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Access Health: providing primary health care to vulnerable and marginalised populations — a practice paper

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abstract

Following an extensive process, spanning nearly two years, the Salvation Army Crisis Services was funded to establish and operate a primary health service in St Kilda in accordance with guidelines set out by the Victorian Department of Human Services. On 1 September 2004, *Access Health* was officially opened in a large building adjacent to Crisis Services and the primary NSP. In this paper, we seek to provide an insight into the initial establishment phase of a primary care facility designed to meet the health needs of a particularly vulnerable population. It outlines early trends in client need and the service response developed to meet these needs. It also touches upon the relationships that service management has pursued, the structure of the service, and the processes that have been put in place to address (the

relatively few) teething problems that have arisen in the facility's first months of operation. In doing so, it provides insight of relevance to all practitioners who encounter the issues that marginalised and vulnerable clients with complex needs often bring.

introduction

Street-based IDUs experience many of the same health conditions as the general population. However they are at a disadvantage in respect of frequency, severity, and co-morbidity given the obvious impact on an individual's health of problematic drug use and the environment in which it occurs (e.g. Rowe 2003; Maher & Dixon 1999). The lack of financial security and the absence of secure housing mean that street-based IDUs suffer disproportionately high rates of chronically poor health (Babidge 1999; Darnton-Hill & Ash 1998; Hodder et al. 1998). Further, without some sense of stability and support to counter these factors, there are limits to improvements in an individual's health.

Despite high levels of need, mainstream health services often fail to provide care that is appropriate for street-based IDUs. The combined need to make (and keep) an appointment, for a Medicare card and/or money, and the reality of prolonged waiting times, is an obstacle to vulnerable clients, particularly those who are transient or in need of immediate care (Rowe 2003). Often health is not considered a priority in a chaotic life where survival takes precedence. Indeed, preventative health care and management of chronic illness is often overlooked (McDonald 2002).

Consequently, there is a need for services to be equipped to respond at *the* moment help is sought. If they are not, then relatively minor ailments may deteriorate to a point at which emergency treatment is required (McDonald 2002). Additionally, the health response that many mainstream services provide may be inflexible and, thus, inappropriate in the context of a client's complex, multiple and interconnected needs (Penrose-Hall et al. 2000). Discrimination, judgmental attitudes and lack of understanding (perceived or otherwise) only further contribute to limited contact with the mainstream health system (Abouyanni et al. 2000; Butt 1992).

practice innovation: *Access Health* and the pursuit of partnerships

Outlining the factors that obstruct the access of street-based IDUs to mainstream health services was, while lengthy, a relatively uncomplicated research task (see Rowe 2004). Developing a service response to address the same obstacles has proven far more challenging. *Access Health* is open five days a week, conforming to conventional 9–5 business hours.¹ However, this is the only extent to which the service could be described as conventional. The services offered by *Access Health* are cost free and, largely, non-appointment based.² At the outset, the service was established with the aim to provide

1 Although *Access Health* is closed on weekends, one of the service's RDNS nursing staff practices from the neighbouring Salvation Army Crisis Services on Saturdays and Sundays.

2 The exception is that appointments are made for the psychiatrist who attends the facility on Thursday afternoons and for Drug and Alcohol counsellors. However, if an appointment is cancelled, it can often be filled immediately by another client seeking such assistance. No appointments are needed to see doctors or nurses. These practitioners are seen on the basis of first in, first seen.

accessible and responsive primary health care to address the needs of:

- vulnerable/street-based injecting drug users;
- street sex workers; and
- people experiencing homelessness.

The nature of *Access Health's* clientele informs the delivery of primary health care within a social health framework, an approach to promoting health that acts to reduce inequalities and injustices. The complexity of health issues compounded by drug use, homelessness and transience demands a multifaceted, expert response. Recognising that the most effective means of offering such a response is through partnerships, *Access Health* collaborates with a range of existing health and support services to ensure appropriate primary care can be provided at *Access Health* while facilitating linkages with mainstream services. Partnerships with other agencies are based on either a co-location or fee for service capacity. At the beginning of March 2005, services offered on-site at *Access Health* and, where relevant, those organisations that they are employed by, include:

- community health nurses (7 days per week)³, RDNS Homeless Persons Program;
- duty workers (5 days);
- general practitioners (4 sessions), St Vincent's Hospital Department of Community Medicine;
- drug & alcohol counsellors (3 sessions), Inner South Community Health Service;
- psychologists / general counsellors (2 days), Melbourne Counselling Service;
- indigenous access worker (1 day per week);
- health promotion worker (4 days);
- drug safety worker (1 session);
- sexual assault counsellors (1 session), South Eastern Centre Against Sexual Assault (SECASA);
- psychiatrist (1 session), Bayside Health / Alfred Hospital Community Psychiatry; and
- researcher/evaluator (2.5 days per week), RMIT Centre for Applied Social Research.

The development of partnerships has facilitated the referral and progression of clients between different elements of the service system while ensuring access to immediate (and opportunistic) care in one location. A more 'seamless' service system means a reduced degree of navigation is expected of clients for whom engagement with just one facility may prove challenging. Further, entering into partnerships has greatly simplified processes such as case conferencing, shared care, secondary consults and has provided for enhanced joint case management and planning with particularly complex clients.

