



'Just people being people': A report on client-feedback for Innerspace Drug and Safety Services.

Chloe Span B Soc.Sci. (Hons)

May 2015

Acknowledgments

This research, conducted as part of my Honours qualification in the discipline of Social Science would not have been possible if it were not for the trust of the clients, staff, and management at *Innerspace Drug and Safety Services*.

I would like to thank each of the people who choose to participate in this project for sharing their experiences so openly and honestly. I am overwhelmed by your input.

Also I am very grateful to *Innerspace* Manager, Danny Jeffcote, and Executive Officer of the Yarra Drug and Health Forum, Greg Denham, for their generous support in allowing me to conduct this research at their service.

Lastly, my supervisor, Dr. James Rowe is the driving force behind this research paper and if it was not for his continued guidance, and encouragement, it may not be the outcome of which we now enjoy.

Abstract

In Australia, 'tough on drugs' rhetoric continues to derail sensible discussion around alternative approaches toward addressing problematic drug dependence within our communities. The following report presents anecdotes from 12 semi-structured qualitative interviews with people who attend a primary health service in Melbourne, specifically, established for highly marginalised 'street based' drug users. Their responses provide valuable insight into how this particular service best operates to minimise further drug-related problems in the lives of its clients. The feedback suggests, *Innerspace* is genuinely engaging with the needs of these individuals, which supports an argument for more harm reduction-oriented policy implementations in Victoria. Despite the 'war on drugs,' doing little to assist the wider society of which we all belong, not all hope is lost to help improve the health and wellbeing of people who inject illegal substances.

Table of contents

Acknowledgments	1
Abstract	2
1 Introduction	5
2 Background and historical context	7
3 <i>Innerspace</i>	8
4 Philosophy	11
4.1 Health promotion	11
4.2 Harm reduction	12
5 Cases studies	14
5.1 'Mark'	14
5.2 'Jase'	17
5.3 'Ally'	19
5.4 Disadvantage	21
6 A non-judgemental environment	22
7 Trustworthy staff	24
7.1 ' <i>Just people being people</i> '	24
7.2 People who used drugs as staff	26
8 Holistic primary health care	29
8.1 Non-appointment based service provision	29
8.2 A one-stop-shop model	30
8.3 A 'drop-in' space	31

9 Companionship	32
10 Opening hours	34
11 A Manager's perspective	35
11.1 Access for women	36
11.2 Access for young adults	37
11.3 Aging clients	38
11.4 Client consultations	40
12 Conclusions	41
12.1 Harm reduction and health promotion	41
12.2 The failed 'war on drugs'	42
12.3 A supervised injecting facility	43
12.4 Conclusion	45
References	47

1 Introduction

In July, 2012, I conducted 12 qualitative interviews with some of the clients who attended *Innerspace Drug and Safety Services* as part of my research component for a Bachelor of Social Science (Honours) degree at RMIT University. The overarching objective was to better understand the lived experiences of stigma and discrimination for people who inject drugs in inner-city Melbourne. Various aspects of life where my participants encountered the stigma attached to injecting drug use were discussed in the interviews. Most notably in healthcare, employment and familial settings, along with more general social situations, including unexpected contact with police. Perceptions of acceptable and unacceptable drug use were also explored, and the extent to which these individuals involved in the project thought substance dependence impacted on their overall sense of confidence, and self-esteem.

Prior to the research commencing, an interview schedule was designed to guide discussion around themes such as the aspects described above. A neutral topic was chosen to smooth initial conversation and build rapport with those who chose to participate, and the interviewer, myself. Separate experiences of attending *Innerspace* for the people who gave of themselves to the research seemed a logical starting point expected to lead onto more in-depth accounts of unpleasant occurrences within the mainstream health system (which did, in fact, unfold in most interviews). Although, the degree to which every individual spoke of *Innerspace* as a 'safe-haven,' 'godsend' and a 'utopia' was an unforeseen finding.

The prevalence of such an encouraging reaction highlights the importance of honest, and genuine, primary health care for those perceivably excluded from mainstream health services arguably on the basis of their assumed, (based largely on physical appearance) or known, (in the form of receiving a pharmacotherapy program) injecting drug use. Questions originally thought to conger stories of ostracization in everyday situations led to the overwhelmingly, encouraging feedback, together with mostly constructive criticism of these participants primary health service, *Innerspace*. Answers to the questions enthusiastically spoken of in the interviews are presented in the main body of this report.

Before doing so, however, I provide a brief summary of the political events leading to the implementation of a number of Melbourne-based primary health services of which *Innerspace* is now an example. Additionally, included, is a prompt description of *Innerspace* and its organisational structure as a part of *CoHealth* (previously a separate organisation called *North Yarra Community Health*) together with a list of health, social, and domestic, services available at the facility. Also, outlined are the philosophical perspectives underpinning the overall service delivery of Victoria's primary health services for people who inject drugs, being the Ottawa Charter of Health Promotion, and the core principle of harm reduction.

To put the transcripts into better sociological context, I introduce three case studies which attempt to illustrate the collective types of cultural, and economic, circumstances lived by the people I was lucky enough to interview. Hopefully this assists in further understanding the issues of homelessness, trauma, unemployment and physical, and mental, ill-health discussed as common for these participants. The feedback on how they felt *Innerspace* best operated to meet their acute, and more chronic needs follow, including the topics of a non-judgemental environment, trustworthy staff, holistic primary health care and companionship. Next is a change in the opening hours receiving a mixed response in the interviews, and why, *Innerspace* decided on this operational shift. Lastly are the thoughts of Manager, Danny Jeffcote, who speaks of the service and boarder Alcohol and Other Drug (AOD) sector, needing to grow in a way which accommodates for its new demographic of clients. Throughout this report, pseudonyms have been applied to protect the true identities of my research cohort and any other potentially recognisable information has been changed.

In conclusion, I explain how *Innerspace* is playing a fundamental role in the lives of the people who graciously agreed be a part of the research. Especially, in it being, a place within the inner-city of Melbourne where the entire group felt comfortable attending. Positive social engagement with the staff led to most of my participants more long-term visitation of the primary health service of which they now invaluablely benefit. This highlights the inadequacies, indeed the dangers of our current drug prohibitionist system in not by any means, meeting the health, welfare and other needs of the individuals interviewed who are most negatively affected, by the illegality of heroin, and other psychoactive drugs.

Finally, the findings strongly support an argument for policy reform of Victoria's and Australia's illicit drug policies in a way that would see the implementation of more, and a wider variety of, harm reduction services within specific areas of Melbourne. According to the interview transcripts, this would be tremendously successful at helping to improve the quality of life for people who experience problematic drug use, not only in the City of Yarra, but other key suburbs throughout this country. Only then will the participants of my research achieve real progress in their being able to gain increased control over unwanted substance dependence, and enjoy, becoming more participatory members of their local communities.

2 Background and historical context

In 2001, the Victorian State Government released its 'Saving Lives' policy response to an increase in publicly visible heroin use, illicit drug trading and overdoses highly concentrated in specific areas of Melbourne (Mugavin et al. 2011a; Rowe 2003). The Drug Policy Expert Committee (2000), previously established by the Government to provide authoritative advice on the looming public health threat posed by injecting drug use at the time, identified five 'hotspots' where heroin markets were most problematic within the community. These included: The Cities of Maribyrnong; Melbourne; Yarra; Dandenong; and Port Phillip (Drug Policy Expert Committee 2000).

An important aspect of this policy response was to fund the implementation of 5 safe injecting facilities in each 'hotspot' to improve the health of people who inject drugs (Drug Policy Expert Committee 2000). Disappointingly, after administration of the 'Saving Lives' funding to all five local councils, legislation was blocked in the inner-house by conservative MP's who claimed supervised injecting facilities 'sent the wrong message' of 'soft on drugs' (Mendes 2004). As a viable alternative, 5 fixed-site primary health services were introduced to properly utilise the funds already disturbed towards assisting those whose well-being is compromised by the illegal buying, and selling, of heroin.

Rowe (2003) specifies, people who frequently engage in 'street-based' drug injecting often are homeless, and living chaotic lifestyles, which led to their

participation in the activity out of need not personal preference. He further notes how those who spend a large proportion of their time on ‘the street’ are at a greater risk of drug-related harm in the form of overdose; blood-borne virus transmission, poor nutrition and mental ill-health (see also Tindal et al. 2010 and Reid et al. 2000). Individuals who experience these extreme life circumstances are less inclined to access mainstream health services, and consequently, receive inadequate medical attention (Mugavin et al. 2011a; Reid et al 2000; Rowe 2003; Rowe 2006).

Thus, a principle aim of the Victorian ‘Saving Lives’ strategy was to meet the needs of some of the most vulnerable members in our community by providing services that empower people whose drug use is mostly ‘street-based’ to lead healthier and more fulfilling lives (Drug Policy Expert Committee 2000).

Since the policy’s implementation, 7 primary health facilities have been established in Melbourne, together with five ancillary services, delivering mobile outreach programs (Mugavin et al. 2011a). The overarching objective which directs all of the above services more recently re-named, Specialist Alcohol and other drugs Primary Health Services (SAPHS), is ‘*to provide services that lead to better health outcomes for their intended clientele*’ (Mugavin et al. 2011a, p. 9).

3 *Innerspace*

Innerspace is a SAPH originally established by the ‘Saving Lives’ drug strategy. First, it was auspiced with *North Yarra Community Health*, a non-for-profit organisation predominantly funded by the Victorian Government overseen, by an independent board of directors responsible for the management of community health centres in Collingwood, Fitzroy, and Carlton.

On the 1st of May 2014, a funding arrangement introduced by the Naphthine Government merged *North Yarra Community Health* with two other metropolitan organisations, *Doutta Galla Community Health Centre* and *Western Region Health Centre* (Austen 2014). The change, known as the Mental Health Community Support Services (MHCSS) program, saw the formation of *Cohealth* a combination of all three non-for-profit services into one (Victorian Government, 2014a). The reason for MHCSS is stated as a simplification of mental health services for clients whose

experience of mental illness is chronic, and who, found the previous system difficult to navigate (Victorian Government 2014b).

Despite this change, *Innerspace*, as it was a part of the *Mental Health and Drug Safety Services* branch of *North Yarra Community Health* is situated on Johnson Street in Collingwood. It opens on weekdays from 11:00am-1:00pm and 3:00pm-5:00pm, and includes a diverse range of services available on an appointment, and non-appointment style basis (Mugavin et al 2011b; Norman 2006). Listed below, as seen in Mugavin et al. (2011b) are the most up-to-date evaluation of *Innerspace* services currently available on the internet:

Services	Availability
Art classes	Thursday 10:30-1:30
Counsellors	9:00-6:00 four days a week
Computers	regular opening hours
Dietician	Tuesday afternoons
Food, tea and coffee	regular opening hours
Football (Reclink)	Wednesday 12:00-4:00
Financial counsellor	Wednesday 2:00-3:00 (fortnightly)
Gardening projects	Thursday 10:30-1:30
General Practitioner	Tuesdays 12:00-6:00 (every week), Wednesdays 12:00-6:00 (fortnightly) and Fridays 12:00-6:00 (every week)
Hepatitis C clinic	Wednesday 2:00-4:00
Housing worker	regular opening hours
Laundry and showers	regular opening hours
Legal aid worker (Fitzroy Legal Service)	Monday 3:30-4:30
Medical nurse	Tuesday to Friday

Outreach	seven nights a week 7:30-11:30
Needle and syringe exchange	Monday to Friday from 10:30-6:30
Mental health nurse	Monday to Friday
Podiatrist	North Yarra Community Health
Physiotherapist	North Yarra Community Health
Social Worker	four hours a week
Women's health worker	Wednesday and Friday afternoons

In 2009, *Innerspace* re-located from a previous position in Smith Street where it was formerly known as '*Next Door*'. At its current address, the primary health service is amalgamated with a needle and syringe program, and accommodates for a wider variety of on-site services, such as health, and welfare professionals (Mugavin et al. 2011b). It has since then been re-named '*Innerspace*', presumably, due to the structural changes that followed the move, including an expansion of resources and services available. In an earlier evaluation conducted in 2006 by Josephine Norman, the Manager of *Innerspace*, or what was then called '*Next Door*' provided a statement clearly outlining the central goal of the primary health service:

To provide as much as possible a 'one-stop-shop' for people who inject drugs with the objective to improve their health and welfare and reduce the problems of injecting drug use such as a reduction in crime etc. Next Door [now known as Innerspace] specifically targets people who inject drugs that do not access mainstream medical services. Next Door [Innerspace] also plays a role in public education, and awareness of drug use (Norman 2006, p. 5).

