



Program Review:
AIDS Vancouver Island Needle Exchange

For Vancouver Island Health Authority
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Rationale and Importance of Needle Exchange

HIV disease is a fatal illness affecting thousands of people in BC. Its symptoms are extremely debilitating. Its treatment brings harsh side effects. Hepatitis C disease affects a significantly larger number of people than HIV and although treatment is effective for some disease subtypes it is not recommended for those who are high risk for re-infection. Both HIV and hepatitis C bear an enduring social stigma. Needle exchange is an indispensable intervention to curb the spread of both these diseases.

Sharing of drug-injecting equipment incurs enormous risk for HIV transmission. It has been responsible for over two thousand HIV infections in BC. Needle exchange works to ensure that injectors do not share any part of their equipment. Without needle exchange, the supply of sterile injecting supplies would not be reliably sufficient and accessible, resulting in the expectation of significant outbreaks of HIV infection.

With each new infection, the well being of the community decreases. Each new infection brings a cost of over half a million dollars in treatment alone over the individual's lifetime. Further social costs result from lost productivity from people living with HIV and their caregivers, and from the disability benefits and clinical supports such as nutrition counselling or case management. These costs draw heavily on the resources of the community. By averting HIV transmission and other injection-related harms, needle exchange supports the community's as well as the individual's well being.

Needle exchange is a public health intervention stemming equally from the fields of addiction services and communicable disease control. Needle exchange prevents not only HIV and hepatitis transmission, but also injection-related harms such as overdoses, bacterial infections and vein collapse. Just as important, the service works as a point of referral to the health care system for people who commonly have little or no connection with it otherwise.

Context of AVI Needle Exchange Operations

Facility and Environment

The needle exchange site operates as a storefront attached to the AVI building in an area of mixed residential and commercial property. Inside the needle exchange site, clients enter a lobby space with the needle exchange counter to the right. An accordion door, typically left open, separates this lobby area from a drop-in space. The drop-in space includes a room for the street nurses with two exits.

The drop-in space has the only door to the area behind the counter, as well as a back door to an enclosed parking area. The door behind the counter is typically left open, and the back door is typically roped but left open for safety reasons.

Public drug use (both smoking and injecting) is evident in the street immediately outside the site. Drug-selling is evident here and, despite staff attempts to monitor, inside the site as well. The descriptions of the public disorder around the site indicate that it has been increasing in recent years. Although there are sanctions for selling and using drugs inside the needle exchange these were not apparent to the reviewer. These sanctions should be applied for every infraction.

Mode of Service Delivery

Each interaction opens with the client providing his or her unique identifier, a code comprised of birth date and other personal details. A client then puts his or her used needles into the large receptacle. The staff member behind the counter provides clients with the standard needle exchange materials available from the provincial harm reduction supplier (needles and syringes, sterile water, alcohol swabs, condoms). The worker records the client's identifier, and the amount of supplies returned and given out.

In the lobby area, clients have free access to a phone, water cooler, and clothes donation box. In the drop-in space, coffee and donated food are provided. Here street nurses provide first aid, wound care, harm reduction education, and other nursing activities.

The AVI needle exchange site operates Monday to Saturday from 3pm to 6pm, then from 7pm to 11pm. On Sundays and holidays the hours are 5pm to 9pm.

Staffing and Organization

Three regular staff members work at the needle exchange. Staff members report to the needle exchange supervisor, who in turn reports to the Executive Director of AVI. Staff members are trained largely through shadow shifts with other workers in the needle exchange. In hiring, for the most part their experience working with the client population is the primary consideration.

The site is currently supported by ten volunteers. They receive the AVI core training and then take part in a few shadow shifts at the exchange. According to policy, volunteers do not empty the buckets of used syringes, though in practice this policy may not be consistently applied.

Other services provide care and support on-site. Street nurses have a space there. An alcohol and drug counsellor is available once per week in most cases. At times, AVI's education staff has worked closely with the program providing client engagement and education about communicable diseases and related topics.

There is a regular meeting of services providers for informal and collective case managing of specific clients. The "Monday Morning Meeting" provides an opportunity for service providers to network regarding direct client care. The staff members have been unable to attend these meetings due to both a lack of resources and the early

morning time. A goal should be made for them to join this group, or a similar one, as often as possible.