At the time that they seek to engage with the service, the majority of clients at *Access Health* initially request intervention for a physical health issue. Consequently, their first contact with the service's practitioners is often with the service nurses who, in addition to

3 As noted above, although *Access Health* operates from Monday to Friday, a community health nurse is available to be seen at the neighbouring Crisis Contact Centre on Saturdays and Sundays.

providing clinical care, record the ‘issues’ with which clients present. In the January–March quarter, community health nurses had 817 client contacts. Clients, however, may present with more than one issue. As a result, the number of presenting issues recorded far exceeds the number of client visits. The percentages listed below refer to the proportion of the 817 client contacts that community health nurses reported:

Physical Health:	625	(76.5% of client contacts)
D&A Issues:	424	(51.9%)
Mental Health:	239	(29.2%)
Behavioural Issues:	124	(15.2%)
Cognitive Disability:	23	(2.8%)
Physical Disability:	18	(2.2%)
Abuse:	13	(1.6%)
Intellectual Disability: ⁴	11	(1.3%)

It is to be expected that the most reported reason for contact with nursing staff would be related to physical health problems. Interestingly, more than half of client contacts with nurses were for drug-related reasons. The range of presenting issues recorded by nursing staff demonstrates how it is often during the course of the initial consultations at *Access Health*, that concerns around drug and alcohol use, mental health and social issues are identified. This is when the benefits of service provision based on co-located partnerships are most apparent. While community health nurses nursing staff (and GPs) offer an immediate primary health response to a number of clients who possibly wouldn't otherwise access care, their assessment skills enable them to make referrals to co-located (and external) specialists.

It is important to emphasise that the development of these partnerships did not take place without sufficient work and effort. Before the establishment of the service, several issues had to be considered to ensure the co-located services were able to work together effectively. These included having:

- a compatible philosophy;
- a shared commitment to the target group;
- a shared understanding of health and homelessness;
- a sense of shared endeavour and ownership; and
- clarity and collaboration regarding issues such as:
 - i. referral / shared care processes;
 - ii. communication between workers / client confidentiality; and
 - iii. service delivery models.

4 A cognitive disability differs from an intellectual disability insofar as the latter is diagnosed before an individual is 18 years of age. A cognitive disability is diagnosed (and typically diagnosed) after an individual turns 18 years of age.

The first three issues are interrelated. Obviously, partnerships would have soon collapsed had not the respective partners shared a commitment to a social health framework and an ability to work with highly stigmatised populations in an accepting, non-judgmental manner. Typically, the main limitations associated with service partnerships arise as a consequence of a lack of clarity around the roles and responsibilities (of both the host and co-located agencies). Referral protocols, client confidentiality and financial costs may also present issues. At *Access Health*, for example, co-located staff are not expected to fulfil administrative functions such as duty work. Nonetheless, it is expected that differing duty of care issues between various disciplines will occur in the context of shared care practices. To minimise any disruption or difficulties that may accompany such issues, all *Access Health* partnerships have been built around formalised contracts that encompass:

- the aim and target group of *Access Health*;
- the nature of the position;
- lines of accountability, responsibility and communication;
- financial agreements;
- grievance procedures;
- termination, variation and disputes;
- joint planning and evaluation;
- client records (including privacy/confidentiality issues); and
- access to resources at the site of operation.⁵

Additionally, a number of communication strategies have been implemented. These include team meetings, shared case notes (in some cases), case presentations and clinical review meetings. These measures enhance clinicians' understanding of their colleagues practices (particularly those of colleagues from other disciplines) and result in collaborative and improved health care for clients. Obviously, there is a need to ensure that the strategies for addressing potential difficulties are identified prior to partnerships becoming operational. Time invested prior to their commencement may well save a much greater amount of time at a later date.

the first nine months — practical lessons for practitioners

In the initial months of operation, many homeless and street-based individuals were attracted to *Access Health* by the availability of food and coffee making facilities. Access to showers (and the free provision of basic toiletries including soap, shampoo and shaving equipment) also attracted those with limited access to the facilities needed to maintain personal hygiene. Many clients initially came into the service purely to use these services. Continued contact with duty workers ultimately led to engagement and the development of a relationship with the service. This stresses the importance of duty workers who are

5 During the review process I received helpful comments from anonymous referees, one of which suggested that the section of contracts needed 'fleshing out'. However, given the idiosyncratic (and highly confidential) nature of formalised contracts, it is not appropriate to do so. This section is deliberately structured as a checklist to draw attention to the areas that should be considered by any service negotiating collaborative arrangements with potential partners.

non-judgmental and possess the skills required to engage and manage complex clients with often challenging behaviours. A number of the more vulnerable clients, initially attracted by the 'drop-in' component of *Access Health*, have been made to feel sufficiently at ease by duty workers to access the facility's clinical staff. Recruitment of ably equipped 'front of house' staff cannot be overstated when seeking to engage marginalised clients in need of health care.

After nearly six months of operation, the decision was made, in early February, to restrict access to food/coffee making facilities. This decision was taken for a number of reasons. Over the six months, regular clients had been made to feel welcome to a new service and the reticence of particularly marginalised individuals had been overcome through a gradual process of engagement. However, and perhaps more importantly, *Access Health* risked losing its focus as a health service and becoming known as a 'drop-in' centre. Further, the issue of prioritising resources was identified. The greater the amount of money spent on food ultimately means less money is available for the provision of material aid such as pharmacy vouchers.

At the same time, *Access Health* staff acknowledge that (poor) nutrition and hygiene are two of the most pressing health issues they confront. Showers remain available to all clients on a drop in basis. Similarly, food is available. However, it is distributed on the basis of nutritional need as assessed by clinical staff and not as an emergency relief response. Further, a drop in lunch is available to all clients one day a week as a continued means of engagement. Fresh fruit and drinking fountains are provided in the waiting room. Certainly, the decision to restrict access to food was a difficult one. But there are valuable lessons to be learnt regarding service identity and the prioritisation of resources. Further, the number of clients registered at the service continued to grow following this decision, suggesting that it has not affected attendance.

In January 2005, the clinical management software program *Pracsoft* was installed. In addition to clinical information, *Pracsoft* records the age and gender of clients 'registered' at *Access Health*. Registration is not a 'condition' for using the services available at *Access Health*. Some clients may be reluctant to disclose personal information for a variety of reasons and, consequently, remain unregistered. They may access the service in an informal capacity (e.g. to use showers and toilets). However, clients *must* be registered when a clinical intervention occurs. In this first month of its operation, 183 clients were registered on *Pracsoft*. By the end of February, 305 clients were registered and at the end of the first quarter of 2005, there were 383 clients on the *Pracsoft* database. The breakdown of the age and gender of clients is provided in Table 1 below.

