



Review of the **Medically Supervised Injecting Room**

Medically Supervised
Injecting Room
Review Panel,
June 2020

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In this document, 'Aboriginal' refers to both Aboriginal and Torres Strait Islander people.

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Chair's foreword

In June 2018 Minister for Mental Health Martin Foley appointed me to chair a panel to review and provide a report on the trial of Victoria's medically supervised injecting room (MSIR). Over the almost two years of this review there have been five panel members.

The establishment of the MSIR has been challenging for many: North Richmond Community Health (NRCH) (the licensee), local residents and businesses in the area, government officials responsible for implementing and overseeing the trial and other health and emergency services, and housing, legal and social support services in the area including the Yarra City Council. It has required police to adapt and attend to law enforcement in the context of a novel service.

This report describes the background of the government's decision to respond to an increasing number of heroin overdose deaths in Victoria by trialling a medically supervised injecting facility. We are aware from media and Hansard records that, prior to the trial, supporters were hopeful that the facility would save lives and reduce harms associated with overdose. We also understand there were concerns raised, largely focusing on the location of the facility adjacent to a primary school, perceived risks of allowing injection of methamphetamine in the facility and the impact of the facility on existing NRCH service users.

I congratulate NRCH and others associated with establishing the MSIR on getting the facility operational in a relatively short time. Many people have taken the opportunity to tour the facility, including health and support service professionals and local residents, businesspeople and interested bystanders, and almost all have commented positively on the professionalism, care, knowledge and skill of the staff and the quality of their delivery of a safe and supportive service.

People who inject drugs are typically suspicious of government service systems, so it surprised even staff that so many began attending on the first day the MSIR opened. This is likely a tribute to the relationship that the NRCH had built with the target population over many years, especially through its harm reduction services.

The operations and impact of the MSIR is the principal focus of this review, but it is only one part of the response to drug use in North Richmond. My experience in the alcohol and drug sector over many years has shown me the complexity of such an endeavour and the requirement to attend to the needs and sensitivities of the local community.

During this review, panel members regularly walked around North Richmond, consulted with local groups and attended and observed community gatherings of people interested in the MSIR. Reactions to its establishment have been mixed. There were high expectations that the opening of the MSIR would resolve previously identified problems linked to the sale and use of drugs in the area. Attitudes and understandings have fluctuated among local people over the time of our review, influenced by people's direct observation and experience of living and working in the vicinity and possibly also by media reporting of activity associated with the MSIR. It is likely that this coverage has also acted as an advertisement for people seeking heroin.

Local people, businesses and other services have provided valuable insights. They have presented their stories, data, experience, thoughts and suggestions. These local people care about and want the best for their locality and their community.

Almost all the community groups that have engaged with the Panel have supported the intent to provide a safer place for people who inject drugs, even though many have expressed concerns about troubling incidents or about people congregating in the area. Some residents have proudly invited Panel members to visit the cleaned-up areas of their housing estate. Some residents have said it is worse. Sorting the different perspectives has been a challenge for the Panel.

Further plans and actions of government and the local council including the precinct and social housing initiative to address amenity began in a visible way sometime after the opening of the original facility. The Department of Health and Human Services reports improvements to security, lighting, drug outreach services, cleaning, sweeps and collection of used needles, along with a more visible police presence. However, by the end of 2019 these initiatives were not especially evident. It will require more time to sort out whether the negative impacts of an active drug market in this local area can be ameliorated.

As detailed in the terms of reference for this review (Appendix A), the Panel was required to develop the review scope, structure and data and evidence collection requirements with the Department of Health and Human Services and to:

- review data and evidence to closely monitor the objects of the *Drugs, Poisons and Controlled Substances Act 1981*, Part IIA
- provide the Secretary to the department with a draft copy of the review to inform a decision on whether the trial should be extended
- provide an endorsed review to the Minister for Mental Health before the end of the two-year trial.

This is the report of our findings on the first 18 months of the MSIR project implementation. We have been supported in this by a team of skilled evaluators from the Centre for Evaluation, Research and Evidence in the department. I thank all who have supported the Panel's efforts to better understand the experience of those in the area and beyond. I especially recognise and thank the staff of the MSIR for the care they provide to service users. Many service users talked with us about their positive experiences. A small number of other people who inject drugs have explained their reasons for not using the MSIR. These stories have been confronting at times for Panel members and yet important in contributing to the views of the Panel expressed in this report.

It has been a privilege to work with my fellow Panel members: Associate Professor Alex Cockram, who contributed especially to the approach to our review (until her resignation early in 2019 to allow her to take up a role as Commissioner in the Royal Commission into Victoria's Mental Health System); Mr John Ryan, with experience of drug-related harm to communities and harm reduction services that included a perspective on overseas injecting facilities; Mr Ken Lay AO, APM, the former Chief Commissioner of Police, who was an active member of the Panel from May 2019 until late January 2020, contributing his experience and insights into crime, law enforcement and emergency services relevant to the operation of the MSIR (Ken resigned to take up the Chair of Bushfire Recovery Victoria in January this year); and Associate Professor Ruth Vine, an experienced senior psychiatrist and health service leader, who joined as a member in January 2020 to provide a medical and mental health perspective. All members participated in site visits, consultations with staff, service providers, community groups and facility users. I have appreciated their engagement, wise counsel and sharing of ideas through debate and discussion.



Professor Margaret Hamilton AO

Acknowledgements

Government departments and agencies	Department of Premier and Cabinet Department of Health and Human Services Coroner's Court of Victoria Victoria Police Ambulance Victoria Department of Education and Training Metropolitan Fire Brigade Crime Statistics Agency
Yarra City Council	Mayor, chief executive officer and staff
North Richmond Community Health	Management, staff and needle syringe program clients
Medically Supervised Injecting Room	Management, staff and service users
Community members	Residents Business representatives Homeless people spending time in Richmond MSIR Residents Action Committee Residents for Victoria Street Drug Solutions Victoria Street Business Association
Content input	Alcohol and Drug Foundation ACSO-COATS Australasian College of Emergency Medicine Australian Medical Association cohealth Fred Hollows Foundation Harm Reduction Victoria Hepatitis Victoria Fitzroy Legal Service Kirby Institute Metropolitan Fire & Emergency Services Board North Western Melbourne Primary Health Network Richmond West Primary School Royal Australian and New Zealand College of Obstetricians and Gynaecologists Royal Australasian and New Zealand College of Psychiatrists St Vincent's Hospital Melbourne

	Sydney Medically Supervised Injecting Centre Uniting NSW.ACT, Uniting Vic.Tas, and UnitingCare ReGen Victorian Drug and Alcohol Association Windana Drug & Alcohol Recovery Inc. Women's Alcohol and Drug Service Victorian Aboriginal Health Services Victorian Aboriginal Community Controlled Health Organisation Yarra Drug and Health Forum Youth Support and Advocacy Service
Technical input	ANZSOG Burnet Institute Centre for Evaluation, Research and Evidence (DHHS) Colmar Brunton KPMG Monash University Q&A Research RMIT University The University of Melbourne Turning Point

Executive summary

In October 2017 a trial of a medically supervised injecting room (MSIR) was announced for Melbourne. This followed growing concern about the number of heroin-related deaths, two parliamentary inquiries and coronial findings that an injecting room would reduce the risk of death from heroin overdose. The location selected was 23 Lennox Street, Richmond, the site of North Richmond Community Health (NRCH), which was licensed to operate the MSIR for two years starting 30 June 2018.

The review was conducted by an independent panel of experts comprising Professor Margaret Hamilton (chair), Mr John Ryan and Associate Professor Ruth Vine (since January 2020). Associate Professor Alex Cockram and Mr Ken Lay were on the Panel for the earlier part of the review. The review has considered relevant research, surveys of the local community and service users, direct observation and communication with a range of stakeholders.

The focus of this review is the first 18 months of the MSIR's operation (June 2018 to December 2019), which includes one year in a transitional facility and six months in a larger facility.

Key findings and recommendations

After the first 18 months of the trial, the Panel found that NRCH successfully implemented a medically supervised injecting room noting that implementation remains a work in progress.

The objectives of the *Drugs, Poisons and Controlled Substances Act 1981* Part IIA were ambitious because, unlike other trials, the legislation underpinning this trial requires improvement in amenity as well as saving lives and reducing harms for people who inject drugs. The trial succeeded in most of the objectives:

- The MSIR had more than 119,000 visits in the first 18 months, making it one of the busiest in the world.
- There have been no overdose deaths in the MSIR, despite 271 extremely serious overdoses.
- While it is not possible to say with certainty how many people would have died without the MSIR, international approaches to modelling suggest at least 21–27 deaths have been avoided.
- There has been a reduction in ambulance attendances due to overdoses.
- There has been a reduction in reports of public injecting.
- Many MSIR service users have accessed other health and support services.
- The MSIR has provided screening, assessment and treatment initiation for blood-borne infections.

Some of the objectives had not been achieved by the end of 2019:

- Amenity had not improved.
- Local people reported no change in their experience of seeing discarded injecting equipment.

Given that North Richmond has long been a major site of heroin use and related harms in Victoria, and that the trial has successfully reduced harms for service users, the Panel call on the

government to continue the trial of the Medically Supervised Injecting Room at North Richmond Community Health for a further three years.

Given also that there are other parts of the state with high concentrations of injecting drug use and related harms, the Panel recommends that the government expands the current trial to include another supervised injecting service. One site cannot effectively address all the needs for such a service in a city the size of Melbourne. Based on analyses of available data, the Panel recommends that the government considers an appropriate location within the City of Melbourne.

Ongoing government implementation needs to focus on community safety and amenity in partnership with local government and the community.

The full list of findings and recommendations is provided at the end of this executive summary.

Recent historic context for the trial

North Richmond has been the main site for heroin use and related harms in Victoria for the past decade. A cohort study (Burnet Institute 2019) following more than 1,000 people who inject drugs identified a noticeable increase in people coming to North Richmond several months before the trial began, reflecting the reputation of North Richmond as a place to access heroin.

The trial occurred in the context of increasing heroin use and increased visibility of people who inject drugs in North Richmond and a high number of overdose deaths.

Operation and use of the licenced MSIR

Establishing any medically supervised injecting facility is a complex, highly visible and challenging endeavour, particularly where there is a requirement for accelerated implementation. The Department of Health and Human Services has had significant input including initial licensing and the usual responsibility for central policy and performance oversight. Government has also had considerable input in approving information about the MSIR for media and community information purposes. In establishing the MSIR, the department has benefited from contributions from a large number of stakeholders including Victoria Police, Ambulance Victoria, the Metropolitan Fire Brigade, the Yarra City Council, the Department of Education and Training, Richmond West Primary School, many local service providers, local residents and people who inject drugs.

Once announced, the trial had a rapid establishment period, reflecting escalating public health and safety concerns about public injecting in North Richmond.

The project greatly benefited from the almost 20 years of experience of Sydney's medically supervised injecting centre (MSIC), including documentation and protocols, especially regarding treatment guidelines, data collection and reporting. There are some important distinctions: the Sydney MSIC operates from a shopfront location with links to local service providers rather than being co-located within a broader community health service. The Melbourne MSIR, unlike Sydney, has the explicit aim of improving amenity and reducing attendance by ambulance services, paramedic services and emergency services and attendances at hospitals.

Implementation of the trial was phased, with an initial focus on the supervision of injecting drug use in a transitional facility, then a move to a larger facility on the same site with longer operating hours and additional client capacity (from 11 to 20 injecting booth positions). This provided better access

for people with an increase in the number of supervised injections alongside additional capacity to provide clinical and other services in new consulting rooms.

Operationally, the initial focus was:

- getting the service operational to provide an accessible place for injecting and other services to people who inject drugs
- attracting the target service users to do their injecting in the facility
- ensuring a safe and appropriate response to anyone who experienced an overdose.

These goals have all been achieved.

The service has been well used by the intended client group.

In the first 18 months of the trial, 3,936 people registered to use the service, associated with 119,223 visits. Thirty people were refused entry, most commonly because they had not previously injected. Some people who inject their drugs in North Richmond choose not to use the MSIR. Efforts to describe and explain the experience, attitudes or beliefs of these people suggest that the reasons are diverse and include discomfort with people watching and the exclusion requirements of the licence. People who inject their drugs elsewhere in public remain highly vulnerable to overdose and other harms.

The service is attracting a group of people who inject drugs with high health and support needs, many with recent experiences of overdose.

The facility is attracting a group of people who inject drugs and have particularly high needs for first aid and other health services, including mental health and drug dependence treatment and social care such as housing and legal services. Those attending the service have higher support needs, even compared with other people who inject drugs in Richmond. They are more likely to be unemployed, homeless or recently released from prison than other people injecting drugs in Richmond. More than 10 per cent of the people using the service are Aboriginal. It may be that these characteristics mean that this group is less likely to have access to private space to inject such as in their own home. People who use the MSIR are injecting, on average, 14 times a week, compared with an average of three times a week for other people who inject drugs, suggesting this cohort would otherwise be more likely to experience higher rates of drug-related harms. Many (56 per cent) who have attended the MSIR report having previously experienced an overdose.

The model of care could be further considered to examine options regarding matters such as staffing, optimum opening hours and the ways of providing additional services, recognising that many service users require navigation to connect to systems of care.

A range of models in different settings with a variety of included or linked services operate in other countries. Various attempts have been made to scale operations to need and context in these other jurisdictions.

The legislation establishing the MSIR provides for a highly clinically oriented model of injecting service, directed at facilitating access to and delivery of services beyond supervision of injecting. NRCH's clinical model relies on nursing staff alongside harm reduction practitioners. The requirement for a medical director has been beneficial; however, the service has found that nursing and other staff can safely manage most clinical incidents without the additional role of a medical supervisor.

Advancement of the objects of the legislation

This review considered the extent to which the trial has contributed to advancing the aims of the medically supervised injecting centre legislation. The results of the Panel's consideration and findings are presented in a summary table at the end of this executive summary.

(a) Advancing a reduction in the number of avoidable deaths and the harm caused by overdoses of drugs of dependence

The MSIR has prevented overdoses and further harm and has saved lives.

The MSIR trial has supervised 116,802 injections (96.6 per cent of which involved heroin) and responded to 2,657 overdoses, with no fatalities. Compared with other people who inject drugs, MSIR clients are significantly more likely to have recently injected in high-risk settings, as well as to have recently experienced a non-fatal overdose, a known predictor of fatal overdose. Prior to registering, more than half of MSIR clients had overdosed and nearly half had witnessed an overdose.

Of those who do attend the service, the nature of the overdoses is significant, and without intervention it is likely that many would have died or been permanently injured.

In the first 18 months of operating, there were 271 extremely serious incidents that required the opioid reversal agent naloxone. Many more required oxygen and measures to keep the airways open, potentially saving additional lives and avoiding harms associated with lack of oxygen to the brain. Advice provided to the Panel from an experienced medical practitioner consulted for the review was that 'the [overdoses] are at least as acute an emergency as those we receive in an [emergency department]'. Of those who attend the service, the nature of the overdoses is significant, and, without intervention, it is likely that some would have died or been permanently injured.

The harms associated with overdoses can be profound; some are permanent. The facility has the appropriate equipment and MSIR staff are well trained and clearly demonstrate the capacity to respond, manage and administer interventions required to avoid death or further harm. Staffing levels ensure timely responses.

The MSIR has advanced its critical objective to save lives. While these results are not observable in coronial data, the Panel assesses that without responses to overdoses provided by the MSIR, the number of deaths could have increased during the trial period.

Modelling allows an estimate of the number of lives that the MSIR may have saved and, while there are different ways to model this, using conservative estimates, these data suggest that between 21 and 27 deaths were avoided over the 18 months of this review. This does not include the prevention of permanent disability including acquired brain injury.

(b) Advancing delivery of more effective health services for clients of the MSIR by providing a gateway to health and social assistance

NRCH and MSIR staff have made significant progress in delivering additional services and developing referral pathways to other service providers.

With the move to the larger facility, the range and number of services is expanding.

The MSIR provided or referred MSIR service users to many additional services during the trial period (most commonly to health promotion, wound dressing, medication provision and first aid) as well as providing specialist services such as diagnosis and treatment of infectious diseases, oral health services and opioid substitution treatment. Primary health clinics have been offered by general practitioners.

Since the move to the larger facility, the original services have been extended and additional services are increasingly being offered, many by organisations other than NRCH but from within the MSIR, enabling better potential connection between this client group and available services such as drug dependence treatment, additional infectious disease diagnosis and treatment, housing support and more mental health interventions.

Although many are now being delivered, the potential benefits of these services have not yet been fully realised as the take-up is still growing and the full complement of services is still being implemented.

An ongoing trial would provide the opportunity to develop and assess ongoing integration of services and possible different ways of achieving this.

The legislation provides for the delivery of integrated services, expecting that this would be a more effective way of attending to the perceived needs of people who inject drugs.

There have been challenges and benefits with service integration for this client group. Not all people who inject drugs seek or want other services and not all take up services when they are offered. Some are clear that they attend the MSIR only to use their drugs in a safe place and then leave. Some prefer to access more extensive services elsewhere.

Given the phased implementation of the service and the ongoing efforts to facilitate referral and connection with services, including through the Gateway Services Reference Group of local service providers, it is too soon to say that the full potential for integrated services has been realised. As at 1 July 2019 there was not yet evidence of a difference in health service use between MSIR service users and other people who use drugs; however, the MSIR has facilitated access to services including hepatitis C and drug treatment. It is not possible to say whether they would have received these services otherwise.

It is not yet possible to fully assess alternative models of providing integrated care, including whether there are advantages of co-locating within a community health service. The work of the Gateway Services Reference Group is promising and could be used as a pilot of an approach to timely and coordinated linking of people with multiple services.

(c) Reducing attendance by emergency services and attendances at hospitals due to overdoses

There has been a reduction in ambulance attendances involving naloxone in the vicinity of the facility during opening hours.

Ambulance attendances involving naloxone have reduced by 25 per cent within 1 km of the MSIR since it opened. This decline was greater for attendances during MSIR opening hours, with the number reducing by 36 per cent. Frequent users of the MSIR trial have had fewer ambulance attendances involving naloxone since the MSIR opened. The MSIR has called an ambulance in only 30 of the 2,657 overdoses responded to in the MSIR.

There have been no observable changes in emergency department presentations that can be attributed to the MSIR.

There has been a small increase in the number of drug-related emergency department presentations during the trial. Interpretation of hospital emergency department data is challenging because of very small numbers of events that could reflect broader changes as well as specific interventions.

(d) Reducing the number of discarded needles and syringes in public places and the incidence of injecting of drugs in the vicinity

There has been a reduction in reports of public injecting. Local people report no difference in seeing discarded injecting equipment. There has been an increase in collected injecting equipment (noting also an increase in collection activity later in the trial).

There was very little change in the proportion of people who reported seeing discarded needles and syringes (16 per cent in the year before and 17 per cent during the trial). Resident reports of the median number of discarded needles and syringes did not change (four per month), but local businesspeople reported seeing more (from six to then 10 per month) in the first year of the trial. The importance of these reports is linked to earlier research in North Richmond that found that the largest impact on the perception of amenity was from seeing discarded needles and syringes and other drug-related paraphernalia. There has, however, been a decrease in the proportion of people (residents and businesses) who report witnessing public injecting at the time of the second wave of the MSIR Review Survey conducted in July/August 2019.

(e) Improving the amenity of the neighbourhood

Amenity has not improved during the review assessment period.

Improvement in amenity has been the most vexed issue during the trial to date and remains to be successfully achieved. Stakeholders were strongly divided on the extent to which there had been a change in amenity. Due to the illegal nature of drug trafficking and use, it is extremely difficult to accurately identify how many people are buying or consuming drugs in Richmond, with data suggesting that the numbers were increasing before the MSIR opened.

While most MSIR service users are not from Richmond, they were coming to the area before the MSIR opened because the area was already an established drug marketplace. Victoria Police members who had worked in the area were surveyed during 2019, and they reported seeing more drug-related activity. The perceptions of people associated with the neighbouring school were mixed. However, enrolments have increased and the school reports that incidents involving discarded injecting equipment or overdoses have decreased, and indicators of both parent and staff satisfaction with the school have remained stable.

There are conflicting results in relation to perceptions of safety. While the Yarra City Council annual surveys suggest that this has not significantly changed, this review found that significantly fewer residents and businesspeople reported feeling safe walking alone during the day and after dark. Reasons offered included concerns about violence and crime, public visibility of drug use and drug deals, safety concerns for their own children and schoolchildren, aggressiveness and unpredictability among people who use drugs and discarded syringes in public places.

It has been difficult to assess the impact on usual clients' use of the community health centre. Concern has certainly been expressed by local people and some staff about the congregation of people, often assumed to be MSIR users, in the entrance and immediate vicinity of NRCH, with a possible reduction in use of some services such as maternal and child health support.

Further evidence suggestive of local people's perception of amenity is that, overall, the community survey conducted by this review of local residents and businesspeople immediately before the trial and again after a year of operation indicates that support for the injecting room in North Richmond reduced in that period (from 61 to 44 per cent among residents and from 48 to 41 per cent among businesses).

The legislated objective of improved amenity had not been achieved by the end 2019. Drug trafficking and antisocial behaviour has significantly affected the local community. Much of the focus of complaint and concern has centred on the MSIR. While aspects of the community concern are beyond the focus of this review, addressing amenity issues in the neighbourhood remains a priority.

During implementation of the MSIR, there have been increasing efforts to engage with and seek to address longstanding issues in the local community, requiring the cooperation of several agencies and organisations and agreement on complex issues. The renewed focus on ways of responding to the concern of local people are more apparent in recent months. Additional changes, such as actions identified through the Crime Prevention Through Environmental Design assessment led by Victoria Police and the recent implementation of the Richmond Community Capacity Building Initiative and planned longer term actions, could help to improve local wellbeing, safety and amenity for locals.

The Panel also notes that the August 2018 Victorian Government Response to the Parliamentary Inquiry into Drug Law Reform provided for a broad set of measures structured around three themes: better, earlier treatment; saving lives and preventing harm; and safer communities. The anticipated responses relevant to this review are those in the saving lives and preventing harm domain, specifically relating to the MSIR. A review of other aspects of the government response is beyond the scope of the review, but it would be prudent to consider the progress of both the MSIR and these commitments insofar as there are interactions if the trial is extended.

Implementation of a necessary suite of responses to local amenity is still in its early stages.

Expectations or hopes that the MSIR would solve all problems in the area are unrealistic. Negative impacts of the drug market have been experienced for many years including on Victoria Street and in the housing estate adjacent to the MSIR. While the reduction of overdoses in the housing estate carpark to the east of the community health centre suggests less use of this area, there are still reports of visitors congregating around the housing estate and of trafficking and consumption of drugs. This is an important priority to address so that residents can peacefully enjoy their neighbourhood.

International reviews suggest that the principal criteria for establishing such a service are the location and co-location of the program and whether people who use drugs will trust the program and therefore access the service. European experience suggests that in establishing these facilities there is a need to consider: proximity to illicit-drug markets; closeness to places of drug purchase where they can be embedded in a wider network of services; compatibility with the needs of

people who inject drugs; and compatibility with the needs and expectations of local residents. It is the last of these that remains contentious.

Given the priority of amenity as a key object of the legislation, there should be an increased emphasis by all service providers and local and state governments to address community safety and amenity. This especially relates to improved coordination of these entities and NRCH and more visible community policing of offensive or inappropriate behaviour.

Noting the relatively rapid uptake of the service, the Panel has reflected on the extent to which one service with one injecting room can manage this increase in numbers and the potential risks associated with any potential further increase in capacity within the same service, were this physically possible.

While no other location provides a perfect blueprint, extensive international experience suggests that consideration should be given to opening more than one medically supervised injecting service in a city the size of Melbourne.

(f) Reduce the spread of blood-borne diseases among MSIR trial clients

The MSIR has provided screening, assessment and treatment initiation and monitoring of blood-borne infections.

The most effective means of avoiding the spread of blood-borne infections among people who inject drugs is to avoid sharing injecting equipment. This sits behind the extensive provision of sterile injecting equipment through needle and syringe programs (NSP) that were established in Australia in the 1980s to prevent HIV/AIDS. Most people who inject drugs in the Richmond area reported not sharing needles and syringes prior to the MSIR opening.

The MSIR is directly providing services to people at high risk of blood-borne infections. In the first 18 months, more than a third of people screened tested positive and a quarter had begun treatment for hepatitis C. The provision of an NSP, and testing, assessment, counselling and treatment of these infections in conjunction with an injecting room, is clearly warranted. While screening, assessment and referral is an (almost) universal provision where such facilities exist, the MSIR is valuably able to offer treatment on site. These services have been available since the early operation of the MSIR and have been extended with the opening of the larger facility and further development of partnerships with other service providers such as St Vincent's Hospital Melbourne.

How the legislation and regulations have operated and whether they require amendment

The *Drugs, Poisons and Controlled Substances Act 1981*, Part IIA – Trial of Medically Supervised Injecting Centre provides for this trial. The regulations of this Part prescribe the drugs of dependence and the permitted quantities of those drugs that can be used at the MSIR and the content required to be included in the internal management protocols of the licensed medically supervised injecting centre.

Some aspects of the legislation, regulations and policy may require further consideration. The specificity of the legislation makes important aspects of the trial difficult to adapt during the trial, and the exclusion of vulnerable groups through regulation and policy decisions have been raised as concerns by a number of stakeholders.

The specificity of the legislation has made it difficult to adapt or innovate during the trial period.

The operating exclusion criteria limit access for vulnerable people who are likely to nevertheless inject their drugs.

Government may wish to monitor the impact of exclusions to the service on vulnerable cohorts if the trial is extended.

Findings

- North Richmond has been the main site for heroin use and related harms in Victoria for the past decade.
- The trial occurred in the context of increasing heroin use and increased visibility of people who inject drugs in North Richmond and a high number of overdose deaths.
- The service has been well utilised by the intended client group.
- The service is attracting a group of people who inject drugs with high health and support needs, many with recent experiences of overdose.
- The model of care could be further considered to examine options regarding matters such as staffing, optimum opening hours and the ways of providing additional services, recognising that many of the service users require navigation to connect to systems of care.
- The establishment of the MSIR has prevented overdoses and further harm and has saved lives.
- Of those who do attend the service, the nature of the overdoses is significant, and without intervention it is likely that many would have died or been permanently injured.
- Modelling allows an estimate of the number of lives that the MSIR may have saved and, while there are different ways to model this, using conservative estimates, these data suggest that between 21 and 27 deaths were avoided over the 18 months of this review. This does not include the prevention of permanent disability including acquired brain injury.
- NRCH and MSIR staff have made significant progress in delivering additional services and developing referral pathways to other service providers.
- With the move to the larger facility, the range and number of services is expanding.
- An ongoing trial would provide the opportunity to develop and assess ongoing integration of services and alternative ways of achieving this.
- There has been a reduction in ambulance attendances in the vicinity of the facility during opening hours.
- There have been no observable changes in emergency department presentations that can be attributed to the MSIR.
- There has been a reduction in reports of public injecting. Local people report no difference in seeing discarded injecting equipment. There has been an increase in collected injecting equipment (noting also an increase in collection activity later in the trial).
- Amenity has not improved during the review assessment period.
- Implementation of a necessary suite of responses to local amenity is still in its early stages.
- The MSIR has provided screening, assessment and treatment initiation and monitoring of blood-borne infections.
- The specificity of the legislation makes any adaption or innovation of the trial elements difficult.
- The operating exclusion criteria limit access for vulnerable people who are likely to nevertheless inject their drugs

Conclusion

The implementation of this service and associated responses remains a work in progress.

It has clearly been possible to establish a medically supervised injecting service that has attracted people who are at high risk of overdoses associated with injecting drugs. NRCH has managed a complex challenge that has included a significant increase in its budget, staffing levels and external attention. The MSIR has been responsive and able to oversee many people injecting drugs within the facility. There have been no overdose deaths in the MSIR, and a number of people have been assisted to access health and support services.

The trial has shown that the concept of a medically supervised injecting service in Victoria can be implemented successfully.

The expectations detailed as objects in the Act are ambitious and completed assessment of their achievement is premature. Considerable detail has been provided in this report. **Most of the objects of the Act have been advanced during the first 18 months of the trial.**

This review has used many sources of data. Findings relating to illicit drug availability, use and associated harm must always consider diverse and often incomplete data in order to draw any conclusions that, at the end of the day, must sometimes rely on inference through the weight of a mix of evidence. There are benefits to using the unique mix of data Victoria has available, and the continued collection of these is warranted. This includes data that provides some insight and opportunity to monitor the drug market for heroin and other injectable drugs, the movement of people who use these drugs as well as their service seeking, and changes to patterns of use and harm as well as uptake of additional services.

The location of the MSIR in a health service should provide benefits of ensuring access to broader health and other support services. Many NRCH staff were already trusted by people who have been injecting drugs in Richmond, evidenced by the very rapid take-up of the MSIR upon opening. However, ongoing efforts to assess changing dynamics in the area including possible shifts in the location of trafficking and consumption will be important as well as monitoring the success of the various ways that the MSIR approaches provision of integrated responses, particularly if additional services are opened.

With only six months of operation in the purpose-built, larger facility, there has not been sufficient data or experience to allow a considered comparison of the two different locations of the MSIR, albeit they have been on the same designated land and physically close. It is too early in implementation to determine if the MSIR should be terminated or made permanent. More time and the possibility of further supervised injecting services in an additional three-year trial period could provide greater experience and an opportunity to explore other means of responding to demand. It would also allow for the measures directed at amenity and precinct renewal that are only now emerging to be actioned in the vicinity of the MSIR.

The trial should continue and be expanded.

Recommendations

Based on these findings, the Panel recommends that:

1. The medically supervised injecting room (MSIR) trial at North Richmond Community Health (NRCH) continues in order to allow it to operate for the possible full duration of the licence (three further years).
2. The MSIR operates with no more than 20 injecting booth positions to ensure ongoing effective management in this high-acuity health setting for the duration of the trial.
3. Based on demand and international experience, the Victorian Government expands the current trial to include another supervised injecting service in an appropriate location within the City of Melbourne.¹ Trialling further services in this period could help manage demand, potentially save a greater number of lives and would allow an opportunity to test effectiveness in different locations as well as trial another model of supervised injecting facility in Victoria.
4. The Department of Health and Human Services continues to lead the MSIR trial as a health response with coordination support from the Department of Justice and Community Safety to ensure that both health and community needs are considered as the trial evolves to improve real and perceived levels of community safety.
5. The Victorian Government works with local government and the community to continue to develop local safety and amenity, including formalising the role of the existing roundtable to be responsible for community engagement, community safety and coordination of relevant services. This should include representatives from at least the Department of Health and Human Services, Victoria Police, Yarra City Council, local service providers (including the MSIR) and the local community.
6. The licensee of any supervised injecting service be proactive in engaging and communicating with the local community and key stakeholders on issues that may potentially affect the community.
7. There be more emphasis on place management, including in the vicinity of the MSIR, with a clear understanding among staff, service users and community members that disturbing and antisocial behaviour will not be tolerated. Visible community policing is required in areas of active drug trafficking to increase the experience and perception of community safety.
8. The model of care be further considered, including:
 - the requirement for medical supervision since clinical (nursing) oversight could achieve the same level of safety more efficiently
 - the current hours of operation to best match demand for the service
 - enhancing the access to and availability of care coordination in areas such as mental health, housing and drug dependence treatment.

¹ This recommendation is based on the international research and experience described in this report, patterns of overdose-related deaths in non-residential locations, ambulance attendance involving the provision of naloxone, publicly available crime data and the Panel's own knowledge and insights into street-based injecting activity in Victoria (see addendum). Consideration of a local government area for another service was not originally part of the terms of reference for this review; however, in recommending another supervised injecting service, the Panel agreed to provide additional advice regarding location.

9. The Victorian Government continues to monitor the implementation of the recommendations of the NRHC Alcohol and Other Drug Review, recognising that further refinement in policy or practice may be required.

10. Further reviews associated with establishing any MSIRs be conducted, with a report to be submitted at least six months before the potential expiry of any licence. This should draw on performance monitoring data from within the service and focus particularly on local amenity planning and implementation, and the experience and perception of local community members.

11. Funding is provided to enable ongoing provision of services that meet the needs of injecting room users.

12. Statewide drug-related patterns of use and harms continue to be monitored through analyses of data such as ambulance attendance, the provision of naloxone and deaths involving heroin and other injectable drugs. This could usefully include use of qualitative research methodologies in locations where evidence indicates high levels of activity related to injecting drugs.

13. Harm reduction initiatives continue to be provided to those areas and people experiencing most harm, such as by expanding overdose response training and the direct provision of naloxone including through needle and syringe programs and in prisons, detoxification and rehabilitation settings and other relevant services.

14. The Victorian Government monitors the impact of current exclusion criteria on access for vulnerable populations with a view to reviewing their suitability for an MSIR.

Table 1 summarises the review findings against the legislative objects.

Table 1: Summary of review findings against the legislative objects

Object	Extent to which the trial has advanced that object
Part 55A(a): Reduce the number of avoidable deaths and the harm caused by overdoses of drugs of dependence	To assess this object, the Panel considered: • Coroner's Court of Victoria data on fatalities involving heroin • MSIR data on the volume and nature of overdose interventions provided • staff and service user consultation. The finding of this review is that the trial has advanced this object and has saved lives. This is based on the following evidence: • The MSIR attracts people who are at high risk of overdose. • The MSIR has supervised 116,802 injections. • There have been no fatalities. • Of the 2,657 overdoses, the MSIR responded to 271 extremely serious overdoses with naloxone, which, based on existing modelling, avoided between 21 and 27 deaths. • Of the 2,657 overdoses the MSIR responded to 2,615 overdoses with oxygen and other measures to keep the airways open, potentially saving additional lives and

Object	Extent to which the trial has advanced that object
	avoiding harms associated with lack of oxygen to the brain. • However, as at the end of September 2019, coronial data show no observable difference in the number of people who have died from heroin overdoses before and after the establishment of the MSIR, either in the City of Yarra or across Victoria.
Part 55A(b): Deliver more effective health services for clients of the licensed medically supervised injecting centre by providing a gateway to health and social assistance which includes drug treatment, rehabilitation support, health care, mental health treatment and support and counselling	To assess this object, the Panel considered: • MSIR data on health needs and services provided • emergency department and hospital data • the results of a cohort study of people who inject drugs linked with Victorian and national health datasets • consultations with professional stakeholders, staff and service users. The finding of this review is that the trial has advanced the object of providing a gateway to health and social assistance but has not yet demonstrated significantly higher levels of service take-up for MSIR users as compared with other people who inject drugs in the first year of operation (from within the transitional facility). This is based on the following evidence: • The MSIR attracts and provides services to people with high health and other support needs. • MSIR clients are significantly less likely to be on opioid substitution therapy at registration than other people who inject drugs. • The MSIR provided or referred 10,540 additional services beyond supervision of injecting during the trial period, as well as providing specialist clinics. • Since the move into the larger facility, additional services are increasingly being provided by other organisations from within the MSIR, enabling better connection between this client group and available services. • As at 1 July 2019 there was not yet evidence of a difference in health service use between MSIR clients and other people who inject drugs. • Given the increased focus on providing services other than supervising injections, and the recent commencement of trialling a new, longer acting drug therapy from within the facility, monitoring health outcomes will be helpful to understand progress against this object if the trial is extended.
Part 55A(c): Reduce attendance by	To assess this object, the Panel considered:

Object	Extent to which the trial has advanced that object
ambulance services, paramedic services and emergency services and attendances at hospitals due to overdoses of drugs of dependence	• Ambulance Victoria data for attendances involving naloxone • the results of a cohort study of people who inject drugs linked with Victorian health datasets • analyses of emergency department presentations and hospital admissions data • consultations with professional stakeholders, staff and service users. The review found that the trial has advanced this object for ambulance attendances, noting there is not yet evidence of an impact of the service on broader health service use or outcomes. • The MSIR attracts people who inject drugs who have had more ambulance attendances involving naloxone than other people who inject drugs. • Frequent users of the MSIR have had fewer ambulance attendances involving naloxone since the MSIR trial opened but a small increase in the number of drug-related emergency department presentations during the trial. • Ambulance Victoria data show a trend towards a reduction in ambulance attendances after the MSIR opened that just failed to reach statistical significance ($p < 0.10$). • There have been no observable changes in emergency department presentations overall that can be attributed to the MSIR.
Part 55A(d): Reduce the number of discarded needles and syringes in public places and the incidence of injecting of drugs of dependence in public places in the vicinity	To assess this object, the Panel considered: • surveys of residents and businesses immediately prior to the trial and after one year of operations (within the transitional facility) • needle and syringe collection data. The findings of this review are mixed regarding the extent to which the trial has advanced this object. There has been a decrease in the proportion of local community members reports of witnessing public injecting (to the time of the MSIR Review Survey in July/August 2019), with: • a decrease in the proportion of residents and business respondents who saw public injecting (24 per cent to 20 per cent of residents; 27 per cent to 22 per cent of business respondents) • no change in the number of injections seen by residents (three per month) and an increase for business respondents (from four to five).

Object	Extent to which the trial has advanced that object
	There has been no change in local community members reporting seeing discarded needles and syringes (to the time of the MSIR Review Survey in July/August 2019), with: - the proportion of people seeing discarded needles and syringes relatively unchanged (16 per cent in the year before and 17 per cent during the trial) - no change in the median number of discarded needles and syringes seen by residents (four per month) but an increase in the median number of discarded needles and syringes seen by business respondents during the trial (six to 10 per month). The number of inappropriately disposed needles and syringes collected in the area surrounding the MSIR grew over the trial period. While some of this growth coincided with an escalation in cleaning activities in the last eight months of the trial, there was also an increase in the number collected in first 10 months of the trial. Stakeholders were strongly divided on the extent to which there had been a change at the end of the first year of operation of the MSIR.
Part 55A(e): Improve the amenity of the neighbourhood for residents and businesses in the vicinity	To assess this object, the Panel considered: - the MSIR Review Survey of local residents and businesses immediately before the trial and after one year of operations (within the transitional facility) - the results of a cohort study of people who inject drugs - surveys of local Victoria Police members - the Yarra City Council community survey - consultations with professional stakeholders, staff and service users - group consultations with local residents and businesses - their own direct observations. This finding of this review is that amenity has not improved during the review assessment period. - Most of the MSIR clients are not from Richmond but were already coming to the area before the MSIR trial began. - Prior research in North Richmond found the largest impact on the perception of amenity is from seeing discarded needles and syringes and other drug-related paraphernalia, and this appears to be largely unchanged. There are conflicting results in relation to perceptions of safety: - A Yarra City Council survey for the North Richmond area shows no change in residents' perceptions of

Object	Extent to which the trial has advanced that object
	safely walking alone during the day or at night before or during the trial. - Victoria Police members reported seeing significantly more: - people buying or selling drugs - people who appear to be under the influence of drugs - antisocial behaviour that appears to be drug-related. - The MSIR Review Survey conducted for this review found that after the first year of operations: - significantly fewer residents and business respondents reported feeling safe walking alone during the day and after dark due to concerns about violence and crime, public visibility of drug use and drug deals, safety concerns for their own children and schoolchildren, concerns about aggressiveness and unpredictability, and discarded syringes in public places - more people reported considering moving house (32 per cent to 37.1 per cent) or their employment (27.6 to 32.5 per cent) because of drug-related activity. The Panel notes that agreement with having an injecting room in North Richmond reduced during the trial period for residents (from 61 to 44 per cent) and businesses (48 to 41 per cent). There are increasing and substantial efforts across a range of organisations to ameliorate concerns, and if the trial is extended both these and community sentiment should be monitored.
Part 55A(f): Assist in reducing the spread of blood-borne diseases in respect of clients of the licensed medically supervised injecting centre, including, but not limited to, HIV and hepatitis C	The Panel notes the implementation of significant screening, assessment, testing and treatment initiation undertaken by the MSIR to address this objective. It is likely that the work of the MSIR is contributing to a reduction in the spread of these viruses. To assess this object, the Panel considered: - MSIR data on health needs and services provided - the reports and views of the St Vincent's Hospital Melbourne Health Independence Program - results of a cohort study of people who inject drugs linked with Victorian health datasets from the first year of operation. It does appear that this trial has contributed to advancing this object, particularly for more frequent users of the service, and for those requiring treatment for blood-borne diseases:

Object	Extent to which the trial has advanced that object
	• The MSIR offers screening and treatment for blood-borne viruses, both directly and through a St Vincent's Hospital care coordinator (Health Independence Program infectious diseases). • Screening showed that most people were already reporting not sharing needles and syringes (an important measure to reduce the spread of blood-borne viruses), with no significant difference between MSIR clients and other people who inject drugs. In the first 18 months, more than a third of people screened tested positive and a quarter had begun treatment for hepatitis C. After the first year of the trial, analysis of linked Medicare and Pharmaceuticals Benefits Scheme data did not yet show any significant difference in relevant tests or prescriptions, noting that efforts to provide these services have increased and the uptake and impact should continue to be monitored. Since previous levels of engagement in treatment of hepatitis C of this high health and support needs group are not known, it is possible that this equivalence is a measure of success of the MSIR in engaging people who might not otherwise be receiving treatment. If the trial is extended it may become possible to assess the extent to which the spread of blood-borne viruses associated with the MSIR has been advanced, noting that this would require a longer time to elapse and significant comparative research.

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Abbreviations used in this report

AOD	alcohol and other drugs
DHHS	Department of Health and Human Services (Victoria)
GP	general practitioner
MSIC	medically supervised injecting centre (Sydney)
MSIR	medically supervised injecting room (North Richmond)
NRCH	North Richmond Community Health
NSP	needle and syringe program
STI	sexually transmitted infection
VACIS	Victorian Ambulance Clinical Information System

Introduction

In October 2017 the Victorian Government announced the trial of a medically supervised injecting room (MSIR), permitted through amending existing Victorian legislation. The trial is for two years (30 June 2018 to 29 June 2020) at a specific location, with provision for the Secretary to the Department of Health and Human Services (DHHS) to amend the licence for another 36 months if the Secretary is satisfied that extending the period of the licence would further the objectives of the trial. The independent Medically Supervised Injecting Room Review Panel (the Panel) was established to conduct a review of the trial. This report gives the findings and recommendations from that review.

About the trial

Part 55A of the *Drugs, Poisons and Controlled Substances Act 1981* provides for the trial of a 'medically supervised injecting centre' as part of a scheme that aims:

(a) to reduce the number of avoidable deaths and the harm caused by overdoses of drugs of dependence; and (b) to deliver more effective health services for service users of the licensed medically supervised injecting centre by providing a gateway to health and social assistance which includes drug treatment, rehabilitation support, health care, mental health treatment and support and counselling; and

(c) to reduce attendance by ambulance services, paramedic services and emergency services and attendances at hospitals due to overdoses of drugs of dependence; and

(d) to reduce the number of discarded needles and syringes in public places and the incidence of injecting of drugs of dependence in public places in the vicinity of the licensed medically supervised injecting centre; and

(e) to improve the amenity of the neighbourhood for residents and businesses in the vicinity of the licensed medically supervised injecting centre; and

(f) to assist in reducing the spread of blood-borne diseases in respect of service users of the licensed medically supervised injecting centre including, but not limited to, HIV and hepatitis C.

(Parliament of Victoria Legal and Social Issues Committee 2017, No. 66)

The site for the trial was specified in the legislation as the land described in Vol. 09195 Fol. 045, which is located at 23 Lennox Street, Richmond, the site occupied by an existing community health centre, North Richmond Community Health (NRCH). Under the current legislation, only one licence can be issued, and the service must operate from that location, although there is provision for partnerships with other service providers.

Part IIA of the Act states that the Minister for Mental Health must arrange for a review to be conducted of:

(a) the operation and use of the licensed medically supervised injecting centre; and

(b) the extent to which the object of this Part has been advanced during the period of the medically supervised injecting centre licence; and

(c) how this Part and any regulations made for the purposes of this Part have operated and whether they require amendment.

The Act specifies that the review must have begun no later than 12 months after the day on which the medically supervised injecting centre licence commenced and may be completed before or after the licence ceases to have effect.²

The Act also stipulates that the Minister must table the review before each house of the Victorian Parliament as soon as practicable after the review is completed.

Role of the Panel

The independent review panel comprised Professor Margaret Hamilton (chair), Associate Professor Alex Cockram, Mr John Ryan, Mr Ken Lay and Associate Professor Ruth Vine. Their role was to oversee the review according to the terms of reference for this review (Appendix A), with support from government evaluators and analysts.

To understand how the MSIR was operated and used, the extent to which the trial was advancing each of the objects (as detailed above) and any potential amendments to the legislation or regulations, the Panel:

- systematically translated legislative objects to research questions and methods
- developed a framework for the review, largely focusing on the first 18 months of the two-year trial, to provide the Secretary with enough time to make a decision about continuing or closing the MSIR trial before the licence was due to expire
- agreed that key stakeholders were people for whom the MSIR trial had a:
 - direct impact (people who inject drugs and people who care about them)
 - professional impact (people who work at the injecting room and related health and social services)
 - geographical impact (people who live, own businesses or work near the facility; people who visit or work at the community health centre; staff, students and parents at the adjacent primary school)
 - systemic impact (emergency services, broader government services)
- developed an analytical approach for systematically reviewing available information (Susan et al. 2019)
- sought and considered two separate peer reviews by evaluation experts at the Australian and New Zealand School of Government and KPMG
- agreed to use a range of sources of information to answer these questions including:
 - existing published and grey literature, including submissions to the parliamentary inquiries that preceded the decision to conduct this trial and the Hansard record relating to this decision

² See the *Drugs, Poisons and Controlled Substances Amendment (Medically Supervised Injecting Centre) Act 2017*, No. 66 of 2017

- existing data collected by the MSIR, NRCH, DHHS, Ambulance Victoria, Victoria Police, the Department of Education and Training and the Coroners Court of Victoria
- a survey of local residents and businesses (referred to in this report as the 'MSIR Review Survey' – see Appendix G for details of the first-wave survey and Appendix H for details of the second-wave survey)
- a survey of local Victoria Police members
- analysis of an existing longitudinal cohort study of people who inject drugs
- direct observation and regular site visits to the facility and surrounding streets, parks and laneways, including the nearby housing estate
- hearing directly from stakeholder groups affected by the MSIR trial through a range of mechanisms including interviews with:
 - service users of the MSIR
 - service users of the needle and syringe program (NSP)
 - staff of the service
 - staff of other relevant services, including the community health centre, gateway service providers, Victoria Police, Ambulance Victoria members, the Department of Education and Training, the Yarra City Council and other local services
 - local community members.

Information about the framework, detailed design and methodologies for each of the above components are provided in Appendix B.

Context

North Richmond has been the main site for heroin use and related harms in Victoria for the past decade, with evidence from a cohort study showing an increase in visits to the area by people who inject drugs increasing before the trial began.

The trial occurred in the context of increasing heroin use and increased visibility of people who inject drugs in North Richmond, and a high number of overdose deaths.

This section provides a brief overview of injecting drug use and the harms associated with injecting drug use for individuals and the community and provides an overview of the recent history of the North Richmond drug market. This section also describes the local community and changes during the trial period.

Harms associated with injecting drug use

Approximately 11.8 million people inject drugs worldwide (UNAIDS 2017). In Australia, approximately six per thousand people aged 15–64 years inject drugs. Injecting drug use is more common among men than women and most common among those aged 35–44 years (Larney et al. 2017).

Injecting drug use poses risks to both the individual who injects drugs and to the broader community. In addition to the harms caused by fatal overdoses, there are significant physical health harms associated with non-fatal overdoses including:

- opioid-induced respiratory depression and hypoxia-related brain injuries from non-fatal opioid overdoses
- kidney failure
- nerve damage, transitional motor paralysis and build-up of fluids in the lungs
- injection-related injuries (scarring, bruising, venous injury, ulcers, arterial injury)
- injection-related infections (thrombophlebitis, cellulitis, abscess)
- complications of injection-related infections (tetanus, septicaemia, endovascular complications, musculoskeletal injections)
- infectious diseases (sexually transmitted infections (STIs), hepatitis B and C, respiratory tract infections, tuberculosis, HIV/AIDS).

Multiple and repeated overdoses correlate with decreasing cognitive performance and increased depression symptoms and suicidal ideation (Zibbell et al. 2019). Other mental health risks associated with drug use or injecting drug use include psychiatric disorders, substance dependence and substance use-related disorders. There are also common general health problems including pain, poor dental condition and constipation (World Health Organization 2009).

These health challenges can also have serious social and economic consequences, both to the individual and the broader community. Community concerns, which can be perceived or actual, include: fears of increased risk of violence and crime; the public health threat of disease transmission; diminished amenity; negative business impacts; and social and family disruptions (Australian Medical Association – Victoria 2017).

Australian government policy

Current policy in Australia governing all drug-related laws and responses is harm minimisation. Harm minimisation considers the health, social and economic consequences of alcohol and other drug (AOD) use in relation to the individual and the community. Harm minimisation has been the primary policy of Australian state and Commonwealth governments for 35 years (Commonwealth Department of Health 2017). This includes:

- harm reduction – strategies aimed at reducing the harm from drugs for both individuals and communities (but do not necessarily aim to stop drug use), with examples including needle and syringe services, methadone maintenance, peer education and brief intervention
- supply reduction – strategies aimed at reducing the production and supply of illicit drugs, with examples including legislation and law enforcement
- demand reduction – strategies aimed at preventing the uptake of harmful drug use, with examples including community development projects and, importantly, drug dependence treatment.

Harm reduction policies and services

Harm reduction comprises a range of services aimed at minimising injury to self, others and the community by people who inject drugs, from the most casual users to those with the most severe drug dependencies. Harm reduction programs include promotion and support for safer AOD use and practices as well as providing medical and social support to AOD users; this includes linking users to AOD and mental health treatment resources. The goal of harm reduction has also historically shaped the design of particular treatment interventions – for example, opiate substitution therapies such as methadone or buprenorphine that is now available with the potential enhanced uptake as a longer acting depot form. Harm reduction services are shaped by the goals of reducing AOD-related transmission of blood-borne viruses such as HIV/AIDS and viral hepatitis, as well as reducing drug overdose deaths.

Victorian harm reduction policy and services

The state government is the primary funder of a range of prevention and treatment services for people who inject drugs in Victoria. This includes harm reduction services such as providing sterile injecting equipment, for which there is a strong evidence base. A number of these are directed at reducing harm from overdose, including direct health services funded to provide primary care, outreach local drug initiatives, mobile NSPs and providing the opioid reversal agent naloxone as part of overdose response training.

A potential harm reduction element in a system of care

There are more than 100 medically supervised injecting services operating across more than 60 cities globally, and it has been more than 30 years since the first such service was established in Switzerland. To date there has been one service in Australia, the medically supervised injecting centre (MSIC) in Kings Cross, Sydney. Aside from providing people who consume drugs with safe and medically supervised locations to inject drugs, they can provide critical services such as case management and medical, social and mental health care. To meet the needs of the populations affected by opioid use, injection centres link to services that can help service users manage the

'social determinants' of health such as housing, income and community stability (Nursing@USC Staff 2019). Service users are provided information about welfare, counselling and legal services in the area. Often, it is the most vulnerable populations that are disproportionately affected by opioid use.

Integrated supervised injecting facilities are the most common model and are part of a broader and interlinked network of services. They are also regarded as best practice because clients can access a range of services in one location. In Germany, the Bonn integrated facility is located directly behind the city's main train station and provides different services on different floors of the building. Specialist drug injecting centres are usually established close to other drug treatment services and near open drug scenes. The injecting facility in Frankfurt is an example of a specialised model with a focus on referral to other services such as counselling, substitution treatment and housing. There are also four mobile injecting facilities in Europe – in Barcelona, Berlin, Copenhagen and Lisbon. In Barcelona and Berlin, the mobile facilities comprise specially fitted vans that have three injecting booths (Dietze et al. (2012).

All the supervised injecting facilities opened near locations of prominent drug markets. Some of these services (for example, Villa De Vallecas in Spain) were located in suburban areas. Evaluations have reported an overall positive impact on the communities where these facilities are located. For example, in Barcelona a four-fold reduction was found in the number of unsafely disposed syringes collected in the vicinity from a monthly average of more than 13,000 in 2004 to around 3,000 in 2012 (Vecino et al. 2013). A review of 584 drug-related emergencies in 18 of the 24 existing injecting facilities in Germany in 2013 found that these severe incidents could have had a fatal outcome if the client had been alone at home or out in the community (Drug consumption rooms in Europe, 2014).

Service users can access a range of primary care services at a supervised injection site, including wound care and HIV/AIDS testing. Some facilities provide withdrawal management services. When users are ready to withdraw, they have access to clinician-monitored facilities and are paired with counsellors and coordinators to facilitate the transition. Cities with large drug markets and drug-using populations (for example, Amsterdam, Hamburg, Frankfurt, Rotterdam and Zurich) have more than one service location and often provide a different suite of services or supplementary service arrangements, in an effort to meet demand.

In general, the objectives of the European facilities are to:

- reach as much of the target population as possible
- achieve health objectives including enabling service users to access a range of primary care services including immunisations, wound care and HIV/AIDS and hepatitis B and C testing and treatment
- provide a safe environment that enables lower risk, more hygienic drug consumption (short-term objective)
- reduce the mortality and morbidity of the target population (medium-term objective)
- stabilise and promote the health of users (long-term objective)
- realise public order and safety/crime objectives:
 - reduce public drug use and associated nuisance
 - avoid increases in crime in and around the facilities.

According to the European Monitoring Centre for Drugs and Drug Addiction (2004), there is no evidence that medically supervised injecting facilities contribute to increased morbidity or mortality risks among people who use drugs. Time series analysis of drug-related deaths in four German cities suggests the facilities can contribute to a reduction in drug-related deaths at the community level (Hedrich 2004).

The European experience shows that the extent to which medically supervised injecting facilities are used is highly dependent on their location (although there are other factors such as capacity, the nature of the drug scene, opening hours and access criteria). Essentially, the facilities need to take the following into account:

- proximity to illicit drug markets
- closeness to places of drug purchase
- locations where they can be embedded in a wider network of services
- compatibility with the needs of people who use drugs
- compatibility with the needs and expectations of local residents.

The European facilities have had a greater impact where there is a political consensus that they are part of a comprehensive local strategy to respond to drug-related problems (European Monitoring Centre for Drugs and Drug Addiction 2004).

A recent analysis of published reviews of supervised injecting programs (Belackova et al. 2019) has similarly identified key features to consider in designing future drug supervision facilities:

- the location and co-location of the program
- whether people who use drugs will trust the program and therefore access the service when the drug is criminalised
- what operational hours will best capture the times and/or periods of increased overdose risk
- what specific harm reduction practices should be prioritised or what level of assistance in referring people to other services is most appropriate.

As an example of how a government has operationalised these considerations, in Canada, the Ontario Ministry of Health and Long-Term Care specified key conditions that must be satisfied before approving the operation of what they call a supervised consumption and treatment service (CTS) (Ministry of Health and Long-Term Care 2018) covering:

- Location conditions – the service is to be located in communities in need based on Ministry-defined criteria (mortality, morbidity, proxy measures for drug use). They will be established in community health centres, Aboriginal health access centres or similar incorporated health care or community-based organisations that offer integrated, wraparound services.
- Service capacity – mandatory services must include supervised consumption and overdose prevention services, on-site or defined pathways to addiction treatment services and wraparound services (including primary care, mental health, housing and/or other social support) and harm reduction services.
- Proximity – the service is to be located at least 600 m from other local CTS or similar services. CTS will not be concentrated in one area or neighbourhood, and where childcare centres, parks and/or schools (including post-secondary institutions) are within 100–200 m, community concerns should be addressed through community consultations and ongoing community engagement.

- Community support – all applicants require evidence of support from local stakeholders, including residents. At a minimum, health and social service stakeholders, local businesses, local citizens, local municipality, police and other emergency services, public health and persons with lived experience should be consulted.
- Accessibility – CTS must comply with the Accessibility for Ontarians with Disabilities Act, be strategically located (walking distance from where open drug use is known to occur) and easily accessible by public transit. CTS should offer services that are culturally, demographically and gender appropriate.

The Canadian experience with the recent opioid crisis, and the resulting increase in the need for such facilities, has placed these processes under such pressure that there are now both formal CTS that meet the above requirements as well as local sites. Findings from a recent review into the Canadian experience has been that, 'When regulations are barriers, unsanctioned actions, such as overdose prevention sites, may be enacted by individuals to respond to urgent public health needs' (Buxton et al. 2019).

In Australia, at a coronial inquest in 2016 into the deaths of six opioid users in New South Wales, the deputy state coroner, Harriet Grahame, noted the need for more than a single injecting centre (Friezer 2018). International experience suggests that consideration should be given to opening more than one MSIR in a city the size of Melbourne where significant numbers of people use drugs. For example, as of April 2018, there were 31 official drug consumption facilities in 25 cities in the Netherlands, 24 in 15 cities in Germany, five in four cities in Denmark and 13 in seven cities in Spain (European Monitoring Centre for Drugs and Drug Addiction 2018). Within Germany, Hamburg operates five and Frankfurt four. There are two consumption rooms in Berlin (International Network of Drug Consumption Rooms 2015).

Context of the North Richmond drug market

During the 1990s the supply of heroin in Melbourne increased and the drug became readily available at levels of high purity in an emergent street-based drug-using setting (Dietze & Fitzgerald 2002). The changes in street-based drug activity was associated with an increase in heroin consumption. Later, between 2003 and 2005, the Yarra local government area (LGA) had the most non-fatal heroin overdose ambulance attendances in metropolitan Melbourne: 21.1 per cent in 2003, 18.8 per cent in 2004 and 22.2 per cent in 2005.

In the early 2000s overall heroin-related harms started to decline, largely attributed to ongoing variable heroin supply including experience of reduced availability compared with the peak period in the 1990s (Yarra Drug and Health Forum 2017). As neighbouring markets reduced or were disrupted through saturation policing, gentrification and other mechanisms, it has been argued that North Richmond became a key heroin market. From 2000–01 to 2001–02 the number of overdoses (non-fatal) in the City of Yarra declined from 199 to 118, but as a proportion of overdoses in Greater Melbourne it rose from 12 per cent to 23 per cent (DHHS 2004).

More recently the topic of injecting drug use in North Richmond was the subject of a research paper that concluded:

... over several years, there has been significant public discussion and media exposure on the impact of public injecting in the City of Yarra. The area of particular interest has been the area known as North Richmond comprising the high-rise public housing estates and surrounding

streets and laneways. An active street-based heroin market has existed in the location for decades, with people who inject drugs coming to the neighbourhood from all over Melbourne to purchase and use heroin. Despite ongoing, regular intensive policing of the illicit drug market, commercial exchange of heroin and public injecting continues. Much of the attention on the North Richmond heroin market has highlighted public health concerns, including overdose, the discarding of drug injecting paraphernalia, witnessing of overdose and public injecting. It was noted that there are also problems associated with public nuisance perceived to be from the illicit drug market (Dwyer et al. 2016, p. 164)

The Panel heard directly from community members that these were current concerns as well and they did not feel there was enough ongoing, visible community policing.

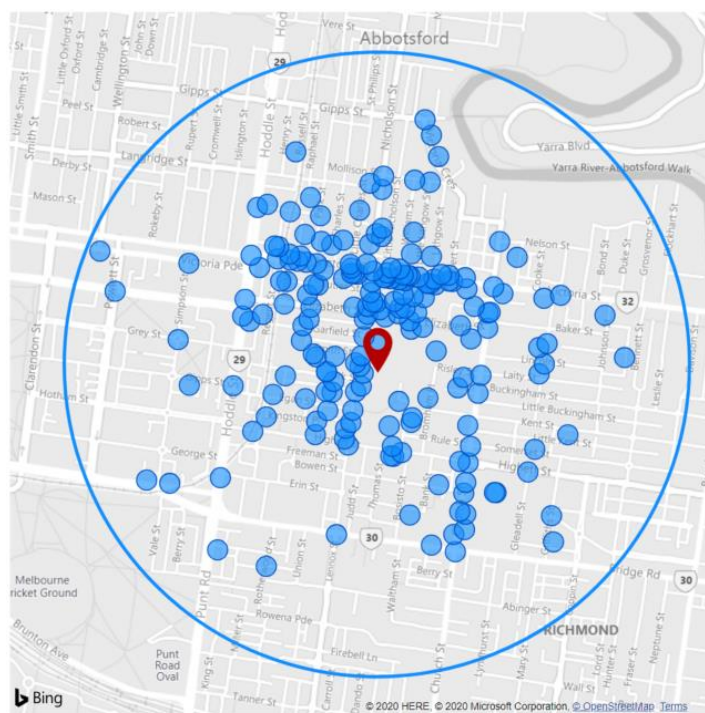
The Coroners Court of Victoria has also been monitoring heroin-related overdose deaths in the City of Yarra since 2012. In a 2016 analysis of heroin overdose deaths in the City of Yarra, Coroner³ Jacqui Hawkins noted that the deaths occurred in streets, parks, alleyways and other non-residential locations, and involved people who had travelled from other parts of Melbourne and Victoria to purchase and use heroin there (Coroners Court of Victoria 2016, p. 2). The coroner held an inquest and recommended that a supervised injecting trial be established in North Richmond. The coroner's data from the period 2012–2017 on heroin-associated harms in the City of Yarra and across Victoria more generally triggered a parliamentary inquiry, which culminated in establishing the *Drugs, Poisons and Controlled Substances Amendment (Medically Supervised Injecting Centre) Act 2017*.

From 2009 to 2017, the City of Yarra had the highest frequency and average annual rate of heroin-related overdose deaths in Victoria (Coroners Court of Victoria 2019). Unlike other Victorian jurisdictions, most people using and overdosing on drugs in the City of Yarra were not residents of the City of Yarra. Of the 91 people who died from heroin-involved overdoses in Yarra from January 2014 to December 2018, about a third (29 per cent) lived in Yarra. Most (64 per cent) lived in other LGAs in Victoria (Coroners Court of Victoria 2019).

DHHS analysis of ambulance attendances where naloxone was administered shows high levels of activity in the area surrounding the location of the MSIR in the 18 months before the MSIR opened (see Figure 1). There were 382 ambulance attendances where naloxone was administered within 1 km of the MSIR for the 18 month-period before the MSIR opened on 30 June 2018.

³ The Coroners Court independently investigates deaths and fires, reduces preventable deaths and promotes public health and safety and the administration of justice.

Figure 1: Ambulance attendances where naloxone was administered in public settings within 1 km of the MSIR (all hours) in the 18-month period before the MSIR opened on 30 June 2018 ($n = 382$)



Source: Victorian Ambulance Clinical Information System.

Note: The current location of the MSIR is shown with the red tag.

Establishing the MSIR trial in North Richmond

Stakeholders within DHHS reported to this review that some community groups in the local area have been advocating for an MSIR since the late 1990s. The decision to conduct a trial of an MSIR was based on support from coroners, a wide range of medical experts, first-responder agencies and the findings of a bipartisan parliamentary inquiry.

Key timelines for recent events leading to establishing the MSIR in North Richmond are:

- 2015 – increasing heroin-related deaths in Victoria, with 172 heroin overdose deaths, the highest since the 1990s (Coroners Court of Victoria 2017)
- November 2015 – announcement of a parliamentary inquiry into the effectiveness of laws and procedures relating to illicit drugs (the Parliamentary Inquiry into Drug Law Reform)
- Coroner Jacqui Hawkins, in the Finding into Death with Inquest of Ms A, delivered on 20 February 2017, recommended that the government 'take the necessary steps to establish a safe injecting facility trial in North Richmond' (p. 24)
- February 2017 – the Legislative Council referred the Drugs, Poisons and Controlled Substances Amendment (Pilot Medically Supervised Injecting Centre) Bill 2017 to the Legal and Social Issues Committee for review
- September 2017 – the *Report of Inquiry into Drugs, Poisons and Controlled Substances Amendment (Pilot Medically Supervised Injecting Room) Bill 2017* tabled in parliament
- October 2017 – the Victorian Government announced the MSIR for a two-year trial.

Following a decade of monitoring deaths by heroin overdose, in 2017 the Coroners Court scoped an inquest to 'explore the nexus between heroin-related harms and deaths and the City of Yarra, with particular focus on potential prevention opportunities in the Richmond area' (Coroners Court Victoria 2017, p. 8). In another finding on the death of David Leslie Chapman in 2017, Coroner Audrey Jamieson stated that:

... if a safe injecting facility can shift drug injecting from public locations to a clinically supervised environment, this would be hoped to lessen the impact of injecting drug use and overdose death on local residents who are exposed to these activities in their everyday life.

(Coroners Court of Victoria 2017, p. 6)

The recommendation by Coroner Jacqui Hawkins to take necessary steps to establish a supervised injecting facility in North Richmond was informed by the success of an equivalent service, the MSIC operating in Sydney's Kings Cross, the only similar facility in the Australian context. The coroner cited a 2010 evaluation by KPMG of the Sydney service that found it had (among other benefits):

- successfully managed more than 4,400 drug overdoses without a fatality
- reduced the average number of overdoses in public locations around the area where it was located
- reduced ambulance callouts to the Kings Cross area by 80 per cent.

This inquest was delivered on 20 February 2017.

Following the coroner's inquiry, the Inquiry into the Drugs, Poisons and Controlled Substances Amendment (Pilot Medically Supervised Injecting Centre) Bill 2017 (Parliament of Victoria, Legislative Council, Legal and Social Issues Committee 2017) was convened and heard evidence from a number of sources, including the coroner. The Yarra Drug and Health Forum provided a submission that suggested the necessary requirements for locating a supervised injecting facility. These included:

- prominence of public injecting
- near drug markets
- high numbers of fatal and non-fatal overdoses occurring in public places
- community concern around publicly discarded injecting equipment.

They reported that 'such conditions currently exist in Melbourne, particularly in North Richmond' (Yarra Drug and Health Forum 2009, p. 4).

The Bill was introduced to parliament on 22 February 2017 in response to the escalating use of illicit drugs and overdose deaths in the North Richmond area. The Bill proposed a trial of a medically supervised injecting centre at an unspecified location in North Richmond.

Parliament received submissions from local government, relevant stakeholders and community members. The overwhelming majority of submissions were in favour of a medically supervised injecting centre, including those from the City of Yarra, the Royal Australian College of General Practitioners, the Royal Australasian College of Physicians, the Royal Australian and New Zealand College of Psychiatrists and the Australian Medical Association (Victoria).

The committee spoke with a number of local residents as part of the inquiry and heard that they were frequently exposed to confronting scenes of drug use, drug dealing, antisocial behaviour and discarded injecting equipment. The committee also considered written submissions made to

another Victorian parliamentary inquiry into drug law reform. The committee noted that all 15 submissions received from Abbotsford and North Richmond residents supported a trial.

In Victoria Police's (2017) submission to the inquiry, Chief Commissioner Graham Ashton noted the strong evidence that the supervised injecting facility in Sydney has reduced the number of deaths from drug overdoses and improved access to drug treatment, health and welfare services (Parliament of Victoria, Legislative Council, Legal and Social Issues Committee 2017).

The Parliament of Victoria Legal and Social Issues Committee (2017) reported in September 2017 and found:

- Drug use in North Richmond had reached crisis levels and was a major concern for residents, business owners and emergency services.
- Medically supervised injecting centres improve the health of people who inject drugs and reduce signs of drug use in surrounding streets.
- Sydney's MSIC has provided public amenity benefits for the local community and reduced demand for ambulance services.

Key themes from the recommendations included:

- the need for integration across government
- diversion from criminal responses in appropriate cases including therapeutic and social responses for complex drug-related offending
- improved access to harm reduction and treatment services
- a focus on connecting healthcare and drug services
- increased community education and awareness on drug issues.

In October 2017 Victorian Premier Daniel Andrews announced that the Victorian Government would establish a medically supervised injecting centre.

In August 2018 the *Victorian Government Response to the Parliamentary Inquiry into Drug Law Reform* was tabled in parliament. The government focused its response to the report on three themes:

- better, earlier treatment
- saving lives and preventing harm
- safer communities.

Investment in concurrent programs to save lives and prevent drug-related harm included:

- eliminating new transmissions of HIV
- eliminating hepatitis B and C as public health concerns by 2030
- strengthening the Victorian NSP program.

Related commitments included:

- additional support to treatment service users who may be at high risk of overdose
- establishing new 'hubs' associated with emergency departments in six Melbourne hospitals to better support and respond to people experiencing a crisis related to their mental health or substance use.

If the MSIR trial is extended, it would be prudent to consider these commitments insofar as they relate to the MSIR in any future evaluation.

Response to trialling a supervised injecting room

Overall, there was strong support for conducting the trial, with most organisations and individuals who provided submissions to both parliamentary inquiries supporting it. Those submissions that advocated for a supervised injecting centre in North Richmond recognised that it had the potential to save lives and improve local safety and amenity.

Organisations that called for an MSIR or supported the concept overall included the Yarra City Council, NRCH, the Australian Medical Association (Victoria), the Royal Australasian College of Physicians, Yarra Drug and Health Forum, Family Drug Support, the Pharmacy Guild of Australia, Turning Point, Alfred Health and Beyond Blue.

A trial, according to the Australian Medical Association (Victoria), had significant potential to lessen the public impact of street-based injecting, improve service users' access to primary and medical care and drug treatment, reduce the incidence of heroin-associated overdose, and assist in reducing blood-borne viral transmission. Victoria Police suggested the trial should be longer than 18 months to allow health, social and justice indicators to be analysed over a significant time period.

There were also submissions against establishing a medically supervised injecting centre. Opposition came from two key organisations: Drug Free Australia and the Australian Christian Lobby. In their submissions to the Inquiry into the Drugs, Poisons and Controlled Substances Amendment (Pilot Medically Supervised Injecting Centre Bill 2017, they argued that establishing an MSIR would appear to condone illicit drug use. Additionally, they highlighted what they perceived as technical limitations with the evaluations of Sydney's MSIC.

There were also concerns expressed in the media about the facility, particularly in relation to the potential impact on the local community including the adjacent primary school. This followed extensive media coverage in the lead-up to the MSIR trial being announced (see Henriques-Gomes 2018) discussing the challenges associated with the local injecting room and community sentiment supporting the trial.

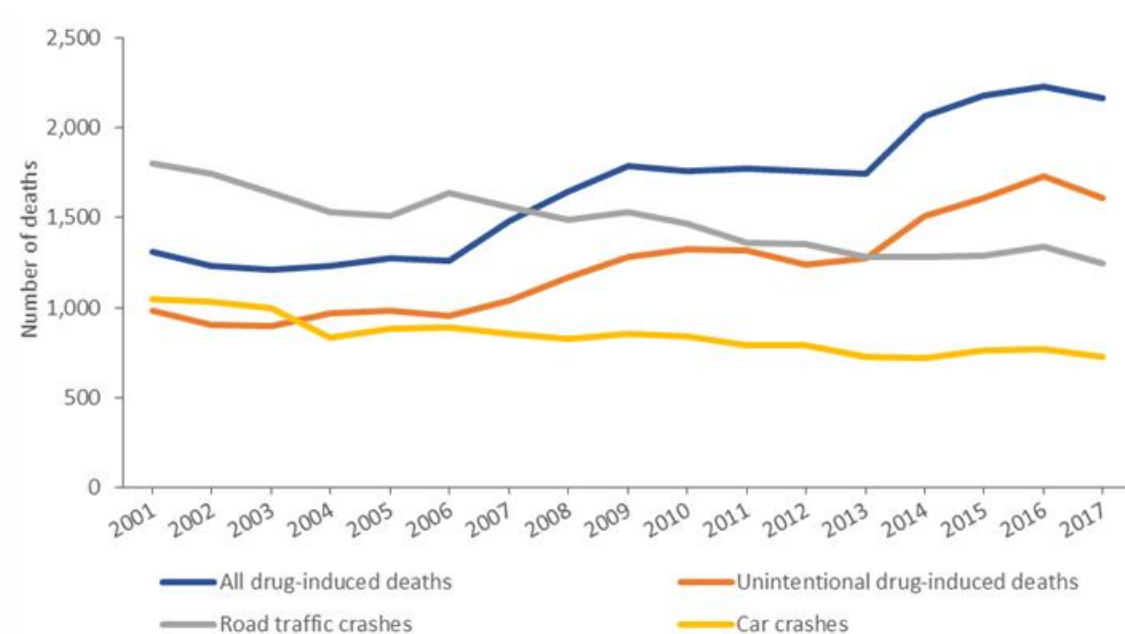
Changes in drug market trends

The pattern of drug injecting is associated with local and international changes of drug production and supply. Drug use and potential harm is determined by the availability of the substance, the characteristics of the person who wishes to use it and the circumstances or context of its use. As with most products, the market largely determines price, and this is influenced by availability (Australian Criminal Intelligence Commission 2018). With illicit products, this can fluctuate significantly.

There are indications that heroin use in Victoria has increased in the recent past and continues to do so. The Penington Institute records and analyses overdose deaths and reports that the number of overall drug-induced deaths in Australia from all drugs increased from 981 in 2001 to 1,612 in 2017, an increase of 64 per cent (Figure 2) (Penington Institute 2019). The number of unintentional deaths nationally relating to heroin rose from 195 deaths in 2013 to 358 in 2017 (an 84 per cent

increase). Victoria recorded the highest increase, with an increase of 225 per cent between 2012 and 2017⁴ (Penington Institute 2019).

Figure 2: Number of drug-induced deaths in Australia compared with road traffic deaths, 2001–2017



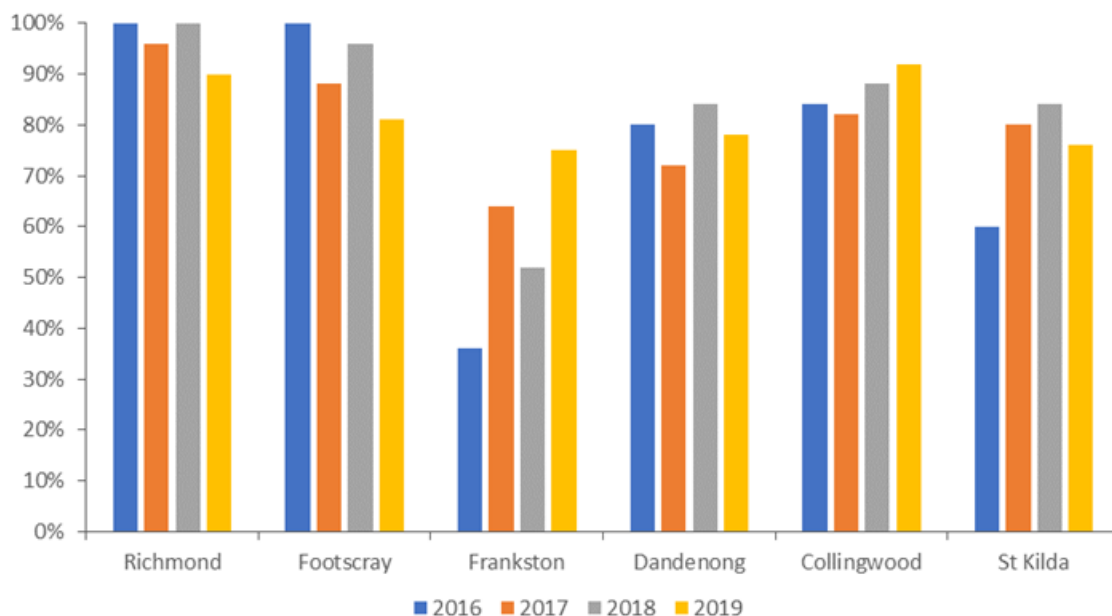
Source: Penington Institute 2019

Self-report studies such as the National Illicit Drug Reporting System interviews also provide some insights. While noting that they generally recruit only participants who self-identify as people who inject drugs (Peacock et al. 2019), within this national cohort, heroin use remained stable in 2019, and 88 per cent of participants reported that heroin was 'easy' to 'very easy' to obtain, consistent with 2018 (Peacock et al. 2019).

The system also noted noticeable differences in the proportion of people at each of its five recruitment sites who reported having injected heroin in the past six months in 2019 – 90 per cent of their sample recruited in Richmond reported this compared with 81 per cent in Footscray, 75 per cent in Frankston, 78 per cent in Dandenong, 92 per cent in Collingwood and 76 per cent in St Kilda (see Figure 3), supporting the impression that Richmond has been and continues to be primarily the site of heroin use (data provided directly to the Panel by the Burnet Institute).

⁴ An increase in drug-related deaths does not necessarily relate to overall increased consumption but may also relate to the purity (strength) and quality (contamination) of drugs available, and to changing patterns of poly-drug use.

Figure 3: Percentage of people who use drugs reporting the use of heroin injection in the previous six months, 2016–2019



Source: National Illicit Drug Reporting System data (2016–2019) provided directly to the Panel

Changes in the national and Victorian heroin market over time are difficult to quantify definitively. Wastewater analysis undertaken nationally provides estimates of drug consumption at more than 50 specific sites, including two sites in Melbourne and up to 10 in rural Victoria (Australian Criminal Intelligence Commission 2019). This analysis concludes that while heroin use has been stable or in decline in most jurisdictions nationally over the two-plus years of collection from March 2017 to August 2019, there have been increases in the capital city sites in both Victoria and New South Wales, with the greatest increases in Victoria.

Local context

This section describes the characteristics of North Richmond and key changes in the local environment during the trial period.

About the local community

The North Richmond MSIR is bounded by a largely residential street, a primary school and a public housing estate. It is in a densely populated, socio-demographic and culturally diverse area. There are also a significant number of people who sleep rough or who are homeless in the area.⁵

⁵ In relation to people requiring specialist homelessness services, there has been an increase in people who were accessing these services while living in Richmond overall, and in proportion to clients living in the rest of the City of Yarra. This increase occurred during the trial period and peaked in January–March 2019, with 140 people who were homeless in Richmond accessing these services in that period compared with 97 people in the three months before the trial began (March–June 2018). There was a small increase in the number of people who were living in Richmond accessing the specialist

DHHS' rationale for the location of the MSIR was:

The City of Yarra is the Victorian local government area with the highest frequency of heroin-related deaths over nine years (2009–2018). In 2015, 35 people died from overdoses related to heroin purchased or used in the City of Yarra.

The MSIR trial is located at the NRCH site on Lennox Street. The site was chosen because it is close to where people buy and sell drugs, and the centre already provides many vital health services to reduce the spread of blood borne viruses and other harms associated with drug use.

(DHHS 2019c)

Based on the above factors, this was a logical location to trial the service. As described earlier, other jurisdictions have taken into account broader factors, which may have been useful in considering the location.

About the licensee

The legislation allows for a trial at the existing site (23 Lennox Street, Richmond) and at no other location. This is the site of the licensee NRCH. This relatively small community health service was established in 1974, largely to serve the needs of the adjoining public housing estate (NRCH 2020). The community health centre offers a wide range of health and social services including:

- general practitioner (GP) services
- dental services
- occupational therapy
- child health and development
- community nurses
- counselling and casework
- AOD treatment
- the Centre for Culture, Ethnicity and Health
- diabetes education
- health and ageing services
- Inner Melbourne Post-Acute Care
- nutrition and dietetics
- the healthy ageing hub.

NRCH operates a range of AOD-related services including an NSP, health promotion, outreach in the local community and overdose response.⁶ From 2016 to late May 2019 it also provided a 24-hour needle and syringe secure dispensing unit.

Physical changes in the local precinct over the review period

There have been several changes in the local area immediately prior to and during the trial period that may contribute to changes in the data being considered, and the experiences of the local

homelessness services as compared with those living in the rest of the City of Yarra who had previously accessed AOD rehabilitation or who been referred by AOD services (24 people in the quarter before the trial began (March–June 2018)) and 31 people in the most recent quarter analysed (July–September 2019).

⁶ Advice provided to the Panel from the DHHS Drug Policy and Reform Unit on 14/08/2019.

community. These include significant capital works undertaken by different organisations including the Yarra City Council and Yarra Trams, as well as roadworks in Lennox Street, including road re-sheeting and upgrades to drainage. Shortly before the MSIR opened, a seating area at the corner of Lennox and Victoria streets (previously a space for congregation by people who buy and sell drugs) was enclosed for refurbishment for several months, with the result that Panel members heard from local community members and also directly observed that more people were dispersed on Victoria Street and also congregating on the adjacent Office of Housing estate.

There have been other changes to the surrounding precinct and the immediate vicinity of the MSIR directed at improving amenity over the past six months. The Panel has not been able to assess the impact of these changes.

Operation and use

Establishing an MSIR is a complex, highly visible and challenging endeavour, particularly with the requirement for accelerated implementation. DHHS has had significant input including initial licensing, central policy and performance oversight. It has also had considerable input in approving information about the MSIR for media and communications purposes.

Although DHHS has been coordinating the trial, it has had significant contributions and goodwill from a number of stakeholders including Victoria Police, Ambulance Victoria, the Yarra City Council, the Department of Education and Training, many local service providers, residents and people who inject drugs.

The initial focus was on getting the MSIR established and opened to begin providing service to people at risk of overdose, ensuring a safe and appropriate response to their activity and, as far as possible, their further health and social support needs.

People began attending on opening day (Saturday 30 June 2018) and have continued to use the service (an average of 321 visits per day as of 31 December 2019). Note that an individual may make more than one visit a day, so visits are not the same as the number of people. In the first 18 months of the trial, 3,936 people registered to use the MSIR trial, with 119,223 visits in this period.

The MSIR trial has supervised 116,802 injections and responded to 2,657 overdoses. There have been no fatalities.

Most injections (96.6 per cent) have been of heroin, with a few (2.5 per cent) injecting methamphetamine.

The MSIR trial is attracting a group of people who inject drugs with particularly high support needs, even compared with other people who inject drugs in Richmond.

Operation

Once announced, the trial had a rapid establishment period, reflecting escalating public health and safety concerns about public injecting in North Richmond.

The MSIR's operating protocols were heavily influenced by the experience of and documentation from the Sydney MSIC. The North Richmond MSIR meets all necessary legislative, national accreditation and Victorian departmental licence requirements. Operational incidents have been reported to DHHS as required.

The trial was phased, with an initial focus on supervising injecting drug use in a transitional facility. The MSIR then moved into a purpose-built facility next to NRCH, which provided additional capacity to provide clinical and other services in new consulting rooms.

The new facility has attracted more people, and there has been an increase in the number of injections overseen. It has also enabled more people to access complementary services at NRCH including GP services, drug dependence treatment, oral health services, infectious disease diagnosis/treatment, wound management support and mental health services.

Although many are now being delivered, the potential benefits of these services have not yet been fully realised because this added aspect of care is still being implemented.

The Panel considers that the core focus in the service's initial establishment was on operational matters, especially those related to the injecting room and the response to overdose experiences. At the time of opening, services such as blood-borne virus testing were mainly available through the pre-existing services at NRCH and through external services, with MSIR staff focusing on referring people to NRCH or off-site services when needed. However, over time it became clear that it was more effective to offer services in the consulting room of the injecting room itself. It has taken some time to develop appropriate protocols, pathways, partnership agreements, memorandums of understanding, record keeping/sharing arrangements and timetabling to facilitate the range of services now present in the injecting room. The larger facility, which opened in July 2019, took the concept of integrated service delivery in an injecting room further with the addition of a consulting area with three more consulting rooms.

As the trial has progressed, it has become apparent that NRCH's responsibility for governance and aspects of coordination and role clarification have needed significant improvement, along with implementing initiatives more directly related to amenity.

Renewed focus on amenity is apparent in recent months, and additional resources have been added to try to minimise real and perceived unwanted impacts on the local community discussed elsewhere. This is involving the cooperation of several agencies and organisations and agreement on complex issues and is ongoing.

The Sydney MSIC, which opened some 20 years ago,⁷ has informed some aspects of the MSIR trial, in particular overdose treatment guidelines, data collection and reporting structure. There are some important distinctions, however.

This section outlines the operation and use of the service, describing first the key activities involved in establishing and implementing the service and supporting activities, and then describing the use of the service.

The review considered implementation and use of the MSIR trial through reviewing the following sources of information:

- results of independent accreditation against the National Safety and Quality Health Service Standards and the Quality Improvement Council's Accreditation program, which occurred before the opening of both the transitional and larger facility
- review of key documentation, including relevant contractual agreements, performance management frameworks, service agreements and internal management protocols
- consultation with staff and service users
- consultation with other local services and community members
- expert observation
- case studies.

The key activities of the trial included:

⁷ Licence issued in October 2000. It opened in the following year.

- initial planning and scoping (October 2017 – February 2018)
- establishing governance and advisory mechanisms (October 2017 – current)
- obtaining relevant approvals (October 2017 – 30 June 2018)
- implementing the service in the transitional facility (30 June 2018 – July 2019)
- additional measures introduced by government to support the trial (April 2019 – current)
- implementing the service in the larger facility (July 2019 – current)
- developing the broader precinct (February 2019 – current)
- independent review of NRCH's AOD program (October–December 2019)
- reviewing the trial (April 2018 – December 2019).

Overview of key stages of implementation

Initial planning and scoping

In October 2017 the Victorian Parliament passed the Drugs, Poisons and Controlled Substances Amendment (Medically Supervised Injecting Centre) Bill and in February 2018 it was proclaimed as an Act. The location of the trial was specified in the legislation, and the prospective licensee was identified when legislation was introduced.

NRCH was identified as a suitable option for several reasons:

- NRCH's NSP was the highest volume program of its kind in Victoria in 2017, evidence that people who inject drugs knew about NRCH, were willing to access it and staff had familiarity with many client issues and needs.
- NRCH was located in the area described as 'North Richmond', recommended by the Coroners Court as the site of a supervised injecting service trial.
- NRCH already operated a naloxone education program, blood-borne virus education, health promotion, outreach in the local community and an overdose response service.
- NRCH was the only integrated community health centre offering AOD harm reduction and treatment in the North Richmond area.
- Most submissions to both relevant parliamentary inquiries supported conducting a trial in North Richmond.
- The service had existing links with the broader service sector as well as the local community.
- NRCH had provided a submission to parliament stating that it supported a trial of a supervised injecting service and would be open to providing this service.

Governance arrangements

Seven governance and advisory mechanisms have been established since October 2017 to support the trial:

- An internal departmental Project Control Group (October 2017 – June 2018) chaired by a senior DHHS executive was responsible for the initial planning stages of the project.
- An Expert Advisory Group (December 2017 – March 2018) chaired by the original medical director of the Sydney MSIC considered critical policy and operational matters in developing regulations and issuing a licence for the room.
- A Capital Project Control Group (January 2018 – December 2019) led by the Victorian Health and Human Services Building Authority oversaw the refurbishment of an existing community room to create the transitional facility and the design and construction of the larger facility.

- A Gateway Services Reference Group (May 2018 – ongoing) was established to develop networks and linkages between service providers that might facilitate referral pathways for clients and encourage client engagement with local services.
- A Local Reference Group (May 2018 – ongoing) provides a forum for working collaboratively with relevant parties including first responders (such as Ambulance Victoria), residents, schools and businesses to address elements of the trial that concern the local community.
- A Consumer Advisory Group (March 2019 – ongoing) composed of MSIR users advises on direct service provision and concerns.
- The Medically Supervised Injecting Room Review Panel (April 2018 – June 2020) was established to conduct this review.

The Panel noted that, as one would expect in this type of contractual arrangement, NRCH had limited involvement in the initial governance discussions until they were the confirmed service provider. The government and DHHS were seen as the primary source of information and comment. This is understandable in the context of the challenges associated with an initiative of this kind but may have resulted in less-than-ideal communication with the local community and the intended service provider. The Panel also noted the findings of a later review into NRCH's AOD program, which commented on the importance of clear lines of accountability and responsibility between the department that funds a service and the entity that provides the service.

The Panel noted that specific advice was also provided from other organisations throughout the trial period to support capital works and service model design. This included Victoria Police in relation to crime prevention, specialist consultants on matters such as security, safety and traffic, the Department of Education and Training, Richmond West Primary School and Yarra City Council.

Commissioning and funding arrangements

In June 2018 NRCH was licensed as the operator for the trial. DHHS amended an existing contract between the two organisations to include providing a medically supervised injecting service. A performance management framework and quarterly reporting requirements were agreed between the department and NRCH.

Funding was provided to NRCH based on the Sydney MSIC's historical operational funding provided by NSW Health. This figure was subsequently revised to more closely reflect actual operating costs associated with the MSIR.

Service model development

There were several aspects of the service model specified in the legislation, including the requirement for registered medical practitioners to fill two of the roles (a medical director to oversee the centre's operations generally and a medical supervisor to oversee the centre's clinical operations).

Within these parameters, the Expert Advisory Group considered critical policy and operational matters relevant to a high-level service model, drawing on the collective experience of the group, experience of the Sydney MSIC and international evidence. The Sydney experience helped inform the development of treatment guidelines, data collection and reporting structure.

This advice was provided to government for decision making on regulations and licence conditions and subsequently informed NRCH's internal management protocols (NRCH 2018) that formed the basis of the licence. These protocols specified important aspects of the model including:

- staffing and the service responsibilities of the workforce profile
- the service model, including nominating the activities that could be undertaken in each of the zones at the facility
- eligibility for registration, including that:
 - service users are 18 years of age or older
 - service users have injected drugs previously
- assessing existing registered service users where, at a particular visit, a client may be denied access to the Injecting Zone for the following reasons:
 - the client possesses a quantity of drugs above the permitted quantity (at a traffickable amount)
 - the client is not willing to adhere to the accepted behaviours outlined in the *Client rights and responsibilities* document
 - the client's access to the MSIR has been limited due to past behaviour
 - the client is accompanied by children
 - the client is intoxicated and deemed to pose an unacceptable level of clinical risk
 - the client is severely unwell, to a level such that their access to the Injecting Zone would pose an unacceptable level of clinical risk
 - the client is identified as being pregnant (NRCH 2018).

These criteria can result in people not being able to access the service.

On reflection it is evident that the core focus in the initial establishment of the service was on the operation of the actual MSIR, especially the Injecting Zone and the response to overdose experiences. At the time of opening, some of the other services such as blood-borne virus testing were also available. However, it has taken some time to develop comprehensive protocols, pathways, partnership agreements and memorandums of understanding, record keeping/sharing arrangements and timetabling to facilitate other responses consistent with the expectations of an integrated service model.

Opening the transitional facility

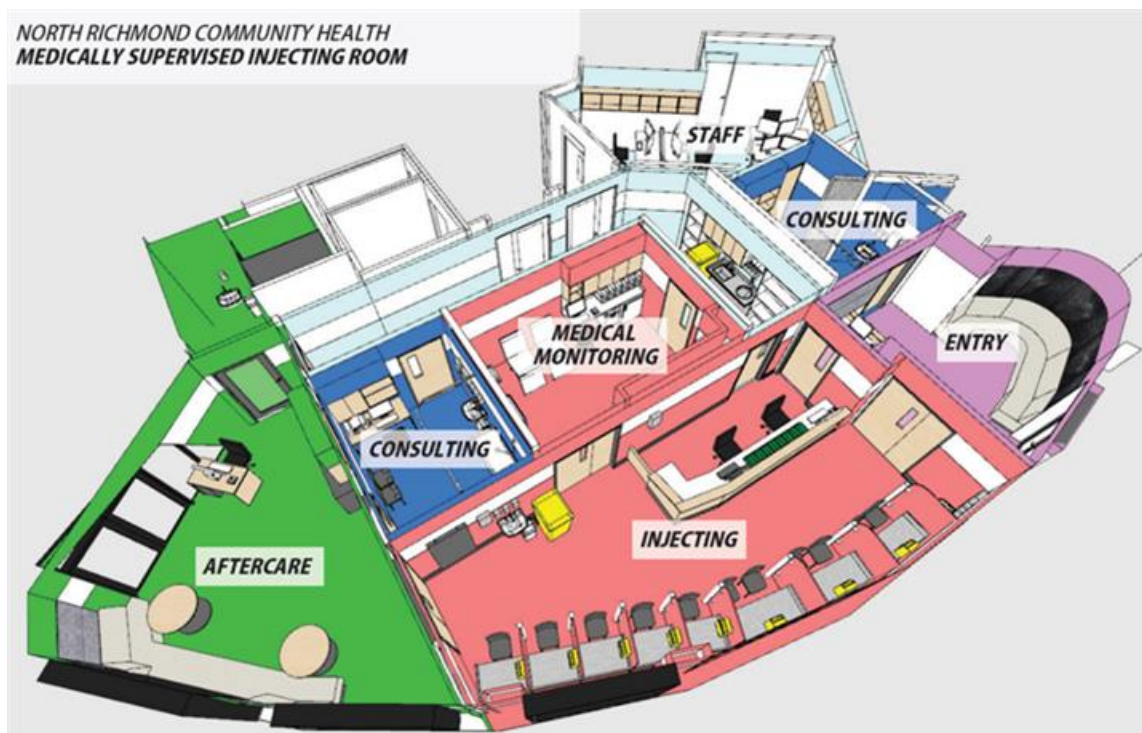
Following it being identified as the prospective licensee, NRCH worked with DHHS to develop the specifics of the service model and aspects associated with implementation, including relevant policies, protocols and infrastructure such as IT systems. There was significant input from DHHS and existing injecting facilities/drug consumption room service providers including sharing of policies and protocols and efforts to build on lessons learnt from other experiences. This included site visits to Canadian and European services by personnel who were to staff the MSIR once it opened. All parties describe this collaboration as essential to enabling the trial.

Over a period of 12 weeks, 57 staff were recruited and trained. This included recruiting the medical director. An addiction medicine specialist began full-time in mid-May 2018, before moving to three days per week with responsibility for overseeing the MSIR. In 2019 this role expanded to overseeing NRCH's existing AOD treatment team. The Sydney MSIC provided some experienced staff to work at the MSIR trial for the initial weeks to support its opening. Some remain employed by the MSIR.

The service was initially located in a refurbished community engagement room accessible from the street-facing side of the community health centre. DHHS advised that refurbishing an internal area of the existing NRCH building had been the quickest way to provide the service.

As shown in Figure 4, the transitional service provided an entry area, 11 injecting positions, a medical monitoring space, two consulting rooms and an aftercare zone.

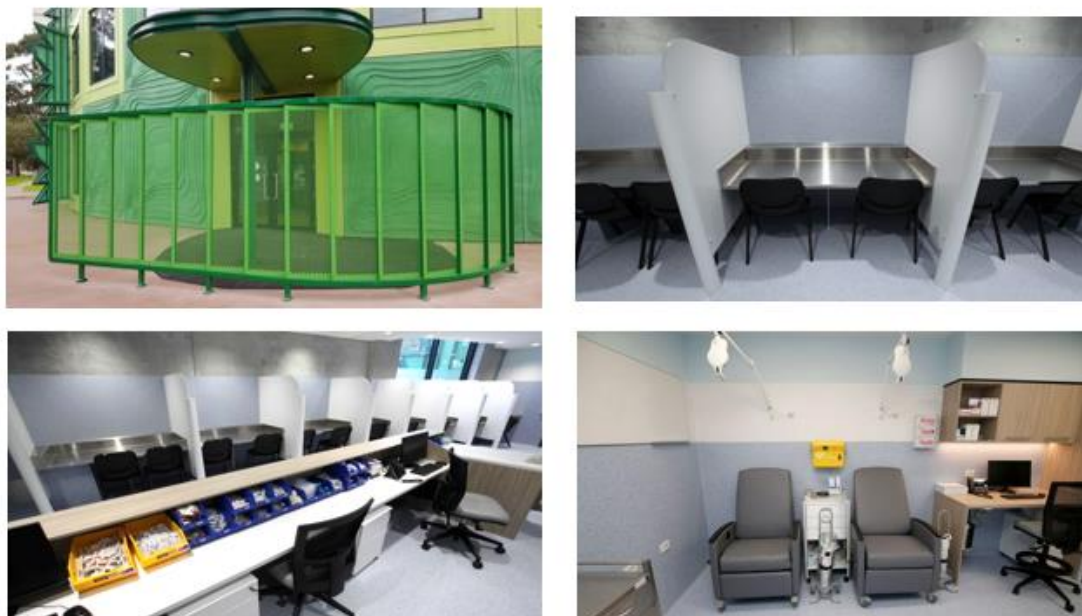
Figure 4: Floor plan of the transitional facility (site of the service 30 June 2018 – 6 July 2019)



Source: Image provided by DHHS

As shown in the photographs at Figure 5, the transitional facility had a separate entrance to the existing community health centre entrance and a standard clinical fit-out. This included booth positions for injecting and observation chairs.