Similarly, in the Mugavin et al. (2011b) evaluation an *Innerspace* staff member offered a short, yet concise, description of the service:

We target the hardest of the hard and we focus of harm, and that is what we are here to prevent (Mugavin et al. 2011b, p. 2).

4 Philosophy

4.1 Health promotion

Interestingly, the 'Saving Lives' policy response is underpinned by the Ottawa Charter of Health Promotion, which in 1986, conceptualised health in a holistic sense to which the Charter more appropriately terms wellbeing (Drug Policy Expert Committee 2000). The Canadian-based Charter provided the following definition of health promotion:

Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, and individual or group must be able to identify and to realise aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector but goes beyond healthy life-styles to well-being (WHO 1986).

The governing philosophy of *Innerspace* was, and still is, - before the implementation of the MHCSS - consistent with the mission of *North Yarra Community Health*. It, too, is guided by the principles in the Ottawa Charter of Health Promotion. The organisation aims to deliver bottom-up healthcare inclusive of spiritual as well as physical health to everyone within the City of Yarra (Norman 2006; Mugavin et al. 2011b). This is specified in the *North Yarra Community Health* mission and vision statement stated on their website:

North Yarra Community Health aims to provide high quality and responsive programs and services and to all members of our community. We work with people to overcome their experiences of disadvantage, discrimination and disempowerment. We respect people's choices and support them to make informed decisions to prevent illness and promote their health and well-being. We encourage active participation in our services and in the life of our community (North Yarra Community Health 2009, p. 2).

While, *Cohealth* does not explicitly mention the Ottawa Charter, its philosophy is heavily based on the values of social justice. The culture of *North Yarra*

Community Health, including that of health promotion lives on through the development *Cohealth* services. These principles, along with the well-established facilities of *Western Region Health Centre* and *Doutta Galla Community Health*, continue to guide the delivery of a wide variety of support to the people of inner-north Melbourne. This includes those whose drug use causes distress, and in their attendance of *Innerspace*, - a *Cohealth* service - aim to improve their overall health and wellbeing. Below is the rationale behind the name and look of the newly orchestrated *Cohealth*:

Cohealth means we stand beside our communities, and work in partnership with them to develop and provide the services they need. We work together to improve lives. “Co” is part of so much that we value – collaboration, confidentiality, cooperation, community and the courage of our clients.

The infinity symbol, co, represents everything about us, from collaborate to consumer to community, but also of course continuum. We recognise that there is no beginning or end to our work – we continuously strive to improve people’s lives in infinite ways.

The three colours represent the three founding organisations, Doutta Galla Community Health, North Yarra Community Health and Western Region Health Centre. The central colour is stronger and a combination of the other colours – because cohealth is stronger at the core, drawing on the strengths of its founders (Austen 2014).

4.2 Harm reduction

Furthermore, the Drug Policy Expert Committee (2000) responsible for the original implementation of *Innerspace* argued the Ottawa Charter, in conjunction with a literal interpretation of Australia’s National Drug Strategy known as a ‘harm minimization’ approach, offered the most successful guidelines in which to address the problems caused by, perceivably, escalating heroin use throughout the state of Victoria, in the late 1990’s. However, the overarching ‘harm minimization’ policy framework is somewhat controversial in this country, perhaps mostly, because it is not applied the way that it claims to be best effective. For optimum ‘harm minimization’, the three pillars which comprise of the framework; demand reduction;

supply reduction; and harm reduction, should be implemented in a balanced manner with equal importance accorded to each other (Ritter et al. 2011; Wodak & Moore 2002).

Nevertheless, since the Hawke Government first introduced the strategy in 1985, illicit drug funding has consistently favoured supply reduction initiatives substantially made up of law enforcement responses (55% of funding) (Ritter et al. 2011). Especially compared to the preventative measures and public health campaigns of demand reduction (40%), and certainly that of allegedly controversial harm reduction strategies, such as needle and syringe programs, and safe injecting facilities (4%) (Ritter et al. 2011).

Besides the preference shown in the disproportionate amount of funding allocated to law enforcement responses, - which shows our current federal and state political leaders continue to endorse the criminal punishment of individuals as an adequate means of addressing problematic drug dependence within our communities - the Drug Policy Expert Committee (2001) advocated for a balanced implementation of all three 'harm minimization' pillars. Most fundamentally, it supported a harm reduction approach towards the issue in the form of establishing five safe injecting facilities. These, now in the form of primary health care facilities, provide accessible health care and social support to those who are marginalised, and whose drug use is considered mostly 'street-based'. According to the recent National Drug Strategy, harm reduction initiatives are primarily concerned with reducing *'the adverse health, social and economic consequences'* of problematic alcohol and other drug use (Commonwealth of Australia 2010, p. 8).

According to a recent evaluation of all the SAPH's operating in Victoria, these primary health services remain committed to the principles of harm reduction in a way which is aligned with the initial intentions of the Drug Policy Expert Committee (2000; Mugavin et al. 2011a). This is further supported by the aforementioned comment of an *Innerspace* staff member (*'We target the hardest of the hard and we focus of harm and that is what we are here to prevent'*) which clearly indicates how the central aim of this particular primary health service is to prevent drug-related problems among its target group.

In Victoria, the philosophies of health promotion and harm reduction directed the implementation of these SAPH's and continue to guide the delivery of non-judgemental service provision in facilities such as *Innerspace* (Mugavin et al. 2011a). This has ultimately led to the feedback from 12 *Innerspace* clients who reported in the interviews on their overall experience of attending one such SAPH presented in the following sections of this report.

5 Case studies

Before, doing so however, it is important to note in respect to being imperative to have non-judgemental service, trustworthy staff and holistic primary healthcare for these participants, broader life experiences of which I heard in the interviews require further sociological context. To properly illustrate the barriers, preventing the individuals who selected to be a part of the research from leading healthier, and more fulfilling lives, I offer three case studies which aim to explain the social, and geographical, circumstances navigated.

While, each case study is based loosely on three individual participants, I stress that they are also a combination of stories and situations heard from others interviewed. They are more a manifested narrative of which I attempt to use as a way of best to represent the shared experiences of the female and male participants respectively. In order to do this, I took a degree of liberty in amalgamating the findings into a more easily digestible, and hopefully, concise form of writing.

Instead of re-telling the whole story of a single participant, I chose to do this as a method to further, accurately, depict obstacles the majority of the research group faced as people injecting drugs in the City of Yarra. Also, theoretically, it further protects the true identities of these individuals in it potentially reducing the likelihood of a reader recognizing the story of someone they know.

5.1 'Mark'

It was common to hear of how lot of the men including 'Mark' grew up in institutional care, and now, well into their adulthood had not received a one-bedroom apartment from the Department of Human Services. For a lot of this time these individuals remained homeless, surviving on the fringes of mainstream life, after their

seemingly indefinite submission to the Victorian welfare system. Additionally, most did not have the social benefits of growing up in a secure family with loving parents who instilled cohesive life lessons in their children. This translated into many being at a disadvantage in terms of how well they adapted to modern life, especially in comparison to a lot of their middle-class, age-related peers:

I was turned into a ward-of-the-state by the time I was fourteen. Single mother, five kids, she couldn't handle five kids and we didn't have much. We were part of the lower class of society and [in] not having things of course we'd get picked on at school. I didn't deal with that too well.

I was young then [when I first started using illegal drugs] because I'd been put into a halfway house and a hostel, then the government closed the halfway house, and left me basically on the street with nowhere to live. They didn't take an interest in me from then on. I was still too young to get a job, too young to get on the dole, so I ended up living with some older people who were criminals as such, and had to do, what they had to do to survive. I was involved in crime and drugs before I really had an alternative.

'Mark' waited on a public accommodation list for over twenty years. '***I still** have not been given a public house they don't seem to care much about single blokes it's just women and kids, and families, looked after first.*' This amazing delay of the Department of Human Services to provide 'Mark' a small flat is surely an abject failure of our current housing system. Particularly, for him to be in the custody of child protection services, and still, be left homeless by the exact institution - the Victorian Government - previously responsible for his wellbeing is arguably grotesque mismanagement.

His lack of access to a private space where it is expected of regular, law-abiding, citizens to rest and recuperate from their role in the public sphere made it difficult for him to form a conventional rhythm. One, possibly, leading to 'Mark's' financial independence as an employee or small business owner. Clearly, without stable accommodation, it is difficult for him to earn a wage and actively participate in the workforce. An essential means of subsistence in any city.

'Mark' effectively maintained day-to-day in a state of limbo without any real perspective of how long it would take the state government to process his housing request. He managed to survive with only the short-term in mind, in mainly, boarding houses with a lot of IV drug use and violent people. He implied the chances of gaining more control over problematic substance dependence were slim in a lot of the other tenants, further, encouraging his participation in regular heroin sessions. When I asked what triggers his drug use, 'Mark' replied:

It is mates. As soon as you associate anyone with your drug habit it is just a never ending story. I've learnt not to get involved with people.

*It's **not** hard for me to say, 'I'm not interested, go harass someone else with your crap. I'm not interested,' you know? Yeah, so I just do what I can do, and yeah, think I'm pretty safe.*

I just hate that jail mentality of places like [my temporary accommodation] because it's not the way I think. They think they can stand over you, trying to push drugs and stuff. They got their own rules. People do what they want in there. There just so many people strutting around like, 'don't look at me the wrong way.' They leave me alone pretty much. You still get the one or two who tries to put it over you, but I just keep to myself and ignore everyone. Unless I know them already, but yeah, just keep to myself. It's worked so far.

It's just a roof over my head in winter until my place comes up so hopefully in the next few weeks? It's good for some people, but for me personally, it just does my head in having to deal with these people all the time. Just the rigmarole of the joint, key card to the room and everything, dorm-style, it's like a jail wing.

'Mark's' future trajectory in finding suitable employment was flattened by his experience of long-term homelessness. Over the years, it stunted the possibilities of him gaining wages and useful industry experience. By which the accumulation of wealth leads to increased quality of life and the mental, and emotional, benefits of residing contented in the mainstream community. Also, this limited his chances of completing high school, and further education, where many Victorian residents have the opportunity to enjoy their intellectual pursuits, and broader careers. 'Mark'

remained optimistic with the help of an *Innerspace* housing worker who *'put me down for a two bedroom, as well as, a one bedroom, it's going to come up a lot quicker,'* and took solace in the fact that a communal, friendly, health service is available in the meantime.

5.2 'Jase'

What is more is that many participants were further limited in capacity to do paid work because of a chronic health condition. To picture this I tell of participant, 'Jase,' who's traumatic life experience exemplifies that of which heard, particularly in him, becoming physically disadvantaged.

'Jase' woke up out a Laminectomy, spinal surgery which he describes as *'very invasive, if they screw it up you're in a wheel chair for the rest of your life,'* and immediately fled the anaesthesia ward. He had an unpleasant encounter with a hospital nurse who he suspected of judging him on the basis of physical appearance - as someone who used drugs. - After, previously, seeking out different surgical opinions in the hope of treating his condition of degenerative disk disease, 'Jase' received inconsistent advice. These two events, essentially, accumulated into his overall perception of the medical profession as *'obnoxious'* and led to his abandonment of supervised rehabilitation:

*When I was fifteen, I was having a lot of back pain. I was dealing with the Royal Children's Hospital and the doctor suggested fusing my spine. It means they drill these things on which take out two disks altogether. I wasn't in the care of my parents at that stage [I was living in an orphanage] and I chose **not** to [fuse my spine]. I only had intermittent problems up until probably five or six years ago and it really started yeah, getting, really bad.*

I went in [to hospital as an adult] originally to get x-rays and a cat-scan, that's one doctor. He goes just rude and abusive, he goes, 'your pain doesn't match you symptoms, you don't want surgery, you don't need surgery, you'll end up paralysed.' I'm like, okay, and booked in for another appointment to see this second doctor.

