HIV/AIDS Survey of Drug Treatment Services in Perth, Western Australia, April 1988

by

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&

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1. Introduction

During the course of Stefan Ronn's student placement at William Street Clinic (WAS), the Alcohol and Drug Authority (ADA) outpatient facility in early 1988 he undertook a survey of the HIV/AIDS policies of representatives of drug programs in Perth which were either non-government agencies or were closely involved with the non-government sector.

Stefan, who had come to Perth for his placement under a foreign placement scheme organised by his home (Swedish) university, devised an interview format and conducted structured interviews with five agencies.

The representatives of the agencies who were interviewed were Greg Moore the Manager of Jesus People Inc (renamed Perth City Mission), Alison Salmon the Director of Palmerston Centre, Rupert Gerritsen a street worker from Perth Inner City Youth Service (renamed as Step One), Dace Tomsons a coordinator from the Central Drug Unit and Geoff Lister a counsellor from Cyrenian House.

The interviews were transcribed and edited, with the intention of undertaking an analysis and producing a report of the findings. However, Stefan did not have sufficient time available to undertake analysis of the information collected through his interviews.

The transcripts of Stefan's interviews have been collated and published in this exploratory study as they may be of use to future researchers, as they represent a snapshot of the state of knowledge and understanding of HIV/AIDS by drug treatment agencies in early 1988 in Western Australia (WA). It is to be remembered that at this time there had just started to be a greater awareness by agencies and counsellors that HIV/AIDS posed an enormous challenge to their clientele and their treatment policies.

The information derived from these surveys enables us to consider how these agencies understood their need to carefully balance their dominant treatment objective of abstinence through detoxification, structured counselling and other rehabilitative strategies, against the risks faced by their clientele when these objectives were not achieved.

HIV/AIDS has unquestionably been and will continue to be an enormous challenge to all drug treatment programs, as it is arguable that the greatest risk to the injecting drug users is posed not from the drugs that may be used, but from the consequences from non-sterile injection practices.

In the words of one of the respondents: *"I think the staff will have to, whether they like it or not, take on a more active role, like maybe showing people how to clean needles and things like that."*

Greg Swensen
Coordinator, WA Drug Data Collection Unit

26 January 1993

2. Survey of Jesus People Inc.

Interviewer: Stefan Ronn
Respondent: Greg More
Date of Interview: 13 April 1988

2.1 Question 1

No. It probably should have an effect but the reality is that we do not have a policy which pertains to AIDS and AIDS management, and so accordingly it as a new entity has not modified the way we care for our drug users.

2.2 Question 2

I can get more precise figures for that, rather than trying to guess, as we do keep some statistics. Identifying statistics in this area is difficult, but we do try and I have got formal statistics going back for many months, which can be dragged out. Come back to that.

2.3 Question 3

No formal policy at present, such a policy is highly desirable. Couple of reasons for that, our organisation is largely struggling to cope with the problems that it meets, in the sense of numbers of staff available, ie basic presentation of people, assessment, and identification of problems, etc.

Resources unavailable at this point to address the AIDS issue in terms of policy and to do something about it. Another factor is that we do not have our own medical services available and we have no formal relationship with any medical service to cater for this area. We know such services are available, but we do not have a good working relationship with them and that hinders anything we want to do in this area and it would just be an enormous demand on our resources at the moment.

(b) and (c) as above.

2.4 Question 4

No. I have personally had some personal training as my background is in medicine. I am actually a registered medical practitioner and I have kept myself reasonably up to date on AIDS, but no other the staff have had specific training, either the training we have given or training that they have gone along to receive from some other agency.

2.5 Question 5

No.
We do receive information about AIDS which is posted out to us, from a variety of sources and information in brochure form certainly are around, but left up to the staff to read them if they choose, no clear directive on my part to say that they must read it. Brochures put out by the AIDS Council, information from the ADA Educational Unit - we are on their mailing list.

2.6 Question 6

We have made no attempt to formally obtain AIDS information.

2.7 Question 7

Firstly we do not have a formal policy on AIDS and that comes into that category, and secondly in this unit here at the Bridge most unlikely we would in fact know if somebody had a positive

result for AIDS screening. It does not really form part of our assessment procedure. Our assessment here is fairly rapid and we primarily provide emergency accommodation and make a fairly rapid assessment of an individual's needs and refer them to an appropriate agency. We make no specific enquiries about somebody's AIDS status, certainly we do no medical screening on them.

2.8 Question 8

We do not do any screening, we have no medical facilities to help us. Nothing in our organisation, nor do we send people for AIDS screening.

(b) No, but clearly desirable, and acknowledge that, but do not have the resources to undertake this. We would need more staff. Do not have the luxury that the Government units have ample staff, you name it they have got it in terms of staff and equipment, they have got this real luxury that we do not have.

If we had extra pairs of hands and competently trained pairs of hands then we could attend to this as a separate issue, at least from the point of view of implementing a formal policy. Even if in the initial instance we had to make use of outside medical services. The ideal situation would be for us to have our own medical services and when the time comes for that to be then yes that will be a major part of any medical services that we have.

In terms of (c) yes, personally would support such a policy, at least the concept of it. I recognise the need for that. Personal feeling is that I would support a policy of that and it would be my recommendation to the JPI organisation as a whole that the JPI organisation should support a policy, I would endorse that.

2.9 Question 9

Very, very indirect information and it really amounts to the educational posters that are pinned up around the place, about the dangers of AIDS. With the number of staff we have it takes our full time to address the basic problems at hand, housing people and sorting out their basic needs.

We do not have time left over. Interestingly enough I guess that we virtually never receive any enquiry from intravenous drug users about AIDS. I have not known of any client here to say to us spontaneously I am worried about AIDS, what can you tell me about it, what should I know, etc. I have not known of a single question about that area to be put forward.