Discussion and Recommendations

Overview of the Challenge

All of the community partners who were interviewed acknowledged that the problems AVI faces reflect several compelling outside forces. Poverty, homelessness and inadequate access to addiction treatment create an overwhelming challenge for the needle exchange to address. It is trying to cope with demands that greatly exceed the prevention of communicable disease. All agencies dealing with this client population echo the sentiments of the AVI staff—no one is able to assist the clients to the necessary degree.

As AVI attempts to meet this challenge, its needle exchange service faces its own unique dilemmas. Generally speaking, the needle exchange service at AVI needs to recognize its role as provider of a health service. The ancillary social supports it provides, such as free phone, clothing, and so on, may facilitate health improvement, but these services distract from the fundamental purpose of the exchange—to reduce the spread of HIV and HCV. Furthermore, needle exchanges are often the first point of contact with the health care system, and that role must be fully realized in the AVI operation. Re-framing its work under that paradigm should allow development of the program to meet the clients' needs in a sustainable manner.

This shift would be most easily enacted through small changes that reflect a new perspective. Re-assessing the goals of the program can easily rectify many of the needle exchange's issues, and identify what is achievable and fundamental to the program's purpose. If the program can implement clear structures and processes (e.g. staff roles, protocols) with the necessary training and support for the staff and management, many problems will be solved. The remaining problems have high potential to be alleviated in the long term through relationship-building with

stakeholders (e.g. client advisory group, pact with police) and integration into a system of health care and support.

Health authorities must provide the leadership in this paradigm shift, and model the integration of services. Among service providers and management in the system of care, harm reduction services do not seem to be understood as a critical piece of the health care continuum. Addiction is a health issue, and the services provided to clients living with addictions should be framed this way.

Specific Aspects of Service

Client and Staff Safety

There are grave concerns about staff and client safety within the needle exchange site. The safety of all staff, volunteers and allied workers is of primary importance when delivering any health service. Likewise, the safety of clients is absolutely necessary. If any individual is not safe, everyone in the site is in jeopardy.

Clients of needle exchange programs live with great need, and rely heavily on social services to provide basic necessities. These individuals are likely to be addicted, homeless and suffering from an untreated mental illness. As a result, these clients are likely to take anything that is offered. With crowds rushing for donated food or hunting through donated clothing, disorder is to be expected when serving this client group. Under the current conditions, these types of ancillary services increase the level of chaos substantially to the point of an unmanageable environment.

The physical layout of the needle exchange space is not ideal. While the drop-in space is large, the front doorway and the doorway between lobby and drop-in space are problematic bottlenecks. Exits are not accessible, client flow is difficult to monitor and congestion spots are abundant. In case of emergency, staff should have quick egress that cannot be blocked by a client. Staff should have open lines of communication with other workers and with clients. The space must be rearranged

or traffic must be coordinated in the space to achieve these conditions. For example, clients may access the drop-in space for specific services, but only upon request, in a monitored and controlled manner, rather than in the current, free-for-all format.

There were no limitations on the number of people in the site or safety protocols relating to overcrowding. Considering the difficulties of the layout, there is significant potential for danger here.

There are no distinctions of staff-only areas that are off-limits for clients. There is free access to the space behind the needle exchange counter. The lack of a clear distinction confuses the roles of the workers with the clients, and allows distraction from the activity of providing quality service.

Aside from needle stick injury protocols posted by the needle exchange counter, no safety protocols were readily available. More emphasis is required for disease prevention and safe handling of used needles.

RECOMMENDATIONS

- Do not provide open access to the drop-in space. Leave the sliding door closed except for appointments with the nurse or counsellor or other specifically requested services. The current staffing is insufficient to effectively monitor both the drop-in space and the exchange.
- Remove the phone or position it away from the desk. Most calls were drug-related (dealing, debts, etc.), and its placement on the counter distracts from and hinders the primary service.
- Ensure that workers are clearly identified, such as with simple uniforms (T-shirts for example). Often several people in different roles work at the exchange, such as volunteers, nurses, or needle exchange workers. Currently, clients and newly introduced staff or volunteers may have difficulty knowing where to direct their requests or concerns.