*He was brilliant, really nice guy. He told me the situation and they got me in for a steroid injection. [But] there's no continuity in any of it, I have **not** seen the same person twice in three and a half years of dealing with the hospital.*

I had no choice I had to get the operation done. And I was supposed to stay in hospital for five weeks but booked myself out on the first day. I've done it all myself the rehab, rather than going through the hospital and I reckon I'm better off for it. But I probably would have had more support behind me if I'd gone through the hospital.

'Jase' ended up with a badly pronounced limp and needing to wear costume-made runners to better align his gait. The likelihood of 'Jase' becoming more self-sufficient in terms of economic freedom, and the associated feelings of empowerment most citizens appreciate in contributing to the betterment of their communities, was damaged by this injury. The public health system appeared basically to malfunction in its efforts to better support, 'Jase' as a patient who needed serious medical attention. When asked what sort of an impact the now, physical, disability had on his proficiency to gain employment, 'Jase' surmounted:

Total impact, I can't work. I have some community work hours to do and I'm, having, to look for community work where I sit down. I can't go and mow lawns and do the regular work, so I'm basically treated like an invalid. I feel like I'm becoming more useless.

The consequences of 'Jase' being unable to stand for extended periods and carry out physically demanding work is obvious in terms of his future career development. His reduced employability causes him worry and as the above quote implies low self-esteem. Whether or not the hospital staff were explicitly, discriminatory, towards him is somewhat irrelevant 'Jase' felt as though he received the opposite of *'professional and caring help.'* Had the health personnel behaved more compassionately may his recovery been better.

Even though, 'Jase' made a conscious decision to reject qualified medical support, his refusal to accept *'rude'* and *'abusive'* treatment on the part of health workers arguably protected his general wellbeing. He acted defensively to what appeared to be a threatening situation. The spinal therapy available in the

mainstream service system would, definitely improved physical health, but at what cost for his emotional health? 'Jase' functioned within his best interests as far as already having endured prolonged stress, and for any person to have this reaction in a world class health system, is an indictment to the overarching policies and principles it is based. This includes the exclusion of people who use drugs from proper health, and medical support, over their apparent criminal activity of engaging in escapist behaviour such as injecting illegal substances. 'Jase' thought that the stigma attached to people who use drugs via injecting equipment may be the reason behind the seeming malicious, and unfair, conduct on behalf of the medical staff:

There wasn't a care factor there. I don't know track marks on my arms, old ones even. I was in good nick and everything it didn't seem to make any difference [to how the doctors and nurses behaved towards me]. I don't know the reason, and I didn't say to find out.

5.3 'Ally'

Similarly, 'Ally' demonstrates the underground culture which tends to unfold in the lives of these participants whose drug use is long-term. She circumvented law enforcement efforts aimed at reducing the demand for street drugs to the best of her abilities. At the age of thirteen, her father introduced intravenous drug use into family life, and as an adult, limited her ability of developing a livelihood outside the confines of daily opiate dependence. It was a challenge for 'Ally' to settle into regular societal behaviour to which others in the local community would feel comfortable because of their comparable advantage:

My dad used to inject me. He's an old booze head and when I started using drugs he decided to tell me he has been using drugs all my life. He'd come in, in the morning and go, 'you got any money in here?' and I'm like, 'no.' And he goes, 'alright well go and get breakfast.' He'd come in [and ask me to] 'stick out your arm.' So that's another fun relationship. But yeah that's me.

Getting out of bed to show up at an office would involve, 'Ally,' having to already scored, used and potentially organised another anticipatory injection to avoid a looming drug withdrawal, rendering her incapable of work. Unlike a lot of 'Ally's' straightedge peers, her main priority as a young person was to raise the necessary

amount of funds that prolonged another opiate sickness. This, eventually, led to her exclusion from conventional social cliques at high school and a premature departure from secondary education.

As a late teen, 'Ally,' entered the sex industry as a means of survival in Melbourne. Her physical tolerance for street drugs required that she pay very expensive drug dealers money. Without the financial wealth of a high-flying salary, 'Ally' had little option but to engage in sex-work as a method of operating within the parameters of her immediate situation. She told of being resilient in negotiations with drug dealers, sex-worker clients, and the police, despite of her undoubted risk of physical and sexual assault:

I've done prostitution. Obviously, I'm doing it to make money to buy drugs so [the police] want to know everything about that. As a prostitute [the police] are pretty good actually. They're more just making sure you're safe. They like to know who is on the street, just in case you go missing which is cool. Then you've got the really shit part. For instance, I'll go down to Richmond and they'll pull me up straight away, they'll think I'm a dealer, and I'll get strip searched.

It's scary [strip searches] because they've got their gloves on and it's like... Please don't [digitally search], but it's never gone too far. Even when I was in prison it never went too far. They just like to humiliate you. I take it with a grain of salt and they don't like that.

[The first time I got strip searched] I was humiliated really embarrassed. But, you know, as time goes on being a [sex]-worker helps and my whole attitude to things. My attitude to things is I don't give a fuck what anyone else thinks. Straight up, I don't care what anyone else thinks, about what I do, and who I am.

I really do. I really take things with a grain of salt and I think that comes with age and just being around this whole system you know? People [who use drugs] want to be treated normal they really do. Most people when they first get into the scene are angry there's a lot of resentment, a lot of anger, a lot of hurt most of the time. And that's why they're using. And as time goes by you

don't know why you're using anymore, it's just a habit. So yeah, that's what makes me, me.

While 'Ally' didn't talk explicitly about any traumatic experiences, her attempts of reaching out to community and mental health organisations for support, especially in relation to her increasing endurance of depression, and anxiety, was indicative of her possible encounters with abuse. Further, while she was in the process of committing herself into a well-known mental health hospital for a psychiatric assessment, 'Ally's' demeanour was not necessarily one of somebody with a biologically-rooted psychological disorder. More of how she kept reiterating that it was the lack of cooperation from available services, including the Department of Human Services, which made her situation all the more painful. She agreed that with the correct amount of financial, medical and community support a lot of her immediate distress would subside.

5.4 Disadvantage

The previous section simply tries to demonstrate how for most of the individuals involved in the research they were navigating multiple forms of disadvantage. To list some the presented issues in the above section these include homelessness, disenfranchisement, poverty, trauma, drug dependence, violence, sexual violence and chronic, physical, and mental health problems.

Many of my participants thought mainstream service staff on the whole encouraged feelings of embarrassment in connection with their apparent failure to abide by regular conventional practices, such as, being able to attend a scheduled appointment. I heard how this contributed to the development of barriers toward the receipt of much needed medical treatment for a number of these individuals. The thought of returning to a mainstream health clinic with a presumably good enough excuse - in the eyes of the wider community - for missing a fixed-booking arranged, sometimes, weeks in advance was intimidating and unlikely to occur for many of the people I spoke to.

As a result, a number of this group expressed clear displeasure towards the idea of fronting up to a health service often unsympathetic towards the on-goings of their current life. The thought of a less-than-subtle reprimand on the part of a medical

professional or their receptionist for appearing unreliable was laborious and off-putting. This included the perception of a number of this group of being looked down upon by healthcare workers for disclosing their previous, or current, intravenous drug use - which in the eyes for many conservative hospital staff, according to the words of these participants, was presumed to mean a general disregard for their own personal health, and well-being.

This meant the mainstream service system presented obstacles for these individuals, in terms of their receiving important health, social and community support. Their lives are already complicated as I attempted to illustrate in the cases of 'Mark,' 'Jase' and 'Ally' in requiring enormous amounts of strength, and determination, to perform the necessary activities that saw progress in their lives within the context of outlawed, criminalised, drug use. This, wholly, emphasises the need for a service as *Innerspace*, operating outside the boundaries of what is commonly considered 'civilised' society as a necessary measure to overcome the entrenched, and pervasive, discrimination associated with injecting equipment and other drug use as told in the interviews.

6 A non-judgemental environment

All of my research participants spoke very positively of their experiences of attending *Innerspace*. Perhaps, most notably, a number told of the primary health service as preferred because it lacked the negative judgement, stigma and discrimination so readily encountered by people who inject drugs, at least, certainly for these participants. Unfortunately, being respected in this way was often a rare occurrence for much of the research cohort - an alarming finding in itself - however it reiterates the importance of having a responsible SAPH purposefully established to meet the needs of people who inject drugs in Melbourne.

A majority of participants visited *Innerspace* for at least several consecutive years. Three quarters (nine people) estimated, having attended for a minimum of four years in a row, while one and a half years was the shortest time reported by a participant. Out of those nine, a total of four had originally entered the service in 2001 when it first opened as '*Next Door*', which equates to exactly, one third of my research cohort intermittently frequenting the facility for over 11 years. The retention

rates among these individuals clearly indicate a sustained re-engagement with the primary health system after consistent and satisfactory contact one of Victoria's SAPH's:

'Kate':

The fact that I can drop in here, there's no discrimination here at all their great people. You can be gone for two years and come back and you're still welcome. Or you can just stick to yourself and keep quiet which is what I've done for most of the time that I've been here. Most of the workers don't even know my name they know my head, its good stuff like that. And that's what you want. You want somewhere where you can just walk in and feel comfortable without [a staff member] going 'and who are you?' And 'what do you want?' Just peering down their nose at you, you don't want that.

'Tia':

All the support and advice and [having somewhere] to come and feel safe and secure. The fact that everyone's here and the workers and clients all go back years. It's a place where you can go and not get judged and it's good to have someone to talk to at times. Absolutely love the doctors here. I have a chronic lung disease and they help me understand it.

Such steady visitation begins to reveal the significance of the primary health service in the lives of these participants who largely felt alienated from mainstream health services on the basis of their known, or assumed illicit drug use, - along with other reasons listed in the above section 'Disadvantage'. - This often manifested for some having no stable relationship with an often seemingly judgemental medical professional. For many participants, whose health is already compromised by the illegal status of their drug use, *Innerspace* is fulfilling a crucial void in their daily world. This is accessible, modern-day, health care which should be a universal right to all in the community and something people who do not have an alleged problem, using banned substances, seem to have the privilege of taking for granted.

7 Trustworthy staff

7.1 '*Just people being people*'

Every single participant told of how *Innerspace* made up for problems encountered when trying to negotiate the apparent bureaucracy in regular health services, and more generally, the local community. A number mentioned how the staff at *Innerspace* remembered almost every individual who walked through service doors, and it was through, being able to cultivate a positive relationship with these employees which made all the difference to their sustained re-engagement with the primary health system.

A number of participants spoke of receiving reliable head nods and eye contact from their needle and syringe workers when first, entering the centre, rejuvenating feelings of being valued, respected and appreciated. This down-to-earth approach seemed based on the staff, being able to take genuine notice of each person who used the facility.

Further, at the crux of this sort of casual acknowledgment of presence, having a profound effect on these individuals is the staff care, honestly, for the people interviewed. This translated into many positive stories of how they learnt to expect personalised attention from *Innerspace* workers and other superior managers at the service. Subsequently, strong bonds were built between those involved and regular community staff, leading to a more, timely receive of health interventions that undeniably improved their quality of life (let alone saved lives in some cases, obvious in the quote of participant, 'Tia' in the above section - 'A non-judgemental environment').