Figure 5: Photographs of the transitional facility



Source: Images provided by DHHS

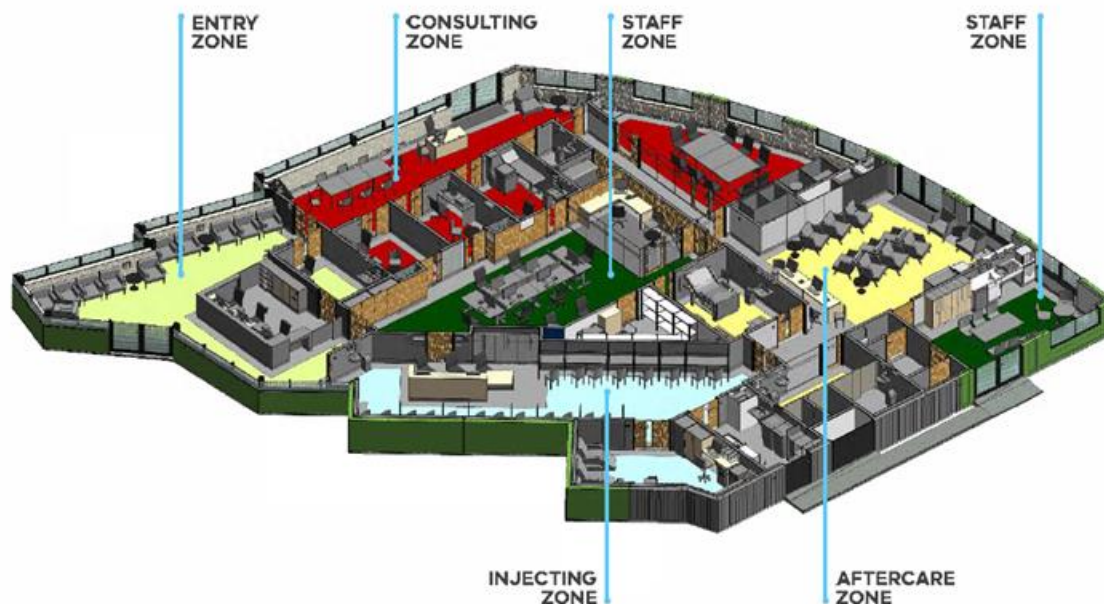
Developing the larger facility

In parallel with the licensing, and before opening the transitional facility, plans were being agreed to build a larger facility to allow time for approvals and construction. As the location is included in the legislation, the larger facility was also constructed at 23 Lennox Street, Richmond. Within that land, the larger facility was constructed on the former turning circle outside NRCH.

Advice from DHHS is that the design of the larger facility was primarily developed between DHHS, NRCH and the Victorian Health and Human Services Building Authority working with the contracted architects and project managers. The Panel was informed that key members of the NRCH MSIR team provided significant input into the design and function of the new building, including consulting directly with existing clients of the AOD program.

As shown in Figure 6, the larger facility includes the Entry Zone (including space for the NSP to be co-located with the reception desk for the facility), 20 injecting booth positions, additional consulting rooms, a larger Aftercare Zone and space for a large meeting room that can be used for group activities.

Figure 6: Floor plan of the larger facility (site of the service 7 July 2019 – current)⁸



Source: Image provided by DHHS

As shown in the photographs in Figure 7, the larger facility is a separate building with its own entrance adjacent to the community health centre. The larger facility is closer to Lennox Street and has more space than the transitional facility and maintains a standard clinical fit-out.

⁸ Image provided by DHHS, available at the Victorian Health and Human Services Building Authority's website <<https://www.vhhsba.vic.gov.au/health-infrastructure/medically-supervised-injecting-room>>. Please note this is an early artist's impression. Some internal infrastructure design changes were completed before the service opened on 7 July 2019. There is also a [virtual tour of the larger facility](https://www2.health.vic.gov.au/alcohol-and-drugs/aod-treatment-services/injecting-room) <<https://www2.health.vic.gov.au/alcohol-and-drugs/aod-treatment-services/injecting-room>>.

Figure 7: Photographs and location of the larger facility



Source: Images provided by DHHS

To support the move into the larger facility, there was a staggered increase in the number of injecting booth positions available. From its opening on 7 July 2019, hours of operation were also extended to 7.00 am – 9.00 pm weekdays and 8.00 am – 7.00 pm weekends and public holidays. (This provided an additional three hours per day on top of the transitional facility hours from 8.00 am – 7.00 pm weekdays and 9.00 am – 5.00 pm weekends and public holidays.) From the opening of the larger facility, there were 12 injecting booth positions operating by September 2019. The NRCH NSP program was transitioned to operate from the larger facility from July 2019, with the two teams sharing a large space in the entry zone.

Relevant policies, procedures and protocols were revised to reflect the new environment. The increased capacity and extended hours necessitated a significant workforce increase, with the internal management protocols requiring at least two staff in each functional zone and additional staff members moving between areas to provide support when necessary, in addition to security staff (NRCH 2019).

Noting the relatively rapid uptake of increased capacity in the service, the Panel has reflected on the extent to which one facility with one Injecting Zone can manage the emerging demand and the risks associated with any further increase in capacity within the same service, were this physically possible. Clients have indicated that one of the reasons they leave before injecting is when there is a waiting period. To manage potential staff shortages during times of peak demand or when acuity requires more focused resources, staff can and do close off new incoming service users at reception/Zone 1. The Panel considered that having more than one service location of this kind would lessen the focus and demand on the current service site.

Quality and safety of the service

NRCH is an independent registered community health organisation and a company limited by guarantee governed by a board of directors. As required by the Australian Government's *Corporations Act 2001*, NRCH is required to have robust governance and operational management processes in place. In the recent review into the NRCH AOD program,⁹ no evidence was found that NRCH has breached these requirements, nor did the DHHS 2017–18 and 2018–19 performance reports for NRCH. Operational incidents have been reported to DHHS as required. Both the transitional facility and larger facility and their operating models were accredited under Quality Innovation Performance Limited against the Australian Commission on Safety and Quality in Health Care Standards. The MSIR is an accredited health service with a licence to store medications and provide medical care.

Stakeholders with experience in acute health settings, particularly emergency departments and inpatient psychiatric settings, including senior and experienced medical staff, a major public hospital emergency department and mental health services noted the high level of acuity of medical and behavioural challenges presented by these service users. The impression formed by these experienced clinicians is of a dynamic and challenging environment. Some clinicians expressed reservations about having 20 injecting booth positions in one location, noting that in other acute settings there is generally a preference for having more but smaller units, making it easier to manage both medical and behavioural problems. Members of the Panel visited the new facility on several occasions. Panel members noted the additional challenges of having a larger number of people who use drugs on site and how busy and dynamic the environment had become.

The increase in staff numbers to support the larger facility was significant, not only from a recruitment and training perspective but also for people and change management. Some staff noted that, in moving into the new facility, they needed to become familiar with a new space and also new colleagues. In the second round of recruitment the facility added people with appropriate clinical skills to respond to overdoses and, in drawing on a broader pool of staff, included others who had not necessarily experienced working with people who inject drugs in a harm reduction framework.

Some external stakeholders voiced concerns to the Panel about NRCH's capacity to provide appropriate clinical governance to the MSIR workforce. Their concerns related to whether the current structure had the capacity to provide sufficient clinical leadership, maintain a focus on scope of practice and provide appropriate clinical supervision (noting the additional complexity of staff coming from a range of clinical backgrounds, which they felt can take additional effort to manage). Feedback from the service is that there are clinical supervision challenges with a shift working cohort; however, these are being addressed with external clinical supervisors. Management noted that having increased access to experienced staff to mentor and support other staff could improve the safety and quality of the service.

Despite the challenging context, the service has provided a generally safe environment for both staff and service users. There was one reportable incident per 1,000 visits during the trial period –

⁹ The review into the NRCH AOD program was instigated in response to an incident involving staff from NRCH in relation to alleged drug offences. The staff were not from the MSIR. The report highlighted the importance of clear governance arrangements and clarity between DHHS and NRCH in relation to key performance areas.

most commonly involving occupational health and safety concerns (28 per cent of all incidents), verbal abuse/assault/aggression not involving staff (21 per cent) and other health concerns (18 per cent) (Table 2).

Table 2: Reportable incidents at the MSIR by type of incident, total numbers reported from Quarter 1, 2018–19 to Quarter 2, 2019–20

Reportable incidents	Number	Percentage
Occupational health and safety	38	28
Verbal abuse/assault/aggression not involving staff	29	21
Other health concerns ^(a)	24	18
Verbal abuse/assault/aggression towards staff	18	13
Other behaviour requiring removal from premises ^(b)	6	4
Other client injury	11	8
Other ^(c)	10	7
Total number of incidents	136	100

Source: MSIR database

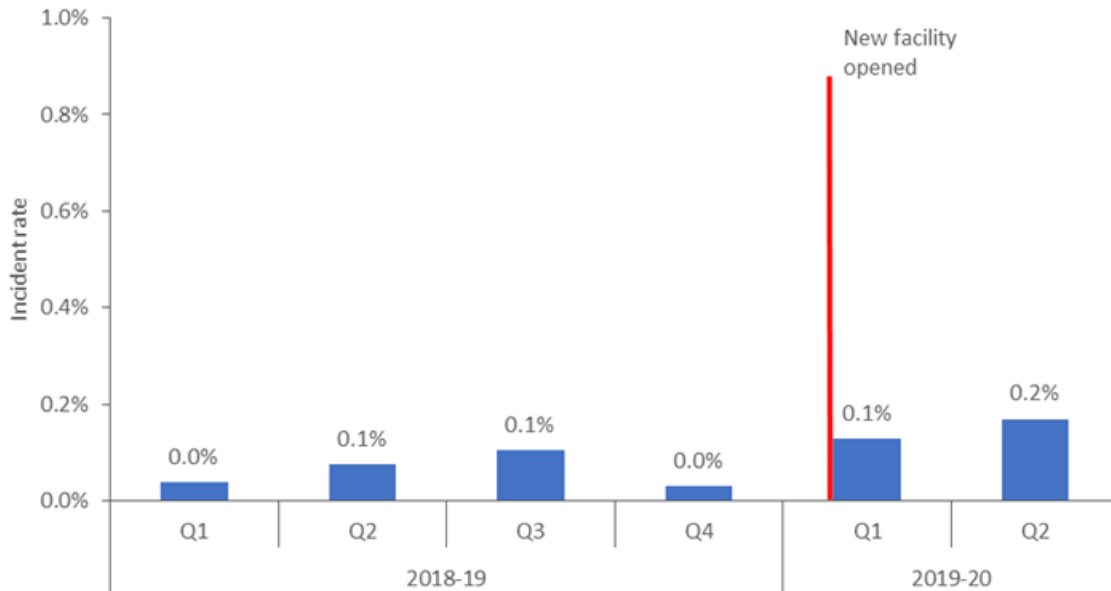
(a) Includes seizures, allergic reactions and arterial injection.

(b) Includes property damage and dealing.

(c) Includes client record system errors, pay errors and a medical error.

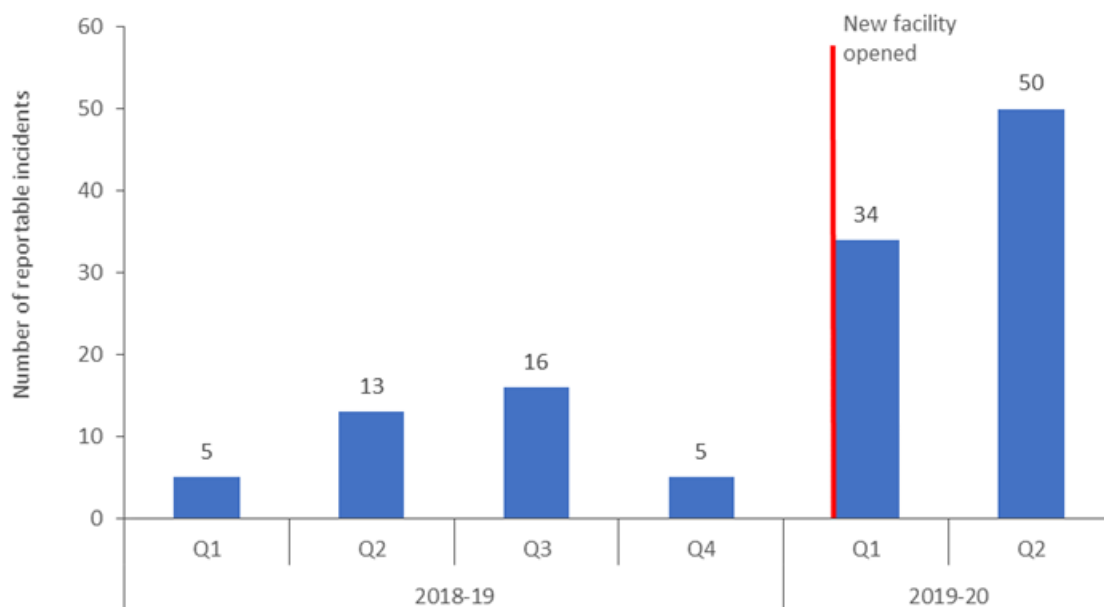
As shown in Figure 8, during the period in the larger facility, despite an increase, the incident rate remained low, with around two incidents per 1,000 visits (0.2 per cent).

Figure 8: Reportable incident rate at the facility from Quarter 1, 2018–19 to Quarter 2, 2019–20



There was an increase in the number of incidents reported in the transition to the larger facility (Figure 9). The increase in the number of reportable incidents appears to reflect, in part, the larger space and extended opening hours in the larger facility, with more potential for interactions between service users. This was also a period in which there was increased attention and training on reportable incidents, which may reflect better reporting.

Figure 9: Reportable incidents at the facility from Quarter 1, 2018–19 to Quarter 2, 2019–20



Source: MSIR database

In October 2019 there was an incident involving two AOD program staff members, which led to the employees involved and the then CEO being stood down, and a separate independent review into the NRCH AOD program. One of the key findings of that review was:

... the recent allegations of inappropriate behaviour by NRCH employees have highlighted gaps and shortcomings in governance, leadership, culture and workforce management that will need to be addressed.

(Aspex Consulting 2019, p. 3)

The review into the NRCH AOD program made 12 recommendations to address the gaps. The incident that led to the review and the review itself were not primarily related to the MSIR. NRCH has implemented changes to meet each of the 12 recommendations.

Broader activities to engage the community and improve the amenity

There have been efforts to engage the community and improve local amenity over the course of the trial. The Panel was informed of a number of events and initiatives to further this goal, particularly in the second half of 2019. Much of the visible activity emerging from an April 2019 announcement by the Minister for Mental Health that committed to more frequent sweeps to remove needles, more AOD outreach teams to help on the street, and an increased security presence and improved lighting on the Richmond housing estate, was not apparent at the time of the repeated MSIR Review Survey in the middle of 2019. Other changes have occurred including Yarra City Council increasing street cleaning in the Victoria Street precinct and Victoria Police's regular proactive patrols seen by Panel members during walks through the immediate vicinity of the MSIR.

Yarra City Council had initiated several locality focused renewal projects just before the MSIR opened. This included the Victoria Street master plan and demolition of an abandoned building with associated rubbish removal at Lennox Street, a reported previous informal injecting site, together with a project to promote graffiti removal and grants for shop roller-door decoration.

DHHS has advised of local briefings and information sessions before and during the trial and establishing a local reference group for the MSIR, though many residents who spoke with the Panel reported a lack of consultation.

The Panel has been informed of a cross-government roundtable, led by DHHS with collaboration from Yarra City Council and other Victorian Government departments and agencies including Victoria Police to oversee broader precinct development in North Richmond to respond to longstanding issues and improve community health, wellbeing and safety. DHHS has reported that the roundtable has met monthly since April 2019 to consider a long-term cross-agency approach to:

- increase community participation and social cohesion in the area
- improve access to health and social support services
- enhance public amenity and infrastructure
- improve experiences and perceptions of safety, security and crime.

The Panel observed that the role of NRCH and MSIR in managing the relationship with the local community surrounding the MSIR trial was at times confusing and apparently compromised. The key service requirements included in the performance monitoring framework for the MSIR contained a clause expecting NRCH to 'engage with the local community to improve understanding of the MSIR', but in parallel the MSIR CEO and the medical director of the MSIR reported to the Panel that they were required to have all their communications cleared through DHHS, making timely and direct responses to locals and the media difficult. Going forward, the Panel suggests that any licensee must be proactive in engaging with and communicating with the local community and key stakeholders.

In July 2019 (shortly after the service moved into the larger facility), there was a joint information session held by DHHS, the Yarra City Council, Victoria Police and NRCH attended by more than 300 people.

More recently, the Panel understands that government has made further improvements on the Richmond housing estate. Victoria Police identified important safety and security issues through a Crime Prevention Through Environmental Design review. In response, DHHS made capital upgrades throughout the estate, including in the multi-deck carpark next to NRCH. Cleaning, needle collection and syringe disposal unit availability has also been increased. As the trial has progressed, the Panel has been informed about more crime prevention activities in the area in the vicinity of the MSIR and on the estate.

In the interests of analysing the data the Panel had already collected, it has not been possible to further assess or review the impact of these changes since the Panel ended formal data collection at the end of 2019 when many of these initiatives might have been starting to take effect.

It is unfortunate that these measures to engage the local community, consult and coordinate the many activities in the area to address public amenity were not initiated much earlier, before the opening of the MSIR trial.

Comparison between the North Richmond and Sydney facilities

The North Richmond MSIR is the second licensed supervised injecting service in Australia. Although it has many similarities with the first centre, the MSIC in Sydney, there are several key differences between the services (see also Table 3):

- **Legislated aims** – the MSIR has legislated aims that go beyond direct service provision, including reducing overdoses requiring ambulance attendance or emergency services and improving local amenity.
- **Responsible authority** – the responsible authority for licensing the MSIR is the DHHS Secretary, while both the Director-General of the Department of Health and Commissioner of Police are responsible authorities for the MSIC.
- **Funding** – the MSIR is funded through the State Budget while the MSIC is funded through proceeds of crime.
- **Licensee** – The MSIR is licensed to a small community health centre, the MSIC to a national health and human services provider.

- **Location** – the MSIR is co-located with a community health service that was designed to meet the primary health and social support needs of local communities, while the MSIC operates from a single shopfront near a railway station and within a commercial precinct.
- **Volume of services in the first 18 months** – there were a similar number of people registered at both services, but the MSIR had more than double the number of visits.

Table 3: Comparison of the MSIR with the Sydney MSIC

Dimension	MSIR (North Richmond)	MSIC (Sydney)
Operating period	Commenced 30 June 2018	Commenced 6 May 2001
Legislated aims	<i>Drugs, Poisons and Controlled Substances Act 1981</i>. Objects to: • reduce the number of avoidable deaths and harm caused by drugs of dependence • deliver and provide a gateway to treatment and counselling for service users • reduce attendance by ambulance services, paramedics and emergency services and attendances at hospitals due to overdoses of drugs of dependence • reduce the number of discarded needles and syringes in public places and the incidence of injecting of drugs of dependence in public places • improve the amenity of the neighbourhood for residents and businesses in the vicinity • assist in reducing the spread of blood-borne diseases in respect of service users of the licensed injecting facility, including but not limited to, HIV and hepatitis C.	<i>Drug Misuse and Trafficking Act 1985 s. 36 B</i>: Objects to: • reduce the number of deaths from drug overdoses • provide a gateway to treatment and counselling for service users • reduce the number of discarded needles and syringes and the incidence of drug injecting in public places • assist in reducing the spread of blood-borne diseases such as HIV and hepatitis C.
Responsible authority	Secretary, DHHS	The Commissioner of Police and the Director-General of the Department of Health (now called Secretary)
Funding	Through usual budget processes to Department of Treasury and Finance	Confiscated proceeds of crime account, managed by the NSW Treasury
Location	23 Lennox Street, Richmond The service is co-located with a broad community health service that was designed to meet the primary health	66 Darlinghurst Road, Potts Point The service is a shopfront, standalone service targeting people who inject drugs in the local area. It operates from a single

Dimension	MSIR (North Richmond)	MSIC (Sydney)
	and social support needs of the local residents	shopfront immediately opposite a railway station and within a shopping precinct
Licensee	NRCH, an incorporated small, not-for-profit community health centre with a board of directors	Uniting, which is the services and advocacy arm of the Uniting Church in NSW and ACT, a faith-based health and human services provider
Workforce	Medical director and medical supervisors, operation manager, nurse unit manager, registered nurses, harm reduction staff, security staff and additional co-located services such as mental health support from St Vincent's Hospital Melbourne	Medical director, operations manager, nurse unit manager, mental health staff, health education staff, registered nurses, security staff and a commonwealth funded co-located mental health nurse.
Visits in first 18 months	3,936 people registered Service users made 119,223 visits	3,810 people registered Service users made 56,861 visits
Core services	• Crisis counselling, and support for a range of medical/physical/social/emotional presentations associated with a vulnerable population of people who have high rates of homelessness, mental ill health, childhood trauma and general poor health • Care to reduce morbidity and mortality associated with drug injection and overdose • A range of practical harm reduction advice and referrals to support service users to engage with drug treatment services and other health care and social services (such as accommodation) • Regular open public tours of the service	<i>The MSIC's core services align with those provided by the MSIR.</i>

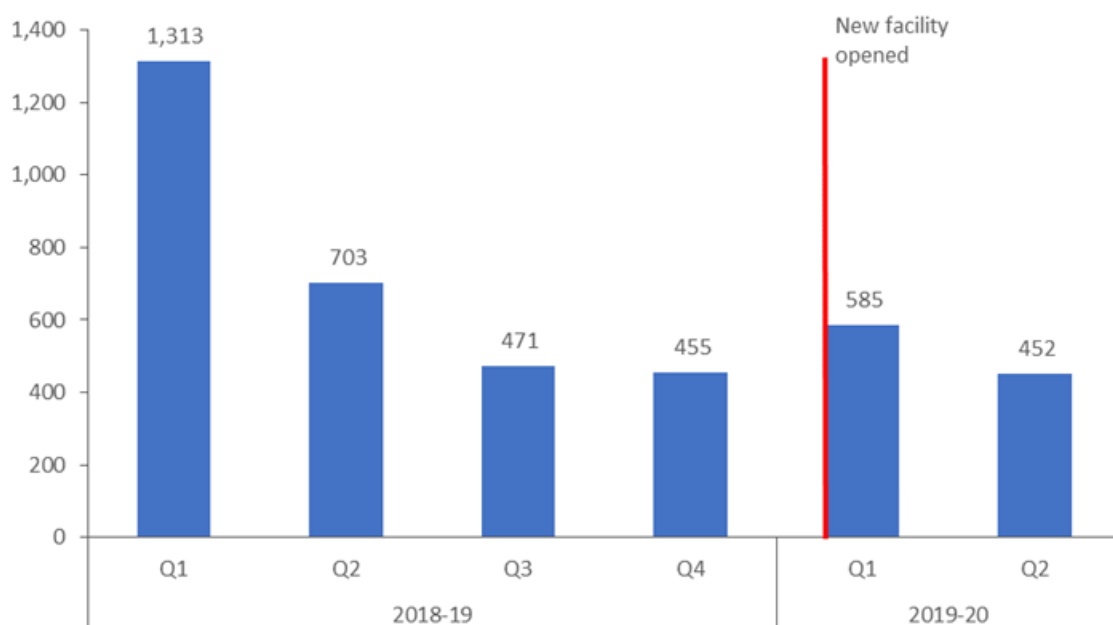
The MSIR also offers on-site services provided by NRCH staff and collaborations with St Vincent's Hospital Melbourne and the Burnet Institute. Other services include GP services, vaccinations, blood-borne virus testing, STI testing, hepatitis treatment, fibroscan, methadone and buprenorphine maintenance prescribing, long-acting buprenorphine administration, suboxone dispensing for the purpose of long-acting buprenorphine initiation, oral health care including silver fluoride varnish and basic oral x-rays, a mental health nurse and a wound care nurse. Additional on-site services are provided by external agencies including Launch Housing, ReGen alcohol and drug workers and Fitzroy Legal Service.

Use of the MSIR

There were significant efforts to 'pre-register' people for the service by engaging existing NRCH service users, encouraging them to complete the intake questionnaire in the period immediately before the MSIR trial opened and answering important questions about the service to reduce barriers to engagement.

As shown in Figure 10, in the first 18 months of the trial, 3,936 people registered for the MSIR. The first three months (including people pre-registered before the service opened) had the most registrations, and there was another increase when the larger facility opened.

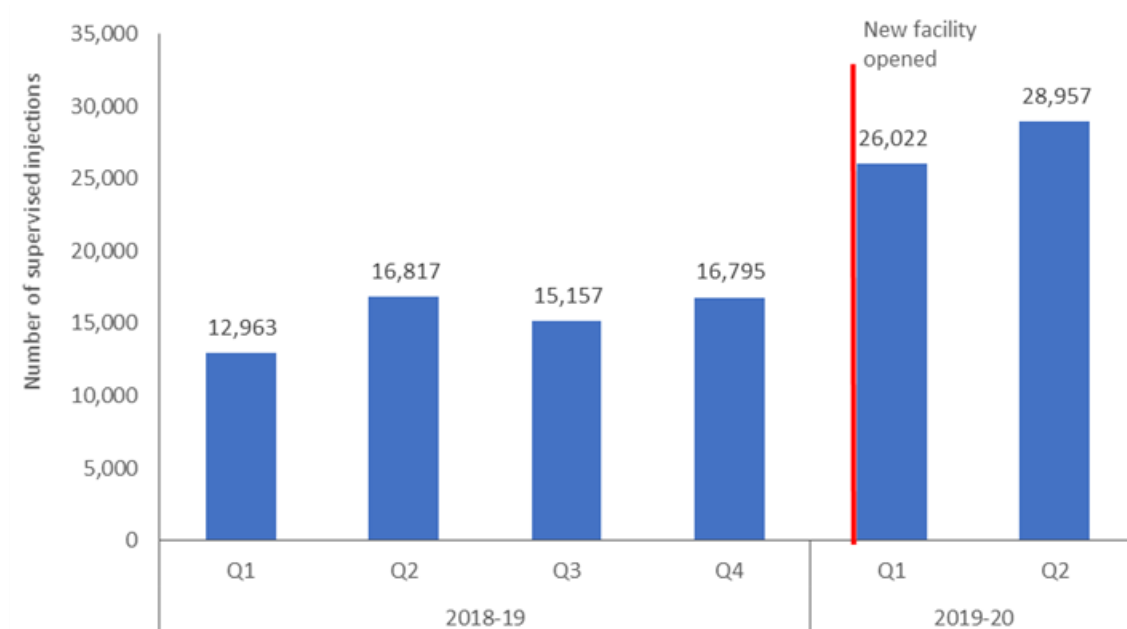
Figure 10: Number of newly registered MSIR service users from Quarter 1, 2018–19 to Quarter 2, 2019–20



Source: MSIR database

The number of supervised injections remained steady between Quarter 2 and Quarter 4, 2018–19, and then began to increase steadily from Quarter 1, 2019–20 (coinciding with the opening of the larger facility) (Figure 11).

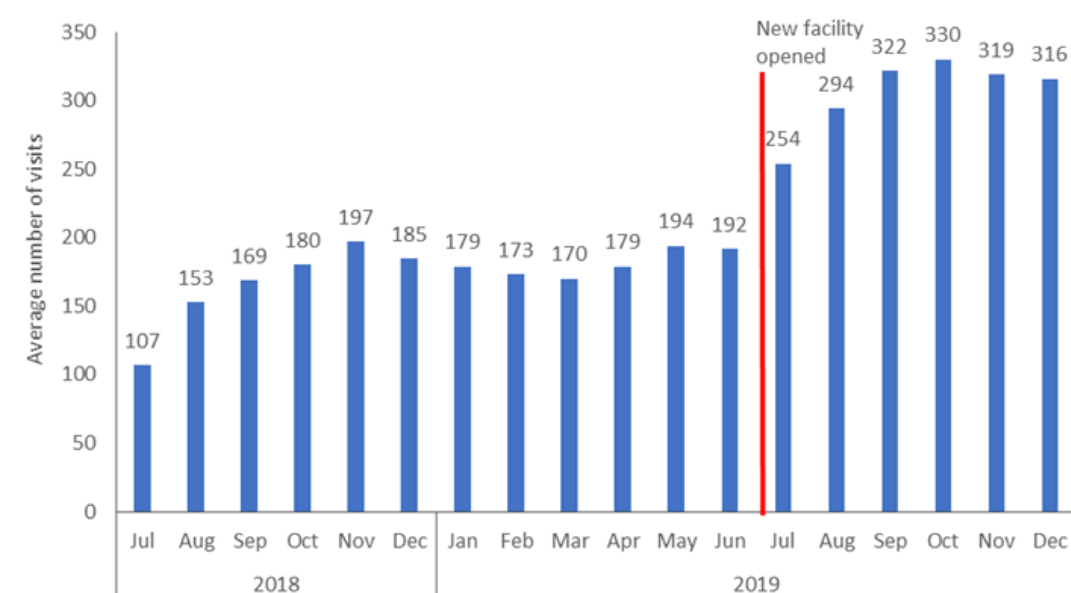
Figure 11: Number of visits that included a supervised injection from Quarter 1, 2018–19 to Quarter 2, 2019–20



Source: MSIR database

The average number of daily visits to the facility gradually increased over the first five months of operation and then remained relatively stable (at around capacity) through the first half of 2019. The opening of the new facility in July coincided with a marked increase in daily visits, consistent with the increased capacity through additional booths and longer opening hours (Figure 12).

Figure 12: Average number of daily visits to the MSIR by month, July 2018 to December 2019



Source: MSIR database

Substances injected at the MSIR

All injectable substances are permitted at the MSIR and there is no testing of the substances that service users bring to inject. Service users must inform the staff about what substance they plan to inject each time (with research indicating that most people who inject drugs are able to accurately identify the main substance in their drugs). As shown in Table 4, the primary drug injected has been heroin (96.6 per cent), whether alone or in combination with diphenhydramine.

Table 4: Substances injected at the MSIR, June 2018 to December 2019

Drug	Percentage of all injections
Heroin	80.8
Heroin plus diphenhydramine	15.8
Methamphetamine	2.5
Mixed sedative and stimulant combination	0.5
Other sedative combination	0.3
Prescription opioid	< 0.1
Other drug	< 0.1
Other stimulant combination	< 0.1
All other drugs/combinations of drugs	0.01

Source: MSIR database

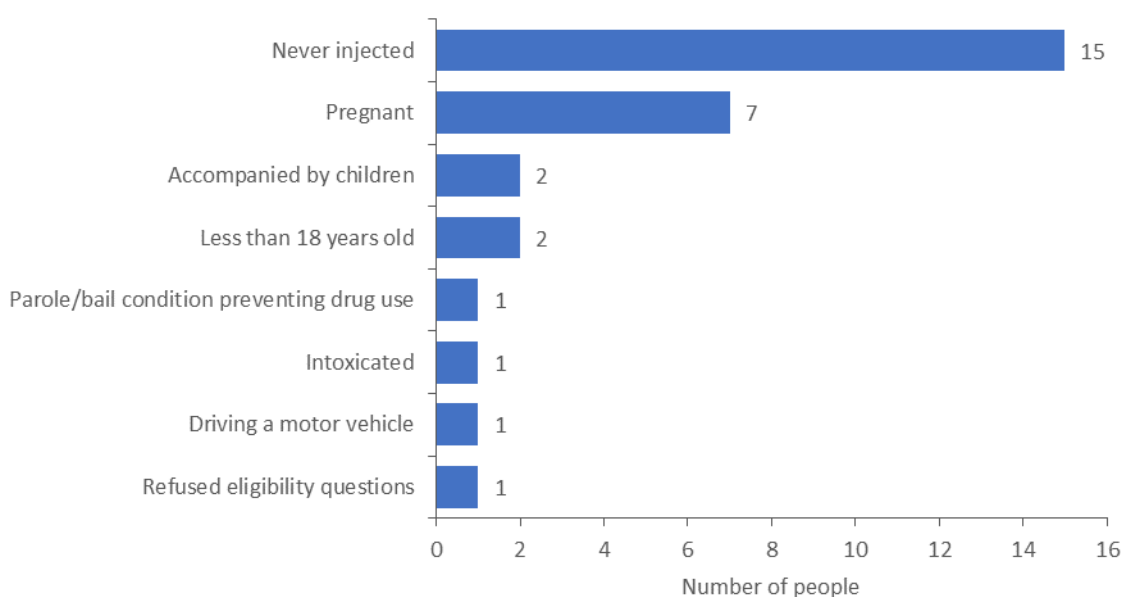
Refusals

There are a number of reasons why some people are not able to access all MSIR services and, in particular, the injecting booths. Some of these are noted in the legislation used to set up the MSIR trial, some in the regulations, and some relate to government or service policy. These various reasons for refusal include:

- people on bail/parole conditions – noting that people leaving custodial settings can be at increased risk of overdose due to decreased tolerance to substances
- pregnant women and people with accompanying children – noting that pregnant women who inject drugs and their children, including unborn children, can benefit when supported by healthcare and other service providers
- young people – noting many people who use the MSIR first injected at a relatively young age
- people who cannot inject themselves – noting this can be a barrier to access for people who do not inject themselves in other settings
- people who typically purchase drugs together – noting that people are unable to share drugs in the service
- people who typically use drugs together – people are unable to attend in groups, and there are no more than two seats in any one booth
- people who use drugs of dependence through routes of administration other than injecting.

From 30 June 2018 to 31 December 2019, 30 people were refused entry to the MSIR (Figure 13). Half involved people who have never injected. Pregnancy was the second most cited ground for refusal. These figures do not capture self-exclusion, either by people leaving before registering, or opting not to attend knowing that they would be refused (several stakeholders and service users reported that the exclusion criteria quickly became known and deterred these people from attempting to use the service).

Figure 13: Number of occasions of refused entry to the MSIR by reason, 30 June 2018 to 31 December 2019



Source: MSIR database

Referrals for people ineligible to attend

MSIR staff offer support to those who are ineligible to access to the MSIR, with a view to assessing their needs and appropriately attempting to refer them to an alternative health or social support service. The facility refers pregnant people to the Women's Alcohol and Drug Service. Referrals are offered to any presenting young person under the age of 18 years to youth services including the Youth Support and Advocacy Service. When people who have never injected present to the MSIR, staff engage them in a discussion about the risks of transitioning from other ways of using drugs and refer them to appropriate treatment. Occasionally, a client may present to the MSIR accompanied by a minor. In such cases, staff would undertake a risk assessment and, where necessary, provide a report to Child Protection.

Other barriers to access

The Panel also became aware of situations where individuals elected not to use the MSIR. These included:

- having a preferred location to inject elsewhere, either in a less clinical private setting or with a preference for injecting outside

- being deterred by a real or perceived waiting time at the MSIR
- being or accompanying someone who had been sanctioned
- wishing to avoid other service users or staff
- concerns about surveillance and police presence.

People who inject at the MSIR

Data provided by the MSIR indicates that, on average, facility service users during the trial were 41 years of age. Three-quarters of the service users were male. A third (34.7 per cent) of service users were homeless or in insecure accommodation.¹⁰ Approximately a quarter (23.3 per cent) of the service users were released from prison or juvenile detention in the preceding three months. Thirteen per cent of service users identified as Aboriginal (see Table C1 at Appendix C).

Most service users had been injecting for a significant period (92 per cent had been injecting for more than five years, and 61 per cent reported injecting for at least 20 years). Advice from the MSIR is that the most common age of initiation of injecting drug use was 16 years old.

People who inject drugs and do not inject at the facility

To understand the client profile, it is also useful to understand who does not use the facility. The data from the Burnet Institute's SuperMIX study show that, of those surveyed ($n = 598$), those who visited the MSIR were more socially marginalised than those who did not visit the MSIR. That is, they were more likely to:

- be unemployed
- live in unstable accommodation
- be homeless
- live by themselves
- have been incarcerated in the previous 12 months.

SuperMIX data show that people who had visited the MSIR were statistically significantly more likely to have been arrested (for any reason) since their previous interview compared with those who had not visited the facility (65 per cent versus 41 per cent, respectively). Those who visited the MSIR were also more likely to identify as Aboriginal, more likely to state heroin as their main drug of choice and to have injected heroin in the last month (Burnet Institute 2019, p. 7). See Table C2 at Appendix C.

This SuperMIX data indicates that many MSIR users have multiple and complex needs.

¹⁰ Homeless and insecure accommodation is defined here as people experiencing primary homelessness (for example, sleeping rough or in improvised dwellings); secondary homelessness (for example, refuges, couch surfing, squat); or tertiary homelessness (for example, boarding house/hostel). This definition of homelessness <<https://www.homelessnessaustralia.org.au/about/what-homelessness>> is widely used in the homelessness sector.

Advancement of the objects of the legislation

Each of the objects of the Drugs, Poisons and Controlled Substances Amendment (Medically Supervised Injecting Centre) Act are addressed in this section.

Part 55A(a): Reduce the number of avoidable deaths and the harm caused by overdoses

To assess this object, the Panel considered:

- Coroner's Court of Victoria data on fatalities involving heroin
- MSIR data on the volume and nature of overdose interventions provided
- staff and service user consultation
- consultations with emergency department doctors and administrators.

The finding of this review is that the trial has advanced this object. MSIR staff have reduced avoidable deaths and harms associated with overdose of drugs of dependence among people injecting within the service.

- Establishing the MSIR has prevented overdoses and further harm and has saved lives.
- Of those who do attend the service, the nature of the overdoses is significant, and without intervention it is likely that many would have died or been permanently injured.
- While it is not possible to say with certainty how many people would have died without the MSIR, international approaches to modelling, based on conservative estimates, indicates that 21–27 deaths were avoided in the first 18 months of the trial. This does not include the prevention of permanent disability such as acquired brain injury.

The MSIR attracts people who are at high risk of overdose, with many reporting previous experiences of overdose. This is recognised as one of the strongest predictors of a subsequent fatal opioid overdose.

- Just over 2 per cent of the visits to the MSIR involved an overdose requiring intervention.
- The MSIR has supervised 116,802 injections.
- Of the 2,657 overdoses, the MSIR responded to 271 extremely serious overdoses with naloxone.
- Of the 2,657 overdoses, the MSIR responded to 2,615 overdoses with oxygen and other measures to keep the airways open, potentially saving additional lives and avoiding harms associated with lack of oxygen to the brain.
- There have been no fatalities from overdoses in the facility.
- All staff and service users interviewed provided examples where they believed the facility had saved lives.

- The early focus of the MSIR was appropriately on the facility's readiness and capacity to oversee the service within the injecting room itself. Protocols, guidelines and staff selection focused on overseeing injecting and preventing overdose and harm.

A detailed analysis of the first 12 months' instances of overdose within the injecting room showed that the overdoses ranged from less severe (reduced respiratory rate and reduced conscious state), which require oxygen and physical manoeuvres to keep the airway open, to severe overdoses with profound unconsciousness (21.1 per cent), with no breathing at all over five minutes (13.5 per cent), that are life threatening and could result in death and required either assisted ventilation with a bag valve mask (13.8 per cent) and/or naloxone (14.2 per cent). An experienced doctor who worked as a volunteer in the facility commented that some of the overdoses were 'at least as acute an emergency as those we receive in an [emergency department]'.

The facility has the appropriate equipment to respond to the medical emergencies that arise as a result of drug use, including administration of necessary responses to administer a response to avoid death or further harm. The MSIR staff are well trained and clearly demonstrate capacity to respond, manage and administer the required intervention. Almost all of the overdose incidents (99 per cent) are managed by the MSIR's harm reduction and nursing staff, and the level of staffing is sufficient to provide timely responses.

The facility was designed to provide medical supervision to service users while they self-administer injectable substances intravenously. Service users are monitored while in the injecting area and elsewhere in the facility for signs of overdose. The legislation states that the facility aims 'to reduce the number of avoidable deaths and the harm caused by overdoses of drugs of dependence' (Part 55A(a) of the Act). The review initially considered evidence that:

- people who inject drugs are attending and injecting at the facility
- those using the facility are injecting under medical supervision
- overdoses are being identified and responded to according to protocols
- staff are engaging service users regarding their needs
- critical incidents are being responded to according to protocols.

As the trial progressed, the review analysed evidence to understand the extent to which:

- people who inject drugs are using the facility in preference to injecting in higher risk settings
- staff can safely and effectively deliver the required services.

Overdoses cause significant harm, even if they are not fatal

A person's overdose risk increases with every overdose they experience (Olfson et al. 2018). Previous experience of overdose is one of the strongest predictors of subsequent fatal opioid overdose (Stoove et al. 2009). Non-fatal opioid overdose victims who experience multiple/recurring opioid overdose are at greater risk for long-term physical and cognitive consequences (Zibbell et al. 2019).

Non-fatal opioid overdoses are associated with a wide range of acute and chronic medical complications (Zibbell et al. 2019). These include aspiration pneumonia, pulmonary oedema, bronchopneumonia, muscle tissue breakdown, hypoxic brain injury, peripheral neuropathy, renal failure, cognitive impairment and traumatic injuries sustained during overdose. One study found

that more than three-quarters of overdose victims report at least one post-overdose morbidity symptom, including pneumonia, palsy, seizure or pulmonary oedema (Warner-Smith et al. 2002).

The facility is attracting people at risk of overdose

On registration, MSIR service users report significant experience of overdose:

- 56 per cent of service users report having experienced an overdose, either on heroin or other opioids
- 49 per cent have witnessed someone else overdose.

The Burnet Institute's (2019) SuperMIX study also found that people who previously injected in high-risk settings are about twice as likely to visit the MSIR than those who did not previously inject in high-risk settings (Table C3, Appendix C). Of the study participants who reported visiting the centre, a third performed at least half of their previous month's injections in the facility (Table C4, Appendix C).

People are injecting at the facility and under medical supervision

People who inject drugs are using the facility and injecting drugs on site under medical supervision. Under the MSIR *Internal management protocols* (DHHS 2019b), service users receive appropriate interventions according to the clinical management protocols including:

- observation, including monitoring of blood oxygen saturation with pulse oximeters
- prompting to breathe
- oxygen
- manoeuvres to open the airway
- assisted ventilation with a bag, valve and mask
- naloxone where required
- advice from the medical supervisor as required
- ambulance as required.

Naloxone can be administered according to best practice

Naloxone is a medication that can be used to reverse the experience of an overdose. Naloxone is an extremely safe medication but can precipitate opioid withdrawal symptoms, including agitation or irritability, anxiety, body aches, nausea/vomiting, diarrhoea and sweating, particularly if too high a dose is administered. More severe reactions are rare but may include acute respiratory distress syndrome, hypertensive emergency, ventricular tachycardia, fibrillation and, in extremely rare circumstances, sudden death (European Monitoring Centre for Drugs and Drug Addiction 2015).

The facility's approach is to attempt to rouse a person first by talking or lightly touching them, then provide oxygen, and only if they are not responding, then provide naloxone. This allows the dose to be sufficient to achieve respiratory function without precipitating withdrawal symptoms. This is consistent with international standards (European Monitoring Centre for Drugs and Drug Addiction 2015).

The MSIR's ability to use non-pharmaceutical responses initially and then low doses is due to the capacity of the service and the skills of the staff to monitor service users, similar to a hospital setting (Lynn & Galinkin 2018).

All staff are trained to identify and respond to overdose incidents. Any staff member can provide oxygen, although in practice it is typically provided by a registered nurse. In the event naloxone is required, a registered nurse administers it. If there are complications, the on-call medical supervisor

is contacted for advice or, if clinically appropriate, MSIR staff will call for an ambulance. It is, in essence, a nurse-led model of care.

Under current protocols, providing naloxone is not within the scope of practice of harm reduction practitioners while working inside the MSIR, although they, as any other community member, are able to administer it when not at work. Some staff would prefer that harm reduction practitioners, as well as the nursing and medical staff, had the authorisation to provide naloxone.

People who have overdosed elsewhere or who are heavily sedated can also be safely observed at the MSIR, providing an opportunity for staff to intervene at an important time and potentially reducing the risk of a subsequent unsupervised overdose.

Ambulance Victoria has sought the support of the facility to manage people who are found to be overdosed or heavily sedated in the community who would benefit from ongoing monitoring (as an alternative to being taken to an emergency department or in the absence of being able to go to family or friends). In addition, staff report that several people have asked to be brought to the facility, where they can be looked after in the consulting space. This is seen as a positive option since the facility is perceived by service users as more supportive and less stigmatising than their experience of emergency departments. It also addresses any risk of a person going into acute withdrawal, which can occur if a higher dose of naloxone is used in community settings. This can lead to the person subsequently using again to achieve the desired state, with a risk of further overdose. This also allows an opportunity to engage with these people, even if they are not existing MSIR service users, noting that anecdotally the period immediately after an overdose can be a valuable chance to discuss harm reduction practices and treatment options.

People are becoming more aware of signs and responses to overdose and increasingly educated in how to respond

Through witnessing or experiencing an overdose in the facility, some service users reported that this had improved their recognition of signs of overdose. The Burnet Institute (2019) study found that MSIR service users were statistically significantly more likely to report a non-fatal overdose since the facility opened than other people who inject drugs (Table C5, Appendix C). The Panel recognises that there could be other interpretations of these data.

Facility data also show that the MSIR trained 193 service users during the trial period (78 in the last quarter) in how to identify and respond to overdoses in the community using naloxone and invited the AOD team to train many additional clients. Depending on the availability of medical staff, clients were either provided with naloxone on the spot or given a voucher to pick it up from a local pharmacy.

Case study 1: Overdose prevention and response training after prison

A client received overdose first response training with naloxone when their partner, another client of the MSIR, was released from prison. Their insight regarding their partner's high risk of overdose after release was terrific to see. 'I know they could drop ... it's best to be safe,' they said. They planned to keep the naloxone kit with them because, as a couple, they were likely to use while out and about. The couple were encouraged to continue accessing the MSIR, and the partner was provided with harm reduction education on using smaller amounts of heroin while tolerance was low.

Case study provided by the MSIR

Naloxone training has been more broadly promoted through other DHHS programs including by the NRCH AOD program. On registration at the MSIR, 220 people reported that they had previously received this training through another program. More than a third of all MSIR service users (34.4 per cent) would like training for overdose response. Given the effectiveness of naloxone in reversing opioid overdoses (European Monitoring Centre for Drugs and Drug Addiction 2015), this could usefully be expanded.

People who work at and use the service believe it has saved lives

All staff members and people who inject drugs interviewed by the Panel reported that they think the service saves lives. Service users frequently provided examples where they feel it had directly saved their own life or that of someone they witnessed overdosing.

Case study 2: Experience of being revived from overdose

One client interviewed for the review described their experience of having an overdose at the MSIR, stating: 'Why use somewhere where you could die when you can use somewhere and know that you're going to be safe? They're absolutely excellent. They do not muck around over there. As soon as you show signs of an OD, bang they're on you. They're on you and make sure you're healthy and happy and safe. They put a mask on you. I might have spent 10 minutes in there before with a mask on me because they said that I might be affected by drugs. I thought, that's beautiful, you know, in the harsh morning here they are still looking after people.'

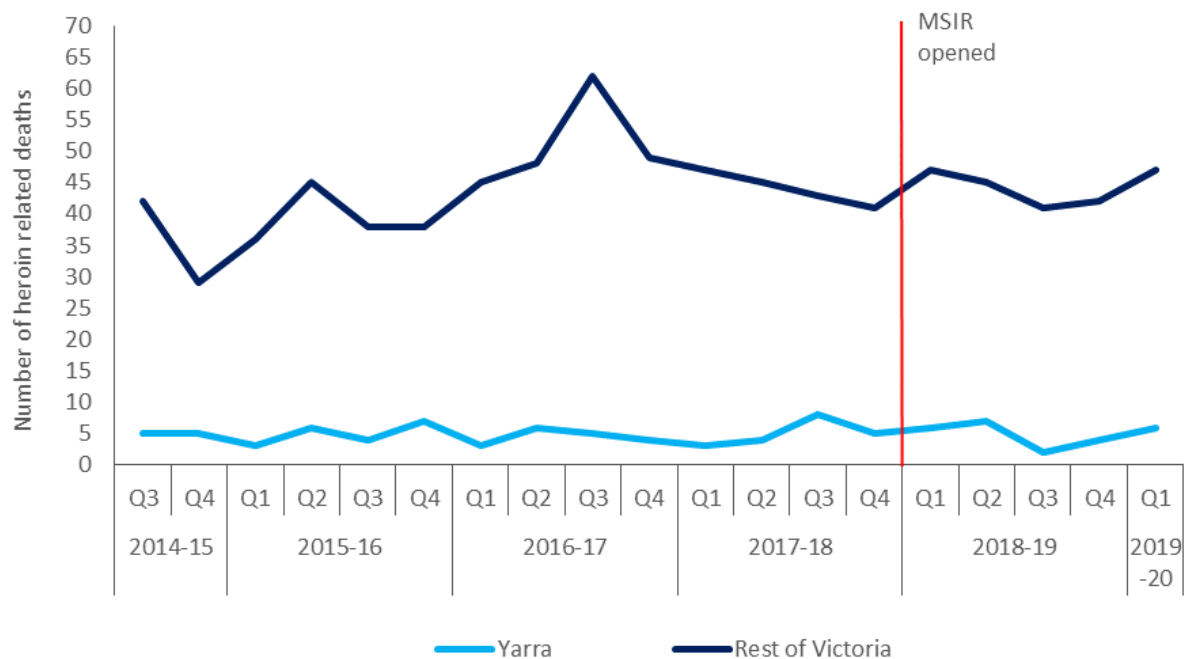
Service user interview, June 2019

Impact on drug-related deaths

To understand the impact of the facility in its geography, coronial data were analysed to examine any changes in the number of deaths in the area immediately surrounding the site. Over a four-year period, the numbers of heroin-related deaths in the Yarra LGA and the rest of Victoria have been relatively stable (Figure 14). The Panel notes that numbers of heroin-related deaths in the City of Yarra in these Coroners Court figures are comparatively small and they are presented here for accurate reporting but do not provide sufficient data for more detailed analysis or commentary at this time.¹¹

¹¹ Please note that data from the Coroners Court of Victoria has been verified at the time of finalising this report. The contents of coronial databases are continually revised and updated as coroners' investigations progress and new information becomes available regarding deaths. In this process, recoding and reclassification of deaths may occur. Consequently, data extracts done at different times may report different results.

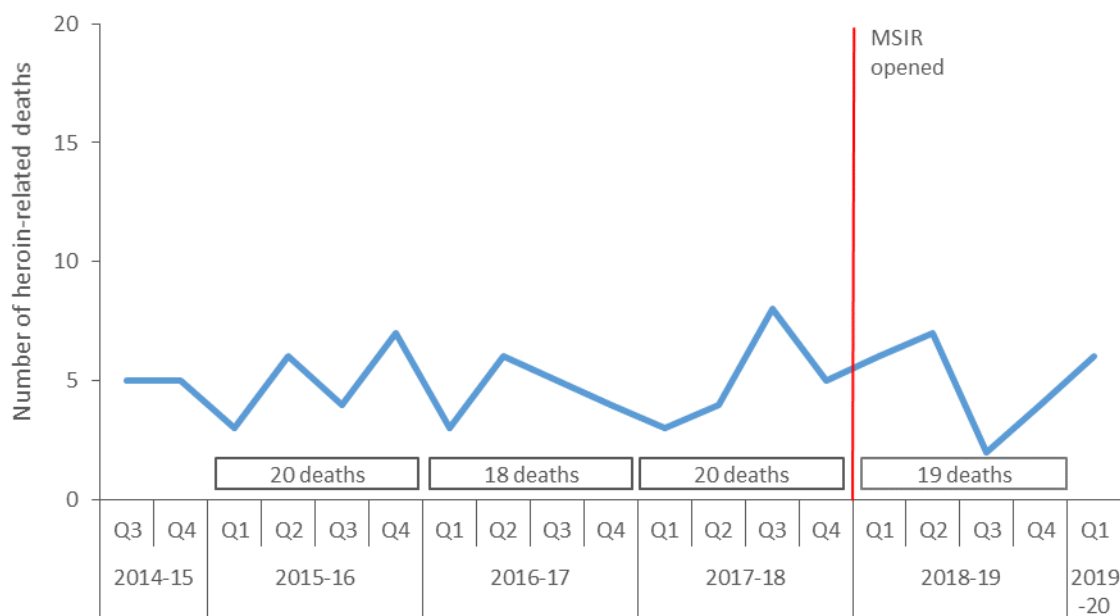
Figure 14: Number of heroin-related deaths in Yarra LGA and the rest of Victoria, Quarter 3, 2014–15 to Quarter 1, 2019–20



Source: Coroners Court of Victoria

Variations in the number of heroin-related deaths in the Yarra LGA across financial year quarters are shown in Figure 15. To robustly establish whether there was a difference in the overdose death trend before and after the intervention, the Panel considered using statistical tests. However, the low frequency of heroin-related overdose deaths in Yarra LGA and the short time period under examination (3.5 years before the intervention, 1.25 years following the intervention) significantly limit the applicability of statistical techniques.

Figure 15: Number of heroin-related deaths in Yarra LGA, Quarter 3, 2014–15 to Quarter 1, 2019–20, quarterly and financial year

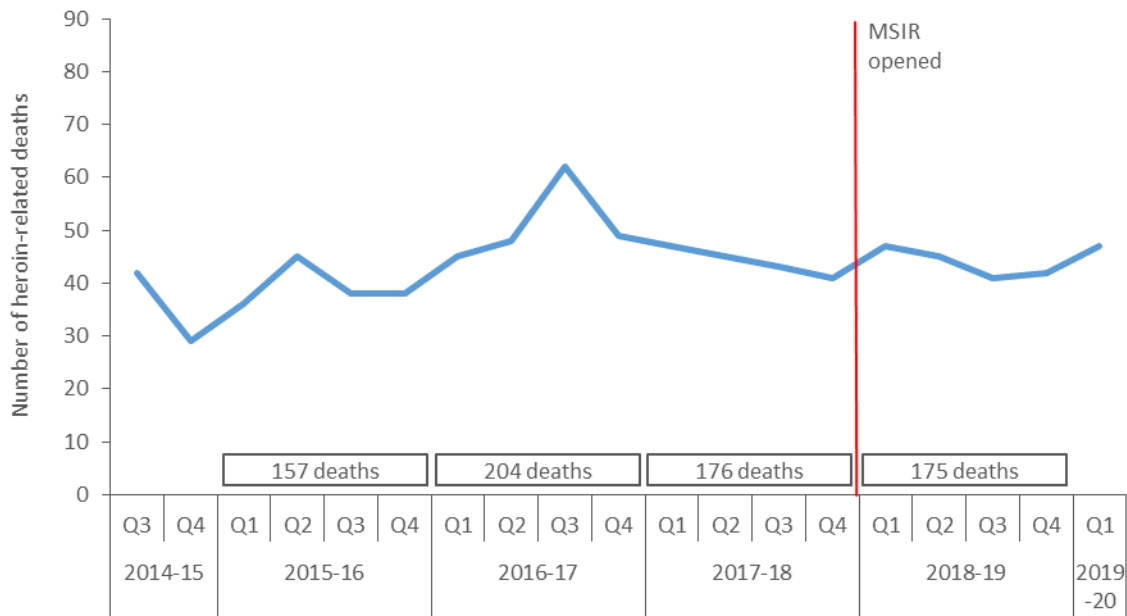


Source: Coroners Court of Victoria

It should be noted that Figure 15 only relates to deaths within the Yarra LGA and does not include those deaths that occurred beyond the Yarra LGA that were linked to heroin purchased within the Yarra LGA. In the Inquest into the death of Ms A (Coroners Court of Victoria 2017), the Coroners Prevention Unit reported that, in 2015, in addition to 20 overdoses that occurred in Yarra, in a further 15 overdose deaths that occurred in other LGAs, there was evidence that the heroin was sourced in the Yarra LGA (a total of 35). This is likely to be conservative as in many overdose cases there is no clear evidence of where the drugs were purchased.

For comparison, Figure 16 shows variations in the number of heroin-related deaths in the rest of Victoria across financial year quarters.

Figure 16: Number of heroin-related deaths in rest of Victoria, Quarter 3, 2014–15 to Quarter 1, 2019–20 – quarterly and financial year



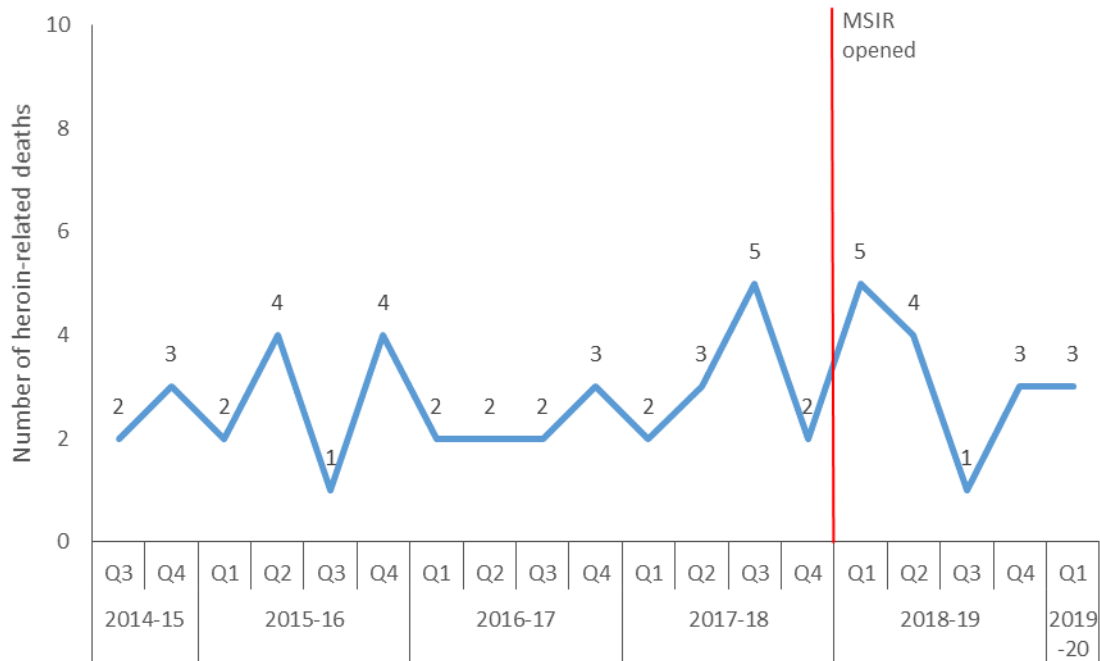
Source: Coroners Court of Victoria¹²

More than half (57 per cent) of heroin-related deaths in Yarra occurred within 1 km of the MSIR. Of the deaths that occurred within 1 km of the MSIR, three-quarters (75 per cent) happened in a non-residential location.

The number of heroin-related deaths within 1 km of the MSIR declined six months after the MSIR opened (Quarter 3, 2018–19) and then increased again in the next quarter (Quarter 4, 2018–19; see Figure 17). This pattern was also evident for heroin-related deaths that occurred in non-residential locations within 1 km of the MSIR (Figure 18).

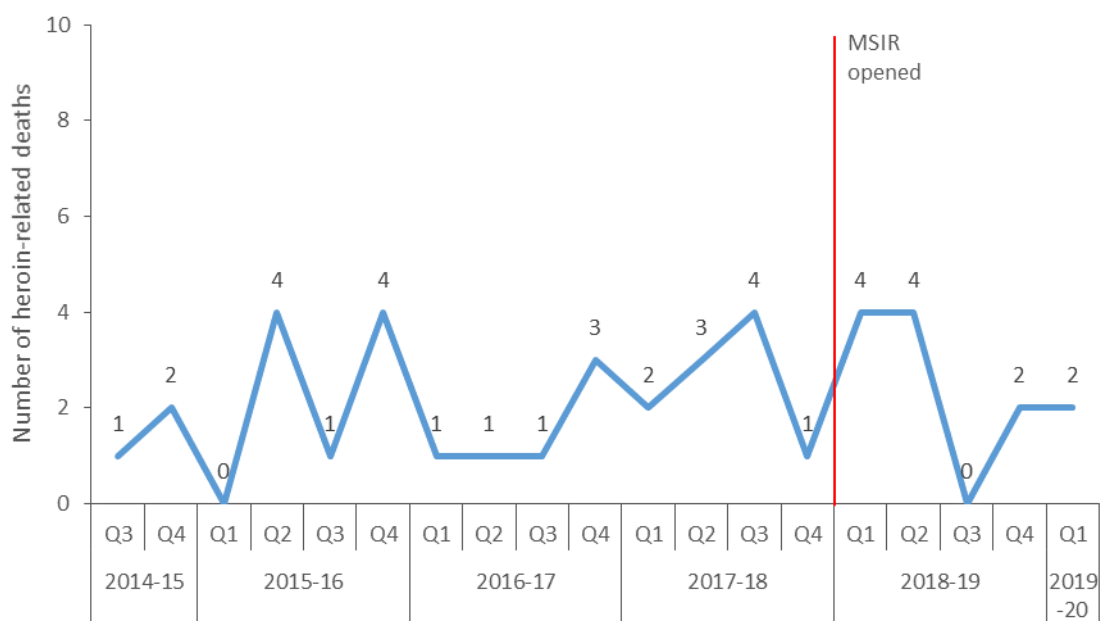
¹² The contents of Coronal databases are continually revised and updated as coroners' investigations progress and new information becomes available regarding deaths. In this process, recoding and reclassification of deaths may occur. Consequently, data extracts done at different times may report different results.

Figure 17: Number of heroin-related deaths within 1 km of the MSIR, Quarter 3, 2014–15 to Quarter 1, 2019–20



Source: Coroners Court of Victoria

Figure 18: Number of heroin-related deaths in non-residential locations within 1 km of the MSIR, Quarter 3, 2014–15 to Quarter 1, 2019–20



Source: Coroners Court of Victoria

Among the top 20 LGAs for heroin-related deaths, the proportion of deaths occurring in non-residential locations varies (Table 5). Between January 2015 and September 2019, Yarra recorded

the highest proportion of heroin-related deaths in non-residential locations (55 per cent), and Melbourne recorded the second highest (49 per cent). For the other LGAs, two to 30 per cent of heroin-related deaths occurred in non-residential locations.

Table 5: Percentage of deaths occurring in non-residential locations – top 20 LGAs for heroin-related deaths between January 2015 and September 2019

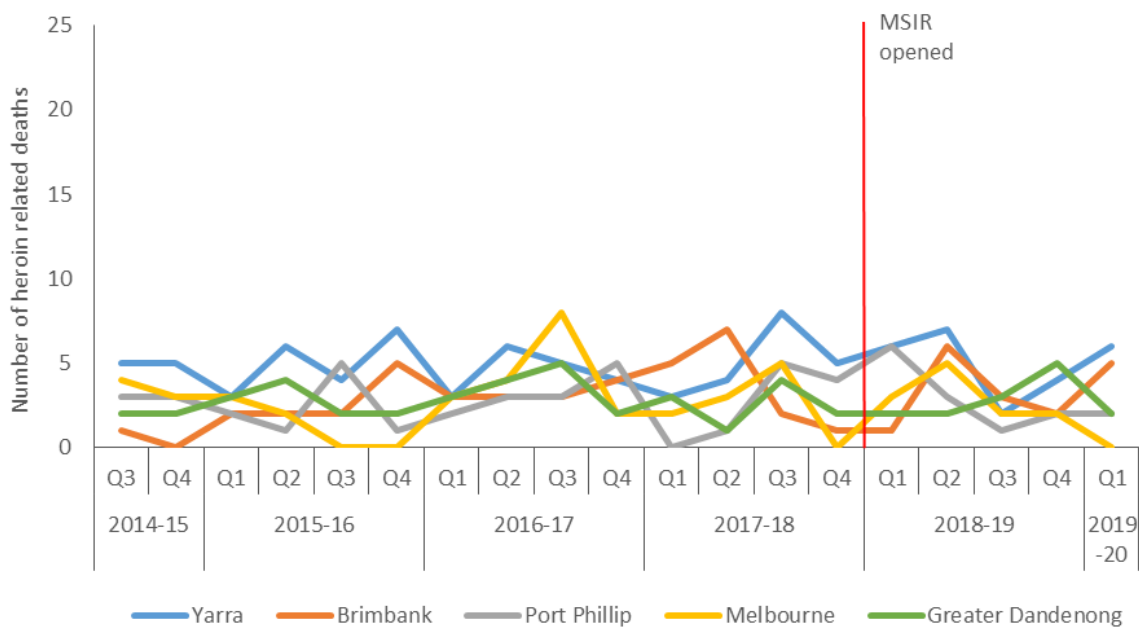
Local government area	Number of heroin-related deaths in non-residential locations	Percentage of heroin-related deaths in non-residential locations	Total heroin-related deaths
Yarra	51	55	93
Melbourne	25	49	51
Brimbank	17	30	57
Port Phillip	10	19	52
Greater Geelong	8	20	40
Frankston	6	20	30
Wyndham	6	26	23
Greater Dandenong	6	11	53
Maribyrnong	5	16	32
Whitehorse	4	16	25
Maroondah	4	21	19
Stonnington	3	17	18
Hume	3	17	18
Yarra Ranges	2	9	22
Moonee Valley	2	11	18
Monash	1	5	22
Greater Bendigo	1	6	18
Boroondara	1	6	18
Moreland	1	3	30
Knox	1	3	29
Darebin	1	2	41

Source: Coroners Court of Victoria

While the top five LGAs for heroin-related deaths all recorded decreases in the number of heroin-related deaths after the MSIR opened, there were no obvious trends observed, with all five LGAs

recording fluctuations in the number of deaths. The numbers of deaths recorded since the MSIR opened were largely similar to those recorded before the MSIR opened (Figure 19).

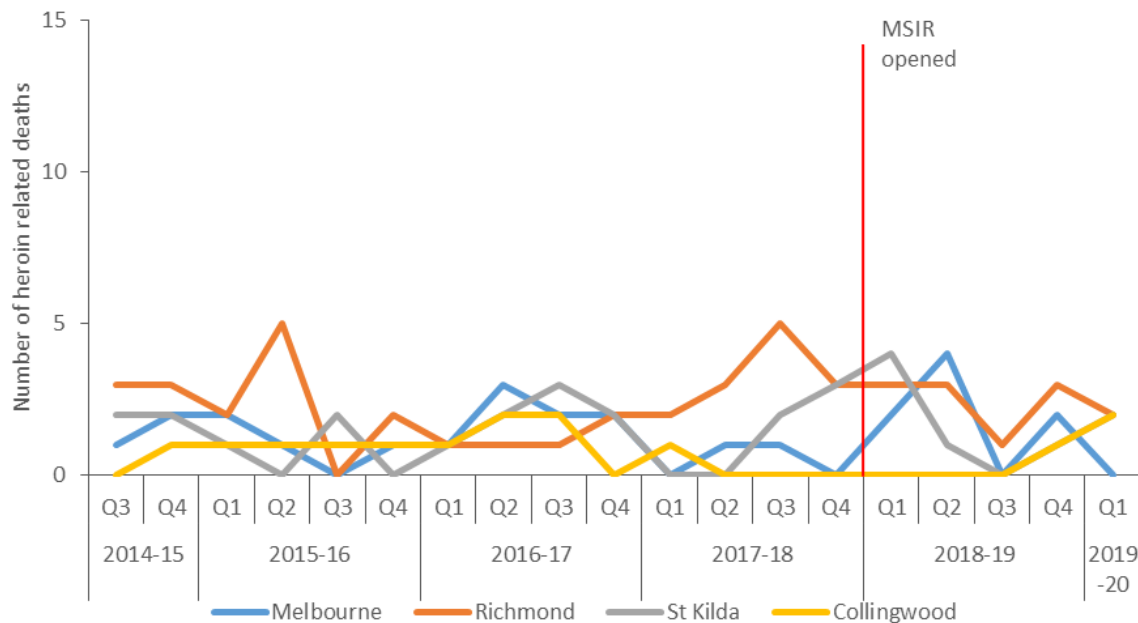
Figure 19: Number of heroin-related deaths in selected LGAs, Quarter 3, 2014–15 to Quarter 1, 2019–20



Source: Coroners Court of Victoria

Of the top four suburbs MSIR service users reported as their location of residences at registration, three – Melbourne, Richmond and St Kilda – recorded decreases in the number of heroin-related deaths three to six months after the MSIR opened (Figure 20). Overall, there were no obvious trends observed, with the numbers of deaths recorded since the MSIR opened largely similar to those recorded before the MSIR opened.

Figure 20: Number of heroin-related deaths in selected suburbs, Quarter 3, 2014–15 to Quarter 1, 2019–20 – top suburbs MSIR users report at registration



Source: Coroners Court of Victoria

Part 55A(b): Deliver more effective health services by providing a gateway to health and social assistance

To assess this object, the Panel considered:

- MSIR data on health needs and services provided
- emergency department and hospital data
- results of a cohort study of people who use drugs linked with Victorian and national health datasets
- consultations with professional stakeholders, staff and service users.

The finding of this review is that the trial has advanced the object of providing a gateway to health and social assistance but in the first year of operation has not demonstrated higher levels of service take-up for MSIR users as compared with other people who use drugs.

Having noted that the MSIR is attracting people with particularly high health and support needs, it is a potential site for proactive engagement and providing supplementary services.

- The MSIR provided 10,540 services beyond the supervision of injecting during the trial period. Most commonly this was health promotion, dressing wounds, providing medication and first aid but also included providing specialist services such as hepatitis treatment, oral health services and opioid substitution treatment.
- MSIR users are considerably less likely than other people who use drugs to be on opioid substitution treatment at registration, and many request access to this.

- NRCH and staff of the MSIR have made significant progress in delivering additional services and developing referral pathways to other service providers.
- With the move to the larger facility the range and number of services is expanding.
- An ongoing trial would provide the opportunity to develop and assess ongoing integration of services and possible different ways of achieving this.

The legislation provides for integrated services, expecting that this would be a more effective way of attending to the perceived needs of people who inject drugs. Many community services struggle to engage people who inject drugs, and the MSIR offers an opportunity to trial doing this differently.

Not all people who inject drugs seek or want other services, and not all take up services when they are offered. Some are clear that they attend the MSIR only to use their drugs in a safer place and then leave. Some prefer to access more extensive services elsewhere.

NRCH and MSIR staff have made significant progress in delivering additional services and developing referral pathways to other service providers, with expanding service offerings. The potential benefits of these services have not yet been fully realised. Take-up is still growing, and the full complement of services was still being implemented when data collection for the review ended. It is too early to assess the pros and cons of alternative models of providing integrated care, including whether there are advantages of co-location within the MSIR. The work of the Gateway Services Group is promising.

Findings indicate that progress is being made on connecting people who attend the MSIR with additional services.

The model of care could be further considered to examine options regarding matters such as staffing, optimum opening hours and the ways of providing additional services, recognising that many of the service users require navigation support to connect to systems of care.

The MSIR was designed to provide health and other services through internal and external referrals. Specifically, the legislation states that the facility is to contribute to advancing the objective to 'deliver more effective health services for service users of the licensed medically supervised injecting centre by providing a gateway to health and social assistance which includes drug treatment, rehabilitation support, healthcare, mental health treatment and support and counselling' (Part 55A(b) of the Act).

The review examined evidence to consider whether:

- staff were able to engage with service users regarding their health and social assistance needs
- referrals were being made to internal and external services.

As the trial progressed, the review analysed evidence to understand the extent to which:

- service users increasingly respond to staff efforts to engage and accept offers of referral
- improvements to the referral procedures and service pathways, as well as service user engagement, intended to lead to increased use of support services as a platform to more effective health service delivery.

This chapter also provides findings from the Burnet Institute's SuperMIX cohort study on the impact the facility has had on health service utilisation for the people who participated in that study.

Service users have very high support needs

People who use drugs, especially those who inject their drugs, are at higher risk of dying from both acute and chronic diseases than people who do not use drugs (Mathers et al. 2013). They are also at risk of a range of mental health disorders and mental illnesses including anxiety disorders, mood disorders and personality disorders. Many people who inject drugs have a history of trauma and abuse, often in the context of family or other domestic relationships. As shown in Table 6, at registration, more than half of MSIR service users reported they were currently taking prescribed medication and nearly a third had been hospitalised in the six months before registration. People who use a supervised injecting service are also more likely to have experienced adverse life events and have a greater risk of mental illness and mental disorder (European Monitoring Centre for Drugs and Drug Addiction 2015).

Table 6: Prior health service utilisation by MSIR service users at initial registration, data collection period 30 June 2018 to 31 December 2019

Reported healthcare utilisation ^(a)	Percentage ^(b)
History of medication for mental health	57.9
Currently taking prescribed medication	55.3
Currently receiving treatment for a drug-use disorder	41.5
Hospitalised in last six months	31.2
Ambulance transport in last 12 months	28.1
Ever hospitalised for mental health	27.7

Source: MSIR database

(a) Service users self-reported health service utilisation at registration as provided in the NRCH MSIR October to December 2019 report. At registration, new MSIR service users are asked questions about their health service utilisation, prescribed medication use and current drug treatment status (such as pharmacotherapy, withdrawal, residential rehabilitation, counselling and self-help groups). Completion of the survey is voluntary.

(b) As a percentage of total registered service users who completed the survey during the period from October to 31 December 2019.

Service needs and priorities of service users are commonly directly related to injecting drug use

There are several mechanisms in place to identify the health and social assistance needs of service users including data collected at their first visit. During the trial period, 77 per cent of service users indicated at least one specific healthcare need, most commonly related to drug dependence, anxiety/depression, hepatitis C or lung problems including asthma. As shown in Table 7, areas of treatment interest captured at registration commonly related to hepatitis, drug treatment and mental health.

Table 7: Areas of treatment interest at registration, 30 June 2018 to 31 December 2019

Areas of treatment interest ^(a)	Percentage ^(b)
Hepatitis testing and/or treatment at MSIR	31.6
Drug treatment	21.8
Referral to a mental health service/professional	11.3

Source: MSIR database

(a) Service users self-reported treatment demand at registration (total from 1 June to end December 2019) as provided in the NRCH MSIR quarterly reports. At registration, new MSIR service users are asked questions about their health service utilisation, prescribed medication use and current drug treatment status (such as pharmacotherapy, withdrawal, residential rehabilitation, counselling and self-help groups). Completion of the survey is voluntary.

(b) As a percentage of registered service users who completed the survey during the period from 30 June 2018 to 31 December 2019.

The combined workforce of registered nursing staff and harm reduction practitioners appears to provide a sound basis for effectively engaging with service users. Staff report being able to engage with service users regarding their health and social assistance needs, noting the need to build trust over time in the light of service users' previous negative experiences with authority, including health providers. This means the proportion of people who take up offered support on each visit is relatively low, but because the number of people who use the service is high, the services offered have high rates of utilisation. This aspect of the MSIR is still evolving and its full potential in providing access to treatment and support for a range of physical and mental health needs is still not realised.

Staff reported that, as a team, they had the skills to engage and directly provide services to service users and had clear roles and protocols to undertake their work in engaging with service users. They were able to identify which of their colleagues had particular skills and networks to meet various needs and to identify whether and when it was more appropriate for the conversation to be with a harm reduction practitioner or nurse. The move into the larger facility has provided more physical space for staff to engage with service users. Posters and a range of health promotion materials about local services targeted at this group of service users are displayed throughout the MSIR.

Based on experience over the trial period and findings from other settings, it is likely that, for many of the people who use the MSIR, providing on-the-spot treatment is the most effective way of providing supplementary services including vaccinations, naloxone training and provision, infectious disease screening, assessment and treatment and initiation of drug dependence treatment. However, not all these services are available at all times the MSIR is open. In addition, given the priority is to keep people safe when injecting, responding to overdose can mean there is not always capacity for staff to engage sufficiently with all service users to facilitate referral to additional services.

The below case study provides an example of service user experiences accessing drug treatment and mainstream health services.

Case study 3: Access to drug treatment services

A client overdosed at the MSIR after having recently left a private rehabilitation facility before the end of their planned treatment. After this event, the client sought support from the MSIR to access drug treatment. Over the next few months the client and their family were supported by the MSIR and ReGen staff in relation to both drug treatment and mental health services. The client ultimately accessed public drug treatment services.

Case study provided by the MSIR

This example demonstrates the value of immediate and assertive referral to engage service users, especially when it requires access to services that are located elsewhere, have waiting lists or need further assessment of needs and wishes. Noting that people who inject drugs have traditionally been hard to engage and provide services to, whether it is a service that is not readily available at the time or in the MSIR, providing service navigators or care coordinators who can follow through with referrals is a valuable approach.

In addition to health needs, MSIR service users have indicated a need for legal advice. Some of these might be directly or indirectly related to crime associated with drug use, but it also includes a need for assistance with rental disputes and other civil matters.

People who are on relevant bail, parole or other orders are excluded from the MSIR because, unlike other clients, they are not exempt from criminal liability under s. 55K of the Act. This can be a significant impediment to responding to people who continue to inject drugs. Some community members and other service providers have noted that at least some of the people who continue to inject in public places in the vicinity of the MSIR do so because of this exclusion. (See also the 'Regulations' section of this report.)

Those who had visited and could access the MSIR were more likely to report committing a property crime in the preceding month (27 per cent) than those who had not visited the MSIR (18 per cent) (Burnet Institute 2019, p. 48), although there was no difference found between people who visited and did not visit the MSIR for reported drug dealing or being arrested for dealing in the last month, either before or after the MSIR opened (Burnet Institute 2019) (see Table C11, Appendix C).

An analysis of follow-up interviews after the MSIR opened showed that those who visited the MSIR were more likely to report being arrested since their previous interview (65 per cent) than those who had not visited the MSIR (41 per cent) (see Table C12, Appendix C).

This is further evidence of the high-needs nature of the people who use the MSIR and the potential value of the Fitzroy Legal Service visiting the MSIR.

The model of service integration is evolving

There are various models that can be used to provide services to this client group, which range from a standalone facility providing a single service, to co-location, to full integration with a range of services.

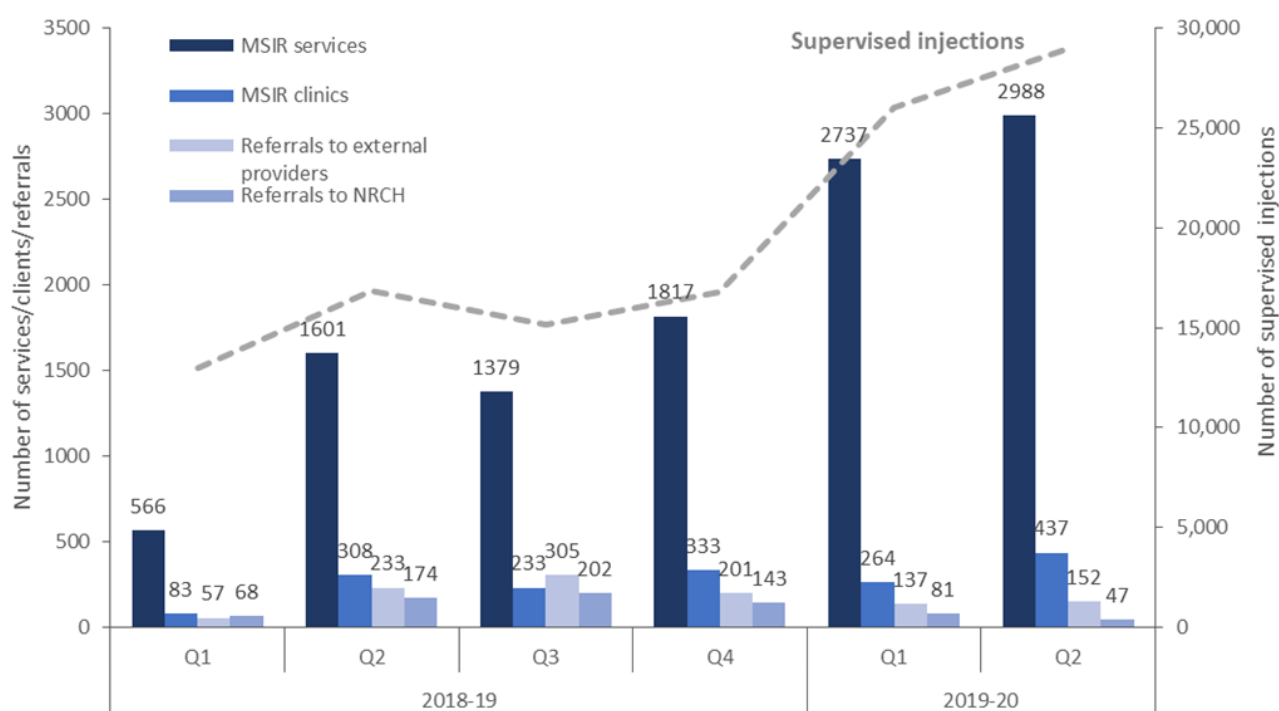
Analyses of the facility data show there are many ways that additional services (beyond injecting oversight) are provided:

- health promotion, nursing and medical care by MSIR staff

- outreach/AOD care, oral health and medical care by NRCH staff in the MSIR (AOD team and GPs, oral hygienists)
- referrals from the MSIR to oral health and GP services at NRCH
- shared care between the AOD and MSIR teams
- shared care between St Vincent's Hospital Melbourne and the MSIR (Health Impact Programme, blood-borne virus screening, mental health assessments including wound care nurses and the St Vincent's hepatitis nurse)
- specialist services by external providers inside the facility (MSIR clinics)
- referrals to external services.

There has been an increase over time in services provided within the MSIR (directly and through clinics). While MSIR data reflected a reduction in referrals to NRCH and external services from the third operating quarter (Figure 21), the MSIR medical director suggests this is mainly due to changes in the way referrals were counted, with access to other NRCH and external services on site considered service provision rather than referral.

Figure 21: Number of services and referrals provided to service users at the MSIR and number of supervised injections over time, Quarter 1, 2018–19 to Quarter 2, 2019–20



Source: MSIR database

Notes:

- MSIR services is a count of the total number of services provided in the facility. MSIR services includes medical services provided in the facility, except in the Quarter 1, 2018–19, where medical services are not included in the count because the data were not available.
- MSIR clinics is a count of the total number of service users seen.
- Referrals to external providers is a count of the total number of referrals.
- Referrals to NRCH is a count of the total number of referrals.

The MSIR directly provides services to service users

Since opening on 30 June 2018 (and up until 31 December 2019), the MSIR provided 10,540 services in addition to injecting supervision (largely health promotion in relation to injecting and wound dressing) (Table 8). Staff at the service indicated that on-site integrated care was preferable to referrals.

Table 8: Number and percentage of types of services provided in the MSIR, 30 June 2018 to 31 December 2019

Service type	Number	Percentage of total services
Health promotion ^(a)	6,206	58.9
Wound dressing / medication provision / other first aid	1,122	10.6
Social welfare ^(b)	791	7.5
BBV/STI testing and treatment	445	4.3
Drug treatment advice and information	445	4.2
Counselling and crisis intervention	439	4.2
Mental health	319	3.0
Material aid	207	2.0
Overdose first response with naloxone training (CPR)	133	1.3
Family violence support	38	0.4
Other	385	3.7
Total	10,540	100

Source: MSIR database

(a) Health promotion refers to services such as safer injecting advice and support and vein care.

(b) Social welfare includes legal, financial, housing and homelessness advice.

This suggests that with the increased capacity for services within the consulting space, more activity is happening within the facility itself, rather than through referrals. The relative benefits of full integration with a co-located community health service compared with providing separate in-house services to those who present to the MSIR are still evolving. It is apparent that a number of those with significant health issues do not or are not able to follow through with further health appointments when they come to self-inject. It is also apparent that many of those who present have their own GP and other health providers closer to where they live. As such, the Panel supports having access to a range of supports and facilitated access to other health services but remains undecided on whether this should be provided by the auspicing agency or by dedicated staff within the MSIR.

Referrals are offered, but the rate of non-attendance has been high for some services

This section contains data about services offered and provides a more nuanced description of the complexity regarding the provision of services beyond supervision of injecting. It represents an account of the experience of the MSIR in making referrals for additional services.

Between 30 June 2018 and 31 December 2019, the MSIR provided 702 referrals to NRCH, largely for health care and AOD harm reduction. MSIR staff reported that it is straightforward to refer service users to NRCH, but they do not always have capacity to walk the service users to the service. This means, at times, MSIR staff recruited other NRCH staff (care coordinators or members of the AOD team) to support the client to facilitate the referral. Some staff working in both the MSIR and NRCH reported that they found it easier to refer between the services while in the transitional facility rather than moving between the buildings.

MSIR staff reported to the Panel that their initial experience of referring service users within NRCH was that there was a low uptake of referrals from the facility to the community health centre. For example, the MSIR staff observed that after referring 30 people for hepatitis testing in NRCH, that only one in 10 of those clients completed the testing process (a combination of seeing a GP and having blood collected from the pathology service). This contributed to the MSIR establishing drop-in clinics using GPs from NRCH and revising its model of hepatitis diagnosis and treatment in partnership with St Vincent's Hospital. This is reported to have resulted in most people who wanted blood-borne virus testing subsequently completing testing and initiating treatment.

As noted above, while people may have several health and social needs, they do not necessarily wish to follow these up at the time or place of self-injecting. The Panel supports providing readily accessible and available primary health care while noting that the preferences of clients to visit their own practitioner need to be respected. The Panel also notes the importance of a trusting relationship that may take some time to form and expect that this aspect of the MSIR will increase over coming months. The Panel also notes the input of St Vincent's Health staff in relation to mental health, wound management and infectious diseases. These are all areas where St Vincent's has expertise in engaging with those who are often socially isolated and disenfranchised (see below). Having staff linked to the local area mental health service means that direct referral is more likely, with better information sharing and communication.

The most frequent mental illnesses or disorders present in those who attend the MSIR are likely to be related to past trauma and to be evidenced by poor affect regulation, poor self-image and impulsivity. Some will have major mental illness such as schizophrenia or other psychoses. For many the most important aspect of care is a consistent level of engagement with a trusted mental health clinician. It is not clear what proportion would be assisted by referral and ongoing treatment through state-funded mental health services or by participating in a mental health plan under Better Access. The Panel noted that in both the MSIR and NRCH, AOD program staff had been able to support service users to comply with prescribed treatment for mental and other illnesses by giving reminders or even storing medication at the centre. The Panel also noted that the mental health support service was still in its early days and such support was not available over extended opening hours. Tables 9 breaks down referrals to NRCH and gateway services.

Table 9: Referrals to NRCH and gateway services, 30 June 2018 to 31 December 2019

Referrals	NRCH (n)	NRCH (%)	Gateway services (n)	Gateway services (%) ^(a)
Healthcare ^(b)	356	50.7	66	6.0
AOD harm reduction ^(c)	142	20.2	63	5.7
Drug treatment	93	13.2	241	21.8
Mental health ^(d)	23	3.3	143	12.9
BBV/STI testing and treatment ^(e)	20	2.8	196	17.7
Counselling and casework	19	2.7	–	–
Housing and homelessness	8	1.1	130	11.7
Social welfare	6	0.9	10	0.9
Legal	–	–	81	7.3
Material aid ^(f)	–	–	66	6.0
Family violence	–	–	11	1.0
Other	35	5.0	101	9.1
Total	702	100.0	1,108	100.0

Source: MSIR database

(a) As a percentage of all referrals

(b) Healthcare referrals to hospitals, GPs, dental services and allied health services

(c) AOD harm reduction referrals include naloxone training, NSP and health promotion

(d) Mental health includes counselling and casework

(e) BBV refers to blood-borne viruses (for example, hepatitis B, C and D viruses and HIV)

(f) Material aid refers to support accessing showers, food and transportation

Referrals made to external services

Within the first 18 months, the facility provided 1,108 referrals to external services, representing 61.2 per cent of all referrals. More than half were for drug treatment such as pharmacotherapy, withdrawal, counselling/support, blood-borne virus and STI testing and treatment and/or mental health.

Table 10 breaks down the number of clinical interactions with MSIR clients seen in MSIR consulting rooms.

Table 10: Number of clinical interactions with MSIR clients seen in MSIR consulting rooms

Service provider	Service type	Q2 Oct-Dec 2019	Total to date (Jul 2018 – Dec 2019)
MSIR staff	Health promotion, e.g. safer injecting advice and support, vein care	1,887	6,206
	Wound dressing/ medication provision/other first aid	272	1,122
	Counselling, crisis management, mental health support, etc.	582	2,624
	Blood-borne virus	62	455
NRCH staff	Oral health clinic	48	361
	Medical (GP and MSIR medical staff)	160	455
Shared care	BBV clinic (Burnet Institute, St Vincent's Hospital)	99	219
	St Vincent's Hospital HIP BBV	195	403
	St Vincent's Hospital HIP Mental Health	226	318
External agencies	ReGen drug treatment clinic	38	161
	Fitzroy Legal Service	11	55
	Launch Housing	21	47
Total		3,601	12,426

Additional services are increasingly being provided by other organisations from within the MSIR. In addition to these services, there are others provided at the facility including:

- a specialist clinic run by an anaesthetist to support service users with poor vein health, including to support pathology tests for service users who are unable to have blood taken at mainstream pathology services due to damaged veins
- non-appointment services in the Aftercare Zone and Consulting Zone to enable opportunistic engagement with key health and psychosocial services that service users may otherwise not access
- oral health care with an oral hygienist, using silver diamine fluoride for on-the-spot treatment of dental caries, an inexpensive way of reducing pain and infection in the mouth.

To provide further insights into these services, descriptions of work being conducted within the facility by St Vincent's Hospital Melbourne and Fitzroy Legal Service are provided below.

St Vincent's Hospital Melbourne

St Vincent's Hospital Melbourne directly provides three clinicians at the MSIR. These are funded through its Inclusive Health Program fund, aimed at improving health outcomes for particularly vulnerable people. The roles are:

- an infectious diseases clinical nurse consultant (since April 2019)
- a mental health clinician (since August 2019)
- a wound nurse consultant (since mid-December 2019).

The reported focus of their work with service users has been direct service provision (most commonly brief interventions, engagement and care coordination). They report that the remainder of their efforts has been on clinical leadership including streamlining existing processes, building relationships and pathways, and capacity building and professional development.

Drug outreach lawyer provided by Fitzroy Legal Service

The Fitzroy Legal Service provides legal advice and representation in several ways, including via a drug outreach lawyer, family violence outreach and its Neighbourhood Justice Centre. The drug outreach lawyer assists individuals with legal problems concerning drug use and works in close collaboration with community and health agencies to promote rehabilitation and harm minimisation. A drug outreach lawyer is provided fortnightly at NRCH and other locations (Inner Space, Youth Support and Advocacy Service, Odyssey House Victoria and Living Room). Case studies provided by this team provide insights into the complexity and benefits of challenges facing service users with appropriate services.

Case study 4: Providing a pathway to legal support and psychosocial care

An MSIR client approached the drug outreach lawyer and told them they had been the victim of a crime. The lawyer referred them to lawyers who specialised in that specific area of law, as well as a social worker at NRCH, who was able to meet them that day to provide support, and to a GP at NRCH to explore a mental health plan for more intensive psychological counselling.

MSIR report: April to June 2019 quarterly report

Case study 5: Access to drug outreach lawyers

A drug outreach lawyer introduced themselves to an MSIR client while on site. The client mentioned they had an outstanding matter and no lawyer. On obtaining the legal documents it became apparent that the client was facing a lengthy term of imprisonment for offences relating to homelessness and drug use.

The lawyer coordinated a treatment plan with the client's existing service providers (external to the MSIR) and made the necessary referrals to ensure appropriate treatment. Because of the presence of wraparound services and the lawyer's advocacy, the magistrate released the client with a reduced sentence.

MSIR report: April to June 2019 quarterly report

Staff commented on how the facility is uniquely positioned to provide service users with a gateway to health and social services. Overall, staff seem to have a positive relationship with service users, which helps when making referrals. Staff observed that service users were often interested in accessing health services, including drug treatment services, but found it challenging for a range of reasons.

It was noted that many service users do not always have access to a phone, and therefore it is helpful that the MSIR has the capacity to link them with services via telephone (such as calling housing services). Overall, staff feel they are doing a good job at using an opportunistic approach to referring service users to other services, particularly dental and GP services, but expressed some frustration with not being able to follow up on client referrals, or to case manage service users to the extent they wanted. The MSIR's 'drop-in' model was cited as a reason for this.

Nurses and harm reduction practitioners report having established strong partnerships with an array of external service providers to increase the service's capacity to respond to client needs. The MSIR believes that the additional four consulting rooms in the larger facility has provided much-needed space from which to provide these services and referrals.

Staff noted that not all staff members have the knowledge of how to help service users access different types of health and social services, including housing services and Centrelink. In the case where a staff member does not feel confident, there is generally another staff member who can assist. When interviewed, many of the nursing staff felt they were ill-equipped to identify and process referrals, particularly to social services. This was partly due to the complexity of those service systems. The range and complexity of issues that arise reflect the importance of having multidisciplinary staff with sound training and supervision and access to a range of expertise either within the MSIR or within NRCH.

Staff reported that it can be difficult to get service users into broader social services due to lack of availability. They also reported that stigma associated with drugs use can act as a barrier to accessing other services for some service users, particularly relating to hospital admissions. Not having stable housing makes access to and delivery of these services difficult.

Impact the facility has had on health service use

At the end of the first year of operation in the transitional facility (using available data, Burnet Institute 2019), there was not yet evidence of an impact on health service use at the population level, although case studies provided illustrate the nature and impact of referrals at the individual level.

Alcohol and other drug services, including opioid substitution therapy

Using linked data from the Alcohol and Drug Information Service and the Burnet Institute SuperMIX study did not find evidence of a difference between the average number of initiated AOD treatments for the participants who reported visiting the MSIR compared with those who did not, either before or after the MSIR opened. This finding applies to withdrawal treatment, drug counselling and all other treatments recorded in the Alcohol and Drug Information System dataset (including residential rehabilitation) (Burnet Institute 2019, p. 13).

People who reported visiting the MSIR were less likely to report being on opioid substitution therapy compared with those who did not visit the MSIR (34 per cent versus 49 per cent, respectively) (Burnet Institute 2019, p. 14).

Case study 6: Supporting access to pharmacotherapy treatment

A person started using the MSIR after leaving prison and subsequently overdosing in the community. The overdose was serious, requiring hospitalisation. The person expressed interest in ceasing their drug use to MSIR staff, who connected them to the ReGen worker at the MSIR. The ReGen worker supported them to start pharmacotherapy treatment, complete an intake and assessment for further AOD treatment and begin AOD counselling. The person was then referred to a residential AOD rehabilitation program.