- Remove the clothing box, or move it to a more appropriate location such as behind the door. The clothing box is a visible distraction, and adds to the chaos in the space.
- Eliminate the music, or keep it low and calm. It is important to monitor conversations and behaviour to enforce a code of conduct, and the music volume undermines staff members' ability to do so.
- AVI should review its needle exchange space for potential safety enhancements, with a commitment that staff and client safety can be ensured at all times.
- Develop site safety guidelines for all workers within the space and ensure consistent implementation, including consequences for contravening the guidelines.

Providing Injection Equipment

As there are three organizations providing needle exchange services under contract with VIHA, it is important that these programs are consistent. To establish this consistency, VIHA would have to provide the leadership, training, resources and support. Each exchange will have modality-specific requirements for delivering quality service, but all groups should be operating under the same overall set of standards.

Harm reduction is a health care philosophy that can test the limits of providers' beliefs about addiction. At its root, harm reduction philosophy is solid public health practice. However, the language of harm reduction has fine distinctions and requires attention to very important details. It is easy to send mixed or inconsistent messages to clients. It is important to develop a common language for harm reduction throughout the health authority to ensure consistent practice and quality of care.

It is fundamental to have the full range of injection equipment required to avoid contamination along the chain of infection. Presently these supplies are not all available to the clients through the AVI needle exchange. In the absence of other

options, VIHA should provide the resources to ensure all of this equipment is available to all VIHA exchanges.

RECOMMENDATIONS

- Develop standards of practice for the needle exchange program in Victoria including consistent training and clinical practice guidelines for all agencies providing harm reduction services.
- VIHA ensure that the harm reduction practices are applied consistently within the region. Needle exchange programs across the health service delivery area should all be regularly monitored to ensure consistency of operations.
- VIHA provide the additional support to ensure that all injection equipment in the chain of infection is available to all needle exchange clients throughout the region. This list includes needles, syringes, filters, swabs, sterile water, ties, and cookers.
- Develop a script for the exchange to ensure staff and volunteers are consistent in their messages to clients and the community.
- Review the client registration process for relevance to the program. Does the data collection assist in program planning or evaluation? Ensure the data collection is as user-friendly as possible both for clients and staff.

Staffing, Training, and Organizational Model

Needle exchange is a health service, specifically a point of contact with marginalized clients, and the providers of the service should recognize their role as such. The needle exchange site should identify itself as a health service, and focus its work on re-establishing that identity.

The training of new staff and volunteers needs expansion. Training of workers is crucial, and should be given the same priority as any other allied health professional. The standard of training should be set and implemented by VIHA in partnership with all of the operating exchanges in Victoria. Workers in the exchange must be

comfortable and competent with topics such as safer injection, safer smoking and addiction services, and they should be actively engaging clients on all of those topics.

The number of needle exchange staff is inadequate. To ensure safety, a minimum of three needle exchange staff members (aside from street nurses or professionals from other services) should be on duty at all times. This would also allow for the exchange to stay open during dinner breaks. Volunteers should augment the staffing complement.

There do not seem to be individual roles and responsibilities for each staff member on duty. This condition creates confusion, duplicates effort unnecessarily, and adds to the difficulty of distinguishing staff from clients and maintaining order within the site.

RECOMMENDATIONS

- Increase Needle Exchange staffing levels to three staff members on duty at all times.
- Develop site-specific harm reduction training for all staff and volunteers.
- Develop a more advanced Needle Exchange training for those volunteers whose primary work area is the Needle Exchange.
- Training should include (at minimum) client engagement, providing referrals, safer injection, safer smoking, and health issues related to injection, addiction, and communicable infections such as HIV.
- Establish clear job duties for staff and volunteers on site to avoid workers unnecessarily duplicating their efforts.
- Offer leadership training for the AVI needle exchange management to facilitate and lead a change management process, involving new standards of practice and new relationships with other service providers.

Engaging Clients

Staff members seem to have positive interactions with the same clients on a daily basis. The staff members seem to know the vast majority of clients by name, and have very good rapport. It is clear that the clients trust the staff and appreciate the available services. The importance of this cannot be overstated, as the service depends heavily on its interactivity with clients.