Even, for some participants, this outward mutual regard for the service and the service for its clients developed into a more permanent fixture in their daily and / or weekly routine as a place to go to feel honoured, respected and supported, and to be the person in which they believed in themselves. According to the words of participant, 'Scott,' it was in the staff going '*out of their way*' which concisely shows genuine care for the most pressing issues in their lives. This is how many of my group spoke in terms of why they decided to return to *Innerspace*:

'Kate':

The workers here are very kick back and they're just here, they don't push their presence on to you which is a big thing. They just come up to you like a normal person – 'do you want a coffee? How's your weekend been?' They don't dig into what services you need they're just people, being people, and that's what you want. So that's what makes it [Innerspace] be what it is, it's just the workers, they just be, they just are, and they're not - 'what service do you want?' 'Hurry up and get out my door' - sort of thing.

'Scott':

*It's the staff, that bring me back here and if you need the services of this place. Right now I **do** need the services because of this football injury and they've given me a whole lot of plastic gloves for in the shower so the water doesn't get in and stays dry so it doesn't get infected. The staff **do**, go out of their way.*

Such seemingly impromptu acts of kindness demonstrated on behalf of *Innerspace*, is characterized by nothing being expected in return of participants. Remuneration in the form of money, or other social courtesies, was not anticipated by any of the SAPH workers who as part of casual engagement with clients offered extra support. Obviously this is an unspoken cultural expectation of mainstream services or at a local doctors' clinic - to pay for extra medication or equipment provided on-site.

Not having to fit medical bills or pay any additional cost at *Innerspace* is a fundamental element to providing flexible and responsive primary health care to people who cannot afford it as many of the people who I spoke to could not. But, also for participant, 'Scott' it was the option of choosing to accept the offer of unexpected medical gloves which made the difference in his increased fondness of *Innerspace*. Being treated as a person of value regardless of any previous lived experience motivated his favouritism of *Innerspace*, over and above the seemingly negative attitudes of other health staff.

7.2 People who used drugs as staff

It is possible that one of the reasons why *Innerspace* has over the years remained so client-focused is because of the employment of staff members who use drugs or have done so in the past. A highly regarded staff characteristic from the perspective of those interviewed was personal experience with substance dependence, and an insider's knowledge into the hardships they faced, as people who use injecting equipment 'on the street' or in public (see Rowe 2003).

For a number of my group, feeling understood by *Innerspace* workers made it easier to open up and receive an empathetic response in return - as opposed to an ignorant and / or judgemental one, usually, elicited by mainstream service workers. - The knowledge of some employees having a previous history with injecting drug use seemed central to the building of trustworthy relationships needed to foster service accessibility. The long-term re-engagement I heard of in the interviews seems substantially based on particular staff members, showing appreciation for the immediate world of these individuals in needing to 'score' (purchase illegal substances) near Victoria Street, Richmond, and its associated confronts:

'Tom':

*That's why we do have to help each other. When people like us do know what each other are going through. It makes it more important that we do help each other because we don't have other people to turn to for help. That's why Innerspace is good you know? You **do** get to talk to other people that aren't on drugs, but have been in the past.*

'Ange':

[The staff members] make you feel pretty alright because that's what they're here for and a lot of the workers have been through that sort of stuff. I've spoken to a lot of these workers and a majority of them have been ex-drug addicts anyway. So they're pretty alright.

'Scott':

[The staff], are people you can talk to, confide in and give you advice. Because some of the staff are ex-users themselves, and have gone through some of the same things you've gone through.

By having staff with lived experience in peer support roles and / or other positions throughout the operational structure of *Innerspace* it may help to avoid the trap of paternalism within service culture. As the quotes from 'Tom' 'Ange' and 'Scott' imply, hiring people who used drugs maintains a high standard of one-on-one client attention, as well as, ensuring these participants are indeed the continued main priority of the primary health service.

Without insider knowledge about the manner in which the underground drug culture operates any centre meeting the needs of people who use drugs runs the risk of becoming less sensitive, and out-of-touch, with genuine client issues. The condemnation which springs from criminalising an activity such as substance dependence is deep-rooted, and implicit, in mainstream services. These recounted stories of my participants are evidence of sub-conscious stigma, and discrimination, in conventional society which leads to their difficulties in attempting to negotiate the red tape of governmental resource distribution (in the form of limited housing options available, especially to a lot of the men interviewed, which the case study of 'Mark' attempts to explain). Even the fact that *Innerspace* needed to be established in itself tells of the negative treatment people who inject drugs receive, and the poor attitudes, circulating within the public domain towards this group.

By lived experience embedded in the Melbourne SAPH culture, as confirmed with the Manager, Danny Jeffcote, it buffers against the tendency of bottom-up organisations as *Innerspace*, undergoing systematic changes at an institutional level from becoming more bureaucratic. Additionally, it may help to maintain appropriate sensitivities when speaking to clients such as these participants in further encouraging important learnings amongst the more regular service staff. For example, a resident physiotherapist might not have the 'street smarts' of frontline community workers integral to gaining the trust of clients who frequent the service.

Informal staff conversations could help to debunk inherent myths held by individual SAPH staff about the nature of drug addiction popularised in mainstream public institutions. Thus, having people who use drugs as employees is an

imperative, underlying attribute to *Innerspace*, having these clients who participated in the research, reporting so positively of the service's ability to meet their needs. As a brief piece of supportive evidence to do with the quality of service culture, this unique personal experience provides, I include a quote from an interview transcript presented in an investigation by Reid, Crofts and Hocking, (2000) from a General Practitioner who specialises in alcohol and other drug dependence:

Having contact with the needle exchange workers had made quite a bit of a difference to the 'normal' reception workers. There is really good cross fertilization taking place when you have drug users or ex-drug users on your staff they have the ability to influence other staff thinking. Research has shown the users are no more skilled at providing services, they will require other qualifications, but they do provide some useful attitudes (Reid, Crofts & Hocking 2000, p. 45)

8 Holistic primary health care

8.1 Non-appointment based service provision

In fact, the writing of Crofts, Reid and Hocking (2000) is the exploratory research behind establishing a community-based service primarily for intravenous drug users in the suburb of Footscray (and is probably the first document coining the phrase 'one-stop-shop' in relation to the operational structure of these primary health services now known as SAPH's in a Victorian context). By a one-stop-shop approach to meeting the needs of the people who I spoke to originally conceptualised in this 2000 document, part of the recommendations was instituting a system for non-appointment based service provision, along with other organisational approaches sensitive to the needs of those whose drug use is largely 'street-based'.

As the findings suggest, *Innerspace* understands the obstacles these individuals face in respect to their dependence on illegal substances, – which entails severe and painful cycles of physical withdrawal the case study of 'Ally' tries to show – and further, evident in the services inclusion of non-appointment based service provision. This factor, characteristic of the Melbourne-based SAPH network,

indicates the service appreciates daily intravenous drug use complicates the lives of these participants, causing unpredictable and chaotic circumstances:

‘Tom’:

Can you tell me what the difference is between *Innerspace* and a government building?

Just the regime really, the feeling of freedom to be able to come and go as you please and not having to turn up at a certain time, whereas a lot of drug users feel sick for part of the day and are okay for the other part of the day. They turn up when they do feel okay, whereas with a government type situation you’d have to turn up crook, and of course, they wouldn’t turn up so they wouldn’t be respected by their workers as much for stuffing them around.

It’s pretty much accepted [at Innerspace] that it does happen [drug dependence prevents the attendance of scheduled appointments] and people are more likely to make an effort here than they would at a government building to get in contact with them [the Innerspace staff who require fixed-appointments] and let them know [the appointment needs cancelling]. But we don’t have to book ahead for a doctor here. We can just come along and see the doctor. Whereas my other prescribing doctor, it would take up to a month to get an appointment.

It is often a matter of urgency for some of the participants involved to see a doctor, community worker, podiatrist and / or physiatrist immediately on arrival at the service. As this report already reiterated - and continues to, due to the extent of which participants thought it badly impacted on their overall wellbeing - a lack of mainstream service accessibility meant medical issues are sometimes at a crisis point and in need of medical attention, straight away, in order to prevent further development of chronic illnesses.

Not letting these participants wait a week or longer to receive their varied treatment - as is demonstrated in the above transcript of ‘Tom’ whose local General Practitioner took over a number of weeks to become available, - *Innerspace* was dramatically reducing the harm caused by it tending to open-air flesh wounds,

providing necessary pain relief, counselling services, and much more to these individuals.

8.2 A one-stop-shop model

Another key element to the development of these SAPHs is the intention to respond accordingly to the unique geographical surrounds in which they are positioned – as mentioned is in accordance with the locations of pre-existing street-based drug markets around Melbourne during the ‘Saving Lives’ policy response. – For *Innerspace* it seems as though, increasing its service capacity in the form of shifting to a new location in Johnston Street is an important development in more adequately responding to the needs of the clients who chose to be involved in the research.

Within the context of Yarra, *Innerspace* in being able to accommodate for more onsite services, provided a larger multidisciplinary array of resources and support to interviewed participants. Instead of relying, heavily on the building of multiple referral pathways with other nearby services as a single way of trying to re-integrate the target group back into the mainstream community, (see Reid et al. 2000) for a number of these individuals, the suitability of getting done a lot of their every-day formalities under the one roof made life more straight forward, and uncomplicated:

‘Youssef’:

Very convenient, just about everything is here - all the resources that they have. To me, it's actually upgraded a bit there's a few more options and that with drug and alcohol counselling. They've always had the exchange and now they've got counsellors, they've got doctors, people who can put you on medication, methadone. We've got physiotherapist which is great because we can get gym passes and that's for free for three months which is great for a lot of us poor people that can't afford it. And they've just up graded a bit and there are so many more options which are good for all of us. It's been good for me because I've been doing drug and alcohol with these guys for a while and now still doing it. So I don't find the place bad at all.

‘Sammy’:

Everything is here, you got the doctor, the nurse, counselling, and just in general, if you're hungry food, it's a place where you've got everything really.

Presumably, a 'one-stop-shop' model of primary health care would prevent the risk of further dis-engagement from regular health services in it having a team of legal workers, housing workers, registered nurses, a mental health worker, community workers, needle and syringe attendees, Hepatitis C meetings, General Practitioners, Physiotherapists and Podiatrists available at *Innerspace* throughout the week. The complex needs spoken of in the interviews, which the section 'Case studies' efforts to display require a multifaceted, non-judgmental, response to continue client access. This is what these participants felt they received at *Innerspace*, and clearly, influenced their constant return to the facility over other conventional services.

8.3 A 'drop-in' space

According to Melbourne-based research a relaxed 'drop-in' space encourages increased client engagement and the provision of adequate services capable of supporting injecting drug users in a new way (Reid et al. 2000; Rowe 2003). It was also thought to provide temporary relief from the street scene, especially for clients who were heavily intoxicated (Narcan or Naloxone is kept on-site at *Innerspace* in the case of needing to administer an opiate antagonist to a client who has 'dropped' to the floor and / or overdosed in respiratory depression) (Mugavin et al. 2011b; Reid et al. 2000; Rowe 2003). Reid et al. (2000) highlighted, by reporting on qualitative interviews with police officers, drug and alcohol workers, and health professionals that a shared communal area helps to facilitate the occurrence of opportunistic staff interventions in a primary healthcare setting.

The 2000 report explains how the success of increased service access is often dependent on the community (or peer) engagement workers' ability to build good relationships with their clients and in having enough credibility - in the eyes of their visitors - to recommend extra, additional, assistance not otherwise considered. The next quote is from participant, 'Tom' who describes how he would be more likely to accept the extra mental health support, from an intuitive community worker, in spite of originally intending to simply pass through *Innerspace* for a warm beverage:

‘Tom’:

Most people just wouldn't sign on the see a social worker, whereas if there was someone here, and you were feeling down for the day, the social worker would just come up to you so you would get that one-on-one. Whereas that guy would not normally go into that type of government building and ask for help.

The user sitting out here having a cup of coffee wouldn't go into a government building and say, 'oh, I need help,' but the people here who know each other are going to look at that guy and say, 'he's not feeling too good today, he's not as happy as he normally is'. So someone will come up and talk to him, find out what is wrong and help him out.

