item/Unit	No. required	Unit Price	Sub total
Staff			
Registered Nurse	1x FTE	$90,000	$90,000
Social workers / Referral coordinators	1x FTE	$80,000	$80,000
Peer support workers	2x FTE	$70,000	$140,000
Reception/administration	1x FTE	$70,000	$70,000
Security	1x FTE	$80,000	$80,000
Staff Total			$460,000
Salary on-costs (25%)	0.25	$460,000	$115,000
Infrastructure cost (10%)	0.1	$575,000	$57,500
Total			*$632,500*

Opinions among stakeholders were divided when discussing whether the money spent on a DCR could be better spent elsewhere. Those that thought a DCR could be a responsible investment cited that such a service could mitigate risks and harms related to drug use, as well as providing linkages with other interventions such as detox and rehabilitation. Some participants argued that even if detox and rehabilitation were better resourced, there would still be people taking drugs whose lives could be saved by a DCR. Other responses in favour of setting up a DCR also mentioned that funding for AOD services in the ACT needed to improve overall, and that it should not be a question of whether a DCR should receive funding over other services that are just as important.

Of those that were not in support of establishing a DCR, one participant argued that the population of people that would use the service is too fractured, spread out and small to justify funding the service. Other responses argued that the money could be better spent on initiatives such as an NSP in the Alexander Maconochie Centre, drug checking services, better diversion pathways for low level offending and housing for homeless people, as well as improving existing services like detox and rehabilitation that are known to be under-resourced and struggling to meet demand.

Governance

As with the discussion of an appropriate DCR model for the ACT, many participants discussed whether a medically supervised model, with a medical director, was most appropriate for the ACT in terms of governance of a potential service. A significant number of participants did not see this model as necessary to ensure appropriate clinical governance and risk management for a DCR. Others mentioned that they did not believe potential clients of a service would want a medical supervision model, and that a non-medical model could be more cost-effective and potentially more effective in general.

There was broad agreement that the service would be best run by a non-government organisation. A board, governance committee and steering committee were all suggested as possible governance structure models. There was consensus that any governance structure should include a balance of professionals and people with lived experience. Some participants discussed the importance of accountability for the service to various directorates within the ACT government including health, justice and community services, as well as associated Ministers. Broad political support for the service was seen as central to its success. A partnership between various services, government and other bodies like the PHN was suggested as a possible approach.

Provider of a DCR in ACT

When asked about who the provider of a potential DCR in the ACT should be, participants mentioned a range of services that would be equipped to provide such a service. These predominantly included harm reduction and AOD services in Canberra. Most participants mentioned more than one service with a few mentioning that a proposed DCR could be operated in partnership, for example between a clinical service and a harm reduction service. There was consensus that a community service or NGO would be best placed to provide the service. However, this would depend upon the service having the appropriate infrastructure for clinical governance and leadership. A private service provider was also mentioned as an option by a small number of stakeholders.

Appendix 6: Quantitative Primary Data: Consumer Interviews and NSP Snapshot Surveys

Consumer Interviews

This appendix provides a descriptive tabulation of the key variables analysed from the consumer survey. Where applicable small numbers (<5) have been suppressed.

Table A13 shows that 84% of those interviewed in consumer surveys said they would use a DCR in the ACT if one were available. Common reasons for use included reduction of overdose risk (52%), concerns about using alone (52%), being away from police (49%) and needing help with and advice about injecting (30%). A substantial proportion of participants (58%) advised that they would use a DCR for 50% or more of their injections.

Table A13: Survey responses related to use of a DCR in the ACT

N = 101	**n**	**(%)**
Familiarity with DCRs		
Yes	91	(90)
Ever used a DCR		
Yes	36	(36)
Intent to use DCR in the ACT		
Yes	84	(83)
Reason for use (multiple choice)		
Being away from police	49	(49)
Concerned about overdose risk	53	(53)
Concerned about using alone	53	(53)
Need help and advice about injecting	30	(30)
Concerned about threat of violence/standover	17	(17)
Curious	6	(6)
'Other' safety-related	20	(20)
Proportion of expected use		
All injections (100%)	23	(23)
Most injections (>70%)	19	(19)
Half of my injections (50%)	16	(16)
Some of my injections (25%-50%)	9	(9)
A few of my injections (<25%)	9	(9)
Hardly any of my injections	<5	<5

Table A11 shows that amongst our sample of 101 people who use drugs, the minimum age was 20 years, with a maximum of 67 years and mean of 42 years. Just over half of the participants identified as male. Just under a third (32%) identified as Aboriginal and/or Torres Strait Islander. Most interviewed (82%) were not currently employed. Most (83%) were currently in stable housing.

Table A14: Consumer and NSP snapshot surveys participant demographics

	Consumer survey 2020	**NSP snapshot survey 2020**
Number of participants (n)	101	242
Males	58%	69%
Age (min.)	20	18
Age (max.)	67	67
Age (mean)	42	45
Sexuality		
Heterosexual	84%	
LGBTIQA+	16%	.
Aboriginal and/or Torres Strait Islander	32%	16%
Post-school qualification(s)	27%	.
Stable housing (includes own home, rent or public housing)	83%	90%
Unemployed	82%	.

* While ACT IDRS data from years 2010-19 have been included in this report, the 2019 sample was similar to that of previous years.

Table A15 shows that in our consumer survey that most participants in the consumer survey reported recent use of heroin (79%). Heroin was also the drug that participants typically nominated as their drug of choice (65%), the drug they had used via any route of administration most frequently in the last month (53%) and injected most in the last month (64%).

In our consumer survey, 55% reported recent use of alcohol, with the most reported frequency being 2–4 times per month. Just over a third (38%) reported no consumption of alcohol in the past month.

Just under half of the participants in our consumer survey reported use of cannabis in the past six months (44%). Twelve per cent reported cannabis being their most used drug in the last month.

A substantial minority of participants reported recent use of cocaine (19%).

Substantial minorities of our consumer survey sample reported pharmaceutical drug use, with 17% reporting recent use of methadone, 26% reporting recent use of benzodiazepines and 8% reporting

morphine use. Very small numbers of participants reported pharmaceuticals as their most frequently used type of drug.

Table A15: Recent drug use reported by the sample

N = 101	**n**	**(%)**
Drugs used in the last six months (multiple choice)		
Heroin	80	(79)
Ice	61	(60)
Cannabis	44	(44)
Benzodiazepines	26	(26)
Cocaine	19	(19)
Methadone	17	(17)
Ecstasy	12	(11)
Morphine	8	(8)
Speed	6	(6)
GHB/GBL	6	(6)
Used both heroin and ice in the past six months		
Yes	47	(47)
Drugs injected in the last six months (multiple choice)		
Heroin	76	(75)
Ice	56	(55)
Cocaine	11	(11)
Methadone	8	(8)
Ecstasy	6	(6)
Cannabis	6	(6)
Drug most used in the past month		
Heroin	54	(53)
Ice	26	(26)
Other (ecstasy, cocaine, morphine, cannabis)	17	(17)
Drug most injected in the past month		
Heroin	59	(58)
Ice	26	(26)
Other (ecstasy, cocaine, morphine, methadone, benzodiazepines)	7	(7)
Drug of choice		
Heroin	65	(64)

Ice	28	(28)
Other (cannabis, cocaine, ecstasy, other opioids)	7	(7)
Alcohol consumption in the past month		
Never	38	(38)
Once in the month	15	(15)
2-4 times a month	18	(18)
2-3 times per week	13	(13)
4 or more times per week	9	(9)
Standard drinks on a day when drinking in the past month		
1 or 2	14	(14)
3 or 4	16	(16)
5 or 6	9	(9)
7,8 or 9	<5	<5
more than 9	9	(9)

Table A16 shows that eighty per cent of consumer survey respondents reported a negative result for hepatitis C at their most recent BBV test, and none reported being hepatitis C positive. Almost half (43%) reported having a test in the last 12 months, and 26% reported having a test more than 12 months ago. Twenty-one per cent reported having completed treatment for hepatitis C.