Table 1: Demographics by age and gender (January–March 2005)

	0–9	10–19	20–29	30–39	40–49	50–59	60–69	70+	Total
Female	–	6	49	50	25	8	4	2	144
Male	–	2	58	89	52	28	9	1	239
Total	–	8	107	139	77	36	13	3	383
Total %	0.0	2.1	27.9	36.3	20.1	9.4	3.4	0.8	100

Female: 37.6% Male: 62.4%

Men have consistently comprised the greater proportion of *Access Health* clients, accounting for slightly more than 60% of those using the service. This has led to some gender-based issues.

Indeed, despite extensive research and feasibility studies and the lengthy negotiations that preceded the opening of *Access Health*, it would have been naïve to expect the facility to operate without encountering some teething problems. Any service dealing with complex issues and vulnerable clients must be structured in a way that allows modification of practice as issues arise. One such issue has been perceived male 'ownership' of common client-based areas (e.g. the waiting room (equipped with television and chairs)) and the front yard area (with tables and chairs). Many of *Access Health's* female clients have had negative, and often violent, relationships with men. A proportion are street sex workers who have experienced significant gender related power abuses in both their private and public domains. Consequently, some women may be understandably reluctant to wait in an area in which men appear to dominate. A number of women have noted the intimidating nature of common areas:

The drop in group [for lunch on Wednesdays] started to be a bit like that. I thought, as soon as something good starts it's like all these guys come and push in, everyone is going to get a meal but they'll just push in, like, you've got to wait in line. Some of them are okay and some of them are no good (Female, aged 31).⁶

This has become less of an issue since unlimited food and coffee was discontinued. Initially, many older, homeless, alcoholic affected men would use the facility for respite from the streets. Many of these men now attend *Sacred Heart Mission* a short walk down Grey Street where coffee, breakfast and a drop in space is offered. Staff have also sought to address concerns regarding the weekly drop-in session. The presence of two skilled, female staff ensures a better gender balance, a feeling of security for vulnerable women and an informal monitoring situation, with the capacity for intervention when needed. Furthermore, in the months of April and May, the number of female clients has increased at a faster rate than male clients, suggesting the women are comfortable with the structure and service model offered at *Access Health*.

The ability to survey and address such issues as they arise is important. For this reason, *Access Health* incorporates an evaluation component, in the form of an on-site researcher, to monitor the facility's operation during its developmental stages. The evaluator/researcher assists staff by identifying areas in which delivery of services may be improved or modified. This is done by gathering information about client outcomes and client satisfaction with the services offered by *Access Health* through interviews (with clients and staff), surveys and collation of electronic data. In addition to providing for the continued assessment of the efficacy of the service model, this allows data to be provided to funding bodies at regular intervals. Both of these outcomes will contribute to the long-term sustainability of *Access Health* as a primary health facility.

6 Each of the two quotes are from clients of the service interviewed by the author. Part of my role as the on-site evaluator is to regular interview clients to gauge client satisfaction (or otherwise) with the service.

Finally, it is essential to note the challenges and rewards (to both the Salvation Army Crisis services and *Access Health*) of establishing a health service within a welfare agency. Both parties have needed, and worked, to gain a thorough understanding of the philosophies and models with in which the other functions. This is one of the few occasions where the two sectors are not functioning in silos but are (becoming) integrated and enriched. Most importantly, however, those who most benefit are the clients who have access to increased service capacity as a result of the expansion of the 'one-stop-shop concept'.⁷

Conclusion

Access Health has only been operational for nine months and unexpected issues may still arise. However, the feasibility studies and research process that preceded this operation has doubtless minimised these to a considerable degree. This and the willingness (and ability) to respond to further issues as they arise are two of the most important aspects that allow the service to function to the degree that client numbers continue to grow. Perhaps more important are the principles according to which the service functions. Namely, that all people are entitled to quality, responsive health care that meets their unique and, at times multifaceted needs. For marginalised individuals and populations, (such as street-based IDUs, street sex workers and people experiencing homelessness), these needs include, not least, a lower health status than other members of the community. Recognition of this fact and the concurrent building of primary health care partnerships has enabled *Access Health* to go some way to addressing these needs while winning the respect of clients who, to many in the health and welfare sector, are seen as too challenging to deal with:

I guess it's like any business in its infantile stages. It's going to have to go through teething and working out what's going to work and what's not ... but stuff from the general community is that it's coming together great. That's the vibe I get. Everyone is happy with it ... and I talk to so many street people, you wouldn't believe it (Female, aged 44).

Acknowledgements

I would like to acknowledge Ms Sue White the manager of *Access Health* for comments and assistance in the drafting of this report and the staff and clients of *Access Health* for their cooperation. Acknowledgement should also go to the Salvation Army Crisis Services for pursuing the best service possible in the interests of their clientele. Finally, I would like to thank the two referees for their constructive criticisms.

⁷ While the one-stop-shop concept of *Access Health* has been outlined, it should be noted that the neighbouring Crisis Services also has a range of services to which clients of the health service can be directly referred. These include employment and housing services, Centrelink, material aid, and legal and domestic violence services within the one building.

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involving the community in shaping drug policy

In early 2003 the Fitzroy Legal Service (FLS) released a report titled *Drugs, the Law and the Sentencing of Offenders: A Community Discussion of Future Directions*,¹ which contains the outcomes of research conducted in August and September 2000 to gain a street level insight into drugs and the law in Victoria. The report consists of two parts: the first, 'A community discussion about drugs and the law', presents the results of a series of focus groups that discussed the effect and effectiveness of the laws relating to drugs (primarily heroin), the policing of those laws and the way the courts deal with drug offenders. The second, 'A peer discussion about sentencing drug offenders', examines the sentencing of drug offenders in Victoria from the viewpoint of interviews with professional service providers.