Knowledge about AIDS? Can only guess that I suspect that it falls into the same category. Same basic reason that people do not spontaneously ask about the dangers of the habit they are undertaking whether it is intravenous drug usage or alcohol abuse.

We do not get the enquiries from people about the risk of what they are doing and I guess that is because at this point in time when they are here as far as they are concerned they have a list of the advantages of drug use against the disadvantages.

Their personal list of the advantages of drug use heavily outweigh the disadvantages and they are not necessarily at this point in time interested in bringing about personal change and so it really amounts to having people for whom it is a waste of time saying to do not use IV drugs, the cops will catch you, you will catch AIDS, whatever.

It is falling on deaf ears because it is not a significant deterrent in itself, they are not particularly interested enough to come and ask. I am not saying there is not room for an educational program I am just commenting on what people do not do here.

2.10 Question 10

There would be some advantages to individual clients obviously as far as their own personal health is concerned, but I think that that is not as important as the advantage to the rest of the clients we care for because our clients either hear or in some other parts of JPI are living in community living. Although we have a residential policy of non-drug use we know that the kids still use.

Clearly I would feel that the main advantage out of this would come from protecting other residents who may not be AIDS infected but who may be as a consequence of their residential stay with us. If we have got somebody in our midst who is a transmitter of AIDS and sharing equipment etc then I think that is a major service we could do for some people to help ensure that that does not happen to them and the other advantages, of course, that extend to general community health.

If everybody has a policy on AIDS that they are actually able to implement then clearly it becomes of major importance to the community at large. The major advantage would not be so much to individuals but to others in a public health consideration.

The disadvantages? There would only be disadvantages if we did not have the facilities to implement all of this, if we had the staff and the facilities then it is not a disadvantage. It would be a disadvantage at the moment because it would be a major drain on already overworked staff; we really could not cope. That would be a major disadvantage as we are at the moment.

2.11 Question 11

The formal sources have been the AIDS Council and information received from the Education Unit of the ADA.

2.12 Question 12

I guess as far as we use it I would have to say yes, the reality is that because we do not take a great use of it would not be correct to say we are dissatisfied.

2.13 Question 13

I guess this would be two-fold, what we would like to have are the medical services on tap, first hand medical services to provide a compulsory screening. I would like to have a policy that it was compulsory for all residents to undergo screening and that we had the medical services available to do this. Secondly, I would like to have staff which forced as it were a separate educational unit, and that this unit could fit into the life-skills program that we offer our clients.

2.14 Question 14

We would certainly like our own resources, there is no question about that. The outside resources are there, but in this point in time it really means horrendous logistic problems in our using those services and that is why we do not, if we had our own internal services we would use it.

2.15 Question 15

That is clearly something we have not thought about. Nobody within the JPI network has sat down and tried to answer such a question, try and predict for the future. I guess that is just in keeping with the fact that we do not have a formal policy on AIDS etc.

I can only guess from my own knowledge of the AIDS problem and that if in fact it comes to be the major community health problem that people are predicting and quite reasonably so, and reaches those proportions then I would see that it would be forced upon us to do something

about it. I would see it being forced upon the Government to give us the services that we want to provide community health measures that would be necessary.

Whilst at this point in time it is no more than a threat as it were, it is there, and has the potential of being disastrous. In terms of the absolute problem. it is not very large, as it were, and so going to government sources in this matter would largely fall on deaf ears. It will need to get to the stage where politicians are in danger of losing votes over the issue.

2.16 Question 16

I do not know if I could give you an innovative approach, I do not know that I could suggest anything that is not in existence, say for example the Central Drug Unit, in terms of compulsory medical screening, education, etc, fairly well recognised approach.

2.17 Question 17

Maybe jointly answer 16 and 17 - this clearly has some ethical barriers perhaps to bringing it to be but I would surmise that if a person was identified as AIDS positive then therefore a potential transmitter of the entity, I would imagine that if that person were to be publicly identified as such that it may well have a significant effect on other people ceasing to share syringes, have sexual relations with them.

That is ethically a major consideration. Do you publicly identify somebody as being a carrier of AIDS? Whilst the existing situation is really that most of the kids have got some vague idea that there is a risk out there of AIDS they do not necessarily know terribly much about it. They know there is a risk of AIDS in sharing syringes with them.

It becomes quite a different situation when somebody is positively identified as being a transmitter of that disease. If we were somehow able to get around the ethical considerations of identifying carriers, and in fact identify them as such I reckon that certainly in terms of what would happen in our residential situation it would be a major step forward.

In terms of that leading onto specific priorities I certainly believe that we should have compulsory medical screening on all our clients. I know it is done, eg in the Central Drug Unit and I endorse that policy and I would like to see it implemented here. I think that it is absolutely essential that we do that. Historically this is the only way that communicable diseases have been eradicated in the past mass major public screening program to identify people, tuberculosis, etc.

2.18 Question 18

I have only been in the unit for seven weeks, which is not a long time. To my knowledge we have not identified one AIDS antibody client. That does not mean they have not been here, I am just saying we have not identified them because of some of the things we have already talked about.

People are here for a brief time; we do not make specific enquiries about AIDS because of our lack of staff, and we do not have medical facilities, etc. We really have no idea of how many AIDS antibody people we have cared far.

3. Survey of Palmerston Centre

Interviewer: Stefan Ronn
Respondent: Alison Salmon
Date of Interview: 6 April 1988

3.1 Question 1

Only in the sense of raising awareness of the possibility of AIDS being an issue. It has not really changed our way, our treatment, or programs in any way, but additional, particularly if someone is using and it is unrealistic for them to stop, and accept that people will continue to use, then our counsellors will bring up the issue of AIDS and mention the prospect of needle exchanges, which they would not have done before.

3.2 Question 2

In a week I should think about 20 to 30.