Despite the success in engaging individual clients while providing injection supplies, there are clear problems with boundaries between staff and clients. To maintain order, staff members should not over identify with the client population to an extent that compromises the staff members' ability to maintain order and manage chaotic, disruptive behaviour. The staff members give the impression that they do not see themselves as part of the larger AVI program or the overall community, nor even health service providers.

Clients seem to feel little responsibility for their actions at the site, which could be improved by more time being spent to inform and integrate them into the program. The role of the client at the needle exchange should be expanded and formalized. Generally, trained peers are best suited to enforcing behavioural expectations among their peer group. The published evidence clearly supports employing peers to provide relevant and responsive harm reductions services. There are a number of needle exchange clients who are engaged with the Rig Dig program, but they do not work specifically at the needle exchange site. Expanding the roles of peers in service delivery will assist in addressing the public disorder issues.

Working with peers requires very structured environments with close supervision and clear expectations for outcomes. It is not easy. Having an engaged client population increases the clients' feeling of ownership over the service. It can result in a strong behavioural shift, and help to ensure that the services are not jeopardized by troublesome behaviour.

Maintaining program relevancy is critical to the success of the service. There are social networks, rules and behaviours among the client population that service providers cannot access. Program relevance should be promoted by recruiting the engaged client population to help define the program.

In cooperation with the needle exchange, the AVI education staff has been developing education initiatives, providing support, developing the peer based alley patrols and training volunteers. Their work in most cases was supported by federal education grants relating to Hepatitis C, but they have no ongoing resources specifically for this work. This team's understanding of engagement approaches could further benefit the needle exchange.

RECOMMENDATIONS

- Develop a client advisory committee.
- Establish site behaviour expectations with clients, or a needle exchange code of conduct. Enforce this code of conduct by addressing every infraction.
- Develop mechanisms for client involvement within the needle exchange—provide specific training for peer workers, and establish specific job duties for them.
- Provide ongoing support by AVI education staff to the Needle Exchange staff.

Bringing Clients into a System of Care

It was reported that the needle exchange clients experience extreme stigma and discrimination when attending other health services, hospitals in particular. Addictions have not yet been integrated into the wider health system. As a result the work to support addicted clients as they navigate the health system is overwhelming. The needle exchange works to provide some of this support for clients, but the program lacks the resources to succeed very much in these areas.

Currently the needle exchange program has a number of impediments—lack of addiction services for this population, disconnects between system partners (mental

health, addictions and communicable disease), inability to refer into existing systems, lack of allied services on-site, and a system-wide lack of understanding of harm reduction programs as a health service.

Removing these impediments will take careful planning and wider partnership. The mental health and addictions portfolios of VIHA should play a role in supporting the needle exchange program. Leadership must come from within VIHA to better integrate services so that the needle exchange works as part of a system of care, with effective referral processes to health care such as mental health and addictions services. Community partners must support the integration efforts whenever possible. There is also a strong need for coordination of services region-wide to achieve consistency and efficiency of service—this is the responsibility of the health authority. Effort is required to educate health service providers on the concepts of harm reduction and addiction as a health concern.

Within AVI, the needle exchange seems to operate in parallel to other AVI services rather than as part of an integrated HIV prevention service. AVI's client support staff work in concert with the needle exchange only to a small extent. This relationship must further develop to improve outcomes for the client population. For example, the Needle Exchange staff members do not seem to show a high level of integration with and support for the street nurse service on-site. A large proportion of the positive day program clients also access the needle exchange, but it does not seem to take advantage of this connection.

Cool Aid Health Services have some connection to the exchange, such as through an addiction counsellor, but without much consistency. Aside from a street nurse presence at the needle exchange there is no other successfully integrated service.

In order for the needle exchange service to be successful, so that clients are receiving quality care and support, it must reconfigure itself as a health service. It is

a first point of contact into health services for some of the most marginalized citizens in the community. For them, service delivery must be integrated to be successful.