The report does not purport to be a comprehensive analysis of issues related to drug use. It does, however, provide an insight into the views of many in our community and a springboard for further research, and highlights key issues that can help guide current public policy decision making and so shape the future direction of drug sentencing laws in this State.

methodology

For Part 1, seven focus groups were convened with participants drawn from the local community, including: people who used drugs; traders or their representatives; community workers from local agencies; and residents from public housing. The use of small focus groups enabled the full range of issues to be explored while allowing all participants ample opportunity for meaningful contribution. The sessions were led by a facilitator who introduced topics with a short outline of the issues, then opened up the session for discussion.

Part 2 of the report was compiled from extensive personal interviews with eleven professionals who were in contact with drug-addicted clients on a daily basis. These professionals included specialist criminal defence lawyers (both in community legal centres and in the private profession), a medical practitioner, drug and alcohol workers, youth workers and other community workers. These professionals were asked a broad range of questions about the purposes behind sentencing, their views of the *Sentencing Act 1991* (Vic), the effectiveness of sentencing options as of late 2000, recommended alternatives and other related issues such as the availability of legal aid funding.

findings

What follows is a brief summary of the key issues raised during the focus groups and professional interviews. The full report includes a range of viewpoints on each of these issues, illustrated by actual comments made by participants in the discussions.

1 Fitzroy Legal Service (2003) *Drugs, the Law and the Sentencing of Offenders: A Community Discussion of Future Directions*. The full text of the report is available from Fitzroy Legal Service, 124 Johnston Street, Fitzroy 3065. Ph: 9419 3744. Fax: 9416 1124. Email: enquiries@fitzroy-legal.org.au

Part 1: Community discussion — drugs and the law

The experiences related in the workshops were notably diverse. Some participants witnessed the impact of laws and attitudes on their immediate welfare and longer term prospects on a daily basis. Within this diversity, however, a number of common views, observations and recommendations emerged that must be acknowledged by all stakeholders if any serious debate about, and improvement to, the effectiveness of drug sentencing laws in Victoria is to take place.

The key observations emerging from the workshop discussions included:

- the failure of current prohibition laws in stemming illicit drug use and abuse;
- the need to improve policing practice within the community through further education; and
- the need to fund more flexible sentencing options and increase access to interlinked rehabilitation and support services.

failure of prohibition

While it was acknowledged that in some instances punitive sanctions for drug offences could act as a deterrent for some users, the majority view was that prohibition remained fundamentally flawed in its application. It was perceived that prohibition often impeded substantial moves towards rehabilitation and instead merely exacerbated existing social, health and financial problems. Legalisation and decriminalisation of drugs were regarded as solutions. Regulation of supply — which would occur as a result of legalisation — was perceived as having certain ‘spin-off’ effects. Such effects could include removing the stigma associated with drug use, reducing negative activities of illegal markets, stabilising quality of supply and allowing users to focus on their own life, health and family needs in a more positive and less chaotic way.

The issues of choice and personal liberty were also raised. The general view was that partial prohibition, while seen by some as a step in the right direction, was likely to have only limited success. Drugs would still be purchased via illegal markets, again exposing users to the dangers of variable supply, quality and associated criminal activity. Police discretion was also seen as a problem under partial prohibition, with many users feeling discriminated against in contrast to more affluent, well-presented members of the community.

improved policing practice

While it was recognised that some police generally understood the reality of drug use, there was an overriding concern that many did not. Concern was also raised over the effect on the community of police drug blitzes and police mistreatment. While the importance of an effective police presence in the community was acknowledged, it was seen as critical that police understand the nuances, people and culture of the community they are policing.

Traders, residents and users considered that programs designed to link offenders with housing, counselling, legal and/or other services would be more effective than measures designed to lock up offenders. Increasing government funding for support programs, such as programs linking arrestees with community workers, was seen as a positive step.

more flexible sentencing options and better access to rehabilitation and support services

Most participants saw that the court system, when dealing with drug offenders, failed to recognise the nature of addiction and to address the underlying causes of criminal activity. Participants emphasised the need for the courts to make rehabilitation the primary focus when sentencing offenders, and advocated a holistic, flexible and responsive approach to rehabilitation.

While it was acknowledged that criminal behaviour which impacted on third parties could not go unchecked, participants questioned whether existing court programs, such as mandatory treatment programs, were successful in preventing such behaviour. Key themes from the discussion included the need to tailor rehabilitation programs to specific needs, to set realistic goals with respect to rehabilitation, to involve offenders in setting up their own treatment programs and to recognise the risk of relapse. It was also noted that any rehabilitation efforts needed to be adequately supported by local services and resources, which at present are critically under-resourced and have substantial waiting lists. Further funding for such support services is therefore critical, in order that courts may link drug offenders with effective rehabilitation programs.

Finally, an overriding message that came out of the focus groups was the need for further discussion, consultation and an opportunity for the community to become involved in the development of future programs, particularly court diversion programs. It was emphasised that the community can offer insights and perspectives into the issues surrounding drug use, policing and the application of drug laws in this state.

Participants agreed that their enthusiasm and commitment should be harnessed in order to help steer the decision-making process in these areas.

Part 2: Peer discussion — sentencing of drug offenders

Drug addiction and the sentencing of drug offenders is an extremely complex area. While those interviewed recognised that the other sentencing purposes (punishment, deterrence, denunciation and protection of the community) have a role to play when sentencing drug offenders, overwhelmingly the respondents were of the opinion that rehabilitation must be the court's primary focus in order to accomplish more practical and progressive outcomes for drug offenders.