Table A16: Recent BBV experience of the sample

N = 101	**n**	**(%)**
Time since last HCV test		
Past month	7	(7)
1 to 2 months	8	(8)
3 to 6 months	6	(6)
6 to 12 months	22	(22)
12 + months	26	(26)
Result of last HCV test		
Negative	80	(79)
HCV treatment received - ever		
On it now	<5	<5
Yes, but didn't finish	9	(9)
Completed, haven't received confirmatory SVR12	<5	<5
Completed, received confirmatory SVR12	21	(21)
Never received treatment	41	(40)
HBV vaccination		

Yes, completed three courses	65	(64)
Yes, but have not completed the course	15	(15)
No, not required (previous exposure/immunity)	<5	<5
No, never been vaccinated	12	(12)

Table A17 shows that participants most commonly reported scoring drugs from a dealer's home (43%), with other common responses being street dealers (16%) and friends (14%). Participants mostly commonly reported scoring drugs from Civic (33%) and Belconnen (28%). Participants typically reported injecting drugs in a private location (63%), including their own home, a dealer's home or another person's home. Public locations (e.g. street, public toilet, stairwell, park, car) accounted for 30% of typical injections.

Table A17: Recent drug purchase and use location characteristics reported by the sample

	n	**(%)**
Most recent drug purchase		
This week	91	(90)
This month	7	(7)
Over a month ago	<5	<5
Usual drug purchase location		
Street dealer	16	(16)
Dealers home	43	(43)
Friend	14	(14)
Mobile dealer	8	(8)
Home delivery	9	(9)
Street drop off	8	(8)
Usual drug purchase suburb		
Civic	33	(33)
Belconnen	28	(28)
Tuggeranong	9	(9)
Woden	7	(7)
Other (Fyshwick, Lyneham, Braddon, Campbell, Dickson, Jamieson, Reid)	10	(10)
Location of last injection episode (categorised)		
Private location[#]	64	(63)
Public location*	33	(33)
Where do you normally inject (>50% of the time)? (categorised)		
Private location[#]	67	(66)

Public location*	30	(30)

#Private location includes own and other person's home

*Public locations include parks, public toilets and cars

Consumer survey participants were asked about experiences with overdose. Twenty-one people reported experiencing one or more accidental heroin overdoses in the last six months, 20 of whom reported being administered naloxone at least once in the same period. Sixteen participants said their most recent overdose occurred in a private location, with a small number reporting a recent public overdose. Most overdoses were managed with the assistance of friends (n=13), while an ambulance attendance occurred at six of the other overdoses. Nine participants reported a recent overdose involving other opioids, eight of whom reported receiving naloxone at least once in the same period. Almost all participants (93%) were aware of THN programs and 63% had received training in how to administer naloxone.

Table A18: Recent experience of overdose among the sample

N = 101	**n**	**(%)**
Number of heroin overdoses – past six months		
0	80	(79)
1	13	(13)
2+	8	(8)
Received naloxone for heroin overdose – past six months		
Yes	20	(20)
Number of times received naloxone – past six months		
1	7	(7)
2-3	6	(6)
5+	7	(7)
Most recent heroin overdose location		
Private	16	(16)
Public	<5	<5
Care received for most recent heroin overdose		
Cared for by friends	13	(13)
Ambulance attendance	6	(6)
Other opioid overdose – past six months		
1+	9	(9)
Received naloxone for other opioid overdose – past six months		
Yes	8	(8)
Familiarity with take-home naloxone		
No	7	(7)

Yes	94	(93)
Received training in take-home naloxone - ever		
No	29	(29)
Yes	64	(63)

Consumer survey participants were asked about their use of the AOD treatment service system (Table A19). Nearly all participants reported ever having received treatment, with the most common types being methadone maintenance, detoxification/withdrawal, counselling, residential rehabilitation and self-help groups. Recent treatment access was reported by more than half of the participants, with common treatments being methadone maintenance, drug counselling and self-help groups. The most common drugs for which participants had received treatment support were heroin and crystal methamphetamine. A substantial minority of participants reported trying to access treatment in the last six months but were unable to. The most commonly reported reasons related to waiting lists and being turned down or turned away by programs. Some also reported not being aware of what programs were available or how to access them. Specific data on service types that individuals were trying to access was not collected. Furthermore, the impact of the COVID-19 pandemic on these responses could not be determined.

Table A19: Recent treatment experience of the sample

N = 101	**n**	**(%)**
Received treatment for drug use - ever		
Yes	88	(87)
Types of treatment received - ever (multiple choice)		
Methadone	62	(61)
Detox/withdrawal	49	(49)
Drug counselling	49	(49)
Residential rehab	47	(47)
Self-help groups	38	(38)
Suboxone	18	(18)
Subutex	9	(9)
Types of treatment received for your drug - past six months? (multiple choice)		
Methadone	56	(55)
Drug counselling	27	(27)
Self-help groups	16	(16)
Residential rehab	13	(13)
Suboxone	7	(7)
Detox/withdrawal	6	(6)
Primary drug of concern in treatment seeking		

Heroin	66	(65)
Ice	14	(14)
Other (ecstasy, oxycodone, methadone, alcohol)	8	(8)
Inability to access treatment – past six months		
Yes	34	(34)
Barriers to treatment access – past six months (multiple choice)		
Waiting list/lack of beds	18	(18)
Turned down/away by program	15	(15)
Don't know of any programs/how to access programs	8	(8)
No treatment program nearby	6	(6)
Currently trying to access drug treatment		
Yes	19	(19)

Table A20 shows the use of other health and support services explored in consumer surveys. Common services recently accessed by participants included GPs for reasons other than OAT (69%), social or welfare workers (41%), dentist (28%), specialist doctor (18%) and psychologist (14%).

