National Drug Strategy Beyond 2009
Anex Response to Consultation Paper
About Anex

Anex is a non-profit, public health, drug policy organisation. A key focus of the work that Anex does is the translation of robust evidence into service delivery and practice. Anex has a national role in advocating for harm reduction service improvement based on the available evidence, particularly in the delivery of Needle and Syringe Programs (NSPs).

NSPs are a proven public health protection measure. They reduce the transmission of blood borne viruses such as hepatitis C and HIV. They also reduce the harms associated with drug use by providing referral to treatment, advice on reducing harms and in some cases, primary health services. In essence, NSPs provide a whole of community benefit by reducing the risk of blood borne virus transmission between individuals affected by drug use, and in turn, reduce the risk of blood borne virus transmission for the whole community. As a result of avoided illnesses and disease, NSPs reduce the costs associated with drug use and provide a referral pathway into treatment.

Anex does not condone drug use nor condemn drug users but rather, seeks to protect people from harms associated with using drugs while at their most vulnerable.

The Consultation Paper asks an overarching question as to how:

"emerging issues and developments identified in the Consultation paper might impact on patterns of tobacco, alcohol and illicit drug use, and the misuse of licit substances, in the next five years and appropriate responses to these patterns". (National Drug Strategy, 2009, p. 1.)

Given the breadth of this question, our response is limited to the area of the use of licit substances in an illicit manner as well as the use of illicit drugs. We note the existence of the Preventative Health Taskforce. The Taskforce has published papers on the broader strategy for preventing harms associated with alcohol, tobacco and obesity in the Australian population both now and into the future. Our view is that much of the work related to tobacco and alcohol that may need to have been included in this strategy has been completed by the Preventative Health Taskforce and the new National Drug Strategy should align with the work of the Taskforce, rather than replicate or repeat work already completed on these topics.

Other emerging issues that you think are relevant to the next phase of the National Drug Strategy

What you think the top priorities for action should be during the next five years;

Anex is of the view that the top priorities for action during the next five years are:

*Increasing the community’s understanding of harm reduction and why it is good policy.*

Harm reduction essentially aims to reduce the harms associated with drug use. As noted above, Anex’s response focuses on the approach of harm reduction to illicit drug use and the use of licit drugs in an illicit manner. Harm reduction measures around tobacco and alcohol have been widely implemented such as decreased access to alcohol at venues, restrictions on tobacco advertising, reduced trading hours for licensed venues, as well as self imposed industry restrictions on the advertising of alcohol. We note that the Preventative Health Taskforce have commented on the advertising of alcohol and we would expect that future action would involve tighter controls around the advertising of alcohol, beyond a self managed system of advertising by the industry.

In 2009 Anex completed a social research project that sought to assess the level of community awareness and support of harm reduction. A sample of 503 Victorians participated in the survey. It included males and females and people from metropolitan, rural and regional Victoria. This research found that when asked to complete the statement: "To me the term harm reduction in relation to a drug problem means..." 24% of the respondents indicated that they did not know what harm reduction was, and another 43% made responses that were totally incorrect. Nineteen per cent of responses were somewhat correct, and only 13% of responses displayed a clear understanding of the term.

*Increased professionalisation of the Drug and Alcohol Workforce*

Given the complexity of the presentation of people to drug and alcohol services, there needs to be an increased investment in the building of capacity within the Drug and Alcohol (D and A) Workforce. This includes people presenting with mental health issues, legal issues, dependents requiring care and the intergenerational nature of drug use. Some of the most
marginalised people in our community are people who use illicit drugs and have a mental health illness and are homeless. Complexity of this degree requires service providers to have a sophisticated understanding of the nature of co-morbidities, the services available to be called upon, the criteria that are met or not met in certain instances thus enabling access or otherwise to a program, as well as workers needing to be expert at handling crisis situations. Investment must occur in the D and A workforce if the issues listed above are to be properly handled and resolved to avoid further generations also being marginalised. Some agencies have suggested that a minimum qualification or minimum standard be adopted by the D and A sector. Indeed, Victoria has the Minimum Qualification Strategy however the nature of service delivery in some sectors makes this difficult. For instance, many secondary NSPs are staffed by administration workers who may not have training in the health sector, nor any specific D and A training. Imposing a Minimum Qualification Standard of D and A services would require mindfulness of the various staffing models used to provide services.