MSIR report: October to December 2018 quarterly report

Use of health services

Based on linked data from the Medicare Benefits Schedule, there was no difference between the average number of GP visits for conditions unrelated to drug use between the group of participants who reported visiting the MSIR and those who did not, either before or after the MSIR opened (Burnet Institute 2019, p. 20).

More frequent MSIR users (who had more than half of their injections at the facility) were significantly less likely than people who didn't use the facility to access after-hours GPs (Burnet Institute 2019, p. 21).

Using linked data from the Pharmaceuticals Benefit Scheme, they did not find evidence of a difference between the average number of prescriptions dispensed between the group of participants who reported visiting the MSIR compared with those who didn't, either before or after the MSIR. This finding applies across all the different pharmaceutical drug groups considered, including mental health medication, sleeping pills and pain management medication (Burnet Institute 2019, p. 26).

Case study 7: Access to general practitioners

A client has been opioid dependent for several years. They regularly attend the MSIR and presented to the GP clinic after a staff referral. For some time, the client had been contemplating reducing and stopping their heroin use, so requested to see a doctor. They met with a GP who discussed strategies for reducing use and prescribed pharmacotherapy. Staff of the MSIR supported the client to find a convenient pharmacy to dispense his methadone. After several follow-up visits, the client asked the NRCH GP to change the methadone prescriber and dispensing pharmacy so that both were closer to home. The client reported no longer needing to visit North Richmond because they had no intention of using. At the time, the client also advised the NRCH GP that they were employed and recently promoted. This person has not attended the MSIR as a client since January 2019.

MSIR report: January to March 2019 quarterly report

Mental health

In a cross-sectional analysis of all interviews undertaken after the MSIR opened, there was no significant difference in the frequency of self-reported visits to a mental health professional for those who visited the MSIR compared with those who did not (Burnet Institute 2019, p. 35). Staff have noted that it takes considerable time to engage service users and to establish trust that will then allow more assertive support and intervention.

Case study 8: Access to mental health services

A client met with the mental health care coordinator with concerns about the effect that homelessness was having on them. The mental health care coordinator engaged the client using a trauma-informed approach and obtained the client's consent for care coordination. The care coordinator enabled access to crisis accommodation. The client also indicated to the care coordinator that they wished to recommence pharmacotherapy and was linked with one of the co-located NRCH GPs in the MSIR. As a result, the client is having fewer general health and accommodation problems. The client has a significant history of trauma and related trust issues, so engaging with them is a slow and continuing process.

MSIR report: July to September 2019 quarterly report

Part 55A(c): Reduce attendance by emergency services and attendances at hospitals due to overdoses

To assess this object, the Panel considered:

- Ambulance Victoria data for attendances involving naloxone
- results of a cohort study of people who use drugs linked with Victorian health datasets
- analyses of emergency department presentations and hospital admissions data
- consultations with professional stakeholders, staff and service users.

This finding of this review is that the trial has advanced this object for frequent users of the MSIR in relation to ambulance attendance, noting there is not yet evidence of an impact on broader health service use or outcomes.

- The MSIR attracts people who appear to be at greater risk of serious harm or death than the overall population of people who inject drugs because more required naloxone.
- Frequent users of the facility have had fewer ambulance attendances involving naloxone since the facility opened but a small increase in the number of drug-related emergency department presentations during the trial.
- There has been a reduction in ambulance attendances in the vicinity of the facility during opening hours.
- There have been no observable changes in emergency department presentations that can be attributed to the MSIR.

The MSIR is designed to respond to people who are experiencing an overdose of any severity (see Part 55A(a) in this report). It is reasonable to assume that Ambulance Victoria or a local hospital would have otherwise managed a portion of these overdoses.

The review examined evidence to consider that relevant emergency services are continuing their usual service to this location and also engaging with the MSIR to track relevant data. To note, all instances where the Metropolitan Fire Brigade had been despatched through the triple zero (000) process and attended with Ambulance Victoria are included in this data. The Metropolitan Fire Brigade is only despatched if conditions represent an immediate threat to life, which is not all overdoses.

As the trial progressed, the review analysed evidence to understand the extent to which there were:

- fewer emergency services attendances for overdoses in this vicinity
- fewer hospital attendances for overdoses.

In the first instance, simply by responding to these overdoses internally, it is reasonable to infer that the MSIR is contributing to the legislated object 'to reduce attendance by ambulance services, paramedic services and emergency services and attendance at hospitals due to overdoses of drugs of dependence' (Part 55A(c) of the Act).

In addition to managing overdoses that have occurred within the MSIR, the facility also monitored and managed people who had overdosed in the community. Management reported that some were transported to the service by Ambulance Victoria for monitoring, having been assessed as not

requiring further intervention or medical care. Others were brought in by other people, including the NRCH AOD program team as part of its outreach service. It is reasonable to assume that some of these individuals would have otherwise used additional paramedic and emergency services.

Staff reported a limited number of overdose incidents that required emergency and health services involvement, including from Ambulance Victoria. Some staff reported referring service users to hospital emergency departments for wounds and other injuries.

Emergency services attendances for overdoses

There are two sources of information about emergency services attendance involving the provision of naloxone:

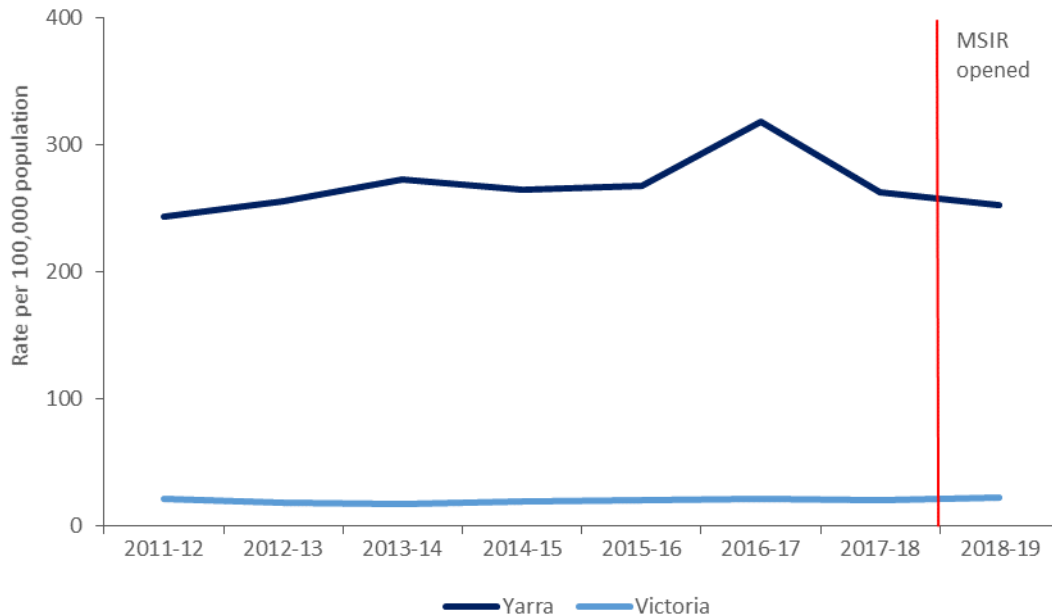
- Ambo-AODstats is a website managed by Turning Point, a national addiction treatment and research centre funded by DHHS that codes the Victorian Ambulance Clinical Information System (VACIS) clinical records to identify ambulance attendances involving over or inappropriate use of alcohol and/or other substances.
- VACIS is Ambulance Victoria's electronic patient care record system, which includes mandatory and supplementary data collected by paramedics. Data from VACIS is synchronised to the Ambulance Victoria Data Warehouse at the end of each shift.

The raw data in VACIS differs from the Ambo-AODstats Victoria data because Turning Point reviews all VACIS case notes, including free-text sections, to identify any attendances involving overdoses. Due to this, Ambo-AODstats reports a higher number of cases involving overdoses compared with VACIS data. The VACIS and Ambo-AODstats systems are therefore not comparable and care needs to be taken when interpreting findings.

Turning Point Ambo-AODstats findings

As described above, the case notes accompanying the data used in the VACIS analysis are further coded by an external research agency, Turning Point, which means that additional cases can be identified qualitatively. Analysis of those data show an increase in the number of attendances for heroin overdoses (measured as where the person was provided and responded to naloxone) in Victoria from 1,241 in 2017–18 (the year before the trial) to 1,423 in 2018–19. In the City of Yarra, there were four more ambulance attendances in that period (245 to 249). However, Figure 22 shows that the rate of ambulance attendances for heroin overdoses (responded to naloxone) per 100,000 population in Yarra decreased from 262.4 to 252.7 the year after the MSIR opened (2017–18 compared with 2018–19). Further analyses of these data are recommended once available.

Figure 22: Heroin overdose (where the person was provided and responded to naloxone) ambulance attendance rate for the City of Yarra and Victoria, 2011–12 to 2018–19



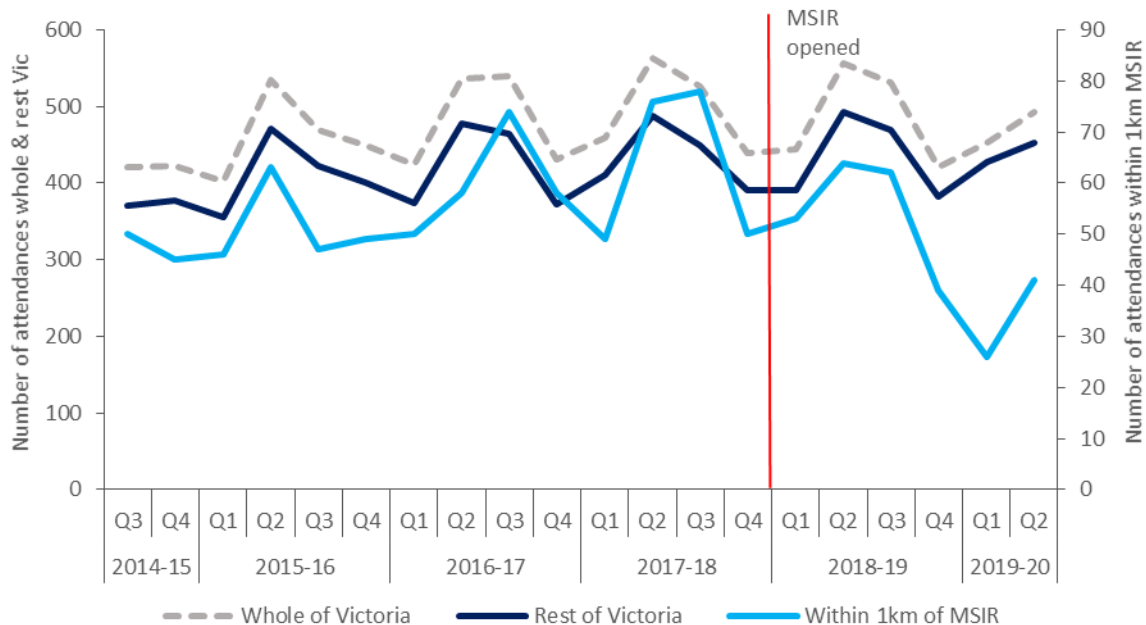
Source: Turning Point Ambo-AODstats Victoria

Victorian Ambulance Clinical Information System findings

Ambulance Victoria provided data to this review. Ambulance attendances involving naloxone administration was used as the review's key measure for identifying overdose cases where death may potentially have occurred without intervention. (The analysis below is based on all ambulance attendances where paramedics administered naloxone and may therefore include overdoses of other opioid drugs as well as heroin overdoses.)

Figure 23 shows the number of ambulance attendances where naloxone was administered over time within 1 km of the MSIR and for the rest of Victoria. Nine months after the MSIR opened the number of ambulance attendances within 1 km of the MSIR decreased, while the number of attendances for the rest of Victoria did not change substantially.

Figure 23: Number of ambulance attendances where naloxone was administered by paramedics within 1 km of the MSIR and for the rest of Victoria, Quarter 3, 2014–15 to Quarter 2, 2019–20



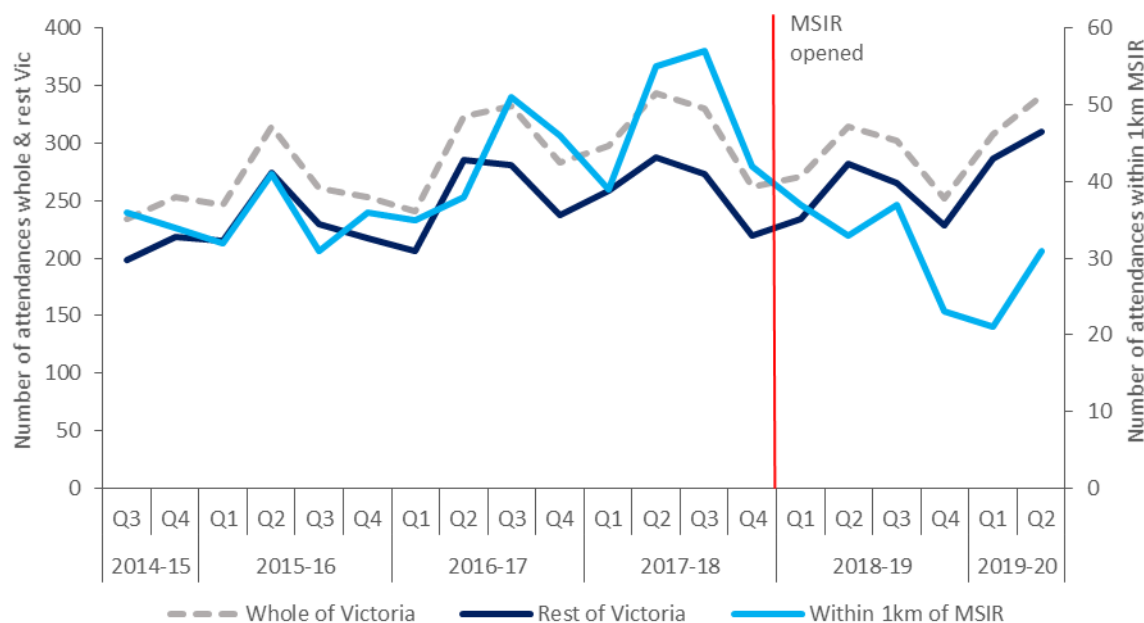
Source: Victorian Ambulance Clinical Information System

Notes:

- 'Rest of Victoria' is a count of all cases in Victoria minus cases identified within 1 km of the MSIR.
- Naloxone is a medication that rapidly reverses an opioid overdose. Naloxone only works on overdoses caused by opioid drugs such as heroin and pharmaceutical opioids such as oxycodone. The VACIS data presented here only includes ambulance attendances where naloxone was reported and may therefore include overdoses that are not heroin-related. The VACIS data presented here differs from the Turning Point Ambo-AODstats data because Turning Point reviews all VACIS case notes to identify any cases involving heroin overdoses where naloxone was administered. The VACIS and Ambo-AODstats systems are therefore not directly comparable and care needs to be taken when interpreting findings.
- This analysis includes data for ambulance attendances at any time of day, including when the MSIR was closed. The impact of the MSIR can be better understood by analysing the change in ambulance attendances during MSIR opening hours.

The opening of the MSIR was expected to primarily have an impact on ambulance attendance during MSIR opening hours, not outside opening hours. During MSIR opening hours the number of ambulance attendances where naloxone was administered within 1 km of the MSIR also declined nine months after the MSIR opened. For the rest of Victoria, the number of ambulance attendances were largely similar to those observed before the MSIR opened (Figure 24).

Figure 24: Number of ambulance attendances where naloxone was administered by paramedics within 1 km of the MSIR and the rest of Victoria during MSIR opening hours, Quarter 3, 2014–15 to Quarter 2, 2019–20



Source: Victorian Ambulance Clinical Information System

Notes:

- 'Rest of Victoria' is a count of all cases in Victoria minus cases identified within 1 km of the MSIR.
- MSIR opening hours before 7 July 2019 are defined as between 8.00 am and 7.00 pm on a weekday and 9.00 am and 5.00 pm on a weekend. From 7 July 2019 MSIR opening hours are defined as between 7.00 am and 9.00 pm on a weekday and 8.00 am and 7.00 pm on a weekend. Note: the MSIR opening hours changed over the trial period; as such, the opening hours measure presented in this review is used as an approximate measure.
- Naloxone is a medication that rapidly reverses an opioid overdose. Naloxone only works on overdoses caused by opioid drugs such as heroin and pharmaceutical opioids such as oxycodone. The VACIS data presented here includes ambulance attendances where naloxone was reported and may therefore include overdoses that are not heroin-related. Due to this, care needs to be taken when interpreting the data because the primary drug injected at the MSIR is heroin (95 per cent), whether alone or in combination with diphenhydramine. The MSIR cannot be expected to influence changes in ambulance attendances for pharmaceutical opioid overdoses.
- The VACIS data presented here differs from the Turning Point Ambo-AODstats data because Turning Point reviews all VACIS case notes to identify any cases involving heroin overdoses where naloxone was administered. The VACIS and Ambo-AODstats systems are therefore not directly comparable and care needs to be taken when interpreting findings.

Comparing trends¹³ before and after the MSIR opened shows that before the MSIR opened the number of ambulance attendances within 1 km of the MSIR during MSIR opening hours appeared to be on an upward trend, although there was a sharp decline just before the MSIR opened¹⁴ (between January 2015 and June 2018). (In Figure 25, the trendlines are presented to show the general trend of the data and are not to be taken as a formal statistical analysis.) After the MSIR

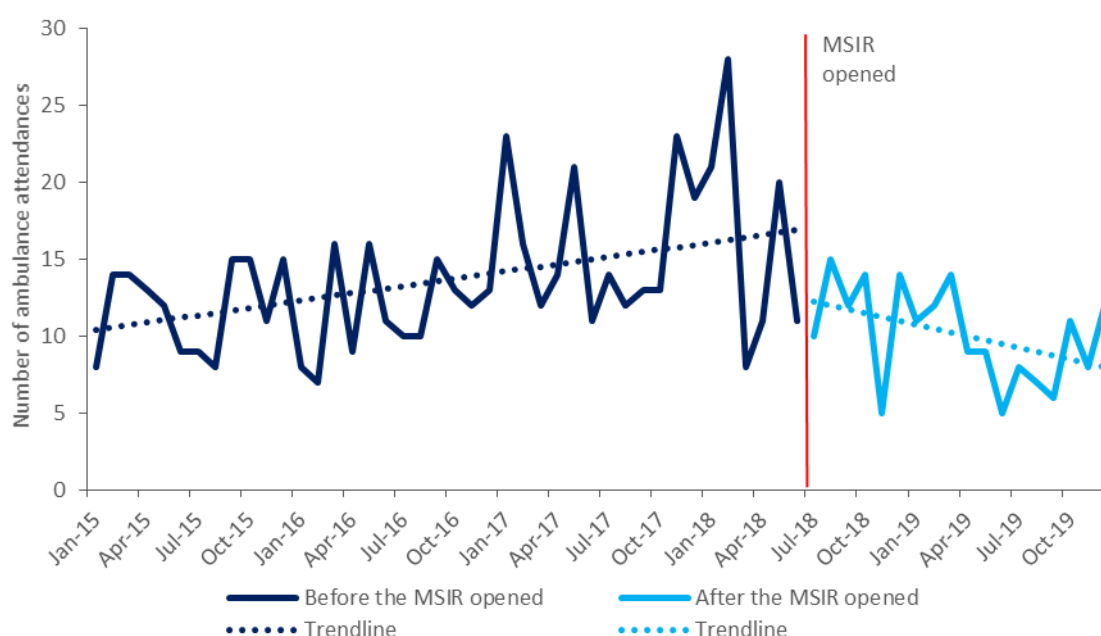
¹³ The trendlines presented are indicative only and not to be taken as formal statistical analysis; they are not intended for statistical inference or prediction purposes.

¹⁴ The sharp decline may be due to changes in the drug market or anticipation of the MSIR opening.

opened the number of ambulance attendances started to trend down (between July 2018 and December 2019). The trend for the rest of Victoria was different, with the number of ambulance attendances before and after the MSIR both showing upward trends (Figure 26 Figure 25).

An interrupted time series method was applied to the monthly aggregate count data to test for any statistically significant change in the number of ambulance attendances within a 1 km radius of the MSIR during opening hours, after the MSIR opened. Results of the analysis showed a trend towards a reduction in ambulance attendances after the MSIR opened that just failed to reach statistical significance ($p < 0.10$).¹⁵

Figure 25: Ambulance attendances where naloxone was administered by paramedics within 1 km of the MSIR during MSIR opening hours, number and trendline before and after the MSIR opened, January 2015 to December 2019



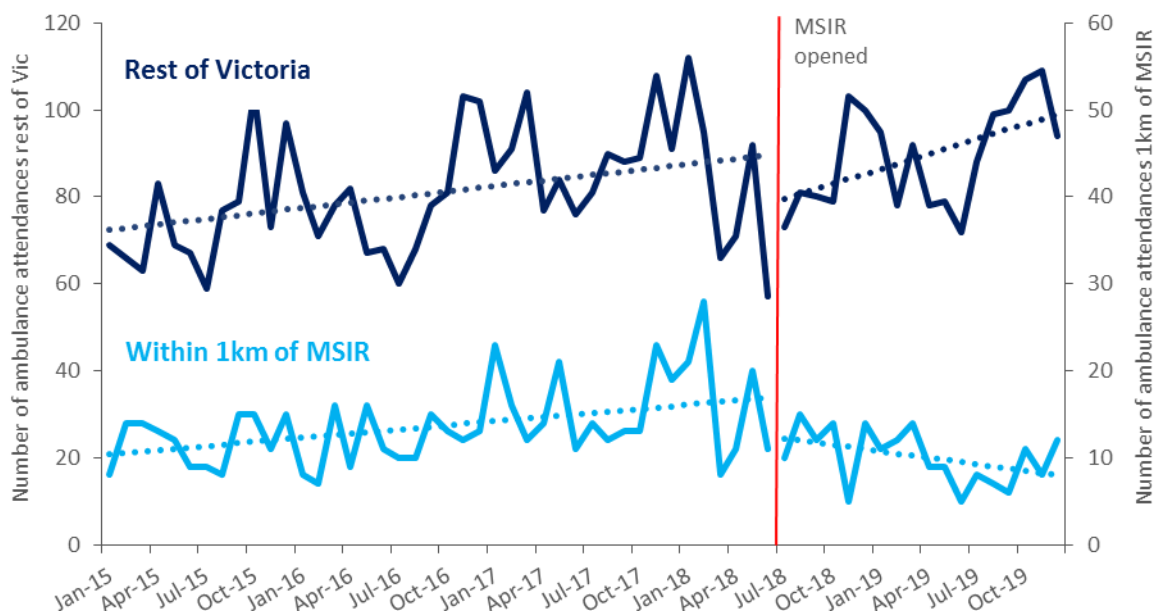
Notes:

- MSIR opening hours before 7 July 2019 are defined as between 8.00 am and 7.00 pm on a weekday and 9.00 am and 5.00 pm on a weekend. From 7 July 2019 MSIR opening hours are defined as between 7.00 am and 9.00 pm on a weekday and 8.00 am and 7.00 pm on a weekend. Note: the MSIR opening hours changed over the trial period; as such, the opening hours measure presented in this review is used as an approximate measure.

¹⁵ An interrupted time series approach was applied to the monthly aggregate count data to determine if there was a statistically significant change in ambulance attendances after the MSIR opened. The approach was based on the method described in Lopez et al. 2017. The results of this analysis should be used with caution. There are several important assumptions made in this analysis. If these assumptions are violated, the results could be invalid. First, the model assumes there is no other time-varying confounders could lead to the reduction of ambulance attendances. For example, in the study period, if there are other time-varying confounders, such as police operations, changes in drug availability or trading in private markets, the results could become invalid. Second, the model assumes the characteristics of the population remain unchanged throughout the study period and study area.

- Naloxone is a medication that rapidly reverses an opioid overdose. Naloxone only works on overdoses caused by opioid drugs such as heroin and pharmaceutical opioids such as oxycodone. The VACIS data presented here only includes ambulance attendances where naloxone was reported and may therefore include overdoses that are not heroin-related. Due to this, care needs to be taken when interpreting the data because the primary drug injected at the MSIR is heroin (95 per cent), whether alone or in combination with diphenhydramine. The MSIR cannot be expected to influence changes in ambulance attendances for pharmaceutical opioid overdoses.
- These trendlines are indicative only and not to be taken as formal statistical analysis; they are not intended for statistical inference or prediction purposes. The trendlines are presented to show the general pattern or overall direction of the data.

Figure 26: Ambulance attendances where naloxone was administered by paramedics during MSIR opening hours, number and trendline before and after the MSIR opened, January 2015 to December 2019



Source: Victorian Ambulance Clinical Information System

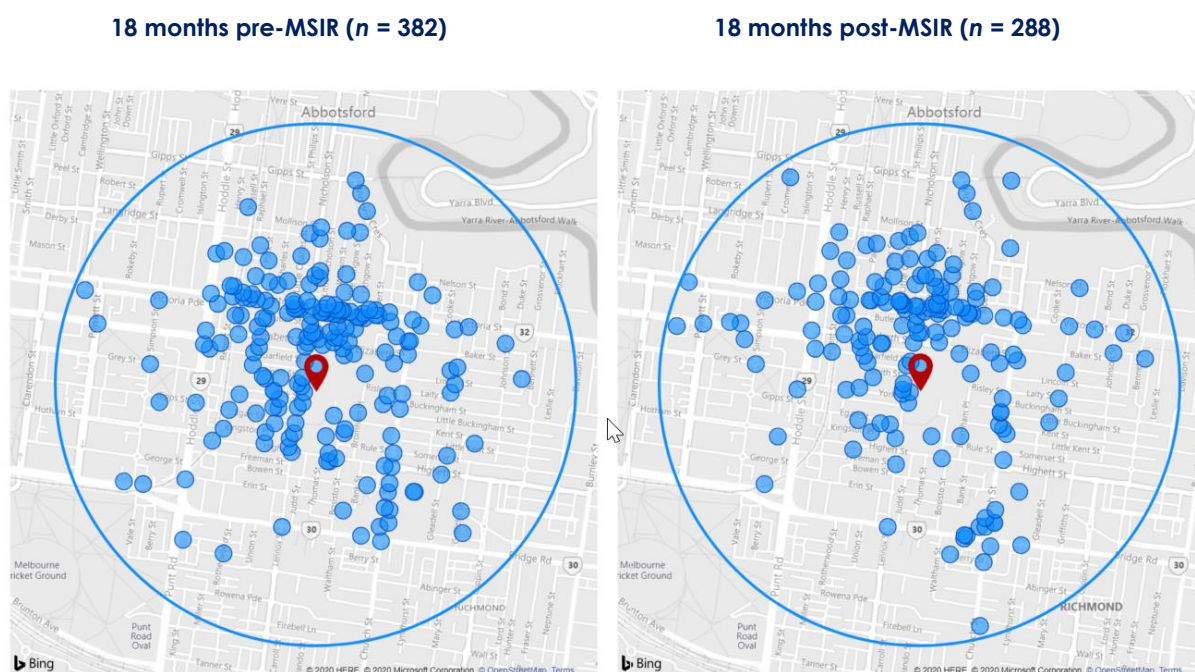
Notes:

- MSIR opening hours before 7 July 2019 are defined as between 8.00 am and 7.00 pm on a weekday and 9.00 am and 5.00 pm on a weekend. From 7 July 2019 MSIR opening hours are defined as between 7.00 am and 9.00 pm on a weekday and 8.00 am and 7.00 pm on a weekend. Note: the MSIR opening hours changed over the trial period; as such, the opening hours measure presented in this review is used as an approximate measure.
- Naloxone is a medication that rapidly reverses an opioid overdose. Naloxone only works on overdoses caused by opioid drugs such as heroin and pharmaceutical opioids such as oxycodone. The VACIS data presented here only includes ambulance attendances where naloxone was reported and may therefore include overdoses that are not heroin-related.
- These trendlines are indicative only and not to be taken as formal statistical analysis; they are not intended for statistical inference or prediction purposes. The trendlines are presented to show the general pattern or overall direction of the data.

In order to explore this trend further, direct comparison was made between the number of attendances during and outside MSIR opening hours. In the 18-month period after the MSIR opened, the number of ambulance attendances where naloxone was administered within 1 km of the MSIR declined by 25 per cent (382 attendances for the 18-month period before the MSIR opened compared with 288 for the 18-month period after the MSIR opened) (Figure 27). As

indicated, the opening of the MSIR was expected to primarily have an impact on ambulance attendances during MSIR opening hours, not outside opening hours. In line with this expectation the overall decrease was largely driven by a decline in the number of ambulance attendances during MSIR opening hours. A visual comparison of ambulance attendances within 1 km of the MSIR in the 18-month period before and 18-month period after the MSIR opened (see Figure 28) shows that the total number of attendances during MSIR opening hours decreased by 36 per cent after the MSIR opened (288 attendances compared with 184 attendances). In comparison, the number of attendances occurring within 1 km of the MSIR outside MSIR opening hours increased by 11 per cent in the 18-month period after the MSIR opened (104 attendances) compared with the 18-month period before the MSIR opened (94 attendances) (Figure 29). This difference in distributions was statistically significant ($X^2(2) = 10.34, p < 0.01$). This result includes the distribution of attendances outside MSIR opening hours, which largely followed the pattern for the remainder of Victoria. The time series analysis above does not include consideration of this trend. While these results are encouraging, further time is needed to fully understand the pattern of results in relation to ambulance attendances.

Figure 27: Ambulance attendances where naloxone was administered by paramedics within 1 km of the MSIR for all hours, 18 months before the MSIR opened and 18 months after the MSIR opened

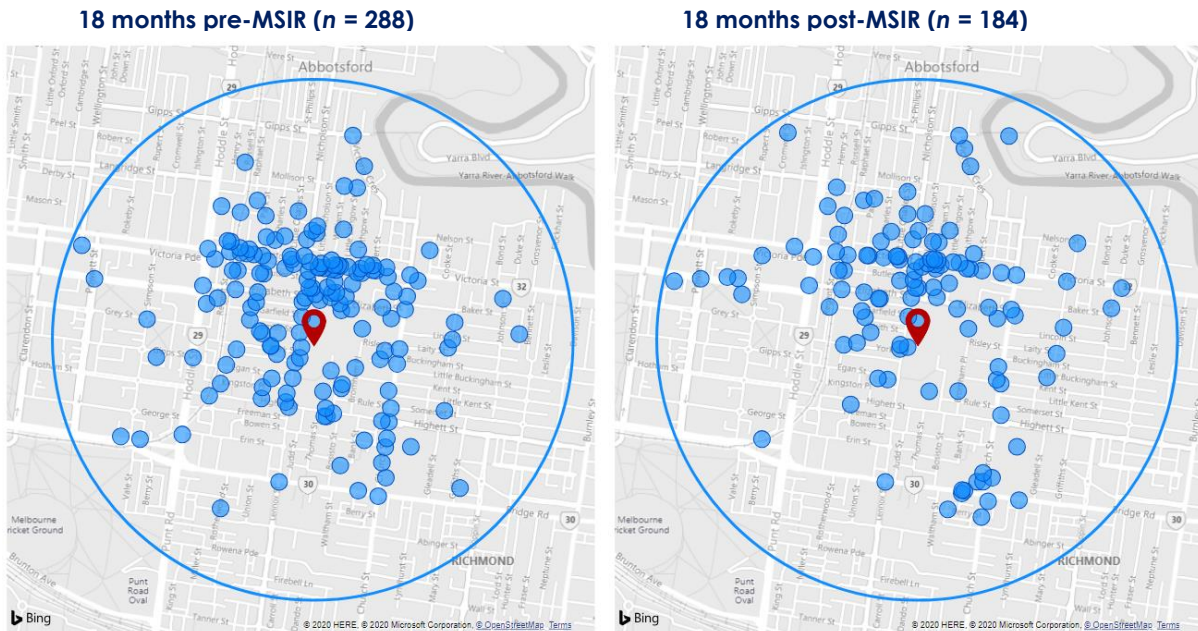


Source: Victorian Ambulance Clinical Information System

Notes:

- Time periods are 18 months before the MSIR opened and 18 months after the MSIR opened; the MSIR opened 18 June 2018.
- Naloxone is a medication that rapidly reverses an opioid overdose. Naloxone only works on overdoses caused by opioid drugs such as heroin and pharmaceutical opioids such as oxycodone. The VACIS data presented here only includes ambulance attendances where naloxone was reported and may therefore include overdoses that are not heroin-related. Due to this, care needs to be taken when interpreting the data because the primary drug injected at the MSIR is heroin (95 per cent), whether alone or in combination with diphenhydramine. The MSIR cannot be expected to influence changes in ambulance attendances for pharmaceutical opioid overdoses.

Figure 28: Ambulance attendances where naloxone was administered by paramedics within 1 km of the MSIR during MSIR opening hours, 18 months before the MSIR opened and 18 months after the MSIR opened

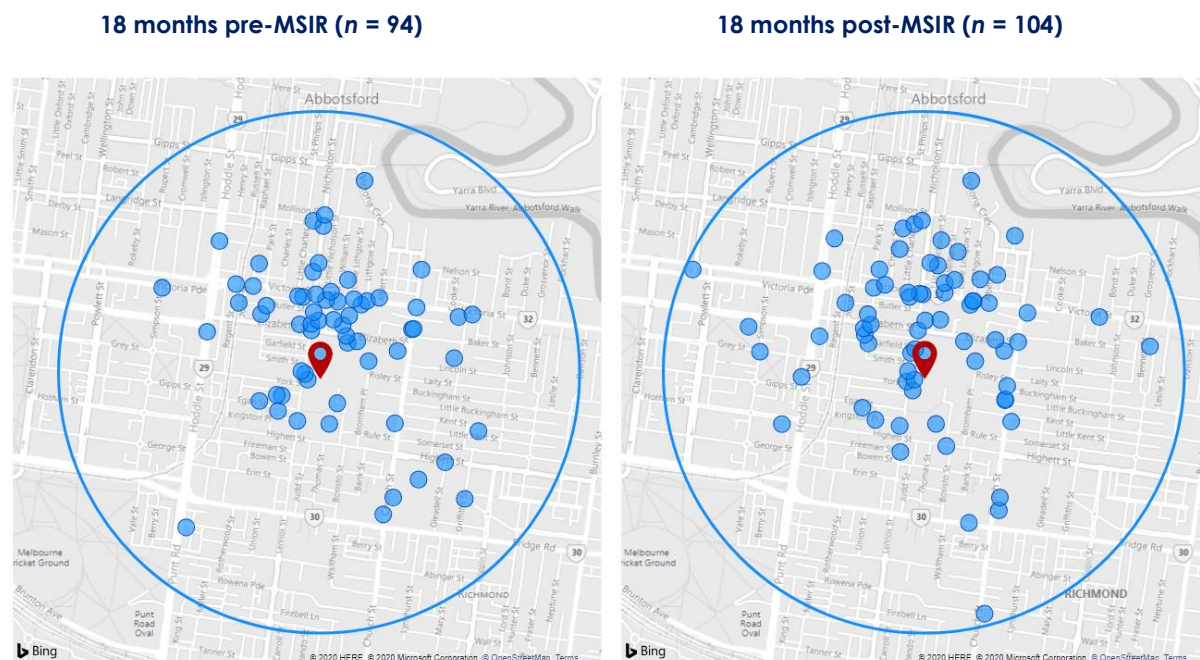


Source: Victorian Ambulance Clinical Information System

Notes:

- Time periods are 18 months before the MSIR opened and 18 months after the MSIR opened; the MSIR opened 18 June 2018.
- MSIR opening hours before 7 July 2019 are defined as between 8.00 am and 7.00 pm on a weekday and 9.00 am and 5.00 pm on a weekend. From 7 July 2019 MSIR opening hours are defined as between 7.00 am and 9.00 pm on a weekday and 8.00 am and 7.00 pm on a weekend. Note: the MSIR opening hours changed over the trial period; as such, the opening hours measure presented in this review is used as an approximate measure.
- Naloxone is a medication that rapidly reverses an opioid overdose. Naloxone only works on overdoses caused by opioid drugs such as heroin and pharmaceutical opioids such as oxycodone. The VACIS data presented here only includes ambulance attendances where naloxone was reported and may therefore include overdoses that are not heroin-related. Due to this, care needs to be taken when interpreting the data because the primary drug injected at the MSIR is heroin (95 per cent), whether alone or in combination with diphenhydramine. The MSIR cannot be expected to influence changes in ambulance attendances for pharmaceutical opioid overdoses.

Figure 29: Ambulance attendances where naloxone was administered by paramedics within 1 km of the MSIR outside MSIR opening hours, 18 months before the MSIR opened and 18 months after the MSIR opened

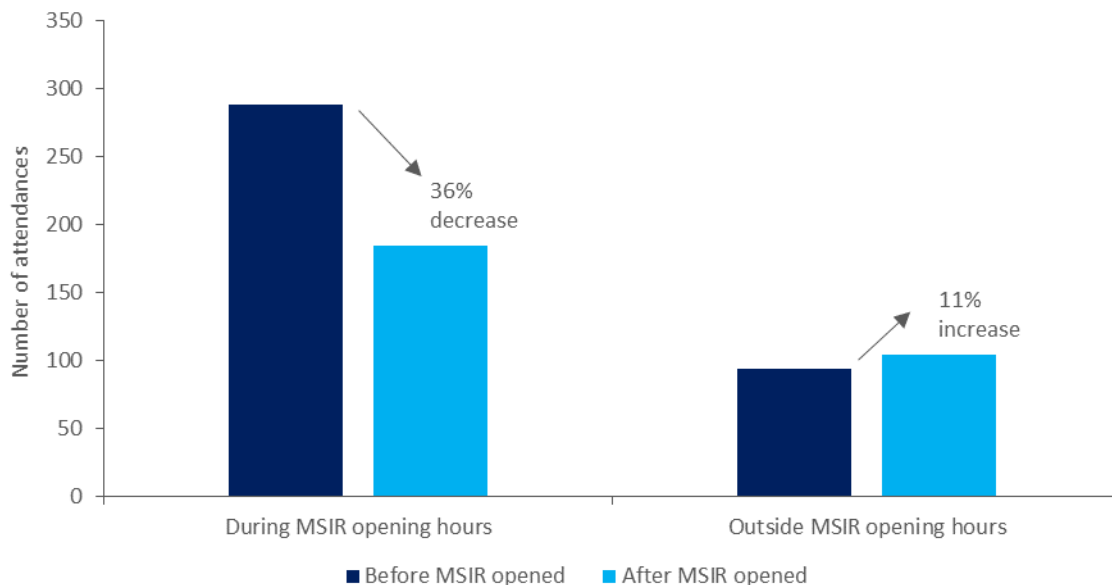


Source: Victorian Ambulance Clinical Information System

Notes:

- Time periods are 18 months before the MSIR opened and 18 months after the MSIR opened; the MSIR opened 18 June 2018.
- MSIR opening hours before 7 July 2019 are defined as between 8.00 am and 7.00 pm on a weekday and 9.00 am and 5.00 pm on a weekend. From 7 July 2019 MSIR opening hours are defined as between 7.00 am and 9.00 pm on a weekday and 8.00 am and 7.00 pm on a weekend. Note: the MSIR opening hours changed over the trial period; as such, the opening hours measure presented in this review is used as an approximate measure.
- Outside MSIR opening hours is defined as the hours not within the MSIR opening hours detailed above.
- Naloxone is a medication that rapidly reverses an opioid overdose. Naloxone only works on overdoses caused by opioid drugs such as heroin and pharmaceutical opioids such as oxycodone. The VACIS data presented here only includes ambulance attendances where naloxone was reported and may therefore include overdoses that are not heroin-related. Due to this, care needs to be taken when interpreting the data because the primary drug injected at the MSIR is heroin (95 per cent), whether alone or in combination with diphenhydramine. The MSIR cannot be expected to influence changes in ambulance attendances for pharmaceutical opioid overdoses.

Figure 30: Number of ambulance attendances where naloxone was administered by paramedics within 1 km of the MSIR, during and outside MSIR opening hours, 18-month total before and after the MSIR opened



Source: Victorian Ambulance Clinical Information System

Notes:

- Time periods are 18 months before the MSIR opened and 18 months after the MSIR opened; the MSIR opened 18 June 2018.
- MSIR opening hours before 7 July 2019 are defined as between 8.00 am and 7.00 pm on a weekday and 9.00 am and 5.00 pm on a weekend. From 7 July 2019 MSIR opening hours are defined as between 7.00 am and 9.00 pm on a weekday and 8.00 am and 7.00 pm on a weekend. Note: the MSIR opening hours changed over the trial period; as such, the opening hours measure presented in this review is used as an approximate measure.
- Outside MSIR opening hours is defined as the hours not within the MSIR opening hours detailed above.
- Naloxone is a medication that rapidly reverses an opioid overdose. Naloxone only works on overdoses caused by opioid drugs such as heroin and pharmaceutical opioids such as oxycodone. The VACIS data presented here only includes ambulance attendances where naloxone was reported and may therefore include overdoses that are not heroin-related. Due to this, care needs to be taken when interpreting the data because the primary drug injected at the MSIR is heroin (95 per cent), whether alone or in combination with diphenhydramine. The MSIR cannot be expected to influence changes in ambulance attendances for pharmaceutical opioid overdoses.

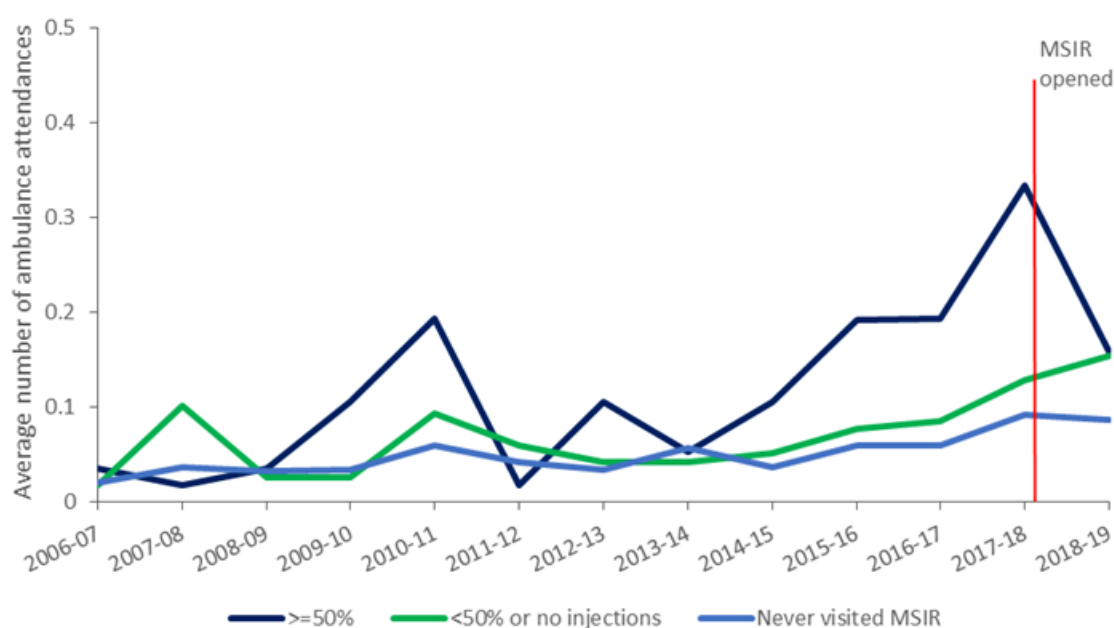
Burnet Institute study

Results from the Burnet Institute's SuperMIX study linked with VACIS data found no evidence at this stage of a difference between the average number of ambulance attendances with naloxone administration between those who visited the MSIR and those who did not.

Using linked data from VACIS, the Burnet Institute findings shows a projected decrease in ambulance attendance with naloxone administration for participants who visited the MSIR (Burnet Institute 2019, p. 38). Despite the overall drop for participants who visited the MSIR, there was no evidence of a difference in the average number of ambulance attendances with naloxone administration between the two groups (Burnet Institute 2019, p. 38).

However, people who used the MSIR had a significant reduction in ambulance attendances with naloxone administration compared with those who had not visited the MSIR (particularly for those who injected more than half of their injections at the MSIR) (Figure 31).

Figure 31: Average number of ambulance attendances with naloxone administration per year by MSIR frequency of use, 2006–07 to 2018–19



Source: Burnet Institute 2019, p. 38

Emergency department attendances

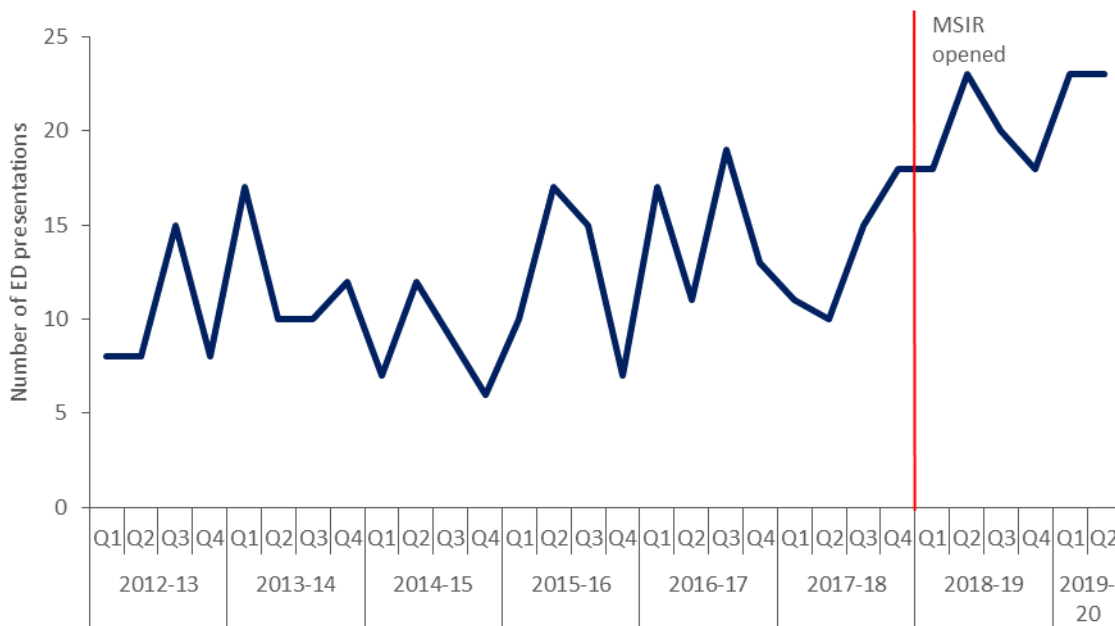
Using linked data from the Victorian Emergency Minimum Dataset, the Burnet Institute SuperMIX study did not find evidence of a difference between the average number of emergency department presentations for drug-related reasons (including overdoses) between the group of participants who reported visiting the MSIR compared with those who did not, either before or after the MSIR opened (Burnet Institute 2019, p. 39).

However, as with the findings for ambulance attendances, for more frequent users of the MSIR (who had more than half of their injections at the facility) there was weak evidence of an increase in the average number of emergency department presentations for drug-related reasons (including overdose) between the group of participants who reported having had 50 per cent or more of their injections in the MSIR and those who had not visited the facility (Burnet Institute 2019, p. 40).

Using the same approach, the study did not find evidence of a difference between the average number of emergency department presentations for conditions unrelated to drug use between participants who visited the MSIR and those who did not, either before or after the MSIR opened (Burnet Institute 2019, p. 16).

An analysis of heroin overdose presentations within MSIR opening hours¹⁶ at St Vincent's Hospital Melbourne (the nearest hospital to the MSIR) from before and after the MSIR opened found that the number of heroin overdose cases did not change significantly after the facility opened. While Figure 32 suggests that the number of cases increased around the time the MSIR opened, this increase was not statistically significant.¹⁷

Figure 32: Heroin overdose emergency department presentations during MSIR opening hours at St Vincent's Hospital Melbourne, Quarter 1, 2012–13 to Quarter 2, 2019–20



Source: Victorian Emergency Minimum Dataset

Notes:

- Heroin overdose emergency department presentations refer to presentations with a primary diagnosis of 'heroin overdose'. The primary diagnosis represents the primary reason for presentation to the emergency department and is recorded when the patient is discharged.
- MSIR opening hours before 7 July 2019 are defined as between 8.00 am and 7.00 pm on a weekday and 9.00 am and 5.00 pm on a weekend. From 7 July 2019 MSIR opening hours are defined as between 7.00 am and 9.00 pm on a weekday and 8.00 am and 7.00 pm on a weekend.

Using linked data from the Victorian Admitted Episode Dataset, the Burnet Institute's SuperMIX study did not find evidence of a difference between the average number of admissions for conditions related to drug use (including overdose) between participants who reported visiting the MSIR compared with those who did not, either before or after the MSIR opened (Burnet Institute 2019, p. 40). Using the same approach, the study did not find evidence of a difference between the average number of hospital admissions for conditions unrelated to drugs between participants who visited the MSIR and those who did not, either before or after the MSIR opened (Burnet Institute

¹⁶ MSIR opening hours defined as: before 7 July 2019: weekdays 8.00 am to 7.00 pm; weekends 9.00 am to 5.00 pm; and after 7 July 2019: weekdays 7.00 am to 9.00 pm; weekends 9.00 am to 7.00 pm.

¹⁷ The review analysed heroin overdose emergency department presentations (within opening hours of the MSIR) at St Vincent's Hospital between July 2012 and December 2019. Structural break detection and interrupted time-series analyses were conducted on the monthly aggregated count and daily rate with statistical significance tested ($p < 0.05$). The interrupted time-series analysis applied was based on the method described in Lopez et al. 2017.

2019, p. 18). It should be noted that presentations at emergency departments for all causes are rising at this time (Australian Institute of Health and Welfare 2018).

Part 55A(d): Reduce the number of discarded needles and syringes in public places and the incidence of injecting of drugs in public places in the vicinity

To assess this object, the Panel considered:

- needle and syringe collection data
- surveys of local residents and businesses before and during the trial (MSIR Review Survey).

The findings of this review are mixed regarding the extent to which the trial has advanced this object. There has been a reduction in reports of public injecting. Local people report no difference in seeing discarded injecting equipment. There has been an increase in collected injecting equipment (noting also an increase in collection activity later in the trial).

There had been no change for local community members reporting seeing discarded needles and syringes but a decrease in the proportion who reported witnessing public injecting at the time of the MSIR Review Survey in July 2019. The number of inappropriately disposed needles and syringes collected in the area surrounding the MSIR grew over the trial period. While some of this growth coincided with an escalation in cleaning activities in the last eight months of the trial, there was also an increase in the number of syringes collected in first 10 months of the trial.

Stakeholders were strongly divided on the extent to which there had been a change.

- There has been very little change in the proportion of people seeing discarded needles and syringes (16 per cent in the year before and 17 per cent during the trial).
- There has been no change in the median number of discarded needles and syringes seen by residents (four per month).
- There was an increase in the median number of discarded syringes seen by business respondents during the trial (six to 10 per month).
- There has been a decrease in the proportion of residents and business respondents who saw public injecting (24 per cent to 20 per cent of residents, and 27 per cent to 22 per cent of business respondents).
- There has been no change in the number of injections seen by residents (three per month) and an increase for business respondents (from four to five).
- Stakeholders were strongly divided on the extent to which there had been a change, some stating that the area had never been better and others stating that it had never been worse.

The MSIR is designed to provide an alternative to injecting in public. Part 55A(d) of the Act states that the facility aims 'to reduce the number of discarded needles and syringes in public places and the incidence of injecting drugs of dependence in public places in the vicinity of the licensed medically supervised injecting centre'.

The review examined evidence to consider whether injections that would have otherwise occurred in public places were occurring in the facility.

As the trial progressed, the review analysed evidence to understand the extent to which there has been:

- reductions in discarded injecting equipment in the vicinity of the MSIR
- reductions in public injecting in the vicinity of the MSIR.

About the needle and syringe program

The Victorian NSP is a public health initiative that aims to minimise the spread of blood-borne viruses such as HIV, hepatitis B and hepatitis C among people who inject drugs and into the wider community. The program began in 1987 and operates through a range of different service providers including:

- funded NSP locations whose primary function is to provide a full suite of NSP services including harm reduction information, advice and referrals
- community health services
- hospital emergency departments
- municipal councils
- drug treatment agencies
- youth organisations
- participating pharmacies.

NSPs provide a range of services including access to sterile injecting equipment and help with disposing of used injecting equipment. There are more than 500 NSP locations in Victoria, including two NSPs in Richmond (located at NRCH and a pharmacy located in the Richmond Plaza Shopping Centre) and a mobile NSP that can also service the area.

Until 7 July 2019 the NRCH NSP operated from the main health centre building, sharing office space with NRCH AOD services. The NSP could be accessed by the public through a dedicated window. From 7 July 2019 the NRCH NSP has been co-located with the MSIR. The NSP desk is situated alongside the MSIR intake desk, although integration arrangements are currently being reviewed.

As previously described, the NRCH NSP also provided a secure dispensing unit (also known as a needle vending machine) to facilitate access to sterile injecting equipment outside of the NSP fixed site's operating hours. This unit operated for two years and closed on 23 May 2019, before the larger facility opened.

People are appropriately disposing of their injecting equipment at the facility

Consideration of counts of both appropriate and inappropriate disposal and collection of injecting equipment before the trial and at the end of 2019 (when data consideration had to end) is complicated by changes in the collection services responsible for data on this measure.

The SuperMIX study found that many people injecting at the facility had previously injected in public or semi-public settings, presumably with some of those injections involving inappropriate disposal of injecting equipment.

The facility also asked a sample of its service users where they would have injected if the MSIR wasn't available and, as shown in Table 11, by far the most common response was in the carpark (a multi-level carpark adjacent to NRCH and a common site of overdoses before the trial began).

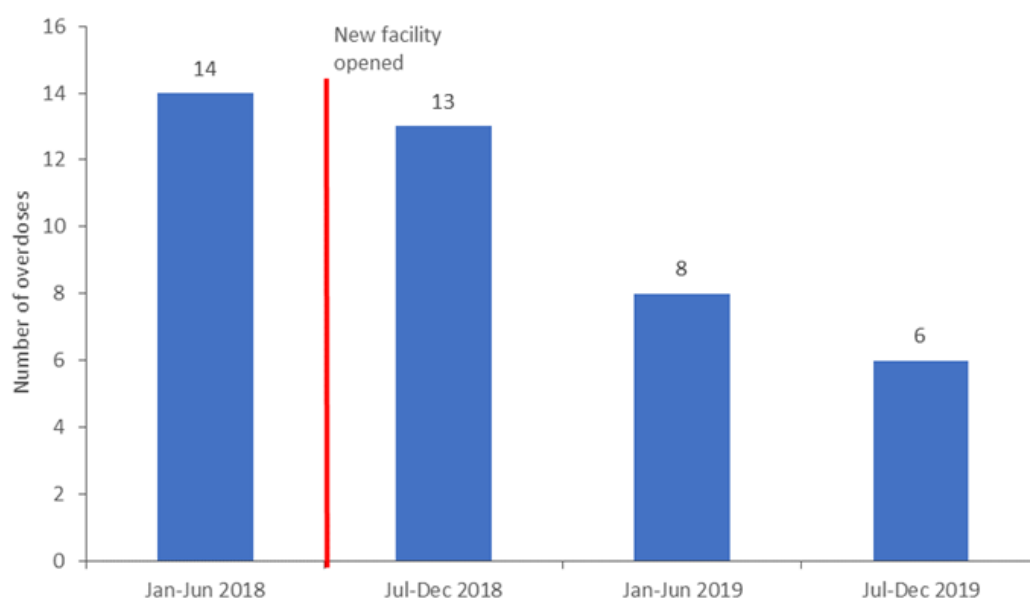
Table 11: Alternative injecting locations reported by people who injected at the MSIR, snapshot as at September 2019

Alternative location	Number of service users
Carpark	121
Public area	22
Public toilet	20
Alleyway	18
Anywhere	19
BBQ area	7
Underneath commission flats	3
Carpark or river	2
Friend's house	2

Source: MSIR database

Reportable incident data are consistent with this, with the number of overdoses attended at the multi-storey carpark adjacent to the community health centre declining from 14 overdoses in the six-month period before the facility opened to eight overdoses over the same period a year later (January to June 2019). Overall, in 2018 there were 27 incident reports concerning overdoses in the carpark, whereas in 2019 there were only 14, almost a 50 per cent decrease in overdoses attended to at the NRCH carpark (Figure 33).

Figure 33: Overdoses attended to at the NRCH carpark from January 2018 to December 2019



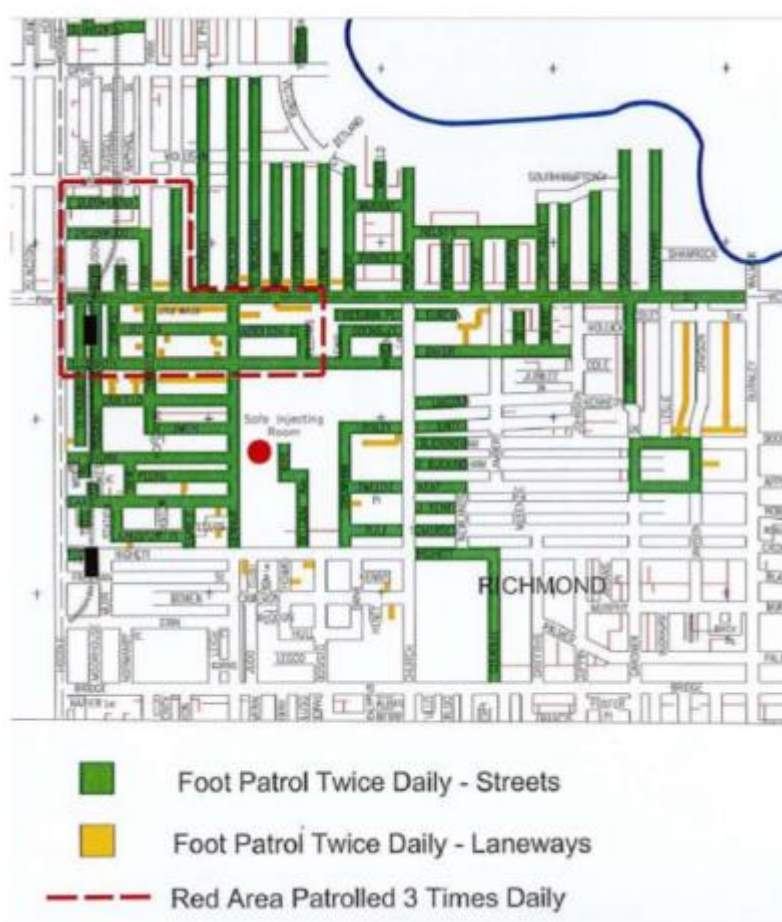
Source: MSIR database

Collection of discarded injecting equipment in the vicinity

Consideration of counts of both appropriate and inappropriate disposal and collection of injecting equipment before the trial and at the end of 2019 (when data consideration had to end) is complicated by changes in the collection services responsible for data on this measure.

The Yarra City Council has primary responsibility for collecting needles and syringes found in public places, including those disposed of appropriately (for example, in sharps bins) and inappropriately (for example, on the street). In mid-2019 the council doubled the level of cleaning services in the local area. The increase in cleaning services included street sweeping and a two-person cleaning crew conducting daily foot patrols in North Richmond and southern Abbotsford, up to three times per day. Figure 34 details the streets and laneways patrolled.

Figure 34: Yarra City Council foot patrols, 2019



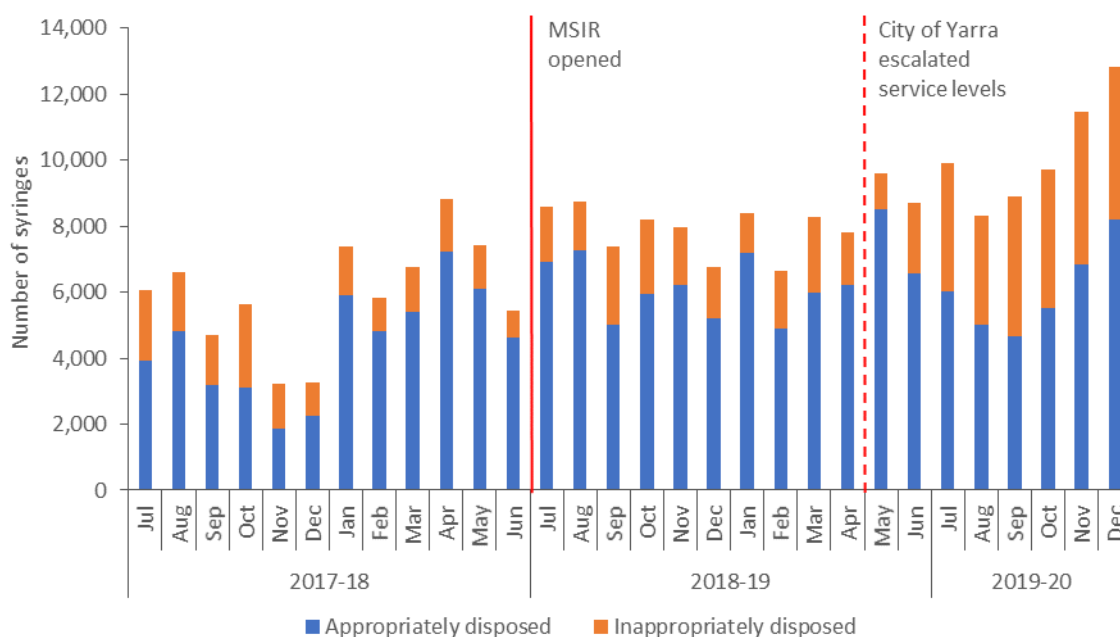
Source: Yarra City Council

There are some other caveats to these data, including that the Yarra City Council is not the only agency collecting disposed syringes within the municipality; pharmacies, community health organisations and others (including the Office of Housing on the Richmond housing estate) also manage safe disposal of syringes. Discarded syringes and associated litter found by the general public (traders, visitors and householders) may not necessitate a service request to the council because people may choose to dispose of these themselves. Regarding syringe disposals, there is no manual counting of syringes and instead the capacity of the unit is used as an indicator of

volume, and this is the figure that is captured. Of those disposed syringes collected, either appropriately or inappropriately, some may not have necessarily been used. Syringe management incident data has historically been recorded by the council's contractor, cohealth, via a manual process, with pen-and-paper recording in the field and data later entered into electronic spreadsheets. In mid-2019 this moved to a 'real-time' system to allow geocoded syringe management for both the council and cohealth. Historic datasets have been retrospectively geocoded to facilitate analysis.

Given the caveats on use of these data, caution should be exercised in drawing definitive conclusions on the number of syringes discarded in the area. In the area surrounding the MSIR,¹⁸ the number of syringes disposed of appropriately and inappropriately have increased over time (Figure 35). For each month between July 2017 and December 2019, more syringes were disposed of appropriately than inappropriately (53–89 per cent of syringes collected were disposed appropriately each month).

Figure 35: Number of appropriately and inappropriately disposed syringes collected in the local area surrounding the MSIR, July 2017 to December 2019



Source: Yarra City Council

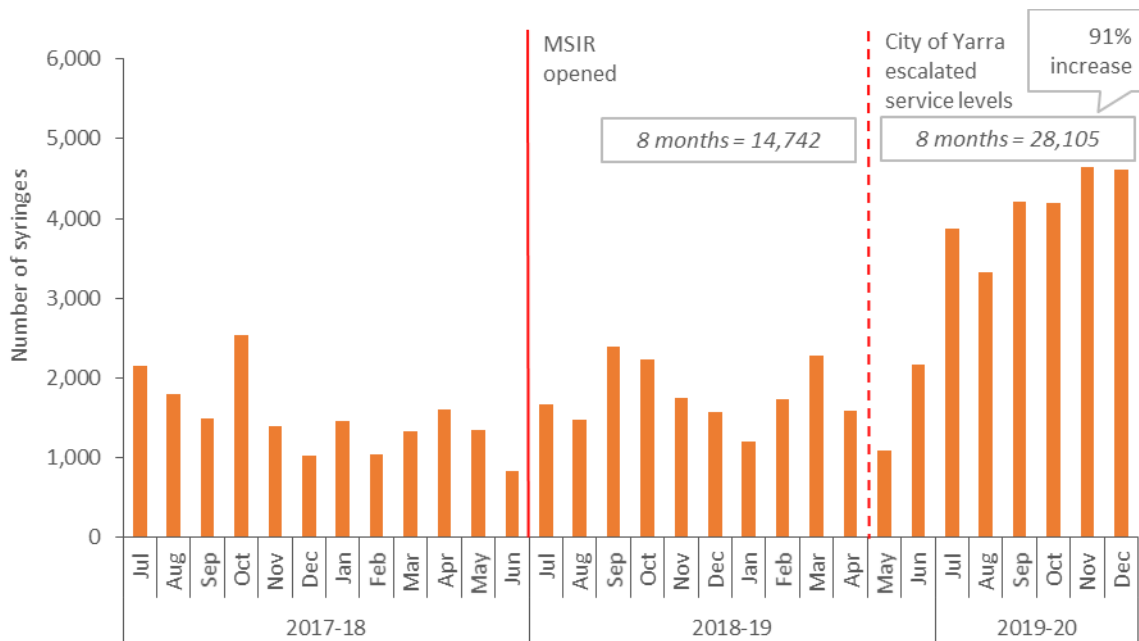
As described in the caveats above, during the trial period the Yarra City Council doubled its cleaning activities in the area surrounding the facility. This escalation of cleaning activities coincided with the number of inappropriately disposed syringes collected in the area almost doubling over an eight-month period (Figure 36).

The number of syringes collected as a direct result of internal and external customer service requests to the Yarra City Council also fell from June 2019, two months after cleaning activities

¹⁸ The area surrounding the MSIR was defined by the City of Yarra – a polygon bounded clockwise by Hoddle St, Gipps St, the Yarra River, Duke St, Johnson St, Coppin St and Bridge Rd (see Appendix C, Figure C1 for a map showing the defined boundary).

escalated. New, larger sharps bins were also recently installed near the NRCH carpark, which some staff at MSIR and NRCH suggest have contributed to a decrease in discarded injecting equipment.

Figure 36: Number of inappropriately disposed syringes collected in the local area surrounding the MSIR, July 2017 to December 2019



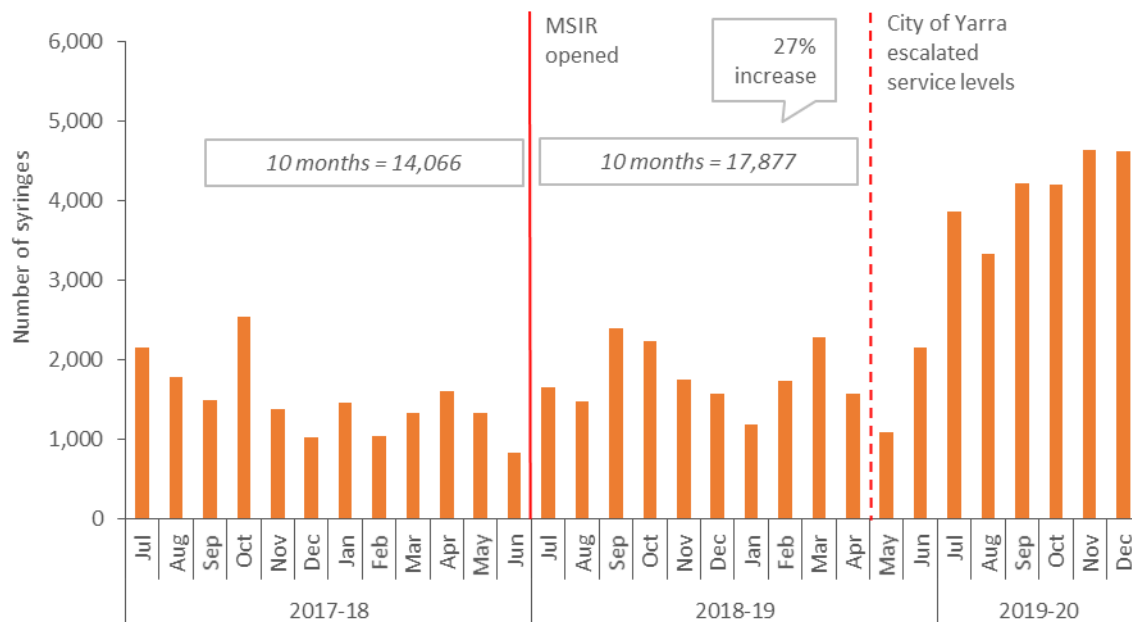
Source: Yarra City Council

Note: The area surrounding the MSIR was defined by the Yarra City Council – a polygon bounded clockwise by Hoddle St, Gipps St, the Yarra River, Duke St, Johnson St, Coppin St and Bridge Rd (see Appendix C, Figure C1 for a map showing the defined boundary).

It should be noted that the escalation in cleaning activities only relates to the last eight months of the trial. Prior to this, in the first 10 months of the trial, the number of inappropriately disposed syringes collected in the surrounding area increased by 27 per cent (compared with the 10 months before the MSIR opened; see Figure 37). This suggests that even before cleaning efforts escalated, the number of inappropriately disposed syringes were already increasing. It is not possible to tell from this data if the increase in the number of syringes collected was due to more people injecting drugs in the area or to other factors.

The Panel heard that after the MSIR opened, local residents were regularly provided with information on the Yarra City Council syringe disposal service through a public awareness campaign that included door knocking and distribution of letters, letterbox drops, posters and fridge magnets. The increasing marketing may have improved awareness and use of the service and increased the number of syringes the council collected.

Figure 37: Number of inappropriately disposed syringes collected in the local area surrounding the MSIR, before and after the MSIR opened, July 2017 to December 2019



Source: Yarra City Council

Note: The area surrounding the MSIR was defined by the Yarra City Council – a polygon bounded clockwise by Hoddle St, Gipps St, the Yarra River, Duke St, Johnson St, Coppin St and Bridge Rd (see Appendix C, Figure 7.1.1 for a map showing the defined boundary).

Community perceptions of discarded needles and syringes

Conducted before the opening of the MSIR and approximately one year later (around the time MSIR operations moved to the larger facility), the MSIR Review Survey assessed whether there had been any change in the experience of local residents and businesspeople regarding seeing discarded injecting equipment.

Most respondents (about 80 per cent) reported seeing discarded needles and syringes. There was little change in the proportion of residents who had seen discarded needles and syringes in the previous year (16.1 per cent to 16.9 per cent) but an increase for business respondents (20 per cent to 24.6 per cent) (see Table C6, Appendix C).

In relation to the number of needles and syringes seen, the average or mean number seen in the month preceding the MSIR Review Survey reduced significantly for both residents and businesspeople (13.3 to 8.7 for residents; 21.9 to 17.5 for businesses) (see Table C6, Appendix C).

Residents noted many concerns regarding discarded injecting equipment. Most related to the frequency and volume of the drug paraphernalia, the health hazard and the safety of children. For example, one survey respondent said: 'I worry about children and don't want kids to be exposed to it on the street and mistakenly pick up a syringe'.

The Panel directly heard a wide range of views on this, from 'the streets have never been cleaner' to the 'streets have never been worse'. Panel members frequently walked in the area during this review. While improvements were apparent on many of these occasions during 2019, there was often still visible evidence of discarded injecting equipment.

Public injecting in the vicinity of the facility

Findings from the Burnet Institute study about public injecting is that there was no significant difference in reports of using the last purchase of heroin in public between those who had visited the MSIR and those who had not (Burnet Institute 2019, p. 42; Table C7, Appendix C).

The results of the MSIR Review Survey regarding public injecting require careful analysis. As with the results relating to needles and syringes, most respondents reported seeing public injecting in the past (see Table C8, Appendix C).

For residents, there was no statistically significant change in the proportion reporting they had seen public injecting in the previous week or month. Residents and businesses reported a statistically significant decline in having seen public injecting in the year preceding the survey (23.5 per cent to 19.7 per cent for residents; 26.8 per cent to 22.2 per cent for businesses).

When asked for estimates of the number of public injections observed in the month before the survey, there was no change for residents (median of three at both time points) and an increase from four to five for businesses (not a statistically significant change).

There is evidence from research that people who inject drugs in public places will almost always inject close to where they obtained the drug. Studies about the nature and reasons for using particular public spaces suggest that, as well as proximity to the place of purchase, there are also factors such as proximity to transport connections, privacy, avoiding police attention, lighting and a sense of personal safety. This can include choosing to use laneways, alcoves and public toilets to avoid other people who might want their drugs but also a place that is sufficiently public to allow someone to see if they have overdosed and seek help.

To understand why some people who acquire their drugs in the vicinity of the MSIR but apparently do not go there to inject, in mid-2019 a Collingwood local primary health centre for people who inject drugs (many of whom do use the MSIR) asked some clients about their experience of the transitional service: 'If you have not used the MSIR, what is preventing you from using it?'. Responses included:

- *Personal preference.*
- *Would feel 'nannied'.*
- *Comfortable using by myself or my friends.*
- *Too busy, you wait to get in, even too busy for the chill out area and too many idiots.*
- *Other users don't go in, too scared – cameras. Believe blood testing being done from used syringes, DNA.*
- *I have a home to safely use at.*

In response to the question: 'Have you injected on the streets while the injecting room has been open? If yes, what was the reason you didn't go to the injecting room?', responses included:

- *Yes, in a rush.*
- *Yes, I couldn't find it, people talk about not going there because it's so packed.*
- *Yes, didn't want to walk there. Comfortable on the streets.*
- *Yes, most people do because they get fed up waiting. Quicker to go to NSP and then on street.*
- *Yes, it was closed, hours need increasing.*
- *Yes, people I was with don't like it due to cameras, etc.*
- *Yes, last night, injecting room would not let me in.*

Research exploring the reasons that people who inject drugs do not use injecting facilities offers some explanations. These include a perception that the facility is too far away, if police were stationed nearby or if the rules and regulations made their preferred practices difficult (Wood et al. 2003). For example, one study identified that potential service users would not use a facility if they could not share drugs (reason given by 34 per cent of those who were not willing to use a service) or if they were prohibited from assisting others to inject (18 per cent of those not willing to use) (Fry & Miller 2001).

Part 55A(e): Improve the amenity of the neighbourhood for residents and businesses

To assess this object, the Panel considered:

- surveys of local residents and businesses before and during the trial (MSIR Review Survey)
- results of a cohort study of people who use drugs
- surveys of local Victoria Police members
- a Yarra City Council community survey
- consultations with professional stakeholders, staff and service users
- group consultations with local residents and businesses
- the impact on the school and community health centre
- direct observations of the area.

This finding of this review is that amenity has not improved during the review assessment period.

- Prior research in North Richmond found the largest impact on the perception of amenity is from seeing discarded needles and syringes and other drug-related paraphernalia, and this appears to be largely unchanged.

There are conflicting results in relation to perceptions of safety:

- A Yarra City Council survey for the North Richmond area shows no change in residents' perception of safely walking alone during the day or at night before or during the trial.
- Victoria Police members reported seeing significantly more:
 - people buying or selling drugs
 - people who appear to be under the influence of drugs
 - antisocial behaviour that appears to be drug-related.
- The MSIR Review Survey conducted for this review found that after the first year of operations:
 - significantly fewer residents and business respondents reported feeling safe walking alone during the day and after dark due to concerns about violence and crime, public visibility of drug use and drug deals, safety concerns for their own children and schoolchildren, concerns about aggressiveness and unpredictability, and discarded syringes in public places
 - more people reported considering moving house (32 per cent to 37.1 per cent) or their employment (27.6 to 32.5 per cent) because of drug-related activity.

- Most of the MSIR service users are not from Richmond but were already coming to the area before the facility opened.
- Victoria Police reported seeing significantly more:
 - people buying or selling drugs
 - people who appear to be under the influence of drugs
 - antisocial behaviour that appears to be drug-related.
- During the first year of the trial period more people reported considering moving house (32 per cent to 37.1 per cent) or their employment (27.6 to 32.5 per cent) because of drug-related activity.
- It is difficult to assess the impact on the school, with the Panel hearing very different perspectives about parent experiences. However, advice from the school is that enrolments have increased, critical incidents involving discarded needles/syringes or overdoses have decreased and results of both parent and staff satisfaction surveys with the school have remained stable.
- Advice from NRCH is that the congregation of clients at the front door of the community health service, who were often assumed to be clients of the MSIR, has influenced other clients. Maternal and child health, general practice patients and some other services have seen some reduction in attendance. Work to address this has recently been undertaken to improve the appearance and amenity of the MSIR entrance. The 2018 Victorian Healthcare Experience Survey reported that 56 per cent of NRCH clients felt safe coming to the community health centre. This compares with other similar services that average in the mid-90 per cent range.
- The trial has been extensively covered in print and social media, with coverage most commonly assessed as being 'negative' in sentiment, which can affect people's perceptions.
- Overall, agreement with having an injecting room in North Richmond reduced for residents (from 61 to 44 per cent) and businesses (48 to 41 per cent) over the first year of the trial.
- There continues to be substantial efforts across a range of organisations to ameliorate concerns, and if the trial is extended both these and community sentiment should be monitored.

In addition to providing a space for using injectable drugs and the secure disposal of associated equipment, the Victorian legislation states that the facility aims to 'improve the amenity of the neighbourhood for residents and businesses in the vicinity of the licensed medically supervised injecting centre' (Part 55A(e) of the Act). While other supervised injecting facilities have been found to contribute to improved amenity, this is not typically one of their stated aims. As described in earlier sections, there is a separate aim of reducing discarded needles and syringes and public injecting. Use of the facility was also anticipated to benefit the amenity of the neighbourhood in other ways; however, these benefits are not defined by the legislation.

The period from mid-1995 to 2001 saw the emergence of street-based markets in Melbourne. Dietze and Fitzgerald (2002, p. 297) note that, 'access to the market is high, drug dealing is highly visible, the market is mobile and redeploys rapidly in response to police activity, there is a high level of associated crime and public disorder and drug use occurs in public locations'. Previous research has found that public injecting has had a substantial negative impact on public amenity in the

North Richmond/Abbotsford area (Dwyer et al. 2013). In particular, discarded needles and syringes and other injecting-related paraphernalia is a key factor in perceptions of amenity.

In relation to broader amenity issues, the Panel initially examined evidence to consider if community engagement was occurring, including tracking amenity issues.

As the trial progressed, the Panel analysed evidence to understand the extent to which there has been:

- improved liveability of the neighbourhood
- improved perceptions of safety
- a reduction in public injecting and discarded injecting equipment
- improvements in amenity of the neighbourhood leading to increased support for establishing the facility over time.

The above indicators relate to potential changes in amenity arising from the operation of the MSIR more broadly. In relation to specific activities undertaken to address amenity, there are several entities with areas of responsibility that may contribute to experiences of amenity, including the MSIR and NRCH, Victoria Police, Yarra City Council and the Office of Housing.

The Panel considers that a person's experience of living or working in the area could reasonably be influenced by the MSIR. This includes the above activities as well as other contributors such as media coverage.

Before the MSIR opened, there had been significant public discussion and media exposure on the impact of public injecting in the City of Yarra, with a particular focus on the North Richmond heroin market. This attention highlighted existing concerns about the discarding of drug injecting paraphernalia, witnessing of overdose, public injecting and the public nuisance perceived to stem from the illicit drug market.

Media coverage

External analysis found the MSIR trial was highly visible in the print media, with articles reaching a potential audience of around 20 million (Media Measures 2020). There was a strong focus during the first 18 months of the trial by the two Melbourne daily newspapers, with 54 stories appearing in the *Herald Sun* and 32 stories in *The Age*.

Print media coverage of the MSIR trial was largely negative (45.9 per cent), with the remainder relatively evenly split between positive and neutral coverage. The bulk of the print media's positive coverage dealt with stories on the state government's release of data on the MSIR that indicated a large number of client visits to the facility and the large number of overdoses successfully managed. The two main negative issues in the print media were public concerns (including from local residents) and the incident involving staff of NRCH incorrectly reported as two MSIR workers being accused of drug trafficking. In some instances, negative reporting was made more intense by the inclusion of emotive photos depicting drug injecting and antisocial activities in the North Richmond precinct.

Analysis across print media, broadcast media and internet media found sentiment was 47 per cent negative and only 9 per cent positive about the MSIR trial. Analysis of social media using a product called 'TalkWalker' found that Twitter was the key forum for discussion of the trial (84.1 per cent of all media results), followed by online news (7.2 per cent). The impact of negative media coverage may have contributed to people's views about the trial.

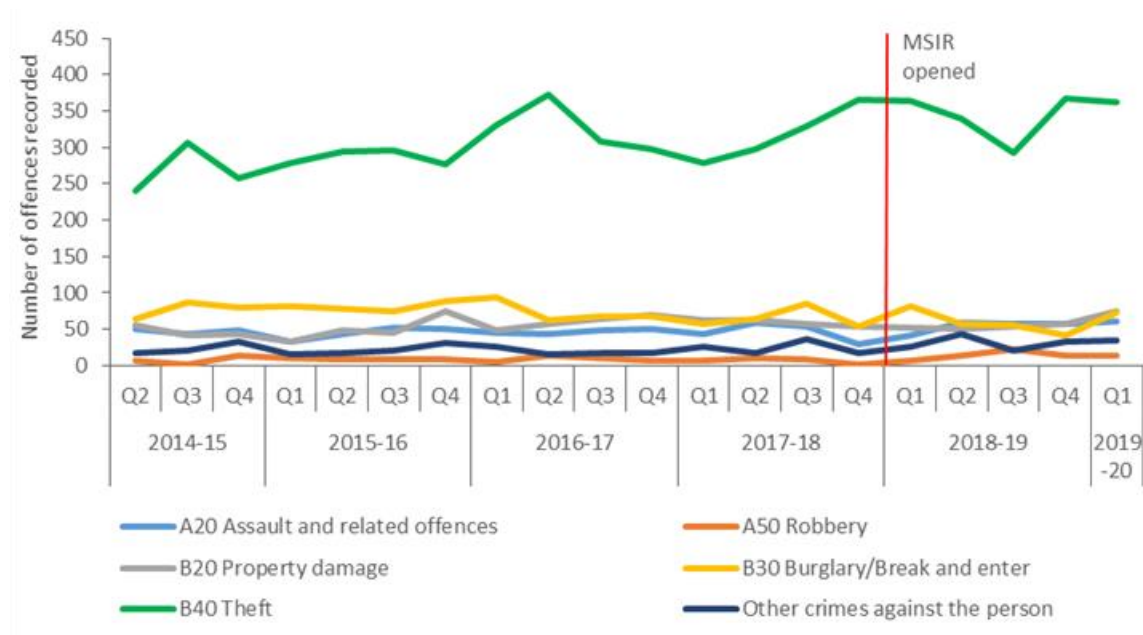
Crime in the local area

The number and type of offences recorded within a 1 km radius of the MSIR largely remained stable between October 2014 and September 2019 (Figures 38 and 39), except for offences relating to drug use and possession (Figure 39). Offences for drug use and possession declined after the opening of the MSIR and then increased again three months later (Figure 40). Almost all offences under this offence category were drug possession offences (98 per cent).

These trends may reflect that in the earlier months of the MSIR trial Victoria Police identified that, after delivering training on the matter, some of its members had developed a misunderstanding about the extent to which they could enforce drug-related crimes in the area, based on an ill-informed reference to an 'exclusion zone' around the MSIR discussed in the media at the time (Sakkal 2019). This led to some members being confused about who and when they could approach, with the result that their drug enforcement activity was lower than usual in the initial period of the trial.

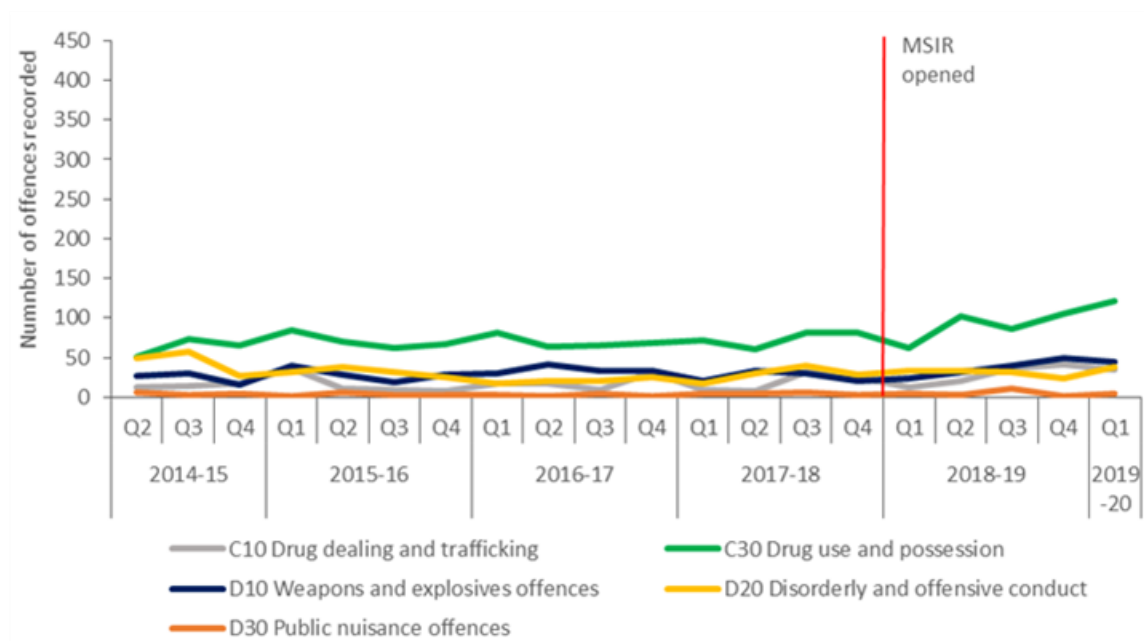
Once this misunderstanding became apparent, Victoria Police provided additional training to members about their remit, with the expectation that the law is enforced in all locations while advising police officers not to 'over-police' the entrance – that is, not to target people as they enter or exit the facility. In addition, more resources were provided to the location, including bike patrols covering the estate and laneways from mid-2019 (data beyond then was not available at the time of reporting). With increased resourcing comes the opportunity to detect more crime, so these figures may increase in the future.

Figure 38: Number of offences recorded within a 1 km radius of the MSIR from Quarter 2, 2014–15 to Quarter 1, 2019–20 – offence subdivisions relating to crimes against the person and property and deception offences



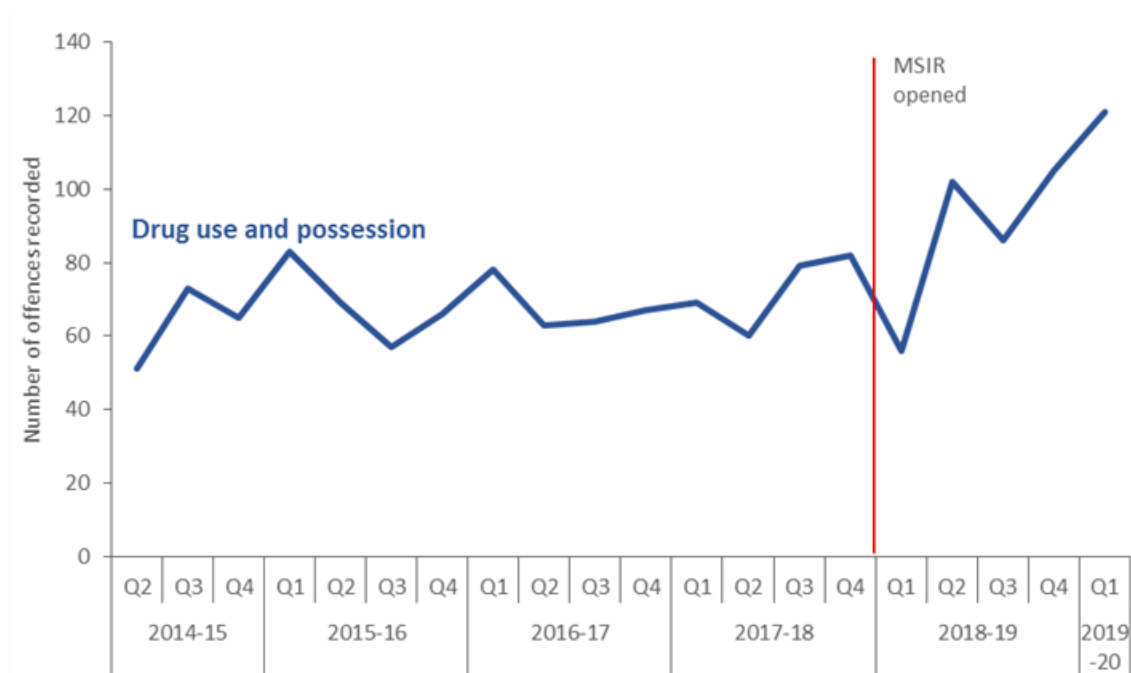
Source: Victorian Crime Statistics Agency

Figure 39: Number of offences recorded within a 1 km radius of the MSIR from Quarter 2, 2014–15 to Quarter 1, 2019–20 – offence subdivisions relating to drug offences and public order and security offences



Source: Victorian Crime Statistics Agency

Figure 40: Number of drug use and possession offences recorded within a 1 km radius of the MSIR from Quarter 2, 2014–15 to Quarter 1, 2019–20

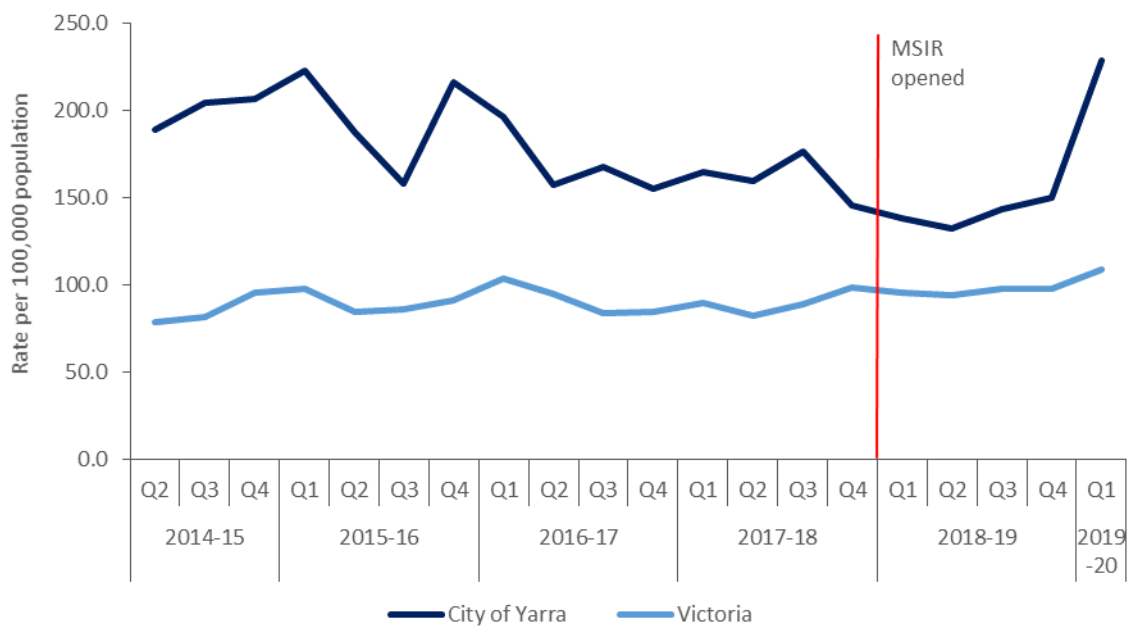


Source: Victorian Crime Statistics Agency

In general, the rate of drug possession offences per 100,000 population in the City of Yarra was higher than the Victorian rate. The rate of drug possession offences increased in Quarter 1, 2019–20

for both the City of Yarra (from 150.2 per 100,000 population to 228.7) and Victoria (from 97.7 per 100,000 population to 108.8), although the increase was larger for the City of Yarra than Victoria (Figure 41). The large increase in the City of Yarra may reflect the increase in policing training and resources to the area from mid-2019, as mentioned above and further considered below.

Figure 41: Rate of drug possession offences for City of Yarra and Victoria from Quarter 2, 2014–15 to Quarter 1, 2019–20 – per 100,000 population



Source: Victorian Crime Statistics Agency

Note: These statistics relate to offence group C32: drug possession.

These data relate to detection of offences only, and they do not necessarily match drug use trends in the area because other possible indicators changed in another direction. For example, the number of needles and syringes dispensed from NRCH increased between 2012 and 2017, possibly suggesting a large increase in drug use in the area before the trial commenced; however, the police statistics on use/possession show a decrease in the same period. These data seem to clearly reflect changes in policing effort, particularly since April 2019 when Victoria police committed to regular, concerted efforts and increased patrols in the area.

Changes in police numbers, training, operational protocols and possible special operations from other police areas can all influence drug crime data, so these are very hard to use as an accurate measure of criminal activity. Additional local policing resources were allocated to the Richmond local police station in the police service area of Yarra at about the time that the MSIR was opened, with local changes in policy direction also likely to have contributed to an increase in arrests.

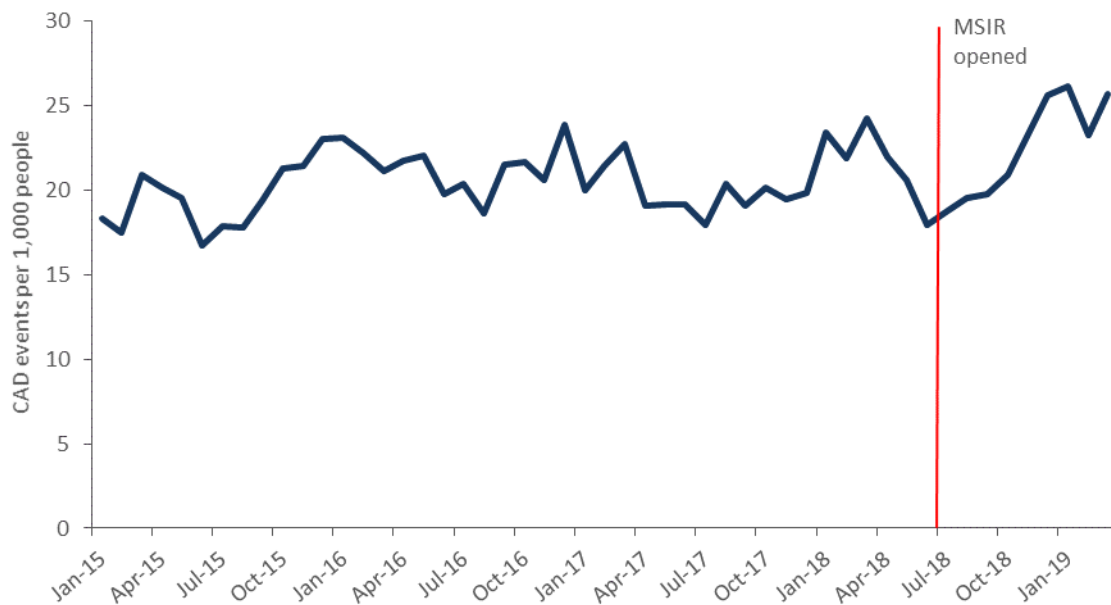
Police attendance in the local area

During the trial several organisations, including Victoria Police, the Yarra City Council, DHHS and some in the community, were actively encouraging people to contact the police if they had drug-related concerns. Several community stakeholders reported to the Panel or others within DHHS that this had led to them calling triple zero (000) in circumstances where they previously might not otherwise have done so. At the same time, Victoria Police were encouraging people to report

drug-related concerns through triple zero (000) rather than the station number. This makes directly comparing figures of emergency calls and police attendance before and during/after comparisons difficult since it is likely to have increased detection and reporting rates rather than necessarily indicating a change in drug-related activity requiring police intervention.