Many of the issues involved in drug addiction are removed from the application of the law, yet must be recognised if sentencing is to achieve effective rehabilitation. This section of the Report examines a number of important considerations that affect this goal, including:

- the realities of drug addiction;
- judicial flexibility and a focus on rehabilitation in sentencing; and
- the need for improved social support systems for drug offenders.

the realities of drug addiction

In order to begin the pursuit of an effective rehabilitation campaign one needs to understand the realities of drug addiction. An important starting point is to recognise that

drug users cannot be stereotyped. Individuals take drugs for various reasons. For some it is a clear-cut case of addiction, for others the addiction may mask underlying social issues. Given the diversity of situations and varying levels of addiction, it is essential that rehabilitation programs and social support schemes cater to the individual rather than adopt a uniform approach. Both sentencing and rehabilitation programs need to appreciate that relapse is common in the recovery process and does not necessarily result in failure. The varying nature of addiction should allow for the rehabilitation process to be defined by the individual drug user.

Our research indicates that rehabilitation, like addiction itself, varies in the form it may take. For some a successful rehabilitation may be a complete withdrawal; for others, it may be a mere reduction of use. Furthermore, the transient and chaotic lifestyle of addiction needs to be recognised by more flexible compliance regimes and rehabilitation campaigns that reflect the unique situations of users. Rehabilitation measures dictated by both the judicial and social support areas need to be cautious of adopting a dogmatic view of 'success' and should instead focus on measures of rehabilitation which best reflect the realities of drug use.

focus on rehabilitation in sentencing

This research revealed a strong and unified opinion that rehabilitation should be the court's primary focus when sentencing drug offenders. The inflexibility of the current sentencing hierarchy was seen as detrimental to the drug offender's progress. Under the present sentencing regime re-offenders are often placed under more onerous compliance orders, which upon default may result in imprisonment.

An approach that permits a degree of failure as part of the rehabilitation process, rather than as grounds for further punishment, is needed (although some respondents noted that a distinction needs to be made between offences which involve third party victims and crimes which are victim-less). Such an approach would not only adequately encompass the reality of addiction through further judicial education but would also operate in conjunction with other social support schemes.

improved social support systems

Insufficient government funding has not only prevented reform, but also hampered the effective running of the present social support system for drug offenders. Funding limitations have contributed to a variety of problems. This investigation indicates it is essential, prior to entering into any rehabilitation program, that basic necessities such as food, shelter and health care are secured as a stable and accessible fixture in a user's life.

Respondents commented that:

- inadequate legal aid funding meant a lack of access to ongoing legal representation and individual case support;
- the financial limitations on publicly funded legal representation often resulted in corners being cut and less individual assistance from social workers and psychologists; and
- community work programs neglected to foster necessary work and life skills in the participants, instead often providing an opportunity for further drug use.

Clearly, these problems alone indicate the need for further funding in order to make improvements.

conclusion

This research has indicated that in order to make rehabilitation the number one priority when sentencing and supporting drug offenders, it is imperative that the three above-mentioned areas operate in conjunction with each other. The effective operation of both the judicial and social spheres in relation to drug offences not only requires further funding, education and debate, it also demands further extensive research, if improvements are to be efficiently implemented and directed.

postscript

Two further issues — not the subject of this research — are nonetheless important.

First, the participants were consistently of the view that discussion was needed on how to prevent people from entering the criminal justice system in the first place.

Second, there is a continued need for debate about the drug laws themselves.

In large part the criminal justice system, including the courts, has failed to improve the situation in relation to drug matters and, in particular, to issues which affect drug users. It is highly recommended that as the prohibitionist approach has been an abject failure, our community needs to consider other options such as decriminalisation, legalisation and/or regulated supply of drugs like heroin. It is hoped this report can be a helpful lead in to consideration of these related issues.

the Fitzroy Legal Service drug outreach lawyer project

Stan Winford, Lawyer / Legal Projects Officer, Fitzroy Legal Service.

The Drug Outreach Lawyer project was conceived at the Yarra Drug and Health Forum,¹ and ultimately received funding in July 2001 under the Victorian Government's Local Drug Strategy Initiatives Grant Scheme, now administered by the Department of Human Services. The local drug strategy funds also supported the establishment of primary health care services, designed specifically for street-based injecting drug users, and were earmarked for communities identified as street drug use 'hot spots'.² Funds for the grant

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- 1 The Yarra Drug and Health Forum (YDHF) is a community group comprising local agencies, government departments, residents and people affected either directly or indirectly by drug use in the Yarra community. The YDHF was established in response to the dramatic increase in heroin use in the City of Yarra in the late 1990s.
 - 2 The five 'hot spots' for street drug use identified by the Drug Policy Expert Committee were the City of Greater Dandenong, Maribyrnong City Council; the City of Melbourne; the City of Port Phillip and the City of Yarra.

scheme were, in part, derived from the inability to establish locally based safe injecting facilities after the defeat of supervised drug injecting legislation in late 2000.

Fitzroy Legal Service (FLS) was a founding member of the Forum, and based on discussions with Forum members and its own lengthy experience working with people facing a range of legal issues associated with drug dependence and homelessness, FLS saw the necessity for the Drug Outreach Lawyer project. The clear associations found in people experiencing poverty, mental illness, disadvantage, social exclusion, homelessness and drug addiction were no less marked amongst street-based drug users with legal problems and, FLS concluded, it required a local and specific response in order to deal with the problem of providing access to legal assistance to street drug users in Yarra.

The most obvious of these problems were faced by those dealing with the criminal justice system. Lawyers working in this area with FLS had observed an unfortunate pattern resulting from the fact that street drug users facing criminal charges would access legal assistance at a very late stage in the legal process, if at all. Structural and systemic barriers to justice are numerous amongst this group, but can be as simple and obvious as problems maintaining appointments and keeping in contact with lawyers without a fixed residential address or telephone number.