Preventing harms caused by injecting drug use in resident Australian population – particularly Aboriginal communities, as well as those migrating to Australia.

Anex has completed work with the Victorian Aboriginal Community Controlled Health Organisation that has sought to increase the effectiveness of responses to injecting drug users and reduce rates of HIV and hepatitis C infection. At present, Aboriginal injecting drug users are reported to contract HIV at a rate which is six times that of the non Indigenous injecting drug user population (Ward et al., 2008). Indigenous women have a three times higher rate of contracting HIV than non Indigenous women. Given the Government’s stated commitment to reducing Indigenous disadvantage and the projected rates of population growth for Aboriginal and Torres Strait Islander populations in Australia, it is imperative that actions are taken to reduce the harms caused by injecting drug use in Aboriginal and Torres Strait Islander communities.

The next National Drug Strategy will also need to take into account the changing demographic of the Australian population with increased levels of migration from countries which have history of war and disadvantage. People migrating from these countries can have a number of problems associated with their exposure to violence, their isolation from family and community in Australia, and economic disadvantage that may occur owing to qualifications acquired overseas not being recognised in Australia. This situation creates a ‘perfect storm’ for further disadvantage and potential harm to all parts of the Australian community as the cultural understanding of blood borne viruses may differ widely from accepted standards of infection control. As a result, people migrating from countries with traumatic histories and interrupted education, may not be aware of how best to avoid blood borne virus infection associated with illicit drug use. Investment will be required in the protection of vulnerable populations to blood borne virus transmission.

Ageing population and use of opioids to treat chronic pain and the diversion of these

Anex wishes to comment in detail on the use of illicit substances and the use of licit substances in a manner for which they have not been prescribed or by person to whom they have not been prescribed. Research completed by Anex in rural and regional areas indicates that large amounts of diverted opioids such as MS Contin, OxyContin, and other tablet forms of opioids are injected, or used by people in a manner that could be termed harmful. In parts of rural and regional Australia it is reported that illicit substances such as heroin and amphetamines are very rarely available, but rather, injecting drug use appears to mainly involve tablet forms of opioids being injected. It can also involve amphetamines – this is largely also dependent on availability.

Emerging patterns include the increasing prescription of these opioids for chronic pain as pain management is occurring in the community setting, but further complexity is added to
this by the ageing of the population. It is likely therefore that there will be larger numbers of people in the community who will need pain management as a result of chronic pain associated with the effects of ageing and ageing related diseases such as arthritis, osteoporosis, pathological fractures, Parkinson’s disease etc.

An intelligent response to this forecast situation would be to increase GP’s expertise in the management of chronic and complex pain presentations. This is not to say that GPs are not currently prescribing pain relief appropriately, but rather, that the provision of peer support through access to pain management specialists who may be available to discuss particularly complicated cases, may be of benefit to GPs handling chronic, and apparently intractable pain. This will require increasing investment in the medical workforce as pain management clinics currently have long waiting periods, and the number of pain management specialists is of concern given the ageing of the population.

There is also an argument to be made for a new approach to chronic pain, which is the management of such pain through slow release synthetic opioids such as methadone and buprenorphine in those individuals in which this proves effective. These drugs may prove more efficient at managing long term pain and the current systems set up in each jurisdiction in relation to their dosing, reduces their risk of diversion. The current use of tablet opioids on a wide scale in the community is a risk to increased rates of diversion of prescribed opioids for illicit use.

The construction of GP Super Clinics also presents an opportunity for the institution of new service models around pain management and this may include housing pain management specialists at these clinics for sessional periods to review the treatment and management of patients with chronic intractable pain. This would provide GPs with on site support as well as possibly increase patient access to pain management expertise. The follow on from this may be a more sophisticated approach to longer term pain management and reduced amounts of prescribing of opioids, thus reducing the risk of diversion.