3.3 Question 3

We have not got a formal policy, that is something that is a omission that we are aware of. One of our staff members is very active in the field and he has brought it to our attention that as an agency we have no formal policy. I suppose our view is that we accept that people are going to use, people are going to use needles and therefore we take the realistic approach and the best we can do is educate them to the risks in terms of AIDS rather than say do not use, we would say if you have to use then take these precautions. So it is a realistic approach rather than an idealistic one.

We will certainly be looking at an AIDS policy and I personally feel we should have one; and I think we should have a written policy.

3.4 Question 4

Two have attended a course on AIDS and IV drug use, and one has been to a national conference on AIDS and IV drug use; the rest of the staff have not had specific training but we are included in latest program. of workshops, so we hope to get someone in from Health Promotions.

3.5 Question 5

Yes information that comes through, and there is a lot of it, which is disseminated to all the staff.

(b) (a) Mainly printed information.
(b) No.
(c) Attendance at external seminars.

3.6 Question 6

No I do not think so. The only area where there perhaps has not been as much - there is lots of information on what AIDS is and how to take various precautions, there is lots of information on that; counselling people who fear that they might have AIDS there is not so much about, there is not so much in the actual counselling that we are concerned with. There is a lot of factual information but in terms of you have got someone who fears they might have AIDS sitting in front of you, it may be an irrational fear, but it is very real to them; we have had that problem.

That would be the sort of training that we obviously need to keep up to date with the information, which is changing so rapidly, but also in terms of counselling skills and issues, I think that would be important for us.

3.7 Question 7

I think we have only had a couple; very, very few. In terms of our residential program up until recently we have had a policy that the residents will be screened and will not be accepted if they are antibody positive at the moment. In terms of any other client I do not think it would make much difference; we would probably link up with other agencies who were more specialised in that area, but in terms of drug use I do not think it would make much difference. There would be a lot of other issues to talk about, of course, the focus of the sessions would be very different, but we would certainly continue to see them, it would be very important that we do.

(a) Yes, but there is a question mark on our residential but we are reviewing that.
(b) No, not in Perth.
(c) Possibly yes.

3.8 Question 8

(a) Outpatient, no we do not require an AIDS screening test; residents yes.
(b) No, only if it was of concern to them or they felt they were at risk then I would discuss it with them, but not a .attar of policy, we would not say all users should necessarily be tested. It is not a part of our treatment program.
(c) I personally would not. I do not like the word compulsory.

3.9 Question 9

Information from the AIDS Council and Health Promotion. on AIDS, the risk of sharing needles, how to clean, how to sterilise, that sort of thing. Information on safe sex. Information on where to obtain needles, where the needle exchanges are.

3.10 Question 10

If AIDS prevention has a primary goal rather than reduction of use, if someone is struggling to keep straight and really trying and they use once or twice, or whatever, and they come in and tell us, that is not the end of the world - okay, so you slipped up, what were the circumstances, that can you learn from this, how will you cope next time, we use relapses of learning experience; I suppose if the focus was more on AIDS we would not be able to do that. It would just bring an additional dimension into it. I think it might shift the focus slightly of the treatment. The advantages, that we as an agency are in contact with a lot of IV drug users, probably more so than most agencies, most welfare agencies, so we are in a very good position and we should take that responsibility to bring issues about AIDS, raise awareness of AIDS on our clientele, but that is not our primary goal. It is certainly up there, and it has gone higher and higher. I suppose it would not really change much.

3.11 Question 11

Health Department, AIDS Council. There was a course run by the AIDS Council, who put on staff training. Health Promotions would have a certain member of staff who would go around staff training; mainly local sources rather than anything else, and certainly not the media. I am very annoyed with the media, I think that might be the major source of the agency's misinformation about AIDS rather than information.

3.12 Question 12

Yes I think it is good quality, but I do not think it has much effect to be honest. I do not think users care. Of all information I think the information of the media is unhelpful and sensationalist in the main; and irresponsible. I think the information that has been targeted at specific groups is good but I question how much effect it has, I mean it is good in terms of that it looks good, in eyes of professionals it is a good leaflet, but as a user I do not think it makes any difference and I do not quite know. I think one of the big problems of AIDS is that the Gay community seems to

have taken a very responsible role and that they have made efforts and taken it upon themselves to raise an awareness, spread an awareness. The drug using community has yet to do that and I think that until the initiatives can come from within the community it is going to be quite hard.

3.13 Question 13

More staff training, .ore money entirely for staff training, we have not got that and that is one of the reasons why perhaps we have not put as much as we could because we cannot get a roster together, on both the information and on dealing with AIDS in clients.

3.14 Question 14

I think (a) would be of more use to us, I think it would be best to train the staff and you have got that resource rather than have outsiders go in, although there is a place for outsiders in terms of training staff, more training resources for staff would be my preference.

3.15 Question 15

I think it will be an issue that becomes greater profile, more important. I think the staff will have to, whether they like it or not, take on a more active role, like maybe showing people how to clean needles and things like that, they are not doing at the moment; there is a resistance to doing that, but I think that they will have to. I would like to see AIDS education become a part of our residential program there is a resistance to that because they say we are here we are not going to use again, so we need not know about it, but the reality is that we cannot guarantee. I think in terms of our youth program I would like to see issues involved, these are the kids that have not got into IV drug use but lay do so, the reality is that they will and the agency needs to have a much clearer policy that we have at the moment. At the moment it is all a bit messy, it is something that is around but we have not really picked up and I think we need to.

3.16 Question 16

I think what I would like to do is to do more work with the youngsters. I think that would be a really important thing and I think maybe using clients who are positive in groups with the others in some sort of way, to raise awareness, I am not sure, but I think the kids given that we have got a youth counselling service, given that a lot of those kids are out on the streets and shooting up, they are quite vulnerable, and you could also in terms of I think the IV use and safe sex could be a problem, so focus on these.

3.17 Question 17

If we accept that people will use then needles should be more available so that there is less and less reason to share. I believe that there is research going on into retractable needles, things like that, I think that is useful, but it would be difficult to share; I think that the move to or the suggestion that heroin is a prohibited drug now in Australia that to actually make the use of it to IV users would be a radical step forward in this country.