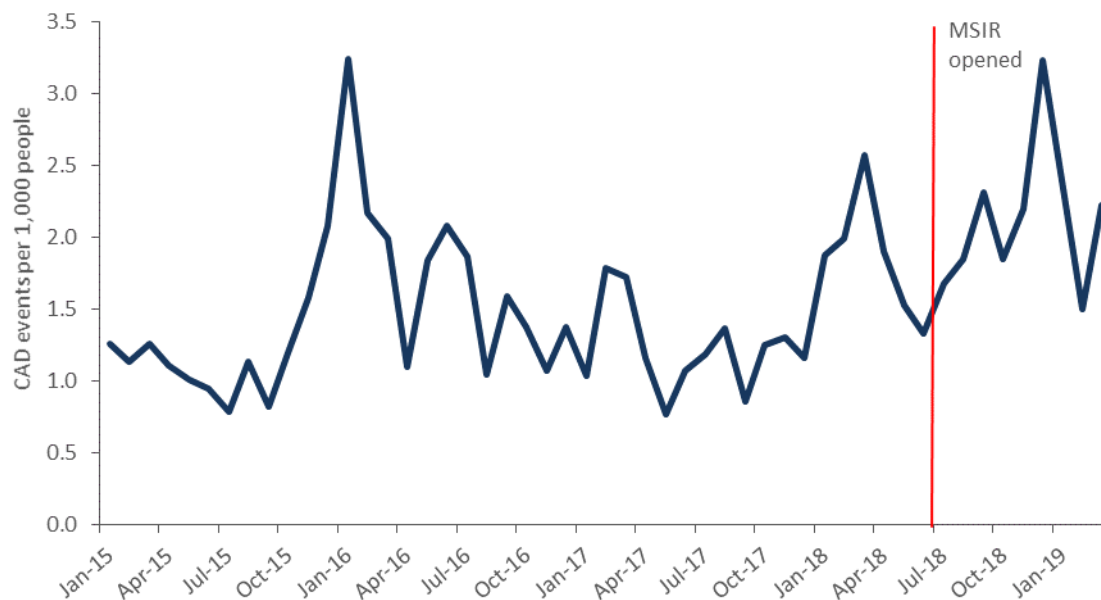
Figures 42 and 43 show total police callouts in the Richmond area compared with drug-related callouts from the end of 2014 to March 2015.

Figure 42: Total Victoria Police computer-aided dispatch events per 1,000 people, Richmond, January 2015 to March 2019



Source: Victoria Police Computer Aided Dispatch data

Figure 43: Drug-related computer-aided dispatch events per 1,000 people, Richmond, January 2015 to March 2019



Source: Victoria Police Computer Aided Dispatch data

Note: The Panel notes that changes in police numbers, training, operational protocols and possible special operations from other police areas can all influence drug crime data, and so these are very hard to use as an accurate measure of criminal activity.

Victoria Police observations

Victoria Police noted their awareness of significant attention from community members who reported concerns about an increase in people using drugs publicly or who appeared to be drug-affected in the community.

This was also the experience of many of the respondents to a survey conducted with local Victoria Police members for this review in November 2019. To note, this survey occurred shortly after the incident involving NRCH staff and may have affected police views at that time. An invitation was sent via email to all members working in the North West Division (which incorporates the area surrounding the MSIR) with at least one year's policing experience including policing the North Richmond area. Of the 41 members who responded, most reported observing significantly more people who appeared to be buying or selling drugs, or who appeared to be under the influence of drugs or undertaking drug-related antisocial behaviour (Table 12).

Table 12: Police observations on drug-related activity, November 2019

Issue	Degree	Percentage
Observed people who appear to be buying or selling drugs	Significantly more	77.5
	About the same	12.5
	Slightly more	10.0

Issue	Degree	Percentage
Observed people who appear to be under the influence of drugs	Significantly more	67.5
	Slightly more	17.5
	About the same	10.0
	Slightly less	5.0
Observed antisocial and/or disorderly behaviour that appears to be drug-related	Significantly more	57.5
	About the same	22.5
	Slightly more	17.5
	Slightly less	2.5

Source: MSIR review of local police

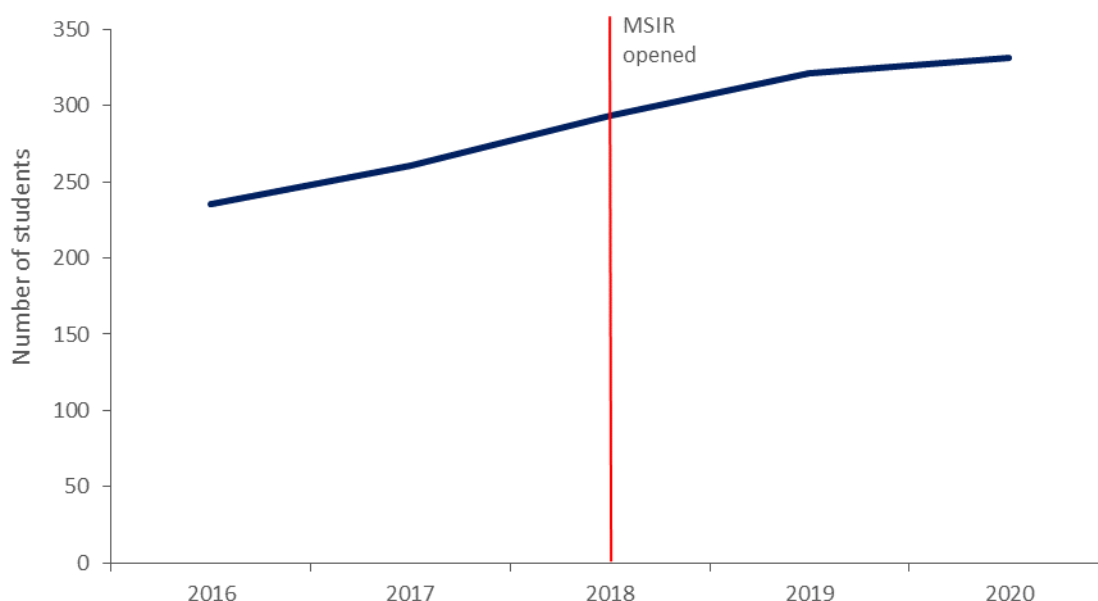
Victoria Police reported to the Panel that, over the period of the MSIR trial, crime in the area surrounding the facility was largely attributable to local crime trends not connected to the trial. For example:

- There was an increase in robberies during the period of the trial, but this did not appear to be associated with drug use.
- There was an increase in reported assaults, but these are typically alcohol-related and from a different cohort of people from those who inject drugs.
- Thefts from motor vehicles were being conducted by individuals already known to Victoria Police and were not associated with injecting drug activities.
- Thefts of motor vehicles in the local area were attributed to an increase in food delivery service personnel coming into the area and leaving their motorbikes unattended with keys in the ignition, leading to opportunistic crime, which also did not appear to be connected to people who inject drugs.
- There was an increase in congregation on the housing estate, particularly in the afternoons and by a group of local people consuming alcohol, although again, Victoria Police believes this was a different group of people from those using the MSIR.
- One possible barrier to effectively policing the stairwells and laundries at the local housing estate, both popular places to inject drugs, was the understanding of some police that they required a warrant to enter these spaces after the introduction of additional 'concierge' services, although this has now been clarified and is not true.

Impact on the nearby primary school

The Panel heard very different perspectives from parents about their experiences of the facility being located close to the school. It has not been possible to draw a conclusion from this feedback. Incidents involving discarded injecting equipment or overdoses have decreased, and results of both parent and staff satisfaction with the school in general have remained stable. Figure 44 shows that enrolment numbers have steadily increased during the period the MSIR has been open.

Figure 44: Number of students enrolled at the local school, 2016 to 2020



Source: Victorian Department of Education

Community surveys

There were two sources of community sentiment expressed in surveys available to the Panel. These were the MSIR Review Survey of local residents and businesses conducted for the Panel by Colmer Brunton immediately before the trial commenced in mid-2018 (see Appendix G) and repeated after one year of operations within the transitional facility in mid-2019 (see Appendix H) and separate surveys of householders conducted by Metropolis Research for the Yarra City Council (see Appendix B). The findings differ somewhat, and responses to questions about perceptions of safety are reported here.

MSIR Review Community Survey results

Results regarding responses to perception of public injecting, disposal of injecting equipment and other indicators of experience of amenity have already been reported above.

The proportion of local people randomly surveyed who reported feeling safe when walking alone during the day had fallen significantly in the first year of operations of the MSIR: businesses from 61.8 per cent to 45.8 per cent, and residents from 69.5 per cent to 54.7 per cent. The trend is similar regarding walking alone after dark.

Significantly more residents and businesses reported being approached and offered heroin within the year of the MSIR opening compared with the year before (21 to 30 per cent of residents and 19 to 22 per cent of businesses).

The percentage of residents who have considered moving out of the area because of drug-related activity increased significantly from 32.0 per cent before the MSIR to 37.1 per cent in mid-2019. Similarly, for business employees and owners, the percentage who have considered finding a new job or moving their business out of the area rose significantly from 27.6 per cent to 32.5 per cent.

For residents, the most frequently reported reasons for feeling unsafe were:

- violence and crime (30 per cent)
- public visibility of drug use and drug deals (29.2 per cent)
- safety concerns for their children and schoolchildren (21 per cent)
- aggressiveness and unpredictability of people who use drugs (19.4 per cent)
- discarded syringes in public places (16.1 per cent).

For businesses, the most common reasons were:

- public visibility of drug use and drug deals (29.7 per cent)
- violence and crime (18.8 per cent)
- aggressiveness and unpredictability of people who use drugs (17.7 per cent)
- safety concerns for their children and schoolchildren (11.8 per cent)
- discarded syringes in public places (9.8 per cent).

Yarra City Council Annual Customer Satisfaction Survey

Respondents to the Yarra City Council Annual Customer Satisfaction Survey are asked to identify any improvements noticed in their local area in the preceding two years. In the 2019 annual survey results, Richmond North¹⁹ and Abbotsford respondents were more likely than average to report improvements to drug-related issues (Yarra City Council 2019). Drug-related issues were the second most noticed improvement in both Richmond North and Abbotsford after parks, gardens and open spaces (Table 13). Respondents for the 2019 survey were interviewed in February–March 2019; this means respondents were asked this question eight to nine months after the MSIR opened. The 2018 survey findings differ from the 2019 findings, with respondents not reporting drug-related issues as a top improvement noticed in Abbotsford or Richmond North (respondents were surveyed in February–March 2018, before the MSIR opened). These findings suggest that after the MSIR opened there have been improvements in drug-related issues in Richmond North and Abbotsford, at least for some people living in the area.

Table 13: Top improvements noticed in the local area in the last two years by precinct, 2018 and 2019

Survey year	Abbotsford	Richmond North
2018	1. Parks, gardens, open spaces: 11.9%	1. Parks, gardens, open spaces: 16.9%
	2. Road maintenance and repairs: 6.0%	2. Cleanliness of areas including streets: 13.3%
2019	1. Parks, gardens, open spaces: 15.7%	1. Parks, gardens, open spaces: 13.3%
	2. Drug-related issues: 9.6%	2. Drug-related issues: 12.0%

Source: Yarra City Council: Annual Customer Satisfaction Surveys, 2018, 2019

Note: 2018 survey conducted February to March 2018; 2019 survey conducted February to March 2019.

Respondents to the Yarra City Council Annual Customer Satisfaction Survey are also asked to identify preferred improvements to the local area in the next two years. In the 2018 annual survey,

¹⁹ The area that the MSIR is located in is referred to by various stakeholders as North Richmond and Richmond North. In the Yarra City Council referred to above, it is referred to as Richmond North, and is presented as such in this section.

Richmond North and Abbotsford participants reported drug, alcohol and cigarette issues as the most preferred improvement to the local area in the next two years (Table 14). This differs from the 2019 findings in which Richmond North participants reported parking as their top preferred improvement, with drug-related issues listed second. For Abbotsford participants, both 'parking' and 'safety, crime and policing' were the top preferred improvements. These findings suggest that drug, alcohol and cigarette issues were identified as a top issue and area of improvement before the MSIR opened; however, after the MSIR opened it moved below parking as the issue where improvements would be preferred.

Overall, findings from the survey indicate that for some people in North Richmond and Abbotsford drug-related issues have improved; however, for other people drug-related issues are an ongoing problem.

Table 14: Top preferred improvements to the local area in the next two years by precinct, 2018 and 2019

Survey year	Abbotsford	Richmond North
2018	1. Drug, alcohol & cigarette issues: 19.0%	1. Drug, alcohol & cigarette issues: 21.7%
	2. Bike tracks & facilities/infrastructure: 13.1%	2. Parking: 13.3%
2019	1. Parking: 12.0%	1. Parking: 20.5%
	2. Safety, crime & policing: 12.0%	2. Drug-related issues: 15.7%

Source: Yarra City Council: Annual Customer Satisfaction Surveys, 2018, 2019

Note: 2018 survey conducted February to March 2018; 2019 survey conducted February to March 2019.

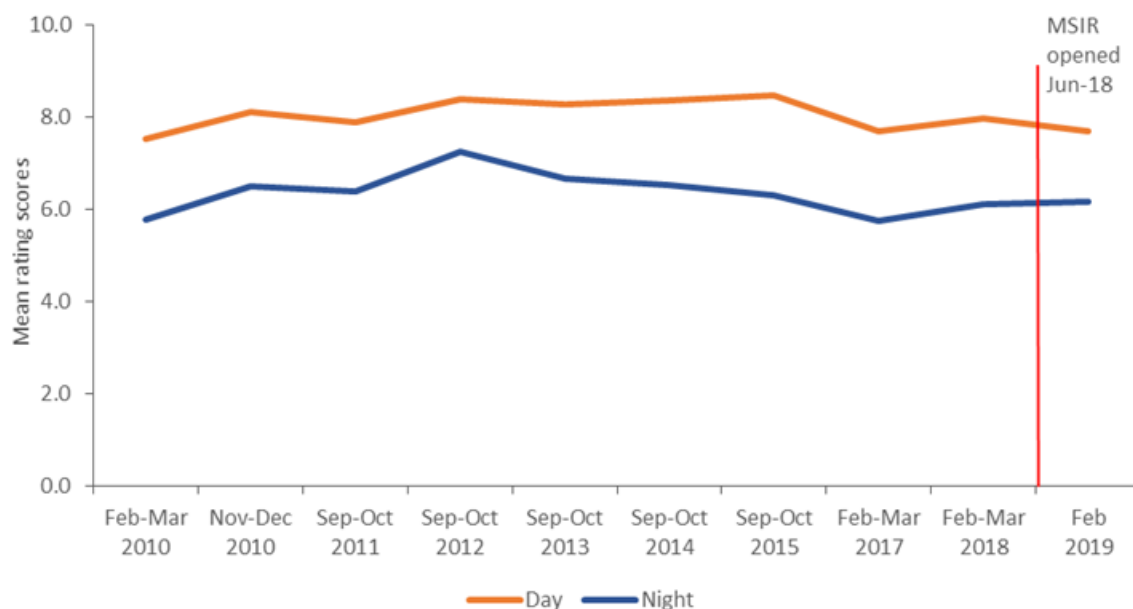
The annual Yarra City Council survey asks local residents: 'On a scale of 0 (very unsafe) to 10 (very safe), how safe do you feel in public areas in the City of Yarra?' In 2018 and 2019 this was conducted in the first half of the year. There was a small decrease in the mean rating score for North Richmond residents, although less than in the neighbouring area of Abbotsford (Table 15). Figure 45 provides the trend for this score between 2010 and 2019.

Table 15: Perceptions of safety during the day and night, Abbotsford and North Richmond, mean rating scores, 2018 and 2019

Time of day/night	Abbotsford residents	North Richmond residents
Safety during the day – 2018	8.7	8.0
Safety during the day – 2019	7.7	7.7
Safety during the night – 2018	7.0	6.1
Safety during the night – 2019	6.4	6.2

Source: Yarra City Council: Annual Customer Satisfaction Surveys, 2018, 2019

Figure 45: Perceptions of safety during the day and night in Richmond North, mean rating scores, 2010 to 2019



Source: Yarra City Council; Annual Customer Satisfaction Surveys, 2018, 2019

Observation and consultation with community members

In forums that Panel members directly observed and in consultations conducted by the Panel with local residents, businesses and interested groups, the Panel heard a range of experiences, with some suggesting improvements in amenity and others speaking strongly about deterioration. These involved real and perceived risks to their safety through what they saw as an increased number of people behaving in unpredictable and at times confronting ways. For example, a resident of the nearby housing estate noted times when 'we cannot leave the flat', having encountered individuals or groups injecting in the stairwell. In that week they made five calls to security and one to police.

Although the Panel heard from a small number of people who did not support the trial at all, the more common view was one of support for the trial but also concerns about the impact of it on the local community. Different people and groups called for different responses: some wanted the trial to continue in the current location; others were supportive of the trial of such a service but wanted the location to move, possibly to a more industrial or commercial area of North Richmond. A number of people suggested opening additional sites to 'spread the load'.

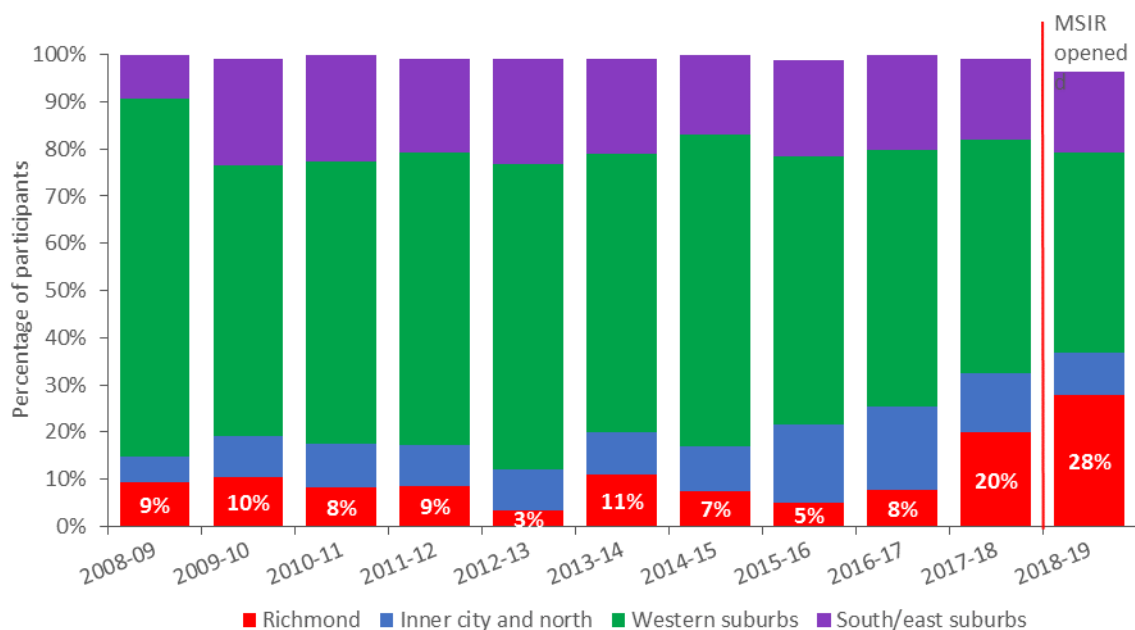
Has the MSIR attracted people who sell or use drugs to the area?

One of the most common concerns historically for supervised injecting facilities and other drug consumption rooms is that they will bring people who inject drugs into an area who otherwise would not have come, a so-called 'honeypot' effect.

This review explicitly sought to test this. It does not appear there has been a direct 'honeypot' effect driven by the MSIR. From data collected at registration, Melbourne is the most commonly cited area of residence, and from the evidence available, most people who have used the MSIR trial do not identify as residents of North Richmond. This could be because it is used as a default by

people who do not want to be more specific. Richmond is the second most often recorded place of residence. Most people using the MSIR (86 per cent) were already coming to North Richmond before the MSIR trial was established to purchase and use heroin. Separately, the Burnet Institute's SuperMIX study (2019) found a shift towards purchasing heroin in Richmond by cohort members in the year before the facility opened, which continued after it opened (Figure 46). There could be many explanations for this.

Figure 46: Location of latest heroin purchase for participants recruited before 2017 and interviewed after MSIR opening, 2008–09 to 2018–19



Source: Burnet Institute 2019

The Burnet Institute study found that MSIR service users were more likely to report purchasing heroin in public spaces (62 per cent) than those who had not visited the MSIR (42 per cent), who usually purchase their drugs in other locations. Frequent users of the MSIR were more likely to have purchased heroin in public than less frequent users of the MSIR – 58 per cent versus 69 per cent respectively (Burnet Institute 2019, p. 44).

Of the Burnet Institute study participants who were interviewed outside Richmond, those who visited the MSIR were more likely to report their last purchase of heroin in public than those who didn't visit the MSIR (see Table C10, Appendix C).

Local community support for the MSIR

Support for an injecting room fell among residents over the first year of the MSIR's operations. Among businesses, there was no marked change in support level. Regarding the location of North Richmond, support decreased in both groups, as much as 17 per cent among residents and 7 per cent among businesses.

Where is implementation up to?

Implementation of a necessary suite of responses to local amenity is still in its early stages.

The main focus of the first year of the trial has been to establish the service and to oversee injecting by people attending the MSIR. The new facility has only recently become fully operational with regular clinics in Zone 4.

The Panel is aware of a series of more recent additional measures that have been initiated to help address the objective of improved community amenity. These have included a precinct and social landlord initiative in the immediate area and actions to respond to a Crime Prevention Through Environmental Design assessment led by Victoria Police. These initiatives demonstrate a commitment to better link various government programs with the Yarra City Council as well as community groups and other services.

The Panel notes that the legislation that enacted the Sydney MSIC did not include improved amenity of the local area as an objective, and a review of the literature suggests that this objective is very hard to achieve or to demonstrate in association with establishing a supervised drug injecting service. The Yarra City Council and the Victorian Government have been more focused on addressing amenity during the most recent phase of the MSIR trial's implementation, especially since late 2019.

Most recently the Panel has been provided with the following by DHHS:

In April 2019, the Minister for Mental Health announced that there will be more frequent sweeps to remove needles, more AOD outreach team providing help on the street, and on the Richmond housing estate, an increased security presence and improved lighting. The announcement was followed by Yarra City Council's decision to increase the amount of street cleaning in the Victoria street precinct and Victoria Police's commitment to regular proactive patrols and ongoing enforcement activity in the area, focused on holding drug traffickers and dealers to account.

The Government recently made further improvements on the Richmond housing estate and Victoria Police identified important safety and security issues through a Crime Prevention Through Environmental Design review. In response, DHHS made capital upgrades throughout the estate, including in the multi-deck carpark next to NRCH. Cleaning needle collection and syringe disposal unit availability has also been increased on the estate. As the trial has progressed, there have also been more crime prevention activities in the area in the vicinity of the MSIR and on the estate.

Given this timing, it is not possible for the review to examine evidence of impact or to comment on change in amenity that these measures might achieve.

Part 55A(f): Assist in reducing the spread of blood-borne diseases among MSIR users

To assess this object, the Panel considered:

- MSIR data on health needs and services provided
- St Vincent's Hospital's Independence Program data
- results of a cohort study of people who use drugs linked with Victorian health datasets.

The trial has advanced this object, particularly for more frequent users of the service, and for those requiring treatment for blood-borne diseases.

- Most people were already reporting not sharing needles and syringes (an important measure to reduce the spread of blood-borne viruses), with no significant difference in needle sharing rates between MSIR service users and other people who inject drugs.
- The MSIR has provided screening, assessment and treatment initiation and monitoring of blood-borne infections.
- In the first 18 months, approximately 300 people were tested for blood-borne viruses, with more than one-third of people screened testing positive for hepatitis C and a quarter had begun treatment for hepatitis C.
- After the first year of the trial, an analysis of linked Medicare and Pharmaceuticals Benefits Scheme data showed no significant difference in relevant tests or prescriptions between people who use the MSIR and other people who inject drugs, noting that efforts to provide these services have increased and the uptake and impact should continue to be monitored.

One of the aims of the MSIR is to 'assist in reducing the spread of blood-borne diseases in respect of service users of the licensed medically supervised injecting centre, including, but not limited to, HIV and hepatitis C' (Part 55A(f) of the Act). For the purpose of this report, blood-borne diseases are defined as blood-borne viruses that are commonly transmitted through risky injecting practices such as sharing injecting equipment.

As outlined in the program logic, the review initially examined evidence to consider whether:

- injecting at the facility is taking place with sterile equipment and according to protocols
- mechanisms are in place for identifying service users with blood-borne viruses.

As the trial progressed, the review analysed evidence to understand the extent to which there are accessible, suitable and effective health promotion and harm reduction messages at the facility, including techniques to minimise the risk of blood-borne viruses.

All injections at the MSIR are conducted with appropriate injecting equipment and access to harm reduction advice and education. Staff indicated that they had the skills and capacity to support practices that aim to reduce the spread of blood-borne viruses, including following sanitation protocols and wearing protective equipment. Staff reported that service users adhere to the operating policy of zero sharing of injecting equipment.

In relation to injections outside of the MSIR, MSIR service users reported a much higher number of injections per week (14 per week compared with three for other people who inject drugs), which may increase their risk of acquiring a blood-borne infection if they are using used equipment. There is not a significant difference between MSIR service users and other people who inject drugs in

reporting that they had injected with someone's used needle/syringe in the previous month (9 per cent of MSIR service users and 11 per cent of other people who inject drugs) (Burnet Institute 2019, p. 51) (see Table C19, Appendix C). Some staff and service users raised concerns that the closure of the secure dispensing unit at NRCH could contribute to an increased risk of acquiring a blood-borne infection.

There is high demand at the service for blood-borne infection testing. At registration, hepatitis C is the fourth most frequently identified health need among service users. Between 30 June 2018 and 31 December 2019, the MSIR screened more than 284 service users for HIV and viral hepatitis (hepatitis A, B and C). Of this number, 35.6 per cent (101) tested positive (via a hepatitis C polymerase chain reaction (PCR) test) and 25.7 per cent (73) initiated hepatitis C treatment.

The co-location of a St Vincent's Hospital care coordinator (Health Independence Program, Infectious Diseases) provides pre- and post-test HIV and viral hepatitis counselling, venepuncture and treatment. The care coordinator provided 195 occasions of service to service users in the October–December 2019 quarter (Table 16). Additionally, 116 occasions of service were provided to MSIR service users in the community.

Table 16: St Vincent's Hospital Melbourne Health Independence Program infectious diseases occasions of service

Service type	Oct–Dec 2019	30 Jun 2018 to 31 Dec 2019
Brief intervention	57	97
Care coordination	46	76
Blood-borne virus education	24	36
Nurse assessment	23	27
Blood-borne virus screening	22	40
Engagement	13	45
Secondary consultation	7	31
Other	3	45

Source: St Vincent's Hospital

The following case study illustrates the work undertaken by the St Vincent's Health Independence Program infectious diseases clinical nurse consultant in the October–December 2019 quarter.

Case study 9: Screening for blood-borne viruses

This client has a long history of intermittent heroin and methamphetamine use and travel to NRCH to access pharmacotherapy due to concerns about privacy and stigma. The client spoke to the infectious diseases care coordinator with concerns about sexually transmitted and blood-borne diseases they were afraid to discuss with their local doctor. The care coordinator referred them to a trusted local GP for future needs, and supported them to undertake a full screen, which gave a positive result on a communicable disease. The care coordinator supported contact with both the new GP and DHHS for partner notification support.

Case study provided by St Vincent's Hospital Melbourne

In relation to the impact of the trial on testing and treatment, there was not yet any evidence through analysis of linked data with the Medicare Benefits Schedule of any significant difference between the average number of hepatitis C PCR tests in preparation for treatment and tests to confirm treatment success for participants who visited the MSIR compared with those who did not in the years surrounding the opening of the MSIR (Burnet Institute 2019, p. 52). There was also not yet any evidence of any significant difference between the average number of hepatitis C prescriptions for participants who visited the MSIR compared with those who did not in the years surrounding the opening of the MSIR (Burnet Institute 2019, p. 53). Since then, there have been substantial efforts to increase the number of people screened and treated at the service, and if the trial is extended, it would be helpful to continue to monitor access, use and clearance rates of diseases such as hepatitis C. Population rates for blood-borne viruses in Victoria have gradually declined over time (between 2016 and 2019), whereas rates in the City of Yarra have fluctuated. While the number of hepatitis C cases involving reported injecting drug use in Victoria shows a decline between 2018 and 2019 (from 579 to 392, respectively), it is not possible to directly attribute this change at the state level to the opening of the MSIR (see Appendix C).

Legislation and regulations

This section of the report describes how the legislation and regulations made for the purposes of trialling a medically supervised injecting centre in Victoria have operated and whether they need amending.

Legislation

The Drugs, Poisons and Controlled Substances Amendment (Medically Supervised Injecting Centre) Act: Part IIA – Trial of medically supervised injecting centre, confers certain powers on the Secretary to DHHS. Under the Act, the Secretary may issue a licence for an MSIR at the permitted site. The Secretary may refuse to issue the MSIR licence to an entity for any reason the Secretary thinks fit. Only one MSIR licence may be issued.

The Secretary must also consider whether to approve the draft internal management protocols proposed by that entity. In doing so, the Secretary must have regard to whether, if the MSIR licence were issued, the draft protocols would require that: (a) the centre must have a director; (b) the centre must be under the supervision of a supervisor at all times; and (c) the centre must be operated so as to facilitate access or referrals to services such as primary healthcare services, drug and alcohol treatment services, services for testing for blood-borne diseases and STIs and services involving a needle and syringe exchange program. With the written approval of the Secretary, the MSIR internal management protocols may be amended or replaced from time to time.

If satisfied that extending the period of the MSIR licence would further the legislative objectives, the Secretary may do so by amending the licence to change the day specified under subsection (1)(b) to a day that is not later than 36 months after the day previously specified under that provision. The period may be extended only once. On extending the period of the MSIR licence under s. 55F (3), the Secretary must publish in the *Government Gazette* a notice that states that the period of the licence has been extended. The MSIR licence is subject to the several conditions including: (a) no child is to be admitted to any part of the facility for the purpose of the administration of any injecting centre drug; and (b) the internal management protocols must be observed at all times.

The Panel notes that the legislation allows for a single non-transferrable licence during the trial period and is specific about the location at which the trial can occur. The specificity of the legislation could be restrictive in the event that government wished to make any changes during the trial period, or if there were external circumstances that meant the site was inaccessible (for example, a fire) that would mean the service would not be able to operate in another site.

The legislative requirement for the medical director to have oversight of the centre, and in addition a medical supervisor to be available at all times, embeds workforce requirements in a way that does not allow DHHS or the licensee to revise them during the trial period.

The specificity of the legislation makes any adaption or innovation of the trial elements difficult.

The legislation is prescriptive in defining many elements of the development and operation of the trial. This makes it difficult to adapt to any change that might occur in the context of the service or among the service users or in other service developments. It prevents innovation and certain adaptations that might make for a more responsive or efficient service. Further, it creates complexity

in the governance arrangements for the MSIR. For example, embedded in the legislation and the internal management protocols that flow from the regulations are the tightly defined requirements of the licensee including specific management directives that may constrain or compromise the usual role of a board and executive management of a contracted service.

Regulations

The Drugs, Poisons and Controlled Substances Amendment (Medically Supervised Injecting Centre) Regulations prescribe that any drug of dependence is able to be used at the MSIR and that individuals are permitted to have with them less than a trafficable amount of those drugs.

The regulations also prescribe the content required to be included in the internal management protocols of the licensed medically supervised injecting centre including:

- (a) responding to clients who are at risk of causing harm to themselves or others
- (b) ensuring minimum staffing levels are maintained at the licensed medically supervised injecting centre
- (c) ensuring minimum security levels are maintained at the licensed medically supervised injecting centre
- (d) excluding the employment of potential and existing staff members deemed unsuitable for employment at the licensed medically supervised injecting centre on the basis of their criminal history
- (e) setting eligibility criteria for accessing any part of the licensed medically supervised injecting centre that is used for the purpose of administration of any injecting centre drug
- (f) preventing access to the licensed medically supervised injecting centre by clients known to be on parole, on bail or subject to any other order of a court or tribunal that prohibits the use of injecting drugs
- (g) preventing and responding to any potential or suspected trafficking in a drug of dependence in the licensed medically supervised injecting centre.²⁰

Impact from legislation and regulations

There are aspects of the legislation and regulations that may require further consideration, such as barriers to access for some individuals who might benefit from attending the MSIR who are unable to do so. This includes:

- people on bail/parole conditions – noting that people leaving custodial settings can be at increased risk of overdose due to decreased tolerance to substances
- young people – noting that many people who use the MSIR first injected at a relatively young age.

A number of groups have expressed concerns about barriers to access, regardless of the mechanism that excludes them. The Panel believes these concerns warrant further exploration if

²⁰ See the [Drugs, Poisons and Controlled Substances Amendment \(Medically Supervised Injecting Centre\) Regulations 2018](https://content.legislation.vic.gov.au/sites/default/files/1118aa87-1c5f-3cb5-82fd-cd6c1f7bca5e_18-045sra%20authorised.pdf) <https://content.legislation.vic.gov.au/sites/default/files/1118aa87-1c5f-3cb5-82fd-cd6c1f7bca5e_18-045sra%20authorised.pdf>.

the trial was extended. **Government may wish to monitor the impact of barriers to or exclusions from the service if the trial is extended.**

Conclusions

The implementation of this service and associated responses remains a work in progress.

It has clearly been possible to establish a medically supervised injecting service that has attracted people who are at high risk of overdoses associated with injecting drugs. NRCH has managed a complex challenge that has included a significant increase in its budget, staffing levels and external attention. The MSIR has been responsive and able to oversee many people injecting drugs within the facility. There have been no overdose deaths in the MSIR, and a number of people have been assisted to access health and support services.

The trial has shown that the concept of a medically supervised injecting service in Victoria can be implemented successfully.

The expectations detailed as objects in the Act are ambitious and completed assessment of their achievement is premature. Considerable detail has been provided in this report. **Most of the objects of the Act have been advanced during the first 18 months of the trial.**

This review has used many sources of data. Findings relating to illicit drug availability, use and associated harm must always consider diverse and often incomplete data in order to draw any conclusions that, at the end of the day, must sometimes rely on inference through the weight of a mix of evidence. There are benefits to using the unique mix of data Victoria has available, and the continued collection of these is warranted. This includes data that provide some insight and opportunity to monitor the drug market for heroin and other injectable drugs, the movement of people who use these drugs as well as their service seeking, and changes to patterns of use and harm as well as uptake of additional services.

The location of the MSIR in a health service should provide benefits of ensuring access to broader health and other support services. Many NRCH staff were already trusted by people who have been injecting drugs in Richmond, evidenced by the very rapid take-up of the MSIR upon opening. However, ongoing efforts to assess changing dynamics in the area, including possible shifts in the location of trafficking and consumption, will be important as well as monitoring the success of the various ways that the MSIR approaches provision of integrated responses, particularly if additional services are opened.

With only six months of operation in the purpose-built, larger facility, there has not been sufficient data or experience to allow a considered comparison of the two different locations of the MSIR, albeit they have been on the same designated land and physically close. It is too early in implementation to determine if the MSIR should be terminated or made permanent. More time and the possibility of further supervised injecting services in an additional three-year trial period could provide greater experience and an opportunity to explore other means of responding to demand. It would also allow for the measures directed at amenity and precinct renewal that are only now emerging to be actioned in the vicinity of the MSIR.

The trial should continue and be expanded.

Findings

- North Richmond has been the main site for heroin use and related harms in Victoria for the past decade.
- The trial occurred in the context of increasing heroin use and increased visibility of people who inject drugs in North Richmond and a high number of overdose deaths.
- The MSIR provides a responsive and safe service to people who inject drugs.
- The service has been well utilised by the intended client group.
- The service is attracting a group of people who inject drugs with high health and support needs, many with recent experiences of overdose.
- The model of care could be further considered to examine options regarding matters such as staffing, optimum opening hours and the ways of providing additional services, recognising that many of the service users require navigation to connect to systems of care.
- The establishment of the MSIR has prevented overdoses and further harm and has saved lives.
- Of those who do attend the service, the nature of the overdoses is significant, and without intervention it is likely that many would have died or been permanently injured.
- Modelling allows an estimate of the number of lives that the MSIR may have saved and, while there are different ways to model this, using conservative estimates, these data suggest that between 21 and 27 deaths were avoided over the 18 months of this review. This does not include the prevention of permanent disability including acquired brain injury.
- NRCH and MSIR staff have made significant progress in delivering additional services and developing referral pathways to other service providers.
- With the move to the larger facility the range and number of services is expanding.
- An ongoing trial would provide the opportunity to develop and assess ongoing integration of services and alternative ways of achieving this.
- There has been a reduction in ambulance attendances involving naloxone in the vicinity of the facility during opening hours.
- There have been no observable changes in emergency department presentations that can be attributed to the MSIR.
- There has been a reduction in reports of public injecting. Local people report no difference in seeing discarded injecting equipment. There has been an increase in collected injecting equipment (noting also an increase in collection activity later in the trial).
- Amenity has not improved during the review assessment period.
- Implementation of a necessary suite of responses to local amenity is still in its early stages.
- The MSIR has provided screening, assessment and treatment initiation and monitoring of blood-borne infections.
- The specificity of the legislation makes any adaption or innovation of the trial elements difficult.
- The operating exclusion criteria limit access for vulnerable people who are likely to nevertheless inject the drugs they have already purchased.

Recommendations

Based on these findings, the Panel recommends that:

1. The medically supervised injecting room (MSIR) trial at North Richmond Community Health (NRCH) continues in order to allow it to operate for the possible full duration of the licence (three further years).
2. The MSIR operates with no more than 20 injecting booth positions to ensure ongoing effective management in this high-acuity health setting for the duration of the trial.
3. Based on demand and international experience, the Victorian Government expands the current trial to include another supervised injecting service in an appropriate location within the City of Melbourne.²¹ Trialling further services in this period could help manage demand, potentially save a greater number of lives and would allow an opportunity to test effectiveness in different locations as well as trial another model of supervised injecting facility in Victoria.
4. The Department of Health and Human Services continues to lead the MSIR trial as a health response with coordination support from the Department of Justice and Community Safety to ensure that both health and community needs are considered as the trial evolves to improve real and perceived levels of community safety.
5. The Victorian Government works with local government and the community to continue to develop local safety and amenity, including formalising the role of the existing roundtable to be responsible for community engagement, community safety and coordination of relevant services. This should include representatives from at least the Department of Health and Human Services, Victoria Police, Yarra City Council, local service providers (including the MSIR) and the local community.
6. The licensee of any supervised injecting service be proactive in engaging and communicating with the local community and key stakeholders on issues that may potentially affect the community.
7. There be more emphasis on place management, including in the vicinity of the MSIR, with a clear understanding among staff, service users and community members that disturbing and antisocial behaviour will not be tolerated. Visible community policing is required in areas of active drug trafficking to increase the experience and perception of community safety.
8. The model of care be further considered, including:
 - the requirement for medical supervision since clinical (nursing) oversight could achieve the same level of safety more efficiently
 - the current hours of operation to best match demand for the service
 - enhancing the access to and availability of care coordination in areas such as mental health, housing and drug dependence treatment.

²¹ This recommendation is based on the international research and experience described in this report, patterns of overdose-related deaths in non-residential locations, ambulance attendance involving the provision of naloxone, publicly available crime data and the Panel's own knowledge and insights into street-based injecting activity in Victoria. Consideration of a local government area for another service was not originally part of the terms of reference for this review; however, in recommending another supervised injecting service, the Panel agreed to provide additional advice regarding location (see addendum).

9. The Victorian Government continues to monitor the implementation of the recommendations of the NRHC Alcohol and Other Drug Review, recognising that further refinement in policy or practice may be required.

10. Further reviews associated with establishing any MSIRs be conducted, with a report to be submitted at least six months before the potential expiry of any licence. This should draw on performance monitoring data from within the service and focus particularly on local amenity planning and implementation, and the experience and perception of local community members.

11. Funding is provided to enable ongoing provision of services that meet the needs of injecting room users.

12. Statewide drug-related patterns of use and harms continue to be monitored through analyses of data such as ambulance attendance, the provision of naloxone and deaths involving heroin and other injectable drugs. This could usefully include qualitative research methodologies in locations where evidence indicates high levels of activity related to injecting drugs.

13. Harm reduction initiatives continue to be provided to those areas and people experiencing most harm, such as by expanding overdose response training and the direct provision of naloxone including through needle and syringe programs and in prisons, detoxification and rehabilitation settings and other relevant services.

14. The Victorian Government monitors the impact of current exclusion criteria on access for vulnerable populations with a view to reviewing their suitability for an MSIR.

Addendum: Additional advice regarding the most appropriate LGA for a possible second service

This addendum provides further detail in relation to the development of Recommendation 3, in particular the rationale for naming the City of Melbourne as the second LGA for an injecting service.

Consideration of an LGA for another service was not originally part of the terms of reference for this review; however, in recommending another supervised injecting service, the Panel agreed to provide additional advice regarding the most appropriate LGA.

The Panel considered the following information to form this recommendation:

- international research and experience described in this report
- patterns of overdose-related deaths in non-residential locations
- ambulance attendances involving the provision of naloxone
- drug-related crime data
- the Panel's own knowledge and insights into street-based injecting activity in Victoria.

International research and experience

As described previously, the European experience shows that the extent to which medically supervised injecting facilities are used is highly dependent on their location. Essentially, the service needs to be:

- near to illicit drug markets
- close to places of drug purchase
- located where they can be embedded in a wider network of services
- compatible with the needs of people who use drugs
- compatible with the needs and expectations of local residents.

A recent analysis of published reviews of supervised injecting programs (Belackova et al. 2019) has identified key features to consider in designing future drug supervision facilities:

- the location and co-location of the program
- whether people who use drugs will trust the program and therefore access the service when possession and use of that drug is criminalised
- what operational hours will best capture the times and/or periods of increased overdose risk
- what specific harm reduction practices should be prioritised or what level of assistance in referring people to other services is most appropriate.

These features need to be fully considered during the period when the service is being designed and decisions made about specific location(s).

Patterns of overdose deaths in non-residential locations

The Panel considered deaths in non-residential locations and identified that the LGA of Melbourne had the second highest number and percentage of these deaths after the City of Yarra (Table 17).

Table 17: Percentage of deaths occurring in non-residential locations – top 20 LGAs for heroin-related deaths between January 2015 and September 2019

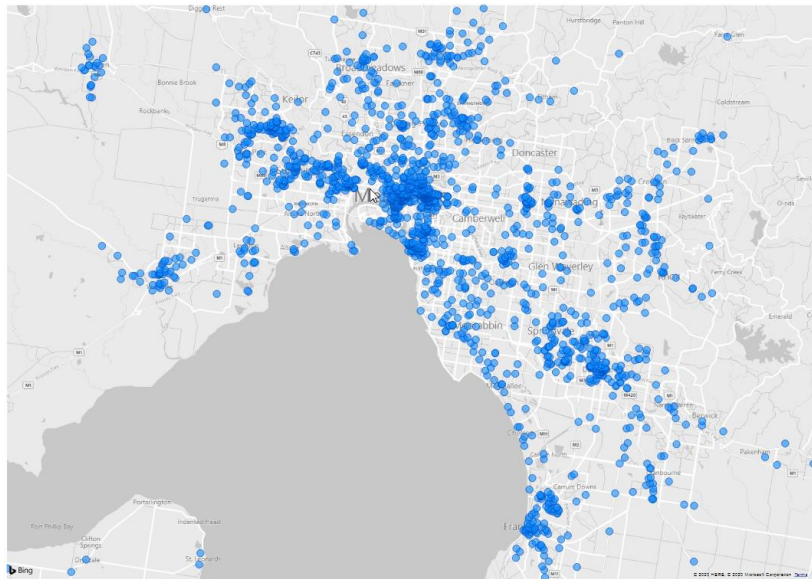
Local government area	Number of heroin-related deaths in non-residential locations	Percentage of heroin-related deaths in non-residential locations	Total heroin-related deaths
Yarra	51	55	93
Melbourne	25	49	51
Brimbank	17	30	57
Port Phillip	10	19	52
Greater Geelong	8	20	40
Frankston	6	20	30
Wyndham	6	26	23
Greater Dandenong	6	11	53
Maribyrnong	5	16	32
Whitehorse	4	16	25
Maroondah	4	21	19
Stonnington	3	17	18
Hume	3	17	18
Yarra Ranges	2	9	22
Moonee Valley	2	11	18
Monash	1	5	22
Greater Bendigo	1	6	18
Boroondara	1	6	18
Moreland	1	3	30
Knox	1	3	29
Darebin	1	2	41

Source: Coroners Court of Victoria

Ambulance attendance involving the provision of naloxone

The Panel considered ambulance attendance involving the provision of naloxone as a proxy for understanding patterns of overdose and identified Melbourne as the LGA with the highest number of attendances during the trial period (Figure 47).

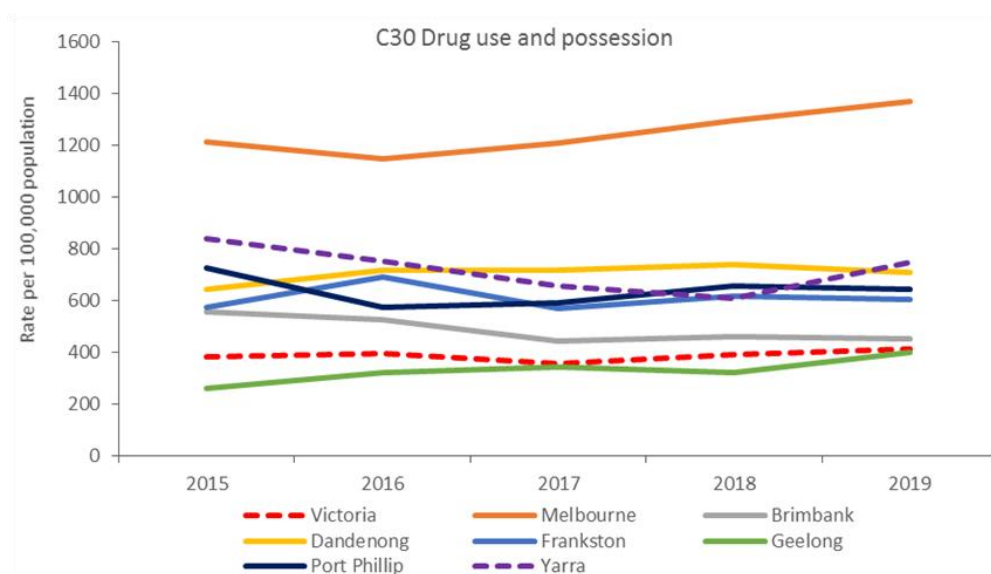
Figure 47: Ambulance attendances where naloxone was administered by paramedics – Greater Melbourne region, July 2018 to December 2019



Drug-related crime data

The Panel also considered drug-related crime data – in particular, drug use and possession – and identified the Melbourne LGA as having the highest rate of these crimes recorded (Figure 48).

Figure 48: Drug use and possession data from Melbourne LGAs and Victoria overall, 2015 to 2019



Based on the above, and the Panel's own knowledge and insights into street-based injecting activity in Victoria, the LGA of Melbourne was identified as the most appropriate LGA for a possible second service.

Appendix A: Terms of reference for the review²²

Overview

The Victorian Government is trialling a medically supervised injecting room at the North Richmond Community Health site in North Richmond, Melbourne.

The trial will take place for an initial two-year period, with the option to extend the trial for a further three years. It is proposed that the trial will commence in mid-2018.

Role of the Panel

The Medically Supervised Injecting Room Review Panel (the Panel) will oversee the conduct of a review as outlined in s. 55P of the *Drugs, Poisons and Controlled Substances Act 1981* (the Act), including:

- the operation and use of the licensed medically supervised injecting room
- the extent to which the objects outlined in Part IIA of the Act have been advanced during the period of the medically supervised injecting room licence
- how Part IIA and any regulations made for the purposes of this Part of the Act have operated and whether they require amendment.

Specifically, the responsibilities of the Panel are to:

- develop, with the Department of Health and Human Services (the department), the review scope, structure (including any preliminary or interim reports) and data and evidence collection requirements
- review data and evidence to closely monitor the objects of the Act
- provide the Secretary to the department with a draft copy of the review, to inform a decision on whether the trial should be extended
- provide an endorsed review to the Minister for Mental Health (the Minister) prior to the completion of the two-year trial, meeting the requirements outlined above.

The review must commence no later than 12 months after the day on which the medically supervised injecting centre licence commences. It may be completed before or after the licence ceases to have effect.

Membership

Composition

1. The membership of the Panel will consist of the following members, appointed by the Minister:
 - chairperson

²² Department of Health and Human Services (DHHS) 2019, Medically Supervised Injecting Room: frequently asked questions, 'Why is the Victorian Government trialling a MSIR in North Richmond?' Online. Accessed February 2020 <<https://www2.health.vic.gov.au/alcohol-and-drugs/aod-treatment-services/injecting-room>>

- up to two other members, as determined by the Minister.
- 2. The Minister shall appoint the chairperson and members in accordance with the Victorian Government's *Appointment and remuneration guidelines* (the guidelines).

Appointment

- 3. A person is not a member of the Panel until appointed by an instrument signed by the Minister.

Probity checks

- 4. Prospective members are subject to probity checks including:
 - a declaration of private interests
 - a national police record check
 - an Australian Securities and Investment Commission (ASIC) check
 - an Australian Financial Security Authority (AFSA) check.
- 5. Members will be required to make a declaration of private interests annually during their term of appointment.

Term of appointment

- 6. Members will be appointed from the date listed in the Instrument of Appointment until 29 June 2020.
- 7. At this time, the terms of reference and membership of the Panel will be reviewed. The Minister will direct whether the Panel should continue and whether any necessary changes to terms of reference or membership are required, or whether the Panel should be dissolved.
- 8. Where a replacement member is appointed, the term of office for that member shall be the balance of the term of office of the replaced member.

Vacancies

- 9. A member of the Panel may resign in writing, addressed to the Minister.
- 10. The Minister may remove a member from the Panel at any time by providing that member with notice in writing, which shall have immediate effect.
- 11. The office becomes vacant if:
 - a member dies
 - for any other reason determined by the Minister.
- 12. Upon a vacancy occurring, the vacancy may be filled in accordance with these terms of reference.

Remuneration and expenses

- 13. Members of the Panel are entitled to receive remuneration as fixed by the Minister in accordance with the guidelines for a Group D2 classified body.
- 14. Members are eligible to be reimbursed for reasonable out-of-pocket expenses in accordance with 7.27 of the guidelines and the policies of the department.

Confidentiality

15. Members shall maintain confidentiality of the following information in order to provide a basis for independent advice and debate:
 - deliberations of the Panel
 - correspondence between the Minister or the department and the Panel
 - departmental papers supplying information in relation to business matters before the Panel
 - any other documents provided to members marked confidential unless otherwise stated by the Minister.
16. Members shall only use and copy information for the purposes set out in the terms of reference and the duties of the Panel.
17. Members may explain and provide general feedback on the work of the Panel and consult closely with their representatives, stakeholders and networks on a needs to know basis for the purpose of carrying out the terms of reference and subject to confidentiality requirements.
18. A member who resigns, retires or is removed from the Panel shall not, without the express approval of the Minister, disclose any information accruing from the membership.
19. Invited attendees at panel meetings may be requested to sign a confidentiality deed.

Conflicts of interest

20. At the start of each panel meeting, a member, non-member or observer shall declare if he or she has an interest in respect to any item on the agenda.
21. In declaring an interest, the individual will state the nature of the interest and the conflict that results or may result. An interest must be declared even if it is already recorded in the member's Declaration of Private Interest.
22. A member or observer who becomes aware during the meeting that he or she has an undeclared interest will declare it immediately.
23. When a chairperson, member or observer makes a declaration of conflict of interest, the chairperson, or in the case of a declaration by the chairperson, the members as a collective may:
 - refuse the member the right to speak to the business
 - refuse the member the right to vote on that business
 - require the member to withdraw from a meeting for the period of discussion and resolution of that business.
24. Where a member or observer declares a conflict of interest, this will be recorded in the minutes of the meeting.

Business operations

Frequency of meetings

25. The Panel shall meet no less than quarterly, or as determined by the chairperson, in consultation with the responsible project manager.

Invitations

26. Invitations to panel meetings are non-delegable.

27. Other persons may be invited to attend panel meetings as required for specific purposes.

Quorum

28. All panel members are required for the meeting to be recognised as an authorised meeting, and for the recommendations or resolutions to be valid. If all members cannot participate in a scheduled meeting, the meeting must be rescheduled.

Chairing

29. The chairperson is not permitted to delegate chairing responsibilities.

Meeting agenda and papers

30. Items can be submitted by members for inclusion on the Panel agenda, in consultation with the responsible project manager.
31. The Panel agenda, with attached meeting papers, will be distributed at least five working days prior to the next scheduled meeting.
32. The chairperson has the right to refuse to list an item on the formal agenda, but members may raise an item under 'Other business' if necessary and as time permits.
33. Any urgent item that cannot wait until the next meeting, or is for information only, can be circulated out of session. All members will be asked to respond to the out-of-session item, endorsing, noting or otherwise indicating their position on the paper.

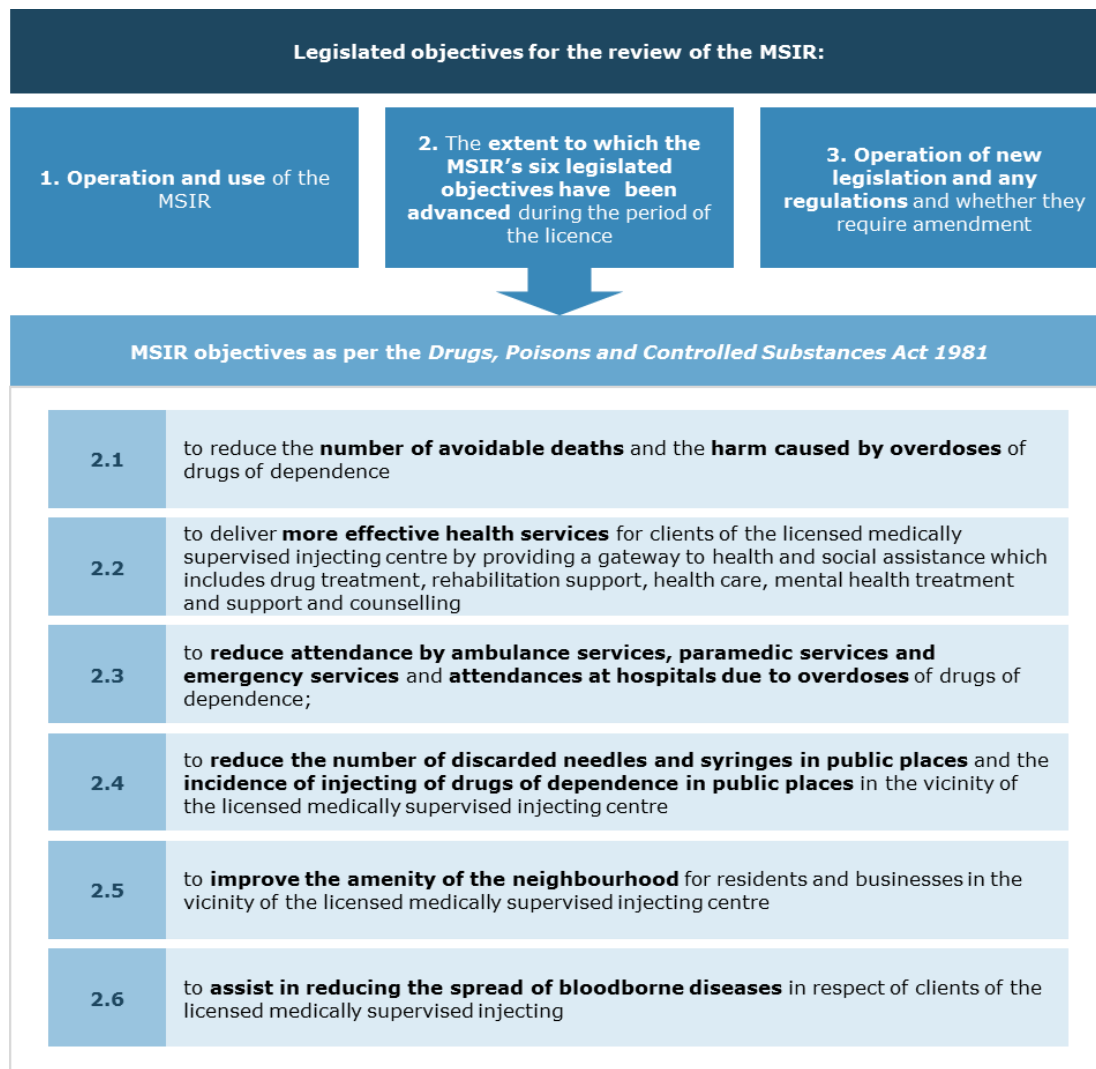
Meeting records

34. The minutes of each panel meeting will be prepared by the responsible project manager. These minutes should accurately reflect decisions or recommendations made by the Panel, specify each item of business discussed and briefly summarise essential items of discussion.
35. Minutes and all meeting papers shall be provided to all panel members no later than five working days following each meeting.
36. Minutes may be circulated to relevant officers within the department, unless the chairperson determines a particular item to be confidential in which case the minutes will be circulated excluding confidential items.
37. By agreement of the Panel, out-of-session decisions will be deemed acceptable. Where agreed, all out-of-session decisions shall be recorded in the minutes of the next scheduled panel meeting.

Appendix B: Framework for the Review of the Medically Supervised Injecting Room

The *Drugs, Poisons and Controlled Substances Act 1981* (the Act) provides the scope of the medically supervised injecting room (MSIR) including the key aims for the facility. This was used to develop the analytic frame for this review (Figure B1).

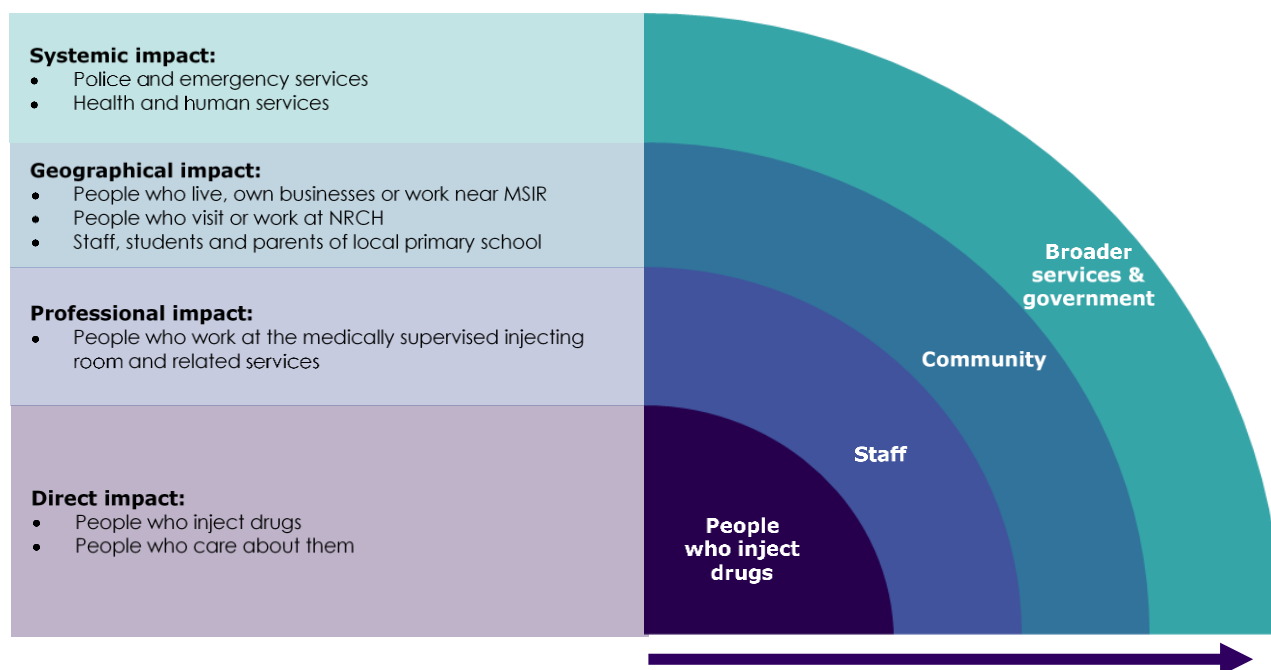
Figure B1: Legislated objectives for the review of the medically supervised injecting room



Key stakeholders for the trial

The Panel considered several groups of individual, community and organisational stakeholders for this trial. This framework considers stakeholders in terms of direct impact, professional impact, geographical impact and systemic impact, as outlined in Figure B2.

Figure B2: Layers of impact for the medically supervised injecting room



About the review

As outlined in s. 55P of the Act, the Panel reviewed: the operation and use of the facility; the extent to which the aims outlined in Part IIA of the Act has been advanced; and how Part IIA and any regulations made for the purposes of the Act have operated and whether they require amendment. As the period for this review was two years from establishing the facility, the review primarily focuses on:

- the implementation of the trial
- early indicators that the trial is on track to deliver longer term outcomes
- the extent to which the facility has contributed to progression of each of the aims identified in the legislation
- identifying potential longer-term indicators of success for consideration beyond the review period
- consideration of any potential amendments.

To enable sufficient time for analyses and to provide the government with findings ahead of decision making, the Panel focused on information from the first 18 months of the trial.

Cost of the review

The review was provided \$500,000 to procure specialist advice and analyses, and to fund specific review activities. This included contracting Colmar Brunton and Q&A Market Research to conduct two rounds of resident and business surveys, and the Burnet Institute to conduct analyses from a longitudinal cohort study of people who inject drugs. The Panel was provided technical and secretariat support from evaluators located in the DHHS Centre for Evaluation and Research.

Design and methods

There are many scientific, practical and ethical challenges that need to be considered when reviewing complex health interventions such as supervised injecting facilities (NCHECR 2007). An early activity of this review was to develop a pragmatic approach that would provide the best evidence possible given these challenges.

Design

In developing the approach for this review, a literature review and other activities were conducted to inform the design and methods of the review. The review included the following approaches:

- a desktop review of key documents and published evidence including:
 - relevant legislation, internal management protocols, performance management requirements and accreditation requirements
 - analytical approaches to international and local evaluations/reviews on medically supervised injecting facilities
- development of a theory of change and program logic to connect the goals and activities described in the legislation to measurable outcomes
- consideration of relevant parliamentary debates, enquiries and submissions to identify further potential lines of enquiry
- site visits to North Richmond Community Health Centre, the MSIR and the Sydney Medically Supervised Injecting Centre
- consideration of observations, reports and opinions expressed during the time of the review
- consultation on the review approach and potential data sources with key stakeholders²³ including:
 - individuals and organisations who had previously made submissions to relevant parliamentary inquiries, members of the expert advisory group, local reference groups and Gateway Services Group to identify particular and/or further potential lines of enquiry²⁴
 - interested groups from the locality through a series of planned, semi-structured consultation meetings.

Review principles

The review is guided by the objects of the legislation, as well as the following principles:

- build on existing information sources where possible to alleviate data collection burden

²³ The Panel thanks the following for their early input to inform this process: the MSIR, North Richmond Community Health, Victoria Police, Ambulance Victoria, Metropolitan Fire Brigade, the Coroner's Court of Victoria, the City of Yarra, the Department of Premier and Cabinet's special advisor on self-determination of Aboriginal and Torres Strait Islanders, the Chair of the Expert Advisory Group (also the founding medical director of the Sydney Medically Supervised Injecting Centre), the chair of the Local Reference Group, the chair of the Gateway Services Group, and the broader Gateway Services Group, the Youth Support and Advocacy Service (YSAS) and the DHHS Drugs Policy and Reform Unit.

²⁴ The Panel thanks the following for their responses: Alcohol & Drug Foundation, Ambulance Victoria, Australasian College of Emergency Medicine, Australian Medical Association, cohealth, Fred Hollows Foundation, Harm Reduction Victoria, Hepatitis Victoria, Kirby Institute, Metropolitan Fire & Emergency Services Board, RMIT University, Royal Australasian and New Zealand College of Psychiatrists, Victoria Police, Victorian Drug and Alcohol Association, Windana Drug & Alcohol Recovery Inc and individuals who had previously provided submissions to the relevant inquiries.

- ensure that structured data collection approaches are independently assessed as ethical or are approved by independent research ethics bodies
- use appropriate data collection techniques that will include analysis of quantitative and qualitative data and, where possible, case studies from the community as illustrations
- use methodologically and statistically rigorous approaches to enable, as far as possible, detection of changes in indicators
- use appropriate quantitative and qualitative analytical techniques
- use appropriate benchmarking to enable fair comparisons across time, locations and populations
- consider using an appropriate modelling approach²⁵ to estimate possible deaths prevented, with due regard to the complexity of such modelling and the availability of data, suggesting use of conservative interpretations in conducting development of this estimate²⁶.
- spend some unstructured time in the vicinity of the MSIR to better understand the local context
- consider the findings within the broader context, including the dynamic nature of drug use and drug markets.

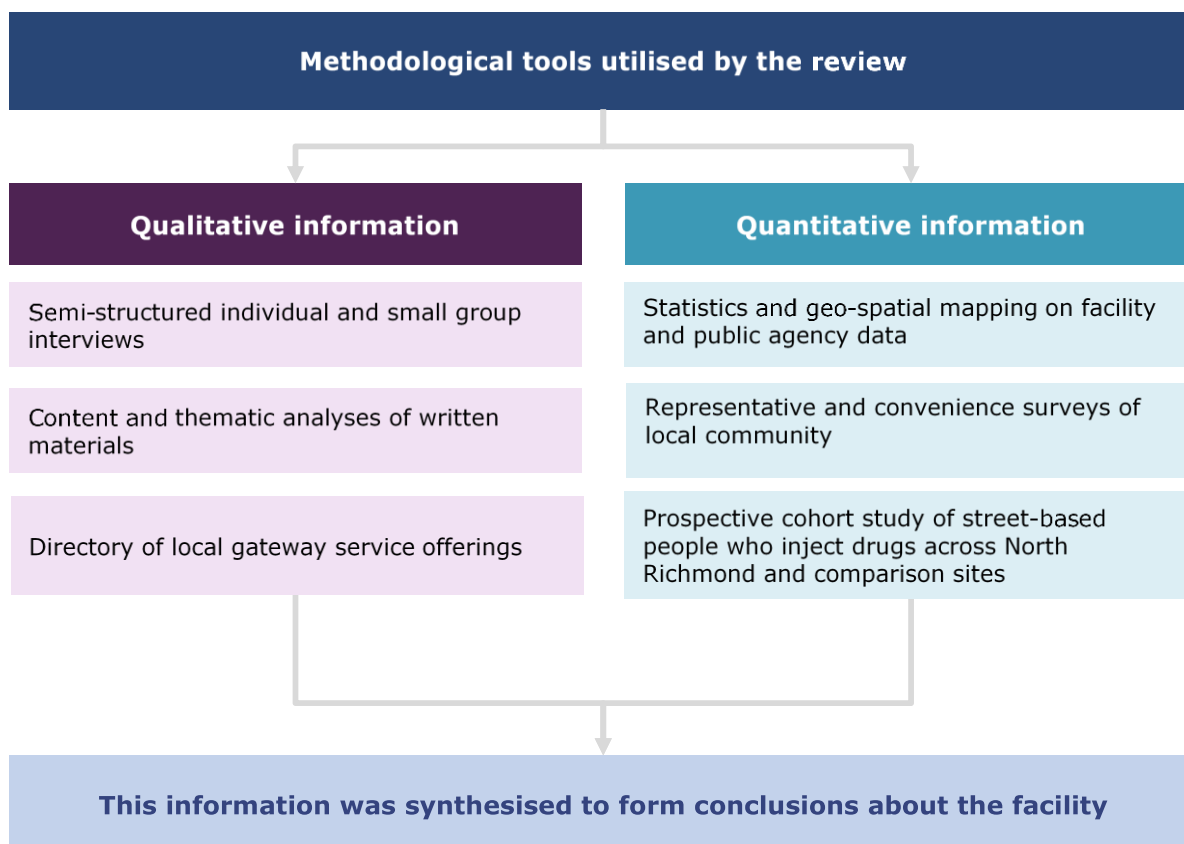
Methods

The review applies a pragmatic mixed-methods approach and draws on multiple information sources to provide a comprehensive understanding of advancement towards the aims of the facility as stated in the legislation (Figure B3).

²⁵ A number of international studies regarding modelling of overdose deaths were consulted to inform the review approach including Irvine et al. 2019 and Babu et al. 2019.

²⁶ Consideration was given to the recent international review on assessing the evidence on supervised injecting services/drug consumption sites including especially Chapter 4: mathematical and simulation studies (Pardo et al. 2018) and further discussed in Caulkins et al. 2019 together with other subsequent academic discussion of these publications. Caution is needed in the estimation of lives saved.

Figure B3: Methodological tools utilised by the review



A note on defining 'vicinity' for this review

Although the legislation refers to 'vicinity', it does not define the geographic area that is in the vicinity of the facility. A specific definition was required so that only those communities directly surrounding the facility were included in the review datasets. The review therefore established a working definition of 'vicinity'. The geographic boundary in the 'vicinity' of the facility was defined through consideration of the following:

- the boundary used for the resident survey in the evaluation of the Sydney Medically Supervised Injecting Centre
- the time, distance and mode of travel that people who inject drugs is likely to take between purchasing and injecting drugs
- data on location and rates of discarded needles and syringes in the City of Yarra
- the available census data on geographic location of residents that could be mapped to geographic data collected as part of the survey to ensure sample representativeness without undue risks to the privacy of respondents.

Ethical assessment

The review used the following approaches to ensure ethical conduct of the review:

- only undertaking review activities that are associated with a clear purpose and benefit
- approval of research activities by a National Health and Medical Research accredited Human Research Ethics Committee, as well as relevant departmental and agency approvals
- obtaining informed consent for the collection and/or use of identifiable or re-identifiable data, including any linkage of individual data records

- working with data custodians on the appropriateness and quality of relevant datasets
- minimisation of distress associated with participating in review activities through careful design of survey and interview protocols.

Qualitative methods

Semi-structured and small group interviews

To understand the experiences and perspectives of individuals who inject drugs, service users and key staff and management at relevant organisations were interviewed, allowing them an opportunity to comment on experience of intended and unintended consequences. Information from these interviews have been subject to content and thematic analyses. These help to inform the focus of data collection and, where appropriate, these form the basis for case studies into specific areas of enquiry and facilitate interpretation of other data.

Almost 100 semi-structured interviews were conducted, led by the Panel. In most cases, interviews were conducted by two interviewers, with a small number conducted by one or three people. Interviews lasted 15 minutes to slightly over an hour in length and followed a semi-structured interview guide to obtain information on predetermined topics aligned with the overarching review framework for the project. Interviewers used prompts throughout the interviews to access information about a variety of additional topics. Interviews were audio-recorded and transcribed. Once transcribed, the interview scripts were analysed thematically using NVivo 12 software.

Interview questions

MSIR staff

38. How long have you worked in the MSIR?
39. Can you please describe your experience of working in the MSIR for the past couple of months?
40. (Have you worked in other injecting facilities? How does the Richmond facility compare to others you have worked in?)
41. Is there anything about the MSIF you believe should be changed?
42. What are the key challenges for you, working in the facility?
43. Have you experienced any obstacles in providing assistance or support to clients?
44. What sort of feedback (if any) are you hearing from clients about the facility?
45. Is there anything else you would like to share about your experience working at the MSIR?

NRCH staff

1. How long have you worked in the NRCH? What is your role here?
2. Can you please describe your experience of working at NRCH since the opening of the MSIR?
3. Have you noticed any changed in the vicinity of NRCH since the opening of MSIR?
4. Is there anything about the MSIR you believe should be changed?
5. What are the key benefits and challenges for you, working so close to the Facility?
6. Have you experienced any obstacles in providing assistance or support to your clients?
7. What have been your experiences working with MSIR clients in a referral capacity, if any?
8. What sort of feedback (if any) are you hearing from clients about the Facility?

People who use the MSIR

1. How many times have you used the facility?
2. When you don't use it, why don't you?
3. Do you feel comfortable here? Why/why not?
4. Do you usually come alone, or with someone?
5. Do you recommend the facility to other people, who are still injecting outside/in a public place? Why?
6. How do you find the staff? What have they done for you? Have they helped look after you in any way?
7. Have you learnt anything new about taking care of yourself, at the MSIR?
8. Do you do anything differently, as a result of something you may have learnt at the MSIR? This could be in relation to how you inject drugs or how you look after yourself afterwards.
9. Do you have any suggestions for how the facility could be improved so that more people would feel comfortable coming here?
10. What is it like for you getting to and leaving the facility?
11. What differences does the MSIR make on your day-to-day life (if any)?
12. Have you noticed any changes in the North Richmond area?
13. Is there anything else you would like to share about your experience using the MSIR?

People who access the North Richmond Needle and Syringe Program

1. Have you heard of the Medically Supervised Injecting Facility?
2. (If yes) What have you heard about it?
3. Have you used the Facility to inject drugs before?
4. (If no) Why not?
5. (If yes) Why aren't you using it today?
6. What would make you more likely to use it (or use it more often)?

Community consultations

1. How long have you been in this area?
2. Are you noticing any changes in drug-related activity in the Richmond area?
3. What has been your experience since the establishment of the trial?
4. What are your perspectives on the trial? Why?
5. What are your suggestions for the trial?

Content and thematic analysis of written materials

To understand policies and procedures, health promotion materials and existing literature and research describing injecting drug use, these documents have been subject to content and thematic analyses. To understand any changes in the community discussion about the facility, parliamentary debate and media coverage was considered throughout the trial.

Analysis of print media was conducted by an external provider, Media Measures, on print media articles and using the analytical tool 'Talkwalker' on social media.

The Media Measures report is at Appendix D and the Talkwalker report is at Appendix E.

Services and referral mapping

A service mapping exercise was undertaken by the local Primary Care Partnership, together with members of the Gateway Services Group, to: (a) identify the capacity of Gateway Services Reference Group members to support MSIR staff and the means through which they can do this; (b) improve the understanding of local referral options and pathways; (c) determine the barriers to, and enablers of, access to health and social support services in the City of Yarra and surrounds for people who inject drugs.

Quantitative analyses

Descriptive statistics have been used to provide an aggregate-level understanding of available data from the facility, departmental and public agency datasets. Where suitable, inferential statistics were used to understand changes over time and/or geography using analytical techniques. The department conducted the following analyses of available data:

MSIR database

The MSIR database is an administrative dataset that includes information on MSIR service users, services accessed, referrals and events at the facility.

The review conducted a descriptive statistical analysis of MSIR data from 30 June 2018 to 31 December 2019, including demographic characteristics of service users, supervised injections, substances injected, service utilisation, referrals to other services, overdoses and reportable incidents.

Coroners Court of Victoria

The Coroners Court of Victoria maintains a database of deaths reported to the coroner. This database includes information around the cause of death, geographic locations and other statistical information.

The review analysed heroin-related deaths data from January 2015 to June 2019, including by local government area, distance from the MSIR and the type of location (residential vs non-residential locations).

Victorian Admitted Episode Dataset (VAED)

The VAED is a comprehensive dataset of the causes, effects and nature of illness and the use of health services in Victoria. All Victorian public and private hospitals, including rehabilitation centres, extended care facilities and day procedure centres, report a minimum set of data for each admitted patient episode.

The Burnet Institute analysed VAED data linked to participants in the SuperMIX cohort sample. A total of 3,579 records were linked to 481 participants in the sample. For more information on the methodology, see the Burnet Institute report at Appendix F.

Victorian Emergency Minimum Dataset (VEMD)

The VEMD comprises de-identified demographic, administrative and clinical data detailing presentations at Victorian public hospitals with designated emergency departments.

The Burnet Institute analysed VEMD data linked to participants in the SuperMIX cohort sample. A total of 11,649 records were linked to 515 participants in the sample. For more information on the methodology, see the Burnet Institute report at Appendix F.

The review analysed heroin overdose related emergency department presentations (within opening hours of the MSIR) at St Vincent's Hospital between July 2012 and December 2019. Structural break detection and interrupted time-series analyses were conducted on the monthly aggregated count and daily rate, with statistical significance tested ($p < 0.05$). The interrupted time-series analysis applied was based on the method described in Lopez et al. 2017.

Victorian Ambulance Clinical Information System (VACIS)

The VACIS is a patient care record computer application specifically designed for Australian ambulance services. VACIS contains all patient data, from ambulance call to discharge.

The Burnet Institute analysed VACIS data linked to participants in the SuperMIX cohort sample. A total of 4,433 records were linked to 499 participants in the sample. For more information on the methodology, see the Burnet Institute report at Appendix F.

The review analysed ambulance attendances where naloxone was administered between January 2015 and December 2019, including by location (within 1 km of the MSIR and the rest of Victoria)

and time of day (during MSIR opening hours and outside MSIR opening hours). An interrupted time series analysis was conducted on the monthly aggregated count of ambulance attendances within 1 km of the MSIR during MSIR opening hours with statistical significance tested ($p < 0.05$). The interrupted time series analysis applied was based on the method described in Lopez et al. 2017. A chi-square test was conducted on the number of ambulance attendances in the 18-month period before and 18 month-period after the MSIR opened, during and outside MSIR opening hours.

Ambo-AODstats Victoria

Ambo-AODstats Victoria is the Victorian alcohol and drug interactive statistics and mapping webpage. Ambo-AODstats provides information on alcohol and drug-related ambulance attendances in Victoria.

The review analysed descriptive statistics from 2011–12 to 2018–19 for the City of Yarra and Victoria. Data presented is the heroin-related overdose ambulance attendance rate per 100,000 population.

Victorian Crime Statistics Agency (CSA)

CSA is responsible for processing, analysing and publishing Victorian crime statistics, independent of Victoria Police. Data presented in this report are offences data within a 1 km radius of the MSIR location at 23 Lennox St, Richmond. Offences are recorded in the Police Law Enforcement Assistance Program (LEAP) database, where Victoria Police have recorded a crime prohibited by criminal law. These include crimes that have been reported to police as well as those identified by police.

The review analysed the number and rate of offences recorded within a 1 km radius of the MSIR from October 2014 to September 2019. Rates per 100,000 population were calculated by CSA. The quarterly rates were calculated using the annual population figures, and fluctuations in populations between quarters has not been taken into account. The CSA advises caution when comparing quarter-on-quarter trends.

Victoria Police Computer Aided Dispatch (CAD)

CAD data captures all triple zero (000) calls. The review received data from January 2015 to March 2019 for total triple zero (000) calls (CAD callouts) and for drug-related CAD calls in Richmond. 'Drug-related' callouts include the following four types of events:

- drug deal/use in public
- suspected lab/plantation
- drug overdose
- drug overdose with violence.

The review analysed the rate of callouts per 1,000 people in Richmond over time. Rates were calculated using Australian Bureau of Statistics population data.

Public Health Event Surveillance System (PHESS)

Under the *Public Health and Wellbeing Act 2008*, the department is authorised by law to collect information from doctors and laboratories about diagnoses of certain health-related conditions in Victoria. The law exists to monitor and control the occurrence of infectious diseases and other specified conditions and helps to prevent further illness. The aim is to protect the health and safety of the community.

The review analysed hepatitis B, hepatitis C and HIV notifications in the City of Yarra and Victoria from 2016 to 2019. The data presented are from the [public local government areas surveillance report](https://www2.health.vic.gov.au/public-health/infectious-diseases/infectious-diseases-surveillance/interactive-infectious-disease-reports/local-government-areas-surveillance-report) <<https://www2.health.vic.gov.au/public-health/infectious-diseases/infectious-diseases-surveillance/interactive-infectious-disease-reports/local-government-areas-surveillance-report>>.

Local community surveys

City of Yarra annual resident survey

Yarra City Council commissions Metropolis Research to conduct an annual survey of householders to gauge their satisfaction with the range of council services and to establish emerging issues and priorities. To ensure results can be generalised, a randomised sample of households is selected, which is stratified by neighbourhood. The results are weighted by precinct (neighbourhood) to ensure each precinct within Yarra contributes proportionally to the municipal result. Metropolis Research interviewers are multilingual to ensure good representation from culturally diverse community members.

The City of Yarra analysed the survey results and provided findings to the review team for inclusion in the report.

The MSIR Community Survey

To understand the impact on residents and businesses in the vicinity of the facility, results from statistically representative surveys at baseline (June 2018, wave 1) and after approximately 12 months (July 2019, wave 2) capture changes in community members' observations, attitudes and support towards the facility. Colmar Brunton conducted the community survey. The Colmar Brunton technical report for wave 1 is at Appendix G and the wave 2 report is at Appendix H.

Prospective cohort study of street-based people who inject drugs

To understand the impact on people who inject drugs, results from an established cohort study being led by the Burnet Institute (SuperMIX) have provided between and within subject measures for people injecting in North Richmond (both inside and outside of the facility), and in comparison with people who inject drugs in other key drug markets in greater Melbourne. The full report is provided at Appendix F.

Synthesis and interpretation

Central to the approach are structured synthesis mechanisms to test the findings of individual data sources with other qualitative and quantitative sources, including with key stakeholders. Information collected through these means was considered in conjunction with direct observations made by the Panel and team through visits to the facility and surrounding areas.

Appendix C: Additional data from various sources

This appendix provides additional detail to expand on key information outlined in the main body of the report.

Table C1: Key demographics of facility clients between 30 June 2018 and 31 December 2019

Measure	Key demographic	Percentage
Gender	Male	74.8
	Female	24.8
	Not specified	0.4
Country of birth	Australia	88.9
	United Kingdom	1.8
	New Zealand	1.7
	Vietnam	1.2
	Other	6.2
Aboriginal and/or Torres Strait Islander peoples	Aboriginal and/or Torres Strait Islander	13.4
Accommodation	Rental house/flat	45.8
	Sleeping rough	15.1
	Family	10.4
	Boarding house/hostel	9.5
	Home owner	7.5
	Friends/couch surfing	6.3
	Shelter/refuge	2.5
	Squat	1.3
	Not specified	1.6
Education	Some high school	50.5
	High school certificate or equivalent	13.5
	Completed tertiary	11.8
	Some tertiary	11.2
	School certificate	6.7
	Primary school	2.6

Measure	Key demographic	Percentage
	Not specified	3.7

Source: MSIR database

Table C2: Demographics – Burnet Institute SuperMIX study (2019)

Measure	Key demographic	Visited MSIR	Hasn't visited MSIR	Total	p-value
Total		181	417	598	
Age at interview	≤ 30	12%	8%	9%	0.007*
	31–40	55%	44%	47%	
	41–50	23%	36%	32%	
	≥ 50	10%	12%	12%	
	Missing	0	0	0	
Gender identity	Male	70%	66%	68%	0.614†
	Female	30%	33%	32%	
	Non-binary/gender fluid	0%	0%	0%	
	Missing	0	0	0	
Employment status	Unemployed	95%	84%	87%	< 0.001*
	Employed	5%	16%	13%	
	Missing	0	0	0	
Housing status	Unstable	39%	28%	31%	0.007*
	Stable	61%	72%	69%	
	Missing	3	3	6	
Housing type	Owner-occupied, rental, community, boarding or other rent-free	68%	85%	80%	< 0.001*
	Homeless, squat or supported accommodation	32%	15%	20%	
	Missing	1	0	1	
Living conditions	With relatives, friends or housemates	51%	67%	62%	< 0.001*
	Alone	49%	33%	38%	
	Missing	11	9	20	
	≤ Year 9	31%	28%	29%	0.432

Measure	Key demographic	Visited MSIR	Hasn't visited MSIR	Total	p-value
Education level	Year 10–12	44%	46%	45%	
	Tertiary/diploma/trade	22%	20%	20%	
	Other	4%	7%	6%	
	Missing	0	0	0	
Aboriginal and Torres Strait Islander	No	73%	88%	83%	< 0.001*
	Yes	27%	12%	17%	
	Missing	2	1	3	
Is a parent	No	35%	36%	36%	0.714
	Yes	65%	64%	64%	
	Missing	5	17	22	
Main drug of choice	Heroin	87%	64%	71%	< 0.001*
	MA	7%	20%	16%	
	Cannabis	3%	12%	9%	
	Other	3%	4%	3%	
	Missing	5	19	24	
Drug injected most in last month	Heroin	89%	59%	68%	< 0.001*
	MA/other	11%	41%	32%	
	Missing	0	0	0	
Previous incarceration	No	18%	23%	21%	0.192
	Yes	82%	77%	79%	
	Missing	2	11	13	
Incarceration in the 12 months prior to interview	No	62%	75%	71%	0.003*
	Yes	38%	25%	29%	
	Missing	9	7	16	
Area of residence	Richmond	9%	3%	5%	N/A
	Western suburbs	16%	27%	24%	
	Mornington Peninsula	6%	25%	20%	
	Inner city	20%	9%	12%	
	St Kilda area	18%	12%	14%	

Measure	Key demographic	Visited MSIR	Hasn't visited MSIR	Total	p-value
	Dandenong area	1%	2%	2%	
	Other south/east	14%	7%	9%	
	Other north	12%	9%	10%	
	Country Victoria	4%	5%	5%	
	Missing	21	29	50	
By location	Richmond	77%	18%	36%	N/A
	Footscray	10%	28%	23%	
	Frankston	4%	26%	19%	
	Collingwood	3%	8%	6%	
	St Kilda	2%	6%	5%	
	CBD	0%	4%	3%	
	Dandenong	1%	1%	1%	
	Outreach	0%	2%	2%	
	Phone	2%	6%	5%	
	Burnet/Alfred	1%	0%	1%	
	Missing	0	10	10	
By type	Baseline	48%	54%	52%	0.168
	Follow-up	52%	46%	48%	
	Missing	0	0	0	

Source: Burnet Institute 2019

* statistically significant, $p < 0.05$

† Fisher exact test instead of chi-square test, due to low numbers in some categories

Table C3: Use of MSIR among those who previously used heroin in high-risk settings

Measure	Most recently used in private	Most recently used in public	Total	p-value
Total	92	89	181	
Has visited MSIR	15%	28%	22%	0.035*
Hasn't visited MSIR	85%	72%	78%	

Source: Burnet Institute 2019

* Represents statistically significant difference; Pearson's chi-squared test

Table C4: Percentage of injections in the MSIR in the month prior to the interview

Measure	Visited MSIR ^(a)	Visited MSIR and recruited in Richmond
Total	181	109
All injections	4%	7%
Most injections (> 70%)	17%	17%
Half of injections	11%	12%
Some injections (25–50%)	4%	6%
A few injections (10–25%)	10%	11%
Hardly any injections (< 10%)	36%	37%
No injections (13%)	13%	6%
Ceased to inject in previous	3%	5%

Source: Burnet Institute 2019

Percentages may not add up to 100 per cent due to rounding errors

(a) Total does not add up to 100 per cent due to missing responses for two participants.

Table C5: Self-reported non-fatal overdose(a) (only follow-up)

	Visited MSIR	Hasn't visited MSIR	Total	p-value
Total	94	191	285	
No	73%	84%	81%	0.027*
Yes	27%	16%	19%	

Source: Burnet Institute 2019

* Represents statistically significant difference; Pearson's chi-squared test

a) Overdose for all drug types (heroin, other opioid, methamphetamines); findings predominately relate to heroin overdose.

Figure C1: Area surrounding the MSIR as defined by City of Yarra (focus area)

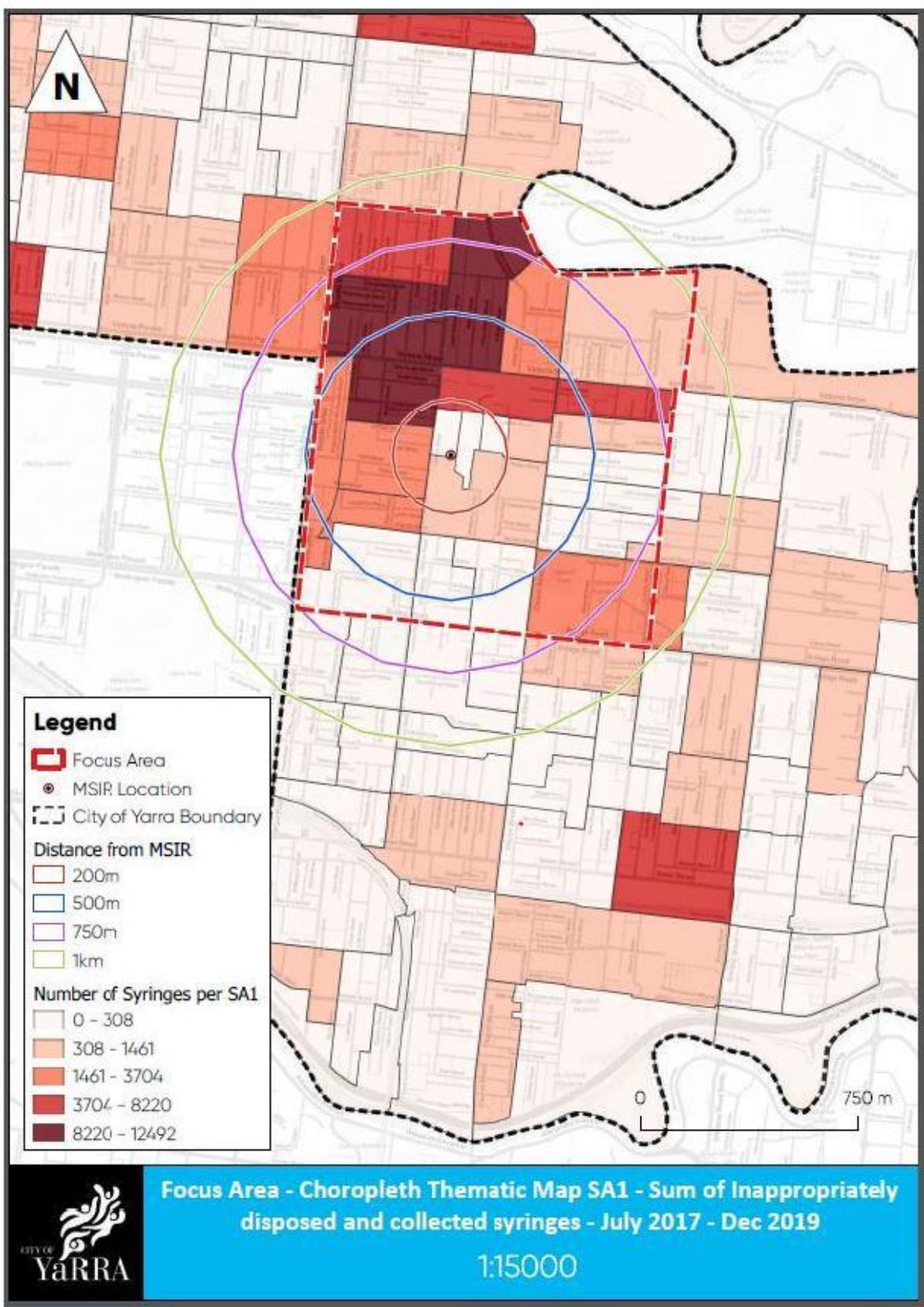


Table C6: Perceptions of discarded needles and syringes in the MSIR Review Community Survey

Issue	Residents ^(a)			Businesses		
	Pre-MSIR	Post-MSIR	p-value	Pre-MSIR	Post-MSIR	p-value
Percentage (%) of respondents reporting having seen discarded needles and syringes in the past week	29.4	30.9	> 0.05	34.0	26.3	< 0.05*
Percentage (%) of respondents reporting having seen discarded needles and syringes in the past year	16.1	16.9	> 0.05	20.0	24.6	< 0.05*
Median estimated number of discarded needles and syringes reported in the past month	4	4	No change	6	10	< 0.05*
Mean estimated number of discarded needles and syringes reported in the past month	13.25	8.73	< 0.05*	21.9	17.5	< 0.05*

Note: (a) Weighted. * Significant

Table C7: Where last purchase of heroin was used

Measure	Has visited MSIR	Hasn't visited MSIR	Total	p-value
Total	181	417	598	
Where last purchase of heroin was used				
Private and MSIR ^(a)	51%	57%	54%	0.248
Public ^(b)	49%	43%	46%	
Missing	29	184	213	

Source: Burnet Institute 2019

* Represents statistically significant difference; Pearson's chi-squared test

In this analysis private locations refers to private spaces, such as private homes (including dealer's homes)

Public locations refer to public spaces, such as streets, public toilets, parks and cars

Table C8: Perceptions of public injecting in the MSIR Review Community Survey

Issue	Residents ^(a)			Businesses		
	Pre-MSIR	Post-MSIR	p-value	Pre-MSIR	Post-MSIR	p-value
Percentage (%) of respondents reporting having ever seen public injection	69.9	71.8	> 0.05	61.1	65.8	< 0.05*
Percentage (%) of respondents reporting having seen public injection in the past week	27.7	29.5	> 0.05	21.8	34.8	< 0.01**
Percentage (%) of respondents reporting having seen public injection in the past month	28.6	28.2	> 0.05	26.3	17.7	< 0.01**
Percentage (%) of respondents reporting having seen public injection in the past year	23.5	19.7	< 0.05*	26.8	22.2	< 0.05*
Median estimated number of public injecting reported in the past month	3.0	3.0	No change	4	5	> 0.05
Mean estimated number of public injecting reported in the past month	7.68	7.94	> 0.05	45.96	13.94	< 0.01**

Note: (a) Weighted. * Significant. ** Highly significant

Table C9: Perceptions of feeling safe when walking in their local area alone in the MSIR Review Community Survey

Issue	Residents ^(a)			Businesses		
	Pre-MSIR	Post-MSIR	p-value	Pre-MSIR	Post-MSIR	p-value
Percentage (%) of respondents reporting feeling safe when walking alone during the day	69.5	54.7	< 0.01**	61.8	45.8	< 0.01**
Percentage (%) of respondents reporting feeling safe when walking alone after dark	61.8	28.2	< 0.01**	26.0	20.3	< 0.05*
Percentage (%) of respondents reporting being approached to buy drugs within the last 24 hours	9.0	10.1	> 0.05	23.4	8.5	< 0.01**
Percentage (%) of respondents reporting being approached to buy drugs within the last week	27.8	21.7	< 0.05*	23.4	32.2	< 0.05*
Percentage (%) of respondents reporting being approached to buy drugs within the last month	26.3	26.4	> 0.05	27.7	25.4	> 0.05
Percentage (%) of respondents reporting being approached to buy drugs within the last year	19.5	31.8	< 0.01**	19.1	22.0	< 0.05*
Percentage 9%) of respondents reporting being approached and offered heroin within the last year	63.8	44.8	< 0.01**	60.0	48.7	< 0.01**
Percentage (%) of respondents (residents) reporting having considered moving out of the area because of drug related activity	32.0	37.1	< 0.05*			

Issue	Residents ^(a)			Businesses		
	Pre-MSIR	Post-MSIR	p-value	Pre-MSIR	Post-MSIR	p-value
Percentage (%) of respondents (businesses) reporting having considered finding a new job or moving their business out of the area because of drug related activity				27.6	32.5	< 0.05*

Note: (a) Weighted. * Significant. ** Highly significant

Table C10: Last location of purchase of heroin in a public versus private space, in percentages (note: Burnet Institute analysis of SuperMIX cohort)

	Visited MSIR (n = 152)		Hasn't visited MSIR (n = 232)		
	Private	Public	Private	Public	Different
Whole sample (n = 384)	38	62	58	42	Yes (p <
Interviewed in Richmond	36	64	53	47	No (p =
Interviewed outside	42	58	60	40	Yes (p =

Table C11: Use of MSIR among those who engaged in property crime and drug dealing

Measure	Response	Visited MSIR	Hasn't visited MSIR	Total	p-value
Total		181	417	598	
Engaged in property crime in the last month	No	73%	82%	79%	0.019*
	Yes	27%	18%	21%	
	Missing	6	6	12	
Engaged in dealing in the last month	No	72%	76%	75%	0.298
	Yes	28%	24%	25%	
	Missing	5	5	10	
Arrested for dealing in the last month	No	86%	87%	87%	0.713
	Yes	14%	13%	13%	
	Missing	0	0	0	

Source: Burnet Institute 2019

* Represents statistically significant difference; Pearson's chi-squared test

Table C12: Use of MSIR among those have been arrested since previous interview (only follow-up)

Measure	Response	Visited MSIR	Hasn't visited MSIR	Total	p-value
Total		94	191	285	
Arrested since previous interview	No	35%	59%	51%	< 0.001*
	Yes	65%	41%	49%	
	Missing	1	0	1	

Source: Burnet Institute 2019

* Represents statistically significant difference; Pearson's chi-squared test

Table C13: Agreement with the idea of injecting rooms in the MSIR Review Community Survey

Issue	Residents ^(a)			Businesses		
	Pre-MSIR	Post-MSIR	p-value	Pre-MSIR	Post-MSIR	p-value
Percentage (%) of respondents agreeing with the idea of injecting rooms generally	67.3	60.0	< 0.05*	59.7	58.5	> 0.05
Percentage (%) of respondents agreeing with having an injecting room in North Richmond	59.7	42.2	< 0.01**	48.1	41.2	< 0.05*

Note: (a) Weighted. * Significant. ** Highly significant

Departmental Public Health Event Surveillance System notification data

Tables C14–C18 show relevant notification data from the DHHS Public Health Event Surveillance System.