**Hepatitis C prevalence and access to treatment.**

As noted by Hepatitis Australia: “In Australia, more than 200,000 people have chronic hepatitis C, and an estimated 160,000 Australians are living with chronic hepatitis B. Worldwide, one in 12 people are living with chronic hepatitis B or C.” While hepatitis B is not as prevalent amongst injecting drug users as hepatitis C, there is no vaccine for hepatitis C, and hence the long term risk amongst this population group is that hepatitis C will continue to remain at high levels amongst injecting drug users. Injecting drug use is the most common way in Australia that hepatitis C is contracted.

This is clearly one of the most serious harms associated with injecting drug use and more needs to be done in the new strategy to increase the distribution of sterile injecting equipment through NSPs, Syringe Vending Machines, Pharmacies and hospitals to prevent a rise in the level of hepatitis C amongst both injecting drug users and the broader community. Also, hepatitis C is treatable, however access to treatment can be problematic. Long term harms arising from untreated hepatitis C include cancer and cirrhosis of the liver. These diseases require sophisticated, intensive medical management. The Australian health care system is unlikely to be able to provide adequate care to people with hepatitis C if rates remain high within the injecting drug using community. The National Drug Strategy should include direction setting imperatives for jurisdictions to re-configure how prevention through NSPs and treatment for hepatitis C is delivered, including the referral process. Many current drug users are unaware of their hepatitis risk profile or treatment effectiveness and availability.

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Getting the balance right between supply reduction, demand reduction, harm reduction. Identifying how we know we have got the balance right.

Harm reduction steps into the gap when both supply reduction and demand reduction have failed. It is clear from the above information that we have not got the balance right in relation to the three pillars of the National Drug Strategy. More investment is required in those services and systems that are required to respond when supply reduction and demand reduction fail. Greater investment in harm reduction is also an investment in the safety of the broader community as it means that diseases such as HIV and hepatitis C are better understood and managed, thus reducing their rates of transmission across sub-population groups.

Harm reduction can also act as an avenue to demand reduction, with NSPs being funded over recent years by the Council of Australian Governments to deliver interventions with clients that would encourage them to seek treatment.

In relation to supply reduction we would suggest that significant investment in this area is already in place and in spite of this, illicit drugs are still being used in Australian communities. Australian communities expect a degree of investment in supply reduction, however, it may be more useful to invest in the development of an ‘early warning system’ that can report when the supply reduction system has failed.

In order to better protect the health of people who are using drugs, better systems of information sharing and management need to be established. We have recently seen a number of episodes of heroin being combined with Anthrax which was first observed in Scotland earlier this year. Networks used to share information in the drug sector were used to provide information to service providers about this incident. However, these mechanisms for information sharing are not formalised but rather have grown organically within and across the harm reduction sector. If a more formalised system was to be used, we stress that carefully agreed protocols would be required. The aim of these protocols would be to ensure illicit drug users were not targeted, but rather, a system wide approach was taken to implement methods of ensuring better responses to illicit drug use.

A number of key consultation questions are asked through the paper. Our response has been prepared to a select number of these:

How can structures and processes under the National Drug Strategy more effectively engage with sectors outside health, law enforcement and education?

There is an existing Intergovernmental Committee on Drugs (IGCD)/Australian National Council on Drugs (ANCD) Annual Strategic Issues Workshop which we believe represents an opportunity for greater direct involvement with structures under the National Drug Strategy. These include peak bodies such as Anex, the Alcohol and Drugs Council of Australia (ADCA), the Australian Council of Social Services (ACOSS), Australian Professional Society on Alcohol and other Drugs (APSAD) and other nationally relevant bodies. The involvement of bodies such as Anex, ADCA and ACOSS would provide wider representation at this workshop and thus ensure that the National Drug Strategy remains relevant, even in the face of a culture of rapidly changing drug use patterns.

The current work taking place on social inclusion also represents an opportunity for synergies to be recognised across Government programs. The social inclusion agenda aims to achieve better connectedness to society and social services for those who may be homeless, have drug use or mental health issues, may be culturally isolated from their community as a result of migration or facing financial issues. The Prime Minister’s Social Inclusion Committee should work closely with the Ministerial Council on Drug Strategy (MCDS) and the IGCD in order to provide better linkages across broad sectors.
There is currently a severe underrepresentation of harm reduction expertise. Anex was not provided with funding support to fulfill its role as the national voice for harm reduction and NSPs during the Howard Government years. Under the new National Drug Strategy, Anex would hope that a shared commitment to evidence based practice would be properly acknowledged and appropriately funded by government. Anex believes that an non-government organisation (NGO) partnership with government is important but requires funded capacity. For example, there are serious drug related issues in the housing and homelessness sector that should be addressed by both governments and the NGO sector in collaboration.