Table A20: Recent other service use reported by the sample

N = 101	**n**	**(%)**
Seen GP in last six months (reasons other than OAT)		
Yes	70	(69)
Seen specialist doctor in last six months		
Yes	18	(18)
Seen allied health professional (e.g. chiropractor, nurse, physiotherapist) in last six months		
Yes	8	(10)
Seen mental health professional (including GP for mental health reason) in last six months (multiple choice)		
Psychologist	14	(14)
Psychiatrist	12	(12)
GP	9	(9)
Seen social/welfare worker in last six months		
Yes	41	(41)

Table A21 presents a range of elements related to a DCR that participants were asked about in surveys. Participants in quantitative interviews strongly agreed that an ACT-based DCR should provide comprehensive information, education, and advice on a range of topics relating to drug use, health, and welfare. Most (75%) thought that additional health and social services should be provided onsite. Most popular services mentioned included drug and alcohol counselling (48%), methadone maintenance (45%), naloxone training (45%), needle and syringe program (40%). Strong preferences were also demonstrated for a comprehensive range of other health and support

services spanning drug treatment, primary healthcare and social support, as well as physical amenities like toilets and relaxation spaces.

Participants in consumer interviews largely concurred with ACT stakeholders that core opening hours would be during normal business hours (58%), with a minority also wanting a service to be open late in the evening. A substantial minority (21%) did want a service to be open from midnight to 9am, which was also described by some stakeholders in qualitative interviews, who believed the service should be 24 hours a day, given that drug use happens around the clock.

Table A21: Preferred DCR characteristics nominated by the sample

N = 101	n	(%)
Desired DCR location		
Civic	42	(42)
Woden	10	(10)
Belconnen	6	(6)
Reasons for location (multiple response)		
Close to my home	27	(27)
That's where many people score drugs	45	(45)
That's where most drug use occurs in the ACT	37	(37)
Other' public transport related	9	(9)
'Other' central location related	11	(11)
Intended route of administration of drug use in DCR (multiple choice)		
Inject	74	(73)
Smoke	35	(35)
Snort	13	(13)
Intended drug use in DCR – sole or group (multiple choice)		
Use drugs on your own	58	(57)
Share drugs with one other person	43	(43)
Share drugs with a group	30	(30)
Route of administration in DCR that should be allowed		
Injecting only	9	(9)
Injecting, smoking only	<5	<5
Injecting, smoking, snorting only	77	(76)
Information/education/advice offered at DCR (multiple choice)		
Injecting vein care advice	79	(78)
Advice on drug treatment	80	(79)
Drug and alcohol information	77	(76)
Sexual health advice	46	(46)
Other health education	21	(21)
Wound dressing	43	(43)
Advice on skin disorders	28	(28)
Advice on asthma/chest infection	20	(20)
General counselling	55	(54)

Advice on accommodation	48	(48)
Advice on legal issues	44	(44)
Advice on finances	27	(27)
Crisis counselling	45	(45)
Advice on tourniquet use	30	(30)
Information on safer injecting	60	(59)
Drug checking/fentanyl testing results	36	(36)
Interest in accessing other health or social services at DCR		
Yes	76	(75)
Additional health or social services (multiple choice)		
Drug Treatment		
Detox program	35	(35)
Buprenorphine treatment	26	(26)
Drug and alcohol counselling	48	(48)
Methadone maintenance	45	(45)
Residential rehabilitation	25	(25)
Naltrexone maintenance	13	(13)
Naloxone Training	45	(45)
Counselling	32	(32)
Case management	26	(26)
Peer treatment support	34	(34)
Needle and syringe program	40	(40)
Health Care		
Medical consultation	34	(34)
Health education	33	(33)
BBV/STI Testing	35	(35)
Social Welfare		
Social welfare assistance	24	(24)
Other counselling	21	(21)
Legal advocacy	30	(39)
Housing advocacy	35	(35)
Other Social Services	18	(18)
Consumer Group	18	(18)
Volunteer Program/opportunities	30	(30)

Interest in accessing other things or services at a DCR? (multiple choice)		
Yes	59	(58)
Additional services		
NSP access	46	(46)
Accessible Toilet	45	(45)
Client space with tea/coffee, internet, phone services, private space, chillout space	46	(46)
Private space for consulting with healthcare workers	35	(35)
Peer treatment support space and case management space	30	(30)
Nurse station for wound dressing etc.	28	(28)
Activities/training/education room (arts and crafts, safer injecting/OD prevention workshops, consumer participation groups)	22	(22)
Access to take home naloxone (THN)	22	(22)
Staff types that should be available at a DCR (multiple choice)		
Medical - Doctors and nurses	83	(82)
Support staff - health education officers, case managers	68	(67)
Peer workers	89	(88)
Counselling staff	61	(60)
Hours of operation (categorised)		
0.00 - 8.59	21	(21)
9.00-16.59	59	(58)
17.01-23.59	<5	<5
Current main mode of transport		
Public transport	49	(49)
Own car	41	(41)
Other (friend's car, bicycle, walk)	7	(7)

Needle and Syringe Program (NSP) snapshot data

Service users of Civic, Phillip and Hepatitis ACT NSPs were invited to participate in two rounds of snapshot surveys. The first snapshot occurred between 24 May 2020 and 5 June 2020 and the second snapshot between 9 June 2020 and 19 June 2020. Questions from each snapshot survey were collated with routine service provision data, which included:

- Demographic information (age; sex: male or female; Aboriginal and/or Torres Strait Islander, postcode)
- Last drug injected
- Injecting equipment distributed

Cell sizes of less than five have been suppressed throughout these results.

Participant demographics

Demographic and drug use characteristics are shown in Table A22. The majority of participants in both snapshots were male (Snapshot one: 72%, snapshot two: 63%) and aged 40 or older (Snapshot one: 66%, snapshot two: 59%). Aboriginal and/or Torres Strait Islander participation varied between snapshots, with a 12% of snapshot one participants identifying as Aboriginal and/or Torres Strait Islander, compared to 23% in snapshot two. Heroin was the most commonly reported drug last injected in both snapshots (Snapshot one: 40%, snapshot two: 53%), but differed between snapshots. All other drugs last injected were approximately even between snapshots.

Table A22: NSP snapshot survey participant demographics

	Snapshot 1		**Snapshot 2**	
	N=164		N=78	
	n	(%)	n	(%)
Age				
18-30years	20	(12)	9	(12)
31-40years	37	(23)	23	(29)
41-50years	55	(34)	24	(31)
51+years	52	(32)	22	(28)
Sex (Male)	118	(72)	49	(63)
Aboriginal and/or Torres Strait Islander	20	(12)	18	(23)
Last drug injected				
Heroin	65	(40)	41	(53)
Methamphetamine	38	(23)	20	(26)
Pharmaceutical opioids*	8	(5)	5	(6)
Other#	5	(3)	<5	<5
Equipment is for another person	<5	<5	<5	<5
Not stated	47	(29)	9	(12)

*Includes methadone and fentanyl

#Includes cocaine, dexamphetamine and other drugs not listed

Snapshot One

A total of 164 people participated in snapshot one. Participants were asked what kind of accommodation they currently resided in and whether they would use a DCR if one was available in the ACT. Participants who indicated that they would use a DCR were then asked to nominate reasons that they would use it, while those who indicated they would not use a DCR were asked to nominate why not.

The majority of respondents resided in public or community housing (64%), followed by private rental (14%), owner occupied (12%) and no fixed address (8%) (Table A23). Support for a DCR in the ACT was strong, with the majority of respondents (64%) indicating they would use one if available in the ACT, with a further 12% indicating that they may use it. Approximately one in four said that they would not use a DCR if it existed in the ACT.