Blood-borne virus notification data and methodology

Among those who identified as having injected drugs in the previous two years, hepatitis C notifications were more common than hepatitis B and HIV notifications. Local government area of residence is calculated using the postcode of the patient's residence provided at the time of diagnosis. This does not necessarily indicate where the infection was acquired. This excludes where postcode of residence was not reported.

Notes on the data

- Where there were fewer than five cases per cell, data are suppressed as < 5.

- Local government area of residence is calculated using the postcode of residence of the patient provided at the time of diagnosis. This does not necessarily indicate where the infection was acquired. This excludes where postcode of residence was not reported.
- Notification follow-up varies for different disease conditions, and availability of data on diseases varies on the type and level of follow-up undertaken.
- All HIV notifications are followed up and risk factor information for HIV are available. Whereas all hepatitis B and C notifications are not routinely followed up as a result, risk factor information such as injecting drug use status is not available. DHHS implemented an enhanced surveillance system in July 2016 with an aim of collecting additional information. This has improved demographic information and risk factor information including injecting drug use status for hepatitis B and C.
- Data are subjected to change due to the ongoing data quality.

Table C14: Number and rate of hepatitis B notifications for the City of Yarra and Victoria, by year, 2016–2019

Year	City of Yarra: Number of cases detected	City of Yarra: Rate per 100,000 population	Victoria: Number of cases detected	Victoria: Rate per 100,000 population
2016	37	39.6	1,825	29.5
2017	20	21.4	1,785	28.9
2018	30	32.1	1,770	28.6
2019	27	28.9	1,669	27.0

Source: Public Health Event Surveillance System, DHHS

Table C15: Number and rate of hepatitis C notifications for the City of Yarra and Victoria, by year, 2016–2019

Year	City of Yarra: Number of cases detected	City of Yarra: Rate per 100,000 population	Victoria: Number of cases detected	Victoria: Rate per 100,000 population
2016	40	42.8	2,420	39.2
2017	37	39.6	1,973	31.9
2018	26	27.8	1,921	31.1
2019	40	42.8	1,702	27.5

Source: Public Health Event Surveillance System, DHHS

Table C16: Number and rate of HIV notifications for the City of Yarra and Victoria, by year, 2016–2019

Year	City of Yarra: Number of cases detected	City of Yarra: Rate per 100,000 population	Victoria: Number of cases detected	Victoria: Rate per 100,000 population
2016	10	10.7	325	5.2
2017	7	7.5	301	4.9
2018	< 5	3.2	259	4.2
2019	9	9.6	273	4.4

Source: Public Health Event Surveillance System, DHHS

Table C17: Number and proportion of notified cases of hepatitis B, C and HIV reported injecting drug use as the risk factor for Victoria, by year, 2016–2019

Infectious disease	2016	2017	2018	2019
Hepatitis B	33 (2%)	43 (2%)	36 (2%)	38 (2%)
Hepatitis C	509 (21%)	676 (34%)	579 (30%)	392 (23%)
HIV	3 (0.9%)	13 (4.3%)	15 (5.8%)	5 (1.8%)

Source: Public Health Event Surveillance System, DHHS

Table C18: Notified cases of hepatitis C, reported injecting drug use as the risk factor for the City of Yarra, by year, 2015–2019

Year	Number of cases detected
2016	8
2017	19
2018	10
2019	11

Source: Public Health Event Surveillance System, DHHS

Table C19: Injected with someone's used needle/syringe in last month and median injecting frequency in past week

Measure	Response	Visited MSIR	Hasn't visited MSIR	Total	p-value
Total		181	417	598	
Injected with someone's	No	91%	89%	90%	0.462
used needle/syringe in the	Yes (once or more)	9%	11%	10%	

Measure	Response	Visited MSIR	Hasn't visited MSIR	Total	p-value
	Missing	5	31	36	
Injecting frequency in past week	Median number	14 (IQR = 4–28)	3 (IQR = 1–13)		< 0.001*

Source: Burnet Institute 2019

* Represents statistically significant difference; Pearson's chi-squared test

Appendix D: Analysis of selected print and radio media

DHHS VICTORIA

MEDICALLY SUPERVISED INJECTING ROOM: ANALYSIS OF SELECTED MEDIA FOR THE PERIOD JULY 2018 – DECEMBER 2019

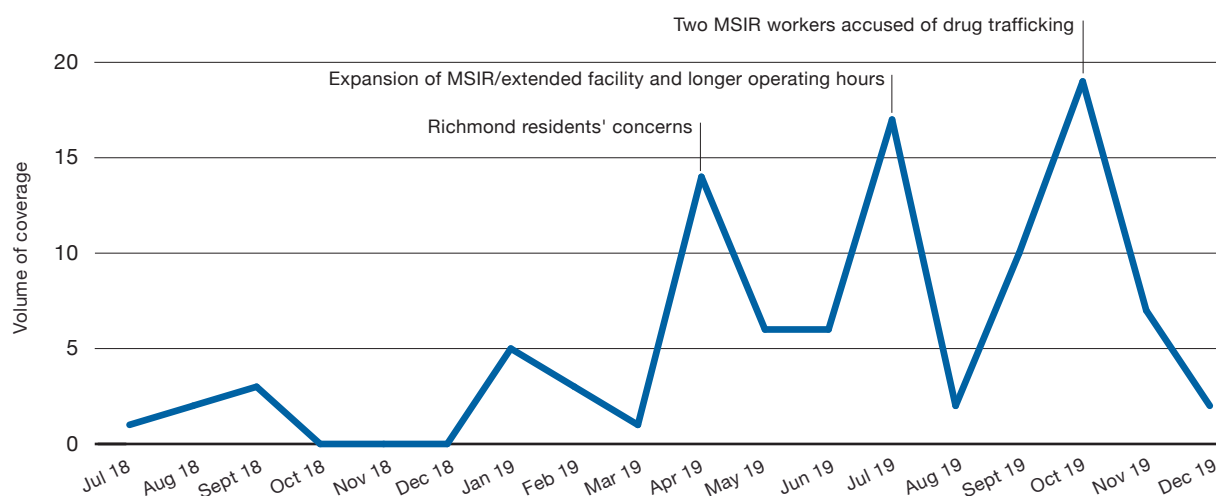
OBSERVATIONS ON MEDIA REPORTING

The following report presents analysis of media coverage on the North Richmond Medically Supervised Injecting Room (MSIR) Trial. Research was based on 98 clippings, provided to Media Measures by DHHS, covering the first 18 months of the trial (July 2018 to December 2019).

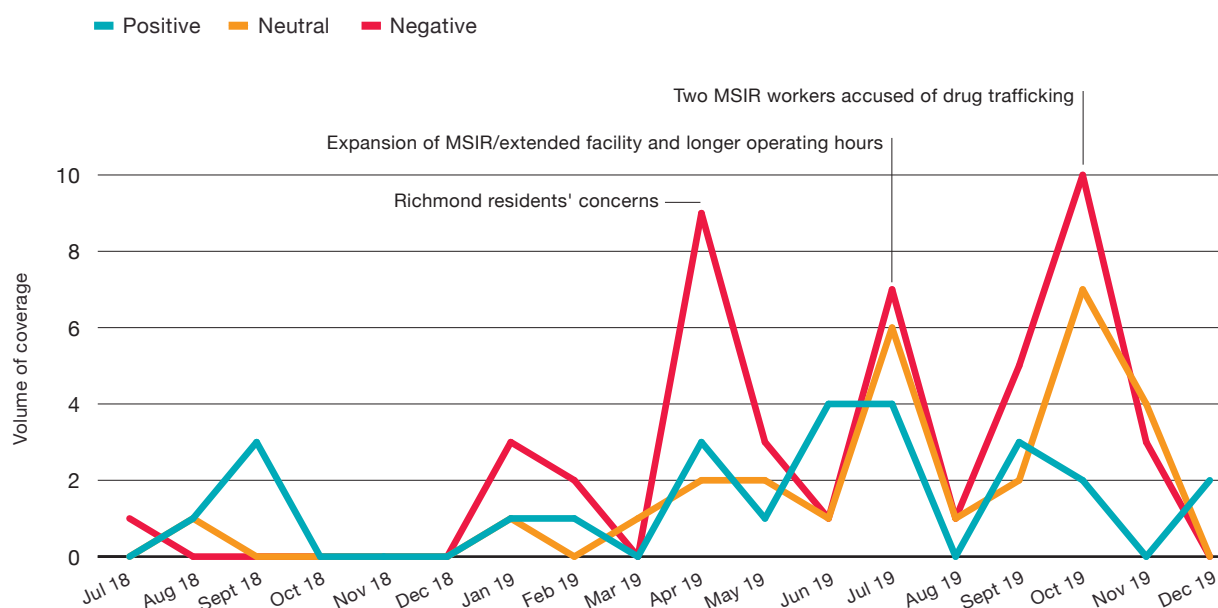
- Of the 98 clippings, 87.8% came from Melbourne daily newspapers. There were 54 stories from the *Herald Sun* and 32 from *The Age*.
- The total reach of the 98 stories was 20,715,796, most of which (16,482,370 or 79.6%) came from the *Herald Sun*.
- Of the 98 stories 25.5% were favourable, 45.9% unfavourable, and 28.6% were neutral.
- The *Herald Sun* provided slightly more favourable coverage (27.7% vs 25.0%) and considerably higher levels of unfavourable (50.0% vs 40.6%) coverage than *The Age*. *The Age* provided more neutral coverage (34.4% vs 22.2%) than the *Herald Sun*.
- *The Australian* did not feature any favourable coverage at all while the *Geelong Advertiser* featured one favourable and two unfavourable stories.
- Monique Hore of the *Herald Sun* authored four positive pieces (50.0%) and four negative pieces (50.0%), while Genevieve Alison, also of the *Herald Sun*, authored one positive (16.7%) and five negative stories (83.3%).
- Jewel Topsfield from *The Age* wrote two positive (25.0%), three neutral (37.5%) and three negative (37.5%) stories.
- Minister for Mental Health Martin Foley was quoted in 21 stories, 21.4% of the total. There were 17 instances in which local residents were quoted (17.3%) and 11 instances in which Cr Stephen Jolly was quoted (11.2%).
- In some instances negative reporting was made more intense by the inclusion of emotive photos depicting drug injecting and anti-social activities in the North Richmond precinct. A *Herald Sun* report on July 6, 2018 for example, featured graphic images of drug users in Richmond streets. As the theme developed, reporting became more graphic, both in written descriptions and accompanying photos, as evidenced in a story in the *Herald Sun* (21 May 2019) featuring photo images of drug injecting in a car park and a laneway near the injecting centre.

VOLUME AND AUDIENCE REACH

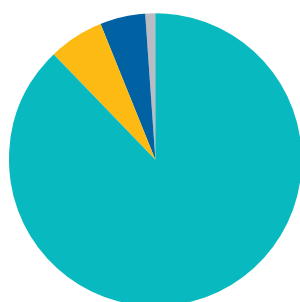
GRAPH 1 > JULY 2018 – DECEMBER 2019 MEDIA COVERAGE



GRAPH 2 > JULY 2018 – DECEMBER 2019 MEDIA COVERAGE – FAVOURABILITY

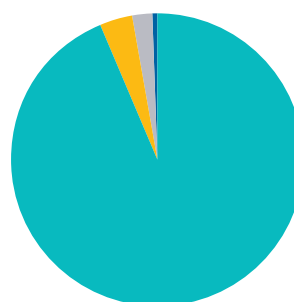


GRAPH 3 > VOLUME



■ Melbourne Daily Newspapers (86) 87.8%
■ National Daily Newspapers (6) 6.1%
■ Victorian Regional Newspapers (5) 5.1%
■ Domestic Online (1) 1.0%

GRAPH 4 > AUDIENCE REACH



■ Melbourne Daily Newspapers (19,412,256) 93.7%
■ National Daily Newspapers (765,208) 3.7%
■ Domestic Online (476,580) 2.3%
■ Victorian Regional Newspapers (61,752) 0.3%

TABLE 1 > MEDIA COVERAGE OVERVIEW

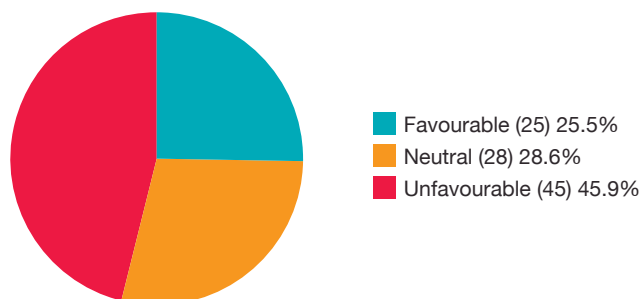
	Total Stories	Audience Reach
Melbourne Daily Newspapers	86	19,412,256
National Daily Newspapers	6	765,208
Victorian Regional Newspapers	5	61,752
Domestic Online	1	476,580
Total	98	20,715,796

TABLE 2 > MAJOR MEDIA OUTLETS

	Total Stories	Audience Reach
Herald Sun	54	16,482,370
The Age	32	2,929,886
The Australian	5	721,828
Geelong Advertiser	3	50,061
Other	4	531,651
Total	98	20,715,796

TONE OF COVERAGE

GRAPH 5 > TONE OF COVERAGE



Media coverage was mainly negative (45.9%), with positive and neutral coverage relatively evenly split. The bulk of the positive coverage dealt with stories on state government's release of data on the MSIR which indicated a large number of client visits to the facility and the large number of overdoses successfully managed. The two main negative issues were the concerns of local residents and two MSIR workers accused of drug trafficking.

GRAPH 6 > FAVOURABILITY – MAJOR MEDIA OUTLETS

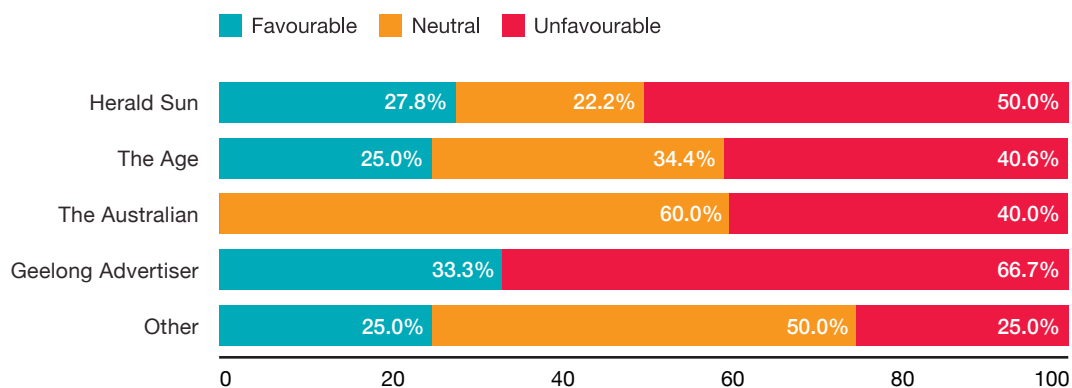
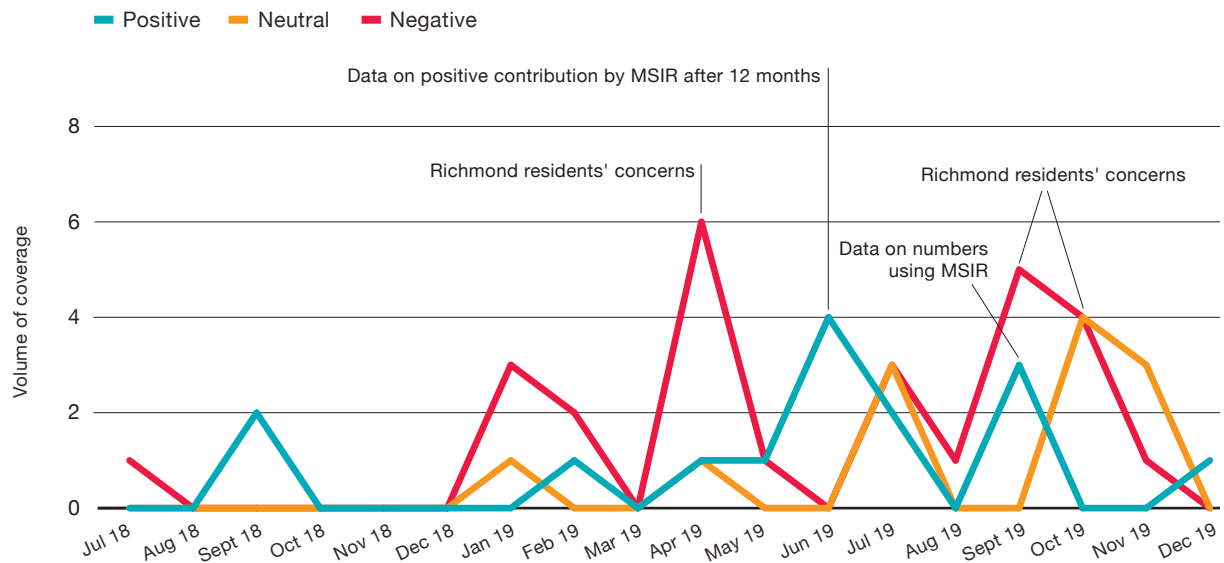


TABLE 3 > FAVOURABILITY – MAJOR MEDIA OUTLETS

	Total Stories	Favourable	Neutral	Unfavourable
Herald Sun	54	15 (27.8%)	12 (22.2%)	27 (50.0%)
The Age	32	8 (25.0%)	11 (34.4%)	13 (40.6%)
The Australian	5	0 (0.0%)	3 (60.0%)	2 (40.0%)
Geelong Advertiser	3	1 (33.3%)	0 (0.0%)	2 (66.7%)
Other	4	1 (25.0%)	2 (50.0%)	1 (25.0%)
Total	98	25 (25.5%)	28 (28.6%)	45 (45.9%)

GRAPH 7 > HERALD SUN FAVOURABILITY



GRAPH 8 > THE AGE FAVOURABILITY



GRAPH 9 > FAVOURABILITY – MAJOR JOURNALISTS

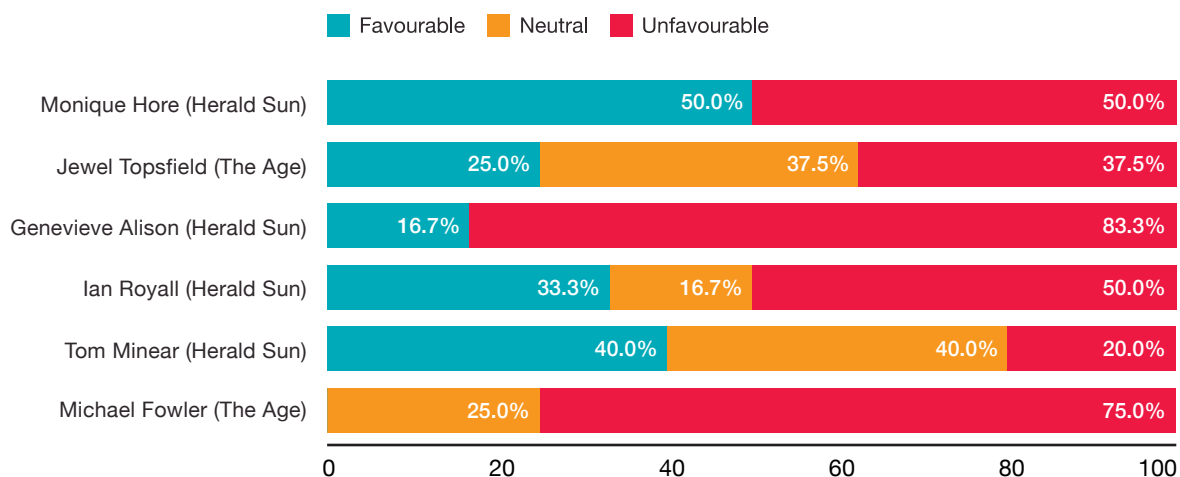


TABLE 4 > FAVOURABILITY – MAJOR JOURNALISTS

	Total Stories	Favourable	Neutral	Unfavourable
Monique Hore (Herald Sun)	8	4 (50.0%)	0 (0.0%)	4 (50.0%)
Jewel Topsfield (The Age)	8	2 (25.0%)	3 (37.5%)	3 (37.5%)
Genevieve Alison (Herald Sun)	6	1 (16.7%)	0 (0.0%)	5 (83.3%)
Ian Royall (Herald Sun)	6	2 (33.3%)	1 (16.7%)	3 (50.0%)
Tom Minear (Herald Sun)	5	2 (40.0%)	2 (40.0%)	1 (20.0%)
Michael Fowler (The Age)	4	0 (0.0%)	1 (25.0%)	3 (75.0%)

MAJOR THEMES

TABLE 5 > MAJOR THEMES – VOLUME AND REACH

	Total Stories	Audience Reach
MSIR is saving lives	25	5,729,123
Residents' concerns re unsuitable location of MSIR	20	3,962,991
Residents' concerns that shooting up is common in Richmond streets and laneways	13	2,777,866
Police action against drug trafficking in Richmond	10	2,654,388
Residents' concerns re public safety eg aggressive behaviour, violence, syringes, etc	10	2,150,347
Residents' concerns re drug trafficking in full view and drug related crime	8	1,874,668
Drug overdoses still taking place in Richmond/City of Yarra despite MSIR	6	1,404,887

GRAPH 10 > FAVOURABILITY – MAJOR THEMES

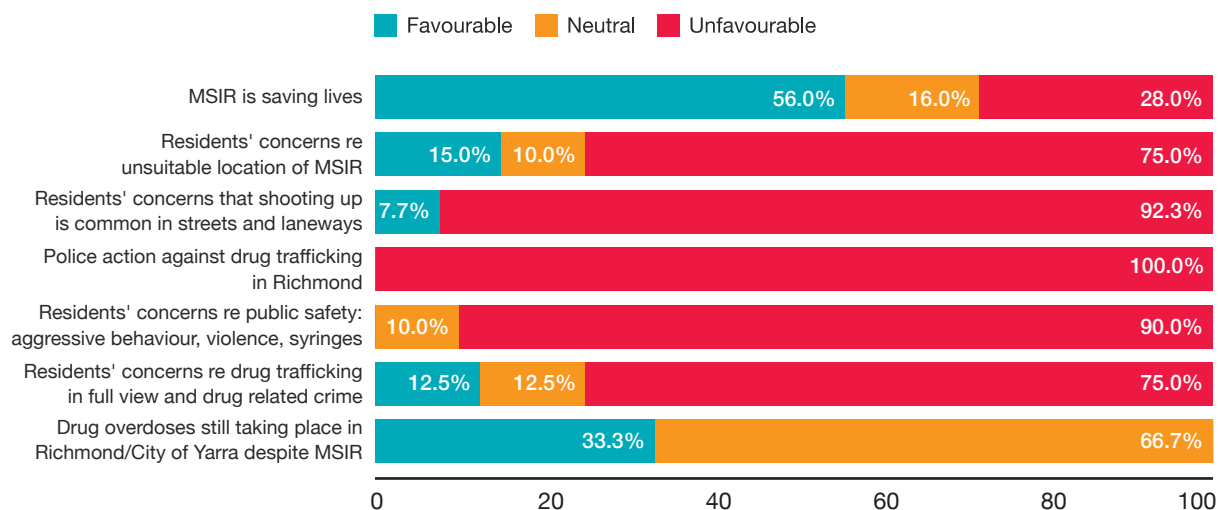


TABLE 6 > FAVOURABILITY – MAJOR THEMES

	Total Stories	Favourable	Neutral	Unfavourable
MSIR is saving lives	25	14 (56.0%)	4 (16.0%)	7 (28.0%)
Residents' concerns re unsuitable location of MSIR	20	3 (15.0%)	2 (10.0%)	15 (75.0%)
Residents' concerns that shooting up is common in Richmond streets and laneways	13	1 (7.7%)	0 (0.0%)	12 (92.3%)
Police action against drug trafficking in Richmond	10	0 (0.0%)	0 (0.0%)	10 (100.0%)
Residents' concerns re public safety eg aggressive behaviour, violence, crime, syringes, etc	10	0 (0.0%)	1 (10.0%)	9 (90.0%)
Residents' concerns re drug trafficking in full view	8	1 (12.5%)	1 (12.5%)	6 (75.0%)
Drug overdoses still taking place in Richmond/City of Yarra despite MSIR	6	2 (33.3%)	4 (66.7%)	0 (0.0%)

COMMON THEMES AND HOW THESE EVOLVED

Councillor Stephen Jolley's Community Consultation Meeting at All Nations Hotel Richmond

The facilitation of a community consultation meeting by City of Yarra Councillor Stephen Jolley, in April 2019, was an important peg in the media sequence. It harnessed negative debate and brought attention to the concerns of residents. Adverse commentary on community impacts of the MSIR grew from this point while commentary on broader issues surrounding the conduct of the trial became less evident.

The location of the injecting facility was a central theme for negative media coverage. Local community concerns were perpetrated by a residents' action group formed at the time of Cr Jolley's community consultation meeting.

Media reporting featured quotes from individuals identifying as representatives of the community action group. These quotes centred on the unsuitability of the location, the demise of community wellbeing, reduced property values and dangers to primary aged school children, who were regularly exposed to drug use, drug dealing and general anti-social behaviours.

The proximity of Richmond West Primary School was a major discussion point, augmented by concerns that student vulnerability was a measure of the degree to which the facility had negatively impacted community safety and wellbeing.

Release of Data

The release of performance data in June and September 2019, appeased concerns over a lack of transparency on the facility's operations and contributed to stronger evidence-based reporting. Statistical information released by the state government presented a counter-argument to the largely negative stories on concerns expressed by Richmond residents.

The use of data provided a positive balance to otherwise negative reporting on the MSIR. The data reported on the number of overdoses managed without loss of life, as well as numbers of referrals to auxiliary health, social support and drug dependency services.

Data references were frequently accompanied by quotes from the minister that lives were being saved and that thousands of people were engaging with health providers for the first time in years.

Increased Services

The announcement of increased MSIR operating hours and expanded facilities in July 2019 brought attention to the increased demand for services, but also gave rise to further action by opposing groups.

Local residents used the announcement to amplify their concerns about the increasing presence of anti-social behaviour, violence and drug taking in the surrounding precinct.

Some coverage raised concerns that the trial expansion would extend to other drug hot-spots in the state. A report in the *Geelong Advertiser* for instance (11 July 2019), presented unfounded suggestions that a MSIR could be established in Geelong.

Arrest of MSIR Workers

The arrest of two MSIR workers on drug trafficking charges in October 2019 was a "last straw" moment. Those opposed to injecting rooms seized on the event and called for the trial to be discontinued forthwith. Headlines also supported local community arguments that the MSIR was diminishing safety and wellbeing across the precinct.

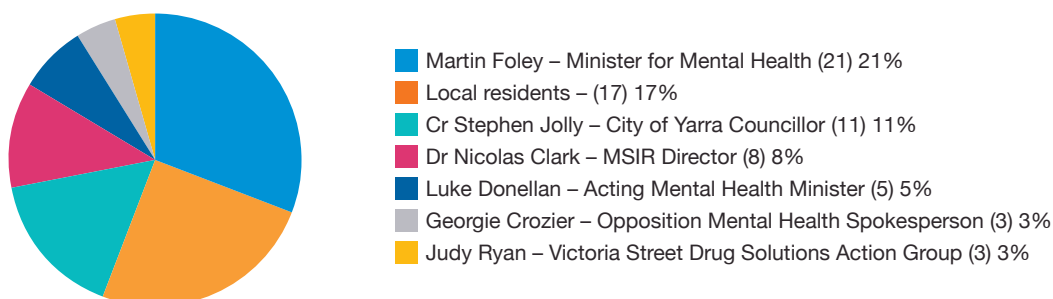
In response to calls for outright closure, Cr Stephen Jolley clarified his position, noting that residents were concerned about the location of the trial in North Richmond, but not the provision of medically supervised injecting room services.

In a perhaps unexpected twist, the arrests also triggered positive content, hedged in the defence of the achievements of MSIR in the face of criticism. Letters, editorials and opinion pieces gave rise to balanced discussion which acknowledged the arrests and called for debate on the Medically Supervised Injecting Room to not lose sight of the lives saved. Many articles referred to the highly successful management of overdoses and the auxiliary support benefits for drug users.

Reports on the Premier's commitment to maintain the trial, and the Minister's actions to dismiss the facility's CEO and announce an independent review of management practices, acted as a circuit breaker. These announcements, and the declaration of zero tolerance for illegal conduct, started a new cycle dedicated to improved practices and governance frameworks at North Richmond Community Health. Later reports reflected the benefits of the review, namely, the removal of a needle exchange program in the precinct and improved governance and the introduction of workplace culture strategies.

SPOKESPEOPLE

GRAPH 11 > KEY SPOKESPEOPLE



SPOKESPEOPLE AND COMMENT ORIGIN

In total there were 124 spokespeople quoted in the media coverage sample. Many quotes came from Members of Parliament with relevant portfolio responsibilities, and from representatives of MSIR, and the City of Yarra and associated organisations.

Minister for Mental Health Martin Foley was quoted 21 times, Acting Minister, Luke Donnellan, five times, and Opposition Spokesperson Georgie Crozier, three times. Others included Police Minister Lisa Neville, and a number of Opposition MPs. MSIR Director Dr Nicholas Clark was quoted eight times and City of Yarra councillor Stephen Jolly was quoted 11 times.

There were 17 quotes from “local residents,” who were either referred to as “local resident(s)” without any further identification (10 instances), or referred to as “Richmond resident,” along with the person’s name (7 instances). No indication was given as to whether they were involved with residents’ action groups or other organisations.

The most prominent organisation quoted was Victoria Police, with 10 quotes in total, including by Assistant Commissioner Luke Cornelius and Victorian Police Association President Wayne Gatt.

Two residents’ action groups were quoted, the MSIR Residents Action Committee (4 quotes) and the Victoria Street Drug Solutions Action Group (3). Spokespeople were not always clearly identified with their specific groups. David Horseman from MSIR Residents Action Committee was referred to by *The Age* (25 October 2019) as “the spokesman for a residents committee calling for the injecting room to be relocated.” Judy Ryan, from the Victoria Street Drug Solutions Action Group, was referred to in *The Weekend Australian* (25 May 2019) as someone “who campaigned for the injecting facility but feels more needs to be done to deal with the large numbers of sick people in the areas.”

Appendix E: Analysis of selected social media

MSIR: Sentiment

Social Media

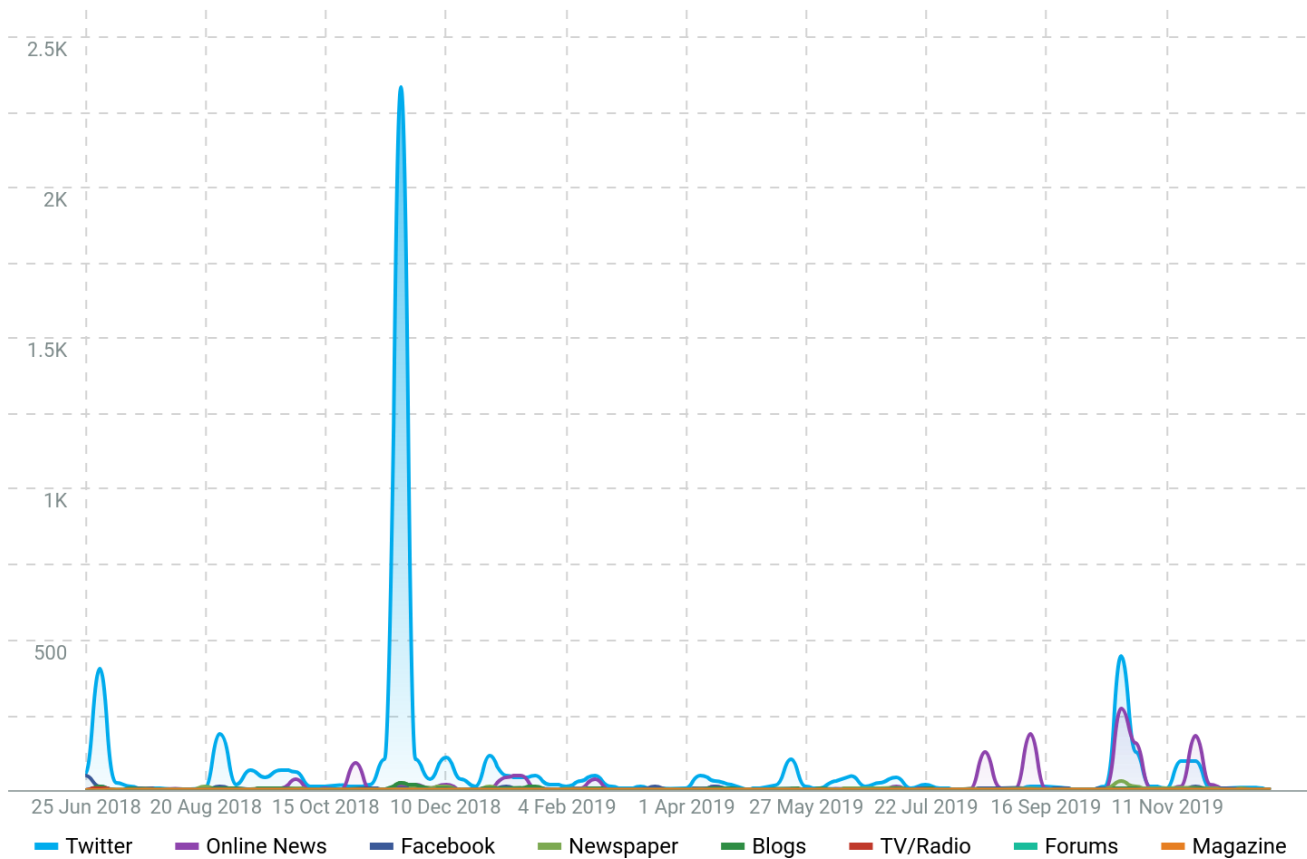
Digital Engagement & Strategy Unit

VIC Department of Health and Human Services

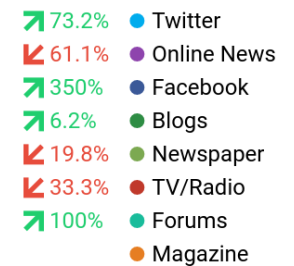
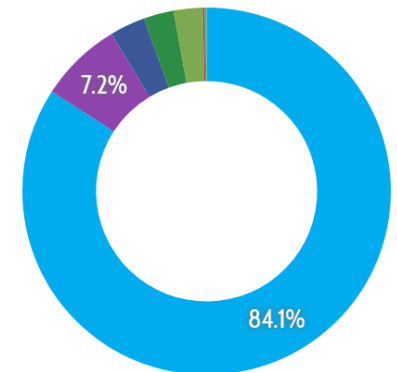
RESULTS OVER TIME

by Media Types

Results **7.4K**



SHARE OF MEDIA TYPES



19/02/20

SENTIMENT

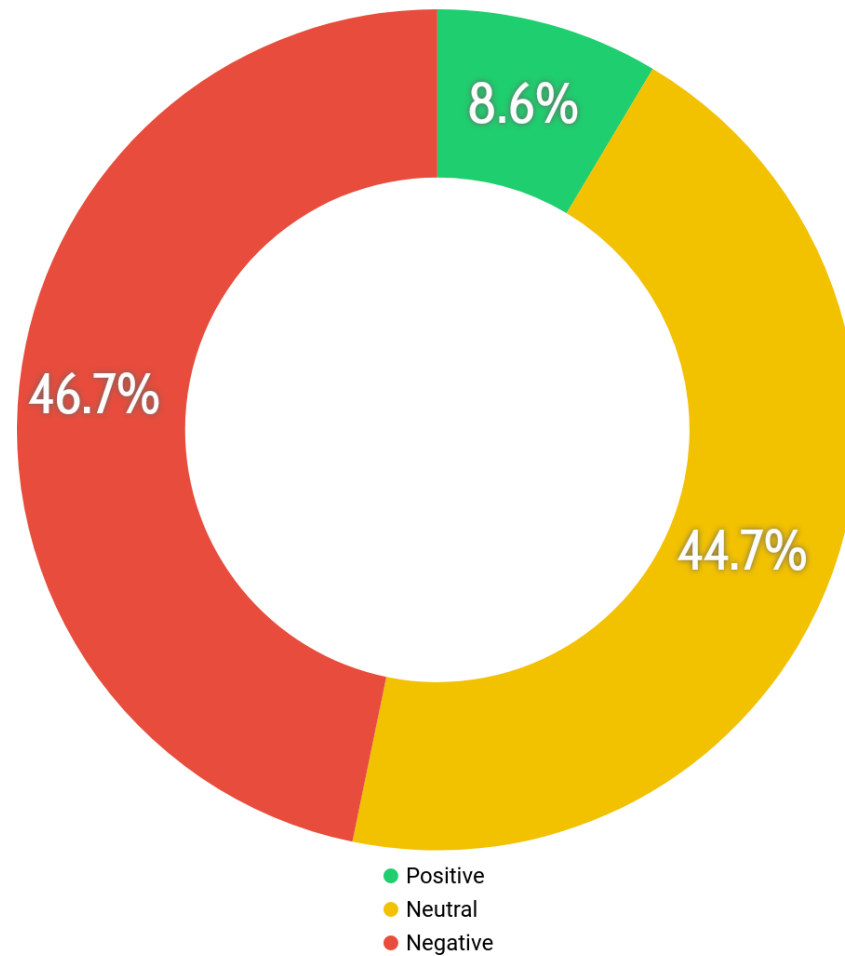
9%

Positive

47%

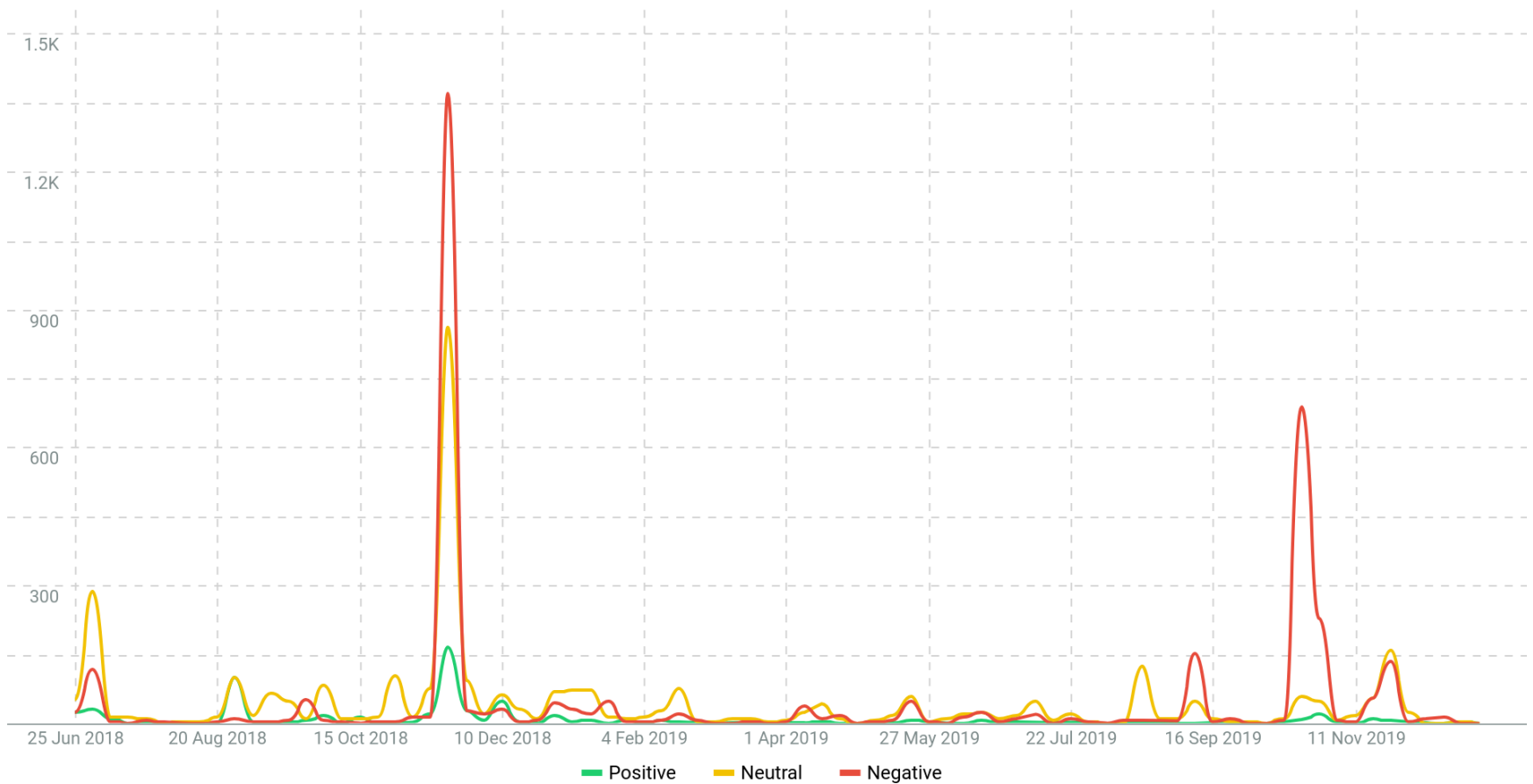
Negative

SHARE OF SENTIMENT



SENTIMENT OVER TIME

Results **7.4K**

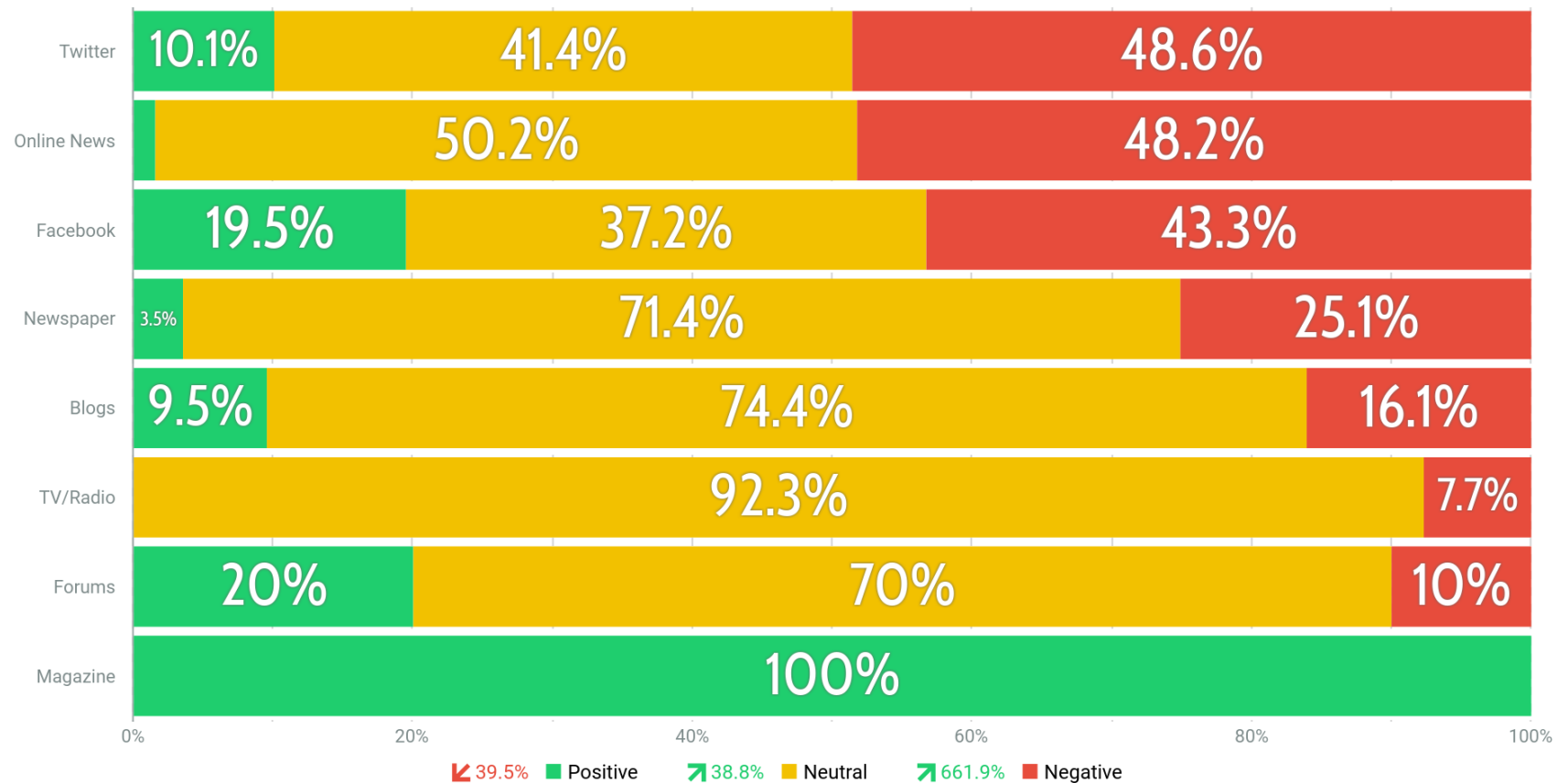


[illegible]

SENTIMENT

by Media Types

Results **7.4K**



Results



[Pill-Testing: Whoa, 'Sunri...](#)

...you," she says. "Do not take these drugs." When Kochie points out that young people will always take drugs, B...

11.8K

jared richards | Online News | 14/01/19 11:23



[Teenage boy dies of drug...](#)

...from a medically supervised injecting room. Police were called to a suspected heroin overdose at a unit on Ega...

2.5K

9news staff | Online News | 24/11/19 18:50



[Victorian Liberals to shut...](#)

...like the Labor government," he said. On the promise to promptly shut down the North Richmond safe injecting...

7.7K

adam carey | Newspaper | 21/11/18 11:44



['12 lives saved' in Richmond...](#)

Melbourne's new safe injecting room has saved 12 drug users' lives and received 400 visits since it... Dr Nico Cl...

2.4K

Chloe Booker | Newspaper | 06/07/18 13:30



[Melbourne safe injecting...](#)

...[set up] to save lives, every indication is this facility is saving lives," Mr Foley said. Safe injecting program sh...

4.3K

abc news michael barnett | Online News | 31/08/18 10:34



[There's only one way to d...](#)

...harm. Recall that Victorian Premier Daniel Andrews spent years opposing a safe injecting centre in Victoria before...

2.1K

Antony Loewenstein | Newspaper | 08/07/19 00:10



[Melbourne residents furious...](#)

Anger is growing over Victoria's controversial 'safe injecting room' after the centre underwent a \$7.1 million ... co...

2.9K

digital staff | Online News | 08/07/19 08:05



[High demand for Victoria's...](#)

...injecting room is doing exactly what we hoped. It's saving lives," Minister for Housing, Disability and Ageing, Ma...

1.8K

39 mins ago | TV/Radio | 31/08/18 12:40

Results



[Victoria's Greens did a lot...](#)

Opinion Politics Victoria Victoria Votes
Victoria's Greens did a lot better than we're
given credit for By ... used...

Ellen Sandell | Newspaper | 03/12/18 13:06

1.7K



[Watching @MatthewGuyM...](#)

Watching @MatthewGuyMP concede I
want us to remember how his party's
campaign made Victorians from ref...

@Kon_K | Twitter | [published on 24/11/18 at 21:04](#)

1.4K



[Crossbench to use numbers...](#)

The deaths have prompted a renewed push
for a trial of pill testing, but the Victorian
Government has so far rule...

facebook beyond the valley | Online News | 21/01/19 06:19

1.7K



[Larger centre opens door...](#)

...room move Benjamin Preiss Updated July
7, 2019 — 11.51am first published at
11.48am The controversial safe-...

Benjamin Preiss | Newspaper | 07/07/19 11:51

1.3K



['I've got a mortgage': Fiona...](#)

... Mr Andrews denied his party had been
"dragged kicking and screaming" to polices
such as the safe injecting ...

Chloe Booker | Newspaper | 26/11/18 13:40

1.6K



[Teenage boy overdoses m...](#)

Victoria Victoria Police Teenage boy
overdoses metres from safe injecting room
Tate Papworth November 24 ... d...

Tate Papworth | Newspaper | 24/11/19 20:13

1.3K



[Victorian election set to d...](#)

...Victorian election, as the Labor victory
that swept Premier Daniel Andrews back
into power hands them up to 1...

Joseph Dunstan | Online News | 25/11/18 15:34

1.6K



[Staff at Melbourne's cont...](#)

...been the site of Victoria's first safe
injecting room since 2018, as part of a two-
year trial. The pair, who work...

hamish goodall | Online News | 25/10/19 08:02

1.2K

Results



[...critical after overdose at...](#)

...at events in Victoria," Mental Health Minister Martin Foley said on Monday. "Advice from Victoria Police tells us...

Chloe Booker | Newspaper | 31/12/18 18:23

1.1K



[Public heroin use spurs c...](#)

National Victoria Drugs Public heroin use spurs calls for change at Richmond injecting room Paul Sakkal April 10 ...

Paul Sakkal | Newspaper | 10/04/19 20:18

907



[Freo considers allowing m...](#)

...test their drugs before swallowing them under a radical proposal by the City. Injecting rooms for addicts is anot...

Josh Zimmerman PerthNow | Newspaper | 06/01/19 09:20

1.1K



[Two workers at Melbourne's...](#)

...17:04:00 Two workers at a medically supervised safe injecting room in Melbourne's inner east are among eight...

aap julian smith | Online News | 24/10/19 17:02

868



['No champagne breakfast'...](#)

" She was integral in some of the Andrews Labor government's signature progressive policy decisions over the past...

Anthony Colangelo | Newspaper | 25/11/18 13:55

1K



[Reason Party promises to...](#)

...zones around abortion clinics and a safe injecting room. However, she is still facing a tough fight to hold her U...

supplied | Online News | 21/11/18 06:04

863



[Reflecting on the #vicvotes...](#)

Reflecting on the #vicvotes debate on @abcmelbourne this morning. The thing that concerns me most is Guy's r...

@jillastark | Twitter | [published on 22/11/18 at 09:36](#)

936



['No danger': Not all Rich...](#)

...at Richmond West Primary believe the school is being used as a political pawn by those who argue the safe inj...

Jewel Topsfield | Newspaper | 19/11/19 11:39

826

Results



[Rural Victoria's ice crisi...](#)

...two-year safe injecting room trial in North Richmond As at November 1, 2018 Ice is relatively cheap in Victoria —...

danny tran | Online News | 01/11/18 06:19

787



[Victorian election loss re...](#)

...issues such as the North Richmond safe injecting room trial and the Safe Schools Program. "This is the most pr...

danny tran | Online News | 25/11/18 13:09

735



[Teen found dead metres ...](#)

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...not targeting addicts who are in North Richmond to use the medically supervised safe injecting centre. "We ar...

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Appendix F: Burnet Institute report

Review of the Medically Supervised Injecting Room (MSIR) using the SuperMIX cohort and linked data sets

25 February 2020

Prepared by Maria del Mar Quiroga, Wijnand Van den Boom, Dagnachew Fetene and Paul Dietze, Behaviours and Health Risks Program, Burnet Institute.

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Introduction

For the analyses below we have used interviewer-administered questionnaire data from the Melbourne injecting drug user cohort study (SuperMIX). SuperMIX commenced in 2008 and has involved recruitment of over 1300 people who inject drugs (PWID) into the study from a range of locations across Melbourne, including North Richmond. It involves collection of a range of indicators (outcome measures) related to the objectives of the Medically Supervised Injecting Room (MSIR) in North Richmond outlined in the legislation. For more information on SuperMIX please refer to Appendix 1: Methods.

Our analysis dataset includes self-report interview data for the period 26/4/2008 through to 1/7/2019, in addition to linked data from Medicare Benefits Schedule (MBS), Pharmaceutical Benefits Scheme (PBS), Alcohol and Other Drugs Information System (ADIS), Victorian Admitted Episodes Dataset (VAED), Victorian Emergency Minimum Dataset (VEMD), and Victorian Ambulance Clinical Information System (VACIS). We have also used data from participants in the Illicit Drug Reporting System (IDRS) as a complement to the SuperMIX participants for demographic, drug use and psychosocial indicators. See Appendix 1: Methods for more information on the data sets used, as well as the different samples that have been used for the SuperMIX self-reported data and the samples for the several linked data set.

Samples used for this report

For the analyses in this report we have used all participants that have responded to the question whether they have visited the MSIR ("MSIR visit"; n=598) or responded to the question about intensity of use in the previous month ("MSIR intensity"; n=596), for all recruitment locations.

At request we can provide the data on those participants who have responded to the MSIR visit question *and* have been recruited in Richmond (n=174), and those who have responded to the MSIR intensity question *and* have been recruited in Richmond (n=172).

Demographics

Among the whole analysis sample (n=598), those who visited the MSIR were relatively younger, with a median age at the time of interview of 36 years, compared to 40 years for those who did not visit the MSIR. They typically reported being more socially marginalised. To this end, they were more likely to be unemployed, more likely to live in unstable accommodation, more likely to be homeless, more likely to live by themselves and more likely to be incarcerated in the previous 12 months than those who did not visit the MSIR. Those who visited the MSIR were also more likely to identify as Aboriginal or Torres Strait Islander, more likely to state heroin as their main drug of choice and to have injected heroin in the last month. See Appendix 2: Demographics for all of these findings and for a comparison with the Illicit Drug Reporting System (IDRS) sample which generally showed similar findings.

MSIR visits

Of the total 598 participants, 181 (30%) reported that they visited the facility compared to 417 (70%) who did not. Of the total of 598, 285 participants had at least *one interview before the MSIR opened*. Of these participants, 94 reported that they visited the MSIR and

191 reported that they did not. Of the 313 new participants *recruited into the study after the MSIR opened*, 87 reported visiting the MSIR, and 226 reported that they did not.

Statistical methods for the self-reported data

To test for changes within the same individuals over time we performed fixed-effects logistic regression models in which we measured associations between changes in “MSIR visit” (yes/no) and changes in the outcome variables. We report on the odds ratio (OR) with “not having visited the MSIR” as the reference category.

Statistical methods for the linked data

To test for changes over time we performed fixed-effects Poisson regression models. A continuous variable “month” was included as a fixed-effect term in the model. We compared MSIR visit groups (yes versus no) and MSIR intensity groups (no visits/<50%/≥50%) for the different outcome measures in the six different linked datasets (i.e. PBS, MBS, ADIS, VAED, VEMD, VACIS). We report on the incidence rate ratio (IRR) with “not having visited the MSIR” as the reference category for both the MSIR visit and MSIR intensity analyses. In these analyses we only considered all records from one year prior to the MSIR opening.

The remainder of this report details the main findings of our analyses of the SuperMIX data related to the stated aims of the MSIR listed in Legislation and the set of indicators required for consideration by the Centre for Evaluation and Research.

2. Aim a: Reduce the number of avoidable deaths and the harm caused by overdoses of drugs of dependence

People who would have previously injected in high-risk settings are now using the facility at least some of the time

We defined previously injected in “high-risk settings” as previously using and scoring heroin in “public spaces”, or having an overdose in a public space. Of the 285 participants who were recruited into the study before the opening of the MSIR, 92 most recently used their heroin in private prior to the MSIR opening, 89 most recently used it in public spaces, and we are missing this information for 104 participants. This is because this question was accidentally left out of the survey in the year prior to the MSIR opening, as well as some participants not answering this question.

Participants who reported most recently using their heroin in public prior to the MSIR opening are about twice as likely to have visited the MSIR (28%) than those who reported most recently using their heroin in private (15%) (Table 2.1).

Table 2.1 Use of MSIR among those who previously used heroin in high-risk settings

	Most recently used in private	Most recently used in public	Total	p-value
Total	92	89	181	
Use of the MSIR				
Visited MSIR	14 (15%)	25 (28%)	39 (22%)	0.035*
Hasn't visited MSIR	78 (85%)	64 (72%)	142 (78%)	

* Pearson's chi-squared test

Of the 285 participants who were recruited into the study before the opening of the MSIR, 126 most recently purchased their heroin in private, 122 most recently purchased it in public spaces, and we are missing this information for 37 participants. Participants who report most recently purchasing their heroin in public are about twice as likely to have visited the MSIR (47%) than those who report most recently purchasing their heroin in private (24%) (Table 2.2).

Table 2.2 Use of MSIR among those who previously scored heroin in high-risk settings

	Most recently purchased in private	Most recently purchased in public	Total	p-value
Total	126	122	248	
Use of the MSIR				
Visited MSIR	30 (24%)	57 (47%)	87 (35%)	<0.001*
Hasn't visited MSIR	96 (76%)	65 (53%)	161 (65%)	

	Most recently purchased in private	Most recently purchased in public	Total	p-value
* Pearson's chi-squared test				

Of the 285 participants who were recruited into the study before the opening of the MSIR, 54 reported most recently overdosing in private prior to the opening of the MSIR, 102 most recently overdosed in public spaces, and we are missing this information for 129 participants (some of these participants did not report having an overdose). Participants who report most recently overdosing in public are almost twice as likely to have visited the MSIR (34%) than those who report most recently overdosing in private (19%) (Table 2.3).

Table 2.3 Use of MSIR among those who previously overdosed in high-risk settings

	Most recently overdosed in private	Most recently overdosed in public	Total	p-value
Total	54	102	156	
Use of the MSIR				
Visited MSIR	10 (19%)	35 (34%)	45 (29%)	0.038*
Hasn't visited MSIR	44 (81%)	67 (66%)	111 (71%)	

* Pearson's chi-squared test

Proportion of injections taking place in the facility

Of the 598 participants interviewed after the MSIR opened, 417 (70%) had not visited the MSIR, and 181 (30%) visited the MSIR at least once. Of those who visited the MSIR at least once, 121 (66%) performed less than half of their previous month's injections in the facility or did not inject in the month prior to their interview, 58 (33%) performed at least half of their previous month's injections in the facility, and 2 were missing the answer to this question. In the IDRS sample similar findings were evident: 59% reported performing less than half of their previous month's injections in the facility and 41% reported performing at least half of their previous month's injections in the facility.

Death of cohort member by overdose of drugs using linked data from National Death Index

No cohort members who were interviewed since the MSIR opened have died.

Self-reported non-fatal overdose

In a cross-sectional analysis of all follow-up interviews done after the MSIR opened, those who visited the MSIR were more likely to have experienced an overdose since their previous interview (27%) compared to those who did not visit the MSIR (16%) (Table 2.4).

Table 2.4 Self-reported non-fatal overdose (only follow up)

	Visited MSIR	Hasn't visited MSIR	Total	p-value
Total	94	191	285	
Any overdose since previous interview (only follow-up)				
No	68 (73%)	160 (84%)	228 (81%)	0.027*
Yes	25 (27%)	30 (16%)	55 (19%)	

* Pearson's chi-squared test

If we only consider participants who were asked this question in both their latest interview before the facility opened (i.e. had a follow-up interview before) and after the MSIR opened (N=190), we found no significant difference between the proportion of participants who reported having an overdose since their previous interview at the interview *before* the MSIR opened, but we found a statistically significant difference for the interview *after* the facility opened (Table 2.5). The fixed effects logistic regression analyses show weak, but inconclusive, evidence of a difference between the two groups (OR=2.9, p=0.122).

Table 2.5 Self-reported non-fatal overdose (only follow up) before and after MSIR opened

	Visited MSIR	Hasn't visited MSIR	Total	p-value
Total	38	152	190	
Any overdose since previous interview at interview before MSIR opened				
No	28 (82%)	117 (85%)	145 (84%)	0.727
Yes	6 (18%)	21 (15%)	27 (16%)	
Missing	n<5	14	18	
Any overdose since previous interview at interview after MSIR opened				
No	26 (68%)	129 (85%)	155 (82%)	0.019*
Yes	12 (32%)	23 (15%)	35 (18%)	

* Pearson's chi-squared test

We do not know, however, what the relative timing of these events are in order to further interpret these findings. One possibility is that after experiencing an overdose, participants decide to start injecting in the MSIR so that future overdoses can be more easily attended to, in which case the self-reported overdose may have occurred before the visit to the MSIR. Another possibility is that MSIR staff have a stricter definition of overdose and therefore participants who have experienced an overdose inside the MSIR are more aware and thus

more likely to report such an event as being an overdose, in contrast to those who have experienced an overdose outside of the MSIR.

Figure 2.1 shows the changes over time between the two interviews.

Figure 2.1 Changes over time in self-reported non-fatal overdose (only follow up) before and after MSIR opened

Any overdose since previous interview



Self-reported intentional overdose

Very few intentional overdoses were reported in the analytic sample (Table 2.6). We did not find evidence of a difference in the rates of intentional overdoses between those who reported visiting the MSIR and those who did not (OR=2; p=0.571). No further analyses are reported due to small numbers.

Table 2.6 Self-reported intentional overdose (only follow up)

	Visited MSIR	Hasn't visited MSIR	Total	p-value
Total	94	191	285	
Intentional overdose since previous interview (only follow-up)				
No	88 (95%)	186 (97%)	274 (96%)	0.304†
Yes	5 (5%)	5 (3%)	10 (4%)	

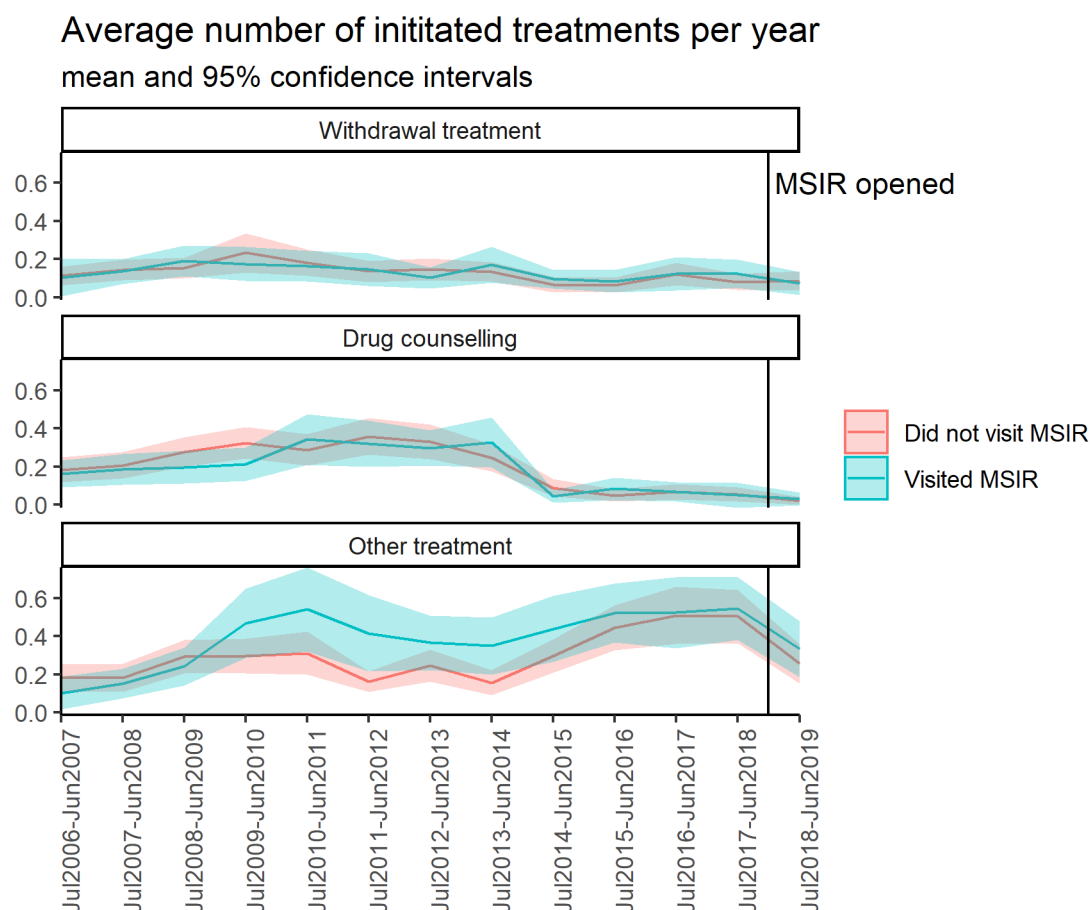
† Fisher exact test, due to low numbers in some categories

3. Aim b: Deliver more effective health services for clients of the licensed medically supervised injecting centre by providing a gateway to health and social assistance which includes drug treatment, rehabilitation support, health care, mental health treatment and support and counselling

Use of alcohol and other drug services

Using linked data from ADIS, we did not find evidence of a difference between the average number of initiated treatments for the participants who reported visiting the MSIR compared to those who did not; either before or after the MSIR opened (IRR=0.90; $p=0.68$). This applies to withdrawal treatment (IRR=0.69; $p=0.31$), drug counselling (IRR=0.85; $p=0.98$), and all other treatments recorded on the ADIS dataset (including residential rehabilitation; IRR=2.63; $p=0.88$) (Figure 3.1).

Figure 3.1 Average number of initiated treatments per year by MSIR use



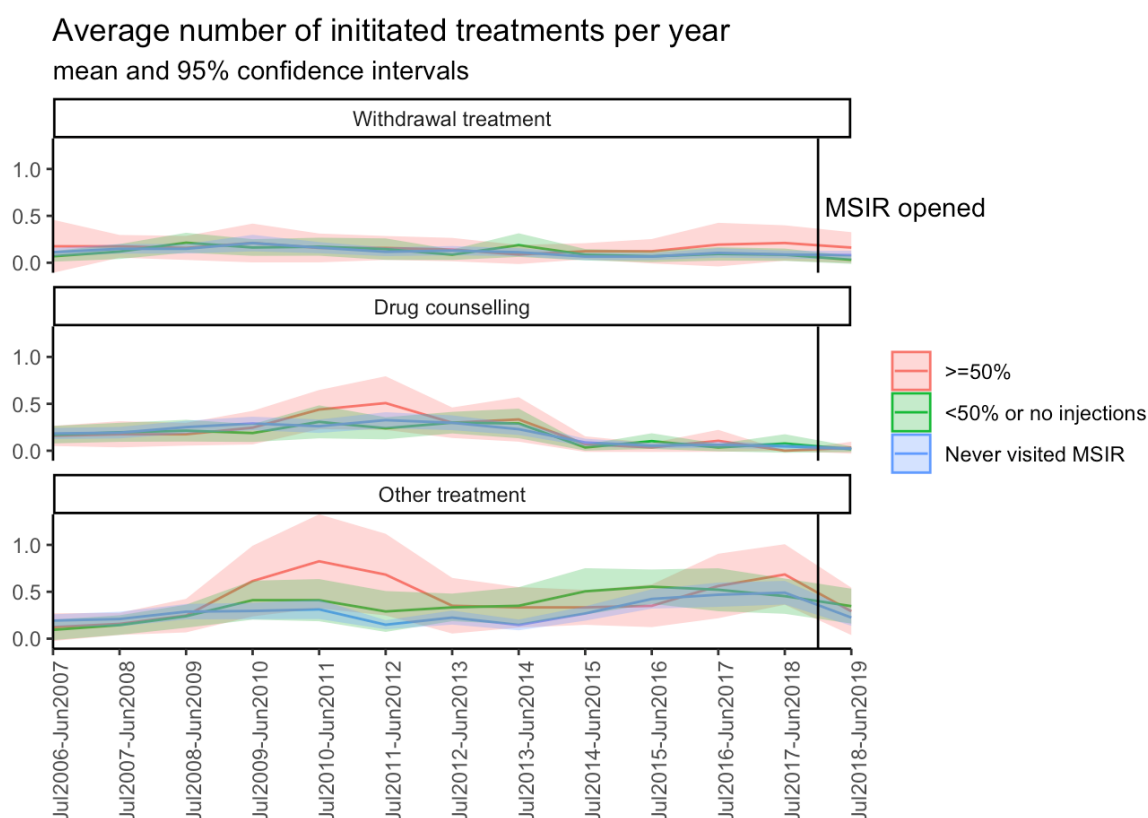
For intensity of MSIR use, we did not find evidence of a difference between the average number of initiated treatments for the participants who reported visiting the MSIR compared to those who did not; either before or after the MSIR opened. This applies to withdrawal treatment, drug counselling, and all other treatments (including residential rehabilitation) (Figure 3.2 and Table 3.1).

Table 3.1 Initiated treatments by MSIR frequency of use: results from the fixed-effects Poisson regression analysis (ADIS)

		IRR	95%CI	P
All treatments	No visit	1		
	<50%	0.97	0.51-1.86	0.93
	≥50%	0.82	0.35-1.95	0.66

Analyses regarding withdrawal treatment, drug counselling, and all other treatments are not reported due to small numbers.

Figure 3.2 Average number of initiated treatments per year for three treatment types by MSIR frequency of use (ADIS)



Use of opioid substitution therapy

Because data on opioid substitution therapy (OST) are not collected through the PBS, we rely on self-report data for assessment of OST use. In a cross-sectional analysis of all interviews done after the MSIR opened, those who reported visiting the MSIR were less likely to be on OST (34%) compared to those who did not (49%) (Table 3.2), and 36% of those who reported having less than 50% of their injections in the facility reported being on OST compared to 25% of those who reported having more than 50% of injections in the facility. These effects reflect pre-MSIR differences between groups, as outlined below.

Table 3.2 On OST at the time of interview

	Visited MSIR	Hasn't visited MSIR	Total	p-value
Total	181	417	598	
On OST at the time of interview				
No	119 (66%)	213 (51%)	332 (56%)	0.001*
Yes	62 (34%)	204 (49%)	266 (44%)	

* Pearson's chi-squared test

If we only consider participants who were recruited into the study before the MSIR opened, we see that there was a pre-existing difference in OST utilisation between those who reported subsequently using the MSIR and those who didn't, and their percentages changed little between interviews (OR=0.90; p=0.77, see Table 3.3 and Figure 3.3).

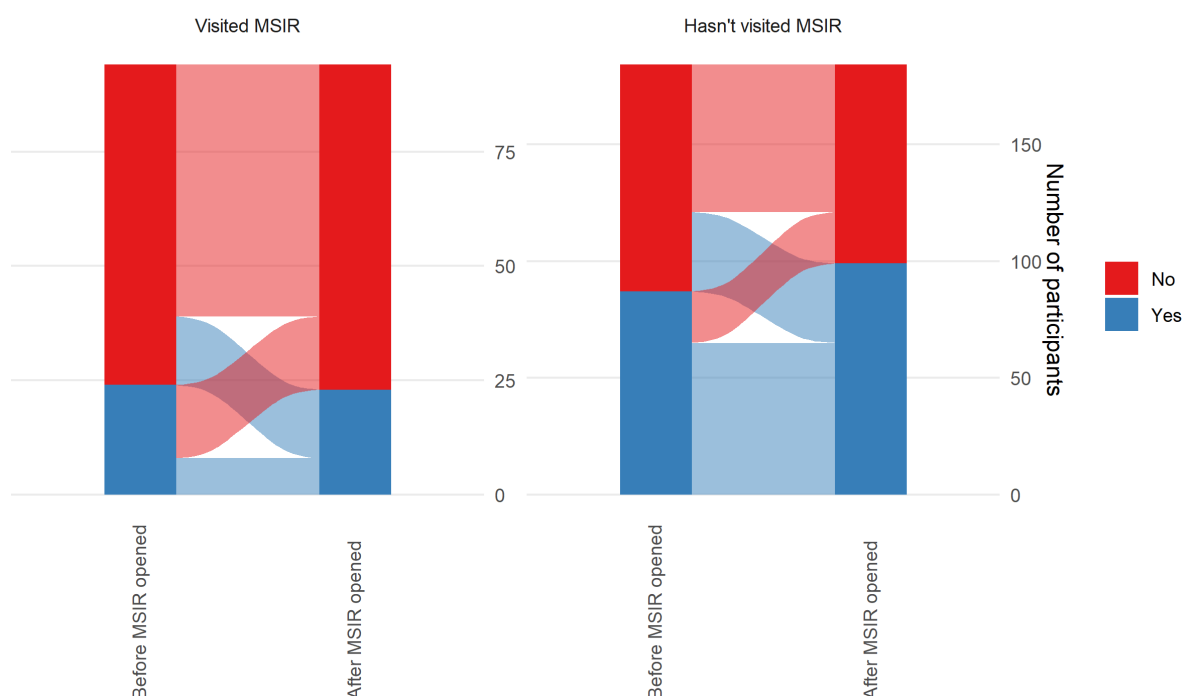
Table 3.3 On OST at the time of interview before and after MSIR opened

	Visited MSIR	Hasn't visited MSIR	Total	p-value
Total	94	184	278	
On OST at the time of interview before MSIR opened				
No	70 (74%)	97 (53%)	167 (60%)	<0.001*
Yes	24 (26%)	87 (47%)	111 (40%)	
On OST at the time of interview after MSIR opened				
No	71 (76%)	85 (46%)	156 (56%)	<0.001*
Yes	23 (24%)	99 (54%)	122 (44%)	

* Pearson's chi-squared test

Figure 3.3 Changes over time in self-reported OST at time of interview before and after MSIR opened

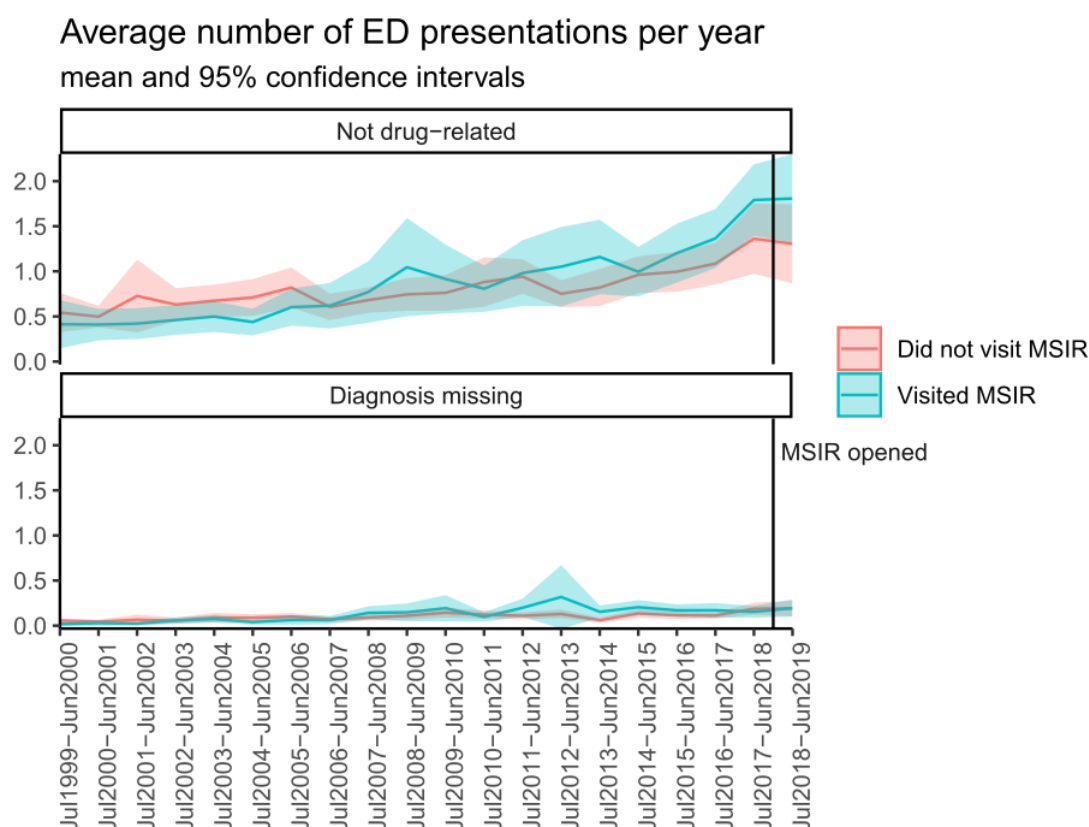
On OST at the time of interview



Emergency department presentations for conditions unrelated to drugs

Using linked data from the Victorian Emergency Minimum Dataset (VEMD), we did not find evidence of a difference between the average number of emergency department presentations for conditions unrelated to drug use between the group of participants who reported visiting the MSIR compared to those who didn't; either before or after the MSIR opened (IRR=0.90; $p=0.47$). Many VEMD records do not contain a diagnosis and so we have included those in Figure 3.4 as "Diagnosis missing".

Figure 3.4 Average number of emergency department presentation per year for not-drug-related presentations and presentations with no diagnosis (VEMD)

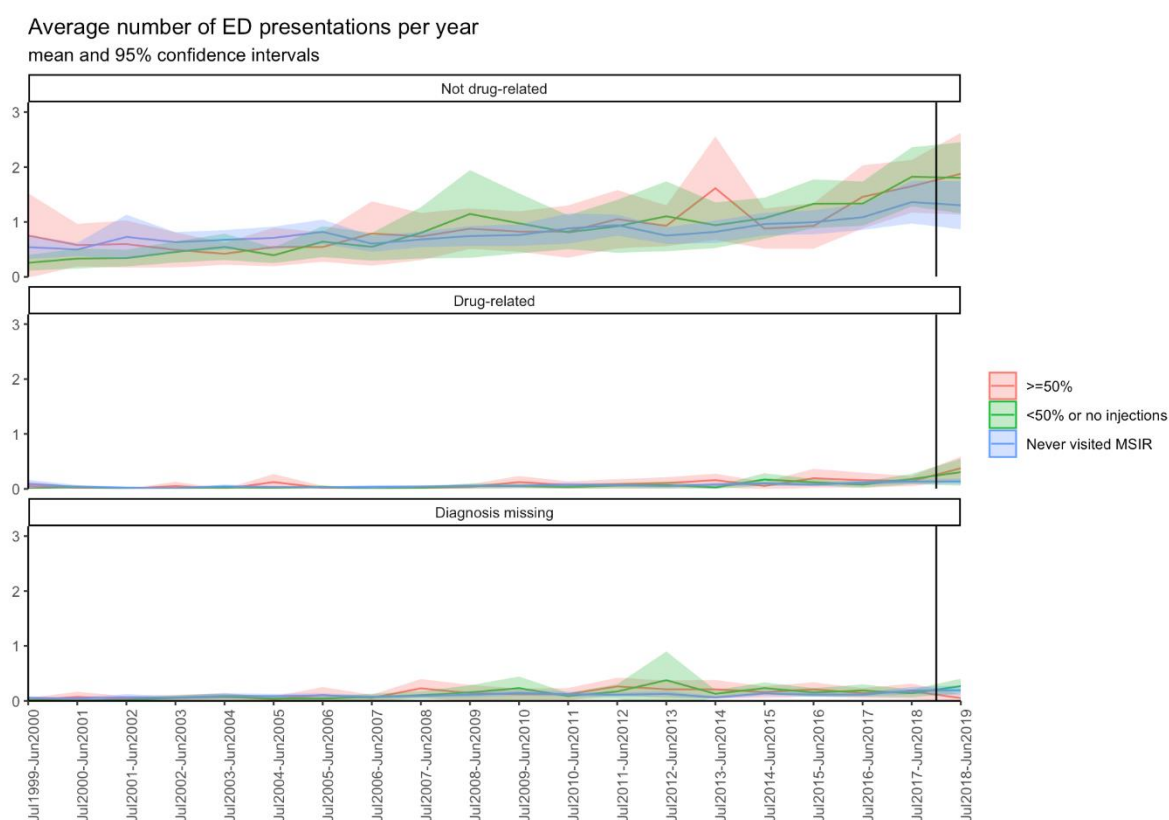


For intensity of MSIR use, we did not find evidence of a difference between the average number of emergency department presentations for conditions unrelated to drug use between the group of participants who reported visiting the MSIR compared to those who didn't (see Table 3.4 and Figure 3.6).

Table 3.4 Initiated treatments by MSIR frequency of use: results from the fixed-effects Poisson regression analysis (VEMD)

		IRR	95%CI	p
Not-drug related ED presentations	No visit	1		
	<50%	0.89	0.66-1.20	0.45
	≥50%	1.01	0.63-1.61	0.96

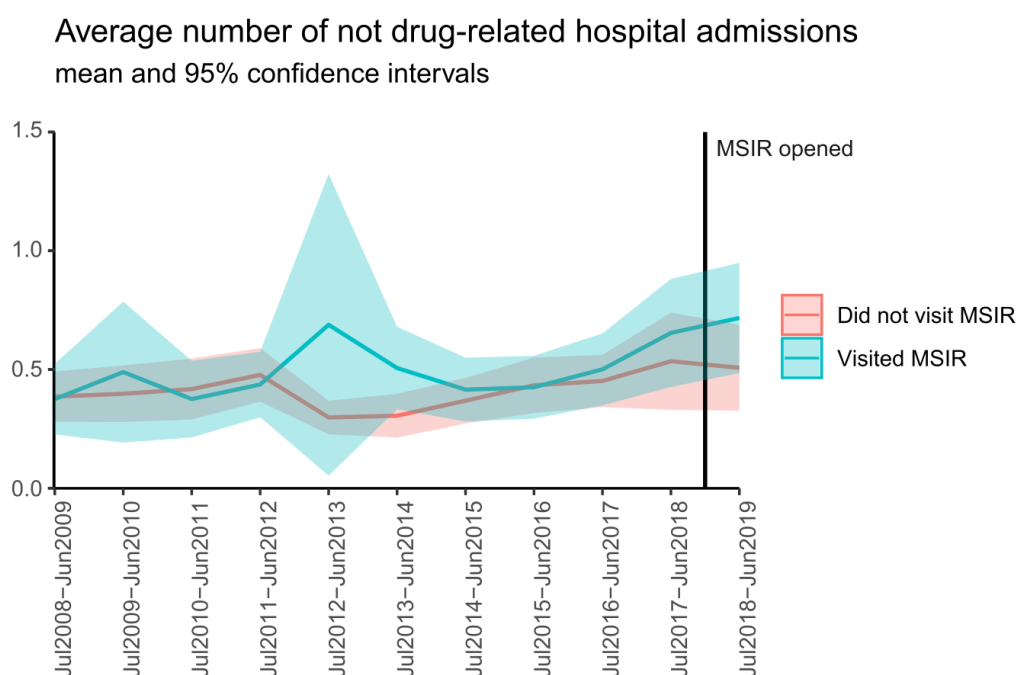
Figure 3.5 Average number of emergency department presentation per year for three types of presentations by MSIR frequency of use (VEMD)



Hospitalisations for not drug-related issues

Using linked data from the Victorian Admitted Episodes Dataset (VAED), we did not find evidence of a difference between the average number of hospital admissions for conditions unrelated to drug use between the group of participants who reported visiting the MSIR compared to those who didn't; either before or after the MSIR opened (IRR=1.09; $p=0.66$, Figure 3.6).

Figure 3.6 Average number of not-drug-related hospital admissions per year (VAED)

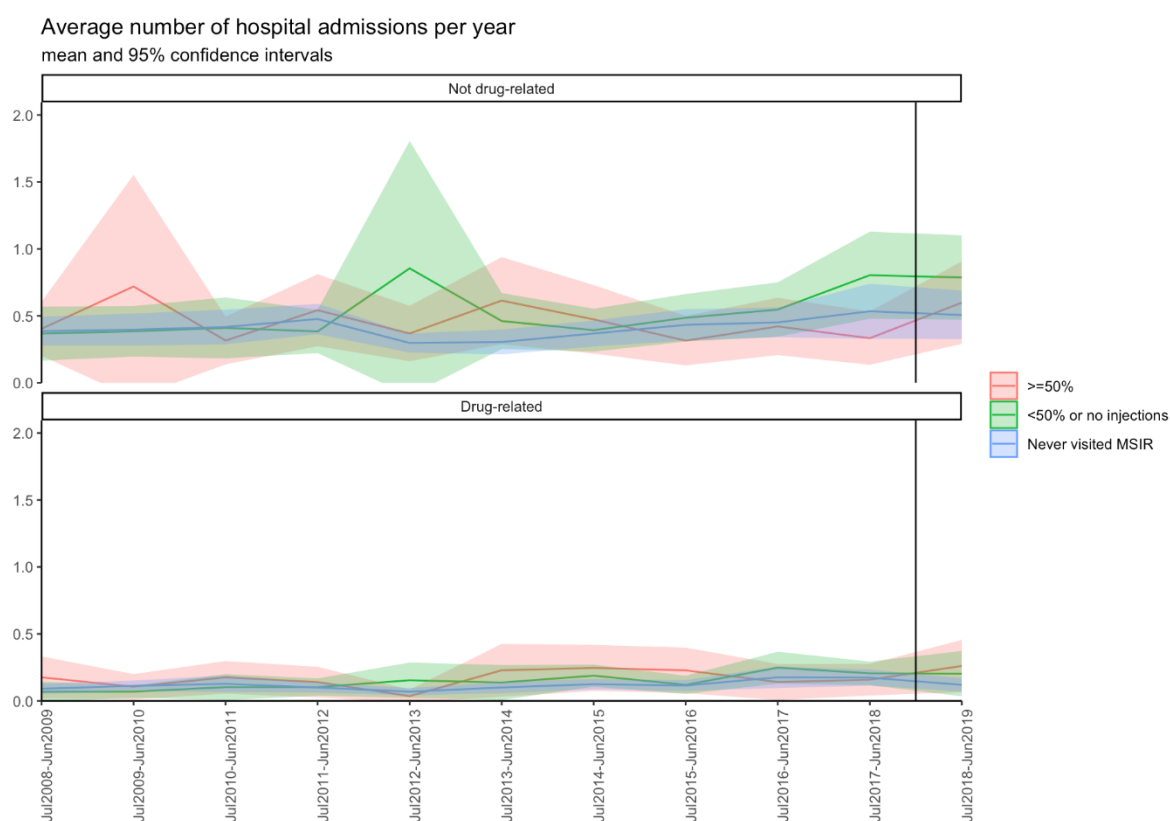


For intensity of MSIR use, we did not find evidence of a difference between the average number of hospital admissions for conditions unrelated to drug use between the group of participants who reported visiting the MSIR compared to those who didn't; (see Figure 3.7 and Table 3.5).

Table 3.5 Not-drug related hospital admissions by MSIR frequency of use: results from the fixed-effects Poisson regression analysis

		IRR	95%CI	p
Not-drug related hospital admissions	No visit	1		
	<50%	0.97	0.66-1.43	0.88
	≥50%	1.78	0.77-4.14	0.18

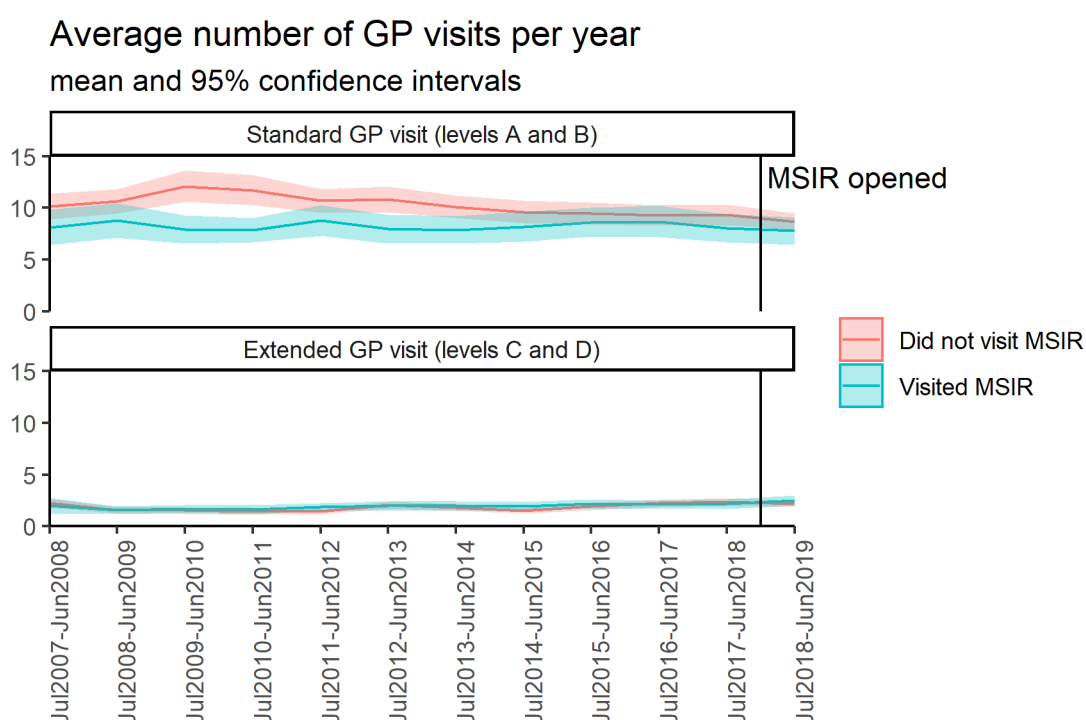
Figure 3.7 Average number of hospital admissions per year for two types of admissions by MSIR frequency of use (VAED)



Use of GP health services – linked data

Using linked data from the Medicare Benefits Schedule (MBS), we did not find any significant difference between the average number of GP visits for conditions unrelated to drug use between the group of participants who reported visiting the MSIR compared to those who didn't; either before or after the MSIR opened, IRR=1.09; p=0.25 (Figure 3.8).

Figure 3.8 Average number of GP visits per year (MBS)

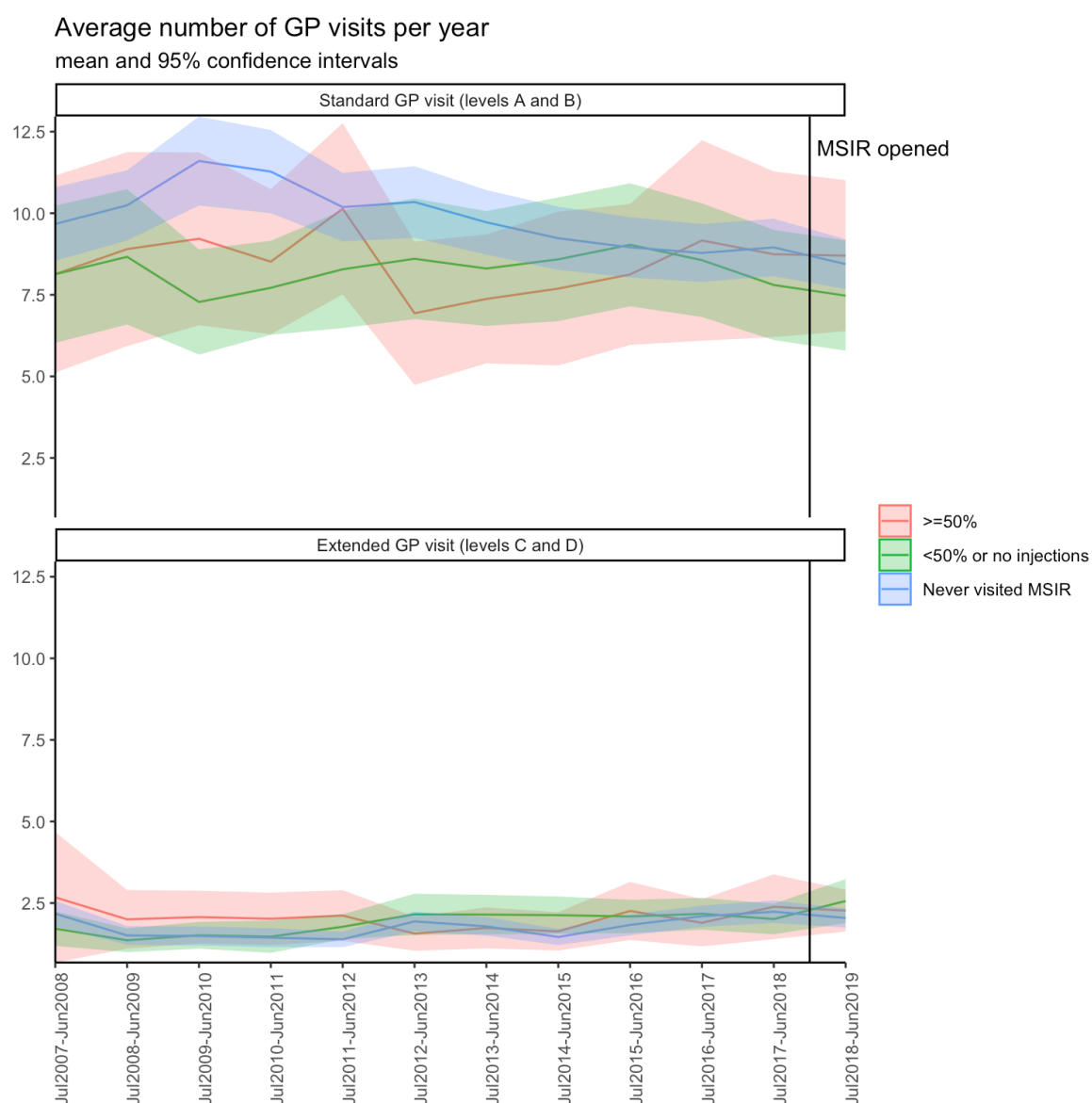


For intensity of MSIR use we did not find evidence of a difference between the average number of GP visits for conditions unrelated to drug use between the group of participants who reported visiting the MSIR compared to those who didn't (Table 3.6 and Figure 3.9). However, the average number of GP after hour visits for conditions unrelated to drug use among those who reported having had 50% or more of their injections in the MSIR was fewer compared to those who had not visited the facility (IRR=0.44, $p=0.03$).