As a result, street users facing criminal charges tended to receive sentences from courts who, faced with little evidence that underlying problems associated with criminal offences had been addressed, cannot be persuaded that the community will be protected from criminal activity by 'soft' rehabilitative sentencing options. Sentencing principles based on escalation of penalty for repeat offenders tend not to recognise the difficulties faced by drug users with little support who, despite efforts to control drug dependence, regularly relapse.³ Punitive or 'tough' sentences based on such principles, in turn, do little more than perpetuate their recipient's marginalised position within the community.⁴

FLS considered that by establishing an outreach service, the Drug Outreach Lawyer could assist street-based drug users to obtain legal assistance earlier in the legal process and work towards establishing links with support agencies before sentencing commenced. Access to material support, accommodation, health, drug treatment and counselling and a degree of stability would more readily translate into sentences geared towards rehabilitation rather than mere punishment or deterrence.

While outreach is not a particularly novel concept for delivering legal assistance amongst community legal centres such as FLS, an outreach lawyer whose sole function is to provide assistance to individuals with drug problems who would not normally access agency services, may be unique.

3 See further: Pauline Spencer and Fitzroy Legal Service (2003) *Drugs, the Law and the Sentencing of Offenders: A Community Discussion of Future Directions*. The full text of the report is available from Fitzroy Legal Service, 124 Johnston Street, Fitzroy 3065. Ph: 9419 3744. Fax: 9416 1124. Email: enquiries@fitzroy-legal.org.au

4 Courts and legislatures are, however, contributing to the development of an emerging 'therapeutic jurisprudence', recognising the importance of rehabilitation with the establishment of drug courts, drug diversionary programs, bail-linked treatment and referral programs and rehabilitative sentencing programs.

The Drug Outreach Lawyer targets people who have existing or potential substance abuse problems and who are not currently accessing existing legal services. Priority is given to people with high needs such as young people; non-English speaking clients; clients with disabilities (including acquired brain injury); clients with 'dual diagnosis' (drug/alcohol *and* psychiatric conditions); homeless people and those residing in rooming houses or public housing. The Drug Outreach Lawyer focuses on clients with 'chaotic' lifestyles and others excluded from conventional legal services for reasons such as discrimination, lack of access to legal aid or an inability to pay for legal services, and cultural background.

The Drug Outreach Lawyer provides legal advice, referral, advocacy and casework services as a means of reducing legal problems faced by drug users, thus assisting rehabilitation and minimising harm and stigma associated with street drug use. By targeting people with existing or potential substance dependence problems the Drug Outreach Lawyer seeks to provide appropriate legal support and education to minimise street drug users' vulnerability to exploitation, negative contact with the criminal justice system and to enhance their opportunities for rehabilitation and treatment.

The Drug Outreach Lawyer combines a mix of outreach advice clinics, seminars, street outreach and court work, often in collaborative partnerships with health services, needle exchanges and drug and alcohol workers. An important means of reaching target clients has been to link clinics with existing drug treatment agency services. Outreach legal clinics have been piloted, evaluated and then permanently established in perceived areas of high need, having regard to the priorities outlined above. Clinic locations are regularly evaluated to ensure that the service responds to the shifts in patterns of drug use and user access that inevitably occur.

To date, outreach advice clinics have been conducted from the premises of a number of agencies in Yarra who provide support to drug users: the Youth Substance Abuse Service day program, the Melbourne Inner City Needle Exchange, the Next Door Primary Health Service, Buoyancy, St Mary's House of Welcome, the Church of All Nations drop in centre and at other locations on request. Appointments are not necessary at outreach clinics — typically attendance is for a two-hour period and clinics are scheduled to coincide with the provision of free food or other attractions to maximise numbers.

Another method of ensuring access for drug users is street-based outreach work. Street outreach is conducted in conjunction with outreach workers from the Youth Substance Abuse Service and through the North Richmond Community Health Service, who cover different areas of Yarra on different days and times. Areas covered during street outreach include housing estates and surrounding streets in North Richmond, Fitzroy (Atherton Gardens) and Collingwood on a weekly basis, and on occasions the Carlton housing estate.

Once contact with clients has been established and additional support secured, ongoing work in the preparation of legal matters may not need to continue as outreach. While much of the advocacy and legal representation work is undertaken by the Drug Outreach Lawyer, involvement in outreach and other duties means that some more complex cases are referred to bodies such as Victoria Legal Aid, barristers and other legal firms.

Part of the Drug Outreach Lawyer role is to provide community legal education; usually, talks or information sessions delivered to users and audiences including social workers and

drug and alcohol workers on topics such as ‘drugs and the law’ are provided regularly from outreach and non-outreach locations.

Law reform and community development initiatives are also a key component of the Drug Outreach Lawyer’s role. Legal issues occurring repeatedly amongst the street drug user community result in attention being devoted to broader, policy-based solutions. Proposed legislation to make discrimination against drug users legitimate and the response of the criminal justice system and the legislature to ‘chroming’ are a couple of recent examples of such issues addressed in collaboration with other organisations and individuals working in related fields.

The unique approach of the Drug Outreach Lawyer has so far proved to be a most effective means of facilitating access to justice for many of those people who have traditionally been marginalised within our legal system.

Independent evaluations of this project and complementary projects such as primary health care services have reported success, concluding that unmet need within the community is being met and that projects such as the Drug Outreach Lawyer hold out considerable promise as initiatives to improve the health and welfare of street-based drug users. Evaluations have also found that these services are well regarded and well-utilised by the client group.⁵

Finally, the Drug Outreach Lawyer project shows that the use of outreach strategies and other methods rarely implemented by lawyers can create a legal resource adaptable to the needs of clients with complex needs who face systemic barriers to accessing the law. It may not be an exaggeration to suggest that many people’s lives have been improved, and much potential for harm significantly reduced by the establishment of this project.