3.18 Question 18

I think we have only had a couple that I know of. Certainly in our residential program, for those screened for our residential program there have not been any, but there has been one here recently and one prior to that. There may well be more if you go back but I do not know. I think we should be recording that, this is an area in which we could do better in.

4. Survey of Perth Inner City Youth Service

Interviewer: Stefan Ronn
Respondent: Rupert Gerritsen
Date of Interview: 20 April 1988

4.1 Question 1

It does, we are quite conscious about it, especially has a lot to do with girls prostituting themselves in the park. They always carry condoms with them, and given a bit of a rave about the dangers and things like that. As for intravenous drug use we have not really said much to them at this point. Primarily I suppose because AIDS is not that common; we have found that there is we think one girl that has AIDS, we have heard rumours of it. It has in a way shown up a deficiency for us as we cannot confirm whether this girl has or not, she is working as a prostitute and so we do not really know. We do not really know how to proceed like we can say to kids and other people around the place do not screw with this girl because she has got AIDS, that might not be true but it could be a major breach of confidentiality, so if she is an AIDS victim and continues it could be extremely dangerous.

4.2 Question 2

We have hundreds of contacts every week, only a small proportion of those would be IV drug users, probably at the maximum 10 I would say. I am sure there are a lot more out there but they do not necessarily hang around the streets or whatever.

4.3 Question 3

(a) No specific policy, the practice is to make workers as informed as possible, there has been a series of talks by experts on AIDS and education - AIDS education people. In practice we would then try to make young people aware of the dangers of indiscriminate sexual contact and also the use of condoms.

(b) 9-12 months.

(c) There is no written policy, purely verbal practice, stuff like that. Speakers were brought in, education people, discussions then took place amongst the staff, and a common strategy was developed, that is the basis of it.

4.4 Question 4

As above.

4.5 Question 5

Usually stuff that comes in like from the AIDS Council, or the Health Department or whatever - brochures, pamphlets.

Guest speakers, someone from the Health Department and the AIDS Council, cannot remember specific names. We have had other offers as well, but it is simply the time as there has really been no point to it, people coming to talk to you about things you do not need to know much more about. The time could be better spent.

4.6 Question 6

Only stuff about clients, stuff that I mentioned about this girl who may or may not have AIDS. I can see that problem is going to crop up again in the future.

4.7 Question 7

The first thing we would do if an individual suspects they have AIDS is to try and encourage them to have a test. We would still maintain contact and work with that person, and obviously take into consideration that special need that they have got. We would probably try to avoid stigmatising them because a lot of them have got enough problems, and if they were stigmatised they would be rejected by everyone else and that would just add to the whole situation.

Referring them to another drug treatment program assumes the people we are dealing with have the drug problem, which they do not necessarily. We would certainly try and refer them to go and have a blood test. Now once they enter that sort of phase, and, of course, if they have a blood test and turn up positive presumably the Health Department processes would carry them along. If, as would quite likely happen, they have the test, get the results back, and refuse or spin out because of that sort of knowledge, and may not want to go and have treatment. Then we would probably intervene, talk to them and convince them that treatment is their best option.

4.8 Question 8

(a) We are not an agency based thing that can operate in that sort of way.

(b) No, not at the moment.

(c) I think it is highly desirable that intravenous drug users will be having AIDS tests. To have a policy to have a compulsory AIDS test would virtually be impossible. Who determines who is an intravenous drug user? There are lots of young people I know out there who are using needles on an irregular basis, you know a bit of this and a bit of that, and stuff like that. I can certainly see in a treatment facility, such as the William Street Clinic, that might be a viable thing to do, but with the casual people who are not linked to any agency, or any treatment, or anything like that. Who would then determine that they are intravenous drug users and dob them into the police? That is very much against our role to be acting as spies, we try and build people's trust not destroy it.

4.9 Question 9

Primarily along the lines of being more discriminate about sexual partners, and the use of condoms, and in actual fact we will supply condoms.

4.10 Question 10

To answer that question I need to have a bit more specific information about what preventative strategies you are talking about. If you talk about, in terms of, giving information to young people saying do not have indiscriminate sex, etc and if you mean it in terms of like use condoms, that is already a major thrust of dealing with young people. Especially the ones that we have identified as being high risk, that is part of our work virtually, so it is not a disadvantage at all. If I understand AIDS prevention to mean those sorts of things like trying to stop it happening before it happens then it is already a major thrust and that presents no disadvantage to us. We see it as being part and parcel of the work. I am not only having to speak for myself but the street work program as well.

It would probably depend on which of our contacts whether it is the homosexual segment or intravenous drug user segment, I know experience overseas has shown that the intravenous drug users are the most explosively growing. Again, I guess if there is evidence of that happening we would probably tend to target more on intravenous drug users and preventative things, such as using clean needles, and using needles only once and not sharing needles, things like that.

4.11 Question 11

Health Department and the AIDS Council.

4.12 Question 12

Yes.

4.13 Question 13

I think it would be better if other professional workers were working in the AIDS field rather than like trying to lump everything onto us and expecting us to do everything, which is quite often what happens. It would be better if those workers were put into the field in some sort of way. Now one suggestion is to have a thing like an AIDS van in an area where lots of high risk individuals congregate and could be identified. They go into those areas and have their little van there, offer on the spot testing, give out condoms, stuff like that, and information. This would probably be a much more cost effective strategy than trying to use us all the time. We really should be only an adjunct to those services not really providing the main services

4.14 Question 14

AIDS prevention is already part of our service, probably the only training we would require would be refresher courses and updating the latest information, The basic training has already taken place.

4.15 Question 15

I think it will obviously be a greater concern. It is a very rare thing now, presumably in five years it will be a bit more common. In that case we will possibly see a greater emphasis in our work on AIDS prevention in dealing with individuals who have got AIDS.