On a final note, the ANCD has a number of meetings throughout the year in different capital cities. Anex is of the view that this is an excellent way for the ANCD to remain up to date on local issues, but also those that have a national impact. The MCDS could consider something similar with bi-annual meetings/forums/seminars in different capital cities/locations. This would enable service providers to have their voices heard at yet another level of the National Drug Strategy infrastructure.

Which sectors will be particularly important for the National Drug Strategy to engage with?

The evidence suggests that many people using drugs problematically have multiple comorbidities. Sectors with which the National Drug Strategy will need to engage with include harm reduction, education, mental health, Aboriginal health, housing, law enforcement, primary health care as well as the broader community. The current engagement with the harm reduction sector reflects its funding profile ie only 3 percent of the drugs budget to harm reduction and about that amount of attention to its issues. Many harm reduction services are delivered at a state level within communicable diseases branches and not drug and alcohol. This requires increased capacity for NGOs to address this complexity and increased intradepartmental collaboration.

Other sectors of great importance include: housing, community health, courts and prisons, media, aged services and employment and training services.

Could the IGCD and MCDS more effectively access external expert advice and if so, how?

There is a vast reservoir of experience and expertise within the harm reduction sector. Anex for instance, has an established Research Advisory Committee and has compiled a Public Statement on the Research Directions for the NSP Sector (see Attachment 1). The work of this group is done by Anex on a pro bono basis, which is unsustainable over the medium term. The Research Advisory Committee is chaired by Professor Steve Wesselingh and has members including Professor Steve Allsop, Professor John Kaldor, Ms Annie Madden, Mr Michael Moore and Professor Robert Power.

A comprehensive research plan for the entire sector would provide a mapped out, detailed, and achievable way forward for the IGCD and MCDS to obtain expert advice in relation to the matters that it requires information on. Further to this, any research plan would need to bematched with appropriate resourcing so as to enable the research to be conducted. Plans that cannot be actioned do all parties a disservice.

Anex has remained unfunded in its national harm reduction and NSP advocacy role and is not represented on various relevant committees even though the Australian NSP sector has called for its inclusion as the national voice. This can be solved by provided a mechanism for Anex's inclusion in government committee and consultation mechanisms. Whilst during the
Tough on Drugs years there was considerable ambivalence about Anex, we believe the next Strategy should better respect the contributions of the harm reduction field.

Where should efforts be focussed in reducing substance use and associated harms in Indigenous communities

Research completed by Anex (unpublished to date) indicates that much harm is caused by alcohol and tobacco in Aboriginal communities. These are not new issues. However, as highlighted above, the harms caused by injecting drug use are also substantial and much greater impact may be seen in the short to medium term by:

- increasing access to sterile injecting equipment in Aboriginal communities;
- increasing access to education on the benefits of harm reduction; and
- greater cross cultural collaboration and education between mainstream and Community Controlled Health Services to enable both workforces to understand different cultural approaches to the provision of harm reduction services.

Access to treatment in the community is inadequate for Aboriginal drug users. Also in prison, where due to their higher rates of incarceration, there is nationally very poor access to quality drug treatment or harm reduction services.

How could Aboriginal and Torres Strait Islander peoples needs be better addressed through the main National Drug Strategy Framework

From the research that Anex has completed, it is noted that Aboriginal and Torres Strait Islander peoples can have similar problems to the broader community, however the most effective responses are sometimes different to those that are on offer or available through mainstream services. Work done by Anex indicates that responses need to be tailored to Aboriginal communities and their needs. That is, there needs to be an individualised response in the context of a broad and jointly endorsed strategy. It is important that we do not replicate service systems as this is cumbersome, slow and inefficient. Rather, we should use existing service systems in smarter ways and more collaboratively.