Among those who said they would use a DCR, the most commonly nominated reasons for to use it included concern about overdose risk (68%), concern about using alone (47%), to use away from police (42%) and to access support and advice to inject (36%). The most commonly reported reasons for not wanting to use a DCR included respondents already having a safe place to consume drugs (77%), that they prefer to consume drugs at home (69%) and that they prefer to keep their drug use private (44%).

Table A23: Snapshot 1 results

	n = 164	**(%)**
Accommodation type		
Owner occupied	19	(12)
Public/community housing	105	(64)
Private rental	23	(14)
Boarding house	<5	(<5)
No fixed address (inc. squat)	13	(8)
Family member's home	<5	(<5)
Intent to use a DCR		
No	39	(24)
Yes	104	(64)
Maybe	20	(12)
Reason for use (Multiple choice)		
Concerned about overdose risk	71	(68)
Concerned about using alone	49	(47)
To use away from police	44	(42)
Need support and advice to inject	37	(36)

Concerned about violence/standover	33	(32)
Curious what it would be like	24	(23)
Social reasons	16	(15)
Total	274	(100)
Reason for not using (Multiple choice)		
Already have a safe space to consume drugs	30	(77)
Prefer to consume drugs at home	27	(69)
Prefer to keep drug use private	17	(44)
Concerned about being seen using it	7	(18)
Prefer to use drugs alone	7	(18)
Worried about police staking it out	6	(15)
Wouldn't want to register to use it	<5	(<5)
Too far from where I live	<5	(<5)
Have to wait too long to inject	<5	(<5)
Don't want to use drugs with strangers	<5	(<5)
Too far from where I score drugs	<5	(<5)
Poor treatment by health professionals	<5	(<5)
Unsure if they'd let someone else inject me	<5	(<5)
Total	107	(100)

Anticipated use of a DCR by key subgroups

Anticipated use of an ACT DCR disaggregated by key subgroups is shown below (Table A24). Anticipated use of a DCR was approximately consistent for each age group and between sexes. Aboriginal and/or Torres Strait Islander participants were as likely to report that they would use a DCR compared to non-Aboriginal and/or Torres Strait Islanders (75% vs 62%). Anticipated use of a DCR among respondents residing in boarding houses (100%), no fixed address (85%) and public or community housing (67%) was strongest, while less than half of those residing in owner occupied (47%) and another family member's home (0%) reported that they would use a DCR in the ACT. Anticipated use of a DCR was strongest among those who reported opioids were the last drug they injected, with 73% of those whose last drug injected was opioids reporting they would use a DCR compared to 63% of those whose last drug injected were stimulants.

Table A24: Anticipated use of a DCR by age, sex, Aboriginal and/or Torres Strait Islander, accommodation type, drug last injected

	No		**Yes**		**Maybe**	
	n	**(%)**	**n**	**(%)**	**n**	**(%)**
Age						
18-30years	7	(35)	12	(60)	<5	<5

31-40years	8	(22)	25	(69)	<5	<5
41-50years	12	(22)	34	(62)	9	(16)
51+years	12	(23)	33	(63)	7	(13)
Sex						
Female	13	(28)	26	(57)	7	(15)
Male	26	(22)	78	(67)	13	(11)
Aboriginal and/or Torres Strait Islander						
No	34	(24)	89	(62)	20	(14)
Yes	5	(25)	15	(75)	0	(0)
Accommodation						
Owner occupied	8	(42)	9	(47)	<5	<5
Public/community housing	21	(20)	70	(67)	13	(13)
Private rental	6	(26)	12	(52)	5	(22)
Boarding house	0	(0)	<5	<5	0	(0)
No fixed address (inc. squat)	<5	<5	11	(85)	0	(0)
Family member's home	<5	(100)	0	(0)	0	(0)
Drug Last Injected						
Stimulants	12	(31)	25	(64)	<5	<5
Opioids	12	(16)	53	(73)	8	(11)

Anticipated use of a DCR by NSP site

Anticipated use of a DCR by sites participating in the NSP snapshot are shown in Table A25. More than 50% of clients of each NSP site indicated they would use a DCR, with this indication highest among those recruited in Civic NSP (70%).

Table A25: Anticipated use of a DCR by NSP site

	No		**Yes**		**Maybe**	
	n	**(%)**	**n**	**(%)**	**n**	**(%)**
Civic	15	(16)	64	(70)	12	(13)
Hep ACT	7	(25)	15	(54)	6	(21)
Phillip	17	(39)	25	(57)	2	(5)

Reasons for and against DCR use by sex

The reasons identified for or against the use of DCR disaggregated by sex are shown below (Table A26). The reasons provided for or against the use of a DCR are approximately equal across sexes.

Table A26: Reasons for and against the use of a DCR by sex

	Female		Male	
	n	(%)	n	(%)
Reasons for DCR use				
Concerned about overdose risk	20	(77)	51	(65)
Concerned about using alone	19	(73)	30	(38)
To use away from police	9	(35)	35	(45)
Need support and advice to inject	13	(50)	24	(31)
Concerned about violence/standover	12	(46)	21	(27)
Curious what it would be like	6	(23)	18	(23)
Social reasons	<5	<5	12	(15)
Total	84	(100)	191	(100)
Reasons for not using DCR				
Already have a safe space to consume drugs	9	(69)	21	(81)
Prefer to consume drugs at home	9	(69)	18	(69)
Prefer to keep drug use private	5	(38)	12	(46)
Concerned about being seen using it	<5	<5	5	(19)
Prefer to use drugs alone	<5	<5	<5	<5
Worried about police staking it out	<5	<5	<5	<5
Wouldn't want to register to use it	<5	<5	<5	<5
Too far from where I live	0	(0)	<5	<5
Have to wait too long to inject	0	(0)	<5	<5
Don't want to use drugs with strangers	<5	<5	<5	<5
Too far from where I score drugs	0	(0)	<5	<5
Poor treatment by health professionals	<5	<5	0	(0)
Unsure if they'd let someone else inject me	0	(0)	0	(0)
Total	34	(100)	73	(100)

Snapshot Two

Seventy-eight people participated in snapshot two. Participants were asked where they last used drugs, what harm reduction services they would like to see introduced in the ACT and if a DCR was introduced, what services they would like it to offer.

Most participants reported that the location of their last episode of drug use was in a private location, with 76% of last episodes of use occurring in the respondent's home and 10% occurring in another person's home (Table A27). Fourteen percent of respondents reported that the last episode of drug use occurred in public locations such as parks, public toilets or cars.

A supervised injecting room was the most commonly identified harm reduction service wanted in the ACT, nominated by 44% of respondents; followed by mobile after-hours NSP services (26%) and a drug consumption room (13%). The most commonly reported services desired in a DCR in the ACT were for it to provide safe drug use education, nominated by 53% of respondents. Advice and support to access drug treatments such as OAT and counselling (41%), mental health support and treatment (41%) and BBV testing and treatment (29%) were the next most commonly reported services.