4.16 Question 16

There is the suggestion that I put forward before like targeting high risk groups and actually going to where they are rather than just waiting for them to come. I think obviously the best, to me, the availability of needles needs to be greatly increased, allied with the message do not use other people's needles, etc. That would probably be the only effective, or most effective, thing.

4.17 Question 17

Possibly, especially the ones who are in programs, I think there is possibly a lot of advantage in the message to them not to share needles, and to use their own needles, and stuff like that, on the assumption that if you can drum that into them they will then pass it on. Like when there are new young people coming into that sort of scene, then by their practices will hopefully pass on that information and sort of practice onto the younger people coming. So you establish, because those younger people tend to be a lot less careful and wild and whatever. Whereas the people who like are on the methadone program for a couple of years tend to have stabilised and be a bit more responsible. I think you can sell that message along the lines to the older age groups, that, ie you do not want to make them sort of like feel responsible, you do not want this to happen to young people, you do not want them to go through what you have gone through, or worse. I think they will respond fairly well to that. I think that just the other preventative strategy about using condoms.

4.18 Question 18

One possibly. Say two possibly because there was one in one of the households who had AIDS or developed AIDS subsequently. Now whether he had AIDS at that time or got that subsequently we are not really sure.

5. Survey of Central Drug Unit

Interviewer: Stefan Ronn
Respondent: Dace Tomsons
Date of Interview: 12 April 1988

5.1 Question 1

Yes. It has had a marked affect because most of our clients are intravenous drug users so obviously that has got a lot do with it. New education programs are a very high priority with all the clients, mainly in terms of education. We do not have any particular sort of protection for the workers other than the normal ones that the Health Department recommends. But we do not make a hysterical thing about it, we keep the physical aspect, you know, the infection control, as very low profile, and a very high profile for education and prevention and stuff like that.

5.2 Question 2

Because we are inpatient we have up to 10 people. Over the last six weeks we have had 10 people, 10 inpatients, that is capacity. We have 10 beds and the 10 beds have all been full for the last six weeks.

5.3 Question 3

We follow the ADA policy in terms of infection control and all that sort of stuff and Government control in notifying and those sorts of things. Our only policy is I guess more the very human sort of aspect of it, like we would look at it as the client being the important thing not the staff. It is hard to explain because it is important that we do not make a big deal about it in the Unit, because everyone gets a lot of AIDS information and its considered very important from that aspect. But if somebody has had AIDS, we have had people in here with AIDS, it is not considered a really big deal and it is up to the client themselves if they want to tell the other clients. And we advise the other clients that everyone in the Unit should be treated as a potential AIDS person so they should not participate in any risky behaviour with anybody here. We do not single out somebody with AIDS and say right this person has got AIDS.

The policy is as per the ADA policy, the AIDS policy there and we follow the same one.

(b) Since we opened the Unit.

(c) The ADA one. What have we got written up about it. It is not a policy about like what is AIDS or how we think about AIDS, it is more in terms of infection control stuff.

5.4 Question 4

Yes. In service training, like we have had workshops here about AIDS, we have had people come in from the AIDS Council to talk about it, couple of staff members are actually actively involved in the AIDS Council. They all deliver groups to the clients about AIDS so they all have to be up to date with the AIDS information so they can teach the clients. They all do pre-test counselling with the clients. lots.

5.5 Question 5

(a) Yes l as above.
Yes - all of it.

5.6 Question 6

No, not really. We use Health Promotions, the AIDS Council mainly. Because one of our staff is on the Intravenous Drug Users' Committee and Terry goes to that as well, so we have very good

communication with the AIDS Council and with Health Promotions. They have been quite good, so we have not had any problems .

5.7 Question 7

They are treated pretty much the same as anybody else. Like I said all the clients are sort of more or less told they should treat all other clients as potentials for AIDS. Like any intravenous drug user dealing with anybody, practising safe sex, not sharing, all that sort of stuff, we do not make a big deal of it at all. It is up to the client themselves if they want to tell other people they are infected, that is their business. Obviously everything is treated quite confidentially.

We would retain a person in treatment. We would not refer them to another agency, but we would probably refer them to a specialised agency or they are all referred to the infection control people, and to the AIDS Council for support, and to antibody positive group. When the person is here, we do link them in with other support agencies for AIDS.

5.8 Question 8

Everyone is asked if they will be tested. They have pre-test counselling and they have a choice, but most people do have it. Most people choose to have it, very few people refuse. But they have got a choice. Well everyone should have it, that should be the policy. They should not have AIDS testing unless they know what it means and what is happening to them and they should be free to make the choice. I think William Street does test anyway doesn't it? You are not suppose to do that.

(b) We give them the information that is required. In pre-test counselling they give them the information about the pros and cons of having the test and they can choose for themselves whether they wish to or not. But we do sort of covertly sort of try to encourage them to have a test but it is you know.

(c) No. Because it really is up to the individual, I do not think anything should be compulsory.

5.9 Question 9

I will give you a copy of the actual information they get at the pre-test counselling. With all the information on that about it, so it is everything, it is all about you know safe sex, needle sharing, categories of AIDS, what the test means, what the test does not mean, the whole lot, you know, everything.

5.10 Question 10

It is a high priority for us anyway. I do not know whether it is a principal goal, but it is right there, as one of our aims is to, AIDS prevention is a very high priority for us. The advantages - well I mean you have healthier clients I suppose in the long run. The disadvantages I guess are in terms of the mechanics of it, the time it takes, like with our blood testing and that because the people have to have counselling before we send the blood away, like we take all the bloods at once, but we keep some blood for the HIV testing, and they have to have their pre-test counselling and then the blood has to be put in the package with the questionnaire, and all this stuff. It is mechanical problems more than any other problems.

5.11 Question 11

AIDS Council, our sector, Health Promotions. Our doctor would be number one as she is really right into it.