5 Centre for Applied Drug and Alcohol Research, *Evaluation of the Five ‘Hot Spot’ Local Drug Strategies*, Monash University, 2003.

overdose prevention and street-based injecting drug use: why we’re heading in the wrong direction¹

David Moore, School of Health Sciences, Deakin University, and Paul Dietze, Turning Point Alcohol & Drug Centre and School of Health Sciences, Deakin University

Summarising the findings of past Australian research on overdose, we can make several points. First, that risk factors for overdose in general include: mixing heroin with benzodiazepines and/or alcohol; being out of drug treatment; and using the drug under conditions of changed tolerance, (e.g. resuming drug use following a period of abstinence or increasing use following a reduction in use). Additional risks for heroin-related death include using heroin by oneself and failing to call for assistance with an overdose for fear of arrest or because of lack of knowledge. We can also note that the ‘typical’ overdose victim

1 Adapted from an article that first appeared in *Centrelines* (the newsletter of the National Drug Research Centres) 8, December: 3–4. Reproduced with permission.

is not a novice but an experienced, male heroin user not in treatment at the time of death; that overdose deaths are only moderately related to fluctuations in purity; that overdose is also possible via smoking, snorting and swallowing heroin; and that ‘instantaneous’ overdose deaths represent only a minority of overdose cases (i.e. most deaths occur some time after the use of the drug).

Based on this research, a number of strategies for the prevention of overdose have been recommended: public and peer-based education and health promotion to reduce the risks outlined above (i.e. sample heroin first, don’t mix with other drugs, don’t inject alone, always call an ambulance in the event of overdose, monitor one’s tolerance); expanded treatment services; a trial of naloxone provision to heroin users for peer administration; greater regulation of benzodiazepines; a trial of safe injecting facilities; overdose-specific support, recovery and referral services; court diversion into treatment; law enforcement that does not increase drug-related harm; and CPR training for drug users. These are all worthwhile prevention strategies. However, they do not address many significant issues identified during recent research on street-based injecting drug use (IDU), street sex work and service provision in the St Kilda area of Melbourne.

Most of the people in the study reported overdose experiences relating to the five behavioural risk factors outlined above, yet many of them were also well aware of prevention messages around polydrug use, and, to a lesser extent, injecting with other people present and resuming use following abstinence. Given this apparently high level of awareness of risk factors for overdose, the question we should now be seeking to answer is: Why do so many people continue to engage in ‘risky’ practices? To begin to explain this, we need to understand the contexts of ‘risk’.

The St Kilda materials contain several useful illustrations. Many of the women in the study are involved in street sex work, an extremely hazardous occupation with a high probability of physical and/or sexual assault, robbery, arrest and sexually transmitted infection. Some of these women and many of the men are also involved in various forms of criminal ‘rorts’ and in unstable accommodation. In this context, messages about overdose prevention are added to a long list of ‘possible risks’ encountered during the course of a typical day. This is not to say that street-based IDUs and sex workers are unconcerned about their health but that, seen in context, there are many other, more pressing, priorities that must also be met, e.g. avoiding arrest and assault, evaluate buy and use drugs, avoiding creditors

Polydrug use is often unplanned, resulting in money and heroin on a regular basis), the search for action and purpose, or mistakes. Because of the relatively low cost of benzodiazepines and highly alcoholic drinks, many study participants had consumed several



John Spooner, *The Age*

units of one or both before unexpectedly having the opportunity to inject heroin, which they then took.

Another clear finding from the research is that categories such as ‘IDU’ and ‘overdose’ do not allow for the variety of cultures and practices within the IDU population, even at the local level of St Kilda. For example, people’s accounts of overdose, and of heroin use more generally, often include descriptions of a ‘honeymoon’ period during the early stages of use. A feature of the honeymoon period is ‘getting smashed’ (i.e. being heavily intoxicated) — tolerance is low, the cost is affordable, and the drug’s effects are powerful and intensely pleasurable. With the age of first use of heroin falling in recent years, we can also assume that this honeymoon period usually corresponds with the mid/late-teens or the early twenties, stages of life when many demands are placed on young people.

If ‘getting smashed’ is the main aim of using, for whatever reason (e.g. coping with family problems, joining a peer group of heavy users), strategies for reducing the amount of heroin used, and therefore the risk of overdose, are less likely to be adopted. Many people involved in street-based drug and sex work markets also have accompanying problems of homelessness, mental illness and acute poverty, and an associated desire for extreme intoxication; they may therefore see messages about testing heroin strength to prevent overdose as irrelevant.

There also appear to be differences in male and female experiences of overdose. Women more often describe situations where part of their role appears to be to regulate their partners’ heroin use, especially after periods of abstinence, in order to prevent overdose. Men are sometimes involved in overdoses through providing too much heroin to their partners. While some women take, or are forced to take, passive roles in managing money, scoring drugs, and preparing them for injection (even some who are the main income earners through street sex work), some men also accept a passive role in situations where their health may be at risk. For example, one young man, with a history of sexual abuse, schizophrenia, suicide attempts and institutional care, calmly described how he took no role in the purchase and preparation of the heroin that was then injected into him by a newly-made friend. In a street drug market such as St Kilda, where ‘friendship’ is relatively rare and networks change rapidly over time, he trusted his accomplice to provide the ‘right’ dose to produce intoxication but not overdose.

The question of ‘friendship’ is related to the social organisation of the drug market. Large segments of the St Kilda drug-using population share little apart from their common participation in street-based IDU and sex work. The transience of people, networks and lifestyle means they are less likely to inject in a private setting and more likely to do so in a public place, where there is increased risk of harm. Likewise, ‘never-use-alone’ advice ignores the difficulty in street drug markets of finding someone to trust without being ‘ripped off’. One exchange witnessed during the research featured a female sex worker urging a female associate not to inject heroin alone in a nearby park. The sex worker suggested that she take her (i.e. the sex worker’s) boyfriend with her to be safe. The would-be park injector looked a little hesitant. The sex worker assured her that the boyfriend would not expect a ‘shot [injection of heroin]’ in return for his company and that she (and her money and drugs) would be quite safe with him. Overdose prevention needs to be aware of these social factors that might undermine attempts at peer education and community development amongst IDUs.