The attraction of free tea, coffee and food facilitates the mingling of *Innerspace* clients with its health workers and professional medical staff. A ‘drop in’ place which emphasises values of trust, respect and appreciation of any person who uses the service is an imperative element to *Innerspace* that cannot be underestimated. Especially in relation to these participant's experiences of multiple forms of disadvantage and their systemic loneliness in an unaccepting legal system for people who use drugs. ‘Tom's’ quote indicates how this community area is indeed, functioning in a sufficiently casual mode for the people interviewed, furthering their uptake of counselling, basic medical care, supportive footwear and other versatile assistance.

9 Companionship

The benefit of *Innerspace* in it being a place where the people involved in the project felt as though they fitted in and / or belonged was a strong underlying theme in a lot of the stories told. A common remark was feeling connected to others, and this, helping ease many participants personal anxiety in relation to the environmental circumstances traversed. Many described relishing in the community vibe at the centre, and further, being a part of a local network of friends. While, the design of all SAPH'S is explicit in its intentions to create an inclusive environment, it is necessary to show how social isolation is very common amongst those interviewed. The unique

ability of *Innerspace* to operate as part drop-in centre is incremental to meeting their needs for social connectivity.

In an attempt to present this finding most accurately, I include a quote from a participant whose transcripts typify this chronic emotional emptiness. Participant, 'Ryan' is an older retired man with a history of psychosis and other mental health complications. He speaks of his existence in the suburbs of Fitzroy, Collingwood and North Carlton in a manner that lends itself to colourful interpretation. Particularly in how his statement paints the solitude he must endure, in the absence of primary health services as *Innerspace*, being available on weekends:

'Ryan':

So the worst days are Saturdays and Sundays for suicidal ... [when facilities like Innerspace and other community services are closed] I just want to get out of this place, [the general vicinity of Yarra] there's no interaction with people, there's nothing, everyone goes away. So you're just left with asphalt and a concrete jungle.

'Ryan' implies being able to informally arrive at the 'drop-in' space is inducing a better experience of his local area in which the quote describes as a barren lifeless wasteland. The ability to roll into *Innerspace* unannounced, and have a light humorous exchange, no matter how brief with a like-minded person is offsetting the inner hurt of 'Ryan's' mental ill-health. For all of the individuals who I spoke to it was very important to have these transitory moments of light social contact at the primary health service. It is, at least, another opportunity for all of these individuals to escape the ridicule, and exclusion they face as people who inject drugs in the broader context of Melbourne.

By seeking out companionship between the other clients, and staff, at *Innerspace* 'Ryan' made personal efforts to amend his acquired spiritual discomfort. The 'Saving Lives' policy response, introduced by the Bracks Government, deliberately planned these SAPH's to boost the services accessed by this group, and in doing so, provided an indirect remedy for the sadness of this man. Having fun and enjoying the vibrant character of those common at the centre was a hugely positive theme in the interviews for people who experienced mental health issues.

10 Opening hours

Besides the service's deliberate design to boost confidence and morale amongst the people who use Melbourne SAPH's, a common theme, receiving mixed responses in the interviews is a change in the opening hours of *Innerspace*. The facility opened originally on weekdays between 10am to 5pm, but after a group of clients seemed to assume more ownership of the 'drop-in' area, management decided to close between 1pm to 3pm. It, also, trialled the community workers more time to email, call and do other tasks besides continually monitoring their clients. The change remains after some attendees reported finding it more helpful in their getting up in the mornings to visit before 1pm.

Management feel that the new times are an indirect motivation for clients driven in agency to achieve better outcomes through their engagement with *Innerspace*. According to the words of Manager, Danny Jeffcote, it deterred those who appeared entitled to the 'drop-in' space from congregating in a way not originally conceived by the 'Saving Lives' policy. Jeffcote says it better enables, clients, less confident in seeking help to do so in a more low-key environment.

As heard in the interviews, Jeffcote explains, those who made initial complaints took a personal offence at the beginning of the two hour closure in it inconveniencing their enjoyment. Touching on this are the transcripts of participant, Hendrik, who is in favour the change being more comfortable himself to visit at the new designated times:

'Hendrik':

The rules have changed, but I think it's for the better. It used to be open from 10 - 5 and now it's broken up into 2 parts, 11 - 1, and 3 - 5. Before, when [Innerspace] ran all through the day people kind of abused it. They came in and did what they wanted and it got a bit rowdy. There was tension building [in the service] and stuff like that, [bad] things [were] happening but now they've [management have] broken it up. Those who really, actually, come here for the purpose [of using the services] come here. They don't just sleep or cause trouble so it's good.

Have others attending thought it hasn't been for the better?

They complained at first because they'd rock up at about 1.30 [when] they'd come in smashed [intoxicated] and use the facilities. It was really... they made a mess of everything. So now it actually pushes them to come [in] at a certain time, or if they are not up to it, or not genuine about it [seeking help], those who are genuine now make [the most of] it.

This attempt to better regulate the 'drop-in' centre is an additional shift in which the service adapts to the need of its clients. As discussed with Jeffcote, even though a small number of clients expressed initial reluctance, the closure, likely assists people to engage who are further marginalised in their experience of the local community. Predominantly it is expected for that of women, younger adults, Indigenous Australians and members of culturally, and linguistically diverse communities.

Jeffcote explains the change in opening times, inadvertently acts as a ploy to encourage the organization of particular clients serious in their wish to attend. It, also, supports staff in carrying out their full duties, including the proper functioning of the 'drop-in' area, administrative duties pivotal to the processing of government housing applications, delivering community referrals and other work.

11 A Manager's perspective

It is possible that conducting the interviews on-site influenced responses in a way where some did not feel happy sharing their full impressions of *Innerspace*. The feedback in this report is resoundingly positive. Carrying out the fieldwork in a more neutral location such as a street café, or even, private home may have produced different results. Especially, in relation to their deeper more personal grievances of the service, besides, the care taken to inform each, individual, of their rights as participants in a qualitative research project. Privacy concerns might have prevented the disclosure of more relevant information, even though adherence to strict ethical protocols ensured their confidentiality and anonymity.

11.1 Access for women

Innerspace Manager, Danny Jeffcote, provided thoughts on how the service could be added to mostly in relation to the identification of client need. He spoke of the demographics of his clients as mainly a lot of men between the ages of 35 to 40 and concern for the lack of engagement on the part of women. Further, he discussed the possibility of expanding the physical structure of the service, to somehow, improve access for women as a main priority. According to registered service contacts, the attendance ratio of men at *Innerspace* compared to that of women remained stable over five years, between 2005 and 2010, men made up two thirds of the client population compared to one third of women (Mugavin et al. 2011b). Similar findings are evident in Rowe (2003) who surveyed a representative sample of SAPH clients (n = 150) of the Health Information Exchange, a St Kilda needle and syringe service, and found a lot more men (n = 84, 56%) attended, compared to that of women (n = 66, 44%).

While, these statistics may reflect a general tendency of men to become more involved in problematic drug use - potentially seen in the above demographical analyses of different SAPH populations - it could indicate, also as Jeffcote suggests, a level of marginalisation for women in their attendance of *Innerspace*. Women who use drugs face different challenges, accessing drug and alcohol services in the sense of needing to be confident enough to potentially run into an ex-partner, pimp or abusive man. In Yarra, and other nearby suburbs, gendered issues like domestic violence, physical and sexual assault, and other dangerous power dynamics might prevent women seeking help.

Further research is needed to better understand the obstacles which face women who use drugs from properly accessing SAPH facilities, especially, thinking about the double discrimination they must face. People who use drugs are highly stigmatized in the eyes narrow-minded conservative networks who support 'tough on drugs' rhetoric (see: Australian Injecting Drug Users League 2011; Bennett 2004; Brener et al. 2010; Crofts et al. 1997; Fitzgerald et al. 2004; Hopwood et al. 2006; Rowe 2005; Simmonds & Coomber 2009; Tindal et al. 2010). Of course, women are also continually subordinated in their experience of unfair resource distribution at a societal level (see: Australian Bureau of Statistics 2013; Australian Bureau of

Statistics 2012; Australian Women's Health Network 2012; Ducey 2014; Toscano 2015; Workplace Gender Equality Agency 2014); at a greater risk of becoming victim to acts of rape, violence, and murder at the hands of men (see: Ford 2014; Gilmore 2014; Katz 2013; Meagher 2014; Plait 2014; Powell 2015; Victorian Women's Trust 2008); and live with everyday sexism in Australia (see: Booker 2015; Ford 2015a; Ford 2015b; Gillard 2012; The Representation Project 2013; Valenti 2015).

It is highly possible that the position of which women fill in society, being decidedly inferior to their male counter parts is at play, during the roll out of SAPH services. Trying to formerly understand how the current service system can adjust to better secure the delivery of treatment to women who use drugs - in the form of in-depth qualitative, and quantitate, interviews with female clients and their staff - would be a sensible response to informing decisions. Likewise, an examination into the gender representation of Victorian AOD institutions - as a way of attempting to stabilize the chance of male privilege, no longer, tampering with female client access (and possibly the hiring of female staff) - could help to guide the changes required for services in the inner-north of Melbourne to greater accommodate for the specific needs of women.

11.2 Access for young adults

The other significant demographic category of which Jeffcote points to declining important harm reduction services is that of young adults. He speculates that the changes in the popularity of street drugs from heroin during the 1990's to crystal methamphetamine, more recently, accounts for the ageing population of *Innerspace* clients. As seen in Mugavin et al. (2011b), the percentage of clients aged under that of 29 years dropped by 32.9% between the five years of 2005 and 2010. An extremely similar trend is noticeable in the increase of clients aged over 30 years to exactly 32.9%, during the same time period (Mugavin et al. 2011b).

Statistics by the Australian Institute of Health and Welfare (2015) show effectively the same findings for the shift in the age of people who access publicly funded AOD services. Nationally, over five years to the beginning 2014, the Institute presents an increase (3%) in clients over the age of forty and a decrease (2%) for those between 20 to 29 years. During this time, a rise (10%) is reported for the treatment for methamphetamine dependence which supports the notion of a change

in drug culture as suspected by Jeffcote (see also Australian Institute of Health and Welfare 2015). He explains, the reasons are difficult to confirm, yet offers a conceivable account of how the availability of heroin is now different - probably due to shifts in international trade - compared to that of 'ice' which seems more readily used (also see Fitzgerald 2015; Kirby Institute 2014; Rood 2009; Stafford & Burns 2013).

The concern for the lack of young adults properly engaging with *Innerspace* is the potential for a lot in their twenties to develop severe drug dependence issues to that of methamphetamine, as it is commonly smoked, not injected. The eligibility for attendance at a non-judgemental government SAPH is injecting drug use. This, fully, excludes those who ingest 'ice' or any other drug through a glass pipe (and / or any other method apart from injecting equipment). As discussed by Jeffcote a way to improve access for people who smoke drugs is in their inclusion as part of the client group of *Innerspace*, and potentially, other Melbourne SAPHs. The suggestion, he indicates was mentioned in passing and a more controlled client consultation of which requires further clarification, as far as, it's acceptability among a wider populous of *Innerspace* visitors. Nevertheless, the idea he believes is of strong merit.

Making *Innerspace* available to people who more generally 'use' drugs could mean greater access for those whose lives are negatively affected by smoking crystal methamphetamine and / or other drugs. Jeffcote noted how teenagers access YSAS and other youth withdrawal clinics, but do not, transfer in his eyes to the adult services. He says, '*we want to make ourselves available to anyone who needs our service,*' which includes, further developments possibly in terms of the physical structure of the service. An extension, he says, is necessary to accommodate for the needs of an expanded client group and the current foyer space is insufficient in its capacity for private conversation. While a total re-fit would be optimum for the rearrangement of a lighter, more welcoming, entrance to *Innerspace*, Danny is interested in fully establishing priority areas in respect to meeting his clients' needs before action.