Table 3.6 GP visits by MSIR frequency of use: results from the fixed-effects Poisson regression analysis (MBS)

		IRR	95%CI	p
GP visits	No visit	1		
	<50%	1.10	0.92-1.32	0.28
	≥50%	1.06	0.85-1.34	0.60
GP mental health	No visit	1		
	<50%	0.93	0.54-1.61	0.79
	≥50%	1.11	0.76-1.63	0.59
GP after hours	No visit	1		
	<50%	1.05	0.74-1.52	0.76
	≥50%	0.44	0.21-0.93	0.03
GP pathology	No visit	1		
	<50%	1.53	0.94-2.51	0.09
	≥50%	0.83	0.42-1.63	0.59
GP HCV testing	No visit	1		
	<50%	0.94	0.52-1.71	0.85
	≥50%	0.93	0.45-1.93	0.85

Figure 3.9 Average number of GP visits by MSIR frequency of use (MBS)



For other professional attendances claimed through Medicare, there is insufficient evidence of an impact of the MSIR opening (see Figure 3.10, Figure 3.11 and Table 3.6).

Figure 3.10 Average number of other doctor visits per year GP visits per year (MBS)

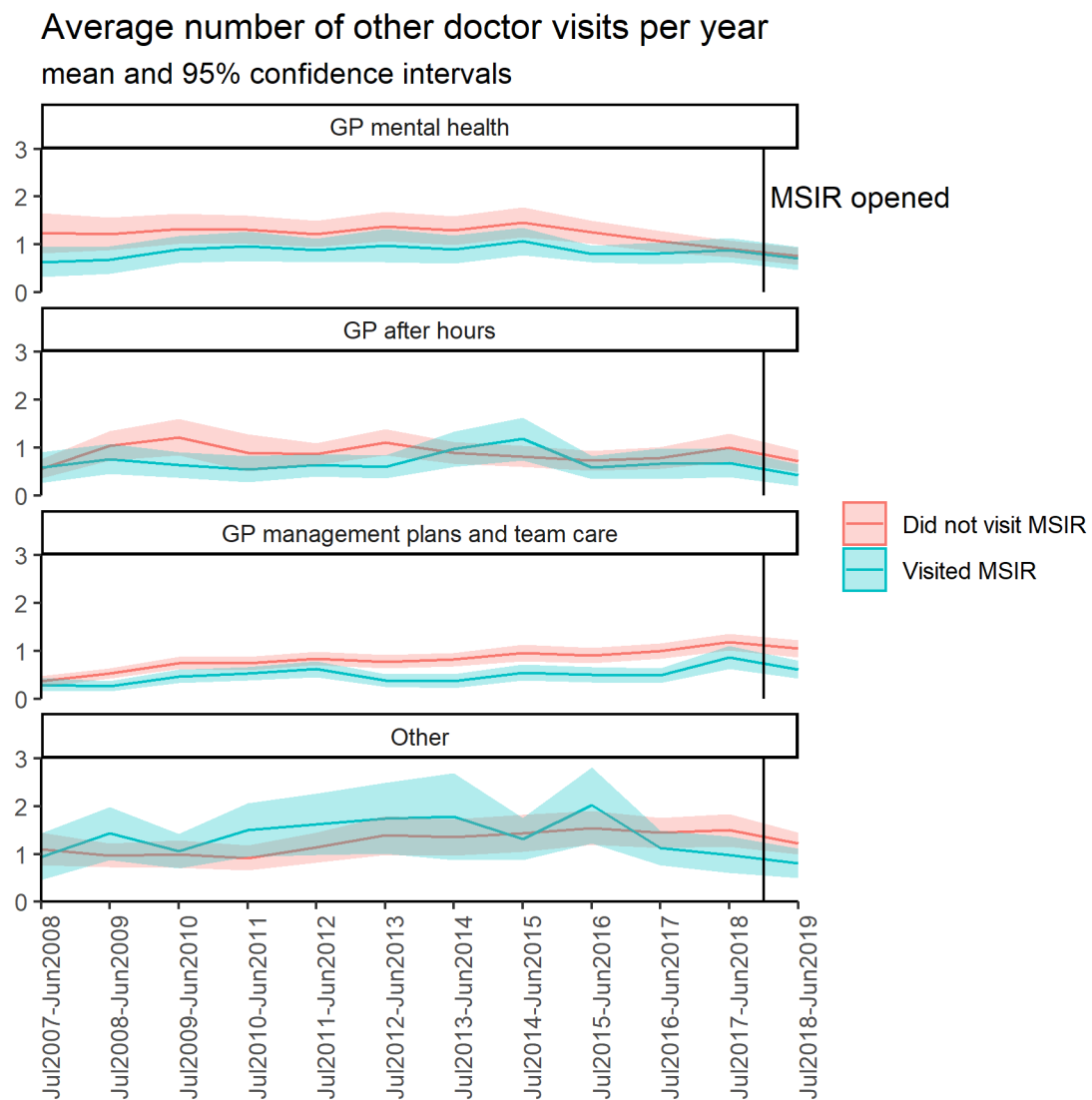
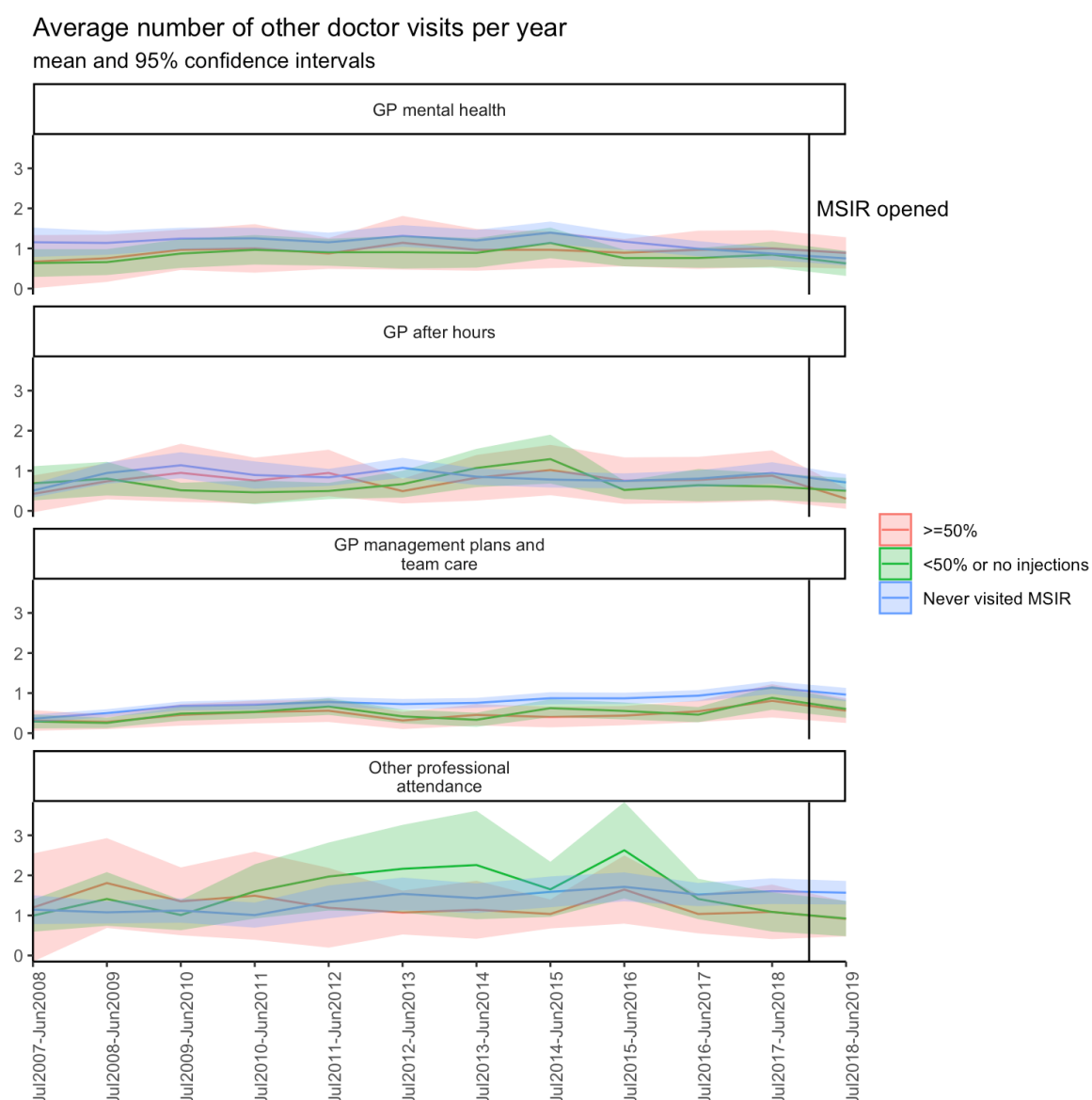


Figure 3.11 Average number of other doctor visits by MSIR frequency of use (MBS)



Use of GPs for non-OST services – self-report

MBS records do not differentiate OST visits from other visits and so we relied on self-report data to explore participants' use of GPs for non-OST related reasons. In a cross-sectional analysis of all interviews done after the MSIR opened, there was no evidence of a difference in the frequency of GP visits for non-OST related reasons for those who visited the MSIR compared to those who did not (Table 3.7).

Table 3.7 Seen GP for reasons other than OST (self-report data)

	Visited MSIR	Hasn't visited MSIR	Total	p-value
Total	181	417	598	
Seen GP for reasons other than OST				
No	78 (43%)	146 (35%)	224 (38%)	0.07
Yes	103 (57%)	268 (65%)	371 (62%)	

* Pearson's chi-squared test

If we only consider participants who were recruited into the study before the MSIR opened, again we find no evidence of a difference (see Table 3.8 and Figure 3.12). There was no significant difference in the rates of seeing a GP between the two groups (OR=0.75; p=0.384).

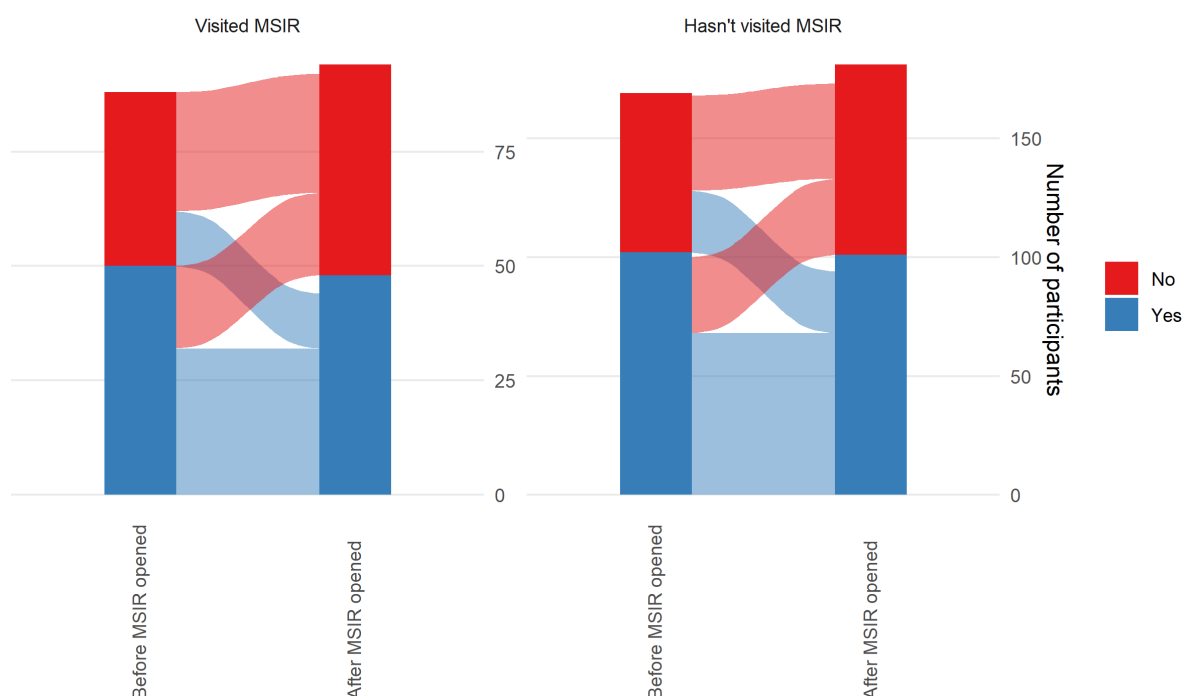
Table 3.8 Seen GP for reasons other than OST at interview before and after MSIR opening (self-report data)

	Visited MSIR	Hasn't visited MSIR	Total	p-value
Total	94	184	278	
Seen GP for reasons other than OST at interview before MSIR opened				
No	38 (43%)	67 (40%)	105 (41%)	0.584
Yes	50 (57%)	102 (60%)	152 (59%)	
Missing	6	15	21	
Seen GP for reasons other than OST at interview after MSIR opened				
No	46 (49%)	80 (44%)	126 (46%)	0.455
Yes	48 (51%)	101 (56%)	149 (54%)	

* Pearson's chi-squared test

Figure 3.12 Changes over time in seeing a GP for reasons other than OST, before and after MSIR opened

Seen GP for reasons other than OST



Prescriptions for medications other than OST

Using linked data from the Pharmaceutical Benefits Scheme (PBS), we did not find evidence of a difference between the average number of prescriptions dispensed between the group of participants who reported visiting the MSIR compared to those who didn't; either before or after the MSIR opened (IRR=1.02; $p=0.85$) (Figure 3.13). This finding applies across all of the different pharmaceutical drug groups considered in Figure 3.14.

Figure 3.13 Average number of mental health prescriptions per year (PBS)

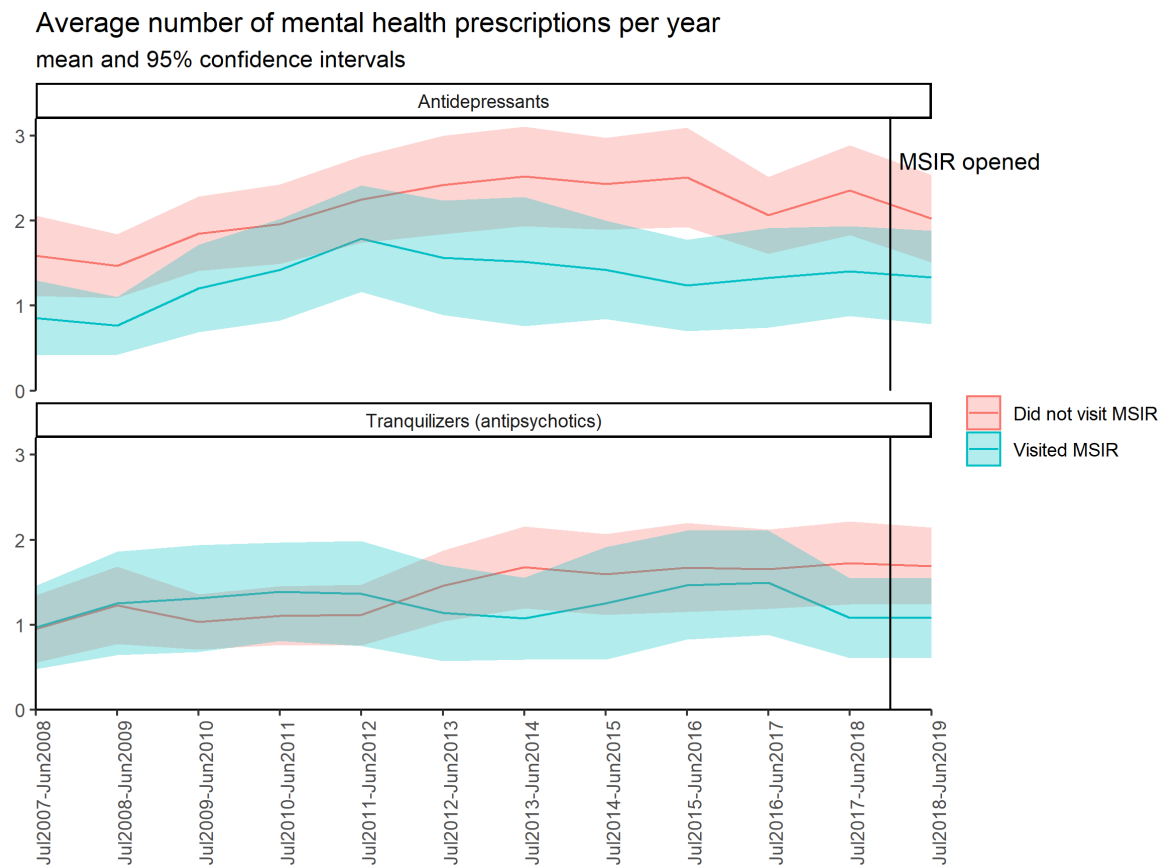
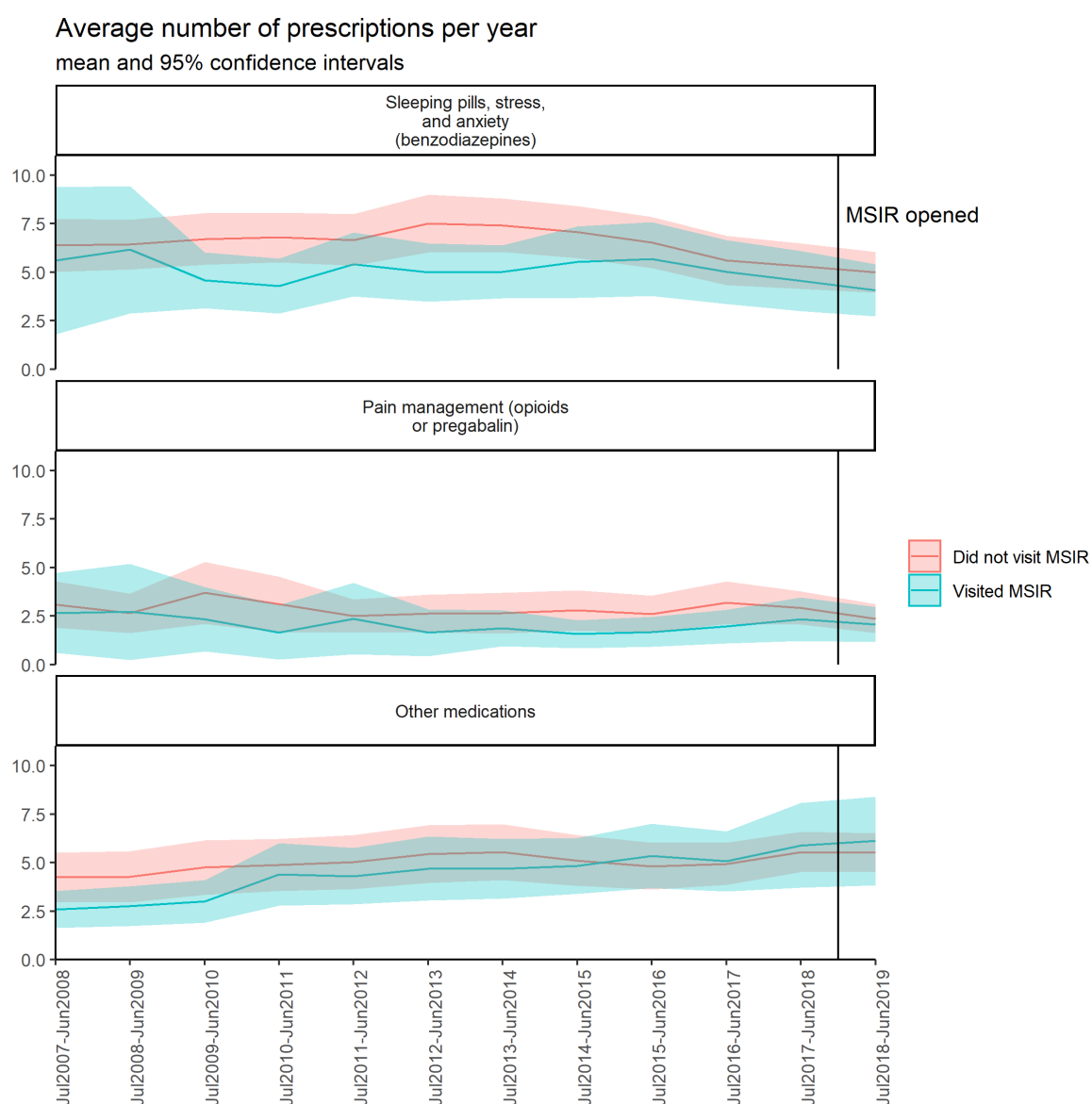


Figure 3.14 Average number of prescriptions per year (PBS)



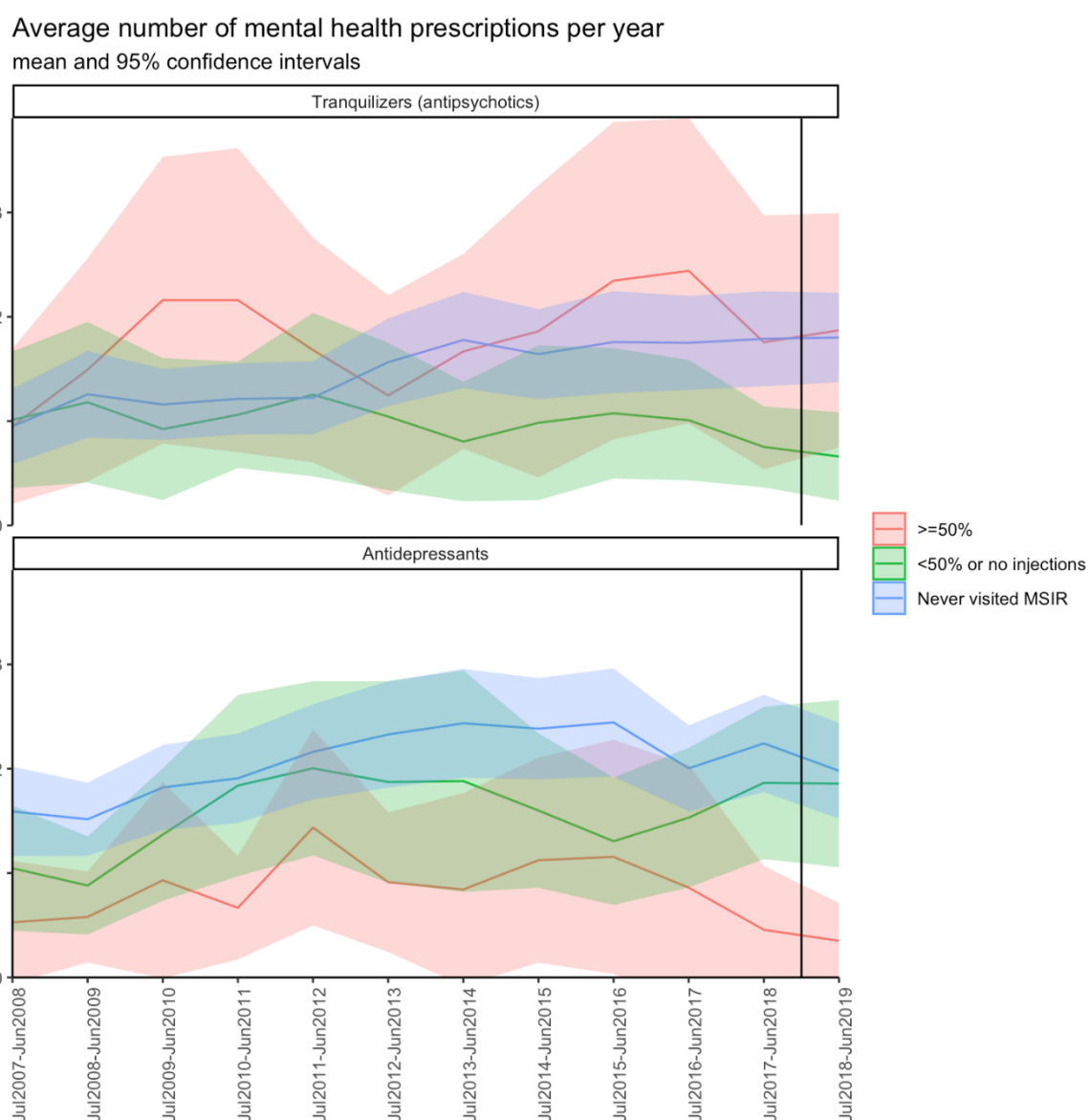
For intensity of MSIR use we did not find evidence of a difference between the average prescriptions dispensed between the group of participants who reported visiting the MSIR compared to those who didn't (

Table 3.9 and
Figure 3.15).

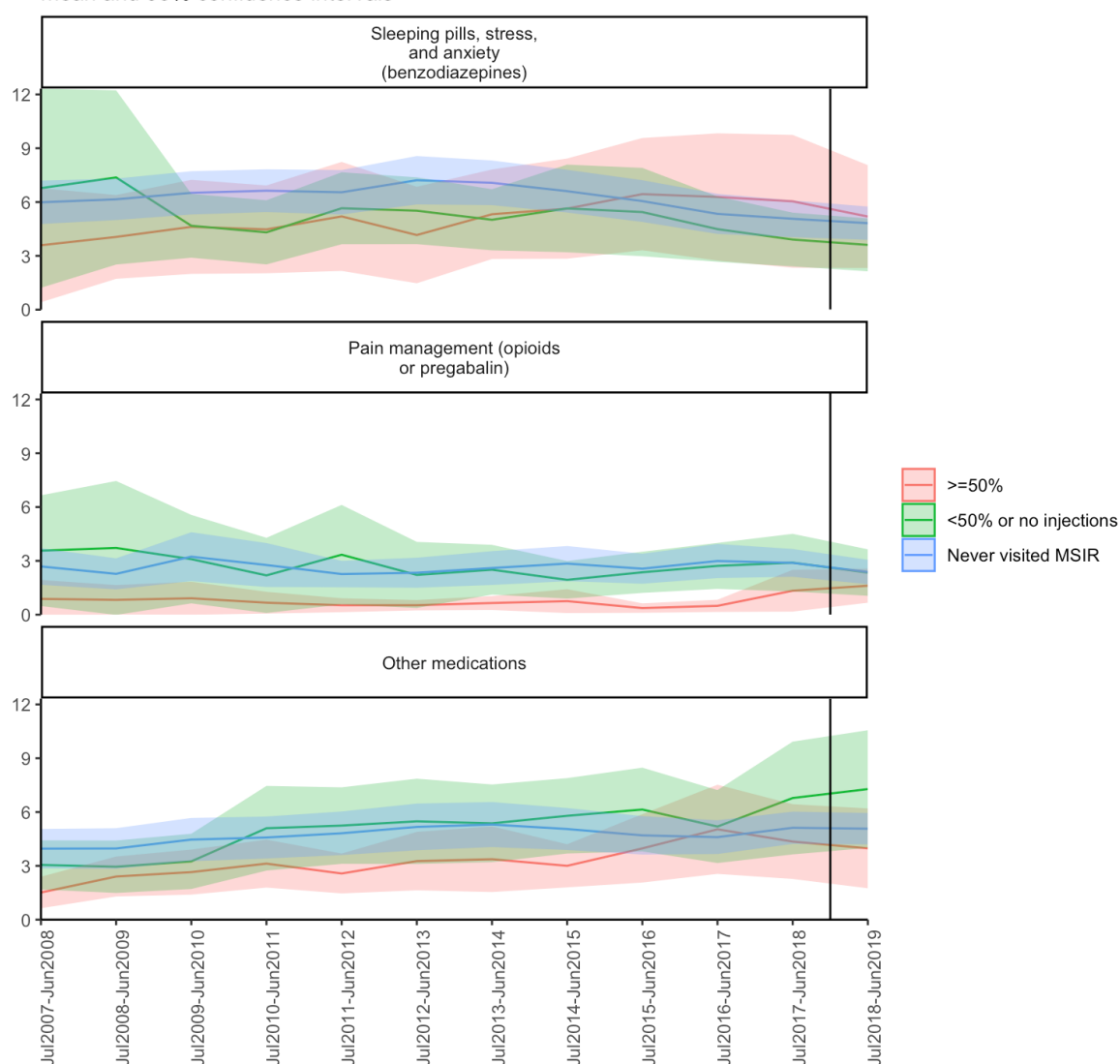
Table 3.9 Average number of prescriptions dispensed by MSIR frequency of use: results from the fixed-effects Poisson regression analysis (PBS)

		IRR	95%CI	p
Mental health medication	No visit	1		
	<50%	0.99	0.81-1.23	0.98
	≥50%	1.04	0.59-1.84	0.89
Sleeping pills (benzos)	No visit	1		
	<50%	0.99	0.75-1.33	0.99
	≥50%	0.93	0.57-1.50	0.77
Pain management	No visit	1		
	<50%	0.93	0.57-1.52	0.78
	≥50%	0.78	0.68-2.85	0.36

Figure 3.15 Average number of prescriptions dispensed per year for five medication types by MSIR frequency of use (PBS)



Average number of prescriptions per year
mean and 95% confidence intervals



IDU-specific primary care services

MBS records do not differentiate IDU primary care visits from other visits and so we relied on self-report data to explore participants' use of IDU primary care services. In a cross-sectional analysis of all interviews done after the MSIR opened, we found no evidence of a difference in the frequency of IDU primary care centre visits for those who visited the MSIR compared to those who did not (Table 3.10).

Table 3.10 Visited primary care centre (self-report data)

	Visited MSIR	Hasn't visited MSIR	Total	p-value
Total	181	417	598	
Visited primary care centre				
No	116 (64%)	299 (72%)	415 (70%)	0.077
Yes	64 (36%)	118 (28%)	182 (30%)	

* Pearson's chi-squared test

If we only consider participants who were recruited into the study before the MSIR opened, again we found no evidence of a difference in the rates of primary care centre visits between the two groups (OR=1.1; p=0.863, see also Table 3.11 and Figure 3.16).

Table 3.11 Visited primary care centre before and after MSIR opening (self-report data)

	Visited MSIR	Hasn't visited MSIR	Total	p-value
Total	94	184	278	
Visited primary care centre at interview before MSIR opened				
No	62 (72%)	135 (79%)	197 (77%)	0.22
Yes	24 (28%)	36 (21%)	60 (23%)	
Missing	8	13	21	
Visited primary care centre at interview after MSIR opened				
No	67 (71%)	146 (79%)	213 (77%)	0.133
Yes	27 (29%)	38 (21%)	65 (23%)	

* Pearson's chi-squared test

Figure 3.16 Changes in visited primary care centre before and after MSIR opened

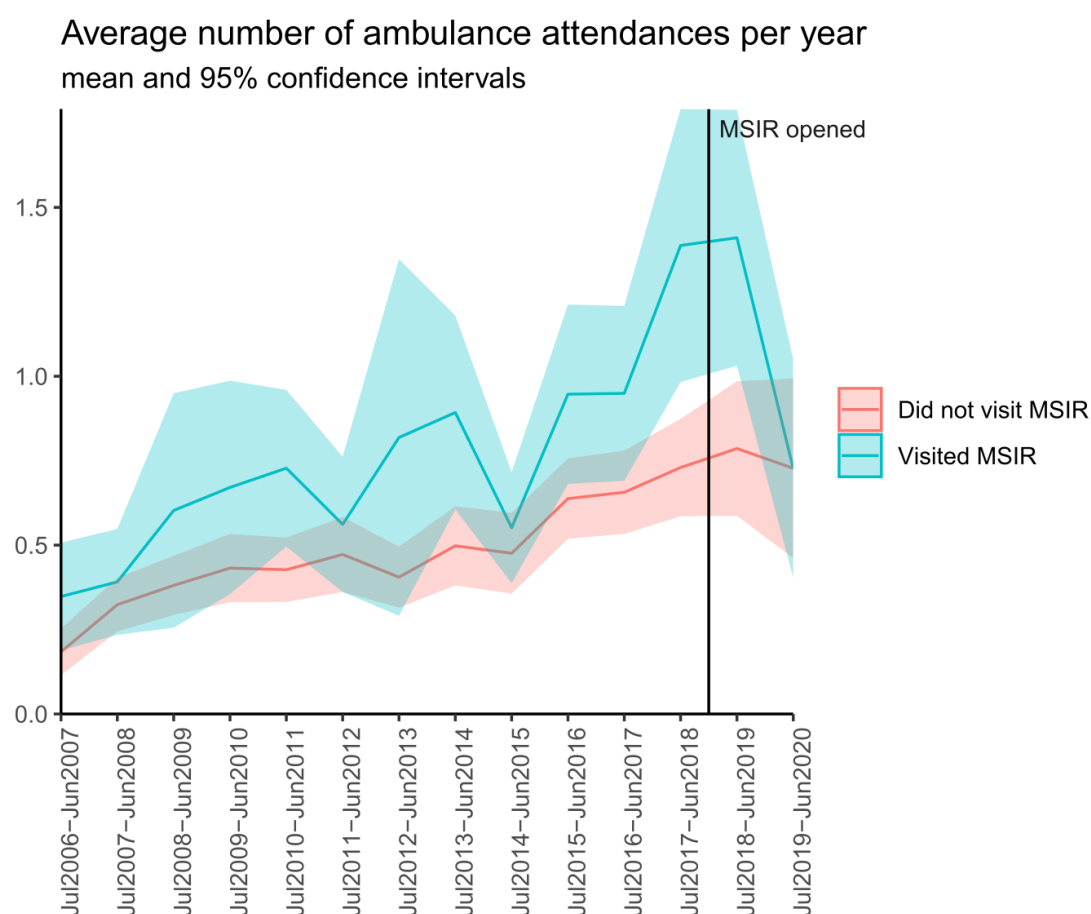
Visited primary care centre



Ambulance for non-overdose

Linked data from the Victorian Ambulance Clinical Information System (VACIS) shows a projected decrease in ambulance attendances for participants who visited the MSIR (Figure 3.17). We only have two months of data for the year offset July2019-June2020 (up to 30 August 2019), so we multiplied that number by 6 to get a projected average number per group per year. Despite an overall drop for the participants who have visited the MSIR, we found no evidence of a difference in the average number of ambulance attendances between those who did visit the facility and those who didn't (IRR=0.95; p=0.77).

Figure 3.17 Average number of ambulance attendances per year

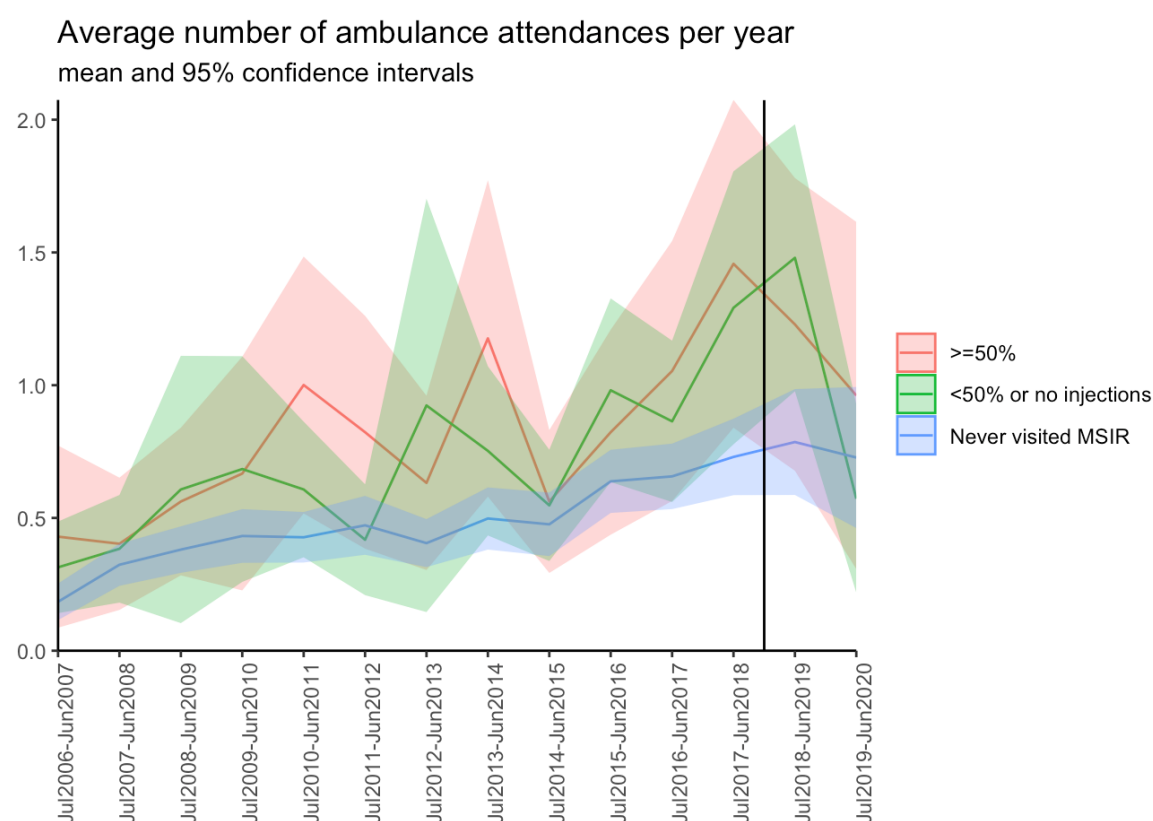


For intensity of MSIR use we did not find evidence of a difference between the average number of ambulance attendances between the group of participants who reported visiting the MSIR compared to those who didn't (Table 3.12 and Figure 3.18).

Table 3.12 Total number of ambulance attendances by MSIR frequency of use: results from the fixed-effects Poisson regression analysis (VACIS)

		IRR	95%CI	p
Ambulance attendances	No visit	1		
	<50%	1.03	0.68-1.57	0.88
	≥50%	0.85	0.53-1.34	0.48

Figure 3.18 Total number of ambulance attendances per year by MSIR frequency of use (VACIS)



Use of dental services

In a cross-sectional analysis of all interviews done after the MSIR opened, there was no evidence of a difference in the frequency of reports of dentist visits for those who visited the MSIR compared to those who did not (Table 3.13).

Table 3.13 Seen a dentist

	Visited MSIR	Hasn't visited MSIR	Total	p-value
Total	181	417	598	
Seen a dentist				
No	130 (72%)	325 (78%)	455 (76%)	0.108
Yes	50 (28%)	90 (22%)	140 (24%)	

* Pearson's chi-squared test

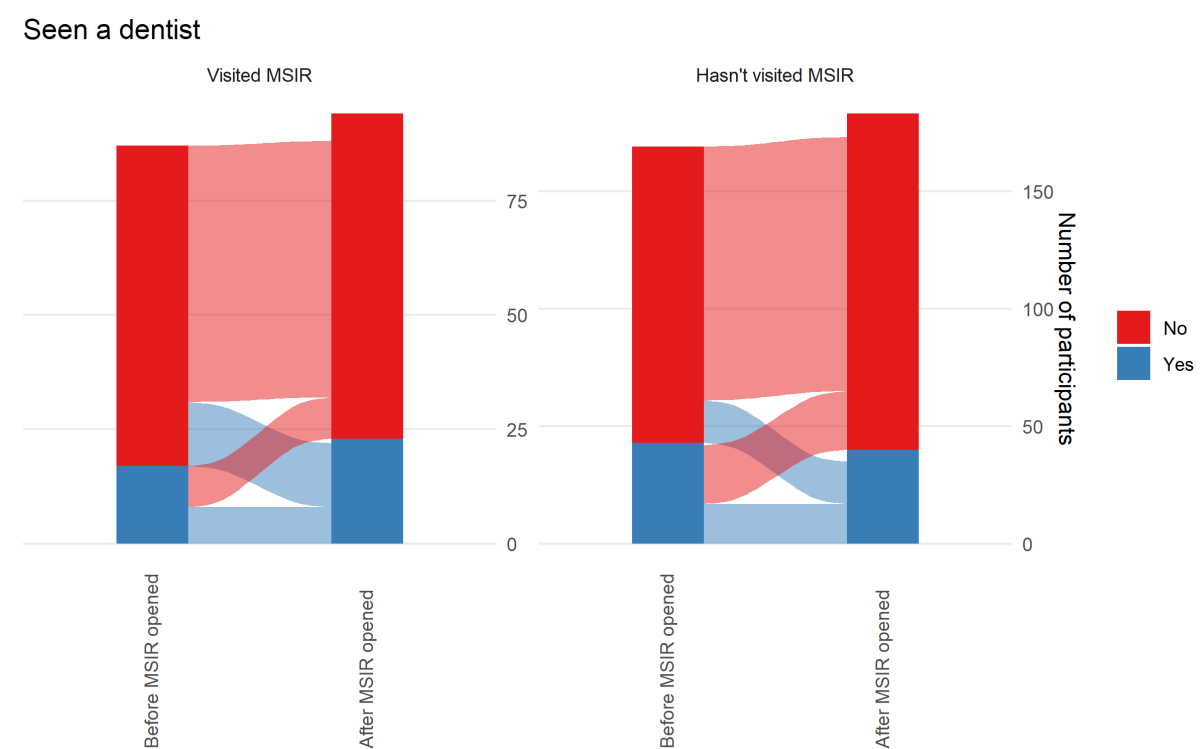
If we only consider participants who were recruited into the study before the MSIR opened, there was weak, but inconclusive, evidence of a difference between the two groups (OR=2, $p=0.08$, see also Table 3.14 and Figure 3.19).

Table 3.14 Seen a dentist before and after MSIR opening

	Visited MSIR	Hasn't visited MSIR	Total	p-value
Total	94	184	278	
Seen a dentist at interview before MSIR opened				
No	70 (80%)	126 (75%)	196 (77%)	0.291
Yes	17 (20%)	43 (25%)	60 (23%)	
Missing	7	15	22	
Seen a dentist at interview after MSIR opened				
No	71 (76%)	143 (78%)	214 (77%)	0.624
Yes	23 (24%)	40 (22%)	63 (23%)	

* Pearson's chi-squared test

Figure 3.19 Changes in seeing a dentist before and after MSIR opened



Use of mental health services

In a cross-sectional analysis of all interviews done after the MSIR opened, there no significant differences in the frequency of reports of visiting a mental health professional for those who visited the MSIR compared to those who did not (Table 3.15).

Table 3.15 Visited a mental health professional in 12 months

	Visited MSIR	Hasn't visited MSIR	Total	p-value
Total	181	417	598	
Visited a mental health professional in 12 months prior to interview				
No	112 (62%)	257 (62%)	369 (62%)	0.918
Yes	68 (38%)	159 (38%)	227 (38%)	

* Pearson's chi-squared test

If we only consider participants who were recruited into the study before the MSIR opened, there was weak, but inconclusive, evidence of a difference (OR=0.51, p=0.071, see Table 3.16 and Figure 3.20).

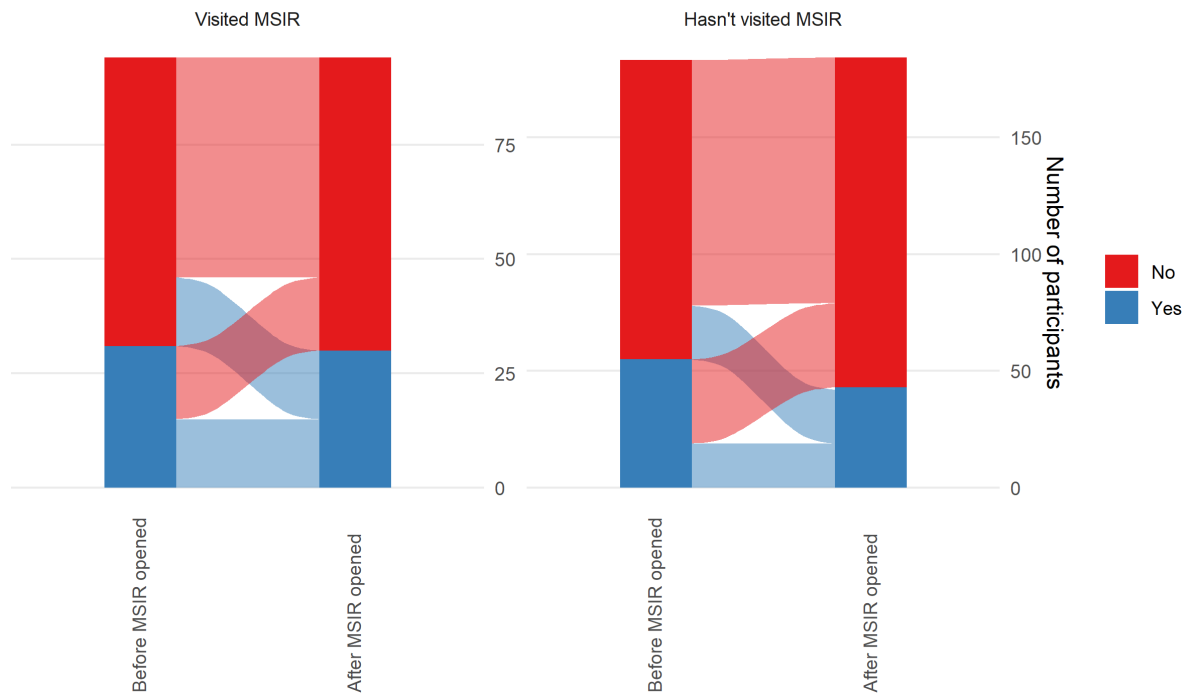
Table 3.16 Visited a mental health professional in 12 months before and after MSIR opening

	Visited MSIR	Hasn't visited MSIR	Total	p-value
Total	94	184	278	
Visited a mental health professional in 12 months prior to interview before MSIR opened				
No	63 (67%)	128 (70%)	191 (69%)	0.618
Yes	31 (33%)	55 (30%)	86 (31%)	
Visited a mental health professional in 12 months prior to interview after MSIR opened				
No	64 (68%)	141 (77%)	205 (74%)	0.126
Yes	30 (32%)	43 (23%)	73 (26%)	

* Pearson's chi-squared test

Figure 3.20 Changes in visiting a mental health professional before and after MSIR opened

Visited a mental health professional in 12 months prior to interview

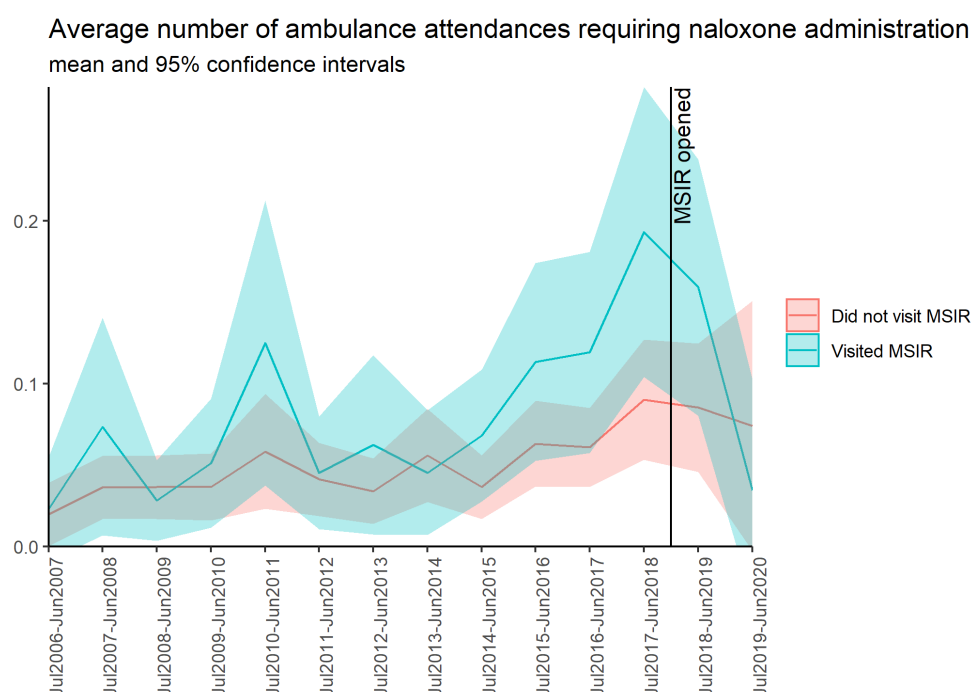


4. Aim c: Reduce attendance by ambulance services, paramedic services and emergency services and attendances at hospitals due to overdoses of drugs of dependence

Attendance by ambulance at overdose over time

Linked data from the Victorian Ambulance Clinical Information System (VACIS) shows a projected decrease in ambulance attendances with naloxone administration for participants who visited the MSIR (Figure 4.1). Despite an overall drop for the participants who have visited the MSIR, we did not find evidence of a difference between the average number of ambulance attendances with naloxone administration between those who did visit the facility and those who didn't (IRR=0.72; p=0.41).

Figure 4.1 Average number of ambulance attendances requiring naloxone administration (VACIS)

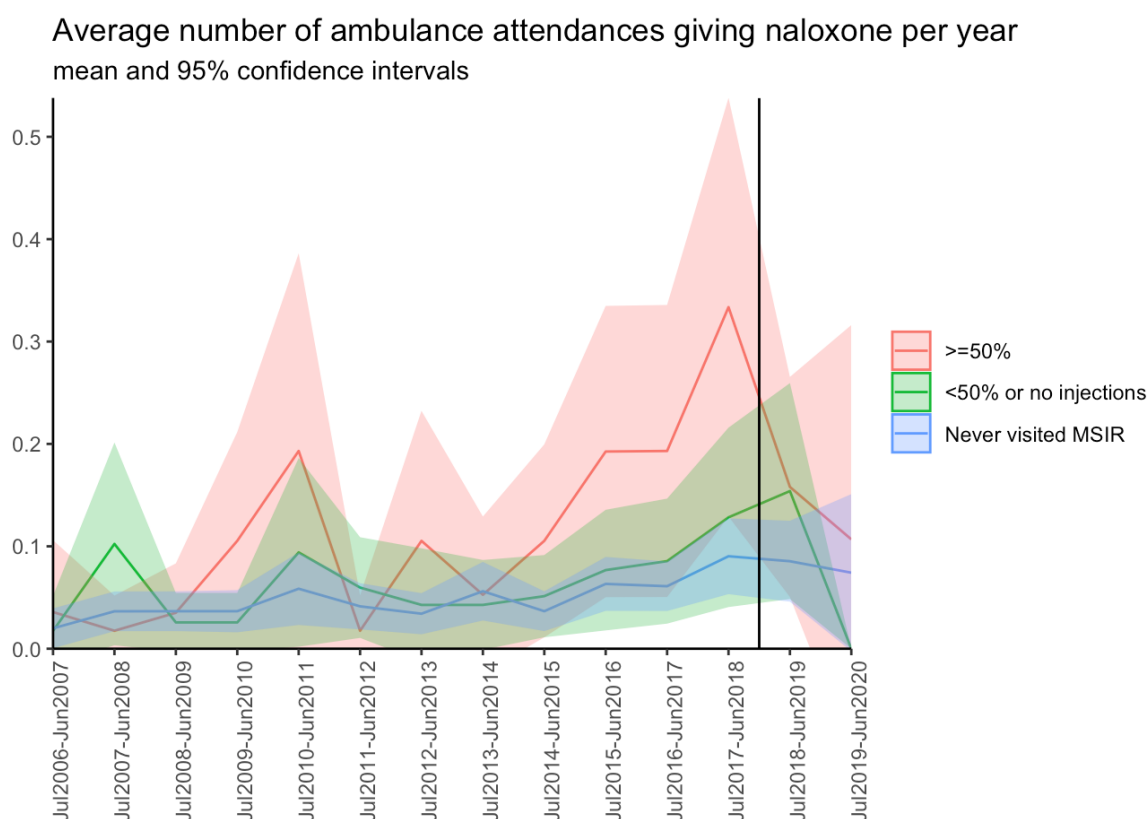


However, for intensity of MSIR use we found the average number of ambulance attendances with naloxone administration between the group of participants who reported having had 50% or more of their injections in the MSIR compared to those who had not visited the facility was lower (IRR=0.39, p=0.03, Table 4.1 and Figure 4.2).

Table 4.1 Total number of ambulance attendances with naloxone administration by MSIR frequency of use: results from the fixed-effects Poisson regression analysis (VACIS)

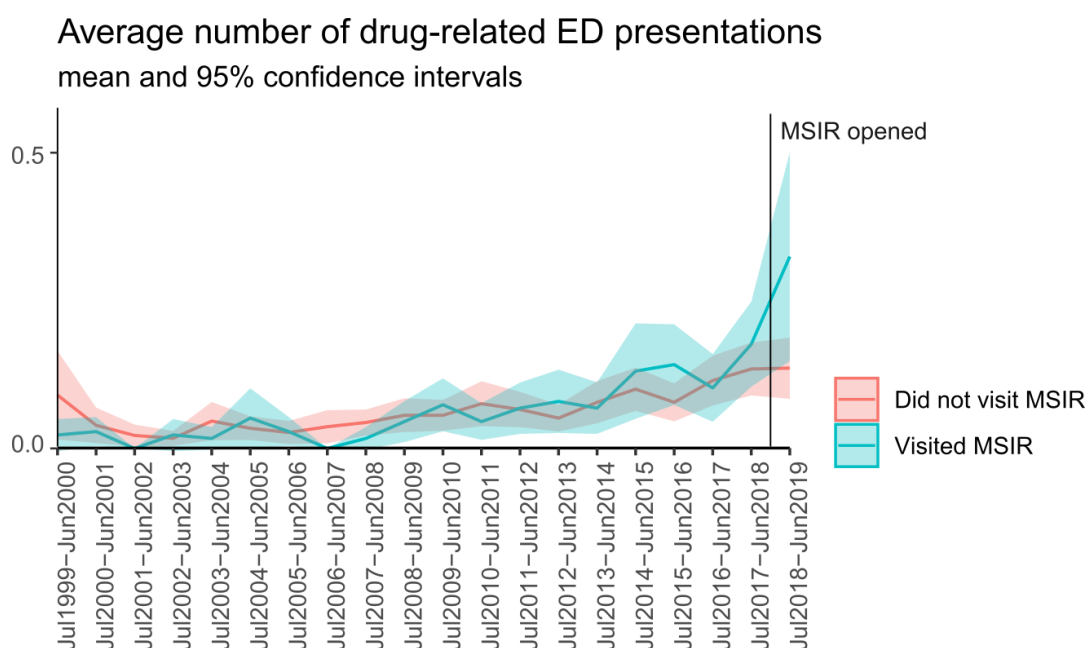
		IRR	95%CI	p
Ambulance attendances with naloxone administration	No visit	1		
	<50%	1.03	0.38-2.99	0.91
	≥50%	0.39	0.17-0.93	0.03

Figure 4.2 Total number of ambulance attendances with naloxone administration per year by MSIR frequency of use (VACIS)



Emergency Department presentations for drug related reasons (including overdose)
Using linked data from the Victorian Emergency Minimum Dataset (VEMD), we did not find evidence of a difference between the average number of emergency department presentations for conditions related to drug use between the group of participants who reported visiting the MSIR compared to those who didn't; either before or after the MSIR opened (IRR=1.71, $p=0.16$, Figure 4.3).

Figure 4.3 Average number of drug-related emergency department presentations (VEMD)



However, for intensity of MSIR use there was weak evidence of an increase in the average number of emergency department presentations for conditions related to drug use between the group of participants who reported having had 50% or more of their injections in the MSIR and those who had not visited the facility (see Figure 3.5 and Table 4.2).

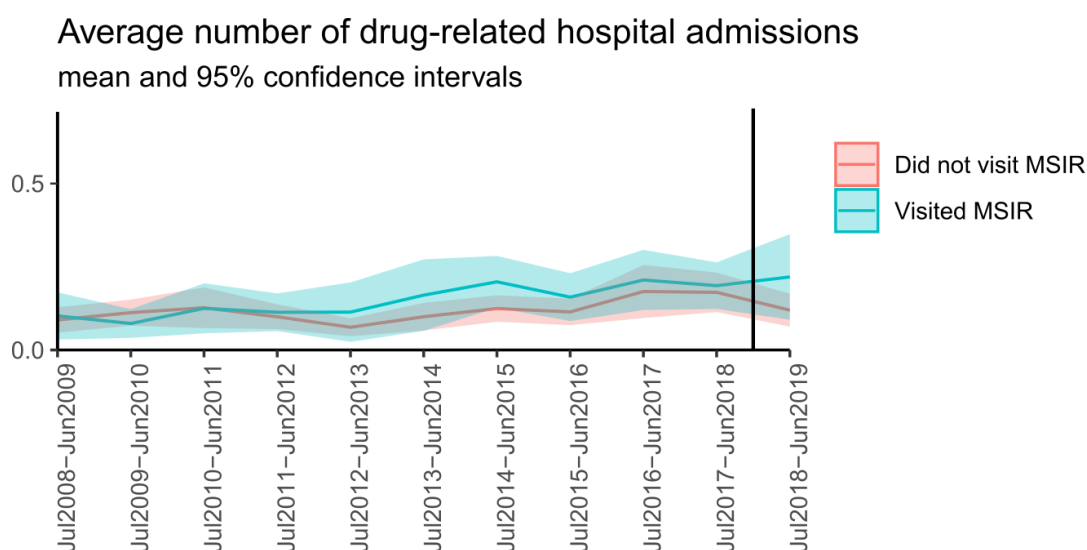
Table 4.2 Drug-related emergency department presentations by MSIR frequency of use: results from the fixed-effects Poisson regression analysis (VEMD)

		IRR	95%CI	P
Drug-related ED presentations	No visit	1		
	<50%	1.60	0.53-4.81	0.41
	≥50%	2.44	0.99-6.02	0.05

Hospitalisations for drug related reasons (including overdose)

Using linked data from the Victorian Admitted Episode Dataset (VAED), we did not find evidence of a difference between the average number of hospitalisations for conditions related to drug use (including overdose) between the group of participants who reported visiting the MSIR compared to those who didn't; either before or after the MSIR opened (IRR=1.56, $p=0.20$, Figure 4.4).

Figure 4.4 Average number of drug-related hospital admissions (VAED)



For intensity of MSIR use we did not find evidence of a difference between the average number of hospitalisations for conditions related to drug use (including overdose) between the group of participants who reported having had less than 50% of their prior month's injections in the MSIR and those with 50% or more, compared to those who had not visited the facility (see Figure 3.7 and Table 4.3).

Table 4.3 Drug-related hospital admissions by MSIR frequency of use: results from the fixed-effects Poisson regression analysis (VAED)

		IRR	95%CI	p
Drug-related hospital admissions	No visit	1		
	<50%			
	≥50%			

5. Aim d: Reduce the number of discarded needles and syringes in public places and the incidence of injecting of drugs of dependence in public places in the vicinity

No data on discarded needles are collected in the SuperMIX study and so only proxies of public drug use were examined in relation to this objective.

Use of heroin purchase by location

In these analyses we categorised public drug use as streets, public toilets, parks, and cars; and private spaces as private homes (including dealer's homes).

In a cross-sectional analysis of all interviews done after the MSIR opened, there was no evidence of a difference in the frequency of reports of purchasing heroin in a public location for those who visited the MSIR compared to those who did not (Table 5.1).

Table 5.1 Where last purchase of heroin was used (SuperMIX)

	Visited MSIR	Hasn't visited MSIR	Total	p-value
Total	181	417	598	
Where last purchase of heroin was used				
Private & MSIR	77 (51%)	132 (57%)	209 (54%)	0.248
Public	75 (49%)	101 (43%)	176 (46%)	
Missing	29	184	213	

* Pearson's chi-squared test

A comparison of interviews before and after the facility opened was not possible as there were not sufficient data available for the interviews conducted prior to the facility opening.

6. Aim e: Improve the amenity of the neighbourhood for residents and businesses in the vicinity

No direct data on public amenity are collected in the SuperMIX study and so only proxies of public drug use and public amenity were examined in relation to this objective.

Location of most recent residence and interview location

In a cross-sectional analysis of all interviews done after the MSIR opened, those who had visited the MSIR were more likely to reside in Richmond (9%) than those who did not visit the MSIR (3%) (Table 6.1). For those who reported visiting the facility, the percentages residing in Richmond were 7% and 12% for those who had less than 50% of their injections within the facility versus those who had 50% of their injections or more within the facility, respectively ($p=0.023$).

Table 6.1 Location of most recent residence

	Visited MSIR	Hasn't visited MSIR	Total	p-value
Total	181	417	598	
Location of most recent residence				
Not Richmond	146 (91%)	375 (97%)	521 (95%)	0.008*
Richmond	14 (9%)	13 (3%)	27 (5%)	
Missing	21	29	50	

* Pearson's chi-squared test

In a cross-sectional analysis of all interviews done after the MSIR opened, those who had visited the MSIR were more likely to be interviewed in Richmond (77%) than those who did not visit the MSIR (18%) (Table 6.2).

Table 6.2 Interview location

	Visited MSIR	Hasn't visited MSIR	Total	p-value
Total	181	417	598	
Interview location				
Not Richmond	42 (23%)	333 (82%)	375 (64%)	<0.001*
Richmond	139 (77%)	74 (18%)	213 (36%)	
Missing	0	10	10	

* Pearson's chi-squared test

Location of drug purchase

We categorised heroin purchases into private (dealer's home, friend or home delivery) and public (street, mobile dealer or street drop off) locations. In a cross-sectional analysis of all interviews done after the MSIR opened, those who reported visiting the MSIR and had purchased heroin in the last week were more likely to report purchasing in public spaces (62%) than those who did not visit the MSIR (42%). For those who have visited the facility, the percentages reporting purchasing in public were 58% and 69% for those who had less than 50% of their injections within the facility versus those who had 50% of their injections or more within the facility, respectively ($p < 0.001$).

Table 6.3 Location where last purchase of heroin was scored from

	Visited MSIR	Hasn't visited MSIR	Total	p-value
Total	181	417	598	
Where last purchase of heroin was scored from				
Private (dealer's home, friend, or home delivery)	58 (38%)	135 (58%)	193 (50%)	<0.001*
Public (street or mobile dealer, street drop off)	94 (62%)	97 (42%)	191 (50%)	
Missing	29	185	214	

* Pearson's chi-squared test

If we only consider participants who were recruited into the study before the MSIR opened, we see that those who reported subsequently using the MSIR were more likely to purchase their heroin in a public space compared to those who didn't use the MSIR both before and after the MSIR opened, and this distribution changed little (Table 6.4).

Table 6.4 Location where last purchase of heroin was scored from, before and after MSIR opening

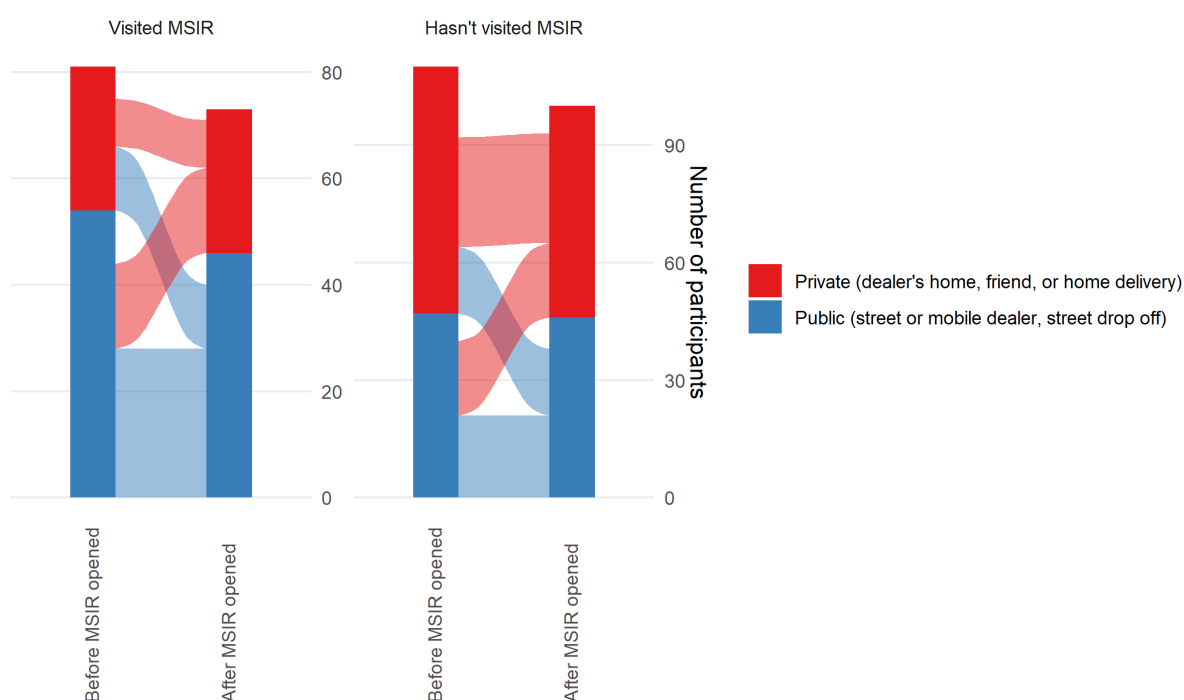
	Visited MSIR	Hasn't visited MSIR	Total	p-value
Total	94	184	278	
Where last purchase of heroin was scored from before MSIR opened				
Private (dealer's home, friend, or home delivery)	27 (33%)	63 (57%)	90 (47%)	0.001*
Public (street or mobile dealer, street drop off)	54 (67%)	47 (43%)	101 (53%)	
Missing	13	74	87	
Where last purchase of heroin was scored from after MSIR opened				
Private (dealer's home, friend, or home delivery)	27 (37%)	54 (54%)	81 (47%)	0.027*
Public (street or mobile dealer, street drop off)	46 (63%)	46 (46%)	92 (53%)	
Missing	21	84	105	

* Pearson's chi-squared test

The changes in place of latest heroin purchase between the two timepoints for participants who have and have not visited the MSIR have been depicted in Figure 6.1.

Figure 6.1 Changes over time in where last purchase of heroin was scored from, before and after MSIR opened

Where last purchase of heroin was scored from



We also looked at the flow of self-reported purchasing locations for heroin over the years for all questionnaires for which participants had reported about this behaviour. Figure 6.2

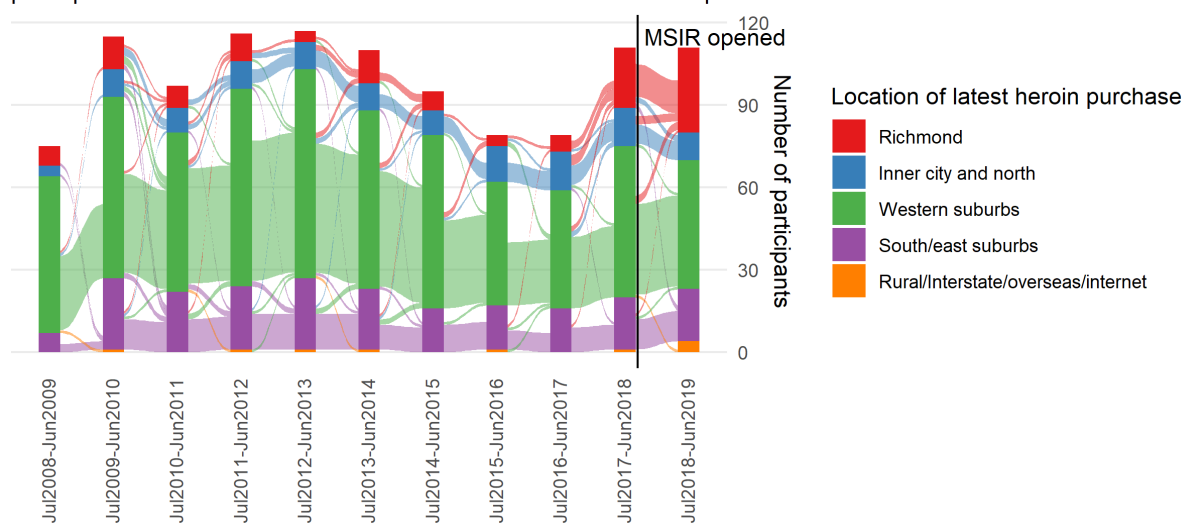
shows a barplot of the reported heroin purchase location between July in each year and June in the next. We have chosen this time interval so that the latest year coincides with the first year of operation of the MSIR (1 July 2018). The bands joining the bars represent the same participant's response in subsequent interviews. For this plot we have only used participants recruited before 2017 (N=223). It should be noted that the data in the plot are not corrected for the location of interview.

Figure 6.2 shows a shift towards heroin purchase in Richmond by cohort members in recent years. This shift occurs in the year prior to the facility opening and continues after the facility opened.

Figure 6.2 Location of latest heroin purchase for participants recruited before 2017 and interviewed after MSIR opening

Location of latest heroin purchase

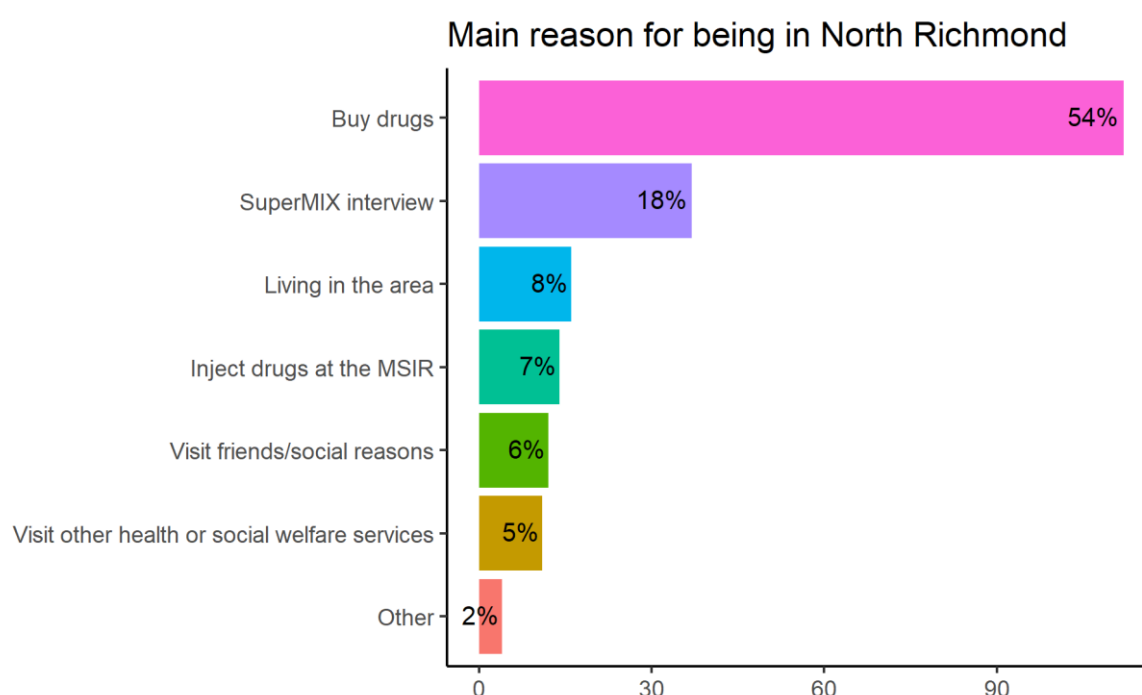
participants recruited before 2017 and interviewed after the MSIR opened: N=223



Main reason for coming to Richmond

The total number of participants who were interviewed in Richmond was 213. Of those, seven did not answer about their main reason for being in Richmond. See figure below for the main reason for being in North Richmond (Figure 6.3).

Figure 6.3 Main reason to be in Richmond



Reasons for using MSIR

Data on reasons given for using the MSIR were available from the SuperMIX and IDRS surveys. Study participants reported that being away from police (IDRS=53%, SuperMIX=35%), concerned about overdose risk (IDRS=32%, SuperMIX=25%) and being curious about the service (IDRS=28%, SuperMIX=34%) were the main reasons for their visit to the MSIR (Table 6.5).

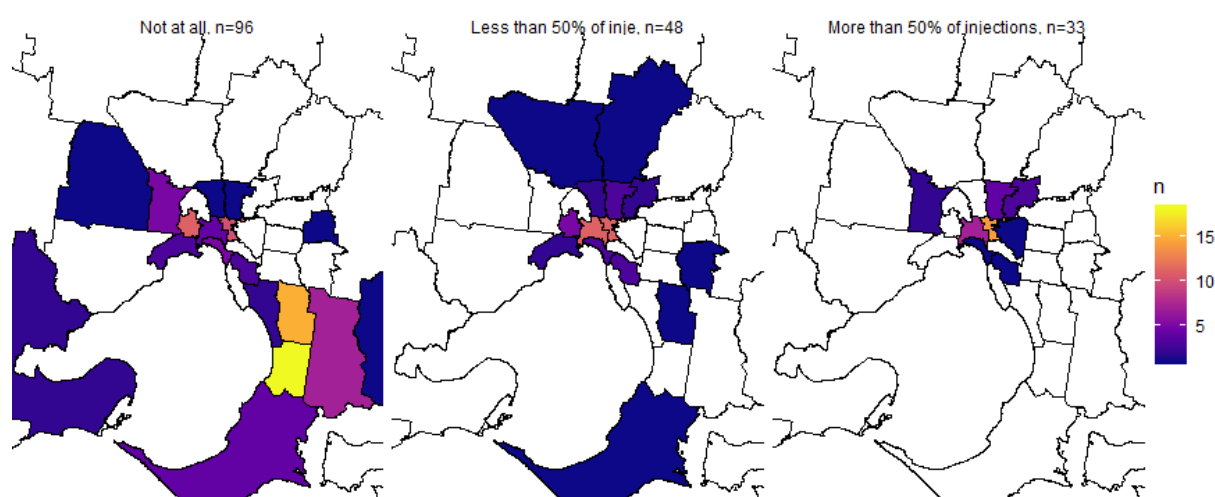
Table 6.5 Reasons for visiting the MSIR, for IDRS and SuperMIX data sets

Why did you visit MSIR?	IDRS 2019	SuperMIX
	Yes (%)	Yes (%)
Being away from police	53	35
Concerned about overdose risk	32	25
Curious	28	34
Concerned about threat of violence/standover	22	15
Concerned about using alone	16	8
Clean / Safe	14	18
Away from the public	9	7
Comfortable/convenient	7	10
Others	7	5
Need help and advice about injecting	4	6

Reasons for not using MSIR

In both IDRS and SuperMIX samples, the main reason for not visiting the MSIR service was distance, 'too far from where I live' (IDRS=50%, SuperMIX=39%) and 'too far from where I score drugs' (IDRS=34%, SuperMIX=27%). A residential map confirms these findings.

Figure 6.4 Number of participants residing in each LGA in the Melbourne metropolitan area, by intensity of MSIR use



The top 5 reasons for not visiting are depicted in Table 6.6.

Table 6.6 Top 5 reasons for not visiting the MSIR, for IDRS and SuperMIX data sets

	IDRS 2019	SuperMIX
Top 5 reasons for not visiting MSIR	Yes (%)	Yes (%)
Too far from where I live	50	39
Too far from where I score drugs	34	27
Prefer to inject at home	28	21
Already have a safe place to inject	15	18
Prefer to keep drug use private	8	8

NB: These are the top five reasons that respondents mentioned. Other reasons that participants mentioned for not using the MSIR includes: Prefer to inject alone, don't want to inject with strangers, long waiting time, for heroin users only, too many police near site/ has been in prison, need help to inject and doesn't want to register.

Engagement in property crime and drug dealing

In a cross-sectional analysis of all interviews done after the MSIR opened, those who had visited the MSIR were more likely to have been engaged in property crime (27%) than those who did not visit the MSIR (18%) (Table 6.7). For those who have visited the facility, the percentage reporting engaging in property crime were 29% and 24% for those who had less than 50% of their injections within the facility versus those who had 50% or more of their injections within the facility, respectively ($p=0.039$).

Table 6.7 Engaged in property crime in the last month

	Visited MSIR	Hasn't visited MSIR	Total	p-value
Total	181	417	598	
Engaged in property crime in the last month				
No	128 (73%)	336 (82%)	464 (79%)	0.019*
Yes	47 (27%)	75 (18%)	122 (21%)	
Missing	6	6	12	

* Pearson's chi-squared test

If we only consider participants who were recruited into the study before the MSIR opened, we see an identical pattern to the table above but smaller numbers means that the effect was not significant (Table 6.8).

Table 6.8 Engaged in property crime in the last month before and after MSIR opening

	Visited MSIR	Hasn't visited MSIR	Total	p-value
Total	94	184	278	
Engaged in property crime before MSIR opened				
No	69 (76%)	149 (82%)	218 (80%)	0.205
Yes	22 (24%)	32 (18%)	54 (20%)	
Missing	n<5	n<5	6	
Engaged in property crime after MSIR opened				
No	66 (73%)	149 (81%)	215 (79%)	0.125
Yes	24 (27%)	34 (19%)	58 (21%)	
Missing	n<5	n<5	5	

* Pearson's chi-squared test

Arrest (since previous interview only)

In a cross-sectional analysis of all follow-up interviews done after the MSIR opened (N=285), those who had visited the MSIR were more likely to have been arrested (65%) than those who did not visit the MSIR (41%) (Table 6.9). For those who have visited the facility, the percentage reporting being arrested was 58% and 79% for those who had less than 50% of their injections within the facility versus those who had 50% or more of their injections within the facility, respectively ($p<0.001$).

Table 6.9 Having been arrested since previous interview (only follow-up)

	Visited MSIR	Hasn't visited MSIR	Total	p-value
Total	94	191	285	
Having been arrested since previous interview (only follow-up)				
No	33 (35%)	112 (59%)	145 (51%)	<0.001*
Yes	60 (65%)	79 (41%)	139 (49%)	
Missing	n<5	0	n<5	

* Pearson's chi-squared test

If we only consider participants who were recruited into the study before the MSIR opened and had a follow-up interview (N=190), there was no statistically significant difference between the two groups before the facility opened).

Table 6.10).

Table 6.10 Having been arrested since previous interview (only follow-up), before and after MSIR opening

	Visited MSIR	Hasn't visited MSIR	Total	p-value
Total	38	152	190	
Having been arrested before MSIR opened				
No	21 (57%)	88 (59%)	109 (58%)	0.833
Yes	16 (43%)	62 (41%)	78 (42%)	
Missing	n<5	n<5	n<5	
Having been arrested after MSIR opened				
No	18 (47%)	94 (62%)	112 (59%)	0.105
Yes	20 (53%)	58 (38%)	78 (41%)	
Missing	0	0	0	

* Pearson's chi-squared test

7. Aim f: Assist in reducing the spread of blood-borne diseases in respect of clients of the licensed medically supervised injecting centre, including, but not limited to, HIV and hepatitis C

Injected with someone's used needle/syringe

In a cross-sectional analysis of all interviews done after the MSIR opened, there was no significant difference in reports of having injected with someone's used needle/syringe in the last month between those who had (9%) and those who had not visited the MSIR (11%) (Table 7.1). There was no significant difference between those who had less than 50% of their injections within the facility versus those who had 50% or more of their injections within the facility, ($p=0.774$).

Table 7.1 *Injected with someone's used needle/syringe in the last month*

	Visited MSIR	Hasn't visited MSIR	Total	p-value
Total	181	417	598	
Injected with someone's used needle/syringe in the last month				
No	160 (91%)	343 (89%)	503 (90%)	0.462
Yes (once or more)	16 (9%)	43 (11%)	59 (10%)	
Missing	5	31	36	

* Pearson's chi-squared test

If we only consider participants who were recruited into the study before the MSIR opened (N=278), there was no significant pre-existing difference the two groups (Table 7.).

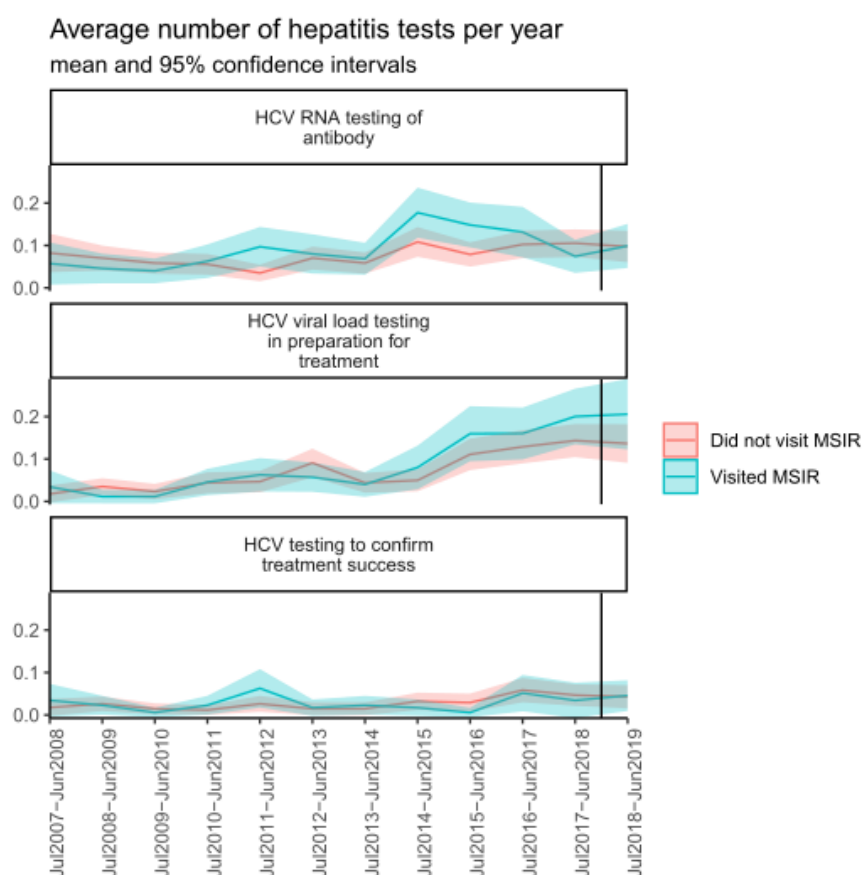
Table 7.2 *Injected with someone's used needle/syringe in the last month, before and after MSIR opening*

	Visited MSIR	Hasn't visited MSIR	Total	p-value
Total	94	184	278	
Injected with someone's used needle/syringe before MSIR opened				
No	80 (88%)	165 (92%)	245 (91%)	0.253
Yes (once or more)	11 (12%)	14 (8%)	25 (9%)	
Missing	n<5	5	8	
Injected with someone's used needle/syringe after MSIR opened				
No	83 (93%)	143 (88%)	226 (90%)	0.168
Yes (once or more)	6 (7%)	20 (12%)	26 (10%)	
Missing	5	21	26	

* Pearson's chi-squared test

Using linked data from the Medicare Benefits Schedule (MBS), we did not find any significant difference between the average number of HCV RNA tests, viral load testing in preparation for treatment and testing to confirm treatment success for the group of participants who reported visiting the MSIR compared to those who didn't in the years surrounding the opening of the MSIR (see Figure 7.1).

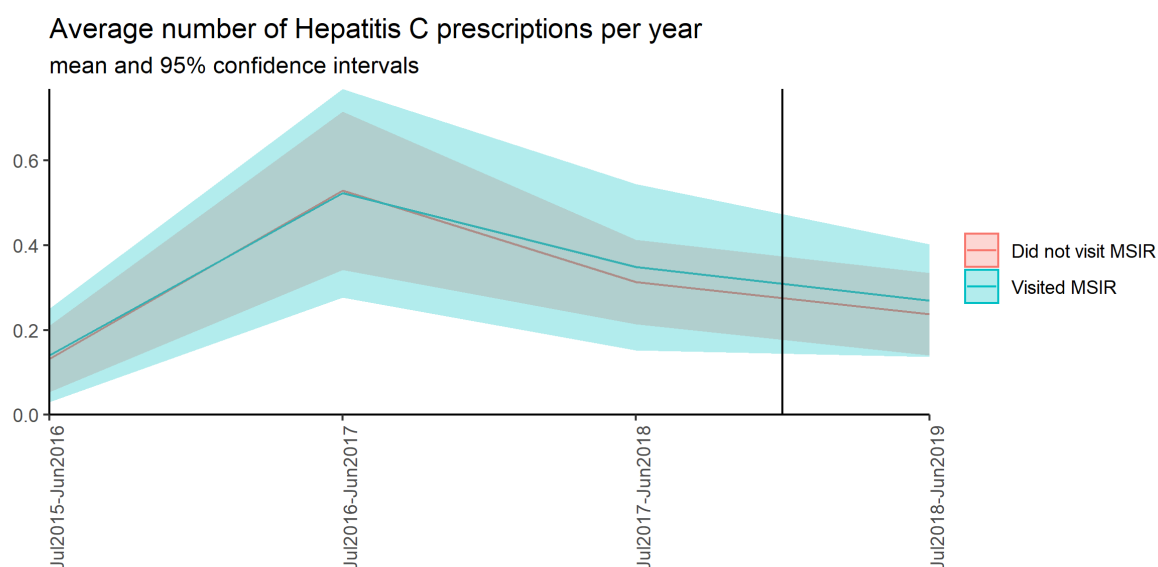
Figure 7.1 Average number of hepatitis C tests per year (MBS)



Hepatitis C prescriptions

Using linked data from the Pharmaceutical Benefits Scheme (PBS), we did not find any significant difference between the average number of Hepatitis C prescriptions for the group of participants who reported visiting the MSIR compared to those who didn't in the years surrounding the opening of the MSIR (Figure 7.2).

Figure 7.2 Average number of hepatitis C prescriptions per year (MBS)



8. Appendix 1: Methods

Study population

The Melbourne Injecting Drug User Cohort Study (SuperMIX) follows people who inject drugs (PWID) recruited from urban locations in Melbourne, Australia, between 2008 and 2019. Initial recruitment (2008-2010) resulted in a cohort of 688 that was subsequently expanded to 757 in 2011 and increased to around 1300 from 2017 onwards. Eligibility criteria included: residing in Melbourne, aged 18 years or over, injected either heroin or amphetamines at least once in the six months prior to entering the study, and having a valid Medicare number (needed for record linkage). Initial age criteria aimed to recruit younger PWID (<30 years) but these were relaxed over time.

Interviews are conducted annually and participants are reimbursed AUD\$30 for their time and expenses, with an extra \$10 if they provide a venous blood sample from 2011. Further study details including detailed baseline characteristics of the cohort are available elsewhere (Horyniak et al., 2013; O'Keefe, Scott, Aitken, & Dietze, 2016).

Linked data

Linkage to records kept in administrative datasets collected by a range of data custodians was performed in different ways depending on the data sources in question. However, several steps were involved in establishing the linkage process. Firstly, a raw cohort file for SuperMIX participants with identifier data and source ID, as well as the questionnaire data files with the same Source ID were sent separately to the Australian Institute of Health and Welfare (AIHW). AIHW created a unique AIHW ID for each participant, and added it to both files. AIHW then linked the cohort file to Medicare Enrolment data to obtain the Person Identifier Number (PINS) on Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) records, as well as National Death Index (NDI). AIHW then extracted MBS and PBS data using these PINs, attached the AIHW ID to de-identified MBS and PBS data, as well as NDI, and removed PINs.

The raw cohort file with identifier data and AIHW ID was then sent to the Centre for Victorian Data Linkage (CVDL) for linkage to state datasets. CVDL linked the cohort file to identifier data of the Alcohol and Drug Information Services (ADIS), the Victorian Emergency Minimum Dataset (VEMD) and the Victorian Admitted Episodes Dataset (VAED). CVDL then extracted the relevant data from all the datasets, attached AIHW ID to the de-identified datasets, and removed the Victorian IDs and then sent the linked files to the AIHW. Ambulance Victoria applied a similar linkage protocol to VACIS data.

AIHW then released all of the de-identified datasets, including the SuperMIX questionnaire, with AIHW ID to a secure environment at the Australian Institute of Family Studies (AIFS) for analysis.

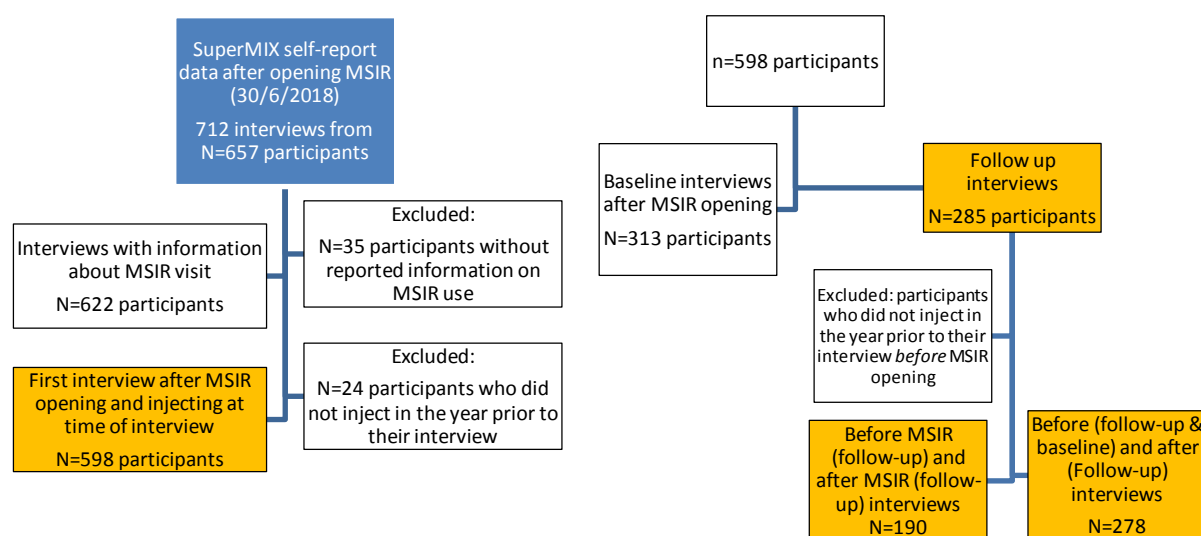
SuperMIX

SuperMIX collects self-report information from PWID on their demographics, drug use, health service use, drug purchasing characteristics, and use of the Melbourne Supervised Injecting Room.

From the self-report data in the SuperMIX dataset, we derived 712 interviews following the opening of the after the Melbourne Supervised Injecting Room (MSIR) on 30 June 2018, from 657 participants. We only kept participants who had answered the question of whether they have had visited the MSIR in the period between its opening and their first interview (n=622) (See Figure 8.1).

Of those, we only included participants who had injected at least one drug¹ in the year prior to the interview (n=598). That leaves us with 598 unique participants who were injecting at their time of the interview and answered the MSIR questions. Of those, 285 were follow-up interviews, and 313 were new baseline participants recruited into the study after the MSIR opened. Therefore, there are 285 participants for which we have at least one interview before the MSIR opened, and one after. For our before and after MSIR analyses, we also excluded those participants who had ceased to inject in the year prior to their interview *before* MSIR opened. For questions that are present in both follow up and baseline interviews this leaves us with 278 participants who had an interview before and after MSIR opened. For follow-up-only questions this leaves us with 190 participants.

Figure 8.1 Flow diagram. SuperMIX participants who have responded to the “MSIR visit” question, regardless of whether they were recruited in Richmond or not. Depicted in yellow are the different samples used in this report for the self-report data.



For each AIHW ID, we extracted the answer to whether the participant had visited the MSIR or not and what percentage of their injections took place in the MSIR in the month prior to their SuperMIX interview, categorised into ‘none’, $\leq 50\%$, $\geq 50\%$. We then merged this subset of SuperMIX data into each of the linked datasets by AIHW ID. This merge left us with a total of 586 out of 598 participants.

NDI

The National Death Index (NDI) contains records of all deaths occurring in Australia since 1980, obtained from the Registrars of Births, Deaths and Marriages in each state and territory. Cause of death information is recorded as ICD10 codes derived by the Australian Bureau of Statistics from the death certificates.

Linked NDI data included deaths occurred up to 2018, but no deaths occurred among the 586 participants considered in this analysis.

¹ any drug injected of the following: heroin, methamphetamine, benzodiazepines, suboxone, buprenorphine, methadone, antidepressants, antipsychotics, cocaine, ecstasy, hallucinogens, morphine, oxycodone, (non-) prescribed, prescription stimulants, pharmaceutical stimulants, unisom, Pregabalin/lyrica, or speed powder.

MBS

Medicare Benefits Schedule (MBS) records contain information on services that qualify for a benefit under the Health Insurance Act 1973 and for which a claim has been processed. The database comprises information about MBS claims, patients, and service providers.

We received linked data comprising the period between 1 January 2008 until 31 March 2019 (n=498,280 records) of which 244,310 records linked to 577 participants in our analysis sample. Nine participants were not present in the linked MBS data, we assumed that they had no claims within the time period for the purposes of this analysis.

N=99,952 records were related to seeing a medical professional (defined as Category 1: professional attendances) and n=73,522 records were specifically related to seeing a GP (defined as Group A1: general practitioner attendances to which no other item applies).

Hepatitis pathology tests

The MBS has three charge categories for hepatitis C RNA testing, which can each be accessed independently. Service providers specify whether the RNA test is either: qualitative to confirm active hepatitis C infection (item number 69499 or 69500); quantitative in preparation for treatment (item number 69488 or 69489); or qualitative to confirm treatment success (item number 69445 or 69451).

N=1,185 records corresponded to hepatitis tests, with 396 participants in our sample having at least one.

PBS

Pharmaceutical Benefits Scheme (PBS) records contain information on prescription medicines that qualify for a benefit under the National Health Act 1953 and for which a claim has been processed. The database comprises information about PBS scripts and payments, patients, prescribers and dispensing pharmacies.

We used the Anatomical Therapeutic Chemical (ATC) codes, controlled by the World Health Organization Collaborating Centre for Drug Statistics Methodology (WHOC), to categorise all prescriptions. We considered two categories of mental health medications: Antidepressants (N06A) and Antipsychotics (N05A). We considered that the likely case-use scenario of anxiolytics (N05B), and hypnotics and sedatives (N05C) for this particular population was as a sleeping aid, rather than mental health concerns, therefore we categorised these as non-mental-health medications, and collectively labelled them “Benzodiazepines”. The other category of interest were pain management medications, grouping opioids (insert ATC code here) and pregabalin (insert ATC code here). All other prescriptions were grouped into the “Other” label.

We received linked data between 1 January 2008 until 31 March 2019 (n=208,187 records) of which n=108,444 records linked to 563 participants in our sample. The other 23 participants were not present in the linked PBS data, we assumed that they had no claims within the time period for the purposes of this analysis.

N=21,774 records corresponded to mental health prescriptions, n=664 records to hepatitis C treatment, and n=86,006 to other medications.

ADIS

The Alcohol and Drug Information System (ADIS) collection is the primary source of data for a number of alcohol and other drug treatment service programs. We categorized “treatment type” into withdrawal, counselling, and other treatment (including residential rehabilitation).

We received linked data between 6 July 2006 until 29 January 2019 (n=10,718 records) of which n=4,559 records linked to 447 participants in our sample. The other 139 participants were not present in the linked ADIS data, we assumed that they had not initiated any drug treatment within the time period for the purposes of this analysis.

N=1,342 records corresponded to drug counselling, 908 to withdrawal, and 2,309 to ‘other’ treatments.

VEMD

The Victorian Emergency Minimum Dataset (VEMD) contains state-wide administrative and clinical data detailing emergency department (ED) presentations at all Victorian public hospitals with designated EDs.