5.12 Question 12

Yes.

5.13 Question 13

I think we deal with them quite well. I think that we get adequate support for the work we need to do with people in terms of an agency operating with intravenous drug users. I suppose if you want to sort of look beyond that to what the person needs in the community once they have left here that I am not aware of. I know there are AIDS groups, support groups and all the rest. I think the framework is probably there in terms of the person who has actually got AIDS I think there is probably enough opportunities for that person. There just needs to be more of it and maybe better staff and better funding, and things like that. But 1 think more energy has to go into prevention, I think that is where the problems are, not so much for people who already have got AIDS, I think there is lots of support for them, but for the younger people, kids who are not in education, that sort of thing. For us I think it is okay.

5.14 Question 14

We do that anyway, we have got qualified outsiders. They probably need more of it. The problem is that we have trouble squeezing it all in. I think probably they do need more training, and they do need constant training, that is the thing with AIDS. I think it is important that every three months or whatever you have another session because it is a very changing area with lots of new things happening all the time. I think that is what we need to put more emphasis on. Not that we have not got the resources to do it is just that we need to do it.

5.15 Question 15

I think it will continue to have a growing effect. In the next five years I can imagine the time when we might have one or two antibody positive people in at any time. I do not think it will be unrealistic to expect that 10% of our clientele will be at least antibody positive, if not more. One of the problems that we are already looking at is that people who are actually quite ill who need a period of stabilisation where we are just about to start with the first client now. She is Category B and getting quite, quite ill, she has got a little baby. Well they are coming in. Not so much, well detox mainly, she will stay on the methadone, we will try to control her pill use a little bit, we will try to build up her weight and build up her health a little bit and just give her a rest really. So I can see that that would be more of a thing we would do, like detox in terms of controlling drug use, but like using a stay here as a period of stabilisation and give people a break and things like that. Yes I can see that the next five years will be a growing effect.

5.16 Question 16

I do not really know, I have not really thought about it. I think that intravenous drug users are a particularly difficult group to educate. If I was given the money I would not put the money into intravenous drug users I would put it into people that are young, heterosexual people, who think that it has got nothing to do with them. I think that most intravenous drug users know there is a risk. Most of them are old enough and bright enough to realise that they have got to do something to change their behaviour and I think that when they start changing their behaviour is when their friends start to die. I think there will be very strong similarities between the intravenous drug using population and the homosexual community. It is not until people around you start dying that you really think yes it could happen to me. It is real ostrich stuff, you know put your head in the sand, pretend it is not happening. I think you can put a lot of time and energy into intravenous drug users. I think that all people that come in here say, ah yes, I know I should not share, I know I have got a fair idea how to sterilise needles. They have the information but choose not to do it. But then again, you turn around and you say how about wearing condoms, they go ah yuck, no. I do not think the sharing needles thing is the problem, I think they know. Well all our clients know. So I would not put time and energy into that area, I would put it into preventative stuff.

5.17 Question 17

Young kids, community as a whole, people that are not at risk of intravenous drug use, people who are just normal heterosexual people, I think that is where the prevention has got to go into. I would not worry about minority groups particularly, I think intravenous drug users will always be a minority and I suppose the risk there is that preventative stuff would be more along the lines like say the guy that you picked up at the club last night how do you know he is not an intravenous drug user. He seems like a really nice guy. Who did he hit up with last night. I mean it would be more on those lines.

5.18 Question 18

Three in two years. One of them actually has not been admitted, he attended here and he will probably be coming in soon. They are all category B, they are not antibody positive people who are actually starting to get sick.

6. Survey of Cyrenian House

Interviewer: Stefan Ronn
Respondent: Geoff Lister
Date of Interview: 30 March 1988

6.1 Question 1

We have a policy statement on AIDS and IV drug users, which simply says they are not precluded from treatment because it is not a contagious disease in the normal domestic setting. This is a residential program, but because it is not a contagious disease like hepatitis would be then we do not have any barrier. What we have done is included AIDS information as part of our group material so we also have increased our coverage of the AIDS issue directly as part of the program. But as far as the clients' acceptance goes it has made no difference. The other thing we do not demand an unnecessary AIDS test, but when there is reason to suspect that person may be affected by AIDS then we will follow it up medically. But we are really cautious about making the results known, and the client has considerable control over the results of an AIDS test, otherwise you tend to get a negative stigma often unnecessarily. They are not forced to have an AIDS test but if the person seems to have a medical condition that does not put down to any of the normal symptoms, then if we suspect there could be an AIDS case then we would encourage. We would have a talk to them and encourage a medical assessment for AIDS. What happens to the information? We need to know of course, but the client has a considerable amount of control over the information. They can of course refuse to take the test.

6.2 Question 2

Residential, up to 10, averaging between six and 10, depending on how many are actually in the residence at the time. Outpatients, between 10 and 20. In the past two weeks we have had 20 different outpatient clients coming through in a single week, so there are two aspects. We also have a halfway house which takes about eight clients and it usually about three-quarters full, so you could say there are about six clients there. All of those people would be in weekly direct, physical contact with out program.

6.3 Question 3

(a) As I said, no barrier to treatment, it is not contagious, basically it is an information approach. Informing clients, client choice, client confidentiality is very strong, but no barrier to treatment.

(b) About 16 months we have had that policy on AIDS. In the first six months that AIDS became a bit of a scare the policy was adopted.

(c) Policy is in a written statement in our rules and guidelines. So it is like a small section in our statement of rules and client acceptance. I can provide you with a written copy of that.

6.4 Question 4

Yes. Counsellors, particularly our senior counsellor, has served on the AIDS Council, gone to seminars and workshops etc on AIDS, and receives constantly the latest research literature from the USA on AIDS. We are on the mailing list for the latest research literature. In fact we are sending it onto the ADA Library now, who are happy to receive this literature, so we are forwarding it after looking at it ourselves, to the ADA Library and a couple of our staff are also members of the AIDS Council.