11.3 Aging clients

The issue of accommodating for an age shift is not limited to addressing younger people, but also, a process of determining how to establish residential

facilities to cater for the older client population. *Innerspace* is grappling with the increased medical and other health care to clients who are developing conditions associated with old age. A quote from an *Innerspace* staff member included in the 2011 Eastern Health evaluation of the service describes this:

We have men 45 – 50 who are getting things and dying from them, which I would never have seen in the past. Whereas the average age 10 years ago would have been 30 – 35 now its 40 – 45. We have clients in their 60's; we have clients who are applying for the old age pension. They are getting things that they never would have got before. They are getting cirrhosis of the liver and arthritis. (Mugavin et al. 2011b, p.15)

The transition of clients from *Innerspace* as a primary health centre to aged care is a new development in the meantime, which needs planning, according to Jeffcote. A client's relocation into a specialised retirement home with the correct staff trained, and other AOD resources, necessary to properly manage the needs of this group requires systematic initiative. It would be wise for the Department of Health and Aged Care to work in close proximity with the Managers of these SAPHS, fully, to realise the complexity of this new chapter in the evolution of Victoria's responsive alcohol and other drug policies.

A true collaboration with the already existing AOD system and that of aged care policy-makers is needed to see the implementation of a smooth process respectful in the treatment of these older clients. The core values of harm reduction and health promotion - as spelt out in this report - would be imperative to the preservation of non-judgemental service provision so successful in facilitating better health and wellbeing for this cohort. An aged care facility, not equipped with the proper knowledge and personal sensitivities for some of the people who I spoke to would, most probably, result in their further exclusion from necessary medical treatment. The possibility of establishing dedicated centres to cater for the shift in the age of these clients would be a feasible, and as Danny agrees, fundamental to upholding their human rights.

11.4 Client consultations

Further, a way of informing new developments at *Innerspace* and maybe the broader SAPH network, in general, is the introduction of client consultations. As already mentioned, the after-hours meetings can help to guide important changes as that of addressing people smoking drugs not receiving important AOD services. On the topic of an increased popularity of the use of the drug 'ice', the idea emerged in the consultations of *Innerspace*, expanding to include a 'low stimulus' room for clients heavily intoxicated on methamphetamine.

A person experiencing an unpleasant psychological, and physiological, reaction to a lot of amphetamines could be properly monitored by the staff to make sure correct treatment is received in the form of anxiety reducing activities, and if necessary, other intervention. The inclusion of a 'safe-place' for people to recover from an unexpected drug reaction is similar to the already existing capabilities of *Innerspace* to manage overdose for clients who use of opiates. It, also, helps to contain the escalation of fuss made over the behaviour of an individual client and any other disruptions to the 'drop-in' area. The service could offer extra support in the shape of counselling to a client whose needs are further identified as a result of their utilization of the 'low stimulus' room. The establishment of a space specifically allocated for managing methamphetamine 'highs' promises to reduce harms by providing immediate treatment, and a form of early intervention, to people who use stimulants. In doing so, it further prevents the occurrence of other community associated problems as that of violence, sexual assault and mental health issues.

While the new client consultations are at the moment in their infancy, the initiation is a development core to the values of bottom up, community-focused, other drug service provision. By encouraging the input of exactly the people the service is designed to help do the consultations have the potential to shape successful, organisational, changes which foster better wellbeing and the empowerment of *Innerspace* clients. The staff, strongly value the opinions of those who generously volunteer their time in the meetings as an incremental contribution to the broader development of *Innerspace*.

12 Conclusions

12.1 Harm reduction and health promotion

The primary health service, *Innerspace* is playing a fundamental role in the lives of the people who gave their time and energy to be involved in my Honours research. So fundamental, it is the only service in the inner-north of Melbourne where the whole group who I interviewed felt comfortable attending. As the edited transcripts presented in this report suggest, the core philosophies of health promotion and harm reduction are arguably some of the most appropriate ways of which to deal with problematic injecting drug use within our community. Having non-judgemental staff that did not look down on their clients and treated each, individual, person who walked through service doors with dignity led to most of my participants, long-term, re-engagement with the primary health system.

Ultimately, the application of both harm reduction and health promotion principles is what distinguishes *Innerspace* from other health, welfare and associated drug and alcohol services within the multiplicity of Yarra. By regarding all of the participants as equally respectful human beings, and not, buying into the offensive stigma, prejudice and discrimination of people who inject drugs was the service doing far more than, simply, mending the physical health of a number of its clients. The, staff, empowered self-esteem in a way which encouraged hope in each of the people who I interviewed. This, inadvertently, seemed to help improve their outlook on building sustainable pathways to a more positive future and broader life.

In the words of 'Kate' one of the most valuable aspects of visiting *Innerspace* was how the staff are always, behaving like regular human beings, '*and that is what you want*'. Many of my participants expressed their clear admiration for having access to trustworthy community workers who related on a personal level to life 'on the streets'. Some of my cohort even felt indebted to particular staff that did all in their power to make-ends-meet for their clients no matter what sort of lived experience the people who I spoke to re-told. Again, if *Innerspace* did not exist, 'Kate' would be, '*begging for money or doing some bullshit for money*', which implies her involvement in prostitution, and presumably other forms of exploitation, she is now able to avoid. Only, however, with the help of a reliable primary health service

that offers an alternative means of survival in 'Kate's' local area for people who inject drugs.

The suitability of using both harm reduction and health promotion principles as a guide to the provision of many different services for individuals who use illegal substances has significant implications for drug policy reform in Victoria, and arguably, the rest of Australia. Especially, considering the large amount of state and federal funding, which continues to be allocated towards law enforcement or 'supply reduction' efforts that have little scientific evidence to suggest their effectiveness at preventing any further harm coming to those whose drug dependence renders their life in danger.

Mainstream services failed to meet the majority of my participant's health, emotional and domestic needs, while on the contrary, *Innerspace* was able to provide the immediate support necessary to save the lives of the individuals who I interviewed, and further, protect their wellbeing. This raises concern about the possibility of a paternalist culture, existing within our current health, and welfare systems, and other alleged rehabilitation services in inner-city Melbourne. The words of my participants also alert us to the apparent inability of, both, the public and private health systems to appropriately assist the true victims of Richard Nixon's 'war of drugs' who are the individuals whose voices are included in this report. The sheer fact that facilities such as *Innerspace* need to be established with the purpose of making up for the current service systems' blatant inadequacies in caring for people whose health is severely jeopardised by illegal substance use, simply, goes to show how dysfunctional the philosophical underpinnings of drug prohibition really are.

12.2 The failed 'war on drugs'

In truth, there is substantial proof of the incapacity of police and the judicial system to properly amend the issue of self-medication through the use of illegal drugs, which many of my participants said was the main reason for their prolonged reliance on heroin, and other addictive substances. While, it is well beyond the scope of this document to list the ever growing research, reports and other conclusive material, which indicates how prohibiting certain drugs is counterproductive to society, I include a number of supportive articles which indicate that this is at least the case for the state of Victoria (Armitage 2012; Australia21a; Australia21b; Beyer

et al. 2002; Green 2012b; Hagan 2012; Hannan 2012; Holden 2012; Irvine 2012; Medew, 2012a; Medew 2012b; Medew 2012c; Middendorp 2012; Silvester 2012; Vikingsson 2012).

The anecdotal evidence which I aim to give a spotlight emphasises a need to invest in alternative governmental approaches to the handling of problematic substance use that are proven to make a positive difference to the lives of people who inject drugs. We need to experiment with more creative policy options such as the already established and impressive frameworks of drug law reform which, currently, function in other parts of the world. Some brief examples are: The 2001 decriminalization of all drugs in the country of Portugal (see Domoslawski 2011; Greenwald 2009; Hollerson 2013; Ritter 2012; Vastag 2013); the 2013 legalization, regulation and taxation of cannabis in the country of Uruguay (see Andavolu 2014a; Andavolu 2014b; Carless; 2014 Castadli & Liambias 2013; Vincent 2013; Watt 2013); and indeed, the more recent full legalization of cannabis in the North American States of Washington DC, and Colorado (see Coffman 2014; Davis 2014; Ferner 2014; Ingold 2013; Marijuana Policy Project 2014; Poltonowics 2014; Reilly 2014; Respaut 2014).

Australian governments, both state and federal should be looking into the possibilities of decriminalizing, regulating, taxing and legalizing the use of illicit substances as a necessary measure in which to help the people who participated in the research, and others struggling with illegal drug dependence, to better manage their day-to-day lives. Or, at least, roll out more harm reduction programs that are strongly supported with scientific evidence to suggest they would be effective at alleviating the risks of unsafe intravenous use in a community-based setting.

12.3 A supervised injecting facility

Perhaps the next step for Victoria, in respect to illicit drug policy reform, is the establishment of a drug summit which investigates the benefits of implementing a supervised injecting facility in the City of Yarra. This is an area that in 2010-2011 had the highest number of ambulance call outs for heroin-related overdose in the state (Lloyd 2012). Further, 15,000 syringes were collected from public spaces in the multiplicity between the months of January and April in 2012 (Hagen 2012). Advocates for supervised injecting facilities highlight the empirical evidence which

indicates that they would be an effective strategy at minimizing the harms of problematic drug use in an Australian context (Bremer & Iten 2001; Dolan et al. 2000; Haasan et al. 2007; Jauncey 2011; KPMG 2010; Papanastiou et al. 2009; Uchentagen 2009).

Yarra City Council even voted in favour of the evidenced-based harm reduction strategy after a community organisation named, *Yarra Drug and Health Forum*, submitted a proposal which argued that it would be an extremely viable policy option for amending the dangers and public nuisance caused by 'street-based' drug use in the area (Caldwell 2011; Fitzsimmons 2011; Jauncey 2011; Papanastiou et al. 2009). Yet, the persistence of our current political leaders to lobby for a hard-line, idealistic, 'tough on drugs' response towards the issue devoid of any meaningful empirical evidence to suggest its success is obvious in the then, Victorian Premier, Ted Baillieu's response to the proposal:

I recognise there's a problem and that's why we want to have more police on the streets... We haven't supported injecting rooms, we won't support injecting rooms, and I don't support the normalisation of any of this sort of behaviour (Merhab 2011).

Implicit in this rationale is that injecting drug use is far from 'normal.' In fact, 'normalization' is a threat that necessitates 'more police on the streets' as the only adequate policy response (Bessant 2008). However, Baillieu ignores how for many people this 'behaviour' is already normal and visible in certain areas of Melbourne (Gordon 2012). Even the president of Victorian branch of the Australian Medical Association, Stephen Parnis, has publicly supported such initiatives declaring 'we cannot allow prejudice to drive illicit drug policy in Australia' (Gordon 2012). However, the Premier's automatic dismissal of implementing a supervised injecting facility shows the strength of political adherence to the alleged vote winning rhetoric of 'tough on drugs' no matter what the outcome may be.

In Australia, the adoption of a 'tough of crime / tough on drugs' fear mongering attempt to frame the issue of community safety is highly criticized among academics, public health experts, policy-makers, barristers and the police for being the last port of call of desperate politicians who are looking to win conservative middle-class votes (Green 2012a; Green 2012b; May 2012; Medew 2012b; Medew 2012c;

Metherell & Jacobson 2012; Norden 2013; Podmore 2014; Short 2011). A quote from UK professor, John Podmore, poignantly describes this irresponsible form of political spin in an article published by the online newspaper, *The Conversation*. He stipulates, '*it is the first refuge of intellectually bankrupt politicians clamouring for votes by "getting tough" on crime*' (Podmore 2014).

12.4 Conclusion

When our current political leaders have the courage to not let this simplistic language of 'hard' or 'soft' on drugs continue to cloud parliamentary debate on the issue of problematic drug use will we see true, positive, change for the people who I interviewed. The benefits of having these individuals and others dependent on illicit substances be given more of an opportunity to regain command over their daily worlds would not only be felt by them, but also, a much larger proportion of the Australian people.