Principal diagnoses at the ED were described using the International Classification of Disease 10th revision Australian Modification (ICD-10-AM). We also considered secondary and tertiary diagnoses, although they were not available for the majority of presentations (95% and 99% for secondary and tertiary diagnoses, respectively). We categorised the presentations using an “any mention method” (Injury Surveillance Workgroup 7, 2012), which included any mention of the relevant codes at any diagnostic level. For any drug-related presentations we included all the codes that can be related to a diagnosis that is wholly (or partially) attributable to any illicit substances (TurningPoint, 2016). Consistent with DiRico et al 2018 (Di Rico, Nambiar, Stooze, & Dietze, 2018), we used F-codes F11.0 to 11.9 for cases representing “mental and behavioural disorders due to opioid use” and T-codes 40.0-40.4 and T40.6 for cases representing “poisoning by drugs, medicaments and biological substances”.

We calculated the average number of total ED presentations, drug- and not-drug-related and poisoning by opioid-related ED presentations and the average number for mental disorder presentations due to opioid use, per year and by year offset.

A total of 26,978 records were retrieved between 1 July 1999 until 14 March 2019. Of those, n=11,649 records linked to 515 participants in our sample. The other 71 participants were not present in the linked VEMD data, we assumed that they had not presented to any of the qualifying ED’s in this period for the purposes of this analysis.

VAED

The Victorian Admitted Episodes Dataset (VAED) provides a comprehensive dataset of the causes, effects and nature of illness, and the use of health services in Victoria. All Victorian public and private hospitals, including rehabilitation centres, extended care facilities and day procedure centres, report a minimum set of data for each admitted patient episode.

For categorising ED presentations and calculating averages per year we used the same methods as for the VEMD data set, as described above.

A total of 9,052 records were retrieved between 5 April 2008 until 4 March 2019. Of those, n=3,579 records linked to 481 participants in our sample. The other 105 participants were not present in the linked VAED data, we assumed that they had not been admitted to any hospitals within in this period for the purposes of this analysis.

VACIS

The Victorian Ambulance Clinical Information System (VACIS) is a patient care record computer application specifically designed for Australian ambulance services. Although originating in Victoria, it is used in every ambulance service in Australia's eastern states, covering 80% the Australian population. VACIS contains all patient data, from ambulance call to discharge.

Probabilistic linkage was conducted by Ambulance Victoria using First Name + Last Name + Date of Birth (DOB) for participants with an available DOB. For participants with missing DOB, the linkage consisted of three steps:

1. Probabilistic match using First Name + Last Name
2. The absolute difference between the 'estimated age captured by paramedics' and the SuperMIX participant's age on the ambulance case date was calculated
3. Records were considered to be a match if the age difference was ≤ 5 years.

Linkage was performed '1 to many' such that a unique SuperMIX participant (AIHW ID) could be linked to many Ambulance Victoria records. All patients with a match score of ~80-85% were manually reviewed for accuracy. Match scores $\geq 85\%$ were assumed to be true, and match scores $< 80\%$ were assumed to be untrue.

Using the provided medication file from VACIS, we flagged each ambulance attendance for whether Naloxone was administered or not, and used that as a proxy for an ambulance attendance for opioid overdose.

A total of 9,726 records were retrieved, covering the period between 3 January 2007 and 30 August 2019. Of those, n=4,433 records linked to 499 participants in our sample. The other 87 participants were not present in the linked VACIS data, we assumed that they had not been attended by any ambulance within this period for the purposes of this analysis. Naloxone was administered in n=464 ambulance attendances.

Illicit Drug Reporting System (IDRS)

The Illicit Drug Reporting System (IDRS) is an ongoing illicit drug monitoring system which has been conducted in all states of Australia since 2000. The IDRS interviews are conducted annually with a sentinel group of people who regularly inject drugs. Participants were recruited using multiple methods such as needle and syringe programs (NSP) and peer referral with eligibility criteria of a) be at least 18 years of age (due to ethical requirements); b) have injected at least monthly during the six months preceding interview; and c) have been a resident for at least 12 months in the capital city in which they were interviewed. In 2019, a total of 148 participants were recruited in Melbourne, Victoria as part of national IDRS study. It was then oversampled to 181 for the purpose of reviewing the MSIR, of whom four participants had missing data regarding MSIR visit.

Exposure variables

From July 2018 onwards we have included items in the questionnaire that ask about the use of the injecting facility. The main exposure variable for the current study is “MSIR visit”: whether participants had or had not visited the MSIR since their last interview (follow up interviews) or ever (baseline interviews). Those who had responded that they had “never heard” of the MSIR were also categorised as “not visited”. We also constructed a variable around the percentage of injections that took place in the facility within the previous months, indicating “intensity of MSIR use”: not visited the facility versus those who did and had less than 50% of their injections within the facility (or no injections) versus those who had more than 50% of their injections within the facility.

References

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9. Appendix 2: Demographics

In this document we outline the demographics of the sample of SuperMIX participants with a first interview after MSIR opening (N=598) and for participants in the IDRS study. Please refer to Appendix 1 (Methods) for more information on the different samples and datasets used (Table 9.1).

SuperMIX: All interviews after MSIR opening (n=598)

Table 9.1 Demographics SuperMIX

	Visited MSIR	Hasn't visited MSIR	Total	p-value
Total	181	417	598	
Age at interview				
<=30	12%	8%	9%	0.007*
31-40	55%	44%	47%	
41-50	23%	36%	32%	
≥50	10%	12%	12%	
Missing	0	0	0	
Gender identity				
Male	70%	66%	68%	0.614†
Female	30%	33%	32%	
Non binary/gender fluid	0%	0%	0%	
Missing	0	0	0	
Employment status				
Unemployed	95%	84%	87%	<0.001*
Employed	5%	16%	13%	
Missing	0	0	0	
Housing status				
Unstable	39%	28%	31%	0.007*
Stable	61%	72%	69%	

	Visited MSIR	Hasn't visited MSIR	Total	p-value
Missing	3	3	6	
Housing type				
Owner-occupied, rental, community, boarding, or other rent-free	68%	85%	80%	<0.001*
Homeless, squat, or supported accommodation	32%	15%	20%	
Missing	n<5	0	n<5	
Living conditions				
With relatives, friends, or housemates	51%	67%	62%	<0.001*
Alone	49%	33%	38%	
Missing	11	9	20	
Education level				
< = year 9	31%	28%	29%	0.432
Year 10-12	44%	46%	45%	
Tertiary/diploma/trade	22%	20%	20%	
Other	4%	7%	6%	
Missing	0	0	0	
Aboriginal and Torres Strait Islander				
No	73%	88%	83%	<0.001*
Yes	27%	12%	17%	
Missing	n<5	n<5	n<5	
Is a parent				
No	35%	36%	36%	0.714
Yes	65%	64%	64%	
Missing	5	17	22	
Main drug of choice				
Heroin	87%	64%	71%	<0.001*

	Visited MSIR	Hasn't visited MSIR	Total	p-value
MA	7%	20%	16%	
Cannabis	3%	12%	9%	
Other	3%	4%	3%	
Missing	5	19	24	
Drug injected most in last month				
Heroin	89%	59%	68%	<0.001*
MA/Other	11%	41%	32%	
Missing	0	0	0	
Previous incarceration				
No	18%	23%	21%	0.192
Yes	82%	77%	79%	
Missing	n<5	11	13	
Incarceration in the 12 months prior to interview				
No	62%	75%	71%	0.003*
Yes	38%	25%	29%	
Missing	9	7	16	
Area of residence				
Richmond	9%	3%	5%	NA
Western suburbs	16%	27%	24%	
Mornington peninsula	6%	25%	20%	
Inner city	20%	9%	12%	
St Kilda area	18%	12%	14%	
Dandenong area	1%	2%	2%	
Other south/east	14%	7%	9%	
Other north	12%	9%	10%	
Country Victoria	4%	5%	5%	

	Visited MSIR	Hasn't visited MSIR	Total	p-value
Missing	21	29	50	
By location				
Richmond	77%	18%	36%	NA
Footscray	10%	28%	23%	
Frankston	4%	26%	19%	
Collingwood	3%	8%	6%	
St Kilda	2%	6%	5%	
CBD	0%	4%	3%	
Dandenong	1%	1%	1%	
Outreach	0%	2%	2%	
Phone	2%	6%	5%	
Burnet/Alfred	1%	0%	1%	
Missing	0	10	10	
By type				
Baseline	48%	54%	52%	0.168
FollowUp	52%	46%	48%	
Missing	0	0	0	

**** statistically significant, $p < 0.05$**

† Fisher exact test instead of chi-square test, due to low numbers in some categories

IDRS 2019 (n=177)

In the IDRS 2019 study, a total of 177 participants were recruited. Of those, 168 have heard of the presence of medically supervised injecting room (MSIR) and 81 (46%) have ever visited the MSIR (Table 9.2). As in SuperMIX, the majority (68%) of those who have visited the MSIR were interviewed in Richmond. Furthermore, comparable to the SuperMIX sample, those who have visited the MSIR are more likely to be young, Aboriginal or Torres Strait Islander, live in unstable accommodation and their main drug of choice is more likely to be heroin than participants who have not visited the MSIR. Those who have visited the facility were also more likely to be currently on treatment, experiencing accidental overall drug overdose and accidental heroin overdose in the last 12 months.

Table 9.2 Demographics IDRS

		Have you ever visited MSIR		
		No (%) N=96	Yes (%) N=81	p-value
Gender	Female	27	33	0.51
	Male	73	67	
Age	≤30	n<5	10	0.012
	31-40	32	49	
	40-50	44	28	
	≥50	21	12	
Aboriginal/Torres Strait Islander	No	90	54	<0.001
	Yes	10	46	
Currently employed	Not employed	93	94	1.00
	Employed	7	6	
Accommodation status	Unstable	24	40	0.034
	Stable	76	60	
Interview site	North Richmond	9	68	<0.001
	Footscray	22	n<5	
	Frankston	25	0	
	Dandenong	24	2	
	Collingwood	9	19	
	St Kilda	10	7	
Interview site - dichotomous	Richmond	9	68	<0.001
	Non-Richmond	91	32	
Ever been in prison	No	31	30	0.75
	Yes	69	70	
MAIN drug of choice	Heroin	63	83	0.016
	Methamphetamine	25	7	
	Cannabis	8	5	
	Others	n<5	5	
Currently on drug treatment	No	45	63	0.035
	Yes	53	37	
Any OD in the last 12months	No	88	72	0.013
	Yes	13	28	
	No	91	72	0.001

Heroin OD in the last 12months	Yes	9	28

Appendix G: MSIR Review Community Survey wave one



Technical Report

Review of the trial of the Medically Supervised Injecting Room, Survey of Residents and Businesses.

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1. Executive summary

This technical report provides an overview of the research design, methodology and data preparation processes employed for The Review of the trial of the Medically Supervised Injecting Room (MSIR), Survey of Residents and Businesses (hereafter referred to as the MSIR Survey of Residents and Businesses). The study is an initiative of the Victorian Government Department of Health and Human Services (the department).

In May 2018, the department contracted independent social research agency Colmar Brunton to conduct the Data Collection component of the MSIR Survey of Residents and Businesses. Colmar Brunton engaged Q&A Market Research as a sub-contractor to conduct the fieldwork for the project.

The purpose of the MSIR Survey of Residents and Businesses was to collect representative data on the experiences and attitudes of the community within a defined geographical area surrounding the MSIR, prior to its operational commencement. The survey covered topics including: witnessing public injecting; discarded needles and syringes; being offered drugs for purchase; experiences of drug activity; and attitudes towards the MSIR. The survey was administered to community members who live in the local area (resident survey) and community members who work in the local area (business survey). The methodology was designed to ensure that the sample was representative of the local community.

The aim was to survey a representative sample of 500 residents and 300 businesses within a predefined geographical area surrounding the MSIR in June 2018, prior to its operational commencement. A total of $N = 944$ community members completed the survey ($n = 651$ residents; and $n = 293$ businesses).

2. Background

The Victorian Government is committed to addressing drug problems within the state of Victoria. Forming part of this commitment, the Government's Drug Rehabilitation Plan will invest \$87 million to address drug harms, including 100 new rehabilitation beds, trialling a medically supervised injecting centre and boosting training in the alcohol and other drug workforce.

The Drug Rehabilitation Plan includes a trial of a medically supervised injecting room at North Richmond Community Health. The Drugs, Poisons and Controlled Substances Amendment (Medically Supervised Injecting Centre) Act 2017 allows for the licence of a medically supervised injecting room trial for a two year period. The objects of the Act are:

(a) to reduce the number of avoidable deaths and the harm caused by overdoses of drugs of dependence; and

(b) to deliver more effective health services for clients of the licensed medically supervised injecting centre by providing a gateway to health and social assistance which includes drug treatment, rehabilitation support, healthcare, mental health treatment and support and counselling; and

(c) to reduce attendance by ambulance services, paramedic services and emergency services and attendances at hospitals due to overdoses of drugs of dependence; and

(d) to reduce the number of discarded needles and syringes in public places and the incidence of injecting of drugs of dependence in public places in the vicinity of the licensed medically supervised injecting centre; and

(e) to improve the amenity of the neighbourhood for residents and businesses in the vicinity of the licensed medically supervised injecting centre; and

(f) to assist in reducing the spread of blood borne diseases in respect of clients of the licensed medically supervised injecting centre including, but not limited to, HIV and hepatitis C.

The department is conducting a review of the operation and use of the MSIR so as to inform potential extension of the trial period. One of the components of the review is the MSIR Survey of Residents and Businesses.

On the 30th of May, the department contracted independent social research agency Colmar Brunton to conduct the Data Collection component of the MSIR Survey of Residents and Businesses. Colmar Brunton engaged Q&A Market Research as a sub-contractor to conduct the fieldwork for the project.

The purpose of the MSIR Survey of Residents and Businesses was to collect baseline data on the experiences and attitudes of a representative sample of the community, prior to MSIR trial commencement. The survey covered topics including: witnessing public injecting; discarded needles and syringes; being offered drugs for purchase; experiences of drug activity; and attitudes towards the MSIR.

3. Methodology

The methodology for the MSIR Survey of Residents and Businesses was designed by the department. A summary of the method is provided below.

3.1. Preparation

3.1.1. Scoping

The initial scoping session was held on the 31st of May, 2018. Dr. Kirstin Couper and Naomi Downer represented Colmar Brunton at this meeting. Josephine Norman and Katherine Scarcebrook attended from the department. Paul Hoger attended from Q&A Market Research.

The following topics were covered during the scoping meeting:

- Confirmation of the objectives of the survey;
- Roles of individuals in Colmar Brunton, Q&A Market Research and the department's project teams;
- Confirmation of the project schedule;
- Confirmation of the participant communication material;
- Confirmation of the methodology including the sampling, recruitment, face-to-face fieldwork and computer-assisted telephone interviewing (CATI) fieldwork;
- Discussion of the ethics application process;
- Discussion of the fieldwork briefing agenda;
- The setup of an online portal to provide real-time updates of fieldwork progress;
- Reporting requirements.

3.1.2. Ethics approval

An ethics application pertaining to the conduct of this study was submitted to The University of Queensland Human Research Ethics Committee (HREC). Initial approval was obtained on the 5th of July and approval of amendments was obtained on the 11th of July (approval number: 20180000982). The department managed this process and were responsible for providing updates to the committee when required.

3.1.3. Sampling

The study population parameters consisted of the boundaries of 26 Statistical Area Level 1's (SA1's), confined to the Melbourne suburbs of Richmond, Abbotsford and East Melbourne (refer to Table 1). These parameters approximated a 500m radius of the location of the MSIR (North Richmond Community Health, 23 Lennox Street, Richmond). A graphical representation of the sampling frame is displayed below in Figure 1.

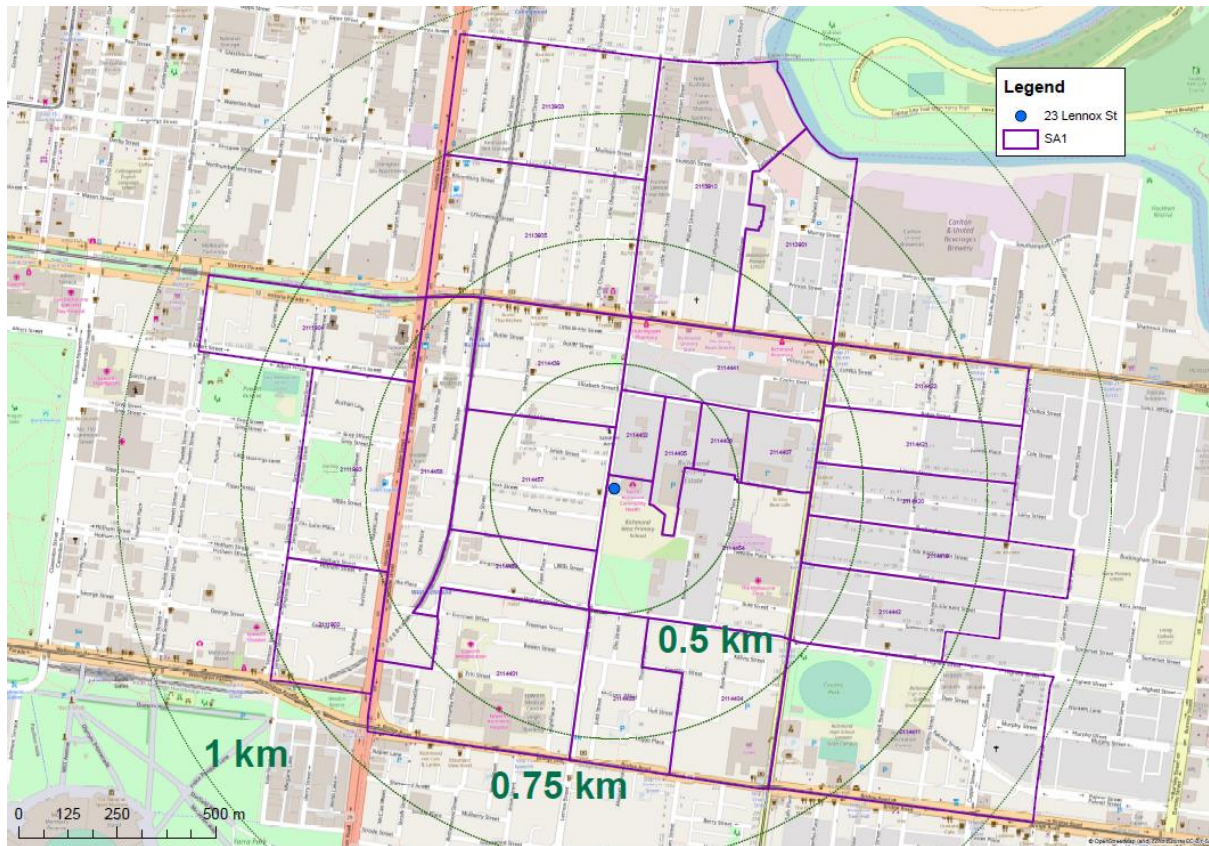


Figure 1: MSIR Survey of Residents and Businesses sampling frame.

Sampling for the resident survey

Household selection

All private dwellings located within the sampling frame were considered eligible for participation in the study. The total count and proportion of private dwellings in each SA1 are listed below in Table 1. This population data was sourced from the Australian Bureau of Statistics (ABS), 2016 Census. The total number of eligible households within the sampling frame was $N = 6,208$.

Prior to the commencement of data collection, Q&A Market Research fieldwork officers conducted a residential address indexation exercise. This involved physically walking the streets of the sample frame and logging all discoverable and accessible households into an electronic database to be used during fieldwork.

The sampling design was guided by three core objectives: (i) to ensure all community residents living within the sampling frame had an even chance of participating in the study, (ii) to ensure that the sample was demographically representative of the population (according to age, gender, SA1/location), and (iii) to maximise the total number of surveys to be completed within the narrow fieldwork timeline (two week period). The timeline was narrow and non-flexible as fieldwork had a hard deadline – the operational commencement of the MSIR.

In order to address these three objectives, the sampling was conducted in two stages.

1. In the first stage, the aim was to maximise the level of response from community residents. As such, the approach was to attempt contact with as many residences as possible within the given timeframe. Using information obtained during the address indexation exercise, the fieldwork team developed logical run sheets that enabled efficiency during fieldwork. Separate run sheets were developed for each SA1 located within the sampling frame. The run sheets excluded premises determined to be non-eligible (i.e. commercial properties, vacant properties and inaccessible properties). All residences were attempted in the order of the run sheets. The first address on each run sheet (i.e. the first address to be approached in each SA1) was selected at random. The run sheets were then ordered such that each eligible address on that first street was approached, in a consecutive manner. Addresses on both sides of the street were approached to participate. Once all eligible addresses on the street had been approached, fieldworkers moved to the next street in closest proximity, and the process was repeated. First calls were initially prioritised over second calls (except in the case of call backs and appointments) to ensure as many residences as possible were given the initial opportunity to participate in the study. If residents were not home at the point of initial contact, a calling card was left to allow the residents to initiate contact.

Fieldwork shifts were allocated to ensure good representation across each SA1. Fieldwork shifts were divided into 2-3 hour blocks by SA1, such that each fieldwork team was allocated a 2-3 hour block of fieldwork in a single SA1, then the team would progress to another SA1 for another 2-3 hour block of fieldwork and so on until they finished their shift. The time and day (weekday/weekend) of the visits were staggered for subsequent allocation of the same SA1. Each SA1 was visited between 5 and 6 times during fieldwork. On return visits to SA1's, fieldworkers would begin approaching addresses at different areas of the SA1 (i.e. not at the end point of the last visit to the SA1). The new start points were not chosen systematically, rather they were chosen at the discretion of the fieldworkers.

2. In the second stage, the sampling strategy shifted focus to ensure a representative sample by SA1/location was achieved. Minimum target quotas were set by SA1. Minimum quotas were determined by actual population spread by SA1. Responses rates and sub-sample sizes by SA1 relative to household-level population data were monitored closely to ensure proportionate representation was achieved.

This sampling approach allowed us to achieve a representative sample of the community; according to age, gender, country of birth and location/SA1. Due to time constraints and the move from stage one to stage two sampling approaches, some addresses in the sampling frame were not approached to participate. However, as the sample is proportionately representative by key demographic variables, we are able to conclude that the data is representative of the views of the community as a whole.

Table 1. Count and proportion of private dwellings and businesses in sample universe.

SA1	Private dwellings ^a		Businesses ^b	
	Count	Proportion of total	Count	Proportion of total
2114402	199	3.2%	0	0.0%
2114405	171	2.8%	0	0.0%
2114406	196	3.2%	0	0.0%
2114407	189	3.0%	0	0.0%
2114454	285	4.6%	90	10.1%
2114404	475	7.7%	28	3.1%
2114403	356	5.7%	24	2.7%
2114401	187	3.0%	89	10.0%
2114459	158	2.5%	9	1.0%
2114457	536	8.6%	15	1.7%
2114458	184	3.0%	42	4.7%
2114439	146	2.4%	78	8.8%
2114441	339	5.5%	79	8.9%
2111902	265	4.3%	22	2.5%
2111903	214	3.4%	11	1.2%
2111904	122	2.0%	31	3.5%
2113910	223	3.6%	55	6.2%
2113901	126	2.0%	63	7.1%
2114422	130	2.1%	47	5.3%
2114421	160	2.6%	26	2.9%
2114420	189	3.0%	7	0.8%
2113905	269	4.3%	98	11.0%
2113903	368	5.9%	29	3.3%
2114411	248	4.0%	24	2.7%
2114419	250	4.0%	8	0.9%
2114442	223	3.6%	15	1.7%
Total	6,208		890	

a. Data source: 2016 Census, ABS.

b. Data source: Discoverable businesses located within the sample frame. Refer to Sampling for Business Survey section of report for details.

Resident respondent selection

Respondents within an eligible household were selected using a conditional-replacement next-birthday method. This means that at the point of initial approach, the householder with the next birthday was invited to participate. In order for the next-birthday householder to participate, the following inclusion criteria must have been satisfied:

- They were contactable during the fieldwork period;
- They were aged 18 years or over;
- They had been living in the area for at least two months;
- They had the ability to participate in English or one of the 5 priority languages: Mandarin, Cantonese, Hakka, Vietnamese, or Greek; and
- They provided informed consent.

In the event that the next-birthday household member could not complete for any of these reasons, the person with the subsequent birthday was invited to participate. If the next-birthday person refused, the household was excluded from the sample and the next household was sampled.

Only a single person per household completed the survey. The target sample size for the resident sample was $n = 500$.

Sampling for the business survey

Business selection

Q&A Market Research purchased a list of business telephone numbers confined to businesses located in Richmond (SA2: 206071144), Abbotsford (SA2: 206071139) and East Melbourne (SA2: 206041119) from Reach DM (Marketing Agency in Victoria). A total of 1,552 telephone numbers were included in this list. The sample universe was confined to businesses located within the study population parameters (i.e. the 26 SA1's). Additional inclusion and exclusion criteria were then applied. Businesses located along Bridge Road and Wellington Parade were excluded, while businesses located on both sides of Victoria Street (between Powlett Street, SA1: 2111904; and Johnston Street, SA1: 2114422) were included. Upon applying these criteria, the list of discoverable business telephone numbers reduced to 669. A further 221 discoverable businesses were added to this list. These were discovered via a comprehensive check of all Google My Business listings and via the address indexation exercise conducted in preparation for the resident survey fieldwork. As a result of these inclusions, the total number of discoverable business numbers located within the sample frame was $N = 890$. The total count and proportion of discoverable business in each SA1 are listed above in Table 1.

Business respondent selection

Initially, a random sampling strategy was to be utilised for the business survey. However, throughout the field period, the sample was exhausted. As such, all discoverable businesses within the sampling frame were approached to participate in the survey ($N = 890$). Business respondents were approached to participate via telephone. In order for respondents to be selected, the following inclusion criteria must have been satisfied:

- They were contactable during the fieldwork period;
- They were aged 18 years or over;
- They had been working in the area for at least two months;
- They were a senior staff member (e.g. business owner or manager). If the business owner or manager were not available, the most senior staff member available at the time of the call was invited to participate;
- They had the ability to participate in English or one of the 5 priority languages: Mandarin, Cantonese, Hakka, Vietnamese, or Greek; and
- They provided informed consent.

Only a single person per business was invited to complete the survey. The target sample size for the business sample was $n = 300$.

3.1.4. Participation of people from non-English speaking backgrounds

The department identified five languages other than English that were most commonly spoken (based on lowest English proficiency) within the area that the survey was being conducted. They were Vietnamese, Cantonese, Mandarin, Greek and Hakka. In order to enable participation of people from non-English speaking backgrounds, the survey was translated into these five priority languages. Both the resident survey and the business survey were translated into the five priority languages.

Translated surveys were facilitated by the following ways:

On the occasion that a fieldworker approached a resident who had difficulty communicating in English, the fieldworker would directly ask whether they spoke English. If the resident's response was not in English, the fieldworker would probe further as to the resident's spoken language. If required, fieldworkers would also use translated cards in order to establish whether the resident spoke one of the five priority languages (these translated cards provided an introduction and a brief overview of the survey). If the resident did speak one of the priority languages, the fieldworker would show the respondent the translated survey preamble (via the tablet) and they would gain consent at this point. If consent was established, the interviewer would follow the normal interviewing procedure (survey was self-completed via the tablet).

For translated surveys completed via CATI, fieldworkers were typically advised by the gatekeeper (person that first answered the phone call) that the eligible respondent spoke a language other than English. The fieldworker would then arrange a call back appointment with an interviewer who speaks the priority language. Alternatively, the interviewer would tell the gatekeeper that they would call back at a later date, and arrange for a foreign language interviewer to re-attempt the call, and subsequent recruitment process.

3.1.5. Data collection procedures

During the scoping stage, the methodology and data collection procedures were discussed with the department and the most suitable approach was agreed upon. The procedures for the resident survey and for the business survey are described below.

Data collection procedure for the resident survey

A total of 14 Q&A Market Research interviewers conducted the face-to-face fieldwork for the resident survey. Fieldwork was conducted via household door knocking between the hours of 10am to 7pm on weekdays and 10am to 6pm on weekends. Fieldwork shifts were allocated across the 26 SA1's to ensure a relatively proportionate number of residents were able to complete the survey, relative to general population spread.

Fieldworkers conducted data collection in pairs (they attended households individually). Fieldworkers used a live call sheet (hard copies were available as well) to track recruitment. On the call sheet they were able to record the recruitment status of every household in the sampling frame (e.g. refusal, not eligible, inaccessible, non-contact, completed survey, unknown eligibility, etc).

Order of sampling per residence:

- Fieldworkers knocked on the door or pressed the intercom button of each private dwelling that was approached. Fieldworkers remained on the doorstep throughout all interactions with residents. At no point did fieldworkers cross the threshold.
- When a resident was available at the time of initial approach, the fieldworker would introduce themselves, and the study (refer to preamble to the survey in Appendix B). They would then screen for eligibility, as per the study inclusion criteria (described above in 3.1.3). If eligible, the resident would be invited to participate in the survey. All respondents were provided with the Participant Approach Letter and Participant Information Form (refer to Appendix C) prior to participating. Participant consent was implied in their completion of the survey.
- If contact was made but the eligible resident was unable to complete the survey at the time of initial approach, the fieldworker would collect the residents' contact name and number and arrange a re-appointment (either via call back to complete the survey via CATI or in person to complete the survey face-to-face at their door step).
- If no contact was made at the address, a call back card was left in the letter box (refer to Appendix C). Residents had the option of calling the Victorian Government Contact Centre (VGCC) telephone number if they wished to participate in the survey. These calls were able to be patched directly through to the Q&A Market Research survey hotline.
- If fieldworkers were not able to do any of the steps listed above, the property was classified as inaccessible.

The survey was administered by one of three modes:

- **English, interviewer-administered, face-to-face, Computer-Assisted Personal-Interviewing (CAPI).** If the respondent was able to complete the survey at the time the fieldworker visited the household, and in English, then the survey was interviewer-administered, face-to-face. The fieldworker would read the survey text from a tablet and record the responses on the tablet.
- **One of the priority languages, self-administered, Computer-Assisted Self-Interviewing (CASI).** If the respondent was able to complete the survey at the time the fieldworker visited the household, was unable to complete the survey in English, but was able to complete the survey in one of the priority languages (Mandarin, Cantonese, Greek, Vietnamese or Hakka) - the survey was self-completed on the tablet.
- **English or one of the priority languages, Computer-Assisted Telephone Interviewing (CATI).** If a respondent indicated they would be willing to participate but they were unable to complete at the time the fieldworker visited the household, the fieldworker arranged a CATI call back. Surveys completed via CATI could be completed in English or in one of the priority languages.

Data collection procedure for the business survey

A total of 9 Q&A Market Research interviewers conducted the telephone interviewing for the business survey. Fieldwork was conducted between the hours of 9am – 5pm on weekdays. All discoverable businesses within the sampling frame were approached to participate in the survey.

Fieldworkers used a live call sheet to track recruitment. On the call sheet they were able to record the recruitment status of every business in the sampling frame (e.g. refusal, not eligible, non-contact, disconnected, completed survey, unknown eligibility, etc.)

Order of sampling per business:

- Interviewer called the business telephone number.
- If the call was answered, the interviewer would introduce themselves, and the study (refer to preamble to the survey in Appendix B). They would then screen for eligibility, as per the study inclusion criteria (described above in 3.1.3. Sampling). If eligible, the owner/employee would be invited to participate in the survey. If respondents requested further information about the study, they were sent the Participant Approach Letter and Participant Information Form (refer to Appendix C) via email. Participant consent was implied in their completion of the survey.
- If contact was made and the respondent was not able to complete the survey at the time of the visit, the fieldworker would collect the employee/owner's contact name and arrange a call back.

3.1.6. Survey programming and testing

The department delivered a final survey instrument to Colmar Brunton on the 6th of June.

Colmar Brunton reformatted and edited the survey instrument to include instructions for survey scripting. The department reviewed this document, provided feedback and final approval on content. The final survey is appended to this report (refer to Appendix B).

The final version of the survey was then sent to Q&A Market Research analysts for the electronic survey build. All routing and validations were programmed into the electronic interface of the survey.

The survey tool was translated into five priority languages (Mandarin, Cantonese, Hakka, Vietnamese and Greek).

Once the survey had been programmed, a number of checks occurred prior to the commencement of fieldwork. The Q&A Market Research analyst who was responsible for the survey build conducted the first test and Colmar Brunton's Account Manager conducted a second test. Dummy datafiles were also checked to ensure all routing and filters were functioning as intended. Once the internal checks had been finalised, the department conducted a check of the dummy datafile and provided approval on the content prior to the commencement of fieldwork.

3.2. Data collection

3.2.1. Training the field team

Training the field team for the resident survey

A total of 14 Q&A Market Research interviewers conducted the face-to-face fieldwork for the Resident Survey. All fieldworkers had substantial experience in the conduct of social research fieldwork and all were accredited with The Australian Market & Social Research Society (AMSRS). The fieldwork team attended a face-to-face briefing at Colmar Brunton South Melbourne office on the 13th of June, prior to the commencement of fieldwork. The briefing was facilitated by Dr. Kirstin Couper, Emily Bariola (Colmar Brunton) and Paul Hoger (Q&A Market Research), with assistance from Josephine Norman and Katherine Scarcebrook (from the department). A total of 12 interviewers attended the briefing session. Two interviewers did not attend the face to face briefing. They were given a full briefing by phone before commencing their first shift. They were also placed with an interviewer that had attended the briefing for their first shift.

The briefing provided an overview of the rationale for the trial, contextual information about the MSIR, the sampling approach, recruitment strategy, participant introductory script, the survey tool, ethical requirements, timelines, escalation processes and interviewer safety.

A detailed fieldwork protocol document was produced to ensure that members of the field team and supervisors had the required reference material.

Prior to the commencement of fieldwork, interviewers were provided with the following materials:

- Q&A Market Research ID on lanyard, to be worn at all times;
- A tablet (for survey administration) and portable battery charger;
- A map of the fieldwork area;
- Interview protocol;
- Survey tool (refer to Appendix B);
- Live contact sheet link and hard copies of the contact sheet (used to record contact/recruitment data); and
- Printed copies of the Call Back Card, Participant Approach Letter and Participant Information Form (refer to Appendix C).

Fieldworkers were encouraged to dress appropriately for cold weather and to carry a light if conducting fieldwork in the late afternoon/early evening.

In the event respondents requested further information about the survey or the MSIR, or had a complaint about the survey or the MSIR, interviewers were instructed to direct respondents to the Victorian Government Contact Centre.

The Richmond Housing Office was notified about the survey and approval to visit the Richmond Housing Estates provided pending notification of residents. The Office was also provided with the names and phone numbers of the fieldworkers who were conducting the fieldwork in the Richmond Housing Estates. Interviewers were provided with the Security Control Room contact number and were instructed to call security should they feel unsafe at any time.

Colmar Brunton maintained regular contact with fieldwork supervisors throughout data collection in order to monitor progress of fieldwork and also provide support/advice to the field team, when required.

Training the field team for the business survey

A total of 10 Q&A Market Research interviewers conducted the CATI data collection for the business survey (and also the resident survey CATI survey completions). As was the case for the face-to-face interviewers, all CATI interviewers who worked on this project had substantial experience in the conduct of social research fieldwork and all were accredited with the AMSRS. The fieldwork team and fieldwork supervisors dialled into a teleconference briefing on 18th of June prior to the commencement of fieldwork for the business survey. The briefing was facilitated by Dr. Kirstin Couper and Emily Bariola (Colmar Brunton) and was also attended by Josephine Norman and Katherine Scarcebrook (from the department). Two interviewers initially attended the teleconference, 8 were subsequently briefed in the main briefing.

This briefing provided an overview of the rationale for the trial, contextual information about the MSIR, sampling approach, recruitment strategy, participant introductory script, the survey tool, ethical requirements, timelines and escalation processes.

A detailed fieldwork protocol document was produced to ensure that members of the field team and supervisors had the required reference material.

Prior to the commencement of fieldwork, fieldworkers were provided with the following materials:

- Interview protocol;
- Survey tool (refer to Appendix B);
- Live contact sheet link and hard copies of the contact sheet (used to record contact/recruitment data); and
- Electronic copies of the Participant Approach Letter and Participant Information Form (refer to Appendix C).

In the event respondents requested further information or wished to lodge a complaint about the survey or the MSIR, fieldworkers were instructed to direct respondents to the Victorian Government Contact Centre.

3.2.2. Recruitment

Recruitment for the resident survey

Fieldwork for the resident survey commenced on the 15th of June and ended on the 29th of June. Fieldwork for the resident survey was finalised prior to the operational commencement of the MSIR on the 30th of June, 2018.

A total of $n = 651$ residents completed the survey. $n = 630$ respondents completed the survey face-to-face and $n = 21$ completed the survey via CATI (these respondents responded to the call back card that was left in their letter box). Average survey completion times were 13.8 minutes and 16.8 minutes for the surveys completed face-to-face and via CATI, respectively. Table 2 provides an overview of the recruitment outcomes for the resident survey.

Table 2: Resident survey recruitment outcomes.

Recruitment outcomes	Count	Proportion of population
Completed total (C)	651	10.5%
Completed face-to-face	630	10.1%
Completed CATI	21	0.3%
Non-contact (eligible, non-interview) total (NC)	11	0.2%
Refusal (eligible, non-interview) total (R)	169	2.7%
Other (eligible, non-interview) total (O)	203	3.3%
Other - language barrier	70	1.1%
Other - unable to complete due to illness or disability	8	0.1%
Other - broken appointment	109	1.8%
Other - other non-response	16	0.3%
Unknown eligibility, non-interview total (UE)	5,159	83.1%
Unknown eligibility - not attempted	3,176	51.2%
Unknown eligibility - inaccessible	91	1.5%
Unknown eligibility - received call back card ^a	1,892	30.5%
Not eligible, non-interview total	15	0.2%
Not eligible - out of sample (aged <18 years; lived in the area <2 months)	15	0.2%
Total population^b	6,208	
Response Rate (RR) - Proportion of cases interviewed of all eligible cases $C / (C) + (NC+R+O) + (UE)$	-	10.5%
Co-operation Rate (COOP) - Proportion of cases interviewed of eligible cases contacted $C / (C)+(R+O)$	-	63.6%
Refusal Rate (REF) - Proportion of eligible sample that refused $R / ((C)+(NC+R+O) + (UE))$	-	2.7%
Contact Rate (CON) - Proportion of eligible sample where a household was reached $(C+R+O) / (C+R+O+NC+UE)$	-	16.5%

a. Households that received a call back card in the letter box, but did not respond are included in this tally.

b. Data source: Count of Private Dwellings, 2016 Census, Australian Bureau of Statistics (ABS).

The overall response rate (proportion of cases interviewed of all eligible cases) for the resident survey was 10.5%. The co-operation rate (proportion of cases interviewed of eligible cases contacted) was 63.6%.

Several reasons for non-completion due to language barrier were recorded. It was noted that fieldworkers encountered individuals that spoke languages not covered by the survey methodology (i.e. other than English, Greek, Vietnamese, Hakka, Mandarin, Cantonese). It was also noted that some individuals who were from non-English speaking backgrounds did not allow the interviewers the time to introduce the study, before they terminated the conversation (i.e. before they could express interest or disinterest in participating).

Recruitment for the business survey

Fieldwork for the business survey commenced on the 19th of June and ended on the 4th of July. A total of $n = 293$ respondents completed the business survey (all via CATI). $n = 271$ respondents completed the survey prior to the commencement of the trial, and $n = 22$ completed the survey within four days after trial commencement (these cases are flagged with a binary variable: COMPLETION=2). The sample was exhausted, meaning all discoverable businesses were approached to participate. The average survey completion time was 19.08 minutes.

Table 3 provides an overview of the recruitment outcomes for the business survey. The overall response rate (proportion of cases interviewed of all eligible cases) for the business survey was 44.5%. The co-operation rate (proportion of cases interviewed of eligible cases contacted) was 58.5%.

In regards to reasons for refusal, it was noted that many instances of refusal occurred at the initial point of approach, by the gatekeeper (i.e. the person who first answered the call). There were many instances of a hard refusal at introduction. For example, individuals would say 'we don't do surveys here.'

Response rates for each sampling unit (SA1)

Response rates for the resident survey and the business survey for each SA1 are presented in Table 4.

For the resident sample, response rates were relatively evenly spread across each of the SA1's, ranging between 7.7% and 18.8%. Response rates for the business sample ranged between 14.3% and 85.7%.

Table 3. Business survey recruitment outcomes.

Recruitment outcomes	Count	Proportion of population
Completed total^a (C)	293	32.9%
Completed face-to-face	0	0.0%
Completed CATI	293	32.9%
Non-contact (eligible, non-interview) total (NC)	18	2.0%
Refusal (eligible, non-interview) total (R)	175	19.7%
Other (eligible, non-interview) total (O)	33	3.7%
Other - language barrier	27	3.0%
Other - unable to complete due to illness or disability	0	0.0%
Other - broken appointment	0	0.0%
Other - other non-response	6	0.7%
Unknown eligibility, non-interview total (UE)	140	15.7%
Unknown eligibility - not attempted	0	0.0%
Unknown eligibility - non-contact (always ringing, always voicemail)	136	15.3%
Unknown eligibility - business number, unknown if eligible person	4	0.4%
Not eligible, non-interview total	231	26.0%
Not eligible - out of sample (aged <18 years; worked in the area <2 months)	2	0.2%
Not eligible - number out of service or disconnected	145	16.3%
Not eligible - other ineligible	84	9.4%
Total population^a	890	
Response Rate (RR) - Proportion of cases interviewed of all eligible cases $C / (C) + (NC+R+O) + (UE)$	-	44.5%
Co-operation Rate (COOP) - Proportion of cases interviewed of eligible cases contacted $C / (C)+(R+O)$	-	58.5%
Refusal Rate (REF) - Proportion of eligible sample that refused $R / ((C)+(NC+R+O) + (UE))$	-	26.6%
Contact Rate (CON) - Proportion of eligible sample where a business was reached $(C+R+O) / (C+R+O+NC+UE)$	-	76.0%

a. Data source: Discoverable businesses located within the sample frame. Refer to 3.1.3. for details.

Table 4. Response rates^a for the resident and business surveys, by SA1.

SA1	Resident survey response rate	Business survey response rate
2114402	9.0%	-
2114405	9.4%	-
2114406	8.2%	-
2114407	7.9%	-
2114454	7.7%	56.9%
2114404	8.0%	42.1%
2114403	6.8%	57.1%
2114401	8.6%	42.5%
2114459	8.3%	16.7%
2114457	8.2%	45.5%
2114458	9.2%	35.7%
2114439	17.8%	35.9%
2114441	9.1%	42.2%
2111902	8.3%	38.5%
2111903	18.8%	14.3%
2111904	13.9%	45.5%
2113910	12.6%	39.5%
2113901	15.9%	40.0%
2114422	13.2%	47.2%
2114421	8.1%	68.4%
2114420	18.1%	50.0%
2113905	11.5%	43.8%
2113903	9.3%	56.5%
2114411	15.8%	38.5%
2114419	8.4%	85.7%
2114442	17.6%	37.5%
Total	10.5%	44.5%

a. Response Rate (RR) - Proportion of cases interviewed of all eligible cases.

3.2.3. Survey outcomes

The count and proportion of respondents who completed the resident and the business surveys by SA1 are presented below in Table 5.

Table 5. Count and proportion of respondents by SA1.

	Resident survey		Business survey	
SA1	Count	Proportion of total	Count	Proportion of total
2114402	18	2.8%	0	0.0%
2114405	16	2.5%	0	0.0%
2114406	16	2.5%	0	0.0%
2114407	15	2.3%	0	0.0%
2114454	22	3.4%	37	12.6%
2114404	38	5.8%	8	2.7%
2114403	24	3.7%	8	2.7%
2114401	16	2.5%	31	10.6%
2114459	13	2.0%	1	0.3%
2114457	44	6.8%	5	1.7%
2114458	17	2.6%	10	3.4%
2114439	26	4.0%	23	7.8%
2114441	31	4.8%	27	9.2%
2111902	22	3.4%	5	1.7%
2111903	40	6.1%	1	0.3%
2111904	17	2.6%	10	3.4%
2113910	28	4.3%	15	5.1%
2113901	20	3.1%	20	6.8%
2114422	17	2.6%	17	5.8%
2114421	13	2.0%	13	4.4%
2114420	34	5.2%	3	1.0%
2113905	31	4.8%	32	10.9%
2113903	34	5.2%	13	4.4%
2114411	39	6.0%	5	1.7%
2114419	21	3.2%	6	2.0%
2114442	39	6.0%	3	1.0%
Total	651		293	

Survey language

The count and proportion of surveys completed in each of the survey languages are presented below in Table 6.

Table 6. Count and proportion of surveys completed in each of the survey languages.

	Resident survey		Business survey	
Survey language	Count	Proportion of total	Count	Proportion of total
English	620	95.2%	286	97.6%
Vietnamese	20	3.1%	6	2.0%
Mandarin	8	1.2%	1	0.3%
Cantonese	2	0.3%	0	0.0%
Greek	1	0.2%	0	0.0%
Hakka	0	0.0%	0	0.0%
Total	651		293	

A relatively small proportion of respondents completed the translated versions of the survey (4.8% of the resident sample and 2.4% of the business sample). It was noted by the field team that the majority of the respondents who were from non-English speaking backgrounds were able to complete the survey in English, hence the low proportion of completions in the surveys translated into languages other than English.

3.2.4. Sample representativeness for the resident survey

An assessment of sample representativeness for the resident survey, relative to population data is presented below in Table 7. The representativeness of the business sample was not assessed as population data was not available.

Table 7: Resident sample representativeness according to demographic characteristics, relative to individual-level population data.

Demographic characteristic	Sample		Population ^a	
	Count	Proportion of total	Count	Proportion of total ^b
Gender				
Male	329	50.5%	5,975	48.6%
Female	321	49.3%	6,314	51.4%
Other	1	0.2%	-	-
Age group				
0 – 17 year olds	-	-	1,473	-
18 – 19 year olds	12	1.8%	197	1.8%
20 – 24 year olds	44	6.8%	1,072	10.0%
25 – 34 year olds	186	28.6%	3,779	35.2%
35 – 44 year olds	124	19.0%	1,801	16.8%
45 – 54 year olds	82	12.6%	1,394	13.0%
55 – 64 year olds	99	15.2%	1,143	10.7%
65 – 74 year olds	62	9.5%	696	6.5%
75 – 84 year olds	33	5.1%	457	4.3%
85+ year olds	9	1.4%	193	1.8%
Country of birth				
Australia	379	58.5%	6,290	56.3%
Overseas	269	41.5%	4,881	43.7%
Total	651		12,292	

a. Data source: Community Profile, 2016 Census, ABS. Population data is reported at the individual level.

b. Count of 0-17 year olds excluded in the calculation of proportions for each age group.

As shown in the table above, the resident sample was representative of the population as per the spread across gender, country of birth and most of the age groups. Some minor under-representation was observed among 20 – 24 year olds and 25 – 34 year olds, and some minor over-representation was observed among 55 – 64 year olds.

Table 8: Resident sample representativeness according to location (SA1), relative to individual and household-level population data^a.

Location (SA1)	Sample		Population (individual-level)		Population (household-level)	
	Count	Proportion of total	Count	Proportion of total	Count	Proportion of total
2114402	18	2.8%	490	4.0%	199	3.2%
2114405	16	2.5%	383	3.1%	171	2.8%
2114406	16	2.5%	465	3.8%	196	3.2%
2114407	15	2.3%	406	3.3%	189	3.0%
2114454	22	3.4%	621	5.1%	285	4.6%
2114404	38	5.8%	821	6.7%	475	7.7%
2114403	24	3.7%	588	4.8%	356	5.7%
2114401	16	2.5%	409	3.3%	187	3.0%
2114459	13	2.0%	291	2.4%	158	2.5%
2114457	44	6.8%	959	7.8%	536	8.6%
2114458	17	2.6%	346	2.8%	184	3.0%
2114439	26	4.0%	378	3.1%	146	2.4%
2114441	31	4.8%	656	5.3%	339	5.5%
2111902	22	3.4%	410	3.3%	265	4.3%
2111903	40	6.1%	376	3.1%	214	3.4%
2111904	17	2.6%	238	1.9%	122	2.0%
2113910	28	4.3%	472	3.8%	223	3.6%
2113901	20	3.1%	314	2.6%	126	2.0%
2114422	17	2.6%	299	2.4%	130	2.1%
2114421	13	2.0%	288	2.3%	160	2.6%
2114420	34	5.2%	431	3.5%	189	3.0%
2113905	31	4.8%	621	5.1%	269	4.3%
2113903	34	5.2%	676	5.5%	368	5.9%
2114411	39	6.0%	432	3.5%	248	4.0%
2114419	21	3.2%	470	3.8%	250	4.0%
2114442	39	6.0%	452	3.7%	223	3.6%
Total	651		12,292		6,208	

a. Data source: 2016 Census, ABS. Population data is reported at the individual level (i.e. total count of persons) and household level (i.e. total count of private dwellings).

As shown in the table above, the resident sample was representative of the population according to the spread across SA1's.

3.2.5. Escalations

An agreed escalation procedure was put in place at the start of the project in order to deal with any sensitive contacts encountered during fieldwork. There were two cases that required escalation during the fieldwork period. They are as follows:

1. **15/06/2018** - an interviewer attended North Richmond Community Health and requested to pick up printed participant information materials. The interviewer misunderstood instructions related to the dissemination of printed participant information material. The printed materials were not at the Community Health Centre, they were being distributed in field. Confusion ensued. The North Richmond Community Health Centre filed a complaint with the department regarding this incident. Colmar Brunton responded by discussing the incident with the fieldworker in question and with the Fieldwork Supervisor. At this stage, all interviewers had the printed materials so the incident could not reoccur. Colmar Brunton requested that the department pass on their apologies for the confusion and inconvenience caused.
2. **19/06/2018** – a resident lodged a complaint with the department regarding the conduct of an interviewer in field. Details of the complaint are as follows: the complainee was conducting an interview with a respondent in an apartment complex. After the complainee had finished interviewing the resident, they knocked on the door of the complainant. The complainant became distressed by the interviewers' presence. The complainee explained why they were there and then moved on when it became clear the complainant did not wish to participate. The interviewer went outside and was buzzed in again by a resident of another unit in the same apartment complex. The complainant came out and again became distressed by the interviewers presence. The interviewer again explained the purpose of her visit. When she closed the interaction with the complainant the interviewer asked, 'are you okay, do you need a hug?'

Later that day, the respondent filed a complaint with the department. The project team took the following actions: the individual interviewer was counselled by Paul Hoyer (Director of Q&A Market Research) on the importance of buzzing in at each unit in an apartment complex, the importance of providing an escalation option to community members who become distressed, and on the inappropriateness of the 'are you alright, do you need a hug' comment. The complainee was taken off the project and conducted no further fieldwork for the study. Colmar Brunton facilitated a re-brief session with fieldworkers and covered off the main topics of appropriate conduct in field and how to escalate a situation if a community member becomes distressed. The department liaised with the complainant regarding the complaint and the steps that had been taken to address the points raised in the complaint.

3.3. Data processing and weighting

3.3.1. Data processing

Practices to ensure high quality data commenced at the set-up phase of the project. The following steps were taken.

- ▶ Once the survey had been programmed, a number of checks occurred prior to the commencement of fieldwork. The Q&A Market Research analyst who was responsible for the survey build conducted the first test and Colmar Brunton's Senior Account Manager conducted a second test.
- ▶ The survey was programmed with built in consistency and validity checks.
- ▶ Dummy datafiles were also checked to ensure all routing and filters were functioning as intended. Once the internal checks had been finalised, the department conducted a check of the dummy datafile and provided approval on the content prior to the commencement of fieldwork.
- ▶ An interim data file was produced after sufficient surveys had been completed. This was checked by Colmar Brunton Senior Account Manager.
- ▶ A full data cleaning and validation process occurred at the end of the project.
- ▶ Two resident respondents mistakenly completed the business survey (interviewer selected 'business' before handing over the tablet to them to complete in one of the priority languages). The two cases were retained in the datafile – they can be identified by a flag variable (Incorrectflag=1).
- ▶ Extreme values were identified on Q5B, Q6B and Q26. These values are retained as raw data in the datafile (not transformed). The department may decide to delete or replace these values depending on their preferred method.
- ▶ The file was weighted in accordance with the requirements set-out by the department. The weighting strategy is described in 3.3.2 below.
- ▶ The required derived variables were computed and included in the datafile.
- ▶ The final data file was delivered in SPSS file format. All syntax and weighting variables were provided with the data file.

3.3.2. Weighting

Weights were calculated for the resident sub-cohort only (ComBusiSamp=1) ($n = 650$). One respondent identified as 'other' gender. This respondent was coded as SYSMISS for the weight variable.

Weights were calculated using the following auxiliary variables: gender (Q17 = 1 'male'; 2 'female') and age group (recage = 1 '18-19 yrs'; 2 '20-24 yrs'; 3 '25-29 yrs'; 4 '30-34 yrs'; 5 '35-39 yrs'; 6 '40-44 yrs'; 7 '45-49 yrs'; 8 '50-59 yrs'; 9 '60-69 yrs'; 10 '70-79 yrs'; 11 '80+yrs').

Population-level data confined to the population parameters of the study (i.e. the 26 SA1's) were used to calculate weights. An interlocking weight structure was used to generate accurate population weights for each gender x age group combination thus ensuring strong alignment to the population level data. Data source: Community Profile, 2016 Census, ABS.

3.3.3. Coding

Colmar Brunton developed codeframes for the following open-ended questions.

- ▶ **S3** - What is your position in this business? (Single response)
- ▶ **Q7B** - Thinking about the last time someone approached you on a street in your local area to sell you drugs, what type of drugs were you offered? (Single response)
- ▶ **Q8** - What, if anything, concerns you about drug-related activity in your local area? (Multiple response)
- ▶ **Q11A** - Do you know the location of the Medically Supervised Injecting Room (MSIR) trial? (Single response)
- ▶ **Q14** - Do you have any further comments you would like to make about the Medically Supervised Injecting Room trial? (Multiple response)
- ▶ **Q15** - Do you have any further comments you would like to make about drug-related activity in your local area? (Multiple response)

The codeframes for these questions are appended to this report. In order to conduct the coding, the following steps were taken:

Develop codeframe

- Two Colmar Brunton researchers separately and independently reviewed open-ended responses and derived themes.
- The two researchers met and discussed themes and agreed on final codeframes.
- The department reviewed and approved the codeframes.

First validation

- One researcher read open-ended responses for the first 50 cases and coded for theme endorsement using the codeframes.
- The department reviewed the 50 coded cases and provided feedback. Feedback was incorporated into the coding strategy going forward.

Coding

- After incorporating the feedback from the department, one Colmar Brunton researcher read each open-ended response and coded for theme endorsement using the codeframes. Additional codes were added to the codeframe if required.

4. Research schedule

The following table provides a summary of the key research tasks and their completion dates.

Table 9: Research schedule.

Task	Dates
Research proposal submitted	18 th of May, 2018
Project commissioned	30 th of May, 2018
Project scoping meeting	31 st of May, 2018
Survey finalised	6 th of June, 2018
Participant information material finalised	13 th of June, 2018
Ethics approval granted	5 th of June, 2018
Ministerial approval received	8 th of June, 2018
Survey program testing and finalisation	14 th of June, 2018
Resident survey field researcher training	13 th of June, 2018
Business survey field researcher training	18 th of June, 2018
Resident survey fieldwork	15 th – 29 th of June, 2018
Business survey fieldwork	19 th of June – 3 rd of July, 2018
Data processing, coding, checking, weighting	4 th July – 31 st of July
Data file delivered	31 st of July
Draft technical report delivered	10 th of August, 2018
Feedback on technical report received	28 th of August, 2018
Final technical report delivered	7 th of September, 2018

5. Recommendations for future surveys

The Victorian Government Contact Centre telephone number was recorded on the Call Back Cards that were deposited in residents' letter boxes. If residents contacted the Contact Centre and expressed interest in completing the survey, the operator was instructed to patch the call through to Q&A Market Research survey hotline so that the survey could be completed via CATI. A very small number of respondents completed the survey via the call-back procedure ($n = 21$). It is recommended that for future waves of household surveys, the direct telephone line of the survey provider be recorded on the call back card. This may increase responses from community members who are not at home during the normal fieldwork hours of operation.

6. Appendices

6.1. Appendix A – Personnel

Kirstin 	Dr Kirstin Couper, Research Director, Colmar Brunton (Melbourne) Kirstin is the Head of the Government research team for Colmar Brunton in Melbourne. Kirstin joined Colmar Brunton in Melbourne from Ipsos MORI in London, where she was a member of the Local Government senior management team; responsible for directing studies for central and local government across England. Since the completion of her PhD Kirstin has worked for research agencies in Social and Government research for over 13 years. She specialises in the design of bespoke research studies to meet specific research objectives. Her experience in random sampling spans her work in London and Melbourne. In London she worked on the National Study of Adult Learning for the Department of Education and Skills, and the Universal Credit study for the Department of Work and Pensions. Both required random probability sampling approaches to be designed and required consideration of ensuring the non-response bias, particularly among non-English speaking groups, was minimised. In Melbourne she is currently directing a large national study of youth for a non-governmental organisation, which focuses on youth mental health.
Emily 	Emily Bariola, Senior Account Manager, Colmar Brunton (Melbourne) Emily is a Senior Account Manager in the Social & Government research team in Victoria. She joined Colmar Brunton in June, 2018. She has a Bachelor of Arts with an Honours degree in Psychology and is currently completing her PhD in Psychology. Emily has worked as a researcher for ten years, with her research spanning behavioural science, public health and social epidemiology. She has worked across university, not-for-profit, government and commercial sectors and has extensive experience working on both agency and client sides of the research process. Emily uses both quantitative and qualitative methodologies to answer research questions and has expertise designing longitudinal surveys, large national cross-sectional surveys, and qualitative studies. She is passionate about evidence-based practice and enjoys translating research knowledge into practice for her clients. Emily has conducted several research studies examining drug, alcohol and tobacco use among specific populations (including marginalised communities and Australian youth). She has a strong working knowledge of substance-use research methodologies.

Naomi



Naomi Downer, Account Director, Colmar Brunton (Adelaide)

Naomi joined Colmar Brunton Research in August 2010. Her role is focused on the successful management and completion of large scale quantitative projects. Naomi has over twelve years research experience in market and social research and operations management. She joined the Colmar Brunton team after two and a half years working with I-view in Australia and two years working with Ipsos-Mori in London.

Naomi has experience managing large scale, high stakes, multi-methodology quantitative studies including the Student Outcomes Survey, the National Secondary Students Diet and Activity Survey, the Victorian Student Health and Wellbeing Survey, Evaluation of the Obesity Prevention and Lifestyle (OPAL) and Child Obesity Prevention and Lifestyle (COPAL) programs, the Self-Reported Health Status surveys, Child Health Status survey and Health Status surveys for Queensland Health, the Longitudinal Study of Humanitarian Migrants and a number of large scale Health Surveys in Queensland and Victoria.

Naomi also has experience working on studies with sensitive subject matter which involves speaking to vulnerable respondents who require specific interviewing and supervision techniques. Her experiences on these and other studies enables her to provide methodological consulting and questionnaire design advice to ensure clients get the best possible research outcomes.

6.2. Appendix B – Survey

QUANT FIELD REQUIREMENTS	
Project No: DHHS0006	Project Name: MSIR Community Survey (Resident and Business Samples)
Main Colmar Brunton Contacts: Kirstin Couper, Emily Bariola	
Issue Date: 13.06.18, Version 3	

1. Fieldwork approach

1.1 Resident Sample

The list of Statistical Area Level 1's (SA1's) provided by DHHS reflect the exact population parameters for this study. The parameters are approximately within a 500m radius of the location of the Medically Supervised Injecting Room (MSIR) – located at North Richmond Community Health, 23 Lennox Street, Richmond. $N = 500$ resident interviews will take place face-to-face with the option of CATI call back.

1.2. Business Sample

$N=300$ operating within a 750m radius of 23 Lennox St, however this should not include Bridge Road businesses at this stage. Further details tbc.

The $n=300$ business interviews will take place via CATI.

INTRODUCTION

1. SOURCE: RESIDENT SAMPLE (FACE-TO-FACE, WITH THE OPTION OF CATI CALL BACK)

INTERVIEWER NOTE: for each household in the sample, the next-birthday person living in the household is selected to complete the survey. The next-birthday person must meet the following criteria: (i) they are contactable during the fieldwork period, (ii) they are aged 18 years or over, (iii) they have been living in the area for at least 2 months, (iv) they have the ability to participate in English or one of the 5 priority languages (Simplified Chinese [Mandarin/Cantonese], Hakka, Vietnamese, Greek), (v) and they have provided informed consent.

If the next-birthday person cannot complete for any of the above reasons, the person with the subsequent birthday is selected. If the next-birthday person refuses, the household is excluded and the next household should be sampled.

Introduction script

Good morning / afternoon / evening. I'm [interviewer] from Colmar Brunton and Q&A Market Research, which are survey companies. We are conducting a survey about community attitudes to drug-related activity in the inner-eastern area of Melbourne. The survey is an initiative of the Victorian Department of Health and Human Services who have engaged us to conduct the interviews. The survey results are for public interest and for research purposes only. The survey involves answering some general questions about yourself as well as some questions relating to drug-related activity in your area. And the survey has received ethics approval. The survey is voluntary, you don't have to participate if you don't want to. The survey will take only 10 minutes, is conducted with me in person, and it is completely anonymous.

Person consolidation 1

We would like to conduct the interview with the person in this household who is next to have a birthday. The person must also be aged 18 years or over and must have lived in the area for at least two months. Is that you?

YES, I AM AGED OVER 18 AND NEXT TO HAVE A BIRTHDAY AND HAVE LIVED IN THE AREA FOR AT LEAST TWO MONTHS > PROCEED TO INTERESTED IN COMPLETING INTERVIEW. NO, I AM UNDER 18 AND/OR I AM NOT NEXT TO HAVE A BIRTHDAY AND/OR I HAVE NOT LIVED IN THIS AREA FOR AT LEAST TWO MONTHS > PERSON CONSOLIDATION 2.

Person consolidation 2

Is the person in this household who is next to have a birthday and who is also over 18 and who has lived in the area for at least two months available to speak to me now?

YES, THEY ARE AVAILABLE > NEXT BIRTHDAY HOUSEHOLD MEMBER 18+. NOT AVAILABLE NOW > ARRANGE CALL BACK. NO ONE INTERESTED > TERMINATE WITH THANKS.

Interested in completing interview

Super. Here is a letter and information form that includes more information about the study. Please take a moment to read through the information now. Please note that if you complete the survey with me you are expressing consent to participate in the survey. Would you be interested in completing

this interview with me right now?. YES, NOW > PROCEED WITH INTERVIEW, YES, ANOTHER TIME > ARRANGE CATI CALL BACK. NEITHER > TERMINATE WITH THANKS.

Next birthday household member 18+ & lived in area > 2 months

Good morning / afternoon / evening. I'm [interviewer] from Colmar Brunton and Q&A Market Research, which are survey companies. We are conducting a survey about community attitudes to drug-related activity in the inner-eastern area of Melbourne. The survey is an initiative of the Victorian Department of Health and Human Services who have engaged us to conduct the interviews. The survey results are for public interest and for research purposes only. The survey involves answering some general questions about yourself as well as some questions relating to drug-related activity in your area. And the survey has received ethics approval. The survey is voluntary, you don't have to participate if you don't want to. The survey will take only 10 minutes, is conducted with me in person, and it is completely anonymous.

Here is a letter that includes more information about the study. Please take a moment to read through the information now. Please note that if you complete the survey with me you are expressing consent to participate in the survey.

Would you be interested in completing this interview with me right now? YES, NOW > PROCEED WITH INTERVIEW, YES, ANOTHER TIME > ARRANGE CATI CALL BACK. NEITHER > TERMINATE WITH THANKS.

2. SOURCE: BUSINESS SAMPLE (CATI)

INTERVIEWER NOTE: For the business survey, the respondent must meet the following criteria: (i) they are contactable during the fieldwork period, (ii) they are aged 18 years or over, (iii) they have been working in the area for at least 2 months, (iv) they are a senior staff member (e.g. business owner or manager), (v) they have the ability to participate in English or one of the 5 priority languages (Simplified Chinese [Mandarin/Cantonese], Hakka, Vietnamese, Greek),

Please note: If the most senior staff member is unavailable or unwilling to participate, it is acceptable to survey the most senior person who is currently available (i.e. attempt to survey the most senior person available at the time).

Introduction script

Good morning / afternoon / evening. I'm [interviewer] from Colmar Brunton and Q&A Market Research, which are survey companies. We are conducting a survey about community attitudes to drug-related activity in the inner-eastern area of Melbourne. The survey is an initiative of the Victorian Department of Health and Human Services who have engaged us to conduct the interviews. The survey results are for public interest and for research purposes only. The survey involves answering some general questions about yourself and the business you work in, as well as some questions relating to drug-related activity in your area. And the survey has received ethics approval. The survey is voluntary, you don't have to participate if you don't want to. The survey will take only 10 minutes, is conducted with me in person, and it is completely anonymous.

Person consolidation

3

2

To participate in the survey you need to be aged 18 or over and have worked in the area for at least two months. And if possible, we would like the most senior person in the business to complete the survey (such as business owner or manager). Would that be you, by chance? If not, is that person available to speak to? YES THAT'S ME AND AGED OVER 18 AND WORKED IN THE AREA FOR AT LEAST TWO MONTHS> PROCEED TO INTERESTED IN COMPLETING INTERVIEW. NO, ITS SOMEBODY ELSE > SOMEBODY ELSE

Interested in completing interview [interviewer note: please check to see whether respondent would like to receive some information about the survey. If they do please send Business Approach Letter and Participant Information Form via email].

Super. Would you be interested in completing this interview with me over the phone? Is now okay, or should I call back another time? YES, NOW > PROCEED WITH INTERVIEW, YES, ANOTHER TIME > MAKE CALL BACK. NEITHER > TERMINATE WITH THANKS.

Somebody else

Would that person be available to speak to now?

YES, NOW > REINTRODUCE AND CHECK ELIGIBILITY FOR COMPLETING SURVEY AND CHECK INTEREST IN COMPLETING INTERVIEW. NOT AVAILABLE NOW > REQUEST TO SPEAK TO MOST SENIOR STAFF MEMBER THAT IS AVAILABLE AND REINTRODUCE STUDY AND CHECK INTEREST IN PARTICIPATING.

GENERAL SCREENING QUESTIONS

ASK ALL, SR

S1. Have you recently participated in a survey conducted on behalf of the Department of Health and Human Services regarding drug-related activity in your local area?

Please select one response

1. Yes
2. No
97. Don't know (DNRO)
99. Prefer not to answer (DNRO)

ASK BUSINESS RESPONDENTS ONLY, OE

S3. What is your position in this business?

99. Prefer not to answer (DNRO)

CORE QUESTION SET

INTRO FOR BUSINESS RESPONDENTS ONLY: For the following questions, when we say "local area" we mean "the area where you work."

INTRO FOR RESIDENT RESPONDENTS ONLY: For the following questions, when we say "local area" we mean "the area where you live."

ASK ALL, SR, RO

Q4A. Thinking about the past 12 months, how safe or unsafe have you felt when you were walking in your local area alone during the day?

Please select one response

1. Very safe
2. Safe
3. Neither safe nor unsafe
4. Unsafe
5. Very unsafe
6. Never alone in this situation
97. Don't know (DNRO)
99. Prefer not to answer (DNRO)

ASK ALL, SR, RO

Q4B. Thinking about the past 12 months, how safe or unsafe have you felt when you were walking in your local area alone after dark?

Please select one response

1. Very safe
2. Safe
3. Neither safe nor unsafe
4. Unsafe
5. Very unsafe
6. Never alone in this situation
97. Don't know (DNRO)
99. Prefer not to answer (DNRO)

ASK ALL, SR

Q5. Have you ever seen anyone injecting drugs in a public place in your local area?

Please select one response

1. Yes
2. No
97. Don't know (DNRO)
99. Prefer not to answer (DNRO)

ASK IF Q5=CODE 1, SR, DNRO INTERVIEWER CODE TO LIST

Q5A. When was the last time you saw someone injecting in a public place in your local area?

Please select one response

1. Within the Last 24 Hours
2. Within the Last Week
3. Within the Last Month
4. Within the Last Year
5. More Than A Year Ago
6. Never
97. Don't know (DNRO)
99. Prefer not to answer (DNRO)

ASK IF Q5A CODE= 1,2 OR 3, OE-NUM (1-999)

Q5B. How often over the last month have you seen someone injecting drugs in a public place in your local area?

Number of times in the last month

-
97. Don't know (DNRO)
 99. Prefer not to answer (DNRO)

ASK ALL, SR

Q6. Have you ever seen a discarded needle or syringe in a public place in your local area, for example a syringe dropped in the street or a park etc?

Please select one response

1. Yes
2. No
97. Don't know (DNRO)
99. Prefer not to answer (DNRO)

6

ASK IF Q6=CODE 1, SR, DNRO INTERVIEWER CODE TO LIST

Q6A. When was the last time you saw a discarded needle or syringe in a public place in your local area?

Please select one response

1. Within the Last 24 Hours
2. Within the Last Week
3. Within the Last Month
4. Within the Last Year
5. More Than A Year Ago
6. Never
97. Don't know (DNRO)
99. Prefer not to answer (DNRO)

ASK IF Q6A CODE= 1,2 OR 3, OE-NUM (1-999)

Q6B. How often over the last month have you seen a discarded needle or syringe in a public place in your local area?

Number of times in the last month

-
97. Don't know (DNRO)
 99. Prefer not to answer (DNRO)

ASK ALL, SR

Q7. Has someone ever approached you on a street in your local area to sell you drugs?

Please select one response

1. Yes
2. No
97. Don't know (DNRO)
99. Prefer not to answer (DNRO)

ASK IF Q7=CODE 1, SR, DNRO INTERVIEWER CODE TO LIST

Q7A. When was the last time someone approached you on a street in your local area to sell you drugs?

Please select one response

1. Within the Last 24 Hours
2. Within the Last Week
3. Within the Last Month
4. Within the Last Year
5. More Than A Year Ago
6. Never
97. Don't know (DNRO)
99. Prefer not to answer (DNRO)

ASK IF Q7A CODE= 1,2,3,4,5 OE

Q7B. Thinking about the last time you were approached, what type of drugs were you offered?

7

-
97. Don't know (DNRO)
99. Prefer not to answer (DNRO)

ASK ALL, OE

Q8. What, if anything, concerns you about drug-related activity in your local area?

-
97. Don't know (DNRO)
99. Prefer not to answer (DNRO)

ASK ALL, SR, RO

Q9. How concerned are you currently about drug-related activity in your local area?

Please select one response

1. Not at all concerned
2. Slightly concerned
3. Moderately concerned
4. Very concerned
97. Don't know (DNRO)
99. Prefer not to answer (DNRO)

ASK BUSINESS RESPONDENTS ONLY, SR. [Interviewer note: If respondent is employee: state 'finding a new job' if respondent is business owner: state 'moving your business.']

Q10A. Thinking about the past 12 months, have you considered finding a new job (or moving your business) out of the area because of drug-related activity?

Please select one response

1. Yes, and I may find a job (or move my business) out of the area
2. Yes, but finding a new job (or moving my business) is not an option for me at the moment
3. No, I have not thought about it
97. Don't know (DNRO)
99. Prefer not to answer (DNRO)

ASK RESIDENT RESPONDENTS ONLY, SR

Q10B. Thinking about the past 12 months, have you considered moving out of the area because of drug-related activity?

Please select one response

1. Yes, and I may move out of the area
2. Yes, but moving is not an option for me at the moment
3. No, I have not thought about it
97. Don't know (DNRO)
99. Prefer not to answer (DNRO)

ASK ALL, SR

Q11. Do you know about the Medically Supervised Injecting Room (MSIR) trial being undertaken by the Victorian government?

Please select one response

8

1. Yes
2. No
97. Don't know (DNRO)
99. Prefer not to answer (DNRO)

ASK IF Q11=CODE 1, OE

Q11A. Do you know the location of the Medically Supervised Injecting Room (MSIR) trial?

-
97. Don't know (DNRO)
99. Prefer not to answer (DNRO)

ASK ALL, SR, RO

Q12. Do you agree or disagree with the idea of Medically Supervised Injecting Rooms generally?

Please select one response

1. Strongly Agree
2. Agree
3. Neither agree nor disagree
4. Disagree
5. Strongly Disagree
97. Don't know (DNRO)
99. Prefer not to answer (DNRO)

ASK ALL, SR, RO

Q13. Do you agree or disagree with having a Medically Supervised Injecting Room in North Richmond?

Please select one response

1. Strongly Agree
2. Agree
3. Neither agree nor disagree
4. Disagree
5. Strongly Disagree
97. Don't know (DNRO)
99. Prefer not to answer (DNRO)

ASK ALL, OE

Q14. Do you have any further comments you would like to make about the Medically Supervised Injecting Room trial?

-
99. Prefer not to answer (DNRO)

ASK ALL, OE

Q15. Do you have any further comments you would like to make about drug-related activity in your local area?

9

99. Prefer not to answer (DNRO)

DEMOGRAPHIC QUESTIONS

ASK ALL, OE-NUM (18-100),

Q16. How old were you on your last birthday?

ASK ALL, SR

Q17. What is your sex?

1. Male
2. Female
3. Other

99. Prefer not to answer (DNRO)

ASK ALL, SR

Q18. Are you a parent or guardian of any children?

1. Yes
2. No

99. Prefer not to answer (DNRO)

ASK IF Q18=CODE 1, OE-NUM (1-99)

Q18A. How many children do you have?

99. Prefer not to answer (DNRO)

ASK IF Q18=CODE 1, SR, [Repeat as necessary for each child, cap at 5], RO

Q18B. How old is your child? If Q18A CODE=1

Q18B. How old are your children? If Q18A CODE>1

Please select one response

1. 0-6 years
2. 7-13 years
3. 14-18 years
4. Over 18 years

99. Prefer not to answer (DNRO)

ASK ALL, SR

Q19. Do you, or your children, currently attend the North Richmond Community Health Centre? If Q18 CODE=1

10

Q19. Do you currently attend the North Richmond Community Health Centre? If Q18 CODE≠1

Please select one response

1. Yes
2. No
97. Don't know (DNRO)
99. Prefer not to answer (DNRO)

ASK ALL, SR, RO

Q20. How would you describe your current employment status?

Please select one response

1. Employed full-time
2. Employed part-time
3. Unemployed
4. Home Duties
5. Student and working
6. Student and not working
7. Retired
8. Unable to work due to health problems
99. Prefer not to answer (DNRO)

ASK ALL, SR, RO

Q21. What is the highest level of education you have completed?

Please select one response

1. Never attended school
2. Some primary school completed
3. Completed primary school
4. Some high school
5. Year 10
6. Year 12
7. TAFE Certificate or Diploma
8. University
9. CAE or some other tertiary institute degree or higher
99. Prefer not to answer (DNRO)

ASK RESIDENT RESPONDENTS ONLY, SR, RO

Q22A. How long have you lived in this area?

Please select one response

1. Less than 2 months
2. 2 to 6 months
3. 7 months to 12 months (1 year)
4. 13 months to 24 months
5. 25 months to 5 years
6. More than 5 years
7. More than 10 years
8. More than 20 years
97. Don't know (DNRO)
99. Prefer not to answer (DNRO)

11

ASK BUSINESS RESPONDENTS ONLY, SR, RO

Q22B. How long have you worked in this area?

Please select one response

1. Less than 2 months
2. 2 to 6 months
3. 7 months to 12 months (1 year)
4. 13 months to 24 months
5. 25 months to 5 years
6. More than 5 years
7. More than 10 years
8. More than 20 years
97. Don't know (DNRO)
99. Prefer not to answer (DNRO)

ASK BUSINESS RESPONDENTS ONLY, OE-NUM (0-7)

Q23. How many days a week do you work in this business?

-
97. Don't know (DNRO)
 99. Prefer not to answer (DNRO)

ASK BUSINESS RESPONDENTS ONLY, SR

Q24. Do you typically work during the day, night, or both?

Please select one response

1. Day
2. Night
3. Both day and night
99. Prefer not to answer (DNRO)

ASK ALL, SR

Q25. Were you born in Australia or overseas?

Please select one response

1. Australia
2. Overseas
99. Prefer not to answer (DNRO)

ASK IF 25 CODE=2, OE-NUM (1900-2018), RO

Q25. If you have lived in Australia for longer than one year, in what year did you first arrive?

-
97. Don't know (DNRO)
 99. Prefer not to answer (DNRO)

ASK ALL, SR

12

26. ASK RESIDENT RESPONDENTS ONLY, SR

[Interviewer note: refer respondents to the map of SA1s and ask if it's ok to record the "area where they live" along with their responses. Note: Only go into the technical detail of the "census area" if necessary. Technical detail as follows: 'A census collection district is the smallest geographic area used by the census/ABS to collect information about the population. Each district has approximately 400 people, so we won't be able to identify you or where you live on the basis of this code. It simply allows the researchers to understand how the experiences of people in this area might differ from people in other areas.']

Would you consent to me recording the area where you live along with your survey responses?

1. Yes
2. No

26. ASK BUSINESS RESPONDENTS ONLY, SR

Would you consent to me recording the area where you work along with your survey responses?

1. Yes
2. No

THANK AND CLOSE

That's it. Thank you so much for taking part in our survey today!

As I mentioned at the start of the survey, this survey is an initiative of the Victorian Department of Health and Human Services who have engaged us (Colmar Brunton and Q&A Market Research) to conduct the interviews.

The information you have provided will be used only for research purposes and your answers will be combined with those of other participants to inform policy, planning and research. Your answers will remain completely anonymous and all information provided will remain confidential.

As I mentioned, we are conducting this survey on behalf of the Victorian Government Department of Health and Human Services. If you have any queries regarding this survey, you can call the Victorian Government Contact Centre on 1300 366 356.

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6.3. Appendix C – Participant Information Materials

6.3.1. Participant Information Form

What steps do we take to protect the privacy and confidentiality of the information you provide?

Your privacy is important to us and we take it seriously. In order to carry out this study effectively, the Department of Health and Human Services has engaged research agency Colmar Brunton to collect personal information about you. Questions regarding this study can be directed to Kirstin Couper at Kirstin.Couper@colmarbrunton.com or by calling the Victorian Government Contact Centre on 1300 366 356 (then select menu option 1).

- There are a number of laws¹ that apply to the collection and use of personal information as part of the study with which the Department of Health and Human Services must comply.
- An accredited Human Research Ethics Committee has approved the study (including any changes) and needs to be satisfied that the study is conducted in a way that protects your privacy, as required by these laws.
- The Ethics Committee also deals with any concerns that a member of the public may have before or after participating in the study.

This study adheres to the Guidelines of the ethical review process of The University of Queensland and the *National Statement on Ethical Conduct in Human Research*. Whilst you are free to discuss your participation in this study with project staff (contactable on 1300 366 356), if you would like to speak to an officer of the University not involved in the study, you may contact the Ethics Coordinators on +617 3365 3924 / +617 3443 1656 or email humanethics@research.uq.edu.au.

- Your participation in the study is *voluntary*. There are no consequences associated with not taking part in the study. You do not have to give a reason for not participating in the study.
- If you decide to take part in the study, you can choose not to answer a particular question if you do not wish to do so. You do not have to give a reason for not answering a question.
- The Ethics Committee pays particular attention to how your personal information (name and telephone number and your address if relevant) and study responses are stored during the study period and how the information collected is stored and used after all the interviews are completed.
- While the study is being conducted by Colmar Brunton (on behalf of the Department of Health and Human Services), your study responses and personal information are stored in password-protected files.
- At the end of the study period, Colmar Brunton is required to delete your name and telephone number (and where relevant your address) and only information you have provided in answering the study questions is kept. This information is added to the information provided by other participants and forwarded to the Department of Health and Human Services for analysis.

¹ These laws include but are not limited to: the *National Health and Medical Research Council Act 1992* (Commonwealth), the *Health Records Act 2001* (Victoria), the *Privacy and Data Protection Act 2014* (Victoria), the *National Statement of Ethical Conduct in Research Involving Humans* and the *Statutory Guidelines on Research under the Health Records Act 2001* (Victoria).

What happens to the data?

The Department of Health and Human Services is the data custodian for the data from the study. It is the duty of the custodian to ensure that the data are used responsibly and respectfully, and that privacy is safeguarded.

The department's privacy policy is available from the Department of Health and Human Services website:

<https://www.dhhs.vic.gov.au/privacy>

Further information

Centre for Evaluation and Research

Department of Health and Human Services

GPO Box 4057, Melbourne VIC 3001

Vietnamese

Nếu quý vị cần thông dịch viên, xin hãy gọi cho Dịch vụ Thông Phiên dịch Quốc gia (TIS Quốc gia) theo số 131 450 và yêu cầu họ gọi cho (Victorian Government Contact Centre) theo số (1300 366 356). Giờ làm việc của chúng tôi là (8:30am to 5:00pm Monday to Friday, except for Public Holidays).

Cantonese

若你需要口譯員，請撥打TIS National電話131 450並請他們轉接 (Victorian Government Contact Centre) 的電話 (1300 366 356)。我們的工作時間是 (8:30am to 5:00pm Monday to Friday, except for Public Holidays)。

Mandarin

如果您需要口譯員，請撥打TIS National 的電話131 450，請他們打電話 給(Victorian Government Contact Centre)，電話號碼：(1300 366 356)。我們的營業時間是 (8:30am to 5:00pm Monday to Friday, except for Public Holidays)。

Greek

Αν χρειάζεστε διερμηνέα, καλέστε την TIS National στο 131 450 και ζητήστε να καλέσουν το (Victorian Government Contact Centre) στον αριθμό (1300 366 356). Οι ώρες λειτουργίας μας είναι (8:30am to 5:00pm Monday to Friday, except for Public Holidays).

Hakka

如果您需要口譯員，請撥打TIS National 的電話131 450，請他們打電話 給(Victorian Government Contact Centre)，電話號碼：(1300 366 356)。我們的營業時間是 (8:30am to 5:00pm Monday to Friday, except for Public Holidays)。

To receive this publication in an accessible format phone 9096 5286, using the National Relay Service 13 36 77 if required.

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6.3.2. Participant Approach Letter (Residents)

Dear Householder

Monitor of community attitudes to drug activity in the inner-eastern area of Melbourne

The Department of Health and Human Services has engaged Colmar Brunton to conduct a survey about community attitudes to drug activity in the inner-eastern area of Melbourne that are of public interest and for research purposes only. It is expected that this knowledge will inform policy, planning and research.

The survey involves answering some general questions about yourself as well as some questions relating to drug activity in your area. The survey will take approximately ten minutes to complete. Questions regarding this survey can be directed to Kirstin Couper at Kirstin.Couper@colmarbrunton.com or by calling the Victorian Government Contact Centre on 1300 366 356 (then select menu option 1).

Participants will remain completely anonymous and all information provided will remain confidential. In addition, data collected through this survey will be analysed and reported in group form only and, therefore, no personal information will be identifiable in the results of the study. Your participation is also completely voluntary. By completing this questionnaire, you are expressing your consent to participate. However, you are free to withdraw from the questionnaire at any time.

The study is being conducted in accordance with the National Health and Medical Research Council Act 1992 (Commonwealth), the Health Records Act 2001 (Victoria), the Privacy and Data Protection Act 2014 (Victoria) and the Statutory Guidelines on Research under the Health Records Act 2001 (Victoria). The study also complies with the Department of Health and Human Services' Privacy Policy which is available at: <https://www.dhhs.vic.gov.au/privacy>. An information brochure that explains the steps taken to safeguard your privacy is attached to this letter.

This study adheres to the Guidelines of the ethical review process of The University of Queensland and the National Statement on Ethical Conduct in Human Research. Whilst you are free to discuss your participation in this study with project staff (contactable on 1300 366 356), if you would like to speak to an officer of the University not involved in the study, you may contact the Ethics Coordinators on +617 3365 3924 / +617 3443 1656 or email humanethics@research.uq.edu.au.

Thank you for your assistance. Your participation in this survey is important in helping to inform policy, planning and research.

Yours sincerely



Kirstin Couper, Research Director

06/06/2018

Vietnamese

Nếu quý vị cần thông dịch viên, xin hãy gọi cho Dịch vụ Thông Phiên dịch Quốc gia (TIS Quốc gia) theo số 131 450 và yêu cầu họ gọi cho (Victorian Government Contact Centre) theo số (1300 366 356). Giờ làm việc của chúng tôi là (8:30am to 5:00pm Monday to Friday, except for Public Holidays).

Cantonese

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Mandarin

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Greek

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Hakka

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6.3.3. Participant Approach Letter (Businesses)

Dear Sir/Madam

Monitor of community attitudes to drug activity in the inner-eastern area of Melbourne

The Department of Health and Human Services has engaged Colmar Brunton to conduct a survey about community attitudes to drug activity in the inner-eastern area of Melbourne that are of public interest and for research purposes only. It is expected that this knowledge will inform policy, planning and research.

The survey involves answering some general questions about yourself and the business you work in, as well as some questions relating to drug activity in your area.. The survey will take approximately ten minutes to complete. Questions regarding this survey can be directed to Kirstin Couper at Kirstin.Couper@colmarbrunton.com or by calling the Victorian Government Contact Centre on 1300 366 356 (then select menu option 1).

Participants will remain completely anonymous and all information provided will remain confidential. In addition, data collected through this survey will be analysed and reported in group form only and, therefore, no personal information will be identifiable in the results of the study. Your participation is also completely voluntary. By completing this questionnaire, you are expressing your consent to participate. However, you are free to withdraw from the questionnaire at any time.

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Thank you for your assistance. Your participation in this survey is important in helping to inform policy, planning and research.

Yours sincerely



Kirstin Couper, Research Director

06/06/2018

Vietnamese

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Mandarin

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Greek

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Hakka

如果您需要口译员，请拨打TIS National 的电话131 450，请他们打电话 给(Victorian Government Contact Centre)，电话号码： (1300 366 356)。我们的营业 时间是 (8:30am to 5:00pm Monday to Friday, except for Public Holidays)。

6.3.4. Call Back Card (Residents)

Have Your Say

Survey of community attitudes to drug activity in your local area

We visited today to ask you if you were willing to participate in a survey of community attitudes to drug activity in your area. Sorry we missed you. It will be possible to complete the 10 minute survey with an interviewer in English / Mandarin or Cantonese / Greek / Vietnamese / Hakka. If you would like more information or to arrange a time to participate by phone, please call 1300 366 356.

Thank you for your assistance.

Mandarin

我们今天拜访过您，问您是否愿意参加社区对您所在地区毒品活动的态度调查。很抱歉我们当时错过了您的意见。

之后我们可以安排一位普通话调查员与您完成这个10分钟的采访调查。如果您想获得更多信息或者另外安排一个时间电话参与调查，请致电1300 366 356。

感谢您的协助。

Cantonese

我們今天拜訪過你，問您是否願意參加社區對你所在地區毒品活動的態度調查。很抱歉我們當時錯過了你的意見。

之後我們可以安排一位粵語調查員與你完成個10分鐘的採訪調查。如果你想獲得更多資訊或者另外安排一個時間電話參與調查，請致電1300 366 356。

感謝你的協助。

Greek

Σας επισκεφτήκαμε σήμερα για να σας ρωτήσουμε αν ήσασταν πρόθυμοι να συμμετάσχετε σε μια έρευνα της στάσης της Κοινότητας στη δραστηριότητα των ναρκωτικών στην περιοχή σας. Δυστυχώς δεν σας βρήκαμε.

Είναι δυνατόν να ολοκληρωθεί η έρευνα 10 λεπτών με μια συνέντευξη στα Ελληνικά. Αν επιθυμείτε περισσότερες πληροφορίες ή για να κανονίσουμε μια ώρα για να συμμετεχετε από το τηλέφωνο, παρακαλώ καλέστε στο 1300 366 356. Σας ευχαριστούμε για τη βοήθειά σας.

Vietnamese

Chúng tôi đã đến thăm hôm nay để hỏi bạn có sẵn sàng tham gia vào một cuộc khảo sát về thái độ của cộng đồng đối với hoạt động ma túy trong khu vực của bạn hay không. Xin lỗi, chúng tôi không thấy bạn ở nhà. Bạn có thể hoàn thành bản khảo sát (chỉ là 10 phút) với người phỏng vấn bằng tiếng Việt. Nếu bạn muốn biết thêm thông tin hoặc sắp xếp thời gian để tham gia qua điện thoại, xin gọi số 1300 366 356. Cảm ơn sự giúp đỡ của bạn.

Hakka

我们今天拜访过您，问您是否愿意参加社区对您所在地区毒品活动的态度调查。很抱歉我们当时错过了您的意见。

之后我们可以安排一位普通话调查员与您完成这个10分钟的采访调查。如果您想获得更多信息或者另外安排一个时间电话参与调查，请致电1300 366 356。

感谢您的协助。

6.4. Appendix D – Codeframes

Table 10: Codeframes for S3, Q7B, Q8, Q11A, Q14 and Q15

Codeframes
S3 - What is your position in this business? SR
Owner
Manager
Employee (not manager)
Q7B - Thinking about the last time someone approached you on a street in your local area to sell you drugs, what type of drugs were you offered? MR
MDMA/Ecstasy
Heroin
Ice/Crystal Meth
Cannabis/Marijuana
Cocaine
Cigarettes/Tobacco
Other drug
Unsure of type/didn't specify
Q8 - What, if anything, concerns you about drug-related activity in your local area? MR
Violence and crime (e.g. theft, burglary, property damage)
Safety concerns for children (own children)
Safety concerns for children (general & school)
Safety concerns for self and others
Safety concerns for drug users
Unpredictability of drug users
Aggressiveness of users (e.g. aggressiveness, yelling)
Discarded syringes in public spaces (e.g. being injured by needle, fear of injury, general discomfort with waste)
Public visibility of drug use/drug deals
Lack of Government regulation / police presence
Bad for business
Begging (e.g. money, cigarettes, food)
General concern about MSIR
Spread of infectious diseases
Normalisation of drug use
Other
No concerns

Table 10: Codeframes for S3, Q7B, Q8, Q11A, Q14 and Q15

Codeframes
Q11A - Do you know the location of the Medically Supervised Injecting Room (MSIR) trial? SR
Exact (building or street, or surrounding area)
Approximate (suburb, or nearby streets, vague explanation of health centre/school)
Incorrect
Q14 - Do you have any further comments you would like to make about the Medically Supervised Injecting Room trial? MR
Negative comments
General negative opinion
Normalisation of drug use
MSIR should not be located near school/near children
MSIR should not be located near residential / community areas
MSIR should be located near a hospital
Increase drug-related activity in area (use and dealing)
Safety concerns
Need to ensure increased security/police presence
Not enough consultation with community
Zero tolerance approach preferred
Other harm minimisation approach preferred (e.g. rehab, education)
Non-endorsement of Ice use in MSIR
MSIR should be in a different location (unspecified)
MSIR will not help/only a short term solution
MSIR is politically motivated/driven
Other negative comment
Affirmative comments
General support for MSIR
Saves lives of users
Reduce spread of infectious diseases
Get drug users off the street
Increased safety for community (e.g. reduced syringe waste, reduced anti-social behaviour in public space, reduced crime)
Recommend introduction of multiple MSIR's
Other positive comment
Neutral comments
No comment
Other neutral comment

Table 10: Codeframes for S3, Q7B, Q8, Q11A, Q14 and Q15

Codeframes
Q15 - Do you have any further comments you would like to make about drug-related activity in your local area? MR
More security in local area (e.g., police presence, security cameras)
Need for rehabilitation services/support services
Concern about MSIR proximity to school/children
Zero tolerance approach preferred
Need for further government and council intervention (e.g. clean up the area, more community consultation)
Need to reduce crime rates
Legalise marijuana use
Public visibility of drug use/drug deal
Safety concerns for children (own children and general youth)
Safety concerns for self and others
Increase drug-related activity in area (use and dealing)
Unpredictability of drug users
Aggressiveness of users (e.g. aggressiveness, yelling)
Public visibility of drug affected individuals
Drug use is a big problem
Wants drug use to stop
Cannot stop drug use
Difficult to fix the problem
Support for MSIR
Other comment
No further comment

6.5. Appendix E – Escalation Procedure

There are four separate escalation procedures that should be adhered to, in the event any of these situations arise throughout data collection. They are:

- (i) Requests for more information about the survey or complaints about the survey.
- (ii) Requests for information about the Safe Injecting Room or complaints about the Safe Injecting Room.
- (iii) Duty of care protocol for distressed respondents (or other household members).
- (iv) Interviewer safety when in housing estate

Requests for more information about the survey or complaints about the survey.

If a respondent would like further information about the survey or if they have complaints about the survey, interviewers should recommend the respondent calls the Victorian Government Contact Centre on 1300 366 356 to log their query or complaint.

Requests for information about the Safe Injecting Room or complaints about the Safe Injecting Room.

If a respondent requests further information about the Safe Injecting Room or complains about the Safe Injecting Room, interviewers should recommend the respondent calls the Victorian Government Contact Centre on 1300 366 356 for more information.

Duty of care protocol for distressed respondents (or other household members).

If a respondent (or other household member present at the time of the interview) becomes distressed at any time during the interview process, the interviewer may rely on the following script.

'I am sorry you are going through a hard time. You could try discussing your concerns with staff at Lifeline or Beyondblue. You can have a confidential chat with a person who is specially trained in supporting people who are going through a tough time. Numbers to call are:

Lifeline. (<https://www.lifeline.org.au/>). Phone: 13 11 14

Beyondblue. (<https://www.beyondblue.org.au/>). Phone: 1300 224 636'

Interviewer safety when in housing estate

Before collecting data in the housing estates, it is important that the Housing Office is notified in advance and that your name and contact details are provided to the Office ahead of time. Before starting the shift in the housing estate, you must sign in at the Housing Office.

If at anytime you feel unsafe – you should contact the security control room on **9428 9725** and they will be able to assist you.

6.6. Appendix F – Methods to Ensure Data Quality

Project-based quality assurance

CBSR's philosophy is to work as a team with our clients. An important element of such a relationship is to seek input and feedback from our clients throughout a project. This enables any potential issues to be dealt with collaboratively and early on, preventing them from becoming major problems. To supplement this process and enable formal tracking of their views, clients are sent a feedback form after the completion of each project, in which to record their satisfaction with the implementation and outcomes of the project and the research consultants who worked with them on it. These forms are monitored, and targets (such as overall satisfaction with the project) are set at both an individual and office level.

Our research executives are members of the Australian/New Zealand Market Research Society and are signatories to the Code of Ethics of our industry. Moreover, Colmar Brunton is a founding member of the Association of Market and Social Research Organisations (AMSRO). Colmar Brunton endorses and fully supports AMSRO aims.

Privacy issues and data security

We are required to work in accordance with the ESOMAR International Code of Conduct for Market Research, the Australian Market & Social Research Privacy Principles (which subsume the National Privacy Principles) and the AMSRS Code of Professional Behaviour, to which our researchers are signatories.

At all times, we respect the confidentiality of our informants and our clients. We therefore guarantee this confidentiality according to our industry standards and the Department's privacy legislation. In particular, confidentiality provisions apply to the supply of unit record data.

In addition, we accept that CBSR, if commissioned, will be bound by Public Service regulations with respect to confidentiality. We recognise that all information gathered in relation to the project is the property of the Department. We recognise that we are not at liberty to disclose any related information to any other party.