In that context, would a separate National Drug Strategy Aboriginal and Torres Strait Islander Complementary Action Plan continue to have value?

On the basis of the points made above, Anex is of the view that a separate strategy document is required, but the new National Drug Strategy must articulate an inclusive, culturally appropriate and tailored approach to tackling drug problems in both mainstream and Aboriginal communities. A separate Action Plan for Aboriginal and Torres Strait Islander people should be developed and include a significant harm reduction component.

Where should effort on the support and development of drug and alcohol sector workforce be focused over the coming five years?

In our view, the effort on the support and development of the drug and alcohol sector workforce should be focused on the following areas:

- Increased professionalisation of D and A Workforce
- The approximately 1000 NSP outlets in Australia have very limited and inconsistent access to quality professional development
- Hepatitis C prevalence and access to primary and secondary prevention
- Harms caused by injecting drug use in resident Australian population – particularly Aboriginal communities, young people, people from socioeconomically disadvantaged areas as well as those migrating to Australia to ensure greater collaboration across sectors
• Ageing population and use of opioids

Where should efforts be focussed over the coming five years to increase the capacity of the generalist health workforce to identify and respond to substance use problems?

Anex considers that training at undergraduate level of medicine and nursing in the area of D and A interventions would be of benefit and enable broader based responses to substance use problems. Another outcome of increased training at undergraduate would be the normalising of D and A treatment/interventions as a part of every day practice. Finally there should be an investment to increase the ability of the health workforce to identify drug and alcohol problems early, and existing co-morbidities, and offer appropriate interventions.

How can efforts under the National Drug Strategy better complement the social inclusion agenda such as addressing unemployment, homelessness, mental illness and social disadvantage?

A matched investment needs to be made in each of the Drug/Alcohol, Housing and Mental Health sectors to form extensive collaborative networks within each jurisdiction. The work being completed by the Prime Minister's Social Inclusion Committee could inform this network and how it is established. We note that the National Homelessness Strategy has recently resulted in a grants round that sought requests for funding for research. This research was required to look at corollary issues affecting homeless people, and in some instances the most marginalised of homeless people, that is, those who are homeless, have mental health problems and are injecting drug users. Intervention at an earlier point provided to someone who has a mental illness or has commenced injecting drug use would have large, follow on benefits for both the individual and the community.

Where should effort be focussed in reducing substance use and associated harms among vulnerable populations?

People in prison continue to inject drugs, regardless of the strict prohibitionist approach that is in place. Sterile injecting equipment is not available in any prison in Australia. Australian prisoners, and in particular, Australian female prisoners who inject drugs, would be one of Australia's most vulnerable and disadvantaged populations. A pragmatic response which would protect prisoners from potentially contracting blood borne viruses while in prison through injecting drug use would be the implementation of needle and syringe exchanges (with exchange being purposefully chosen) in Australian prisons. This would also represent an opportunity for improved occupational health and safety for Australian prison officers as they are less likely to acquire a needle stick injury from injecting equipment that has been secreted in prison walls, clothing, containers or other non-visible places.

Further as Aboriginal people are disproportionately represented in Australian prisons, this could also reduce the rates of HIV and hepatitis C transmission in Aboriginal communities. This is because prisoners who return to their communities may have acquired a blood borne virus whilst in prison. Therefore not protecting the health of the people resident in our prisons, has a follow on effect for the communities to which they return.

Are publicly available performance measures against the National Drug Strategy desirable?

Our view is that some high level measures against the National Drug Strategy would provide useful evidence as to the success of the strategy. However, if the measures were to be complex, this would add to the workload of the sector and serve to be a distraction rather than of assistance unless properly supported.
If so, what measures would give a high level indication of progress under the National Drug Strategy?

Supply Reduction:
A comparative measure of seizures of illicit drugs versus reports of drugs being used via early warning system outlined above. Estimates of the proportion of total drugs stopped at border control based on data obtained via early warning system and distribution patterns for those drugs that did penetrate borders.