Instead of my participants, having to commit street crime and other unwished for deeds to afford the drugs that allow for their maintenance a somewhat-normal feeling, the establishment of additional harm reduction services, including that of a supervised injecting facility would help to further break up the every-day cycle of destructive heroin, and other drug use. I should note that the majority of my research group were not using opiates every-day, had ceased frequent injecting and stabilised on a drug treatment program. Occasionally, however, heard were stories of a period in their lives where drug dependence had spiralled out-of-control, which usually, involved their elaboration on these incidents in the context of a traumatic life experience. Many were able to develop practical coping methods in hindsight of these mid-term crises which prevented any further drug-related turmoil. Such techniques were often revealed in the form of these participants extra sensible budgeting, the prioritization of food over recreational drug use, and adherence to court orders which promised for the return of a beloved child whose custody was temporarily lost.

Efforts demonstrated on the part of members of my group, show their ability to take charge of their immediate lives and work towards a more promising future. They, also, solidify the sureness that with the correct types of health, welfare, and social support, can the people interviewed grow away from problematic drug use and

onto their enjoyment of being part of a broader lifestyle within the city of Melbourne (or any other town, or place, they feel connected). If these participants were more equipped to systemically remove the environmental circumstances, which they confessed, led towards a turbulent reliance on black-market substances might the people who I spoke to lead more, happy, and fulfilling livelihoods. Undoubtedly, with the assistance of honourable harm reduction workers who empower their clients to better carry out the seemingly mundane tasks needed to not let drug dependence dominate their direct reality.

It was my groups' uninvited encounters with abusive relationships, childhood neglect, chronic pain, and low self-esteem, which they thought triggered their initial introduction, and subsequent development of, an inflexible drug habit. Thus, once, more stability is recovered in their access to genuinely helpful community-health services might the participants of my Honours project be progressively able to sustain the changes required to work towards overcoming the original causes of their not always helpful drug use. Without, these individuals, being given the chance to rebuild their regular comings-and-goings, are we in Australian society, wasting their unique, and diverse, contribution to the social, cultural, and economic, verve of our local neighbourhoods. It is high time that our nation got serious about reforming the twisted patriarchal system of heroin, and other drug, prohibition as a means of fighting the injustices which people who inject drugs experience every day.

References

- Andavolu, K. (2014a) 'Smoking weed with the President of Uruguay: Full Length' Vice, [YouTube] 26 April. (Online) <https://www.youtube.com/watch?v=1BwVxmJPies>
- Andavolu, K. (2014b) 'Vice podcast special with Jose 'Pepe' Mujica' Vice, [YouTube] 12 May. (Online) <https://www.youtube.com/watch?v=VtCPYneggEY>
- Armitage, C (2012) 'Losing the war' *The Age*, 19 May.
- Australian Bureau of Statistics (2013) 'women still under-represented in position of leadership', 4125.0 – *Gender Indicators, Australia, 2013*, 30 January (Online) [http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4125.0~Jan%202013~Media%20Release~Women%20still%20under-represented%20in%20positions%20of%20leadership%20\(Media%20Release\)~6152](http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4125.0~Jan%202013~Media%20Release~Women%20still%20under-represented%20in%20positions%20of%20leadership%20(Media%20Release)~6152)
- Australian Bureau of Statistics (2012) 'employed people', 1301.0 *Year Book Australia*, 2012, 24 May (Online) <http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/1301.0~2012~Main%20Features~Employed%20people~46>
- Australian Institute of Health and Welfare (2015) 'Drug treatment clients increasingly older – more treated for amphetamine use', 24 April. (Online) <http://www.aihw.gov.au/media-release-detail/?id=60129550783>
- Australian Women's Health Network (2012) 'Women and Health and Wellbeing: Position Paper 2012'. (Online) https://www.google.com.au/url?sa=t&rct=j&q=&esrc=s&source=web&cd=5&ved=0CDkQFjAE&url=http%3A%2F%2Fawhn.org.au%2Fwp-content%2Fuploads%2F2015%2F03%2F124_AWHNWomenHealthWellbeingPositionPaper2012word.doc&ei=QpRaVajCPNe78gWMI4LQCg&usg=AFQjCNFMVOhwccf0pX6XuIV7syIR2W_LVA&sig2=cf5pALRNtHAijHXpObciHA
- Austen, G. (2014) 'Welcome to cohealth,' 1 May. (Online) <http://cohealth.org.au/wp/wp-content/uploads/2014/05/Welcome-to-cohealth.pdf>

Australia21 (2012a) 'The prohibition of illicit drugs is killing and criminalising our children and we are all letting it happen'. (Online) <http://www.australia21.org.au/wp-content/uploads/2013/11/ASIllicitDrugsR1.pdf>

Australia21 (2012b) 'Alternatives to prohibition illicit drugs: How we can stop killing and decriminalizing young Australians'. (Online) <http://www.australia21.org.au/wp-content/uploads/2013/11/ASIllicitDrugsR1.pdf>

Australian Injecting Drug Users League (2011) 'Why wouldn't I discriminate against all of them?' (Online) <http://www.aivl.org.au/database/sites/default/files/images/AIVL%20IDU%20Stigma%20&%20Discrimination%20Report%20Nov%202011.pdf>

Bennett, G. (2004) 'Blacklisted in the city: How stigma affects primary health care for people who inject drugs' *Australian Journal of Primary Health*, Vol. 10, No. 2, p. 121-128.

Bessant, J. (2008) 'From 'harm minimization' to 'zero tolerance' drugs policy in Australia: how the Howard Government changed its mind' *Policy Studies*, vol 29 no 2, p. 197-214.

Beyer, L., Crofts, N. & Reid, G. (2002) 'Drug offending and criminal justice responses: practitioners' perspectives,' *International Journal of Drug Policy*, Vol 13, pp. 203-211.

Booker, C (2015) 'I was groped on public transport... and decided to fight back', *Daily Life*, 12 January. (Online) <http://www.dailylife.com.au/news-and-views/dl-opinion/i-was-groped-on-public-transport-and-decided-to-fight-back-20150112-12mg7i.html>

Brehmer, C. & Iten, P. (2001) 'Medical prescription of heroin to chronic heroin addicts in Switzerland- a review,' *Forensic Science International*, Vol 121, pp. 23-26.

Brener, L., Von Hippel, W., Kippax, S. & Preacher, K.J. (2010) 'The role of physician and nurse attitudes in the health care of injecting drug users', *Substance Use and Misuse*, Vol. 45, p.1007-1018.

Caldwell, A. (2011) 'Melbourne council votes yes to supervised drug injecting room' *AM* [radio program], ABC Radio National, 18 May.

Carless, W. (2014) 'Uruguay's pot-legalising President goes to Washington' *Global Post*, 9 May. (Online)
<http://www.globalpost.com/dispatch/news/regions/americas/140506/uruguay-jose-mujica-washington-visit-obama>

Castaldi, M. & Liambias F. (2013) 'Uruguay becomes the first country to legalise marijuana trade' *Sydney Morning Herald*, 11 December. (Online)
<http://www.smh.com.au/world/uruguay-becomes-first-country-to-legalise-marijuana-trade-20131211-hv59x.html>

Coffman, K. (2014) 'Majority of Colorado voters say legal pot has been good for state: poll' *Reuters US*, 28 April. (Online)
<http://www.reuters.com/article/2014/04/28/us-usa-colorado-marijuana-idUSBREA3R17V20140428>

Crofts, N., Louie, R. & Loff, B. (1997) 'The Next Plaque: Stigmatization and Discrimination Related to Hepatitis C Virus Infection in Australia' *Health and Human Rights*, Vol. 2, No. 2, p. 86-97.

Davis, A (2014) D.C. 'Board of Elections allows marijuana legalisation effort to move forward' *The Washington Post*, 12 March. (Online)
http://www.washingtonpost.com/local/dc-politics/dc-elections-board-allows-marijuana-legalization-effort-to-move-forward/2014/03/11/7821db7c-a402-11e3-84d4-e59b1709222c_story.html

Dolan, K., Kimber, J., Fry, C., Fitzgerald, J., McDonald, D., Trautmann, F. (2000) 'Drug consumption facilities in Europe and the Establishment of Supervised Injecting Centres in Australia,' *Drug and Alcohol Review*, Vol 19, p.337-346.

Domoslawski, A. (2011) 'Drug policy in Portugal: The benefits of decriminalising drug use' *Open Society Foundations, Global Drug Policy Program*. (Online)
<http://www.opensocietyfoundations.org/sites/default/files/drug-policy-in-portugal-english-20120814.pdf>

Drug Policy Expert Committee (2000) *Drugs: Meeting the Challenge -Stage 2 Report*. The Department of Human Services, Victoria. (online) [http://docs.health.vic.gov.au/docs/doc/5C6238CD0E3D7045CA2578A20019C01F/\\$FILE/dpec_stg2fi.pdf](http://docs.health.vic.gov.au/docs/doc/5C6238CD0E3D7045CA2578A20019C01F/$FILE/dpec_stg2fi.pdf)

Ducey, L. (2014) 'Wage gap between men and women grows but only just' *The Age*, 15 August, (online) <http://www.theage.com.au/it-pro/wage-gap-between-men-and-women-grows-closer-but-only-just-20140815-104ngb.html>

Ferner, M (2014) 'Crime still isn't devouring Denver 4 months after legal pot' *Huff Post*, [Television Program] 13 May. (Online) http://www.huffingtonpost.com/2014/05/13/marijuana-crime-denver_n_5319298.html

Fitzgerald, J. (2015) 'Don't worry: the 'ice pandemic' is a myth', *The Age*, 18 May. (Online) <http://www.theage.com.au/comment/dont-panic-the-ice-pandemic-is-a-myth-20150517-gh2plm.html>

Fitzgerald, J.L., McDonald, K. & Klugman, M. (2004) 'Unspoken but Ever Present: Hepatitis C in a Regional Setting' *The Centre for the Study of Health and Society and The Sociology Program*. The University of Melbourne.

Fitzsimmons, H. (2011) 'Victoria blocks supervised injecting room' *Lateline* [television program], Australian Broadcasting Corporation, 18 May.

Ford, C. (2014) 'I work as a men's behaviour change practitioner' *Daily Life*, 28 November. (Online) <http://www.dailylife.com.au/life-and-love/real-life/i-work-as-a-mens-behavioural-change-practitioner-20141127-11vfao.html>

Ford, C. (2015a) 'Q&A: Men Don't Need To Hear Other Men Speak Out About Violence In Order To Change' *Daily Life*, 24 February. (Online) <http://www.dailylife.com.au/news-and-views/dl-opinion/qa-men-don8217t-need-to-hear-other-men-speak-out-against-violence-in-order-to-change-20150223-13mum3>

Ford, C. (2015b) 'Why the boys club in parliament can't handle smart women', *Daily Life*, 28 February. (Online) <http://www.dailylife.com.au/news-and-views/dl-opinion/why-the-boys-club-in-parliament-cant-handle-smart-women-20150227-13rcuz>

Gillard, J. (2012) 'Julia Gillard's Misogyny Speech' *YouTube*, 10 October. (Online) <https://www.youtube.com/watch?v=SOPsxpMzYw4>

Gilmore, J. (2014) 'No, women aren't as likely to commit violence as men', *Daily Life*, 19 November. (Online) <http://www.dailylife.com.au/news-and-views/dl-culture/no-women-arent-as-likely-to-commit-violence-as-men-20141118-3km9x.html>

Gordon, J. (2012) 'Why is a sensible debate on drugs beyond our politicians?' *The Age*, 11 October.

Green, S. (2012a) 'Drug expert slams political leaders' *The Age*, 23 May.

Green, S. (2012b) 'New Pillars of Wisdom' *The Age*, 23 May.

Greenwald, G. (2009) 'Drug Decriminalization in Portugal: lessons for creating fair and successful drug policies' *Cato Institute*. (Online) http://object.cato.org/sites/cato.org/files/pubs/pdf/greenwald_whitepaper.pdf

Haasen, C., Verthien, U., Degkiwtz, P., Berger, J., Krausz, M., Naber, D. (2007) 'Heroin-assisted Treatment of Opiate Dependence,' *British Journal of Psychiatry*, Vol 191, pp. 55-62.