RECOMMENDATIONS

- Members of the AVI team represent the needle exchange at a weekly meeting of service providers, where many community partners share information in confidence about common clients.
- Further integrate the street nurses into the operations of the needle exchange, so that they are recognized as an equal partner in service delivery.
- AVI client support staff should work to increase integration with the Needle Exchange staff.
- VIHA provide leadership to its community partners by developing practice guidelines, standardized training, evaluation processes and educational support for its partners.
- VIHA implement an internal planning process to better integrate Mental Health, Addictions and HIV/AIDS services, such as by establishing mutually agreeable and consistent referral pathways, or even a common vernacular for discussing service outcomes. Integration with addictions services is critical for the needle exchange. Its staff, including the street nurses, must be able to refer into addiction and mental health services.
- VIHA work in partnership with its contracted agencies in the community to develop a system of care that can, to the greatest extent possible, appropriately address the needs of the needle exchange clients.

Public Disorder & Integration with the Community

The goals of harm reduction and policing are not easily compatible. However it is critical that every effort be made to engage the police in the productive operations of the needle exchange.

Upper levels of police and AVI management have established good and respectful working arrangements. However, an agreement must be established between the needle exchange workers and the front-line police officers about the approach to public disorder around the site. Police officers should be aware what services are offered through AVI and the needle exchange specifically, the purpose of those services, how the services are delivered, and the staff's limitations in providing those services. The staff members must respect the police officers' role of upholding order.

There must be greater attention among needle exchange staff members about public drug use or drug-selling. There are no signs or monitoring to discourage these behaviors or other nuisance behaviours such as littering and noise in the area immediately outside the Needle Exchange. On the three occasions site observation took place in this outside area, clients did not alter this behaviour in the presence of staff members.

Inappropriately discarded injection equipment is always a flashpoint for community concerns regarding needle exchange service. Everyone shares the responsibility of ensuring that used equipment is collected in a timely fashion, and clients have adequate disposal options. Victoria has a few public disposal boxes, and they seem to have positively impacted the neighbourhoods where they are located.

Increasing options for appropriate disposal is always a good idea. Engaging clients about the design of disposal boxes and development of the disposal box program will lead to more appropriate needle disposal. The impact on the community will decrease as the number of groups that regularly collect used injection equipment expands and as they coordinate their efforts. This process is onerous, and thorough planning should take place before the disposal program expands.

RECOMMENDATIONS

- Establish ongoing operational relationships with the police. For example, jointly develop roles and responsibilities for monitoring behaviour directly outside the

needle exchange site. Identify how police and staff can work together to reduce the public disorder issues.

- Inform clients that the needle exchange staff will be working in partnership with the police to uphold the agreements. Clients should also be involved in that process when appropriate. Work with clients toward consensus on a code of conduct for everyone in and around the needle exchange site.
- Monitor the outside area every 15 minutes, and enforce a policy of not using outside the site.
- Develop a harm reduction training curriculum for police, and assist in implementing it if possible.

Conclusion

Options for Management of Needle Exchange

Option 1: Maintain the status quo. Not advisable.

Option 2: Cease fixed site needle exchange entirely. Not advisable.

Option 3: Shift the needle exchange fixed site to completely new management. Not advisable.

Option 4: Decrease the service level at the fixed site and increase the service level of mobile needle exchange. Somewhat advisable.

Option 5: Develop the AVI needle exchange program with extensive adjustments. Most advisable.

Rationale

The status quo involves a number of safety concerns for staff and clients. There are clear problems with public disruption and conflict with the community that are unsustainable. The service is not functioning to achieve optimal outcomes for clients, most notably because of a shortfall in several areas: structure, guidelines, staffing, and training. The lack in these areas is remediable, in many cases quite quickly with good leadership. Other very significant problems can be managed over a longer term by building positive relationships with the community, and integrating complementary health services.

Without the AVI needle exchange, it is very likely that communicable disease rates would escalate as well as other addiction-related health issues. It is a significant priority to avoid disruption in the current operation of the service.

There is no significant gain in rebuilding the service from the ground up with new management, since the problems do not seem to be entrenched in any intractable conflict or behaviour among the directly involved staff and management. The current staff has excellent rapport with clients, and this highly valuable asset should be

protected wherever possible. Major changes in the needle exchange program brought on by massive changes in operations (i.e. change in location or entirely new staff complement) may decrease the consistency of the service and therefore its reliability for clients, thereby decreasing its effectiveness.