Quality assurance accreditations

Colmar Brunton puts a real and applied focus on quality.

- ▶ We have a QMS system in place and have ISO 20252 accreditation.
- ▶ We abide by the AMSRS Code of Professional Behaviour and Privacy Principles; and
- ▶ We have created a position in our company dedicated to keeping up to date with best practice in research and providing internal systems that facilitate quality management.

The current status of our ISO 20252 accreditation process is in the table below.

Office	Audit Status
Canberra	Passed Audit April 2009
Brisbane	Passed Audit April 2009
Adelaide	Passed Audit April 2009
Sydney	Passed Audit June 2009
Melbourne	Passed Audit June 2009

6.7. Appendix G - Quality Assurance

Colmar Brunton is committed to helping its clients achieve and sustain market success by providing superior market research and strategic direction.

A critical foundation of our commitment to our clients is the implementation of Quality Assurance in all relevant areas of its operations. We have implemented and achieved certification for our **Quality Management System AS-ISO 20252** for all areas of our operations.

Colmar Brunton (and its field company, Your Source) also operates under the Australian Market & Social Research Society (AMSRS) Professional Code of Behaviour and the Market & Social Research Privacy Principles administered by the Association of Market & Social Research (AMSRO) Secretariat.

In accordance with our Quality Management System (QMS) this proposal has been reviewed and approved by:

NAME	David Spicer
ROLE	Research Director Colmar Brunton

DATE	5 th December 2019
Document version	1.0

All methodologies and findings outlined in this proposal are provided solely for use by the client.
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In accordance with Article 15 of the ICC/ESOMAR International Code of Marketing Research, this document remains the property of Colmar Brunton and unless commissioned, its contents shall not be communicated from one Researcher to another Researcher

Appendix H: MSIR Review Community Survey wave two



Technical Report

Review of the Trial of the Medically Supervised Injecting Room, Survey of Residents and Businesses, Wave II.

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1. Executive summary

This technical report provides an overview of the research design, methodology and data preparation processes employed for the Review of the trial of the Medically Supervised Injecting Room (MSIR), Survey of Residents and Businesses, Wave II (hereafter referred to as the MSIR Survey of Residents and Businesses). The study is an initiative of the Victorian Government Department of Health and Human Services (the department).

In May 2019, the department contracted independent social research agency Colmar Brunton to conduct the Data Collection component of the MSIR Survey of Residents and Businesses. Colmar Brunton engaged Q&A Market Research as a sub-contractor to conduct the fieldwork for the project.

The purpose of the MSIR Survey of Residents and Businesses was to collect representative data on the experiences and attitudes of the community within a defined geographical area surrounding the MSIR, approximately one year following its operational commencement. The survey covered topics including: witnessing public injecting; discarded needles and syringes; being offered drugs for purchase; experiences of drug activity; and attitudes towards the MSIR. The survey was administered to community members who live in the local area (resident survey) and community members who work in the local area (business survey). The methodology was designed to ensure that the sample was representative of the local community.

The aim was to survey a representative sample of 500 residents and 300 businesses within a predefined geographical area surrounding the MSIR approximately one year following its operational commencement. A total of $n = 844$ community members completed the survey ($n = 543$ residents; and $n = 301$ businesses).

2. Background

The Victorian Government is committed to addressing drug problems within the state of Victoria. Forming part of this commitment, the Government's Drug Rehabilitation Plan will invest \$87 million to address drug harms, including 100 new rehabilitation beds, trialling a medically supervised injecting centre and boosting training in the alcohol and other drug workforce.

The Drug Rehabilitation Plan includes a trial of a medically supervised injecting room at North Richmond Community Health. The Drugs, Poisons and Controlled Substances Amendment (Medically Supervised Injecting Centre) Act 2017 allows for the licence of a Medically Supervised Injecting Room trial for a two year period. The objects of the Act are:

(a) to reduce the number of avoidable deaths and the harm caused by overdoses of drugs of dependence;

(b) to deliver more effective health services for clients of the licensed medically supervised injecting centre by providing a gateway to health and social assistance which includes drug

treatment, rehabilitation support, healthcare, mental health treatment and support and counselling;

(c) to reduce attendance by ambulance services, paramedic services and emergency services and attendances at hospitals due to overdoses of drugs of dependence;

(d) to reduce the number of discarded needles and syringes in public places and the incidence of injecting of drugs of dependence in public places in the vicinity of the licensed medically supervised injecting centre;

(e) to improve the amenity of the neighbourhood for residents and businesses in the vicinity of the licensed medically supervised injecting centre; and

(f) to assist in reducing the spread of blood borne diseases in respect of clients of the licensed medically supervised injecting centre including, but not limited to, HIV and hepatitis C.

An independent panel, supported by the department, is conducting a review of the MSIR to inform potential extension of the trial period. One of the components of the review is the MSIR Survey of Residents and Businesses.

On the 23rd of May, the department contracted independent social research agency Colmar Brunton to conduct the data collection component of Wave II of the MSIR Survey of Residents and Businesses. Colmar Brunton engaged Q&A Market Research as a sub-contractor to conduct the fieldwork for the project.

The purpose of the MSIR Survey of Residents and Businesses was to collect data on the experiences and attitudes of a representative sample of the community, approximately one year into the MSIR trial and to ensure that this data is comparable to baseline data captured prior to the commencement of the trial. The survey covered topics including: witnessing public injecting; discarded needles and syringes; being offered drugs for purchase; experiences of drug activity; and attitudes towards the MSIR.

3. Methodology

The methodology for Wave II of the MSIR Survey of Residents and Businesses was designed by the department. The sampling approach was co-designed by the department, Colmar Brunton and Q&A Market Research. A summary of the method is provided below.

3.1. Preparation

3.1.1. Scoping

The initial scoping session was held on the 30th of May, 2019. Emily Bariola represented Colmar Brunton at this meeting. Josephine Norman, Katherine Scarcebrook and Shannon Fox attended from the department. Paul Hoyer attended from Q&A Market Research.

The following topics were covered during the scoping meeting:

- Confirmation of the objectives of the survey;
- Roles of individuals in Colmar Brunton, Q&A Market Research and the department's project teams;
- Confirmation of the project schedule;
- Confirmation of the participant communication material;
- Confirmation of the methodology including the sampling, recruitment, face-to-face fieldwork and computer-assisted telephone interviewing (CATI) fieldwork;
- Discussion of the ethics application process;
- Discussion of the fieldwork briefing agenda;
- The setup of an online portal to provide real-time updates of fieldwork progress; and
- Reporting requirements.

3.1.2. Ethics approval

An ethics application for this study was submitted to The University of Queensland Human Research Ethics Committee (HREC). Approval was obtained on 19th of June 2019 (approval number: 2019001002). The department managed this process and were responsible for providing updates to the committee when required.

3.1.3. Sampling

The study population parameters consisted of the boundaries of 26 Statistical Area Level 1s (SA1s), confined to the Melbourne suburbs of Richmond, Abbotsford and East Melbourne (refer to Table 1). These parameters approximated a 500m radius of the location of the MSIR (North Richmond Community Health, 23 Lennox Street, Richmond). A graphical representation of the sampling frame is displayed below in Figure 1.

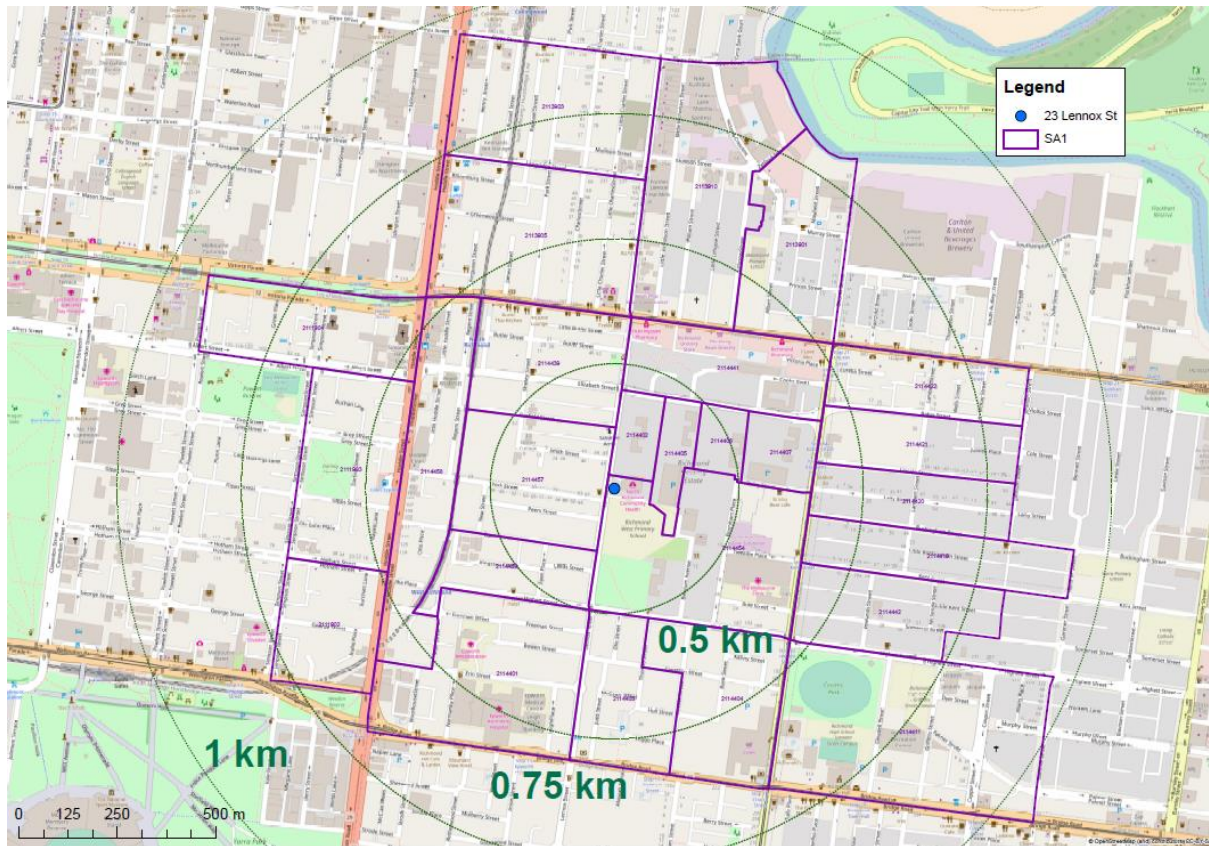


Figure 1: MSIR Survey of Residents and Businesses sampling frame.

Sampling for the resident survey

Household selection

The total count and proportion of private dwellings in each SA1 are listed below in Table 1. This population data was sourced from the Australian Bureau of Statistics (ABS), 2016 Census. The total number of eligible households within the sampling frame was $N = 6,208$.

In preparation for the fieldwork for the first wave of this study (2018), Q&A Market Research fieldwork officers conducted a residential address indexation exercise. This involved physically walking the streets of the sample frame and logging all discoverable and accessible households into an electronic database to be used during fieldwork. This data was made available for the conduct of the second wave of the study.

Minimum quota targets were set for each SA1. Quotas for each SA1 were determined according to population data at the household level (ABS, 2016 Census). Minimum quota targets are listed in Table 1. Total number of households to be approached in each SA1 was determined by multiplying each SA1 quota target by 5. A factor of 5 was selected as it was determined that an average of 5 households would need to be approached in order to achieve a completed survey (based on response rates achieved in the first wave of the study). In wave 2, these numbers were sufficient in achieving quota targets in all SA1s with the exception of two SA1s: 2114459 (required a factor of 8) and 2114419 (required a factor of 7).

Then, using a geo-mapping tool, a number of start points (i.e. the first addresses to be approached in each SA1) were randomly selected in each SA1. The number of start points (and subsequently the number of runs¹ per SA1) were determined according to the size of the SA1 (i.e. the more households in the SA1 – the more start points were selected). A single address was never included in more than one run. Start points that resulted in a high degree of overlap were discarded (thus preventing clustering of participating households). The number of start points ranged between 2 and 4 across the SA1s. From each start point, run sheets were drawn and each household to be approached was selected using the right shoulder to the curb approach² and every n th household was selected. The value of n was determined according to the number of accessible households identified in the address indexation exercise in each SA1. n ranged between 2 and 4 across the SA1s, with a higher n for SA1s where more households were accessible.

The run sheets excluded premises determined to be non-eligible (i.e. commercial properties, vacant properties and inaccessible properties). All residences were attempted in the order of the run sheets. Each selected household was approached up to three times, depending on the conversion rate in that particular SA1. In the event of a high conversion rate, each household would need to be approached only one time (in some instances a household may not be approached at all if the conversion rate was high). If residents were not home at the point of initial contact, a calling card was left to allow the residents to initiate contact.

Fieldwork shifts were allocated to ensure good representation across each SA1. Fieldwork shifts were divided into 2-3 hour blocks, with one SA1 run per block. For the next 2-3 hour block of fieldwork, the team would progress to a new run within the same SA1, or to a different SA1 altogether, and so on until they finished their shift. The time of day and day of the week (weekday/weekend) of the visits were staggered for subsequent allocation (i.e. subsequent visits) of the same SA1. Each SA1 was visited between five and six times during fieldwork. On return visits to SA1s, fieldworkers would attempt second calls (i.e. visits) within the run before continuing to approach addresses from the end point of the last visit to that SA1s run (as per the run sheets). Households that were left a calling card were also approached subsequent times. Each household was visited up to three times, unless the quota for the SA1 was already achieved.

Minimum target quotas that were set by SA1 relative to household-level population data were monitored closely to ensure proportionate representation was achieved. Minimum quota targets were achieved for each SA1.

This sampling approach allowed us to achieve a representative sample of the community according to age, gender, country of birth and location/SA1. As the sample is proportionately representative by key demographic variables, we are able to conclude that the data is representative of the views of the community as a whole.

¹ A run refers to a discrete selection of households within an SA1. Households within a run are approached consecutively to participate in the study.

² The interviewer commenced at their start point and then progressed with their right shoulder to the curb and their left shoulder to the road. This determines direction of fieldwork.

Table 1. Count and proportion of private dwellings and businesses in sample universe.

SA1	Private dwellings - population ^a		Private dwellings – quota targets		Businesses - population ^b	
	Count	Proportion of total	Count	Proportion of total	Count	Proportion of total
2114402	199	3.2%	16	3.2%	0	0.0%
2114405	171	2.8%	14	2.8%	0	0.0%
2114406	196	3.2%	16	3.2%	1	0.1%
2114407	189	3.0%	15	3.0%	0	0.0%
2114454	285	4.6%	23	4.6%	97	9.8%
2114404	475	7.7%	39	7.7%	25	2.5%
2114403	356	5.7%	29	5.7%	24	2.4%
2114401	187	3.0%	15	3.0%	98	9.9%
2114459	158	2.5%	13	2.5%	7	0.7%
2114457	536	8.6%	43	8.6%	14	1.4%
2114458	184	3.0%	15	3.0%	55	5.6%
2114439	146	2.4%	12	2.4%	84	8.5%
2114441	339	5.5%	28	5.5%	86	8.7%
2111902	265	4.3%	22	4.3%	28	2.8%
2111903	214	3.4%	17	3.4%	11	1.1%
2111904	122	2.0%	10	2.0%	31	3.1%
2113910	223	3.6%	18	3.6%	64	6.5%
2113901	126	2.0%	10	2.0%	71	7.2%
2114422	130	2.1%	11	2.1%	53	5.4%
2114421	160	2.6%	13	2.6%	27	2.7%
2114420	189	3.0%	15	3.0%	9	0.9%
2113905	269	4.3%	22	4.3%	109	11.1%
2113903	368	5.9%	30	5.9%	33	3.3%
2114411	248	4.0%	20	4.0%	25	2.5%
2114419	250	4.0%	20	4.0%	13	1.3%
2114442	223	3.6%	18	3.6%	21	2.1%
Total	6,208		500		986	

a. Data source: 2016 Census, ABS.

b. Data source: Discoverable businesses located within the sample frame. Refer to Sampling for Business Survey section of report for details.

Resident respondent selection

Respondents within an eligible household were selected using a conditional-replacement next-birthday method. This means that at the point of initial approach, the householder with the next birthday was invited to participate. In order for the next-birthday householder to participate, the following inclusion criteria must have been satisfied:

- They were contactable during the fieldwork period;
- They were aged 18 years or over;
- They had been living in the area for at least two months;
- They had the ability to participate in English or one of the five priority languages: Mandarin, Cantonese, Hakka, Vietnamese, or Greek; and
- They provided informed consent.

In the event that the next-birthday household member could not complete for any of these reasons, the person with the subsequent birthday was invited to participate. If the next-birthday person refused, the household was excluded from the sample and the next household in the run sheet was sampled.

Only a single person per household completed the survey. The target sample size for the resident sample was $n = 500$.

Sampling for the business survey

Business selection

The list of businesses used in the first wave of the study that had a call outcome that identified they were an active business and were in the target area (sample universe) were used this wave. A description of how this list of businesses were sourced is described in the Technical Report prepared for the first wave. As per the first wave of the study, the sample universe was confined to businesses located within the study population parameters (i.e. the 26 SA1s). Additional inclusion and exclusion criteria were then applied. Businesses located along Bridge Road and Wellington Parade were excluded, while businesses located on both sides of Victoria Street (between Powlett Street, SA1: 2111904; and Johnston Street, SA1: 2114422) were included. Upon applying these criteria, the list of discoverable business telephone numbers was 885.³ A further 53 discoverable businesses were added to this list. These were discovered via a comprehensive check of the Yellow Pages and an additional Google maps check. Additionally, during fieldwork, for all of the businesses that had a disconnected phone number, a secondary google maps review was conducted in order to identify new businesses at the address. As a result of this, an additional 48 numbers were added to the list. As a result of these inclusions, the total number of discoverable business numbers located within the sample frame was $N = 986$. The total count and proportion of discoverable business in each SA1 are listed above in Table 1.

Business respondent selection

³ The total number of discoverable businesses in 2018 was 890. 5 businesses were excluded because they were found to be closed.

Initially, a random sampling strategy was to be utilised for the business survey. However, throughout the field period, the sample was exhausted. As such, all discoverable businesses within the sampling frame were approached to participate in the survey ($N = 986$). Business respondents were approached to participate via telephone. In order for respondents to be selected, the following inclusion criteria must have been satisfied:

- They were contactable during the fieldwork period;
- They were aged 18 years or over;
- They had been working in the area for at least two months;
- They were a senior staff member (e.g. business owner or manager). If the business owner or manager were not available, the most senior staff member available at the time of the call was invited to participate;
- They had the ability to participate in English or one of the five priority languages: Mandarin, Cantonese, Hakka, Vietnamese, or Greek; and
- They provided informed consent.

Only a single person per business was invited to complete the survey. The target sample size for the business sample was $n = 300$.

3.1.4. Participation of people from non-English speaking backgrounds

The department identified five languages other than English that were most commonly spoken (based on lowest English proficiency) within the area that the survey was being conducted. They were Vietnamese, Cantonese, Mandarin, Greek and Hakka. In order to enable participation of people from non-English speaking backgrounds, the survey was translated into these five priority languages. Both the resident survey and the business survey were translated into the five priority languages.

Translated surveys were facilitated by the following ways:

On the occasion that a fieldworker approached a resident who had difficulty communicating in English, the fieldworker would directly ask whether they spoke English. If the resident's response was not in English, the fieldworker would probe further as to the resident's spoken language. If required, fieldworkers would also use translated cards in order to establish whether the resident spoke one of the five priority languages (these translated cards provided an introduction and a brief overview of the survey). If the resident did speak one of the priority languages, the fieldworker would show the respondent the translated survey preamble and they would gain consent at this point. If consent was established, the interviewer would hand the tablet to the participant and they would self-complete the survey.

For translated surveys completed via CATI, fieldworkers were typically advised by the gatekeeper (person that first answered the phone call) that the eligible respondent spoke a language other than English. The fieldworker would then arrange a call back appointment with an interviewer who speaks the priority language. Alternatively, the interviewer would tell the gatekeeper that they would call back at a later date and arrange for a foreign language interviewer to re-attempt the call, and subsequent recruitment process.

3.1.5. Data collection procedures

During the scoping stage, the methodology and data collection procedures were discussed with the department and the most suitable approach was agreed upon. The procedures for the resident survey and for the business survey are described below.

Data collection procedure for the resident survey

A total of 17 Q&A Market Research interviewers conducted the fieldwork for the resident survey (13 face-to-face interviewers and 4 telephone interviewers). Face-to-face fieldwork was conducted via household door knocking between the hours of 10am and 6pm on weekdays and 9am and 6pm on weekends. Fieldwork shifts were allocated across the 26 SA1s to ensure a relatively proportionate number of residents were able to complete the survey, relative to general population spread.

Fieldworkers conducted data collection in pairs (they attended households individually). Fieldworkers used a live call sheet loaded on an app (hard copies were available as well) to track recruitment. On the call sheet they were able to record the recruitment status of every household in the sampling frame (e.g. refusal, not eligible, inaccessible, non-contact, completed survey, unknown eligibility, etc).

Order of sampling per residence:

- Fieldworkers knocked on the door or pressed the intercom button of each private dwelling that was approached. Fieldworkers remained on the doorstep throughout all interactions with residents. At no point did fieldworkers cross the threshold.
- When a resident was available at the time of initial approach, the fieldworker would introduce themselves, and the study (refer to preamble to the survey in Appendix B). They would then screen for eligibility, as per the study inclusion criteria (described above in 3.1.3). If eligible, the resident would be invited to participate in the survey. All respondents were provided with the Participant Information Form (refer to Appendix C) prior to participating. Consent was obtained verbally and evidence of consent was recorded on the tablet and included in the final datafile.
- If contact was made but the eligible resident was unable to complete the survey at the time of initial approach, the fieldworker would collect the resident's contact name and number and arrange a re-appointment (either via call back to complete the survey via CATI or in person to complete the survey face-to-face at their door step).
- If no contact was made at the address, a call back card was left in the letter box (refer to Appendix C). Residents had the option of calling the Q&A Market Research survey hotline if they wished to participate in the survey. In the Housing Estate, call back cards were pushed under the door of households, as fieldworkers were not able to gain access to letterboxes. This approach was endorsed by the Richmond Housing Office.
- If fieldworkers were not able to do any of the steps listed above, the property was classified as inaccessible.

The survey was administered by one of three modes:

- **English, interviewer-administered, face-to-face, Computer-Assisted Personal-Interviewing (CAPI).** If the respondent was able to complete the survey at the time the fieldworker visited the household, and in English, then the survey was interviewer-administered, face-to-face. The fieldworker would read the survey text from a tablet and record the responses on the tablet.
- **One of the priority languages, self-administered, Computer-Assisted Self-Interviewing (CASI).** If the respondent was able to complete the survey at the time the fieldworker visited the household, was unable to complete the survey in English, but was able to complete the survey in one of the priority languages (Mandarin, Cantonese, Greek, Vietnamese or Hakka) - the survey was self-completed on the tablet.
- **English or one of the priority languages, Computer-Assisted Telephone Interviewing (CATI).** If a respondent indicated they would be willing to participate but they were unable to complete at the time the fieldworker visited the household, the fieldworker arranged a CATI call back. Surveys completed via CATI could be completed in English or in one of the priority languages.

Data collection procedure for the business survey

A total of 7 Q&A Market Research interviewers conducted the telephone interviewing for the business survey. Fieldwork was conducted between the hours of 9am and 5pm on weekdays. All discoverable businesses within the sampling frame were approached to participate in the survey.

Fieldworkers used a live call sheet to track recruitment. On the call sheet they were able to record the recruitment status of every business in the sampling frame (e.g. refusal, not eligible, non-contact, disconnected, completed survey, unknown eligibility, etc.).

Order of sampling per business:

- Interviewer called the business telephone number.
- If the call was answered, the interviewer would introduce themselves, and the study (refer to preamble to the survey in Appendix B). They would then screen for eligibility, as per the study inclusion criteria (described above in 3.1.3. Sampling). If eligible, the owner/employee would be invited to participate in the survey. If respondents requested further information about the study, they were sent the Participant Information Form (refer to Appendix C) via email. Consent was obtained verbally and evidence of consent was recorded and included in the final datafile.
- If contact was made and the respondent was not able to complete the survey at the time of the visit, the fieldworker would collect the owner/employee's contact name and arrange a call back.

3.1.6. Survey programming and testing

The department delivered a final survey instrument to Colmar Brunton on the 29th of May.

Colmar Brunton reformatted and edited the survey instrument to include instructions for survey scripting. The department reviewed this document, provided feedback and final approval on content. The final survey is appended to this report (refer to Appendix B).

The final version of the survey was then sent to Q&A Market Research analysts for the electronic survey build. All routing and validations were programmed into the electronic interface of the survey.

The survey tool was translated into five priority languages (Mandarin, Cantonese, Hakka, Vietnamese and Greek).

Once the survey had been programmed, a number of checks occurred prior to the commencement of fieldwork. The Q&A Market Research analyst who was responsible for the survey build conducted the first test and a Colmar Brunton researcher conducted a second test. Dummy datafiles were also checked to ensure all routing and filters were functioning as intended.

3.2. Data collection

3.2.1. Training the field team

Training the field team for the resident survey

A total of 13 Q&A Market Research interviewers conducted the face-to-face fieldwork for the Resident Survey. All fieldworkers had substantial experience in the conduct of social research fieldwork and all were accredited with The Australian Market & Social Research Society (AMSRS). The fieldwork team attended a face-to-face briefing at Colmar Brunton Melbourne office on the 4th of June, prior to the commencement of fieldwork. The briefing was facilitated by Paul Hoyer (Q&A Market Research) and Emily Bariola (Colmar Brunton), with assistance from Katherine Scarcebrook and Shannon Fox (from the department). A total of 10 face-to-face fieldwork interviewers attended the briefing session. Three face-to-face fieldwork interviewers did not attend the face to face briefing. They were given a full briefing by phone before commencing their first shift. They were also placed with an interviewer that had attended the briefing for their first shift. The fieldworkers who conducted the telephone interviews for the resident survey were also briefed separately.

The briefing provided an overview of the rationale for the trial, contextual information about the MSIR, the sampling approach, recruitment strategy, participant introductory script, the survey tool, ethical requirements, timelines, escalation processes and interviewer safety.

A detailed fieldwork protocol document was produced to ensure that members of the field team and supervisors had the required reference material.

Prior to the commencement of fieldwork, interviewers were provided with the following materials:

- Q&A Market Research ID on lanyard, to be worn at all times;
- A tablet (for survey administration) and portable battery charger;
- A map of the fieldwork area;
- Interview protocol;
- Survey tool (refer to Appendix B);
- Live contact sheet link (used to record contact/recruitment data); and
- Printed copies of the Call Back Card and Participant Information Form (refer to Appendix C).

Fieldworkers were encouraged to dress appropriately for cold weather and to carry a light if conducting fieldwork in the late afternoon/early evening.

In the event respondents requested further information about the survey or the MSIR, or had a complaint about the survey or the MSIR, interviewers were instructed to direct respondents to the Victorian Government Contact Centre.

The Richmond Housing Office was notified about the survey and approval to visit the Richmond Housing Estates. The Office was also provided with the names and phone numbers of the fieldworkers who were conducting the fieldwork in the Richmond Housing Estates. Interviewers were provided with the Security Control Room contact number and were instructed to call security should they feel unsafe at any time.

Colmar Brunton maintained regular contact with fieldwork supervisors throughout data collection in order to monitor progress of fieldwork and also provide support/advice to the field team, when required.

Training the field team for the business survey

A total of 7 Q&A Market Research interviewers conducted the CATI data collection for the business survey. As was the case for the face-to-face interviewers, all CATI interviewers who worked on this project had substantial experience in the conduct of social research fieldwork and all were accredited with the AMSRS. The fieldwork team and fieldwork supervisors dialled into a teleconference briefing on 11th July prior to the commencement of fieldwork for the business survey. The briefing was facilitated by Brodie Black and Heidi Berry (Q&A Market Research) and was also attended by Emily Bariola (Colmar Brunton) and Katherine Scarcebrook (DHHS). 3 business fieldwork interviewers initially attended the teleconference, 4 were subsequently briefed. The fieldworkers who conducted the telephone interviews for the resident survey were also briefed separately.

This briefing provided an overview of the rationale for the trial, contextual information about the MSIR, sampling approach, recruitment strategy, participant introductory script, the survey tool, ethical requirements, timelines and escalation processes.

A detailed fieldwork protocol document was produced to ensure that members of the field team and supervisors had the required reference material.

Prior to the commencement of fieldwork, fieldworkers were provided with the following materials:

- Interview protocol;
- Survey tool (refer to Appendix B);

- Live contact sheet link (used to record contact/recruitment data); and
- Electronic copies of the Participant Information Form (refer to Appendix C).

In the event respondents requested further information or wished to lodge a complaint about the survey or the MSIR, fieldworkers were instructed to direct respondents to the Victorian Government Contact Centre.

3.2.2. Recruitment

Recruitment for the resident survey

Fieldwork for the resident survey commenced on the 4th of July and ended on the 10th of August.

A total of $n = 543$ residents completed the survey. $n = 527$ respondents completed the survey face-to-face and $n = 16$ completed the survey via CATI (these respondents responded to the call back card that was left in their letter box). Average survey completion times were 10.7 minutes and 27.5 minutes for the surveys completed face-to-face and via CATI, respectively. Table 2 provides an overview of the recruitment outcomes for the resident survey.

Table 2: Resident survey recruitment outcomes.

Recruitment outcomes	Count	Proportion of population
Completed total (C)	543	8.7%
Completed face-to-face	527	8.5%
Completed CATI	16	0.3%
Non-contact (eligible, non-interview) total (NC)	0	0.0%
Refusal (eligible, non-interview) total (R)	191	3.1%
Other (eligible, non-interview) total (O)	286	4.6%
Other - language barrier	87	1.4%
Other - unable to complete due to illness or disability	2	0.0%
Other - broken appointment	58	0.9%
Other - other non-response	139	2.2%
Unknown eligibility, non-interview total (UE)	5,148	82.9%
Unknown eligibility - not attempted (selected)	132	2.1%
Unknown eligibility - not attempted (not selected)	3,205	51.6%
Unknown eligibility - inaccessible	199	3.2%
Unknown eligibility - received call back card ^a	1,612	26.0%
Not eligible, non-interview total	40	0.6%
Not eligible - out of sample (aged <18 years; lived in the area <2 months)	40	0.6%
Total population^b	6,208	
Response Rate (RR) - Proportion of cases interviewed of all eligible cases $C / (C) + (NC+R+O) + (UE)$	-	8.8%
Co-operation Rate (COOP) - Proportion of cases interviewed of eligible cases contacted $C / (C)+(R+O)$	-	53.2%
Refusal Rate (REF) - Proportion of eligible sample that refused $R / ((C)+(NC+R+O) + (UE))$	-	3.1%
Contact Rate (CON) - Proportion of eligible sample where a household was reached $(C+R+O) / (C+R+O+NC+UE)$	-	16.5%

- a. *Households that received a call back card in the letter box, but did not respond are included in this tally.*
- b. *Data source: Count of Private Dwellings, 2016 Census, Australian Bureau of Statistics (ABS).*

The overall response rate (proportion of cases interviewed of all eligible cases) for the resident survey was 8.8%. The co-operation rate (proportion of cases interviewed of eligible cases contacted) was 53.2%.

Several reasons for non-completion due to language barrier were recorded. It was noted that fieldworkers encountered individuals that spoke languages not covered by the survey methodology (i.e. other than English, Greek, Vietnamese, Hakka, Mandarin, Cantonese). It was also noted that some individuals who were from non-English speaking backgrounds had no/insufficient English to determine their language.

Recruitment for the business survey

Fieldwork for the business survey commenced on the 11th of July and ended on the 31st of July. A total of $n = 301$ respondents completed the business survey (all via CATI). The sample was exhausted, meaning all discoverable businesses were approached to participate. The average survey completion time was 10.7 minutes.

Table 3 provides an overview of the recruitment outcomes for the business survey. The overall response rate (proportion of cases interviewed of all eligible cases) for the business survey was 47.0%. The co-operation rate (proportion of cases interviewed of eligible cases contacted) was 71.7%.

Response rates for each sampling unit (SA1)

Response rates for the resident survey and the business survey for each SA1 are presented in Table 4.

For the resident sample, response rates were relatively evenly spread across each of the SA1s, ranging between 7.5% and 11.7%. Response rates for the business sample ranged between 0.0% and 73.3%.

Table 3. Business survey recruitment outcomes.

Recruitment outcomes	Count	Proportion of population
Completed total^a (C)	301	30.5%
Completed face-to-face	-	-
Completed CATI	301	30.5%
Non-contact (eligible, non-interview) total (NC)	3	0.3%
Refusal (eligible, non-interview) total (R)	101	10.2%
Other (eligible, non-interview) total (O)	18	1.8%
Other - language barrier	17	1.7%
Other - unable to complete due to illness or disability	1	0.1%
Other - broken appointment	0	0.0%
Other - other non-response	0	0.0%
Unknown eligibility, non-interview total (UE)	218	22.1%
Unknown eligibility - not attempted	0	0.0%
Unknown eligibility - non-contact (always ringing, always voicemail)	218	22.1%
Unknown eligibility - business number, unknown if eligible person	0	0.0%
Not eligible, non-interview total	345	35.0%
Not eligible - out of sample (aged <18 years; worked in the area <2 months)	15	1.5%
Not eligible - number out of service or disconnected	203	20.6%
Not eligible - other ineligible	127	12.9%
Total population^a	986	
Response Rate (RR) - Proportion of cases interviewed of all eligible cases $C / (C) + (NC+R+O) + (UE)$	-	47.0%
Co-operation Rate (COOP) - Proportion of cases interviewed of eligible cases contacted $C / (C)+(R+O)$	-	71.7%
Refusal Rate (REF) - Proportion of eligible sample that refused $R / ((C)+(NC+R+O) + (UE))$	-	15.8%
Contact Rate (CON) - Proportion of eligible sample where a business was reached $(C+R+O) / (C+R+O+NC+UE)$	-	65.5%

a. Data source: Discoverable businesses located within the sample frame. Refer to 3.1.3. for details.

Table 4. Response rates^a for the resident and business surveys, by SA1.

SA1	Resident survey response rate	Business survey response rate
2114402	8.0%	-
2114405	8.8%	-
2114406	9.2%	0.0%
2114407	11.7%	-
2114454	9.9%	63.1%
2114404	8.6%	46.2%
2114403	8.3%	73.3%
2114401	8.6%	41.9%
2114459	10.3%	60.0%
2114457	8.7%	44.4%
2114458	8.7%	54.3%
2114439	9.0%	50.0%
2114441	8.6%	50.0%
2111902	8.3%	46.2%
2111903	9.9%	0.0%
2111904	8.3%	47.6%
2113910	8.5%	44.7%
2113901	8.0%	47.3%
2114422	7.7%	22.9%
2114421	7.5%	50.0%
2114420	7.9%	25.0%
2113905	9.3%	39.7%
2113903	8.2%	63.6%
2114411	8.6%	38.9%
2114419	10.4%	25.0%
2114442	8.1%	54.5%
Total	8.8%	47.0%

a. Response Rate (RR) - Proportion of cases interviewed of all eligible cases.

- indicates there were no eligible businesses in the SA1.

3.2.3. Survey outcomes

The count and proportion of respondents who completed the resident and the business surveys by SA1 are presented below in Table 5.

Table 5. Count and proportion of respondents by SA1.

	Resident survey		Business survey	
SA1	Count	Proportion of total	Count	Proportion of total
2114402	16	2.9%	-	-
2114405	15	2.8%	-	-
2114406	18	3.3%	0	0.0%
2114407	22	4.1%	-	-
2114454	28	5.2%	41	13.6%
2114404	41	7.6%	6	2.0%
2114403	29	5.3%	11	3.7%
2114401	16	2.9%	31	10.3%
2114459	16	2.9%	3	1.0%
2114457	45	8.3%	4	1.3%
2114458	16	2.9%	19	6.3%
2114439	13	2.4%	25	8.3%
2114441	29	5.3%	28	9.3%
2111902	22	4.1%	6	2.0%
2111903	20	3.7%	0	0.0%
2111904	10	1.8%	10	3.3%
2113910	20	3.7%	17	5.6%
2113901	10	1.8%	26	8.6%
2114422	10	1.8%	8	2.7%
2114421	12	2.2%	9	3.0%
2114420	15	2.8%	2	0.7%
2113905	25	4.6%	27	9.0%
2113903	30	5.5%	14	4.7%
2114411	21	3.9%	7	2.3%
2114419	26	4.8%	1	0.3%
2114442	18	3.3%	6	2.0%
Total	543		301	

Note: a '-' indicates that there were no businesses to contact in that particular SA1.

Survey language

The count and proportion of surveys completed in each of the survey languages are presented below in Table 6.

Table 6. Count and proportion of surveys completed in each of the survey languages.

	Resident survey		Business survey	
Survey language	Count	Proportion of total	Count	Proportion of total
English	508	93.6%	296	98.3%
Vietnamese	19	3.5%	5	1.7%
Mandarin	12	2.2%	0	0.0%
Cantonese	3	0.6%	0	0.0%
Greek	1	0.2%	0	0.0%
Hakka	0	0.0%	0	0.0%
Total	543		301	

A relatively small proportion of respondents completed the translated versions of the survey (6.4% of the resident sample and 1.7% of the business sample). It was noted by the field team that the majority of the respondents who were from non-English speaking backgrounds were able to complete the survey in English, hence the low proportion of completions in the surveys translated into languages other than English.

3.2.4. Sample representativeness for the resident survey

An assessment of sample representativeness for the resident survey, relative to population data is presented below in Table 7. The representativeness of the business sample was not assessed as population data was not available.

Table 7: Resident sample representativeness according to demographic characteristics, relative to individual-level population data.

	Sample		Population ^a	
Demographic characteristic	Count	Proportion of total	Count	Proportion of total ^b
Gender				
Male	273	50.5%	5,975	48.6%
Female	268	49.5%	6,314	51.4%
Other	-	-	-	-
Age group				
0 – 17 year olds	-	-	1,473	-
18 – 19 year olds	8	1.5%	197	1.8%
20 – 24 year olds	42	7.7%	1,072	10.0%
25 – 34 year olds	122	22.5%	3,779	35.2%
35 – 44 year olds	112	20.6%	1,801	16.8%
45 – 54 year olds	80	14.7%	1,394	13.0%
55 – 64 year olds	92	16.9%	1,143	10.7%
65 – 74 year olds	47	8.7%	696	6.5%
75 – 84 year olds	34	6.3%	457	4.3%
85+ year olds	6	1.1%	193	1.8%
Country of birth				
Australia	324	59.9%	6,290	56.3%
Overseas	217	40.1%	4,881	43.7%
Total	543		12,292	

a. Data source: Community Profile, 2016 Census, ABS. Population data is reported at the individual level.

b. Count of 0-17 year olds excluded in the calculation of proportions for each age group.

As shown in the table above, the demographic spread of the sample closely approximates the demographic spread of the population, indicating the sample is representative of the population. Some minor under-representation was observed among 25 – 34 year olds, and some minor over-representation was observed among 55 – 64 year olds. A weighting variable was created to account for any minor dis-representation and is included in the datafile provided to the department. Weighting factors are within acceptable range (0.39 and 2.26), providing confirmation that the sample is representative.

Table 8: Resident sample representativeness according to location (SA1), relative to individual and household-level population data^a.

Location (SA1)	Sample		Population (individual-level)		Population (household-level)	
	Count	Proportion of total	Count	Proportion of total	Count	Proportion of total
2114402	16	2.9%	490	4.0%	199	3.2%
2114405	15	2.8%	383	3.1%	171	2.8%
2114406	18	3.3%	465	3.8%	196	3.2%
2114407	22	4.1%	406	3.3%	189	3.0%
2114454	28	5.2%	621	5.1%	285	4.6%
2114404	41	7.6%	821	6.7%	475	7.7%
2114403	29	5.3%	588	4.8%	356	5.7%
2114401	16	2.9%	409	3.3%	187	3.0%
2114459	16	2.9%	291	2.4%	158	2.5%
2114457	45	8.3%	959	7.8%	536	8.6%
2114458	16	2.9%	346	2.8%	184	3.0%
2114439	13	2.4%	378	3.1%	146	2.4%
2114441	29	5.3%	656	5.3%	339	5.5%
2111902	22	4.1%	410	3.3%	265	4.3%
2111903	20	3.7%	376	3.1%	214	3.4%
2111904	10	1.8%	238	1.9%	122	2.0%
2113910	20	3.7%	472	3.8%	223	3.6%
2113901	10	1.8%	314	2.6%	126	2.0%
2114422	10	1.8%	299	2.4%	130	2.1%
2114421	12	2.2%	288	2.3%	160	2.6%
2114420	15	2.8%	431	3.5%	189	3.0%
2113905	25	4.6%	621	5.1%	269	4.3%
2113903	30	5.5%	676	5.5%	368	5.9%
2114411	21	3.9%	432	3.5%	248	4.0%
2114419	26	4.8%	470	3.8%	250	4.0%
2114442	18	3.3%	452	3.7%	223	3.6%
Total	543		12,292		6,208	

a. Data source: 2016 Census, ABS. Population data is reported at the individual level (i.e. total count of persons) and household level (i.e. total count of private dwellings).

As shown in the table above, the resident sample was representative of the population according to the spread across SA1s.

3.2.5. Escalations

An agreed escalation procedure was put in place at the start of the project in order to deal with any sensitive contacts encountered during fieldwork. There was only one incident that required escalation throughout fieldwork. This is described below.

An employee of Neighbourhood House in Richmond contacted the department and made a formal complaint regarding the conduct of the survey. They were contacted via telephone and invited to participate in the business version of the survey. They felt they were contacted too many times to participate. A review of the call log revealed that on the 15th of July an interviewer called the Neighbourhood House and spoke to complainant. Complainant said the head office Manager needs to approve before they can participate. Complainant provided email address so interviewer can send participant information so they can supply to head office management. The call centre supervisor doesn't recall being asked to send the email by the interviewer. Unfortunately, the participant information was not passed on to complainant. An interviewer then attempted to call back on three occasions to speak to complainant (not realising that a participant information sheet was not passed on to complainant). On the third call, interviewer spoke to complainant – and they again reiterated that they need clearance from management. The complainant then proceeded to lodge a complaint with the department/

In response to the complaint, Colmar Brunton provided the department with details of the call log, as well as the exact survey script interviewers use when recruiting via telephone. Colmar Brunton explained that miscommunication occurred and multiple calls were made and perceived as unnecessary by complainant because the participant information sheet was not sent. The department progressed this by following up with complainant.

3.3. Data processing and weighting

3.3.1. Data processing

Practices to ensure high quality data commenced at the set-up phase of the project. The following steps were taken.

- Once the survey had been programmed, a number of checks occurred prior to the commencement of fieldwork. The Q&A Market Research analyst who was responsible for the survey build conducted the first test and a Colmar Brunton researcher conducted a second test.
- The survey was programmed with built in consistency and validity checks.
- Dummy datafiles were also checked to ensure all routing and filters were functioning as intended. Once the internal checks had been finalised, the department conducted a check of the dummy datafile and provided approval on the content prior to the commencement of fieldwork.
- An interim data file was produced after sufficient surveys had been completed. This was checked by a Colmar Brunton researcher.
- A full data cleaning and validation process occurred at the end of the project.

- One resident respondent mistakenly completed the business survey. This case was retained in the datafile – and can be identified by a flag variable (Incorrectflag=1).
- The file was weighted in accordance with the requirements set-out by the department. The weighting strategy is described in 3.3.2 below.
- The required derived variables were computed and included in the datafile.
- The final data file was delivered in SPSS file format. All syntax and weighting variables were provided with the data file.

3.3.2. Weighting

Weights were calculated for the resident sub-cohort only (ComBusiSamp=1) ($n = 543$). Two respondents chose not to respond to the gender question. As no gender information was provided by these two respondents, these two cases were coded as 1 for the weight variable. Applying a weight of 1 means that survey responses for these two cases are not weighted up or down.

Weights were calculated using the following auxiliary variables: gender (Q17 = 1 'male'; 2 'female') and age group (recage = 1 '18-19 yrs'; 2 '20-24 yrs'; 3 '25-29 yrs'; 4 '30-34 yrs'; 5 '35-39 yrs'; 6 '40-44 yrs'; 7 '45-49 yrs'; 8 '50-59 yrs'; 9 '60-69 yrs'; 10 '70-79 yrs'; 11 '80+yrs').

Population-level data confined to the population parameters of the study (i.e. the 26 SA1s) were used to calculate weights. An interlocking weight structure was used to generate accurate population weights for each gender x age group combination thus ensuring strong alignment to the population level data. Data source: Community Profile, 2016 Census, ABS.

3.3.3. Coding

Colmar Brunton developed codeframes for the following open-ended questions.

- **S3** - What is your position in this business? (Single response).
- **Q7B** - Thinking about the last time someone approached you on a street in your local area to sell you drugs, what type of drugs were you offered? (Single response).
- **Q8** - What, if anything, concerns you about drug-related activity in your local area? (Multiple response).
- **Q11A** - Do you know the location of the Medically Supervised Injecting Room (MSIR) trial? (Single response).
- **Q11B** - Please describe what you understand about what happens in the Medically Supervised Injecting Room. (Multiple response).
- **Q13A** - Do you think the Medically Supervised Injecting Room has contributed to any changes in the area? This could include positive and negative changes. (Yes/No). **Q13B** - Can you describe the changes that you have noticed? (Multiple response).
- **Q14** - Do you have any further comments you would like to make about the Medically Supervised Injecting Room trial? (Multiple response).
- **Q15** - Do you have any further comments you would like to make about drug-related activity in your local area? (Multiple response).

The codeframes for these questions are appended to this report. In order to conduct the coding, the following steps were taken:

Develop codeframe

- One Colmar Brunton researcher reviewed open-ended responses and derived themes.
- Two researchers met and discussed themes and reviewed responses and agreed on final codeframes.
- The department reviewed and approved the codeframes.

First validation

- One researcher read open-ended responses for 100 resident cases and 75 business cases and coded for theme endorsement using the codeframes.
- The department reviewed the 175 coded cases and provided feedback. Feedback was incorporated into the coding strategy going forward.

Coding

- After incorporating the feedback from the department, one Colmar Brunton researcher read each open-ended response and coded for theme endorsement using the codeframes. Additional codes were added to the codeframe if required.

4. Research schedule

The following table provides a summary of the key research tasks and their completion dates.

Table 9: Research schedule.

Task	Dates
Research proposal submitted	7 th of May, 2019
Project commissioned	23 rd of May, 2019
Project scoping meeting	30 th of May, 2019
Survey finalised	21 st of June, 2019
Participant information material finalised	21 st of June, 2019
Ethics approval granted	19 th of June, 2019
Resident survey field researcher training	4 th of June, 2019
Business survey field researcher training	11 th of July, 2019
Resident survey fieldwork	4 th July – 10 th August, 2019
Business survey fieldwork	11 th July – 31 st July, 2019
Data processing, coding, checking, weighting	19 th November, 2019
Final data file delivered	19 th November, 2019
Draft technical report delivered	11 th October 2019
Feedback on technical report received	4 th November, 2019
Final technical report delivered	XXXX

5. Appendices

5.1. Appendix A – Personnel

David



David Spicer, Research Director, Colmar Brunton (Melbourne)

BA (hons) Psychology. Member of the Australasian Evaluation Society and Market and Social Research Society.

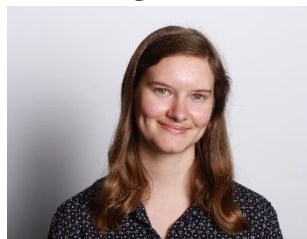
David is the Head of the Government research team for Colmar Brunton in Melbourne.

With a background in psychology, social research and evaluation, David has over 18 years' experience in the design and implementation of evaluation projects for a broad range of public and private sector clients. He has designed and managed many projects with a focus on the evaluation of programs, communications, products and services.

David has led a number of research and evaluation projects relevant to this project including:

- The development of program logics and evaluation frameworks in many sectors including justice, aged care and Indigenous services;
- Research and evaluation to assess initiatives in a number of workplace contexts including work with the Department of Premier and Cabinet, Department of Education and the Diversity Council of Australia
- A range of other research and evaluation experience including:
- Outcome/impact evaluations for state and federal government in a range of sectors including occupational health and safety; and primary and secondary healthcare;
- The development of performance monitoring frameworks and systems in the healthcare sector;
- Research and evaluation with potentially sensitive populations such as the frail aged, Aboriginal peoples, people from Culturally and Linguistically Diverse backgrounds, illegal immigrants and incarcerated offenders.

Emily



Emily Bariola, Senior Consultant, Colmar Brunton (Melbourne)

Emily is a Senior Account Manager in the Social & Government research team in Victoria. She joined Colmar Brunton in June, 2018. She has a Bachelor of Arts with an Honours degree in Psychology. Emily has worked as a researcher for ten years, with her research spanning behavioural science, public health and social epidemiology. She has worked across university, not-for-profit, government and commercial sectors and has extensive experience working on both agency and client sides of the research process. Emily uses both quantitative and

	qualitative methodologies to answer research questions and has expertise designing longitudinal surveys, large national cross-sectional surveys, and qualitative studies. She is passionate about evidence-based practice and enjoys translating research knowledge into practice for her clients. Emily has conducted several research studies examining drug, alcohol and tobacco use among specific populations (including marginalised communities and Australian youth). She has a strong working knowledge of substance-use research methodologies.

5.2. Appendix B – Survey

QUANT FIELD REQUIREMENTS	
Project No: DHHSCM0175	Project Name: MSIR Community Survey – Wave 2
Main Colmar Brunton Contacts: David Spicer, Emily Bariola	
Issue Date: 21.06.19 Version 5	

1

INTRODUCTION

1. SOURCE: RESIDENT SAMPLE (FACE-TO-FACE, WITH THE OPTION OF CATI CALL BACK)

INTERVIEWER NOTE: for each household in the sample, the next-birthday person living in the household is selected to complete the survey. The next-birthday person must meet the following criteria: (i) they are contactable during the fieldwork period, (ii) they are aged 18 years or over, (iii) they have been living in the area for at least 2 months, (iv) they have the ability to participate in English or one of the 5 priority languages (Simplified Chinese [Mandarin/Cantonese], Hakka, Vietnamese, Greek), (v) and they have provided informed consent.

If the next-birthday person cannot complete for any of the above reasons, the person with the subsequent birthday is selected. If the next-birthday person refuses, the household is excluded and the next household should be sampled.

Introduction script

Good morning / afternoon / evening. I'm [interviewer] from Colmar Brunton and Q&A Market Research, which are survey companies. We are conducting a survey about community attitudes to drug-related activity in the inner-eastern area of Melbourne, including about the Medically Supervised Injecting Room. The survey is an initiative of the Victorian Department of Health and Human Services who have engaged us to conduct the interviews. The survey results are for public interest and for research purposes only. The survey involves answering some general questions about yourself as well as some questions relating to drug-related activity in your area. And the survey has received ethics approval. The survey is voluntary, you don't have to participate if you don't want to. The survey will take only 10 minutes, is conducted with me in person, and it is completely anonymous.

Person consolidation 1

We would like to conduct the interview with the person in this household who is next to have a birthday. The person must also be aged 18 years or over and must have lived in the area for at least two months. Is that you?

YES, I AM AGED OVER 18 AND NEXT TO HAVE A BIRTHDAY AND HAVE LIVED IN THE AREA FOR AT LEAST TWO MONTHS > PROCEED TO INTERESTED IN COMPLETING INTERVIEW. NO, I AM UNDER 18 AND/OR I AM NOT NEXT TO HAVE A BIRTHDAY AND/OR I HAVE NOT LIVED IN THIS AREA FOR AT LEAST TWO MONTHS > PERSON CONSOLIDATION 2.

Person consolidation 2

Is the person in this household who is next to have a birthday and who is also over 18 and who has lived in the area for at least two months available to speak to me now?

YES, THEY ARE AVAILABLE > NEXT BIRTHDAY HOUSEHOLD MEMBER 18+. NOT AVAILABLE NOW > ARRANGE CALL BACK. NO ONE INTERESTED > TERMINATE WITH THANKS.

Interested in completing interview

Super. Here is a letter and information form that includes more information about the study. Please take a moment to read through the information now. [ALLOW SUFFICIENT TIME FOR READING PARTICIPANT INFORMATION AND CONSENT FORM AND FOR ANY QUESTIONS]

2

NOTE IF CATI: Interested in completing interview [interviewer note: please check to see whether respondent would like to receive some more information about the survey. If they do please send Resident Participant Information and Consent Form via email].

Would you be interested in completing the survey with me right now?

[YES, NOW > PROCEED WITH BELOW SCRIPT, YES, ANOTHER TIME > ARRANGE CALL BACK.
NEITHER > TERMINATE WITH THANKS.]

Great. Before we proceed I need to check a few things with you. Can I confirm the following:

- *You have read the Participant Information and Consent Form or someone has read it to you in a language that you understand (IF CATI: Can I confirm you have been offered to be sent a Participant Information and Consent Form if you wanted further information?*
- *You understand the purpose of the research and what this survey involves?*
- *You understand that the results of this survey will be provided to the Parliament of Victoria as part of a report.*
- *You have had an opportunity to ask questions and you are satisfied with the answers you have received?*
- *You freely agree to participate in this research project as described and understand that you are free to withdraw at any time while completing survey without any consequences for you?*
- *You understand that if you choose to withdraw while completing the survey researchers will delete your survey responses. However, if you wish to withdraw after completing the survey researchers will be unable to delete your survey responses because your individual responses cannot be identified in the dataset.*

[IF ANY STATEMENT IS NOT CONFIRMED, FIELDWORKER TO ADDRESS AS APPROPRIATE TO THE STATEMENT]

Finally, can I confirm that you consent to participate in this project?

☐ VERBAL CONSENT PROVIDED [Fieldworker to tick if consent provided.]

[FIELDWORKER TO CLICK CONSENT BOX ON SURVEY PLATFORM WHEN VERBAL CONSENT IS GIVEN]

Next birthday household member 18+ & lived in area > 2 months

Good morning / afternoon / evening. I'm [interviewer] from Colmar Brunton and Q&A Market Research, which are survey companies. We are conducting a survey about community attitudes to drug-related activity in the inner-eastern area of Melbourne, including about the Medically Supervised Injecting Room. The survey is an initiative of the Victorian Department of Health and Human Services who have engaged us to conduct the interviews. The survey results are for public interest and for research purposes only. The survey involves answering some general questions about yourself as well as some questions relating to drug-related activity in your area. And the survey has received ethics approval. The survey is voluntary, you don't have to participate if you don't want to. The survey will take only 10 minutes, is conducted with me in person, and it is completely anonymous.

3

Here is a letter that includes more information about the study. Please take a moment to read through the information now. Please note that if you complete the survey with me you are expressing consent to participate in the survey.

Would you be interested in completing the survey with me right now?

[YES, NOW > PROCEED WITH BELOW SCRIPT, YES, ANOTHER TIME > ARRANGE CALL BACK.
NEITHER > TERMINATE WITH THANKS.]

Great. Before we proceed I need to check a few things with you. Can I confirm the following:

- *You have read the Participant Information and Consent Form or someone has read it to you in a language that you understand?*
- *You understand the purpose of the research and what this survey involves?*
- *You understand that the results of this survey will be provided to the Parliament of Victoria as part of a report.*
- *You have had an opportunity to ask questions and you are satisfied with the answers you have received?*
- *You freely agree to participate in this research project as described and understand that you are free to withdraw at any time while completing survey without any consequences for you?*
- *You understand that if you choose to withdraw while completing the survey researchers will delete your survey responses. However, if you wish to withdraw after completing the survey researchers will be unable to delete your survey responses because your individual responses cannot be identified in the dataset.*

[IF ANY STATEMENT IS NOT CONFIRMED, FIELDWORKER TO ADDRESS AS APPROPRIATE TO THE STATEMENT]

Finally, can I confirm that you consent to participate in this project?

☐ VERBAL CONSENT PROVIDED [Fieldworker to tick if consent provided.]

[FIELDWORKER TO CLICK CONSENT BOX ON SURVEY PLATFORM WHEN VERBAL CONSENT IS GIVEN]

2. SOURCE: BUSINESS SAMPLE (CATI)

INTERVIEWER NOTE: For the business survey, the respondent must meet the following criteria: (i) they are contactable during the fieldwork period, (ii) they are aged 18 years or over, (iii) they have been working in the area for at least 2 months, (iv) they are a senior staff member (e.g. business owner or manager), (v) they have the ability to participate in English or one of the 5 priority languages (Simplified Chinese [Mandarin/Cantonese], Hakka, Vietnamese, Greek),

Please note: If the most senior staff member is unavailable or unwilling to participate, it is acceptable to survey the most senior person who is currently available (i.e. attempt to survey the most senior person available at the time).

4

Introduction script

Good morning / afternoon / evening. I'm [interviewer] from Colmar Brunton and Q&A Market Research, which are survey companies. We are conducting a survey about community attitudes to drug-related activity in the inner-eastern area of Melbourne, including about the Medically Supervised Injecting Room. The survey is an initiative of the Victorian Department of Health and Human Services who have engaged us to conduct the interviews. The survey results are for public interest and for research purposes only. The survey involves answering some general questions about yourself and the business you work in, as well as some questions relating to drug-related activity in your area. And the survey has received ethics approval. The survey is voluntary, you don't have to participate if you don't want to. The survey will take only 10 minutes, is conducted with me in person, and it is completely anonymous.

Person consolidation

To participate in the survey you need to be aged 18 or over and have worked in the area for at least two months. And if possible, we would like the most senior person in the business to complete the survey (such as business owner or manager). Would that be you, by chance? If not, is that person available to speak to? YES THAT'S ME AND AGED OVER 18 AND WORKED IN THE AREA FOR AT LEAST TWO MONTHS> PROCEED TO INTERESTED IN COMPLETING INTERVIEW. NO, ITS SOMEBODY ELSE > SOMEBODY ELSE

Interested in completing interview [interviewer note: please check to see whether respondent would like to receive some information about the survey. If they do please send Business Participant Information and Consent Form via email].

Super. Would you be interested in completing this interview with me over the phone? Is now okay, or should I call back another time? [YES, NOW > PROCEED WITH BELOW SCRIPT, YES, ANOTHER TIME > ARRANGE CALL BACK. NEITHER > TERMINATE WITH THANKS.]

Great. Before we proceed I need to check a few things with you. Can I confirm the following:

- *Can I confirm you have been offered to be sent a Participant Information and Consent Form if you wanted further information?*
- *You understand the purpose of the research and what this survey involves?*
- *You understand that the results of this survey will be provided to the Parliament of Victoria as part of a report.*
- *You have had an opportunity to ask questions and you are satisfied with the answers you have received?*
- *You freely agree to participate in this research project as described and understand that you are free to withdraw at any time while completing survey without any consequences for you?*
- *You understand that if you choose to withdraw while completing the survey researchers will delete your survey responses. However, if you wish to withdraw after completing the survey researchers will be unable to delete your survey responses because your individual responses cannot be identified in the dataset.*

[IF ANY STATEMENT IS NOT CONFIRMED, FIELDWORKER TO ADDRESS AS APPROPRIATE TO THE STATEMENT]

Finally, can I confirm that you consent to participate in this project?

☐
5

VERBAL CONSENT PROVIDED

[Fieldworker to tick if consent provided.]

[FIELDWORKER TO CLICK CONSENT BOX ON SURVEY PLATFORM WHEN VERBAL CONSENT IS GIVEN]

Somebody else

Would that person be available to speak to now?

YES, NOW > REINTRODUCE AND CHECK ELIGIBILITY FOR COMPLETING SURVEY AND CHECK INTEREST IN COMPLETING INTERVIEW. NOT AVAILABLE NOW > REQUEST TO SPEAK TO MOST SENIOR STAFF MEMBER THAT IS AVAILABLE AND REINTRODUCE STUDY AND CHECK INTEREST IN PARTICIPATING.

GENERAL SCREENING QUESTIONS

(ASK ALL) , SR

S1. Have you recently participated in a survey conducted on behalf of the Department of Health and Human Services regarding drug-related activity in your local area? (INTERVIEWER NOTE: RECENTLY MEANS IN THE PAST FEW MONTHS).

Please select one response

1. Yes
2. No
97. Don't know (DNRO)
99. Prefer not to answer (DNRO)

(ASK BUSINESS RESPONDENTS ONLY), OE

S3. What is your position in this business?

99. Prefer not to answer (DNRO)

CORE QUESTION SET

INTRO FOR BUSINESS RESPONDENTS ONLY: For the following questions, when we say "local area" we mean "the area where you work."

INTRO FOR RESIDENT RESPONDENTS ONLY: For the following questions, when we say "local area" we mean "the area where you live."

(ASK ALL) , SR, RO

6

Q4A. Thinking about the past 12 months, how safe or unsafe have you felt when you were walking in your local area alone during the day?

Please select one response

1. Very safe
2. Safe
3. Neither safe nor unsafe
4. Unsafe
5. Very unsafe
6. Never alone in this situation
97. Don't know (DNRO)
99. Prefer not to answer (DNRO)

(ASK ALL) , SR, RO

Q4B. Thinking about the past 12 months, how safe or unsafe have you felt when you were walking in your local area alone after dark?

Please select one response

1. Very safe
2. Safe
3. Neither safe nor unsafe
4. Unsafe
5. Very unsafe
6. Never alone in this situation
97. Don't know (DNRO)
99. Prefer not to answer (DNRO)

(ASK ALL) , SR,

Q5. Have you ever seen anyone injecting drugs in a public place in your local area?

Please select one response

1. Yes
2. No
97. Don't know (DNRO)
99. Prefer not to answer (DNRO)

(ASK IF Q5 = 1) , SR, DNRO INTERVIEWER CODE TO LIST

Q5A. When was the last time you saw someone injecting in a public place in your local area?

Please select one response

1. Within the Last 24 Hours
2. Within the Last Week
3. Within the Last Month
4. Within the Last Year
5. More Than A Year Ago
6. Never
97. Don't know (DNRO)
99. Prefer not to answer (DNRO)

(ASK IF Q5A = 1,2 OR 3), OE-NUM (1-999)

7

Q5B. How often over the last month have you seen someone injecting drugs in a public place in your local area?

Number of times in the last month

-
97. Don't know (DNRO)
 99. Prefer not to answer (DNRO)

(ASK ALL) , SR

Q6. Have you ever seen a discarded needle or syringe in a public place in your local area, for example a syringe dropped in the street or a park etc?

Please select one response

1. Yes
2. No
97. Don't know (DNRO)
99. Prefer not to answer (DNRO)

(ASK IF Q6 = 1), SR, DNRO INTERVIEWER CODE TO LIST

Q6A. When was the last time you saw a discarded needle or syringe in a public place in your local area?

Please select one response

1. Within the Last 24 Hours
2. Within the Last Week
3. Within the Last Month
4. Within the Last Year
5. More Than A Year Ago
6. Never
97. Don't know (DNRO)
99. Prefer not to answer (DNRO)

(ASK IF Q6A = 1,2 OR 3), OE-NUM (1-999)

Q6B. How often over the last month have you seen a discarded needle or syringe in a public place in your local area?

Number of times in the last month

-
97. Don't know (DNRO)
 99. Prefer not to answer (DNRO)

(ASK ALL) , SR

Q7. Has someone ever approached you on a street in your local area to sell you drugs?

Please select one response

1. Yes
2. No
97. Don't know (DNRO)
99. Prefer not to answer (DNRO)

8

(ASK IF Q7= 1) , SR, DNRO INTERVIEWER CODE TO LIST

Q7A. When was the last time someone approached you on a street in your local area to sell you drugs?

Please select one response

1. Within the Last 24 Hours
2. Within the Last Week
3. Within the Last Month
4. Within the Last Year
5. More Than A Year Ago
6. Never
97. Don't know (DNRO)
99. Prefer not to answer (DNRO)

(ASK IF Q7A = 1,2,3,4,5) OE

Q7B. Thinking about the last time you were approached, what type of drugs were you offered?

-
97. Don't know (DNRO)
 99. Prefer not to answer (DNRO)

(ASK ALL) , OE

Q8. What, if anything, concerns you about drug-related activity in your local area?

-
97. Don't know (DNRO)
 99. Prefer not to answer (DNRO)

(ASK ALL) , SR, RO

Q9. How concerned are you currently about drug-related activity in your local area?

Please select one response

1. Not at all concerned
2. Slightly concerned
3. Moderately concerned
4. Very concerned
97. Don't know (DNRO)
99. Prefer not to answer (DNRO)

ASK BUSINESS RESPONDENTS ONLY. [Interviewer note: If respondent is employee: state 'finding a new job' if respondent is business owner: state 'moving your business.'

Q10A. Thinking about the past 12 months, have you considered finding a new job (or moving your business) out of the area because of drug-related activity?

Please select one response

1. Yes, and I may find a job (or move my business) out of the area
2. Yes, but finding a new job (or moving my business) is not an option for me at the moment
3. No, I have not thought about it

9

97. Don't know (DNRO)
99. Prefer not to answer (DNRO)

(ASK RESIDENT RESPONDENTS ONLY) , SR

Q10B. Thinking about the past 12 months, have you considered moving out of the area because of drug-related activity?

Please select one response

1. Yes, and I may move out of the area
2. Yes, but moving is not an option for me at the moment
3. No, I have not thought about it
97. Don't know (DNRO)
99. Prefer not to answer (DNRO)

(ASK ALL) , SR

Q11. Do you know about the Medically Supervised Injecting Room (MSIR) trial being undertaken by the Victorian government?

Please select one response

1. Yes
2. No
97. Don't know (DNRO)
99. Prefer not to answer (DNRO)

ASK IF Q11 = 1, OE

Q11A. Do you know the location of the Medically Supervised Injecting Room (MSIR) trial?

-
97. Don't know (DNRO)
 99. Prefer not to answer (DNRO)

(ASK ALL) , OE

Q11B. Please describe what you understand about what happens in the Medically Supervised Injecting Room [open text response]

-
97. Don't know (DNRO)
 99. Prefer not to answer (DNRO)

[If respondents talk about what happens outside of the MSIR, fieldworker to clarify the question is asking about their understanding of what happens IN the MSIR, not outside of it.]

(ASK ALL) , SR, RO

Q12. Do you agree or disagree with the idea of Medically Supervised Injecting Rooms generally?

Please select one response

1. Strongly Agree
2. Agree
3. Neither agree nor disagree

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- 4. Disagree
- 5. Strongly Disagree
- 97. Don't know (DNRO)
- 99. Prefer not to answer (DNRO)

(ASK ALL) , SR, RO

Q13. Do you agree or disagree with having a Medically Supervised Injecting Room in North Richmond?

Please select one response

- 1. Strongly Agree
- 2. Agree
- 3. Neither agree nor disagree
- 4. Disagree
- 5. Strongly Disagree
- 97. Don't know (DNRO)
- 99. Prefer not to answer (DNRO)

(ASK ALL) , SR

Q13A. Do you think the Medically Supervised Injecting Room has contributed to any changes in the area? This could include positive and negative changes.

Please select one response

- 1. Yes
- 2. No
- 97. Don't know (DNRO)
- 99. Prefer not to answer (DNRO)

(ASK IF Q13A = 1) , OE

Q13B. Can you describe the changes that you have noticed? [open text response]

- 99. Prefer not to answer (DNRO)

(ASK ALL), OE

Q14. Do you have any further comments you would like to make about the Medically Supervised Injecting Room trial?

- 99. Prefer not to answer (DNRO)

(ASK ALL), OE

Q15. Do you have any further comments you would like to make about drug-related activity in your local area?

- 99. Prefer not to answer (DNRO)

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DEMOGRAPHIC QUESTIONS

(ASK ALL) , OE-NUM (18-100),

Q16. How old were you on your last birthday?

(ASK ALL) , SR

Q17. What is your sex?

- 1. Male
- 2. Female
- 3. Other
- 99. Prefer not to answer (DNRO)

(ASK ALL) , SR

Q18. Are you a parent or guardian of any children?

- 1. Yes
- 2. No
- 99. Prefer not to answer (DNRO)

ASK IF Q18=1, OE-NUM (1-99)

Q18A. How many children do you have?

- 99. Prefer not to answer (DNRO)

ASK IF Q18= 1, SR, [Repeat as necessary for each child, cap at 5] , RO

Q18B. How old is your child? **If Q18A = 1**

Q18B. How old are your children? **If Q18A >1**

Please select one response

- 1. 0-6 years
- 2. 7-13 years
- 3. 14-18 years
- 4. Over 18 years
- 99. Prefer not to answer (DNRO)

ASK IF Q18= 1 & Q18B= 1, 2 or 3

IF Q18A = 1, SR

Q.18C Has your child attended Richmond West Primary School in 2018 or 2019?

- 1. Yes
- 2. No
- 99. Prefer not to answer

IF Q18A = >1, SR

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Q.18C Have your children attended Richmond West Primary School in 2018 or 2019?

1. Yes
2. No
99. Prefer not to answer

(ASK ALL) , SR

If Q18 =1

Q19. Do you, or your children, currently attend the North Richmond Community Health Centre?

1. Yes
2. No
97. Don't know (DNRO)
99. Prefer not to answer (DNRO)

If Q18 #1, SR

Q19. Do you currently attend the North Richmond Community Health Centre?

Please select one response

1. Yes
2. No
97. Don't know (DNRO)
99. Prefer not to answer (DNRO)

(ASK ALL) , SR, RO

Q20. How would you describe your current employment status?

Please select one response

1. Employed full-time
2. Employed part-time
3. Unemployed
4. Home Duties
5. Student and working
6. Student and not working
7. Retired
8. Unable to work due to health problems
99. Prefer not to answer (DNRO)

(ASK ALL) , SR, RO

Q21. What is the highest level of education you have completed?

Please select one response

1. Never attended school
2. Some primary school completed
3. Completed primary school
4. Some high school
5. Year 10
6. Year 12
7. TAFE Certificate or Diploma
8. University
9. CAE or some other tertiary institute degree or higher
99. Prefer not to answer (DNRO)

13

(ASK RESIDENT RESPONDENTS ONLY) , SR, RO

Q22A. How long have you lived in this area?

Please select one response

1. Less than 2 months
2. 2 to 6 months
3. 7 months to 12 months (1 year)
4. 13 months to 24 months
5. 25 months to 5 years
6. More than 5 years
7. More than 10 years
8. More than 20 years
97. Don't know (DNRO)
99. Prefer not to answer (DNRO)

(ASK BUSINESS RESPONDENTS ONLY) , SR, RO

Q22B. How long have you worked in this area?

Please select one response

1. Less than 2 months
2. 2 to 6 months
3. 7 months to 12 months (1 year)
4. 13 months to 24 months
5. 25 months to 5 years
6. More than 5 years
7. More than 10 years
8. More than 20 years
97. Don't know (DNRO)
99. Prefer not to answer (DNRO)

(ASK BUSINESS RESPONDENTS ONLY) , OE-NUM (0-7)

Q23. How many days a week do you work in this business?

-
97. Don't know (DNRO)
 99. Prefer not to answer (DNRO)

(ASK BUSINESS RESPONDENTS ONLY) , SR

Q24. Do you typically work during the day, night, or both?

Please select one response

1. Day
2. Night
3. Both day and night
99. Prefer not to answer (DNRO)

(ASK ALL) , SR

14

Q25. Were you born in Australia or overseas?

Please select one response

- 1. Australia
- 2. Overseas
- 99. Prefer not to answer (DNRO)

ASK IF 25 =2, OE-NUM (1900-2019), RO

Q25A. If you have lived in Australia for longer than one year, in what year did you first arrive?

-
- 97. Don't know (DNRO)
 - 99. Prefer not to answer (DNRO)

(ASK ALL)

(ASK RESIDENT RESPONDENTS ONLY) , SR

[Interviewer note: refer respondents to the map of SA1s and ask if it's ok to record the "area where they live" along with their responses. Note: Only go into the technical detail of the "census area" if necessary. Technical detail as follows: 'A census collection district is the smallest geographic area used by the census/ABS to collect information about the population. Each district has approximately 400 people, so we won't be able to identify you or where you live on the basis of this code. It simply allows the researchers to understand how the experiences of people in this area might differ from people in other areas.']

Q26. Would you consent to me recording the area where you live along with your survey responses?

- 1. Yes
- 2. No

(ASK BUSINESS RESPONDENTS ONLY) , SR

Q26. Would you consent to me recording the area where you work along with your survey responses?

- 1. Yes
- 2. No

(ASK ALL), SR, VARY WORDING IN BRACKETS DEPENDING ON WHETHER INTERVIEWING RESIDENTS OR BUSINESSES.

Q27. The Independent Review Panel appointed to Review the Medically Supervised Injecting Room would like to further explore the experiences of *[local residents/businesses]*.

Would you be interested in being contacted to share more about your experiences *[living/working]* near the Medically Supervised Injecting Room?

- 1. Yes
- 2. No

[IF Q27 = 1, field worker to collect first name and preferred contact number on separate platform.] Ensure unique participant ID, first name and contact number are recorded. We need these details to be on a separate survey platform – not within the main survey platform].

15

NEW SURVEY PLATFORM

ASK IF Q27 = 1

Q1. That's great, thank you. In order for the researchers to contact you – could you please provide us with your first name and best contact number? Rest assured – these details will only be used to organise the follow-up interview and will not be stored alongside any survey or follow-up interview responses. Researchers will not be able to identify you from your responses.

Also, it is important for us to note that providing your details does not guarantee an invitation to participate in a follow-up interview as it is possible that many people will agree to receiving the invitation and it will not be possible to interview all people.

What is your first name? _____

What is your best contact number?

THANK AND CLOSE (DISPLAY AT END OF SURVEY PLATFORM IF Q27=2). DISPLAY AT END OF FOLLOW UP INTERVIEW PLATFORM IF Q27=1).

That's it. Thank you so much for taking part in our survey today!

As I mentioned at the start of the survey, this survey is an initiative of the Victorian Department of Health and Human Services who have engaged us (Colmar Brunton and Q&A Market Research) to conduct the interviews.

The information you have provided will be used only for research purposes and your answers will be combined with those of other participants to inform policy, planning and research. Your answers will remain completely anonymous and all information provided will remain confidential.

As I mentioned, we are conducting this survey on behalf of the Victorian Government Department of Health and Human Services. If you have any queries regarding this survey, you can call the Victorian Government Contact Centre on 1300 366 356.

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5.3. Appendix C – Participant Information Materials

5.3.1. Participant Information Form (Residents)



Dear Householder

Monitor of community attitudes to drug-related activity in the North Richmond area

The Department of Health and Human Services has engaged Colmar Brunton to conduct a survey about community attitudes to drug-related activity and the Medically Supervised Injecting Room in the North Richmond. These are of public interest and for research purposes only. The results of this survey will be part of a report that will be tabled in the Parliament of Victoria. It is expected that this knowledge will inform policy, planning and research.

The survey involves answering some general questions about yourself as well as some questions relating to drug-related activity in your area. The questionnaire is being conducted by research agency Colmar Brunton. The survey will take approximately ten minutes to complete. Questions regarding this survey can be directed to the Victorian Government Contact Centre by calling 1300 366 356 (then select menu option 1).

Participants will remain completely anonymous and all information provided will remain confidential. In addition, data collected through this survey will be analysed and reported in group form only and, therefore, no personal information will be identifiable in the results of the study. Your participation is also completely voluntary.

Consent

By completing this questionnaire, you are expressing your consent to participate. However, you are free to withdraw from the questionnaire at any time.

By providing verbal consent you are telling us that you:

- Understand the information contained in this form
- Consent to take part in the research project
- Consent to be involved in the research described
- Consent to use your responses in the manner described

The study is being conducted in accordance with the National Health and Medical Research Council Act 1992 (Commonwealth), the Health Records Act 2001 (Victoria), the Privacy and Data Protection Act 2014 (Victoria) and the Statutory Guidelines on Research under the Health Records Act 2001 (Victoria). The study also complies with the Department of Health and Human Services' Privacy Policy which is available at: <https://www.dhhs.vic.gov.au/privacy>. An information brochure that explains the steps taken to safeguard your privacy is enclosed.

This study adheres to the Guidelines of the ethical review process of The University of Queensland and the National Statement on Ethical Conduct in Human Research. Whilst you are free to discuss your participation in this study with project staff (contactable at MSIRReview@dhhs.vic.gov.au), if you would like to speak to an officer of the University not involved in the study, you may contact the Ethics Coordinators on +617 3365 3924 / +617 3443 1656 or email humanethics@research.uq.edu.au.

Thank you for your assistance. Your participation in this survey is important in helping us to inform policy, planning and research.

Yours sincerely

David Spicer, Research Director
21/06/2019

Colmar Brunton, Level 2, 16 Palmer Parade, Cremorne 3121
call +61 3 8851 4800, visit www.colmarbrunton.com
ABN 22 003 748 981



Answers to questions people sometimes have about the community attitudes to drug-related activity monitor



What steps do we take to protect the privacy and confidentiality of the information you provide?

Your privacy is important to us and we take it seriously. In order to carry out this study effectively, the Department of Health and Human Services has engaged research agency Colmar Brunton to collect personal information about you. Questions regarding this study can be directed to the Victorian Government Contact Centre by calling 1300 366 356 (then select menu option 1).

- There are a number of laws¹ that apply to the collection and use of personal information as part of the study with which the Department of Health and Human Services must comply.
- An accredited Human Research Ethics Committee has approved the study (including any changes) and needs to be satisfied that the study is conducted in a way that protects your privacy, as required by these laws.
- The Ethics Committee also deals with any concerns that a member of the public may have before or after participating in the study.

This study adheres to the Guidelines of the ethical review process of The University of Queensland and the National Statement on Ethical Conduct in Human Research. Whilst you are free to discuss your participation in this study with project staff (contactable on MSIRReview@dhhs.vic.gov.au), if you would like to speak to an officer of the University not involved in the study, you may contact the Ethics Coordinators on +617 3365 3924 / +617 3443 1656 or email humanethics@research.uq.edu.au.

- Your participation in the study is *voluntary*. There are no consequences associated with not taking part in the study. You do not have to give a reason for not participating in the study.
- If you decide to take part in the study, you can choose not to answer a particular question if you do not wish to do so. You do not have to give a reason for not answering a question.
- The Ethics Committee pays particular attention to how your personal information (name and telephone number and your address if relevant) and study responses are stored during the study period and how the information collected is stored and used after all the interviews are completed.
- While the study is being conducted by Colmar Brunton (on behalf of the Department of Health and Human Services), your study responses and personal information are stored in separate password-protected files.
- At the end of the study period, Colmar Brunton is required to delete your name and telephone number (and where relevant your address) and only information you have provided in answering the study questions is kept.
- Any information that you provide is added to information provided by other participants and forwarded to the Department of Health and Human Services for analysis.

¹ These laws include but are not limited to: the *National Health and Medical Research Council Act 1992* (Commonwealth), the *Health Records Act 2001* (Victoria), the *Privacy and Data Protection Act 2014* (Victoria), the *National Statement of Ethical Conduct in Research Involving Humans* and the *Statutory Guidelines on Research under the Health Records Act 2001* (Victoria).

What happens to the data and how is it used?

The information collected from those who participate in the study is used to answer questions about community attitudes to drug-related activity and the Medically Supervised Injecting Room in the North Richmond area. These topics are of public interest and for research purposes only.

The Department of Health and Human Services is the data custodian for the data from the study. It is the duty of the custodian to ensure that the data are used responsibly and respectfully, and that privacy is safeguarded.

The department's privacy policy is available from the Department of Health and Human Services website:

<https://www.dhhs.vic.gov.au/privacy>

Further information

Centre for Evaluation and Research

Department of Health and Human Services

GPO Box 4057, Melbourne VIC 3001

CER@dhhs.vic.gov.au

Vietnamese

Nếu quý vị cần thông dịch viên, xin hãy gọi cho Dịch vụ Thông Phiên dịch Quốc gia (TIS Quốc gia) theo số 131 450 và yêu cầu họ gọi cho (Victorian Government Contact Centre) theo số (1300 366 356). Giờ làm việc của chúng tôi là (8:30am to 5:00pm Monday to Friday, except for Public Holidays).

Cantonese

若你需要口譯員，請撥打TIS National電話131 450並請他們轉接 (Victorian Government Contact Centre) 的電話 (1300 366 356) • 我們的工作時間是 (8:30am to 5:00pm Monday to Friday, except for Public Holidays) •

Mandarin

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Greek

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Arabic

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5.3.2. Participant Information Form (Businesses)



Dear Sir/Madam

Monitor of community attitudes to drug-related activity in the North Richmond area

The Department of Health and Human Services has engaged Colmar Brunton to conduct a survey about community attitudes to drug-related activity and the Medically Supervised Injecting Room in the North Richmond. These are of public interest and for research purposes only. The results of this survey will be part of a report that will be tabled in the Parliament of Victoria. It is expected that this knowledge will inform policy, planning and research.

The survey involves answering some general questions about yourself as well as some questions relating to drug-related activity in your area. The questionnaire is being conducted by research agency Colmar Brunton. The survey will take approximately ten minutes to complete. Questions regarding this survey can be directed to the Victorian Government Contact Centre by calling on 1300 366 356 (then select menu option 1).

Participants will remain completely anonymous and all information provided will remain confidential. In addition, data collected through this survey will be analysed and reported in group form only and, therefore, no personal information will be identifiable in the results of the study. Your participation is also completely voluntary.

Consent

By completing this questionnaire, you are expressing your consent to participate. However, you are free to withdraw from the questionnaire at any time.

By providing verbal consent you are telling us that you:

- Understand the information contained in this form
- Consent to take part in the research project
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Mandarin

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Arabic

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5.3.3. Call Back Card (Residents)



Have Your Say

Survey of community attitudes to drug-related activity in your local area

We visited today to ask you if you were willing to participate in a survey of community attitudes to drug-related activity in your area. Sorry we missed you.

If you would like to participate in this survey you can do so over the phone, it will take approximately ten minutes to complete.

- If you would like to complete this survey in English please call 1300 653 560.
- If you would like to complete the survey in Mandarin or Cantonese / Greek / Vietnamese or Hakka please call 1300 366 356.
- Or if you would like more information please call 1300 366 356.

Thank you for your assistance.

Mandarin

我们今天拜访过您，问您是否愿意参加社区对您所在地区毒品活动的态度调查。很抱歉我们当时错过了您的意见。

之后我们可以安排一位中文调查员与您完成这个 10 分钟的采访调查。如果您想获得更多信息或者另外安排一个时间电话参与调查，请拨打 1300 366 356。

感谢您的协助。

Cantonese

我哋今日來訪，想問你是否願意參與針對你所在區域毒品相關活動展開的社區態度調查。非常抱歉我哋當時錯過咗你嘅意見。

之後我哋可以安排一位粵語調查員與你進行個 10 分鐘嘅採訪調查。如果你想獲得更多資訊或者另外安排一個時間電話參與調查，請致電 1300 366 356。

感謝你的協助。

Greek

Σας επισκεπήκαμε σήμερα για να σας ρωτήσουμε αν ήσασταν πρόθυμοι να συμμετάσχετε σε μια έρευνα της στάσης της Κοινότητας στη δραστηριότητα των ναρκωτικών στην περιοχή σας.

Δυστυχώς δεν σας βρήκαμε.

Είναι δυνατόν να ολοκληρωθεί η έρευνα 10 λεπτών με μια συνέντευξη στα Ελληνικά. Αν επιθυμείτε περισσότερες πληροφορίες ή για να κανονίσουμε μια ώρα για να συμμετεχετε από το τηλέφωνο, παρακαλώ καλέστε στο 1300 366 356.

Σας ευχαριστούμε για τη βοήθειά σας.

Vietnamese

Hôm nay chúng tôi đã đến thăm để hỏi bạn có sẵn sàng tham gia vào một cuộc khảo sát về thái độ của cộng đồng đối với hoạt động ma túy trong khu vực của bạn hay không. Rất tiếc bạn không có ở nhà. Bạn có thể hoàn thành bản khảo sát (chỉ là 10 phút) với người phỏng vấn bằng tiếng Việt. Nếu bạn muốn biết thêm thông tin hoặc sắp xếp thời gian để tham gia qua điện thoại, xin gọi số 1300 366 356.

Cảm ơn sự giúp đỡ của bạn.

Hakka

我们今天拜访过您，问您是否愿意参加社区对您所在地区毒品活动的态度调查。很抱歉我们当时错过了您的意见。

之后我们可以安排一位普通话调查员与您完成这个 10 分钟的采访调查。如果您想获得更多信息或者另外安排一个时间电话参与调查，请致电 1300 366 356。

感谢您的协助。

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colmar brunton.

Q&A
market research

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5.4. Appendix D – Codeframes

Table 10: Codeframes for S3, Q7B, Q8, Q11A, Q11B, Q13B, Q14 and Q15

Codeframes
S3 - What is your position in this business? SR
Owner
Manager
Employee (not manager)
Q7B - Thinking about the last time someone approached you on a street in your local area to sell you drugs, what type of drugs were you offered? MR
MDMA/Ecstasy
Heroin
Ice/Crystal Meth
Cannabis/Marijuana
Cocaine
Cigarettes/Tobacco
Other drug
Unsure of type/didn't specify
Q8 - What, if anything, concerns you about drug-related activity in your local area? MR
Violence and crime (e.g. theft, burglary, property damage, trespassing)
Safety concerns for children (own children)
Safety concerns for children (general & school)
Safety concerns for self and others
Safety concerns for drug users (incl. health concerns e.g. users suffering for their habit)
Unpredictability of drug users
Aggressiveness of users (e.g. aggressiveness, yelling)
Antisocial/bad behaviour/attitude of users
Discarded syringes in public spaces (e.g. being injured by needle, fear of injury, general discomfort with waste)
Public visibility of drug use/drug deals
Blood, faeces, urine, rubbish etc. left by drug users
Lack of Government regulation / police presence
Bad for business
Begging (e.g. money, cigarettes, food)
General concern about MSIR
Affirmative towards MSIR, with suggestions for improvement
Spread of infectious diseases
Normalisation of drug use
No concerns
Other

Table 10: Codeframes for S3, Q7B, Q8, Q11A, Q11B, Q13B, Q14 and Q15

Codeframes
Q11A - Do you know the location of the Medically Supervised Injecting Room (MSIR) trial? SR
Exact (building or street, or surrounding area)
Approximate (suburb, or nearby streets)
Incorrect
Don't know (not allocated to Q11A_RC_97 by fieldworker)
Q11B. Please describe what you understand about what happens in the Medically Supervised Injecting Room. MR
People inject themselves with/take drugs
It's safe/controlled
There is medical supervision/monitoring
Overdoses are prevented
People can get injected with drugs/are given drugs
Sterile injecting equipment is provided
Injecting equipment can be discarded safely
People must register/provide information to staff
People can access mental health/counselling services
People can access medical help/health services
People can access drug rehab/cessation services
People can access support/treatment/information (NFI)
There is legal immunity
Other
Null response
Don't know (not allocated to Q11BDK_97 by fieldworker)
Q13B. Can you describe the changes that you have noticed? MR
Fewer people injecting in public
More people injecting in public
Fewer drug users in the area
More drug users in the area
Fewer people overdosing/dying
More people overdosing/dying
Fewer syringes in public
More syringes in public
Decreased crime/violence/antisocial behaviour
Increased crime/violence/antisocial behaviour
Increased homelessness
More dealers in the area/in public
Increased police presence
Decrease in property value

Table 10: Codeframes for S3, Q7B, Q8, Q11A, Q11B, Q13B, Q14 and Q15

Codeframes
People moving out of/avoiding moving into the area
Businesses closing
Area no longer hospitable
Decreased sense of public safety
General/other positive change
General/other negative change
Other
Did not describe any change
Q14 - Do you have any further comments you would like to make about the Medically Supervised Injecting Room trial? MR
Negative comments
General negative opinion
Normalisation of drug use
MSIR should not be located near school/near children
MSIR should not be located near residential/community areas
MSIR should be located near a hospital
Increase drug-related activity in area (use and dealing)
Safety concerns
Need to ensure increased security/police presence
Not enough consultation with community
Not enough information provided to community
Zero tolerance approach preferred
Other harm minimisation approach preferred (e.g. rehab, education)
Non-endorsement of Ice use in MSIR
MSIR should be in a different location (unspecified)
MSIR should be in a rural/isolated area
MSIR should be in an industrial area
MSIR should be in St Kilda
MSIR should be in the CBD
MSIR has not helped
Only a short term solution
MSIR is politically motivated/driven
Not adequately resourced e.g. opening hours too limited/not enough staff/premises
Drug users not using the MSIR
Bad for business
People moving out of the area
Other negative comment
Affirmative comments
General support for MSIR

Table 10: Codeframes for S3, Q7B, Q8, Q11A, Q11B, Q13B, Q14 and Q15

Codeframes
Saves lives of users
Reduce spread of infectious diseases
Get drug users off the street
Increased safety for community (e.g. reduced syringe waste, anti-social behaviour in public space and crime)
Recommend introduction of multiple MSIRs
Other positive comment
Neutral comments
Require evidence of effectiveness
No comment
Other neutral comment
Q15 - Do you have any further comments you would like to make about drug-related activity in your local area? MR
More security in local area (e.g., police presence, security cameras)
Police being more rigorous/police need to do their job better incl. want police to arrest more dealers, want harsher penalties for dealers/users
Need for rehabilitation services/support services
Concern about MSIR proximity to school/children
Zero tolerance approach preferred
Wants drug use to stop
Need for further government and council intervention (e.g. clean up the area, more community consultation)
Crime rates have increased
Need to reduce crime rates
Legalise marijuana use
Public visibility of drug use/drug deal
Safety concerns for children (own children and general youth)
Safety concerns for self and others
Increase drug-related activity in area (use and dealing)
Decrease in drug-related activity in area (use and dealing)
Unpredictability of drug users
Aggressiveness of users (e.g. aggressiveness, yelling)
Public visibility of drug affected individuals
Drug use is a big/widespread problem
Cannot stop drug use
Difficult to fix the problem
Support for MSIR
Property values decreasing
Bad for business
People moving out of/avoiding moving into the area
Making the area inhospitable

MSIR should be moved
Other comment
No further comment

5.5. Appendix E – Escalation Procedure

There are several separate escalation procedures that were adhered to, in the event any of these situations arise throughout data collection. They are:

- (i) Requests for more information about the survey or complaints about the survey.
- (ii) Requests for information about the Medically Supervised Injecting Room or complaints about the Medically Supervised Injecting Room.
- (iii) Duty of care protocol for distressed respondents (or other household members).
- (iv) Interviewer safety when in housing estate.
- (v) Ineligible respondent would like to participate.
- (vi) Reporting any significant community interactions.

Requests for more information about the survey or complaints about the survey.

If a respondent would like further information about the survey or if they have complaints about the survey, interviewers should recommend the respondent calls the Victorian Government Contact Centre on 1300 366 356 to log their query or complaint.

Requests for information about the Medically Supervised Injecting Room or complaints about the Medically Supervised Injecting Room.

If a respondent requests further information about the Medically Supervised Injecting Room or complains about the Medically Supervised Injecting Room, interviewers should recommend the respondent calls the Victorian Government Contact Centre on 1300 366 356 for more information.

Duty of care protocol for distressed respondents (or other household members).

If a respondent (or other household member present at the time of the interview) becomes distressed at any time during the interview process, the interviewer may rely on the following script.

'I am sorry you are going through a hard time. You could try discussing your concerns with staff at Lifeline or Beyondblue. You can have a confidential chat with a person who is specially trained in supporting people who are going through a tough time. Numbers to call are:

Lifeline. (<https://www.lifeline.org.au/>). Phone: 13 11 14

Beyondblue. (<https://www.beyondblue.org.au/>). Phone: 1300 224 636'

Interviewer safety when in housing estate

Before collecting data in the housing estates, it is important that the Housing Office is notified in advance and that your name and contact details are provided to the Office ahead of time. Before starting the shift in the housing estate, you must sign in at the Housing Office.

If at anytime you feel unsafe – you should contact the security control room on **9428 9725** and they will be able to assist you.

Ineligible respondent wants to participate

In the event a community member is determined ineligible after screening (approached at household doorstep or patched through to Q&A Survey Hotline), but becomes disgruntled because they really wish to participate - interviewers should recommend the respondent calls the Victorian Government Contact Centre on 1300 366 356 for more information.

Reporting any significant community interactions

Please make a record of any significant community interactions in the interviewer portal. These should be fed back to Colmar Brunton on a regular basis.

5.6. Appendix F – Methods to Ensure Data Quality

Project-based quality assurance

CBSR's philosophy is to work as a team with our clients. An important element of such a relationship is to seek input and feedback from our clients throughout a project. This enables any potential issues to be dealt with collaboratively and early on, preventing them from becoming major problems. To supplement this process and enable formal tracking of their views, clients are sent a feedback form after the completion of each project, in which to record their satisfaction with the implementation and outcomes of the project and the research consultants who worked with them on it. These forms are monitored, and targets (such as overall satisfaction with the project) are set at both an individual and office level.

Our research executives are members of the Australian/New Zealand Market Research Society and are signatories to the Code of Ethics of our industry. Moreover, Colmar Brunton is a founding member of the Association of Market and Social Research Organisations (AMSRO). Colmar Brunton endorses and fully supports AMSRO aims.

Privacy issues and data security

We are required to work in accordance with the ESOMAR International Code of Conduct for Market Research, the Australian Market & Social Research Privacy Principles (which subsume the National Privacy Principles) and the AMSRS Code of Professional Behaviour, to which our researchers are signatories.

At all times, we respect the confidentiality of our informants and our clients. We therefore guarantee this confidentiality according to our industry standards and the Department's privacy legislation. In particular, confidentiality provisions apply to the supply of unit record data.

In addition, we accept that CBSR, if commissioned, will be bound by Public Service regulations with respect to confidentiality. We recognise that all information gathered in relation to the project is the property of the Department. We recognise that we are not at liberty to disclose any related information to any other party.

Quality assurance accreditations

Colmar Brunton puts a real and applied focus on quality.

- ▶ We have a QMS system in place and have ISO 20252 accreditation.
- ▶ We abide by the AMSRS Code of Professional Behaviour and Privacy Principles; and
- ▶ We have created a position in our company dedicated to keeping up to date with best practice in research and providing internal systems that facilitate quality management.

The current status of our ISO 20252 accreditation process is in the table below.

Office	Audit Status
Melbourne	Passed Audit March 2019

5.7. Appendix G - Quality Assurance

Colmar Brunton is committed to helping its clients achieve and sustain market success by providing superior market research and strategic direction.

A critical foundation of our commitment to our clients is the implementation of Quality Assurance in all relevant areas of its operations. We have implemented and achieved certification for our **Quality Management System AS-ISO 20252:2012** for all areas of our operations.



Colmar Brunton also operates under the Australian Market & Social Research Society (AMSRS) Professional Code of Behaviour and the Market & Social Research Privacy Principles administered by the Association of Market & Social Research (AMSRO) Secretariat.

In accordance with our Quality Management System (QMS) this proposal has been reviewed and approved by:

NAME David Spicer
ROLE Research Director
Colmar Brunton

DATE 5th December 2019
Document version 1.0

All methodologies and findings outlined in this proposal are provided solely for use by the client.
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In accordance with Article 15 of the ICC/ESOMAR International Code of Marketing Research, this document remains the property of Colmar Brunton and unless commissioned, its contents shall not be communicated from one Researcher to another Researcher.

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