6.5 Question 5

Yes, we get the bulletins and distribute them. Put up posters and so on.

(b) (a) Yes.
(b) Yes.
(c) Not sure about (c) it would be safer to say no.
(d) Yes.

6.6 Question 6

None at all. One of our staff did a tour of about six or eight states of the US and made a lot of contacts, brought back a comprehensive library and a comprehensive list of contacts and we found it not difficult at all to get information. So we have regular information from the US - that was a Rotary Club, a tour sponsored by ourselves and Rotary, in terms of drug prevention, focussing considerably on AIDS. So the person went to the Centre for Diseases Control, all the big centres in the US that deal with AIDS, brought back the report, brought back information from those centres, looked at the way they deal with the AIDS issue. That was in February last year. So there is the report that the staff member wrote up to describe all the places that she went to.

6.7 Question 7

(a) Yes.
(b) No.
(c) No.

We would, instead of (c), we would ensure that they have accurate information about how to, the medical implications of their condition, the things they need to do to monitor their condition, and the things they need to do - safe sex and healthy practices like diet, exercise, vitamins, minerals. So the person would not be barred from treatment. We would of course take care that if the person was involved in an injury on the premises we would know to be careful of blood contamination.

6.8 Question 8

(a) No.

(b) No.

(c) No. Basically what we do there is, every client has a thorough medical within 48 hours of entry and any conditions that are detected in that, or symptomatology, is then diagnosed. If there are concerns that AIDS could be a problem then we would follow that up with those clients. Otherwise we are blanket testing everyone, and it is probably a bit expensive, and all it really does mean too is that probably a lot of people would be put off by being labelled or perhaps grouped as part of that.

6.9 Question 9

We have groups on AIDS as part of our health area, so we talk about safe sex, how you can get AIDS and how you cannot get AIDS, diet, health monitoring and what to do about testing. So that yes, if you are concerned get a test, but be sure that if you get a test that it is adequately analysed and discussed through, because there tends to be a difficulty of people having a freak out response to getting test information. And after all, just because your test comes up negative does not mean you will not have AIDS next month, so banking everything on the results of a test is a bit of a false sense of security or doom. So you can either be falsely secure about it or pessimistic about it. So regardless of the implications of a test you still need to adopt all those other practices, so those are what we emphasise.

6.10 Question 10

As far as treating the clients we have now it might make us more publicly acceptable, it might make us eligible for some funds from additional resources that we are currently not eligible for. Except that most of the AIDS funds seem to be directed through established research projects. We put up a proposal to do a very low cost research here last year that would cost about $8,000, and we were willing to interview something like 200 intravenous drug users, about sex practices, attitudes to AIDS, knowledge of AIDS, how they might have changed their lifestyle in response to the AIDS concerns, and we got know where with it. But possibly $100,000 projects were undertaken because they were associated with universities. So the research industry is rather locked up in that fashion. So in that sense we have lost interest in it because we see that big money is spent on stuff and we are offering to do it right at street level and we did not even get a look in, so we think, well, you know, they are not interested in that kind of involvement.

Certainly I think the public profile is in terms of taking a protection of the public. It can help to offset the negative attitude that a lot of the public would have towards drug clients, they probably see that they do not deserve much resources or treatment, they basically need to disappear from the face of the other. So it would not affect what we already do in our residential program, it would only mean that we would have an outreach recognition value. But what it would mean is that we would have to take away treatment staff to provide that role because we do not have these spare resources. It would have to be a funded thing anyway. One that we would like to do but one that we do not have separate funding for.

That is why when we were doing the survey if we were going to do that survey we would have put someone on that role part-time for six months going around doing the interviews and so on and we would have provided the secretarial backup there to make all that possible, and the data analysis. It would not change our existing treatment but only if we got funding it would give us an outreach tool and that might have some public value. Prevention is important and because we are primarily a treatment agency we would like to do more in the area of prevention. So we already have a prisons program where we go to prisons but things like having a direct specific outreach about AIDS would also be desirable because you are seen to be doing something about prevention and not just fixing them up when they already have got the problem. But the problem is we do not have the resources to divert from treatment into that area.

6.11 Question 11

Official AIDS information brochures from authoritative sources like the AIDS Council, but also overseas, American particularly, the latest research bulletins on both medical aspects of AIDS, treatment aspects and prevalence, and of course the prognosis of AIDS sufferers in response to various treatments. And that is a regular supply of bulletins we get.

6.12 Question 12

Yes. We ignore media information and concentrate on the authoritative sources.

6.13 Question 13

I would say we would like to probably have some spare staff time to actually work in a preventative way, in an educational way, independent of our actual need to provide residential treatment services.

6.14 Question 14

I would say, although they expressed as either/or, I would say yes to both, because in all aspects we continually do that. We continually send our staff to the Community Services Training College (CSTC) for counselling skills for example in a counselling area. We also send staff for other training workshops, and we also invite in people like from Family Planning Association

and so on, people from the area of health. In every area of our program we have a continual schedule of both outside visits that we send our staff to and also have people come in to give little presentations. So we would include AIDS and deal with in the same way. We would do exactly the same policy with AIDS as we do for other things.

6.15 Question 15

I guess our general expectation of AIDS will become still an increasing problem. We do not expect it to be diminished in the short term. We expect the manifestation of AIDS to become an increasing problem, because it is already carried by a lot of people in whom it could break out as an infection. The main considerations there would be just our existing ongoing knowledge and awareness and caution with the AIDS infected client, sustaining the information, keeping that up, possibly dealing with clients who are terminally ill. So in that respect that would be an increasing concern to us in that we could well have clients whose motivation to get free from drugs might be complicated by the knowledge or suspicion they have that their life span is short. So there is an added concern there about grief counselling.