Regarding different modalities of needle exchange, a fixed site is able to serve more clients than the mobile needle exchange because it can accommodate more staff and clients at once. Furthermore, mobile exchange works to serve a somewhat different client population that the fixed site does. The mobile approach frequently serves clients who are not mobile and need to be met at their location, or client who do not want to attract attention to their drug use. As such, it requires a more flexible and discrete approach. On the other hand, fixed site needle exchange works to be consistent rather than flexible, to draw in clients by being widely known throughout the community. These approaches cannot be interchanged to achieve the same results.

Limitations of the Report

Due to tight timelines, the report was based on a review of all available background documents and three days divided between onsite observation and interviews. There were a number of factors that impinged on the development of this report. The short time frame resulted in cutting back the number of possible interviews. The executive directors of both AVI and VARC (mobile needle exchange) were out of town, so that those interviews had to be conducted by phone. The Chief of Police was on administrative leave, which unfortunately resulted in the police not being interviewed for the review. The conflict associated with the current operations of the needle exchange and the impending court case created difficult circumstances under which to gather information. Many people in the community who were interviewed were upset that the situation had reached this point without any prior intervention, though they were very hopeful that the situation could be rectified.

APPENDIX A – Documents Reviewed

Closing the Gap: An Integrated HIV/AIDS and Hepatitis C Strategy for Vancouver Island Health Authority. 2006-2009

Mayor's Task Force on Breaking the Cycle of Mental Illness, Addictions and Homelessness. October 2007

Compiled media coverage January 2007- October 2007

AVI services briefing note

VIHA Contract for Services Agreement with AIDS Vancouver Island – March 2003

VIHA contract Schedule 'A' with AIDS Vancouver Island – 2007

AVI Rig Dig program overview and collected data.

AIDS Vancouver Island Job Description – Street Outreach Worker

AIDS Vancouver Island Job Description – Rig Dig volunteer

AIDS Vancouver Island Job Description – SOS Program Coordinator

AIDS Vancouver Island: An Integrated Needle Exchange for Victoria

Street Outreach Services policies and procedures – February 2007

Funding for HIV/AIDS and Hepatitis C Services – A discussion paper prepared for Vancouver Island Health Authority by AIDS Vancouver Island. March 2007

Fitting the Pieces Together: Towards an Integrated Harm Reduction Response to Illicit Intravenous Drug Use in Victoria BC. City of Victoria, July 2005

Good Neighbour Agreement (Draft) and chronology of process to date. AIDS Vancouver Island

Street Outreach Services “101” – A Volunteer Orientation guide – AIDS Vancouver Island

Street Outreach Services Policies and Procedures – AIDS Vancouver Island. February 2007

APPENDIX B – Interviews Conducted

Karen Dennis – Executive Director VARCS (mobile needle exchange)

Wendy Zink – City of Victoria Social Planning

Warren O’Brian – Ministry of Health

Kenneth Tupper – Ministry of Health

Katrina Jensen – Executive Director AIDS Vancouver Island

Marilyn Callahan – Board Chairperson AIDS Vancouver Island

Erin – Outreach staff AIDS Vancouver Island

Heidi – Education staff AIDS Vancouver Island

George Pine – Acting Executive Director AIDS Vancouver Island

Al Tysik – Director Our Place

Billy – AIDS Vancouver Island needle exchange client

Jo – AIDS Vancouver Island needle exchange client

Tanya Horton – Street nurse

Lisbet – Street nurse

Stephen Smith – Ministry of Health

Chuck Schactman – Vancouver Island Health Authority

Dr. Murray Fyfe – Vancouver Island Health Authority

Audrey Shaw – Vancouver Island Health Authority

Carol Romanow – Former Director SOLID (peer based exchange)

APPENDIX C – Summary List of Recommendations

Note: The recommendations are not listed in order of importance.