Table A27: Snapshot 2 results

	n	(%)
Location of last episode of drug use		
Home	59	(76)
Other person's home	8	(10)
Public Location*	11	(14)
Total	78	(100)
New harm reduction services that could be introduced in the ACT		
Supervised injecting room	34	(44)
After Hours mobile NSP services	20	(26)
Drug consumption room	10	(13)
Subsidised opioid substitution therapy	5	(6)
Safer smoking kits available in NSPs	<5	(<5)
Don’t know	<5	(<5)
Not applicable	<5	(<5)
Increased access to harm reduction education	<5	(<5)
Expanded access to take home naloxone	<5	(<5)
Total	78	(100)
Services a DCR should offer (1-3 responses)		
Safe drug use education	41	(53)
Advice and support to access drug treatment (e.g. OAT, counselling)	32	(41)
Mental health support and treatment	32	(41)
BBV testing and treatment	23	(29)
Take-home naloxone training and provision	21	(27)
Onsite drug counselling	21	(27)
Onsite legal services	17	(22)
Sexual health advice and testing	16	(21)
Onsite social welfare support	11	(14)
Medication provision (incl., but not limited to, OAT).	10	(13)

Primary care	8	(10)
Total	232	(100)

*Public locations include parks, public toilets and cars

Snapshot 2 by sex

Snapshot two results were approximately equal across all questions between sexes (Table A28). Similar proportions of males and females reported that their last episode of drug use was in a private home, with few reporting public injecting. A supervised injecting room was the most commonly desired harm reduction service for both males (49%) and females (38%). The services which males and females thought a DCR should offer were approximately equal between sexes.

Table A28: Snapshot 2 results by sex

	Female		Male	
	n	(%)	n	(%)
Location of last episode of drug use				
Home	22	(76)	37	(76)
Other person's home	<5	(≤5)	7	(14)
Public Location*	6	(21)	5	(10)
Total	29	(100)	49	(100)
What new harm reduction services would you like introduced in the ACT				
Supervised injecting room	10	(34)	24	(49)
After Hours mobile NSP services	8	(28)	12	(24)
Drug consumption room	<5	<5	6	(12)
Subsidised opioid substitution therapy	<5	<5	<5	<5
Safer smoking kits available in NSPs	<5	<5	<5	<5
Don’t know	0	(0)	<5	<5
Not applicable	<5	<5	<5	<5
Increased access to harm reduction education	0	(0)	<5	<5
Expanded access to take home naloxone	0	(0)	<5	<5
Total	29	(100)	49	(100)
If a DCR was established in the ACT, what services should it offer? (Multiple choice)				
Safe drug use education	15	(52)	26	(53)
Advice and support to access drug treatment (e.g. OAT, counselling)	11	(38)	21	(43)
Mental health support and treatment	13	(45)	19	(39)
BBV testing and treatment	7	(24)	16	(33)
Take-home naloxone training and provision	6	(21)	15	(31)
Onsite drug counselling	5	(17)	15	(31)
Onsite legal services	<5	<5	17	(35)
Sexual health advice and testing	<5	<5	12	(24)
Onsite social welfare support	<5	<5	7	(14)

Medication provision (inc., but not limited to, OAT).	6	(21)	<5	<5
Primary care	<5	<5	6	(12)
Total	79	(100)	159	(100)

*Public locations include parks, public toilets and cars

Snapshot 2 by last drug type

Last drug injected appears to be associated with a number of differences in snapshot two (Table A29). All instances of last drug use occurring in public were among people who reported that their last drug injected were opioids (n=10). Almost one in four (22%) of respondents who reported opioids were the last drug injected reporting that the location of their last episode of drug use was a public location, compared to 0% of people who last used stimulants. Support for a DCR was greatest among those who last used opioids (52% vs 32%). Services offered by a potential DCR did not differ substantially by drug last used.

Table A29: Snapshot 2 results by drug type last injected

	Stimulants		**Opioids**	
	n	**(%)**	**n**	**(%)**
Location of last episode of drug use				
Private location#	22	(100)	36	(78)
Public Location*	0	(0)	10	(22)
Total	22	(100)	46	(100)
What new harm reduction services would you like introduced in the ACT				
Supervised injecting room	7	(32)	24	(52)
After Hours mobile NSP services	6	(27)	10	(22)
Drug consumption room	<5	<5	5	(11)
Subsidised opioid substitution therapy	0	(0)	5	(11)
Safer smoking kits available in NSPs	<5	<5	<5	<5
Don't know	<5	<5	0	(0)
Not applicable	<5	<5	0	(0)
Increased access to harm reduction education	<5	<5	0	(0)
Expanded access to take home naloxone	0	(0)	<5	<5
Total	22	(100)	46	(100)
If a DCR was established in the ACT, what services should it offer? (1-3 responses)				
Safe drug use education	12	(55)	25	(54)
Advice and support to access drug treatment (e.g. OAT, counselling)	8	(36)	21	(46)
Mental health support and treatment	8	(36)	20	(43)
BBV testing and treatment	<5	<5	18	(39)
Take-home naloxone training and provision	8	(36)	12	(26)
Onsite drug counselling	6	(27)	12	(26)

Onsite legal services	<5	<5	11	(24)
Sexual health advice and testing	<5	<5	9	(20)
Onsite social welfare support	<5	<5	7	(15)
Medication provision (inc., but not limited to, OAT).	<5	<5	9	(20)
Primary care	<5	<5	<5	<5
Total	61	(100)	147	(100)

#Private location includes own and other person's home

*Public locations include parks, public toilets and cars

NSP Snapshot Surveys: Conclusions

The snapshot surveys conducted at three NSP services in the ACT found that that there was significant support for a DCR in the ACT among NSP clients. The majority of respondents said that they were likely to use a DCR if one were available, with motivations for use including people being concerned about their risk of experiencing an overdose, using alone, encountering police while consuming drugs and wanting support to inject. Among those who said they would not use a DCR if one were established in the ACT, most cited already having somewhere else they would prefer to inject. Related to this, participants who were homeless, living in boarding houses or living in public or community housing were more likely to report they would use a DCR compared to people in other forms of housing. Anticipated use of a DCR was greater among men and Aboriginal and/or Torres Strait Islander participants. If a DCR were to be established in the ACT, participants felt that the service should prioritise AOD education and treatment, mental health treatment and BBV testing. That few participants prioritised a DCR provide primary health care, medication dispensing and sexual health testing suggest that ACT NSP service users may favour a non-medical DCR model. If the ACT govenrment elected not to establish an DCR in the ACT but sought to improve harm reduction services available, NSP snapshot respondents favoured the establishment of a mobile after-hours NSP service.