Prevention messages also need to recognise the different kinds and levels of resources available to different groups of IDUs. Middle-class, privately educated, tertiary-qualified IDUs are more likely to have family, work and social networks and financial resources to draw on in organising their drug use and in coping with related problems. Street-based IDUs (some of whom are also from middle-class backgrounds but who have exhausted these resources) do make ‘choices’ about their drug use, but these ‘choices’ are much more limited.

There are many starting points in these data for designing individual behaviour change and peer education programs targeting particular aspects of IDU and overdose. However, the effectiveness of well-intentioned but individually-focused peer education and community development programs is likely to be limited unless they take account of the stages in drug careers, variation in IDU cultures (e.g. based on gender, social class, stage of drug career), reasons for use and broader aspects of risk environments (e.g. the unavailability of overnight NSPs in St Kilda leading to risky IDU). Reducing overdose, and drug-related harm more generally, requires a range of approaches that, working together, take account of all levels — from the individual through to the environmental.

the Victorian Human Rights Charter and the alcohol and other drugs sector

Stan Winford, Legal Projects Officer, Fitzroy Legal Service

It may be difficult to give a comprehensive account of what the Victorian Charter of Human Rights and Responsibilities will mean for the AOD sector in the coming months and years, and it is almost impossible to do so in brief and without resorting to ‘legalese’. Nonetheless, it’s probably worth starting by pointing out what it won’t mean. Some of the common expectations are that it will allow individuals to go to court, US-style, and sue for compensation claiming that their human rights have been violated. To have legislation declared invalid and struck down by the courts — it won’t allow this.

The way in which the Charter will affect this sector — service users, service providers and government agencies alike — will be something more akin to a gradual sea-change. The gradual sea-change will occur as a result of the paradigm shift of language and thinking about drugs and alcohol and how to deal with them in our community. The Charter is based on a dialogue model of human rights, which means that while government action and the actions of ‘public authorities’ will be subject to scrutiny based on their compliance with a human rights framework, there is no overriding power for courts to impose particular changes.

The Charter means that the human rights implications raised by a particular policy, program or issue can now be considered within a consistent set of standards regarding what is expected of government and agencies carrying out functions ‘of a public nature’, which in many cases will include AOD services, particularly those funded by government. The Charter will require that human rights are accorded consideration and attention in the development of policies, and will provide a clear way of assessing whether particular departures from human rights can — or cannot — be justified.

Under the Charter, rights are not absolute: they may be restricted where reasonable and necessary and often balanced against competing rights. The benefit of this new approach for policy making is that, firstly, human rights are explicitly considered when forming policies to deal with drug and alcohol treatment and laws concerning the regulation of drugs, but it also allows the best possible decisions about these policies to be made. While a previous government considering legislation that would enable the commitment of people for involuntary or coerced drug treatment would probably have thought about these sorts of issues, they will now explicitly be required to make such legislation compatible with the human rights of the person who may be treated involuntarily.

Using the Charter to help make these decisions will also lead to the development of knowledge and experience across public authorities and agencies charged with implementing laws and policies to do with drugs and treatment. They will come to understand what types of issues might give rise to human rights concerns, and how those concerns might be then addressed in the development, design and implementation of policies, services or laws.

What does all of this mean in practical terms? An important point to note at the outset is that the Charter means quite different things for different groups in the sector. For drug users, it may mean greater observance of their rights by public authorities, in ways that lead to less explicit discrimination, stigma and social exclusion. For drug user groups and advocates, it may be another means of advocating on behalf of their constituents and peers to call for an end to discrimination for instance in the provision of OST by pharmacists, or to call for an end to particular laws or practices that undermine the effectiveness of harm reduction strategies.

Human rights provide a framework for assessing and moderating the impact of legislation, policies and practices on the interests of a range of often marginalised groups whose voices can be absent from, or drowned out in an environment where other values or needs often take precedence: whether budgetary, administrative, bureaucratic or crisis-driven.

For services and government, the Charter clearly means increased obligations: to comply with the rights in the Charter, and more explicitly, to take them into account both in what they do and in how they operate. It might mean that public authorities such as Victoria Police — who will now have a duty to promote and protect human rights as well as uphold the law — will think carefully before implementing enforcement or supply reduction strategies that result in the exclusion of users from geographic areas and therefore disrupt access to treatment services or needle exchanges. The desire to reduce supply or demand will have to be appropriately limited by upholding the right to health for drug users. The police may also begin to think about the use of public searches of individuals that don't appropriately take into account the right to privacy, the right to health and the additional harms such a search might cause.

When government considers how to allocate money across programs and services, a human rights framework could lead to shifts in focus across supply, demand and harm reduction strategies.

For services involved in developing and delivering drug treatment, the Charter will require human rights to be respected and protected. Some of these rights include:

- the right of people who use drugs to enjoy the highest standard of physical and mental health;
- patient rights, including confidentiality and the right to receive information regarding one's state of health;
- the right to informed consent to treatment and the right to withdraw from treatment; and
- the right to non-discrimination in health care and to be free from torture or other cruel, inhuman or degrading treatment.

These considerations must inform the types of programs that are undertaken and the procedures and regulations that govern their operation. For a primary health centre considering whether to ban someone from the service, the Charter may impose an obligation to provide a fair process, one that includes a right to be heard, the provision of reasons and an avenue of appeal.

Finally, what's the point of all this? Apart from getting a handle on the new compliance obligations, why should we do it? One of the main reasons is that it works. When taken into account early in policy making processes or in the design and provision of services, human rights tend to generate policies and services that ensure reasonable objectives are achieved by fair and just means. Good policies and services contribute to social cohesion, which is in turn an important aspect of the promotion of health and well-being. Policies or services which respect and reflect human rights are more likely to be inclusive and of good quality. And that's surely a change for the better.