Demand Reduction:
Treatment episodes provided and who required repeat treatment in the last 24 months given that some treatments appear to have varying levels of efficacy; extent of work conducted collaboratively across agencies and service systems. There is currently very little analysis of need in the D and A field. Anex believes that there is likely to be significant unmet demand for pharmacotherapy treatment for opioid dependence and measuring this need and how it is addressed would improve our understanding of the effectiveness of the current system. The number of employees recruited, number of employees who left to work in another sector (i.e. not retained by the D and A sector) and level of qualification. Extent of work conducted collaboratively across agencies and service systems.

Harm Reduction:
The most important indication of progress would be reducing the number of occasions of reuse of needles and use of another person's used needle. This data is currently collected at sentinel sites but seems to have no impact on allocation of resources either financial or services. The consistent number of approximately 20% of people having shared someone else's used needle in the last month is totally unacceptable in relation to hepatitis transmission and is an ongoing risk for an HIV outbreak among Australian injectors. The number of needles and syringes distributed compared to population of injectors and need, number of contacts with clients, access to 24 hour services and community understanding of harm reduction and its interventions should be measured.
Key Research Needs - Australian Needle and Syringe Program Sector

Public Statement

Consultation Draft
Purpose of this Paper

The purpose of this Consultation Paper is to invite comment on the research directions that Anex is proposing specifically for the Needle and Syringe Program Sector. This is so that the evidence base on which needle and syringe programs operate can be further expanded, thus better informing practice.

In 2008, Anex established the Anex Research Advisory Committee. This paper reflects the research priorities of the Anex Research Advisory Committee and we are now seeking input from interested individuals and organisations.

The projects listed in this paper are currently not funded. Part of the work of Anex and the Research Advisory Committee would be to generate funding for projects that are considered to be of highest importance.

Submission Process

Submissions close on COB Monday 2 November 2009

Submissions can be made via hard copy or email using the addresses as set out below:

Hard copy:

Ms Anne-Maree Bajada
Feedback on Public Research Statement – Consultation Draft
Level 2/Suite 1
600 Nicholson Street
FITZROY NORTH VIC 3068

Email:

info@anex.org.au
Feedback on Public Research Statement – Consultation Draft (in subject line)

If you have any queries, please contact Ann Maree Bajada on 03 9486 6399.

About Anex

Anex is a non-profit, public health, drug policy organisation. A key focus of the work that Anex does is the translation of robust evidence into service delivery and practice. Anex has a national role in advocating for service improvement based on the available evidence, particularly in the delivery of Needle and Syringe Programs (NSPs).

NSPs are a proven public health protection measure. They reduce the transmission of blood borne viruses such as hepatitis C and HIV. They also reduce the harms associated with drug use by providing referral to treatment, advice on reducing harms and in some cases, primary health services. In essence, NSPs provide a whole of community benefit by reducing the risk of blood borne virus transmission between individuals affected by drug use, and in turn, reduce the risk of blood borne virus transmission for the whole community. As a result of avoided illnesses and disease, NSPs reduce the costs associated with drug use and provide a referral pathway into treatment.

Anex does not condone drug use but rather, seeks to protect people from harms associated with using drugs while at their most vulnerable.
About Research and This Paper

There are a number of national, community-based and academic institutions undertaking research which relate to NSP practice. Anex seeks to work with the organisations undertaking research and to partner with them, as appropriate, to complete required research.

Anex has established the Anex Research Advisory Committee to identify the research needs of the needle and syringe program sector. This paper does not aim to provide an exhaustive list of all research for the sector, nor does it specify a timeframe to complete the identified high priority research projects. Completion times are dependent on the ongoing resourcing of both Anex and other organisations.

About the Anex Research Advisory Committee

Anex has established a Research Advisory Committee comprised of experienced individuals to provide advice on research that is being conducted or has recently been completed and provide advice on research gaps and needs. With the assistance of this Committee, Anex will develop strategic partnerships and undertake advocacy activities which strengthen the evidence for the delivery of NSP services and the reflection of this evidence in policy.