Appendix 7: Qualitative Primary Data: Stakeholder Interviews - DCR provider data

Establishment

Both the MSIR and MSIC were established out of a perceived need to respond to overdose deaths in Melbourne and Sydney, respectively. In Melbourne, support and lobbying for a SIF followed recommendations made by multiple Coroners[2], including after the overdose death of a woman in a Richmond fast food restaurant toilet. These included family groups, the AMA, Ambulance Victoria, Victoria Police, the Herald Sun newspaper and local advocacy group Residents for Victoria Street Drug Solutions. In the late 1990s, there was increased media and political attention on fatal overdoses in the Kings Cross area of Sydney. In 1997 an inquest into police corruption recommended the establishment of a sanctioned SIF (as there were several clandestine shooting galleries operating in the area at the time) to combat the problem. Support within politics was also pivotal in the establishment of both facilities, with Fiona Patton's Reason Party and Special Minister of State John Della Bosca being champions of the initiatives in Victoria and NSW, respectively. In the case of BC, Canada, the key stakeholder that we interviewed described an inclusive and collaborative process when establishing the first DCR, which involved local health services, police and the local activist group, Vancouver Area Network of Drug Users.

The department stakeholder from Victoria described the support from multiple Victorian Coroners, medical experts, first responder agencies and the findings of a bipartisan Parliamentary Inquiry as being the basis for the decision to conduct the trial of the MSIR. They also made reference to the City of Yarra being the local government area with the highest frequency of overdose deaths over an eight-year period from 2009 to 2017.

Suite of Services

There are a number of regular in reach services at MSIC, including primary healthcare from a Kirkton Road Centre GP, therapist from St Vincent's homeless health, dental nurse, housing service, as well as occasional visits from Centrelink and Inner City Legal.

Onsite services at MSIR include oral health (both in MSIR and NRCH for further treatment), BBV testing, injecting advice and THN training. In-reach services provided include legal advice, GP services, BBV care (testing, FibroScan®, treatment initiation and support), mental health care coordination, emergency accommodation and housing, and linkages to drug treatment support including withdrawal, rehabilitation, counselling and OAT support.

The Victorian department stakeholder explained that services such as lockers, showers and laundry were not offered at the MSIR because there were other services nearby that offered these. However, they recommended that they should be considered for a potential DCR in the ACT if there were no other services offering them nearby.

[2] For example: 7 September 2017 Legal and Social Issues Committee *Inquiry into the Drugs, Poisons and Controlled Substances Amendment (Pilot Medically Supervised Injecting Centre) Bill 2017;* and Coroners Court of Victoria, 2018, *Finding into the death of Samuel Jack Morrison without inquest*

Staffing

The staffing profile at MSIC comprises two teams of frontline staff: (1) health education officers and (2) registered nurses. The *Drug Misuse and Trafficking Amendment - Medically Supervised Injecting Centre* legislation determines that there needs to be three nurses on site in order to open, and a minimum of six staff in total. In practice, there are normally 7-8 frontline staff, plus two clinical nurse consultants: one to manage referrals and the other as a mental health coordinator. There are two medical directors, one part time, one full time; a full-time office manager; a part time research manager; and a security guard.

When asked about MSIR's staffing profile, the Victorian department stakeholder explained that the facility has strong medical oversight, referring to the Medical Director and Medical Supervisor being required to be registered medical practitioners. They described the rest of the staffing profile as being comprised of an operations manager, nurse unit manager, registered nurses, harm reduction team leader and harm reduction staff with backgrounds in fields such as social work, counselling, mental health, peer work and health education. There are also security staff and additional co-located services such as mental health support from St Vincent's Hospital Melbourne. NRCH also provides overall support on human resources, quality and risk management, security, information technology, facilities management, cleaning and other functions.

Clientele

Stakeholders from MSIR and MSIC both described a high number of homeless or unstably housed service users, as well as 10-15% Indigenous clients; a large representation of mental health comorbidities; and clients with a history of incarceration and recidivism. The stakeholder from MSIR described cohorts of clients that will use the service once or twice a week, those that have come almost every day since it opened, and some that do not live in the area and will use it infrequently or try the service out of curiosity. They also made the observation that those who used the service more often are more likely to be accessing the local drug market and be part of the North Richmond drug user community, as well as having a higher likelihood of being homeless.

The Victorian department stakeholder described the MSIR clientele as approximately three-quarters male, over 10% Aboriginal and/or Torres Strait Islander, and having an average age of 41. Most MSIR service users had been injecting for a significant period (92% injecting more than five years, 61% injecting for at least 20 years). They also described the cohort of MSIR clients as a population with high needs for first aid and other health services, including mental health and drug dependence treatment and social care such as housing and legal services. Reference was made to the high rates of unemployment, homelessness (a third) and recent incarceration (a quarter) among clients, and how these characteristics may mean that a person is less likely to have access to a private space to inject such as their own home and be more likely to experience drug-related harm.

Eligibility

The main consistent eligibility criteria at MSIC and MSIR are having a history of injecting drug use, being aged 18 years or over and not being pregnant. At MSIC, intoxicated clients are ineligible. The exclusion of pregnant clients was noted to be against the best available evidence and personal views of MSIC management. This sentiment was expressed in the recommendations made by MSIC management to NRCH when establishing the Melbourne facility. However, as was the case in NSW, pregnant people were determined to be ineligible to use the MSIR.

The NSW regulatory stakeholders identified the exclusion of pregnant people and people under the age of 18 as a service gap. They discussed the strong advocacy for changing these eligibility criteria coming from MSIC and professional groups, as well as a statutory review four years ago finding that there was support in the community for allowing these groups to access the MSIC. When asked what the process for changing the eligibility criteria would be, they discussed the need for evidence, public acceptability, and an established need to change the policy.

The Victorian department stakeholder listed the various reasons for refusal of MSIR use as: people with bail or parole conditions prohibiting them from using the service or being in North Richmond; pregnant people and people with accompanying children; young people (under 18); people who cannot inject themselves; people who are seeking to inject in groups larger than two people; and people who use drugs through routes of administration other than injecting. In relation to these conditions, they discussed the DH's recognition that people that are refused supervised injection will have pre-obtained drugs and intend to use them, and thus refusal to the service will be unlikely to deter these individuals from injecting. They also stated that people who are refused the service for the above reasons are likely to be drug-dependent or at a higher risk of overdose (e.g. recently released from prison affecting one's tolerance). It was also noted that refusing supervision may reduce client engagement with other health and social supports offered in drug consumption facilities, including for vulnerable cohorts who do not normally access other health facilities.

The Victorian department stakeholder noted that there were various reasons for potential clients electing not to use the facility of their own accord. These included having a preference to inject at another location, either in a less clinical private environment or preferring to inject outside; being deterred by a real or perceived waiting time at the MSIR; being or accompanying someone who had been sanctioned; wishing to avoid other service users or staff; and concerns about potential surveillance or perceived risk of police presence. In relation to these factors, the stakeholder discussed MSIR's highly medicalised operations in comparison to other services globally; specific reference was made to DCRs that follow a peer directed, low threshold model that is also cheaper to run because of the staffing profile requiring fewer medical professionals.

In BC, the eligibility criteria vary across sites, but there was a reported age restriction of 16 years and older. However, it was also reported that in practice people do not get turned away from services. In Vancouver, there is also SisterSpace, a service that can only be accessed by women.