1. Eliminate the drop in space. Leave the sliding door closed except for appointments with the nurse or counsellor, or other specifically requested services. The current staffing is insufficient to effectively monitor both the drop-in space and the exchange.
2. Remove the phone or position it away from the desk. Most calls were drug-related (dealing, debts, etc.), and its placement on the counter distracts from and hinders the primary service.
3. Ensure that workers are clearly identified, such as with simple uniforms (T-shirts for example). Often several people in different roles work at the exchange, such as volunteers, nurses, or needle exchange workers. Currently, clients and newly introduced staff or volunteers may have difficulty knowing where to direct their requests or concerns.
4. Remove the clothing box, or move it to a more appropriate location such as behind the door. The clothing box is a visible distraction, and adds to the chaos in the space.
5. Eliminate the music, or keep it low and calm. It is important to monitor conversations and behaviour to enforce a code of conduct, and the music volume undermines the staff's ability to do so.
6. AVI review its needle exchange space for potential safety enhancements, with a commitment that staff and client safety can be ensured at all times.

7. Increase Needle Exchange staffing levels to three staff members on duty at all times.
8. Develop site safety guidelines for all workers within the space and ensure consistent implementation, including consequences for contravening the guidelines.
9. Provide ongoing support by AVI education staff to the Needle Exchange staff.
10. AVI client support staff should work to increase integration with the Needle Exchange staff.
11. Develop standards of practice for the needle exchange program in Victoria including consistent training and clinical practice guidelines for all agencies providing harm reduction services.
12. VIHA ensure that the harm reduction practices are applied consistently within the region. Needle exchange programs across the health service delivery area should all be regularly monitored to ensure consistency of operations.
13. VIHA provide the additional support to ensure that all injection equipment in the chain of infection is available to all needle exchange clients throughout the region. This list includes needles, syringes, filters, swabs, sterile water, ties, and cookers.
14. Establish a script for the exchange to ensure staff and volunteers are consistent in their messages to clients and the community.
15. Review the client registration process for relevance to the program. Is the data being collected able to assist in program planning or evaluation?

16. Develop site-specific harm reduction training for all staff and volunteers.
17. Develop a more advanced Needle Exchange training for those volunteers whose primary work area is the Needle Exchange.
18. Training should include (at minimum) client engagement, providing referrals, safer injection, safer smoking, and health issues related to injection, addiction, and communicable infections such as HIV.
19. Establish clear job duties for staff and volunteers on site to avoid workers unnecessarily duplicating their efforts.
20. Offer leadership training for the AVI needle exchange management to facilitate and lead the change management process, which involves new standards of practice and relationships with other service providers
21. Develop a client advisory committee.
22. Establish site behaviour expectations with clients, or a needle exchange code of conduct. Enforce this code of conduct by addressing every infraction.
23. Develop mechanisms for client involvement within the needle exchange—provide specific training for peer workers, and establish specific job duties for them.
24. Members of the AVI team represent the needle exchange at a weekly meeting of service providers, where many community partners share information in confidence about common clients.
25. VIHA implement an internal planning process to better integrate Mental Health, Addictions and HIV/AIDS services, such as by establishing mutually agreeable

and consistent referral pathways, or even a common vernacular for discussing service outcomes.

26. VIHA provide leadership to their community partners by developing standards of practice, clinical practice guidelines, standardized training, evaluation processes and educational support to their partners.
27. VIHA work in partnership with its contracted agencies in the community to develop the most appropriate system of care.
28. Further integrate the street nurses into the operations of the needle exchange, so that they are recognized as an equal partner in service delivery.
29. Integration with addictions services is critical for the needle exchange. Staff, including the street nurses, must be able to refer into addiction and mental health services.
30. Establish ongoing operational relationships with the police. For example, jointly develop roles and responsibilities for monitoring behaviour directly outside the needle exchange site. Identify how police and staff can work together to reduce the public disorder issues.
31. Inform clients that the needle exchange staff will be working in partnership with the police to uphold the agreements. Clients should also be involved in that process when appropriate. Work with clients toward consensus on a code of conduct for everyone in and around the needle exchange site.
32. Monitor the outside area every 15 minutes, and enforce a policy of not using outside the site.

33. Develop a harm reduction training curriculum for police, and assist in implementing it if possible.