Hagan, K. (2012) 'Police 'displace' Richmond's heroin injecting problem' *The Age*, 24 May.

Hannan, L. (2012) 'Parents feel agony of needle and damage done' *The Age*, 19 December.

Holden, K. (2012) 'Take it from an ex-addict, outlawing drugs does not work' *The Age*, 25 May.

Hollerson, W. (2013) 'This is working: Portugal, 12 years after decriminalizing drugs' *Spiegel online International*, March 27. (Online) <http://www.spiegel.de/international/europe/evaluating-drug-decriminalization-in-portugal-12-years-later-a-891060.html>

Hopwood, M., Treloar, C. & Bryant, J. (2006) 'Hepatitis C and injecting-related discrimination in New South Wales, Australia', *Drugs: Education, Prevention and Policy*, Vol. 13, No. 1, p.61-75.

Ingold, J. (2013) 'A Colorado marijuana guide: 64 answers to commonly asked questions' *The Denver Post*, 31 December. (Online) http://www.denverpost.com/marijuana/ci_24823785/colorado-marijuana-guide-64-answers-commonly-asked-questions

Irvine, J. (2012) 'Counting the cost of drug prohibition' *The Age*, 26 May.

Jauncey, M. (2011) 'Injecting centres a realistic, compassionate response to drug use,' *The Age*, 26 May.

Katz, J. (2013) 'A TED talk that might turn every man who watches into a feminist? It's pretty fantastic' *TEDxFiDiWomen*, 3 May. (Online) <http://www.upworthy.com/a-ted-talk-that-might-turn-every-man-who-watches-it-into-a-feminist-its-pretty-fantastic-7>

Kirby Institute (2014) *Australian NSP Survey national data report 2009-2013*, The Kirby Institute, University of NSW, Sydney. (Online) <http://kirby.unsw.edu.au/sites/default/files/hiv/resources/ANSPS-NDR-2009-2013-2.pdf>

KPMG (2010) *Evaluation of the Medically Supervised Injecting Centre during its extended Trial period (2007-2011) Final report*, NSW Government. (Online) www.health.nsw.gov.au/resources/mhdao/pdf/msic_kpmg.pdf

Lloyd, B. (2012) *Trends in Alcohol and Drug Related Ambulance Attendances in Melbourne* Turning Point Alcohol & Drug Centre, Fitzroy, Melbourne.

Marijuana Policy Project (2014) 'Colorado tax revenues exceeding expectations', [YouTube] 24 February. (Online) <https://www.youtube.com/watch?v=7fiGo-Oor84&app=desktop>

May, J. (2012) 'When drugs meet crime' *The Age*, 21 May.

Meagher, T. (2014) 'The Danger of the Monster Myth' *White Ribbon Campaign*, 17 April. (Online) <http://whiteribbonblog.com/2014/04/17/the-danger-of-the-monster-myth/>

Merab, B. (2011) 'Baillieu won't approve a heroin centre' *Sydney Morning Herald*, 18 May.

- Medew, J. (2012a) 'Drug addicts die waiting for treatment' *The Age*, 20 March.
- Medew, J. (2012b) 'Punishing users doesn't work: experts' *The Age*, 4 April.
- Medew, J. (2012c) 'Within these walls' *The Age*, 21 July.
- Mendes, J. (2004) 'The Victorian Supervised Injecting Facilities Debate,' in P. Mendes, J. Rowe (eds) *Harm Minimization, Zero tolerance & Beyond*, Pearson, Sydney.
- Metherell, M. & Jacobson, G. (2012) 'Carr urges drug reform' *The Age*, 3 April.
- Middendorp, C. (2012) 'The beatings of old are a far cry from police beat today' *The Age*, 20 November.
- Mugavin, J., Strickland, H., Berends, L., Eleftheriadis, D. & Hunter, B. (2011a) *Evaluation of Specialist Alcohol and other drug Primary Health Services (SAPHS): Overview report*, Victoria: Turning Point Alcohol and Drug Centre.
- Mugavin, J., Strickland, H., Berends, L. & Eleftheriadis, D. (2011b) *Evaluation of Specialist Alcohol and other drug Primary Health Services (SAPHS): Innerspace, including the Alcohol and Drug Counsellor*, Victoria: Turning Point Alcohol and Drug Centre.
- Norden, P. (2013) 'As Victoria's prisons overflow; it's time to stop criminalizing disadvantage' *The Conversation*, 30 October. (Online).
<http://theconversation.com/as-victorias-prisons-overflow-its-time-to-stop-criminalising-disadvantage-19626>
- Papanastasiou, Kirwan, Winter & Power (2009) 'The potential and viability of establishing a Supervised Injecting Facility (SIF) in Melbourne: Position Paper - October 2009' *Yarra Drug and Health Forum* (online).
<http://www.ydhf.org.au/SIF%20Position%20Paper%20YDHF.pdf>
- Plait, P. (2014) '#yesallwomen' *Slate*, 27 May. (Online)
http://www.slate.com/blogs/bad_astronomy/2014/05/27/not_all_men_how_discussing_women_s_issues_gets_derailed.html

Podmore, J. (2013) 'Tough on crime: Victoria is not learning lessons from abroad' *The Conversation*, 21 October. (Online) <http://theconversation.com/tough-on-crime-victoria-is-not-learning-lessons-from-abroad-19023>

Potlunowicz, J. (2014) 'Marijuana legalization may spur America's next big industry' *The Guardian Liberty Voice*, 23 March. (Online) <http://guardianlv.com/2014/03/marijuana-legalization-may-spur-americas-next-great-industry/>

Powell, A. (2015) 'Women's personal experiences of violence should indeed incite fury' *The Conversation*, 17 February. (Online) http://theconversation.com/womens-personal-experiences-of-violence-should-indeed-incite-fury-37713?utm_medium=email&utm_campaign=Latest+from+The+Conversation+for+18+February+2015+-+2453&utm_content=Latest+from+The+Conversation+for+18+February+2015+-+2453+CID_347da49b01e972828a2f78fda5c9be52&utm_source=campaign_monitor&utm_term=Womens+personal+experiences+of+violence+should+indeed+incite+Fury

Reid, G., Crofts, N. & Hocking, J. (2000) *Primary Health Care among the Street Drug Using Community in Footscray: A Needs Analysis*. The Centre of Harm Reduction of the Macfarlane Burnet Centre for Medical Research.

Reilly, M. (2014) 'Rick Steve's is tired of the racist war on weed', *Huffington Post*, 19 February. (Online) http://www.huffingtonpost.com/2014/02/19/rick-steves-marijuana_n_4819131.html

Respaut, R. (2014) 'Colorado legalised tax revs ahead of expectations: Moody's' *Reuters US*, 11 April. (Online) <http://www.reuters.com/article/2014/04/11/us-colorado-marijuana-idUSBREA3A1X720140411?irpc=932>

Ritter, A. (2012) 'Decriminalization or legalisation: injecting evidence in the drug law reform debate' *The Conversation*, 12 April. (Online) <http://theconversation.com/decriminalisation-or-legalisation-injecting-evidence-in-the-drug-law-reform-debate-6321>

Ritter, A., Lancaster, K., Grech, K., Reuter, P. (2011) 'An assessment of illicit drug policy in Australia (1985 to 2010) themes & trends' *Drug Policy Modelling Program Monograph* 21. (Online)

[http://www.dpmp.unsw.edu.au/DPMPWeb.nsf/resources/monograph1.pdf/\\$file/DMP+MONO+21.pdf](http://www.dpmp.unsw.edu.au/DPMPWeb.nsf/resources/monograph1.pdf/$file/DMP+MONO+21.pdf)

Rowe, J. (2003) *Who's Using? The Health Information Exchange [St Kilda] and the development of an innovative primary health care response for injecting drug users*, Salvation Army Crisis Services, Melbourne.

Rowe, J. (2006) *Access Health: Towards best practice in the delivery of primary health care*, Salvation Army Crisis Services, Melbourne.

Rowe, J. (2005) 'From Deviant to Disenfranchised: The evolution of drug users in AJSI', *Australian Journal of Social Issues*, Vol. 40, No. 1, p.107-123.

Short, M. (2011) 'Getting it right' *The Age*, 23 May.

Silvester, J. (2012) 'War on drugs an absolute bust' *The Age*, 4th April.

Simmonds, L. & Coomber, R. (2009) 'Injecting drug users: A stigmatised and stigmatising population' *International Journal of Drug Policy*, Vol. 20, p. 121-130.

Stafford, J., & Burns, L. (2013) *Australian Drug Trends 2012: Findings from the Illicit Drug Reporting System, (IDRS)* NDARC Australian Drug Trends Series No. 91. National Drug and Alcohol Research Centre, University of NSW, Sydney. (Online) <https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/National%20IDRS%20report%202012.pdf>

The Representation Project (2013) 'How the Media Failed women in 2013', *YouTube*, 3 December. (Online) <https://www.youtube.com/watch?v=NswJ4kO9uHc>

Tindal, C., Cook, K. & Foster, N (2010) 'Theorizing stigma and the experiences of injecting drug users in Australia' *Australian Journal of Primary Health*, Vol 16, p.119–125.

Toscano, N. (2015) 'Drastic improvement needed to close gender pay gap: Andrews government', *The Age*, 10 April. (Online) <http://www.theage.com.au/victoria/drastic->

[improvement-needed-to-close-gender-pay-gap-andrews-government-20150409-1mhnxe.html](http://www.improvement-needed-to-close-gender-pay-gap-andrews-government-20150409-1mhnxe.html)

Uchtenhagen, A. (2009) 'Heroin-assisted treatment in Switzerland: a case study in policy change,' *Addiction*, pp. 29-37.

Valenti, J. (2015) 'You might not think your sexist until you look at your bookshelf' *The Guardian*, 18 May. (Online) http://www.theguardian.com/commentisfree/2015/may/18/you-might-not-think-youre-a-sexist-until-you-take-a-look-at-your-bookshelf?CMP=soc_567

Vastag, B. (2013) '5 years after: Portugal's drug decriminalization policy shows positive results' *Scientific American*, 7 April. (Online) <http://www.scientificamerican.com/article/portugal-drug-decriminalization/>

Victorian Government, (2014a) 'MHCSS Reform – Consumer Fact Sheet 2014,' June. (Online) <http://www.health.vic.gov.au/mentalhealth/pdrss-reform/resources.htm>

Victorian Government (2014b) 'PDRSS Reform Factsheet 1: New service delivery responsibilities – North and West Metropolitan Region – May 2014,' May. (Online) <http://www.health.vic.gov.au/mentalhealth/pdrss-reform/resources.htm>

Victorian Women's Health Trust (2008) 'Be the hero'. (Online) <http://www.bethehero.com.au/index.php?id=9>

Vikingsson, P. (2012) 'Target crime assets in war on drug gangs' *The Age*, 4 April.

Vincent, M (2013) 'Uruguay legalises the production and sale of Marijuana' *ABC News*, 11 December. (Online) <http://www.abc.net.au/news/2013-12-11/uruguay-set-to-legalise-the-production-and-sale-of-marijuana/5148364>

Watt, P. (2013) 'What Uruguay's legal weed means for the war on drugs' *The Conversation*, 2 April. (Online) <http://theconversation.com/what-uruguays-legal-weed-means-for-the-war-on-drugs-16646>

Wodak, A., & Moore, T. (2002) 'How did we get into this mess?' *Modernizing Australia's Drug Policy*, University of NSW Press, Sydney.

Workplace Gender Equality Agency (2012) 'Gender workplace statistics at a glance', 14 February. (Online) https://www.wgea.gov.au/sites/default/files/2014-02-10-Stats_at_a_Glance.pdf

World Health Organisation (1986) *The Ottawa Charter of Health Promotion*, Canada. (Online) <http://www.who.int/healthpromotion/conferences/previous/ottawa/en/>