Registration

At MSIC and MSIR, all new clients are required to register with the service. However, no documentation or evidence is required (unless clients are suspected to be under 18 years of age), so those with privacy concerns can provide pseudonyms. According to the stakeholder from MSIR, the registration process exists so that clients are briefed on eligibility and acceptable behaviours the first time they use the service only, rather than at each visit. At MSIR there is also an optional process of providing more details around demographics and healthcare needs, as well as a requirement to provide a name and Medicare number if a medical intervention such as hepatitis C treatment or OAT are provided. This medical record can be part of a record separate to the initial registration details.

The Victorian department stakeholder described client registration as a brief assessment with a team member, first for eligibility and then for registration, whereby the client's medical history is discussed and they provide a name, which can be a pseudonym, and a password for subsequent

visits. On each visit, eligible clients provide their name and password, and other information including the drug they intend to inject. This assists staff in responding to any potential overdose. They also noted that all drugs of dependence are permitted in the MSIR, provided the client has less than a traffickable quantity, and there is no testing of substances that clients bring to inject.

At some but not all DCRs in BC, clients have a handle which they provide on each use, mainly for keeping records on how frequently people use the service. OPSs do not collect any information on clients using the service, similar to how primary NSPs in Australia operate.

Opening Hours

Both the MSIC and MSIR are open seven days a week, with shorter operating hours on weekends: MSIR is open 7am to 9pm during the week and 8am to 7pm on weekends; MSIC is open 9am to 9.30pm during the week and 9.30am to 5.30pm on weekends. Both services began with shorter opening hours, which were extended in Melbourne after the service moved into a purpose-built facility, and in Sydney after advice by the consumer committee.

The Victorian department stakeholder stated that the opening hours of the MSIR had been reviewed and amended over time to better meet capacity and the needs of community and clients. They also mentioned that client demand may be modelled by assessing a range of data including ambulance overdose response data and NSP access by time of day. Regarding current operating hours, they noted that they may be skewed too early (weekdays from 7am, weekends and public holidays from 8am), and key demand occurred closer to 9am to 10am.

Location, Environment and Amenity

The North Richmond location was chosen for the MSIR because of its proximity to one of Melbourne's drug centres in Richmond and being physically connected to NRCH, a community health service, which is built on a site owned by DH. When asked about issues of amenity related to the North Richmond location, the MSIR stakeholder discussed how long-standing issues such as discarded needles, verbal interactions, public injecting, and rarer incidents involving violence existed before the opening of the MSIR and that there was an unrealistic expectation from some members of the public that the MSIR would comprehensively address all of these issues. It was also recognised that engaging with local residents takes a lot of work, and more needs to be done to support real and perceived levels of safety and amenity.

The Victorian department stakeholder noted that international evidence demonstrated that in order to be effective, DCRs need to be located close to where injecting drug use and harm is most prevalent and where they can be embedded in a wider network of services. They then explained that NRCH is located near the epicentre of ambulance overdose callouts and historical drug overdose deaths in North Richmond. They also explained that NRCH was chosen because it already operated the busiest NSP in the region, and offered naloxone and overdose response services, BBV education, health promotion and outreach in the local community. The department stakeholder also advised that there is a broader program of work occurring relating to community activation, crime prevention and environmental actions to respond to community issues with health, wellbeing and safety in the local area.

In the case of Sydney's MSIC, Kings Cross was identified among 39 other locations being considered, mainly due to the sheer volume of drug activity in the area, including a high number of fatal overdoses. Kings Cross also had a history of drug activity, housing the country's first NSP, which

opened in 1988. After initial push-back from local community and business representatives, support has grown since evidence of a reduction in crime and fatalities in the area has mounted.

As there are dozens of DCRs and OPSs set up in BC, Canada, a variety of community responses was described by the BC stakeholder. Issues around 'not in my backyard' attitudes were described as a lack of understanding around how DCRs can help reduce needle litter and public drug use. There was also mention of people using every excuse they can to shut down DCRs in their region. However, there was also reference to examples of residents no longer objecting to facilities once they had opened and the anticipated negative effects were not experienced.

Governance

In Melbourne, the MSIR is operated by NRCH who are licensed to operate the MSIR by DH. Sydney's MSIC is part of the Uniting organisation, and while it does follow some policy directives from the NSW state government, it is officially a non-government organisation. A key practical difference between the MSIR and MSIC in terms of governance is that in Victoria, the state government represents the MSIR in the media, while Sydney's MSIC approaches this independently from the government. In BC, there are various arrangements across the dozens of DCRs and OPSs. Most commonly, local health authorities run the service and governance occurs within their organisational structures.

Sydney's MSIC does not have its own board, rather, it operates under the broader governance of Uniting's board. In practice, the governance structure involves frontline nursing and health education staff reporting to their respective manager, and each of those managers reporting to two operations managers, who then report to the clinical director. MSIR also has its own operations manager who reports to the clinical director. The clinical director reports to the CEO of NRCH who then reports to the NRCH board.

When asked about governance mechanisms for MSIR, the Victorian department stakeholder stated that the facility operated in accordance with legislation, regulations, license conditions, internal management protocols, and NRCH policies and procedures, with the Medical Director being responsible for ensuring the implementation, compliance and review of policies and procedures. The MSIR's operations are also monitored and supported by oversight and engagement from several DH areas, including a central project team in the Mental Health Division and operational staff, while the Medicines and Poisons Regulation branch is the regulator. There are regular meetings between DH and NRCH, as well as license inspections and audits. There are also meetings held with DH, NRCH and local services advisory groups.

Regulations

There are three different levels of regulation that dictate the operation of Sydney's MSIC. The *Drug Misuse and Trafficking Amendment - Medically Supervised Injecting Centre* outlines regulations at a parliamentary level. For example, the condition that only adults can use the service is outlined in this legislation, and any change to this policy will require the NSW state parliament to amend the legislation. There is also a license for the MSIC that sets out its own conditions and is overseen by the police commissioner and secretary of health, as well the policies of Uniting and NSW Ministry of Health. In addition to these, there are also policies of Uniting and NSW Ministry of Health that guide the operation of the facility.

According to the Victorian department stakeholder, the *Drugs, Poisons and Controlled Substances Amendment (Medically Supervised Injecting Centre) Act* 2017 established the legal framework for the MSIR. This Act served to amend and include Part IIA in the *Drugs, Poisons and Controlled Substances Act* 1981, and stipulates that there can only be one license for a DCR in Victoria, which must be at the Richmond location. Other regulatory requirements for the MSIR outlined by the stakeholder include statutory conditions and other safeguards relating to the facility's operation, including internal management protocols. They also noted that as a state funded AOD service provider, NRCH must meet key service delivery requirements and minimum performance and reporting standards in accordance with existing performance management frameworks, tools and processes that apply across the DH.

The NSW regulatory stakeholders described a three-level system of regulations for the MSIC. This includes the state legislation, MSIC license and internal management protocols. To change the clinical protocols, the Commissioner of Police in NSW, the MSIC service provider and Secretary of NSW Health must come to an agreement and first change the licensing conditions. The regulatory stakeholders also described an MSIC liaison committee featuring a range of partners that routinely meets to ensure cooperation and sharing of information between MSIC stakeholders. The committee also contributes to the broader engagement with local businesses and stakeholders, a process that the regulatory stakeholders said was especially important in the last 10 years with the Kings Cross area constantly changing and becoming more gentrified.