Instead of trying to get someone off drugs and back to a reasonably constructive lifestyle with many years ahead of them to be fulfilled, we could have an increasing percentage of clients who have got nowhere to go because their life is coming to an end and they may well be aware of that. So the concern there would be an increasing intensity of the same problems we get in terms of motivation, unwell clients, physically unwell, increases the difficulty of staying off drugs because their life span could be short and the problems there of grief counselling as well. So that could be a major impact.

6.16 Question 16

One of the problems that seems to be that with the clientele you have got essentially reluctant clients. They do not come to you until they are in difficulty, legal difficulty, physical difficulty, run out of money for drugs, or whatever, or they have been caught, something like that. Most of them perhaps, the majority, come because they have been coerced by some circumstance or arrest or so on. The problem there is that the people who would be affected or at risk of AIDS as intravenous drug users we would probably certainly we would not be in a position to provide clean syringes or anything like, we cannot be seen to be doing a treatment agency as well as that.

What we would probably do is contribute to information at a public and subculture level in terms of physically presenting information by visits, to such as schools, prisons, places of employment where you have got large numbers of people who would receive someone to come in and talk about a problem and we would be happy to send staff to do that. We would also be willing to get information to the subculture level wherever we could, that would mainly be a matter of probably using the informal network and actually being where those subculture people actually tend to accumulate. We would not look at trying to duplicate supply of existing literature. But if we felt that the literature was not written for the street level client we would consider preparing our own information brochures so that it is addressing the client and not the social worker or medical practitioner, to encourage the acknowledgement and response to the information, write it up for the client themselves, put it in street language so that it services that client. The sort of thing that you can actually leave somewhere and that it will not be off-putting. Different to what you would leave in a doctor's surgery where a lot of literature is probably written for the level that you would put in a doctor's surgery or Department of Community Welfare front office or something like that.

We would be looking at supplying the information to appeal directly to the user. So it would be written at a personal level to the user, so its colouring would be different, the wording would be different, probably the graphical pictorial information would be different and probably not comprehensive booklets, but short cards and so on that warn people about some of the things, make positive suggestions and supply very essential contact phone numbers or addresses to go

to for further advice. A bit like they do in parts of New York. When a client comes in off the street to actually get a card and on that card is all the emergency numbers and basic information about where they can get what information. So things like ambulance all that kind of thing relating to medical treatment, all that is on a little card, so that even if the person does not use it, if they are found in the street, there is information there that someone can take action on.

So there is that directed to the client not to the practitioners, because I believe they already have a lot of information so we would be going more direct to the client, as well as servicing the public who are potential AIDS clients, schools, workplaces. The approach there incidentally would be not just to deliver information of a technical kind but to deliver attitudinal try and change attitude towards AIDS and AIDS sufferers, to see themselves as being part of the problem too by the very fact that we are part of the same society. Attitude changes are lot harder than providing technical information. You could argue that in many areas of human problems we do not need to know more we just need to do better what we already know.

6.17 Question 17

I think some of them have already been taken like needle exchange, testing services are available, public advertisements are available as far as safe sex. I think more directed to the clients, more directed to the people who are possibly carrying or could most easily carry the virus. So we are not talking about the public here now we are talking about those who are already intravenous drug users. I suspect that the video material we have for example as well as the brochure material we have is still probably not directed at the established intravenous drug user. I think it is still directed more at the public campaign or at the supplying information to the practitioners. It is a reluctant client group, you have to appeal, get the message very much in their own terminology and in their own style. If you do not it will tend to be discounted immediately, they will not even listen to it.

6.18 Question 18

I will give you an estimate on that. The estimate would be, these would be known cases who have been tested, those who have actually been tested and have come up positive, I am aware of about four in the last 18 months.

7. Appendix: Interview schedule

Name and Address of Agency:
Date of Interview:
Respondent:

1. Has AIDS had any effect on the way your agency operates and treats IV drug users?

2. How many IV drug users are usually in contact/contact with your agency in a week?

3. (a) What is your agency's policy on AIDS?
(b) How long have you had an AIDS policy?
(c) What form is the policy in? (Ask for a copy if available).

4. Have the staff/workers of your agency had specific training/education about AIDS?

5. (a) Does your agency regularly disseminate information to staff/workers about AIDS?

(b) If yes, has the information been in the form of:

(a) medical/health information and talks?
(b) printed AIDS brochures, pamphlets, etc.
(c) audio visual .material?
(d) attendance at training seminars?

6. Have you had difficulties in obtaining AIDS information for use by your agency?

7. What is your agency's preferred management approach when dealing with persons attending .ho are known antibody infected?

a) Would you retain such persons in the treatment program. in the same way as any other person?
b) Refer them to another drug treatment program?
c) Refer them to a specialised AIDS facility?

8. (a) Does your agency routinely require AIDS screening tests of all persons who attend for treatment?
(b) Do you actively encourage all IV drug users to have AIDS testing?
(c) Would you support a policy of compulsory AIDS testing of all IV drug users?

9. What kind of advice/advice does your agency give to clientele about reducing/.minimising AIDS?

10. If your agency was to emphasise AIDS prevention as a principal goal of treatment, what advantages and disadvantages would this mean for your agency?

11. What have been the .major sources of your agency's information about AIDS?

12. Have you been satisfied with the quality and relevance of available information?

13. What kind of resources/services would you ideally like to have for your agency to adequately deal with AIDS and intravenous drug use?

14. If AIDS prevention was to become a regular part of your services, would you:

(a) like more training and resources for your staff to better carry out this activity, or
(b) have qualified outsiders attend the agency for this express purpose?

15. What are your predictions for the effect of AIDS on your agency's services aver the next five years?

16. If given necessary resources, what would be an innovative approach your agency could take now towards reducing the spread of AIDS amongst IV drug users?

17. Are there any specific priorities you believe require attention to reduce the spread of AIDS among IV drug users?

18. How .any AIDS antibody positive people have attended your agency so far?