Membership of the Committee is as follows:

Professor Steve Wesselingh (Chair)
Dean, Faculty of Medicine, Nursing and Health Sciences – Monash University

Professor Steve Allsop
Director - National Drug Research Institute
Curtin University of Technology

Professor John Kaldor
Deputy Director - National Centre in HIV Epidemiology & Clinical Research

Ms Annie Madden
Chief Executive Officer - Australian Injecting Drug Users League

Mr Michael Moore
Chief Executive Officer - Public Health Association of Australia

Professor Robert Power
Principal for Disease Prevention & Senior Harm Reduction Adviser,
Burnet Institute for Medical Research and Public Health

Knowledge Gaps and Research Priorities

The Anex Research Advisory Committee has identified a number of priority research areas. There are three broad elements of action for the organisation:

Anex as an Advocate for Research
Anex as Research Partner
Anex as Research Leader

This paper considers research and Anex’s relationship to that research using these three categories.
Anex as Research Advocate

In the context of Anex as research advocate, the current priority areas for Anex are set out below.

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<tr>
<th>Proposed areas of research</th>
<th>Project Description</th>
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<tbody>
<tr>
<td>Advocacy</td>
<td>Examine and evaluate political support for harm reduction interventions, looking in particular at issues of local government. Research should be conducted that establishes evidence to guide individual NSPs to broaden community support or exploring elements other than education which can impact on levels of community support.</td>
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<tr>
<td>Community Support</td>
<td>Examine the media's representation of illicit drugs and harm reduction and the effects this representation has on community support for NSPs.</td>
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<tr>
<td>Prisons/Criminal Justice</td>
<td>ACT implementation of new prison policy, NSPs in prisons and occupational health and safety. Research on prison officer attitudes and the relationship between needlestick injury risk and occupational health and safety concerns for prison officers.</td>
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<tr>
<td>Workforce</td>
<td>Evaluate the support currently available to the NSP workforce. In particular, the training available and issues relating to worker burnout.</td>
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Anex as Research Partner

In the context of Anex as research partner, there are a number of priority areas, as outlined below.

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<thead>
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<th>Proposed areas of research</th>
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<tbody>
<tr>
<td>Drug Patterns/trends</td>
<td>Research different drug trends among different IDU groups (i.e. CALD, young people, rurally based populations). Research into HBV vaccination provided via NSPs in Australia.</td>
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<tr>
<td>Clinical Practice/duty of care</td>
<td>Research into access of HCV treatment by IDUs and how specific NSP policies or practices in relation to dispensing equipment and services may impact on BBV transmission in Australia may also require further research, rather than what appears to be a focus on IDU practices. This could include evaluating the impact of information/education and referral services on HCV transmission.</td>
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<tr>
<td>Guideline implementation</td>
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Population Groups and Service Design

Young People - Research into the design of services so as to better connect with young people who may be early initiates to injecting and therefore at high risk of acquiring a BBV.

Women - research into the design of services that meet the needs of women who may be at risk of acquiring a BBV through either IDU or unprotected sex with an IDU.

Anex as Research Leader

The high priority areas in which Anex should take a leadership role lead research are:

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<tr>
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<th>Project description</th>
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<tr>
<td>Provision of NSP Services</td>
<td>Service and workforce planning – including the mapping of NSP staffing (profile of qualifications and experience) services provided by which staff and systems used to manage NSP services.</td>
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<tr>
<td>Provision of NSP Services</td>
<td>Research into how NSPs can contribute to improved access to mental healthcare, given the prevalence of mental health harms associated with injecting drug use.</td>
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<tr>
<td>Provision of NSP Services</td>
<td>Research that explores how dispensing policies for equipment and services in primaries, secondaries and pharmacies and costs associated with obtaining equipment impact on effectiveness and risk behaviours.</td>
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<tr>
<td>Provision of NSP Services</td>
<td>Research into strategies for improving access and engagement of different client groups (i.e. CALD, young, rural IDUs) through qualitative and quantitative data collection.</td>
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<tr>
<td>Provision of NSP Services</td>
<td>Research into access issues and whether it leads to an increase in sharing, looking in particular to opening hours, geographic location. Also examine restrictions on access at a program and policy level which results in sharing. Examine client satisfaction, perceived access to services and met and unmet needs.</td>
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Funding

Anex currently does not receive ongoing funding for research. In order to address some of the research needs listed above, funding opportunities will be actively sought by Anex. Funding partnerships will be welcomed based on their fit and alignment with Anex's broad strategic plan and the priorities described above.