Operating Costs and Funding

According to the NSW regulatory stakeholders, MSIC's budget is $4.083million per year, with fixed costs such as salaries and wages comprising 70% of the budget. They also discussed the MSIC's fixed service delivery model, which required a certain number of qualified staff on site at any one time. The lack of flexibility in this model was described as a potential issue for operations, using the example of fewer clients using the service during the current COVID19 health emergency and the resulting over-staffing of the service.

The Victorian department stakeholder recommended costing a potential DCR model based on a staffing profile and award requirements, rather than relying too heavily on costing data from other DCRs. This would then take into account requirements around shift length and operating hours to align with award requirements and mandatory additional payments. They discussed factors that would influence the staffing profile, and therefore costings, such as the level of medical supervision, booth sizes, co-located services and whether there are services and staff funded by external organisations. For example, the provision and funding of BBV nurses by St Vincent's at the MSIR.

Challenges and Successes

The Victorian department stakeholder discussed MSIR's main successes as providing life-saving injecting supervision services, and the opportunistic provision of a growing range of health and social services onsite, which they saw as particularly important for MSIR's client group, because they may struggle to access external services or navigate complex health and social systems. Another strength that they describe was the comprehensive suite of services offered at MSIR and NRCH and the opportunities it provides to link people with life-changing support, where and when they need it. They also noted the importance of offering long-acting pharmacotherapy (buprenorphine implants)

since the beginning of the COVID-19 pandemic, which has helped reduce the need for accessing illicit drugs and maintaining contact with pharmacies and other pharmacotherapy dispensers.

When asked about the most important successes of the service, aside from the lives saved by preventing fatal overdose, the NSW regulatory stakeholders praised MSIC's advocacy for the clients of the service and harm reduction in the community more broadly. This local level advocacy was described as being nuanced, palatable and unique in how it engages community, police and political stakeholders. An example of this advocacy provided was the MSIC from the Heart event, which exhibits art made by MSIC clients to the Kings Cross and broader local community.

The MSIC stakeholder also described the inclusion of people with lived experience in the service staff as a success of the operation. Past criticism of the service for not employing peers was briefly addressed in discussion of political pressures on the service. The stakeholder stated that risk mitigation would be essential when considering peer involvement for a potential DCR in the ACT.

For the BC stakeholder, the main success discussed was the engagement of peers in DCR and OPS services and how they provide a more welcoming, less clinical environment. They also described the opportunity created by peers to build relationships and trust with clients, as well as being able to have important conversations with around what substances clients were using and providing information around the strength and purity of drugs being circulated.

When discussing challenges with each stakeholder, the common experience between the MSIR and BC representatives was the stigma that exists around drug use. It was recognised by the MSIR stakeholder that Richmond is a diverse suburb of Melbourne that still has a large amount of public housing, leading to a lack of understanding between residents of different backgrounds. The organisational structure of MSIR was also described as being a matter to consider through implementation, mainly due to the MSIR being such a large and complex service which has been integrated into NRCH, a relatively small organisation. In contrast, part of MSIC's success was linked to the benefits of operating as part of Uniting, which is an established and diverse service with presence across all of NSW, making it less susceptible to media and public scrutiny.

The NSW regulatory stakeholders discussed two main challenges. Firstly, the prescriptive nature of the legislation over the location of the service was seen as being too restrictive. The legislation states that the service must be at its current address, which could create issues if there are drug trends change over time and the service may need to be relocated. The other challenge was around the license conditions whereby a certain number of clients needed to access the services each day. This is a challenge because the number was defined when heroin use was at its peak, and now when the number is not met, a liability review is triggered for the Ministry of Health.

Evaluations

We asked each of the stakeholders how their services approached evaluations. The original evaluation of the MSIC was conducted by NDARC, and since then there have been several independent evaluators such as The Kirby Institute and NSW Bureau of Crime Statistics and Research. In BC, there is a less formal evaluation of OPSs that involves qualitative interviews with the peer workers that staff the services.

From a NSW Ministry of Health perspective, auditing involves an annual process of examining MSIC policies and procedures; as well as MSIC providing regular activity reports and other requirements as part of the Minister-approved grants and monitoring of any incidents that occur.

The MSIR is still under a trial period, which has recently been recommended to be extended for another three years, after an initial two. The evaluation of the first two years of operations was based on objects that are listed under the *Drugs, Poisons and Controlled Substances Act 1981*, which include reduction of fatal and non-fatal overdoses, BBV-related deaths, discarded syringes in public, increase in the uptake of treatment and a range of health and social services, improvement in the amenity of the neighbourhood and reduction in drug-related ambulance and emergency department attendance.

The Victorian department stakeholder stated that the expert panel who reviewed the initial two-year period of the MSIR trial noted that the facility was introduced in the context of escalating drug harms for people who inject drugs. They also referred to the panel's views that the objectives of the trial are ambitious, especially around improving amenity as well as saving lives and reducing harms for people who inject drugs. Despite this, the stakeholder discussed the panel's finding that the service was meeting most of its ambitious targets, with at least 21 deaths avoided in its first 18 months of operation and a reduction in ambulance attendances in the vicinity and spread of BBVs. However, they noted that more needed to be done to improve amenity for local residents.

ACT suitability

When asked about the suitability of a DCR for the ACT, two of the stakeholders recommended having multiple DCRs to address the issue of a geographically dispersed drug consumption scene. One suggestion was for one facility to serve as a touchstone, which could then be followed by other small services in different areas where there are concentrations of drug use as need is identified. It was also suggested that a small site could be easily integrated into existing health facilities. The third stakeholder advised that it was important to have a street-based drug market, as well as clients having the ability to walk or be able to catch public transport to the facility.

The MSIC stakeholder also warned against establishing a mobile DCR because of its limited capacity, which could lead to clients injecting outside of the facility instead of waiting for a booth inside. They also raised the potential for the service to be shut down too easily compared to a fixed-site service. Regarding an integrated model service being set up in the ACT, they provided advice around ensuring that it is a low-threshold service, with a focus on providing supervised drug consumption rather than ancillary services.

When asked to comment on the need for a DCR in the ACT, the NSW regulatory stakeholders provided the example of Kirkton Road Centre operating its own mobile NSP van. They mentioned advocacy for a mobile DCR in NSW from what they described as more conservative service providers. However, they acknowledged that public amenity, stigma and community opposition would remain a challenge, even if the ACT was to adopt a mobile DCR model.

When asked specifically whether they would recommend a specialised or integrated model for the ACT, they stated that both models had their advantages. The main advantages of MSIC's specialised model was its integration with nearby harm reduction and health services, highlighting the need for wraparound services whether they are co-located or not.

When asked about the suitability of a DCR in the ACT, the Victorian department stakeholder referenced findings from European reviews that helped inform MSIR's expert evaluation panel. These reviews stressed the importance of proximity of illicit drug markets; closeness to places of purchase of drugs; facility to embed a DCR in a wider network of services; compatibility with the

needs of people who use drugs; and compatibility with the needs and expectations of local residents.